Chapter 9

The Organization of Experience: Skills for Working with the Body in Present Time[1]

THE CLINICAL PRACTICE OF SENSORIMOTOR PSYCHOTHERAPY blends techniques from both cognitive and psychodynamic therapies (such as attention to cognitive schemata and putting language to felt experience) with somatically based interventions (such as learning to track bodily sensations and working with movement). This combination is thought to foster the client's ability to engage the frontal lobes in mindful self-witnessing and in practicing new actions that promote empowerment and success. Interventions are implemented that help clients learn about and become aware of the interplay between cognitive, emotional, and sensorimotor levels of information processing. Mindfulness techniques that help clients notice how self-representations (e.g., "I'm a bad person") or trauma-related emotions (e.g., panic) affect physical organization. These types of interventions gradually increase integrative capacity by helping clients become capable of and facile at moving from one layer of experience (cognitive, emotional, or sensorimotor) to another, thereby laying the groundwork to unify both the physical and mental components of traumatic events. The body becomes an ally

[1] The concept of the organization of experience, and the skills of tracking, contact, mindfulness questions, and experiments are adapted from Ron Kurtz's Hakomi method of body-centered psychotherapy (1990).

in the task of overcoming of posttraumatic defeat, no longer experienced as the source of vulnerability and humiliation and no longer omitted from therapeutic attention (Levine, 1997; Ogden & Minton, 2000; Rothschild, 2000; van der Kolk, 2002).

TRACKING AND BODYREADING

The foundational skill of a sensorimotor psychotherapist is that of tracking present experience, especially as it is encoded in the body (Kurtz, 1990). *Tracking* refers to the therapist's ability to closely and unobtrusively observe the unfolding of nonverbal components of the client's immediate experience: movements and other physical signs of autonomic arousal or changes in body sensation. Somatic signs of emotions (e.g., moist eyes, changes in facial expression or voice tone) and how beliefs and cognitive distortions that emerge from the client's narrative and history affect the body (such as the thought "I'm bad" correlating with tense shoulders and downcast eyes) are also tracked.

Most therapists are skilled at tracking the client's affect, thoughts, and narrative. Sensorimotor psychotherapy also requires tracking, in precise detail, the moment-by-moment physical organization of experience in the client, both the subtle changes (e.g., flushing or paling of the skin, dilation of the nostrils or pupils, slight tension or trembling) and the more obvious gross changes (e.g., flexion or "collapse" through the spine, a turn in the neck, a lifting of the hand or push with the arm, or any other muscular movement). These changes may be fleeting, such as a momentary narrowing of the eyes or a sigh, or they may be more lasting, such as mobilizing defensive "fight" actions emerging in the clenching of the fists and arm muscles, or a continuing tension across the shoulders accompanying a recount of the trauma experience. The therapist especially tracks the physical changes that correspond to emotions, thoughts, and narrative. For example, Jennifer's body tensed as she talked about attachment relationships but then relaxed when she spoke of her job.

Whereas *tracking* is defined as the moment-by-moment observation of physical changes, *bodyreading* refers to the observation of persistent action tendencies, such as the habitual posture of lifted, tense shoulders. Bodyreading helps therapists become aware of the client's chronic patterns of physical structure, movement, and posture that remain consistent over time and are correlated with longstanding beliefs and emotional tendencies. For example, chronically hiked shoulders may correspond to the belief "I'm always in danger" and a perpetual feeling of fear.

When therapists learn to read the body for ever-present physical tendencies that indicate chronic beliefs and regulatory capacities, they glean the

information needed to teach clients the movements necessary to change not only the body but also to influence cognitive and emotional levels of processing. In the words of Janet, "Does it not seem likely enough that a transformation of movements by means of a process of [somatic] education may have an effect upon the totality of the [client's] activities, and thus prove competent to prevent or remove the mental troubles?" (1925, p. 725). Different movements and postures are addressed in different phases of treatment, and therapists bodyread for the presence or absence of a variety of physical capacities depending on the phase of treatment. In phase 1, bodyreading is used to assess somatic abilities that foster stabilization (such as alignment in the spine, grounding in the legs, or breathing fully); the therapist thus notes which abilities are missing and need to be taught to the client. In phase 2, bodyreading is used to assess potential mobilizing defensive responses that were not executed at the time of the trauma, such as tension in the shoulders, arms, or hands (possibly indicating an incomplete "fight" response) or tension in the legs (possibly indicating a truncated "flight" response), thus providing information about actions that may need to be executed to meet the goals of phase 2. In phase 3, bodyreading is used to assess the physical manifestation of chronic beliefs that interfere with the client's ability to meet the goals of engaging more fully in normal life. For instance, the belief that "I have to be a high achiever to be loved" may be reflected in overall tension, quick, focused movements, and erect, rigid posture, all of which are physical tendencies that support working hard.

