Healing the Fragmented Selves of Trauma Survivors: A Trauma-Informed Approach

Vancouver Mental Health Summit
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Janina Fisher, Ph.D.

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Trauma ⟹ Alienation from One's Self

- **To survive overwhelming events, we need keep some distance from them.** Maintaining any sense of self requires dissociative separation from the enormity of the trauma
- **Disowning "the bad child" or "wounded child"** (the child who endured the abuse and humiliation) **is a survival response**: it preserves self-esteem, motivates us to be the "good child," helps us go to school and do our homework
- **We disown the trauma by disowning these traumatized parts,** too, as well as parts that are not safe in a dangerous world: parts that carry needs or anger or any feelings or behavior unacceptable in that environment

Fisher, 2023

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Alienation from one's self as a survival strategy, cont.

- When children can disown needs that won't be met or feelings that are unacceptable, **adaptation is easier---but at the price of altered consciousness and automatic habits of self-alienation.** Our vulnerable feelings and needs feel 'bad' or 'not me,' even decades later
- **Self-alienation and fragmentation also aid in maintaining the attachment to abusive parents that is necessary** for survival when we are young.
- **Because an unsafe environment and attachment figures prevent internalizing a coherent sense of self,** it is easier to remain split and compartmentalized

Fisher, 2022

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We remember these early experiences with our bodies

•**Our adaptations to early experience are encoded in the body** in the form of visceral responses, emotions of fear or pleasure, habits, beliefs, even autonomic and muscle memory—all divorced from the events that shaped us in childhood.

•**"Remembering" with our bodies and our emotions is adaptive in intent:** it helps us to automatically avoid whatever feels bad or threatening and to anticipate threat. The prefrontal cortex might evaluate the world as safe, but the body and nervous system become conditioned to respond to potential threat Fisher, 2023

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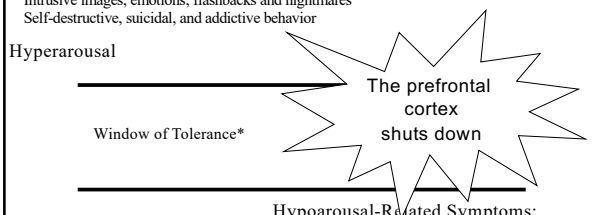
A nervous system adapted to a dangerous world

Hyperarousal-Related Symptoms:
Impulsivity, risk-taking, poor judgment
Hypervigilance, mistrust, resistance to treatment
Anxiety, panic, terror, post-traumatic paranoia, racing thoughts
Intrusive images, emotions; flashbacks and nightmares
Self-destructive, suicidal, and addictive behavior



Hypoarousal-Related Symptoms:
Flat affect, numb, feels dead or empty, "not there"
Cognitive functioning slowed, "lazy" thinking
Preoccupied with shame, despair and self-loathing
Passive-aggressive, victim identity

Ogden and Minton (2000); Fisher, 2009
*Siegel (1999)
Sensorimotor Psychotherapy Institute

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Remembering somatically: how can you tell it's a "memory"?

•**When we "remember" attachment experiences implicitly, we don't know that we are 'remembering.'** When we feel warmth around the heart, clenching in the stomach, impulses to reach out, or feelings of suffocation, it doesn't "feel" like memory. It feels like something being felt right "now" in response to current relationships

•These non-verbal physical and emotional memory states or muscle memories do not "carry with them the internal sensation that something is being recalled. . . . **We act, feel, and imagine without recognition of the influence of past experience on our present reality."** (Siegel, 1999)

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Manifestations of self-alienation

- **Self-loathing,** self-judgment, low self-esteem, no ability to take in mitigating information: one side attacks the other
- **"Terminal ambivalence:"** stuck, can't commit to a course of action, 'self-sabotage:' the two sides are in conflict
- **Numb, intellectualized,** no emotion
- **Overwhelmed,** emotional outbursts, no ability to soothe
- **Acting out,** addicted, eating disordered, self-destructive
- **Paradoxical, contradictory behavior**, mood shifts
- **Regressive or aggressive behavior** without 'ownership'
- **Dissociative disorders, chronic depression and anxiety**

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"The concept of a single unitary 'self' is as misleading as the idea of a single unitary 'brain.' *The left and right hemispheres process information in their own unique fashion and represent a conscious left brain self system and an unconscious right brain self system."*

Schore, A. N. (2011). The right brain implicit self lies at the core of psychoanalysis. *Psychoanalytic dialogues*, 21:75-100. p. 76-77.

