

The sensational body

Tony Buckley illustrates a somatic approach making important distinctions between traumatic and developmental injury

A sense of wonder fills me when I consider just how marvellous the body is as a container, communicator, healer and living document of life's injuries.

Most daily movements and actions, such as sitting, walking, talking, driving etc, are executed at will; but in moments of danger, voluntary control is taken over (hijacked) in the interest of faster-acting survival responses. Threat can be experienced as bodily sensation.

Sensorimotor psychotherapy is a phase-oriented treatment model¹ which makes sensation, impulse and movement patterns the primary focus for attention and treatment interventions, developing somatic resources for stabilisation, processing traumatic memory and mastering somatic integration.

In this article I aim to highlight general sensation, movement patterns and important distinctions between voluntary (top down) impulse and movement patterns, versus involuntary (bottom-up) patterns mediated by the autonomic nervous system (ANS) as part of the emergency stress response system. Trauma and developmental issues will of course overlap, where both types of experience combine on the bodily level. Trauma can be problematic when re-triggered years later. Body awareness is invaluable to those of us in a workplace setting, where organisational constraints impinge, and focusing on a somatic level will bring about integration and settling of symptoms throughout the entire system.

Practitioners should have a well-developed sense of tracking through observation, picking up cues such as shifting posture, change in tone of voice, eye movements, gestures and mannerisms. I hope to inspire further confidence and trust in this somatic detail, encouraging you, in collaboration with the client, towards more precise intervention through faithful tracking of the body's wisdom 'organacity'² in the direction of resolution and integration.

Tracking

Movement, posture, autonomic arousal responses and habituated expression reflect core beliefs and emotion which may be themes for the client. The body will usually demonstrate corresponding

physical patterns such as collapsed posture to a stream of negative cognitions or self-doubting emotion such as guilt and shame. Practitioners can observe lack of movement, patterns of stillness, staring, numbing, freezing, lack of energy or general animation in life. Familiar observations include hands making a fist, kicking leg, a look of shock. The more subtle cues include a narrowing of the eyes, a light flushing or blanching of the face, dilation of the pupils, flaring of the nostrils, small changes to breath and sighing. 'Small gestures and changes in breathing are at times more significant than the family tree.'³

Other observations include muscular tensions, gross motor movement, micro movement, trembling, shaking, tremors, spinal movement and a range of signs indicative of autonomic nervous system activation. The client is encouraged to report on internal experience particularly the less visible signs, including heart rate, temperature, tension, (butterflies in tummy) and preparatory movement impulses.

Mindfulness

It's not that this vast array of phenomenological data requires analysis or interpretation. If therapist and client simply hold awareness, with mindful attention and spontaneous cognitions, emotions and meaning are likely to emerge. This enables the client to integrate physical aspects along with emotional and cognitive experience. Mindful internal awareness disrupts autonomic dysregulation, bringing symptoms under conscious control. Mindfulness invites insight into how we habitually organise experience, which is essential if clients are to be able to make combined, meaningful change on cognitive, emotional and sensory levels. 'Mindful awareness is a form of experience which promotes neural plasticity.'⁴

Mindfulness is key for traumatised clients to gain precious distance from the debilitating symptoms that accompany traumatic reminders, further increasing affect tolerance and stabilisation towards recovery.

Case study example

Marcus, a train operator, felt very disturbed by the symptoms he was having one month after witnessing

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a train suicide death. Each time he was reminded, he would break out in a light sweat, heart racing, stomach knotted with overpowering feelings of dread. Following just two sessions of counselling, consisting of some basic, psycho-education and grounding exercises with directed mindful observation of his body, the symptoms subsided dramatically. Marcus ended the treatment after the third session, satisfied to know the reactions were 'normal' and he could have control over these.

Traumatic injury

'An overwhelming experience to mind and body where the individual experiences (subjectively) a threat to life, bodily integrity, or sanity.'⁵

This definition of psychological trauma helps us to focus in particular on why the autonomic nervous system generates a repertoire of responses for survival, both active and passive. These impulses, movements and behaviours are mediated by the HPA (hypothalamo-pituitary-adrenocortical axis)⁶, which releases a cascade of chemical/hormonal messengers to activate either sympathetic, active defence, (fight, flight, freeze) or parasympathetic, passive defence (flop, numbness, submission, feigned death) behaviours.

This emergency response system also includes

activation of a range of behaviours (screaming, shouting, talking your way out of trouble) mediated by the vagus nerve 'social engagement system'¹. Fight, impulse, tension manifests in the fists, arms, shoulders and jaw, flight in leg movements (to run) and freeze/submission impulse from the torso. Darting eyes, scanning and rotation of head movement are part of the orienting response away from or towards danger.

Case study example

In therapy, Karla turns her head and stops, eyes blazing and fixed, staring in the direction of the position of the knife blade as she remembers the mugger holding it.

Bottom-up hijacking

These responses are subconsciously activated at great speed while cortical function (thinking) is inhibited. This explains the common response of individuals who go blank when retriggered and report the feeling of 'speechless with terror'.