The sensorimotor-trained therapist is unobtrusively and consistently attuned to the communications of the body, and tracking and bodyreading take place throughout the session. Whether the client is standing, walking, sitting, talking, or gesturing, the therapist is noticing which movements are habitual, easy, and familiar, which movements are difficult to execute or apparently unfamiliar, and hypothesizing about what these tendencies might mean.

It is essential that the therapist note not only the bodily organization that reflects traumatic reactions (e.g., hyperarousal, held breath, constriction, collapsed chest and shoulders, trembling), but also the physical signs of competence and well-being (e.g., deep, regular breath, physical alignment or length in the spine, flexibility and relaxation) (Eckberg, 2000; Levine, 1997; Ogden & Minton, 2000). For example, when Jennifer described how her boss paid her a compliment, her spine lengthened and her chin lifted. But when she described her childhood, her shoulders slumped and her head turned down. The therapist may choose to spend a session working with the memory of the compliment so that Jennifer becomes aware of the length in her spine and learns to maintain that length in the face of challenging experiences.

Contact Statements

Through tracking and bodyreading, the therapist gathers information and then communicates relevant information to the client in the form of a "contact statement" (Kurtz, 1990). Physical experiences often remain unnoticed by the client until the therapist brings attention to them through a simple statement that describes what has been noticed; for example, "Seems like your body is tensing," or "As you say those words, your hand is beginning to curl up into a fist," or "It looks like your legs are starting to tremble." Most therapists are familiar and comfortable with reflecting the client's cognitions and emotional states: "Yes, it feels frightening, doesn't it?" or "It makes you feel worthless when people treat you that way." In sensorimotor psychotherapy, the therapist also pays particular attention to tracking the client's sensorimotor reactions and then verbally reflecting them.

To ensure that attention is paid to all levels of information processing, the therapist follows and mirrors emotional or cognitive aspects of the narrative while simultaneously noting how the narrative affects present body experience. In other words, the therapist must track and contact the physical process communicated by the body as well as the meaning making and emotion evoked by the content (Kurtz, 1990). For example, when Jennifer spoke about her boss complimenting her work, which challenged her belief that he did not value her, her spine lengthened. A contact statement about her body might be "You seem to be sitting taller"; a contact statement about her emotions might be "It feels good to remember that!"; a contact statement about her cognitions might be "You seem to realize that you have something to offer."

By tracking and describing changes that occur in the body as they unfold in the moment, the therapist redirects the client's orienting and attention to present bodily experience and engenders curiosity in how that experience is being organized in both mind and body (Kurtz, 1990). If a therapist only references the content of the story the client is telling, or the emotions accompanying it, then the client will attend to content or emotion, assuming that is what interests the therapist or what is most important in therapy. If a therapist also tracks and contacts the client's physical experience rather than only the emotions or story, the client will orient toward, and become interested in, his or her physical experience as well.

When therapists attend to both the traumatic reactions and the physical signs of mastery and well-being, clients' "phobia" (Steele et al., 2005) of internal experience diminishes and they become "friendlier" toward their inner landscape. The therapist's contact statements assist the "interactive regulation of the [client's] state [and] enables him or her to begin to verbally label the affective [and sensorimotor] experience" (Schore, 2001b, p. 76). As

clients acquire the skills needed to track and name their own physical, emotional, and cognitive experiences, an internal locus of control is strengthened.

Contact statements are simple and short, intended to facilitate self-observation rather than analysis (Kurtz, 1990; Naranjo, 1993). Clients are not required to think about or translate a short, uncomplicated statement such as "Your hand seems to be tightening." Such precise and clear statements of obvious changes keep clients aware of present experience and minimize the effort required to think about the therapist's words. Because the focus is on the organization of present experience, the therapist does not try to interpret or make meaning of the client's physical phenomena (Gendlin, 1981), but rather simply observes and describes the sensorimotor elements in the simplest, most concrete terms possible.

Contact statements evoke and maintain social engagement. As Kurtz noted: "Contact statements are not mandatory. They are optional. Creating a connection is mandatory" (1990, p.77). Good contact statements may be few, but if they are precise and resonant for the client, social engagement and attunement are induced, maintained, and increased. For that reason, contact statements that demonstrate the therapist's attunement not only to the body but to emotion and cognition, as they emerge in the client in the present moment, cannot be overlooked: "Looks like a lot of emotion is coming up right now" or "Seems like these thoughts are confusing" are ways of contacting mental and emotional experience that demonstrate attunement without encouraging a *thinking about* action.

To preserve social engagement, attunement, and collaboration, the client is always provided with the opportunity to refute or refine the therapist's contact statements. Thus, contact statements should carry a sense of subtle questioning, a tone that implies an invitation for revision by the client. Adjunct clauses at the beginning of a statement (e.g., "sounds like," "seems as if," "looks like") leave contact statements appropriately open-ended, as do adjunct expressions at the end of a statement. For example, in the phrase "Starting to relax, huh(?)" the "huh" turns it into a rhetorical question. If a therapist observes "You seem to be pulling back," and the client's response is a furrowing of the brow or words such as "No, I'm not," the therapist does not dispute the client's experience. Rapport and social engagement would be sacrificed if identifying present experience were to turn into a struggle over who is "right." The therapist's statement may be accurate, but accepting and even encouraging the client's disagreement maintains social engagement by showing respect, patience, and a willingness to collaborate, as well as a validation that no one but the client can know his or her inner experience.