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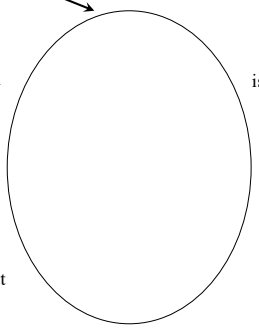
How does the brain self-alienate?

Left Brain

Slow to develop, the left brain is verbal, can reason, plan and organize. It can learn from experience and anticipate problems. The left brain is the verbal, analytical, information-gathering brain that manages right brain emotions/impulses. It assesses danger but does not sense it.



Right Brain

Dominant for the few five years of life, the right brain is the survival brain. It lacks verbal language but reads body language and facial expression to scan for danger or pleasure. It is intuitive and emotional, senses danger instead of evaluating it.

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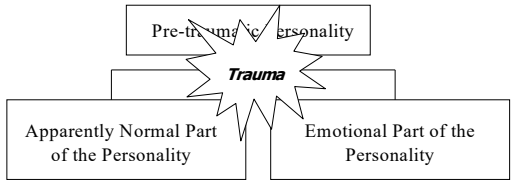
Primary Dissociation: even a single incident trauma leads to a divide between left and right brain selves



This Left Brain part of the self "carries on" with daily life during and after the trauma. It minimizes the trauma: "It wasn't that bad"

The Right Brain part of self holds both implicit memories and survival defense responses. Hypervigilance leads to preoccupation with anticipated threat

Van der Hart, Nijenhuis & Steele, 2006

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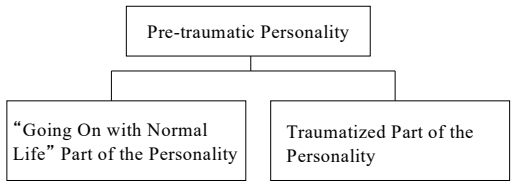
Client-Friendly Language



The Left Brain part of the self is driven by the instinct to "keep on keeping on" with daily life and normal development during and after the trauma

This Right Brain part of self holds both the implicit memories and the survival responses necessary for anticipated threat

Van der Hart, Nijenhuis & Steele, 1999

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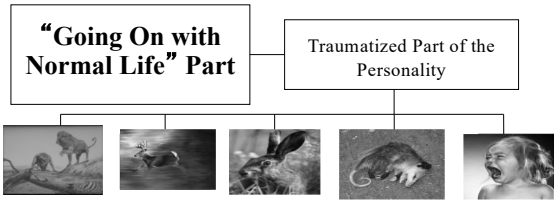
With chronic trauma, more splitting is necessary to defend against danger



Although the client appears to be one whole person, each survival defense causes a shift in personality and mood and even memory. Each part is driven by a different animal defense survival response

Van der Hart, Nijenhuis & Steele, 1999

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Each part contributes a conflicting defensive strategy

Van der Hart, Nijenhuis & Steele, 2006; Fisher, 2009

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The parts remain ready to defend

"When the traumatized individual is faced with reminders of the trauma and experiences a defensive response, the function of that defensive response has shifted from reacting to an immediate threat to reacting to an anticipated threat. ***What began as a necessary defense in the face of a real threat becomes a pervasive, unrelenting reaction to the anticipation of a threat."***

Ogden, Minton & Pain, 2006

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Alienated parts are not experienced as 'parts' but as feelings

- Overwhelming emotions: desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- Chronic expectation of danger: hypervigilance, fear and terror, mistrust, "post-traumatic paranoia"
- Body sensations: numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- Impulses: motor restlessness, 'hang-dog' posture, impulses to "get out," violence turned against the body
- Beliefs: "I hate myself," "No one cares," "I'm not safe here"

Fisher, 2012

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Or parts are experienced as:

- **Loss of ability to communicate:** client becomes mute, shut down, unwilling to speak, can't find words
- **Voices**: usually shaming, punitive, controlling
- **Constriction:** withdrawal, social isolation, agoraphobia
- **Regressive behavior:** loss of ability for well-learned skills, personal hygiene, ADLs, social engagement
- **Increasing preoccupation with helpers:** the only safe/unsafe place becomes the office/hospital/house
- **Alternating dependence and counterdependence**
- **Unchecked self-harm,** suicidality and addictive behavior

Fisher, 2014

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"I've got different minds at different times—and they are not working together. . ."