Trauma symptoms return unbidden (hijacking as body sensation) with hair trigger sensitivity, often in response to benign stimulus. Traumatic reactions can sometimes display re-enactment behaviours as renewed attempts to gain mastery over the original

situation. Janet holds that these actions are the residual movements of truncated defences; the actions which may have needed to happen but were inhibited in favour of some other more adaptive survival action: '[Traumatised] patients ... are [repeatedly] continuing the action, or rather the attempt at action, which began when the thing happened, and they exhaust themselves in these everlasting recommencements'⁷.

At a time of intense danger we appear to have minimal influence over the ANS response. We may think later, 'I should have fought back' but the autonomic response (often more wisely) chooses a freeze or submit response instead. The impulse to fight remains encoded in the body as a truncated defence. Notice tensions in the client's jaw or the impulse of the hand to make a fist, movements seeking resolution of an active defence.

The essence of the sensorimotor approach is in supporting the development of this action potential through mindful tracking to completion. Whichever defence is utilised at the time of trauma, whether active or passive, the opposite action potential remains inherent in the system. In some survival situations, people will move through the repertoire of defences.

Case study example

Lucy is accosted at night and at first struggles (fight) with her attacker before pushing him back. Panicked, she tries to talk to him, saying: 'What do you think you are doing?' (social engagement). He ignores this and lunges aggressively towards her. She runs fast (flight) but he catches up and overpowers her, dragging her to the ground. She struggles momentarily (fight) but quickly senses the futility and ceases all movement (submission).

The submit response proved most adaptive for Lucy but the flight and freeze remain as truncated responses in her system. 'Each component of the ordinary response to danger, having lost its utility tends to persist in an altered state.'⁸

A post-trauma complication for Lucy is that she finds herself defaulting to a submit position in subsequent situations, which has now become an implicit memory state. For bodily integration Lucy needs to reactivate and complete the truncated responses to restore full utility of the ANS defensive repertoire.

Procedural learning and implicit memory

Procedural learning is part of the innate functional learning system. Swimming, driving, walking, playing the piano are all procedurally learned then

become implicit memories. This efficient system allows us to non-consciously draw on a vast array of action systems for life. Unfortunately, survival responses also get encoded as implicit (body) memory which is why traumatised clients get repeatedly triggered. Mindful reflection, and experimentation with sensation, impulse and movements of the habitual defence, allows for the opportunity to exercise cortical (top down) control to regulate emotion, sensation and embody new outcomes.

Interactive versus auto regulation

Clients benefit from your compassion and attunement in much the same way as infants are soothed by an attentive mother. 'Attachment schemas are a category of implicit social memory that reflects our early experience with caretakers.'⁹

In trauma, the client's capacity for self-soothing is disrupted by the feeling of being unsafe and unable to defend oneself. Therapist support provides interactive regulation which entails high support until the client regains capacity to auto regulate. The client learns to self-soothe with mindful self observation, which increases capacity for affect tolerance, thus restoring a sense of safety.

Big T versus small T

The range of trauma (T) we treat differs in intensity, type and duration and is influenced by people's individual resilience levels and resources. Trauma is also influenced by other variables, such as workplace culture and the level of support available in the immediate aftermath.

One useful distinction, to separate intensity and impact of events, is to consider Big T to represent exposure to events representing threat to existence, real or perceived. Events such as violent assault, abuse and neglect illicit our animal defence survival responses. Small T represents non life-threatening events, such as inadequate parenting and attachment issues and emotional neglect. These affect healthy development, core beliefs and self esteem for the individual, and will have corresponding sensation, movement and behavioural patterns.

Case study example

Lorraine presented for counselling as very timid, nervous and extremely apologetic. When the counsellor said there was no need to apologise, Lorraine replied, 'I am sorry'. Lorraine's presenting issue is tearfully described as 'I am getting on the nerves of everyone in my office which causes them to get really annoyed with me'. She sits on the edge of the chair, hunched forward, mostly looking down with furtive glances and hands wringing together in placatory, pleading or prayerful gestures.

Subsequent counselling reveals a developmental story of early teen years spent waiting hand and foot on a bedridden mother who would treat Lorraine with continuous verbal cruelty.

Developmental wounding

We are possessors of a 'social brain'⁹ and, as such, there is little doubt that childhood environment significantly shapes neural networks of developing brain/mind and the manner in which we inhabit and animate our body for living.

Consider how significant development traits have become embodied in your own personality and way of being in the world. Our sensation, movement and behavioural patterns slowly evolve to become habituated in response to the early environment. Although grief and pain are associated with development issues, they are not necessarily experienced as life threatening.

Some clients show splits, adult body/child face, vice versa, others arrested development in their growth patterns. Please refer to Sapolsky¹⁰ for 'stress-induced dwarfism'.

Attachment strategies

Consider the securely attached infant: although preferring soothing from an attuned caregiver, they can also relax and auto regulate in their absence. Anxious ambivalent babies tend to seek proximity to the caregiver but are less able to self-soothe. Avoidant infants show clear preference for self-regulation, rejecting caregiver comfort, visible through arching their back away from an embrace when held. Disorganised attachment strategy infants show conflicted distress, loss of basic trust in the caregiver, and the inability to self-soothe. These infants demonstrate a typical range of avoidant, distancing and freezing behaviour¹¹.