The opportunity to correct the therapist may also allow the client to attune more deeply to what is actually happening in his or her body and fine-tune the description of how he or she experiences sensations in the body. For instance, if the therapist says "Your shoulders are tensing, huh?" the client might respond by saying "No, it's more like they're pulling in . . . like I'm getting smaller." In this interaction the therapist was not rebuffed; on the contrary, the rapport may be enhanced after the client offers this "correction."

The invitation to the client to accept, refute, correct, or refine a contact statement places the authority and locus of control within the client, rather than the therapist, thereby reinforcing the sense of collaboration so necessary in sensorimotor work. In addition, the client's adjustment of the therapist's statements is usually an emotional risk, and taking it provides an opportunity for the client to differentiate him- or herself from the therapist.

Mindfulness

Tracking and contact statements set the stage for exploring present-moment experience by facilitating mindfulness in the client. Kabat-Zinn defines mindfulness as "paying attention in a particular way; on purpose to the present moment, and nonjudgmentally" (1994, p. 4). Linehan (1993) describes mindfulness as a combination of the "what" skills of observing, describing, and participating and the "how" skills of a nonjudgmental attitude, focusing on one thing at a time, and being effective. In a sensorimotor approach, mindfulness entails orienting and attending to the ebb and flow of present internal experience. Awareness and attention are directed toward the building blocks of present experience: thoughts, feelings, sensory perceptions, inner body sensations, muscular changes, and movement impulses as they occur in the here-and-now. In normal daily life, the beliefs and habits that exert their influence on our perceptions and actions usually remain just outside of conscious awareness. "One of the main goals of the therapeutic process is to bring this organizing material into consciousness, to study it and understand it. Mindfulness, as a state of consciousness, is the tool we use" (Kurtz, 1990, p. 27). In a discussion or conversation, we "talk about" rather than study our internal experience. In ordinary consciousness, we tell the story; in mindful awareness, we watch the experience of the story unfold in the present moment, through changes in body sensation, movement, sensory perception, emotion, and thought.

Through tracking and contact, the therapist redirects the client's orienting to present experience, and through mindfulness, the client's ability to attend to present experience is maintained and expanded. Although mindfulness does not exclude awareness of the external environment, it is directed internally to the effect of internal stimuli (e.g., remembering a traumatic event) and of external stimuli (e.g., a contact statement) on sensations, perceptions, movements, emotions, and thoughts.

The therapist teaches mindfulness by asking questions that require awareness of present-moment experience to answer. Such questions might include:

"What do you feel in your body right now?"

"Where exactly do you experience that tension?"

"How big is the area of the tension—the size of a golf ball or the size of an orange?"

"What sensation do you feel in your legs right now as you talk about your abuse?"

"What happens in your body when you feel angry?"

The more precise the question, the more deeply "tuned-in" and mindful of body experience the client will become.

The intention of mindfulness is to "'allow' difficult thoughts and feelings [and body sensations and movements] simply to be there, to bring to them a kindly awareness, to adopt toward them a more 'welcome' than a 'need to solve' stance (Segal, Williams, & Teasdale, 2002, p. 55). This nonjudgmental mindful observation has a positive effect on brain functioning (Davidson et al., 2003): It engages the prefrontal cortex in support of observing sensorimotor experiences, rather than allowing these bottom-up trauma-related processes to escalate and "hijack" higher-level information processing. As thoughts or emotions emerge, mindful observation leads not to interpretation but to curiosity and self-study: for example, the therapist might ask, "When that thought comes up, what happens to that tension in your shoulder?" or "When you have that feeling, what happens in your body?"

Mindfulness questions discourage discussion, ordinary conversation, and brooding about past or future experiences. When we have a "conversation," a discussion, or tell a "story," we are not necessarily mindful. We are not observing the *effects* of our speaking on internal experience: We are "talking about." To facilitate mindfulness when the client is talking *about* a significant event, recent or past, the therapist gently directs the client's orienting back to the internal experience evoked by that content: the feelings, thoughts, and body sensations and movement that occur as the client remembers the past or thinks about the future. In this way, mental and physical action tendencies that reveal the client's legacy of procedural learning become the objects of exploration, rather than the events that engendered that procedural learning (Grigsby & Stevens, 2000).

Because mindfulness questions require an "observing ego," clients are "forced" to step back from the chronic somatic or emotional experiences of trauma in order to formulate a mindful answer. In endeavoring to answer a question framed to deepen mindfulness, the client no longer "is" the traumatic experience. Instead, by observing and reporting on current experience with an observing ego, the client "has" an experience rather than "being" it (Ogden & Minton, 2000). Retraumatization is minimized because the prefrontal cortex remains "online" to observe inner experience, thus inhibiting escalation of subcortical activation.