"Annie"

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Trauma-Informed Stabilization Treatment [TIST]

Mission: to create a trauma-informed therapeutic model specifically focused on stabilizing chronically suicidal and unstable patients. These were 'chronically mentally ill' clients who had spent years in hospitals without much change in their symptoms.

- Some of these clients also were violent toward staff, and they were viewed negatively as attention-seeking, manipulative, oppositional, passive-aggressive, and non-compliant.
- They were viewed as personality disordered, not as individuals who had experienced trauma

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Trauma-Informed Stabilization Treatment [TIST], p. 2

- **The premise underlying the TIST model** was that this **self-destructive behavior was inherently a survival strategy** instinctively mobilized to regulate unbearable or unsafe affects/impulses.
- **The high risk resulted from trauma-related inhibition of the prefrontal cortex** in response to stress
- Non-trauma-informed treatments did not have the desired results because **these clients were structurally dissociated and internally conflicted: '***do I want to be safe? Or do I want relief and a sense of control?'*

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What are the ingredients of TIST?

- **Neurobiologically-oriented understanding** of trauma
- **Focus on reinstating prefrontal cortical activity** as the prerequisite for behavior change and trauma resolution
- **Psychoeducational component:** patients are educated in the method, not just treated with it
- **Re-frames and externalizes the symptoms** to give client more psychological space between emotion and action
- **Combats shame- or paranoia**-related interpretations
- **Use of mindfulness skills** to decrease affect dysregulation
- **Assumption of "organicity:"** the brain and body's inherent intent is always adaptation and survival Fisher, 2023

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With "whom" will we work?

- **In traditional talking therapies, each affect or reaction is treated as an expression of the client's whole self.** But what if we are working with just a **part** of a whole person? A fragment or "slice" of the client? What if there is no observing ego or witnessing self?
- In trauma treatment, **we should assume the presence of structurally dissociated parts** so that we can be alert to their appearance in the therapy hour. By using the language of parts to differentiate a "Going On with Normal Life" Self from traumatized parts, we increase curiosity, support the ability to function, and increase the capacity for mindful internal awareness

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Cultivation of the Normal Life Self as a witness or observer

- **Neuroscience research tells us restoration of frontal lobe functioning is a prerequisite for trauma treatment** because traumatic threat and autonomic activation automatically cause inhibition of cortical activity.
- **Thus, the first priority is the cultivation of a witnessing self**, a part of the self that can observe, be curious, notice patterns, and hold the "reality principle"
- In Structural Dissociation theory, that self-witness is **the "Going On with Normal Life" self. S/he is asked to become** less disconnected or critical and **more curious, observant, to be more 'wise minded'** Fisher, 2008

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Noticing 'who I am' moment to moment

- **We assume that 'we are what we feel:'** but the repercussions of trauma complicate that assumption. What "I feel" could be a spontaneous response to the present moment, the implicit memory of a part, or a survival response. Further, what we feel gives rise to meaning-making which affects what we feel about what we feel
- **Self-study**: what is happening right here, right now, in this particular moment? **Ask the client to avoid interpretation in favor of just noticing with curiosity. What part feels nausea? Which part feels angry? Whose words is the patient voicing?**

Fisher, 2014

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"In order to do what you want, you have to know what you're doing."

Feldenkreis

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Learning parts language as a second language

- **Clients speak "I" fluently but not parts language, so we have to provide an intensive language class for them**
- **The therapist becomes a 'simultaneous translator.** Each time the client says, "I feel," the therapist translates the statement into parts language: *"A part of you feels hopeless," "the critical part thinks that's weakness," "a part of you wants to die."*
- **As in a language class, the more intensive the use of the second language, the more quickly the student learns.** The habit of prefacing each feeling with "I" is automatic for most people but dangerous for some clients Fisher, 2020

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"Speaking the Language" of Parts

- **Use of the "language of parts" increases mindfulness,** helps clients tolerate vulnerable feelings more easily
- **"Relentless re-framing"** helps clients to see the internal struggles and distress as messages from parts. When the client says, *"I hate myself,"* the therapist responds, *"Is that a part that hates the other parts? does that part just hate their feelings? Or is it angry at you?"*
- **"Relentless re-framing" encourages clients to pause, step back, and notice rather than react** to their thoughts, feelings or impulses. When they notice mindfully, their interest, curiosity and compassion naturally increase Fisher, 2022

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Don't be afraid to be 'relentless'!