Character strategy

Not only in infancy, but progression through formative years further moulds character traits and personality. Kurtz², when describing the 'Hakomi method' gives a useful outline of eight typical 'character (bio) strategies' with emotional, cognitive, postural and movement correlates. Think of a client whose over-ambitious parents prize achievement to such an extent that the individual does not feel worthy unless striving for perfection. This strategy manifests as the industrious/over-focused pattern with a restless agitation, focused eyes and highly toned body in a state of readiness. Clients of this pattern rarely feel nourished, avoid intimacy and are unable to celebrate or relax after achievement. It is easy to see how character strategies, such as burdened/enduring and dependent/endeavouring

types, are further reinforcement of neural pathways which began with attachment patterns. Such repetitive relationship experiences are ingrained subconsciously as procedural learning and become implicit body memories.

Development and trauma combined

I have set out some distinctions between signs of trauma and those of developmental wounding. The more the therapist notices these phenomena, the more others will come into view. Distinctions become clearer with instant recognition of autonomic dysregulation. In relationship you can sense, through resonance, something of client activation inside your own body, ie 'somatic markers'¹². Clients present a jumble of thoughts, emotions, and body sensed experience which can be a mixture of both developmental and trauma issues.

Case study example

Harvey describes himself as 'old school': a train operator for 27 years, during which time he has experienced several train suicide incidents. Harvey remembers events from his early career when he says, 'We were tough then; you just got on with it.' More recently, Harvey is perplexed to discover he is struggling to come to terms with a 'near miss incident' where a graffiti artist had a lucky escape. Harvey presumed the worst and has since experienced hyperarousal with intrusive imagery (flashbacks) not from the 'near miss' but from earlier events. Harvey is a proud man, appearing strong with a set jaw and large chest. The primary obstruction to Harvey's recovery is his embarrassment at asking for help, based on the developmental belief that 'big boys don't cry'.

Problems are more pronounced for individuals who have had multiple or complex trauma. Early vulnerability (disorganised attachment) leaves people predisposed to later traumatic experiencing. When children are too young to have any meaningful defence against trauma (too small to fight back), dissociation (flight in mind) is the optimal survival resource.

Pre-verbal traumatised children will have no language memory, only body sensation from which to integrate trauma. Children who suffer at the hands of frightened or frightening caregivers set out in life with a high level of relationship disturbance. The therapist's first port of call must be in creating somatic safety in the relationship. Interpersonal trauma, especially at the hands of a caregiver, is often perceived as being far worse than natural disasters and accidents to the young mind. The



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reason for this double bind is, quite simply, that there is no respite from terror if the source of threat is the same person who should provide comfort. For this child, the irresolvable conflict is between competing survival systems of attachment and defence. There is no solace, comfort or protection, only a further consolidating of the neural networks of fear.

Opposite treatment approaches are required in making interventions to trauma versus development issues. When approaching trauma, we start away from the memory of the danger, gradually working with dual awareness towards this as somatic resource, and resilience develops. In contrast, developmental work starts with the narrative and memories, and when it is expressed as an emotion, the body becomes more resourced.

Cautions

If a client's level of disturbance is so severe (early multiple trauma), this may result in a fragmentation of the sense of self into parts. The client may appear at times to have one or more different personalities. Sometimes these parts display a striking difference which often points to dissociative identity disorder, requiring more specialist support. It is important for workplace counsellors to recognise and work within the limits of training, knowledge and ability. It is often more appropriate to carefully refer on the most complex cases for longer-term multidisciplinary care.

For some clients, turning attention towards the body could be threatening, destabilising and dysregulating. The body could be the target of violation, the source of pain, with embedded memories. Coupled with a feeling of shame, the body feels like the enemy. The potential for clients to re-traumatise is great.

It is also worth being aware of cultural differences, where there could be a wide variance in the significance of movement and gesture.

Having outlined important cautions, do not underestimate the value and benefit to your work from increased body awareness and intervention strategies, leading to greater therapeutic precision and integration.

Conclusion

The primary value of clients developing body awareness is to support dual awareness, which is inherently regulating. In this outline I have given some indication of some basic tenets of a sensorimotor approach to therapy, which readers may choose to explore further.

With experience, practitioners can learn to quickly recognise and intervene to help clients modulate physiological reactions, develop some control and mastery of the retriggered autonomic system and so aid integration. There are many clues and cues to be observed in the body, leading to specific interventions in organic direction, growth and homeostatic equilibrium.

The literature on trauma treatment, neuroscience and recent brain scanning technologies further confirms some universal truths about how human experience is embodied as movement toward pleasure, or away from pain, in the environment. I am sure you will agree, the body does a sensational job in negotiating the challenge. ■

Please note: in the interest of confidentiality, case study examples are largely fictional illustrations based on composite aspects of actual clinical experience.

References

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