Using questions to elicit present-moment attention to a symptom or behavior manifesting in the client in the here-and-now provides conscious access to underlying traumatic tendencies and resources (Eckberg, 2000; Kurtz, 1990; Levine, 1997; Ogden & Minton, 2000; Rothschild, 2000). For example, rather than sensing tension in the body and immediately trying to relax it, mindful attention would be used to observe the tension and discover more about it—how it is pulling, how strong is it, what its parameters are, what the sensation of the tension is like, if the tension is a precursor to a particular physical action, and perhaps what emotions or thoughts accompany it.

Experiments and Exploration

In a state of mindfulness, action tendencies can be observed and studied and then transformed through the practice of new actions (Janet, 1925). The therapist adopts an "experimental attitude"—a mind-set of openness and receptivity that is characterized by curiosity and playfulness rather than effort or fear (Kurtz, 1990). The experimental attitude invites exploration of new experiences without investment in a specific outcome—an attitude that renders "right" and "wrong" answers irrelevant and is reflected in the phrasing of contact statements and mindfulness questions. Jennifer's therapist invoked an experimental attitude by reflecting back to her: "Isn't it interesting that today, you are having the feeling that I might hurt you? Let's find out more about that. Maybe first we can experiment: What would happen if you looked at me and just noticed what happens in your body?" This first experiment failed to help Jennifer feel safer. Instead, she reported feeling more frightened and tense. The therapist was surprised but remained nonjudgmentally curious about how Jennifer had responded to the experiment of looking at him. He then gently suggested another experiment: "I wonder if we could experiment with what would make you feel safer? How about exploring what would feel like a 'safe' or or 'right' distance between us is right now? What if I moved my chair back? Let's see what happens." As her transferential defensiveness was challenged by this experiment, and as she mindfully felt her fear diminish, she was able to recognize how dysregulated she had felt, and the therapy progressed to the practice of new, more adaptive actions.

Therapeutic experiments are always conducted to make discoveries about the organization of experience (Kurtz, 1990), to bring awareness to the

effects of trauma and the ensuing action tendencies. These discoveries arise unprompted from mindful experiments; they are "unforced, automatic, and spontaneous, and therefore reflective of habits and core organizers" (Kurtz, 1990, p. 69). Often both therapist and client are surprised by the unanticipated result of an experiment, as exemplified by Jennifer: She was amazed that, when she experimented by drawing a circle around herself to indicate "her space" (Rosenberg et al., 1986), she spontaneously relaxed and had the thought "I am worth something!"

Through conducting collaborative experiments, the curiosity of both therapist and client is engaged; the exploration action system is activated, in turn deactivating the defensive action system; and without the domination of the defensive action system, unpredictability is expected and welcomed. The client's experience of separation from the event and the ability to observe internal experience rather than merge with it leads to a deepening of dual awareness: "I am terrified" becomes "I experience a violent trembling in my extremities." Both client and therapist can then become interested in how the elements of experience change: "When you direct me [the therapist] to move across the room, what happens in your body? What thoughts emerge? What emotions or pictures are evoked spontaneously by the experiment?" The experimental attitude requires that the therapist remain unattached to any particular agendas or outcome and willing to work with whatever emerges from the client's organization of experience, while all the time providing interactive regulation to maintain arousal within a window of tolerance.

Experiments occur in the context of collaboration and social engagement. Clients are asked if they "would be willing" to participate in the described experiment in a tone that suggests that the answer "No" is just as welcome as the answer "Yes." The client's willingness and resistance are of equal interest to the therapist and equally merit further curiosity and study. If the client responds negatively, collaboration helps to determine the next step in the session. If the client responds positively, the question is then followed by the mindfulness-invoking phrase, "Let's notice what happens when . . ." (and then the particular experiment is stated; possible experiments are explored below). This clause instructs the client to observe the effect of the experiment on body and mind: how he or she organizes experience in response to the experiment.

The experimental attitude encourages thoughtful "trials" of new responses as an alternative to maladaptive tendencies and emphasizes nonbiased observation of their impact. As a challenge to the automatic action tendencies, small, precise experiments are conducted to gather new information and heighten curiosity. For example, clients might experiment with grounding exercises of softening and relaxing their feet against the floor and unlocking their knees, noticing what happens as they do so. An "experiment" is a "trial

change": a change in words used, a change in posture, a movement or a stilling of movement, a change in orientation, a change in sensory modality. Experiments can be either physical or verbal, as in the following illustrations (adapted from Kurtz, 1990):