- **'Relentless' means that we discipline ourselves to consistently use the language of parts** to counteract the automatic assumption of one "I." **We** have to hold the perspective that there is more than one "I"
- **It means that we consistently challenge habitual assumptions by re-stating them in the language of parts.** When the client says, "I hate myself," we respond, "Yes, there's a part of you that hates herself—and is there also a part that judges her"
- Just as with any foreign language, it is important to **practice to become fluent**. The therapist's fluency reassures the client that it isn't a sign of mental illness to have parts Fisher, 2010

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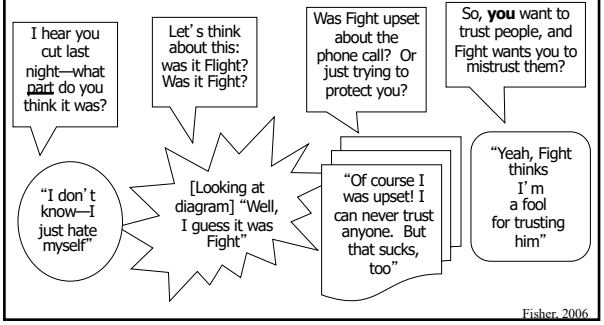
Connect Symptoms to Parts

In the context of client's having cut herself, therapist tries to evoke curiosity:



Fisher, 2006

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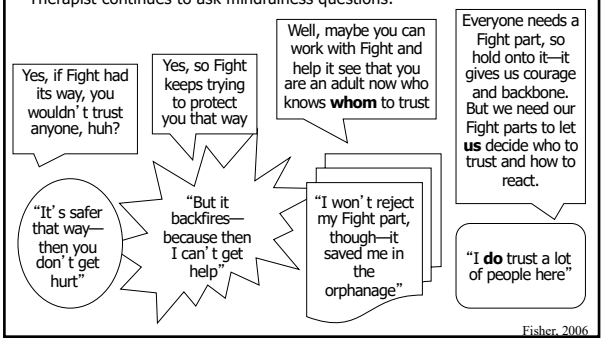
Connect Symptoms to Parts, cont.

Therapist continues to ask mindfulness questions:



Fisher, 2006

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The question trauma survivors don't know to ask . . .

"Which one of the many people who I am, the many inner voices inside of me, will dominate [today]? Who, or how, will I be? Which part of me will decide?"

Hofstadter, 1986

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How the parts dominate: "blending"
[Schwartz, 2001]

•When clients become flooded with a part's feelings and sensations and identify with or "blend" with them, **the thoughts and feelings of that part feel like "me."**

•Because they are **not aware that** they are blended and **these feelings belong to the parts**, clients act on them or try to suppress them, **forcing parts to become more intense**

•If only to ensure safety, **it becomes the therapist's job to help clients identify that they are blended:** *"There's a part of you here that feels utterly worthless, and you are blended with her. That doesn't help her—or you."*

Fisher, 2021

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Mindful "un-blending"

•**Unblending is a two-step process.**

•**First, we have to help clients begin to notice when they are "blending:"** *"Notice the hopelessness as a communication from a depressed part," "Notice the shame as the shame of that little girl…"*

•The therapist's compassionate tone is essential here. . .

•**Then clients are asked to 'just separate' from the part a little**: *"Just stay with that feeling and notice it as a part trying to tell you how angry he is. . . When you notice the anger and you name it as '**He** is angry,' do you feel better or worse?"* Most clients report feeling better when they use the 3rd person

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Building compassion, step by step

•**A direct approach tends to be too triggering for clients.** Keep in mind that compassion and kindness were once very dangerous in their experience

• Start with the basic ingredients of self-compassion:

•**Interest and curiosity:** once clients can use the language of parts, at least with you, ask them to be 'interested' in the part.

•**Listening:** could you listen to the part who's speaking?

•Interest, curiosity and listening rarely provoke resistance.

•**Next, we need to evoke more empathy for the part. . .**

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Building compassion, p. 2

•**There are two ways to evoke empathy for the parts in distress:**

- Facilitate imagining them: "Imagine that little child was right here in front of you. . . You can see the fear in her eyes. . . You can see the tear marks on her cheeks. . . Notice your impulse as you see her here with you."
- "How did this part help you survive?:" "Did it help that she was so quiet and afraid?" "Did it help he was ashamed?"

•**Next, empathy builds with inner dialogue:** "Ask the protector part what it's worried about if it doesn't harm the body?" "Ask the hopeless part what it's worried about if you have hope?"