1. In one type of experiment, therapist and client might study what happens when the *client senses or performs something physical.* For example, as a client becomes aware of tingling in her arms, the therapist proposes an experiment by asking, "Notice what happens when you focus just on that tingling in your arms." Or, as the client makes a pushing gesture with the arms, the therapist asks, "Would it be okay if we studied what happens when you repeat that gesture with your arms? Let's see what happens when you repeat it again." Or the therapist might say, "Let's explore what happens if you stand up and plant your feet and then make that same gesture?"
2. Another type of experiment involves the *client's verbalization of a particular word, phrase, or sentence.* For example, a client with a tendency toward collapse and submission said, "I wish I could say 'No.' " The therapist then proposes that the two of them explore what happens when the client instead repeats the phrase "I *can* say 'No' *now.*" Or, a client might spontaneously say, "I know it was not my fault." The therapist might ask, "What happens in your body and emotions when you repeat that sentence?"
3. In yet another way of experimenting, therapist and client study what happens *when the therapist performs a physical action.* For example, the therapist notices, and asks the client to study, how she (the client) averts her eyes while simultaneously turning her body away. In one case, the client reported the belief that "it's not safe to be seen," accompanied by the physical response of an accelerated heart rate and constricted breathing. To talk about that belief and its origins might provide some insight, but an experiment would offer an opportunity to challenge the belief in some way. The therapist might try a variety of experiments: "Could we study what happens inside you if I close my eyes and you keep your eyes open? How about if I pull my chair back a little—what happens? How about if I pull my chair back and turn my head slightly away from you?" Each experiment is studied by client and therapist and its results evaluated: They notice that, as the therapist pulls her chair back and looks slightly away, the client's heart rate and breathing settle, and she reports a sense of greater control. This exploration of her bodily responses results in a kind of somatic insight, a felt change resulting in an understanding from the body up.
4. In yet another variation on experiments, the therapist and client observe the results when *the therapist says a certain statement or repeats a phrase.* For example, the client says, "I know I have the *right* to be angry, but I can't *let* myself get angry." The therapist offers him the opportunity

effects of trauma and the ensuing action tendencies. These discoveries arise unprompted from mindful experiments; they are "unforced, automatic, and spontaneous, and therefore reflective of habits and core organizers" (Kurtz, 1990, p. 69). Often both therapist and client are surprised by the unanticipated result of an experiment, as exemplified by Jennifer: She was amazed that, when she experimented by drawing a circle around herself to indicate "her space" (Rosenberg et al., 1986), she spontaneously relaxed and had the thought "I am worth something!"

Through conducting collaborative experiments, the curiosity of both therapist and client is engaged; the exploration action system is activated, in turn deactivating the defensive action system; and without the domination of the defensive action system, unpredictability is expected and welcomed. The client's experience of separation from the event and the ability to observe internal experience rather than merge with it leads to a deepening of dual awareness: "I am terrified" becomes "I experience a violent trembling in my extremities." Both client and therapist can then become interested in how the elements of experience change: "When you direct me [the therapist] to move across the room, what happens in your body? What thoughts emerge? What emotions or pictures are evoked spontaneously by the experiment?" The experimental attitude requires that the therapist remain unattached to any particular agendas or outcome and willing to work with whatever emerges from the client's organization of experience, while all the time providing interactive regulation to maintain arousal within a window of tolerance.

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The experimental attitude encourages thoughtful "trials" of new responses as an alternative to maladaptive tendencies and emphasizes nonbiased observation of their impact. As a challenge to the automatic action tendencies, small, precise experiments are conducted to gather new information and heighten curiosity. For example, clients might experiment with grounding exercises of softening and relaxing their feet against the floor and unlocking their knees, noticing what happens as they do so. An "experiment" is a "trial

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to study that predicament by proposing, "Let's study what happens in your body when I repeat your words, 'You have a right to be angry.' Let's notice what happens inside when I repeat those words again."

The variety of experiments and their potential uses are almost infinite. Experiments can be utilized when clients become hyper- or hypoaroused to help them regulate traumatic activation. When a client is numb and hypoaroused, active strategies are indicated (Courtois, 1991). The therapist might suggest an experiment in which the client stands and walks purposefully to the door. Or what happens if the client rotates her head and neck to orient to the environment around her? If, on the other hand, the client is hyperaroused and feeling overwhelmed, "containment" strategies may be useful (Courtois, 1991). The therapist might propose that they experiment with what happens inside when both of them stand up and ground themselves, sensing their legs and feet. With each experiment, the responses are carefully studied, and the next experiment reflects what has been learned from the last.

Putting Skills Together

At any given moment in a therapy session, there are numerous options for tracking, making contact statements, applying mindfulness, and experimenting. Through bodyreading and tracking, the therapist selects which elements of present-moment experience to identify with a contact statement. The therapist must discriminate thoughtfully among the myriad of sensorimotor, emotional, and cognitive phenomena occurring at any given moment and select elements that best support the overall therapeutic process and the aims of each session: for example, strengthening a resource, regulating arousal, executing truncated defensive responses, or other adaptive actions. Because contact statements bring attention to a particular aspect of experience, they influence the direction of the therapy session; the choice of mindfulness questions and experiments further enhances the focusing of attention on those aspects of the client's experience most likely to support a transformation of the habitual maladaptive responses.

Integrating Resources

Tracking the indicators of the client's resources—that is, his or her strengths, competencies and skills—is just as vital as working with traumatic material (Eckberg, 2000; Levine, 1997; Phillips, 1995; Rothschild, 2000). Indeed, care must be taken to balance interventions that address traumatic material with interventions that support the client's resources for integrating that material. Therapists look for signs of competence, integrative capacity, positive experiences, and empowering or playful actions. Potential or manifest resources can be noted at all three levels of information processing. Sensorimotor, or somatic, resources include muscular tone that is neither too relaxed nor too tense; a balanced, erect, relaxed posture; states of optimal arousal; and movements that are graceful and economical. The therapist might track emotional or cognitive resources that become available when a client expresses, even momentarily, positive affects (e.g., joy, calm, delight) or verbalizes new, more positive thoughts (e.g., "I have a right to say 'no.'"). In each and every moment, the therapist is monitoring the client's level of arousal to assess: Is it optimal? Too low? Too high? If arousal is outside the window of tolerance, working with resources may bring it back to within the window of tolerance.

Differentiating the Building Blocks of Present Experience

For traumatized individuals, body awareness can be problematic in a variety of ways. First, becoming aware of the body may be disconcerting or even frightening, sometimes triggering feelings of being out of control, terrified, rageful, panicky, or weak and helpless. Second, traumatized clients often experience the body as numb or anesthetized. Rather than becoming overly activated by body awareness, these clients are challenged by a level of hypoarousal that lowers their sensitivity to the body. A third difficulty emerges when body awareness stimulates thoughts such as "My body is disgusting," "I hate my body," "My body let me down," "I don't have a body," or "My body is dead."

Clients are taught to distinguish between physical sensations or actions and trauma-based emotions or cognitions through cultivating deeper, more focused awareness of sensations and movement. One client experienced panic when he became aware of his body; he learned to "put aside" the panic and just follow his body sensations as they fluctuated in texture, quality, and intensity, until they settled. Another client who stated "I hate my body" was encouraged to differentiate this thought from the actual sensation of the accompanying physical action: curling up in a fetal position, which relaxed her muscles and felt comforting. Another who felt her body had betrayed her by not protecting her from abuse explored the sensation and movement of making a "stop" gesture with her arms and hands, putting aside her thoughts and emotions to notice only how this movement felt physically.

The therapist asks the client to limit the amount of information to integrate by focusing attention exclusively on body sensations and movement, experiencing them as distinct from emotions and thought (Ogden & Minton,

2000). In this way, clients gain an effective tool with which to address their disturbing body perceptions and sensations: learning to uncouple sensations and movements from trauma-related emotions and cognitive distortions.

Linking Building Blocks

As clients become increasingly able to track present-moment somatic experience, the therapist builds on that increased awareness by helping them study the interplay of their thoughts, feelings, movement impulses, sense perceptions (images, smells, sounds, tastes, and touch) and body sensations. The therapist directs the client's attention to how thoughts and emotions are affecting present-moment body experience by making contact statements such as "I notice that your jaw tightens as you talk about feeling angry," which links the tension with the emotion. Mindful questions are asked to further "stitch together" elements of experience: "What happens when you notice both the anger and the tightening?" or "What happens in your body or your feelings when you have the thought, 'I'm a loser?'" or "When you feel happy, how does your body respond? What images emerge?" The therapist pays close attention to how linking together these building blocks affects the client's arousal and sense of mastery. Generally speaking, therapists choose to facilitate the linking of experiential elements when doing so when does not take the client's arousal out of the window of tolerance, and when the client's integrative capacity is sufficient to be able to tolerate and utilize more information. These building blocks are also linked when exploring memories or experiences during which a client feels a sense of mastery, pleasure, or positive affect. This helps to reinforce and expand upon the sense of mastery or pleasure, and to offset clients' frequent experience of pain or lack of competence (discussed in Chapter 11).

Touch Interventions in Psychotherapy Practice

In traditional psychotherapy practice, the use of touch has generally been avoided out of concerns that it might be misinterpreted or misexperienced by the client as sexual, the effects on the transference would promote regression or gratification instead of insight, or the therapist would misuse it to further his or her own psychological or sexual needs. The same concerns exist in sensorimotor psychotherapy. Although touch can be therapeutic, there are potential pitfalls and it must be used cautiously and judiciously, if at all. If therapists choose to use touch in their clinical work, they should be well trained not only in the use of touch itself but also in combining touch with psychotherapy. The laws of their licensing body must condone the use

of touch in clinical practice, and their liability insurance should cover the use of touch. Therapists are advised to use a written informed consent form that describes the use of touch and explicitly states that the client is always in control of the use of touch in the therapeutic setting. Conducting a "touch history" that includes inquiring about clients' past experience with being touched, touching, and witnessing touch can be a useful intervention to elucidate their past difficulties with touch (Caldwell, 1997b). Establishing the client's capacity to differentiate past from present and therapeutic from non-therapeutic uses of touch is also a necessary component of the therapeutic work preceding any consideration of incorporating touch into treatment.