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Building compassion, p. 3

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From alienation to attachment

- **There is a way for all wounded human beings to experience the love and comfort they didn't get 'then:'** by visualizing or imagining experiences, we evoke the same somatic responses as having had the experience
- **"Secure attachment," "comfort," "attunement" are all somatic:** we feel warm, our bodies relax, we feel an energetic connection and sense of safety. When our wise minds begin to provide those felt sensory experiences for young child parts, old wounds begin to heal
- As in all attachment relationships, this work requires what can seem like an endless and monotonous attention to the dysregulated feelings of the child parts Fisher, 2013

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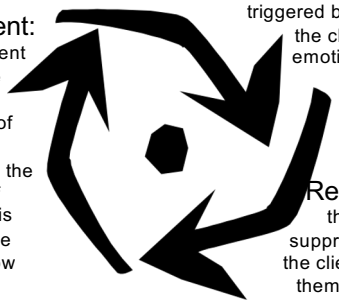
'Rupture and repair' of internal attachment

Rupture: a part is triggered by something; the client feels the emotional reaction

Attunement: when the client provides the missing experience of comfort or acceptance, the felt sense of attunement is evoked in the here-and-now



Repair: rather than ignore or suppress feelings, the client relates to them as a child's feelings

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Parts and reparative experiences

•In treating trauma, **we should not just be interested in what happened. We should also be interested in what should have happened but DID NOT.** Was the child offered comfort? Safety? A safe base for exploration? Freedom from fear of abandonment? Acceptance of anger and sadness? What were the "missing experiences"?

•**Each part has had a different missing experience:** Submit was not able to say "no" or set boundaries and still be safe and loved. Fight was not able to exercise control or defend the body against harm. Flight was trapped; Freeze couldn't move; Cry for Help was abandoned.

Fisher, 2023

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Types of missing experiences, cont.

•**A 'missing experience' is always offered as an experimental trial:** "Notice what happens when . . . ."

•**The missing experience could be a message:** "What happens to those feelings of emptiness when you say to that little one, 'Right here, right now, you are not alone'?"

•**It could be a gesture or movement:** "Notice what happens if you place your hand over the place that feels the sadness. . ." "What happens for the depressed part if you lift your chin a bit?"

•**It could be visualization :** "What happens when you take her hand in yours?" "When you hold her…"

Fisher, 2020

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Providing reparative or "missing experiences" for their parts

- **Encourage inner communication:** "Ask her if she can feel you here with her now? Let her know that we are listening, and we want to understand how scared she is."
- **Then, use the Four Befriending Questions to help clients frame the core fear:** is it fear of annihilation? Or is it fear of abandonment?
- **And answer the question:** "What does this part need from the Normal Life self in order to feel safer?? What is its 'missing experience'?
- **The Normal Life self is then asked to meet the need:** either verbally, somatically or emotionally Fisher, 2009

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Building trust with parts

- **Building trust with the parts is based on a series of steps:**
  - **Clients must be able to notice the parts** and communicate that they hear and see the part
  - **They must show curiosity and interest** by listening to the parts and trying to understand their feelings
  - **Awareness of blending** and being able to unblend builds trust
  - **Internal communication** is also a requirement for trust
- This gradual building of trust leads to a sense of being able to depend on the client to create a safe world for them

Fisher, 2023

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Establishing relationships with parts

- ***"How do you feel toward this part now?"*** is an IFS question that invites compassion and tests for mindfulness: **does the client have enough mindful distance to feel curiosity or compassion for this part?**
- If the client responds with indifference or hostility, we can assume that s/he is "blended" (Schwartz, 2001) with a part. **If the client responds, "I feel badly for her" or "I want to help him," we know that a relationship is beginning to form.**
- **Start by making sure client can feel the part:** "Is she here with you right now?" "What tells you she's there?"

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Repair of internal attachment

- **Emphasize the togetherness of Adult and child:** "What's it like for her to feel you here with her? To feel your interest and concern?"
- **Encourage inner communication:** "Ask her if she can feel you there with her now? Let her know that we are listening, and we want to understand how upset she is."
- **Cultivate trust:** "Let her know you understand: she wants to trust you but it's hard—she's been hurt so much. What's it like for her to sense that you 'get' it?"
- **Find the part's core fear**: "Could you ask the hopeless part what she is worried about?"