Consideration of the therapist's own potential contertransferential reactions to, and beliefs and attitudes toward, touch and what effects the use of touch might have on the therapist, the client, and the power differential inherent in the therapeutic relationship is essential (Hunter & Struve, 1998). In order to utilize touch, the therapist must be capable of maintaining his or her own very clear psychological and sexual boundaries and be comfortable with the use of therapeutic touch in professional contexts. Therapists must assess the appropriateness of using touch on a case-by-case, session-by-session basis, evaluating the client's ego strength, sense of boundaries, diagnosis, and overall functioning, as well as assessing their own capacity to manage any transference responses, including sexual, that might ensue. Both the therapist and the client's motivations for the use of touch should be examined: For example, touch that is used to rescue either the client or therapist from uncomfortable emotions should be avoided (Caldwell, 1997b). Touch—even well-considered, boundaried, therapeutic touch—may evoke unworkable transference if the therapist is uncomfortable or unskilled, if the patient has poor ego strength, if the therapeutic alliance is weak, or if the connection resulting from touch exceeds the working intimacy in the therapeutic relationship.

It should also be noted that the use of direct touch between client and therapist is not necessary to accomplish the goals of sensorimotor psychotherapy. In the case where some type of physical contact might enhance therapeutic outcome, but direct touch is ill advised, objects such pillows or balls can be used to buffer physical contact between client and therapist. The client's use of his or her own touch can also be effective (e.g., wrapping arms around him- or herself).

Despite all of the cautions inherent in the use of touch as an intervention in psychotherapy, it can be an efficient, useful, effective intervention and there are specific clinical purposes for its judicious use (Caldwell, 1997a; Hunter & Struve, 1998). Physical touch activates nerve endings on the surface of the skin, thereby increasing sensation intensity, making touch particularly useful in restoring or increasing awareness of body sensation. If

the client tends to lose connection with the body or has little awareness of body sensation, having him or her touch a particular area (e.g., neck, shoulder, stomach) can restore body awareness.

The efficacy of using touch in this way lies in helping the client become aware of the exact depth, placement, and type of touch (with palm of hand, fingertips, etc.) that would accentuate the sensations in a particular area. For example, a client who suffered from alexythymia reported numbness in her chest, especially around her heart. Her therapist suggested that she place her own hand on this area. At first, the client said she felt "nothing." However, when the therapist suggested that she try different kinds of touch until she discovered the exact form of touch that helped her feel this area of her body, the client found that a certain depth and movement of her own fingers indeed promoted sensations in her chest. The client remarked, "I can feel my heart—this is the first time my heart has felt supported by me."

Touch can also help build new somatic resources or support awareness of existing resources. If a client has difficulty staying grounded, touching his or her own legs and feet to increase sensation may facilitate the experience of feeling grounded. When a client is mindfully executing a defensive movement of pushing with the hands and arms against the therapist's hands, or against a pillow held by the therapist, he or she may experience a welcome feeling of strength and competence. The client is encouraged to find the exact kind of touch and pressure that is used with the pillow or hands that feels "right," such as pushing with one hand or both, pushing against firm resistance or against resistance that "gives way," or any number of other variations. A client who had been sexually abused reported that she was not allowed to refuse the advances from her father, and said she thought pushing would be frightening. With encouragement from her therapist, she first chose to stand and push against the wall, reporting that that would be "safer" than pushing against her therapist. Feeling confident in this act, she then decided to experiment with pushing against a pillow held by the therapist. With the help of her therapist, she discovered that by directing the pressure the therapist used (she requested that the therapist use strong pressure that then gave way as she pushed hard), she felt in control and her body felt strong and capable. This sense of competency contradicted the feelings of futility that she had previously associated with using her arms to defend herself.

The use of touch can facilitate the learning of new actions and postural patterns. For example, for a client who exhibited a collapsed or flexed chest and swayback, gentle pressure in the lower back with the instruction for him to press back against the hand of the therapist led to spontaneous straightening and alignment of the spine. In that squared stance, the client began to experience a more energized, less overwhelmed relationship to the environment.

Because touch is always used as a collaborative experiment, it is necessary to allow time for clients to observe and verbalize their inner experience prior to the touch (whether self touch or pressing against the therapist's hands, etc.) and then the resultant effects of the touch on the client's organization of experience after the experiment. Asking a client to become aware of his or her body prior to using touch increases mindfulness and enhances awareness of the effects of touch once it does happen. Such awareness may also prevent some of the pitfalls discussed previously, because the client may notice somatic signals that indicate the expectation of a boundary crossing before the touch occurs, as did one client who observed that her body was bracing prior to the use of touch. Awareness of the body as a client considers the possibility of touch may also clarify transference; the client who braced discovered she had placed her therapist in the role of perpetrator, for example.

When physical contact is made, a reaction happens: The client may feel an impulse to pull away, experience movement in the body, breathe a sigh of relief, have a particular thought, emotional response, or memory emerge. All of these reactions are grist for the mill, and provide jumping-off points for therapeutic inquiry: What about the touch helps you relax (or pull away)? Does it feel safe? Do you feel like you are in control of the kind of touch? What is the nonverbal message of the touch that made you relax (or pull away)? What does the touch tell you? The effect of the experiment with touch may be contrary to the therapist's intention or the client's expectation, so it is imperative that the therapist track the client's reaction and elicit reports on "what happens inside" as the touch is implemented.

Provided that the therapist's touch is attuned and professional, the client's reaction will tend to reflect his or her automatic translation of the sensation in the context of past experiences of touch. Experiencing a particular sensation in a part of the body that has been injured or abused may remind the client of past trauma (Janet, 1925). For example, a client who had been beaten in political torture requested gentle touch on his back, but when the therapist first touched his back, the client cringed and was reminded of the torture. Eventually, with skillful therapeutic intervention, he was able to experience the therapist's touch as different, and slowly the physical sensations changed to positive ones.

Mindful, collaborative experiments with touch may help the client become aware of how she or he might use touch outside of the session. Many clients have discovered types of touch (touching their legs to promote a sense of grounding, placing their own hands on their belly or heart, etc.) that they utilize in their daily lives. Numerous clients who have been sexually abused have explored self touch on their forearms and hands under the guidance of their therapist, and have been able to slowly appreciate their own sensual touch. They have often gone on to successfully enjoy touch with their partners, provided that they felt sufficient control and influence on the kinds, placements, timing, and contexts of the touch.

The meaning of the physical contact for the client may derive from a previous negative or traumatic experience. For example, one client wanted to push against the therapist's hands to experience a sense of boundary. However, she tensed her body and pulled away as the therapist began to put her hands in a position so that the client could push. Actual touch had not yet occurred, but the client already had a reaction of tensing. As the meaning was explored, the client said, "I know this is not true, but your hand looks menacing." Her previous abuse had biased her toward interpreting any kind of touch as hurtful. Other times the meaning is positive: Another client experienced relaxation and took a deep breath when touch was used. He reported that he could tell that this touch was different from the past, saying to the therapist, "These hands want to help me, not hurt me." When the therapist asks for the meaning or words of the touch, it is most effective to set up the process as an experiment in mindfulness. In this example, the therapist had the client feel the exact kind of touch that felt "right" to him. When they had negotiated the right touch, the therapist said in a slow, mindful voice, "Feel the quality of this touch. If my hands could speak in words instead of sensation, what would they be saying to you? Let the meaning come from my hands rather than your thoughts." As therapist and client mindfully explore clients' automatic reactions to touch, and the meaning of the reactions, a new experience can be facilitated and the habitual response transformed.

The client's physical and psychological state is constantly fluctuating, so, to be effective, touch must be adapted moment by moment to the client's process and boundary needs: more pressure or less, on the side of the shoulder or the back of the shoulder, experimenting with decreasing the touch or increasing it to determine how much is "enough." The therapist offers an experience of "boundaried" touch that is respectful, noninvasive, and consistently open to refinement by the client. Consequently, clients know that they are in complete control of the touch and can modify or terminate it at any time—an experience that can be a powerful new learning for those who were not in control of when and how they were touched in the context of past trauma. The effective use of touch in therapy can anchor the client to the here-and-now and to the relationship with the therapist, not catapult the client back into trauma-related implicit memory states.

Conclusion

The sensorimotor-trained therapist approaches the phase-oriented treatment of trauma with a repertoire of techniques that serve specific functions:

- Gathering information by tracking and bodyreading trauma-related action tendencies and regulatory abilities;

- Evoking the social engagement system via the use of attuned contact statements;
- Engaging the exploration system by heightening the client's mindfulness and self-study;
- Challenging habitual responses and promoting the acquisition of new patterns by using experiments.

Differentiating or linking the different levels of information processing, developing the client's resources, and judiciously using the therapist's touch or client's self touch all serve to meet the goals of each phase of treatment.

In different phases of treatment, as we describe in subsequent chapters, these techniques provide the substrate upon which a variety of therapeutic interventions can build. In phase 1 treatment, the techniques help the client develop his or her ability to regulate arousal by learning the resources needed to inhibit the overactivation of defensive responses. In phase 2 treatment, tracking, making contact statements, applying mindfulness, and experimenting support the resolution of traumatic memory by facilitating the client's ability to tolerate and track the sensations of traumatic arousal until the sensations themselves settle to a point of resolution in the body, and complete truncated mobilizing defensive responses. And, finally, in phase 3, these very same tools are put to use in the service of expanding the client's capacity to engage action systems of daily life, develop intimate relationships, create new meanings, and increase tolerance of positive affects.