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Repair of internal attachment, p. 2

- To maximize the sense of attunement so that it can be experienced in the body, **the therapist tries to help the client connect to his/her spontaneous compassion for children**: "If this little girl were standing in front of you right this minute, what would you want to do? Feel it in your body. . . Reach out to her? Take her hand? Or pick her up and hold her?
- **"Feel what that's like to have this little boy in your arms? To feel his hand in yours? Is it a good feeling?**
- **"Take in the warmth of his body and the feeling of holding him safely. . .** Ask him if he would feel less scared if you did this every time he got afraid? Fisher, 2013

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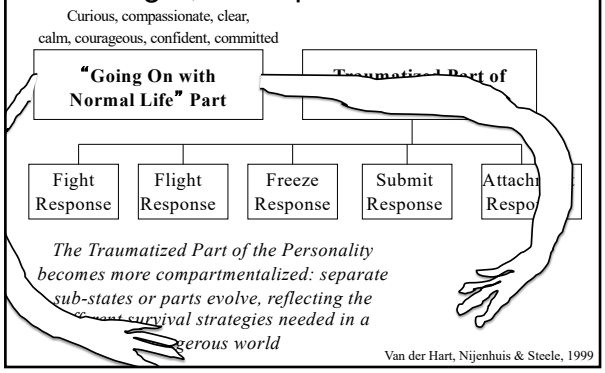
Common Ground: 'we are all held by a stronger, wiser person who cares'



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Sensorimotor Psychotherapy:
Somatic Interventions in the Treatment of Trauma

Vancouver Mental Health Summit
14 November 2023

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What is a **"trauma"** ?

"**Psychological trauma is the unique individual experience of an event, a series of events, or a set of enduring conditions**, in which:

- The individual's ability to integrate his or her emotional experience is overwhelmed (i.e., hate the feelings, and or
- The individual experiences (subjectively) a threat to life, bodily integrity, or sanity."

Saakvitne et al, 2000

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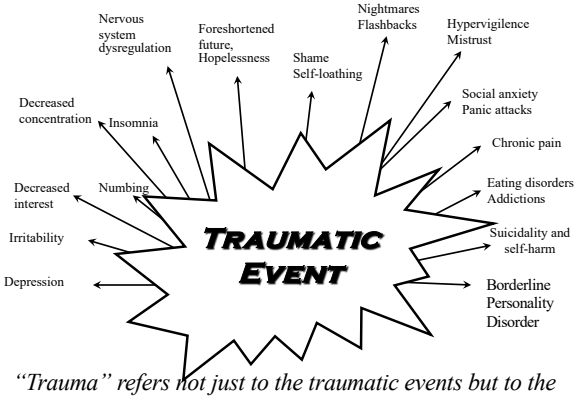
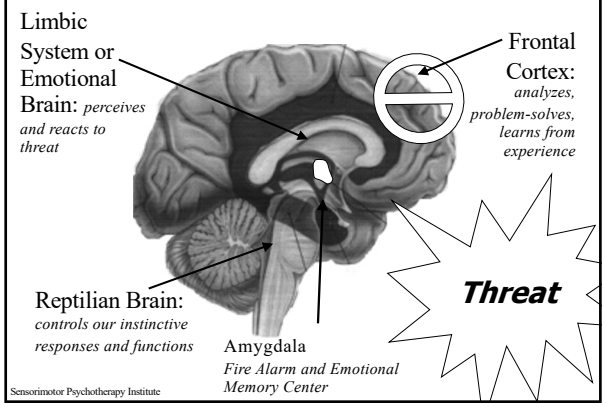


"Trauma" refers not just to the traumatic events but to the 'living legacy' of symptoms that result

3

Threat and the brain



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Why is it a 'living legacy'?

*"**Under conditions of extreme stress, there is failure of . . . memory processing**, which results in an inability to integrate incoming input into a coherent autobiographical narrative, **leaving the sensory elements of the experience unintegrated and unattached**. These sensory elements are then prone to return. . .when. . . activated by current reminders."*

Van der Kolk, Hopper & Osterman, 2001

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Sensory elements without words = implicit memory

- Brain scan research demonstrates that **traumatic memories are encoded primarily as bodily and emotional feelings** without words or pictures—detached from the event
- These implicit memories do not "carry with them the internal sensation that something is being recalled. . . . **we act, feel, and imagine without recognition of the influence of past experience** on present reality." (Siegel, 1999)
- **"Emotional memory** converts the past into an expectation of the future. . . [and] **makes the worst experiences in our past persist as felt realities."** (Ecker et al, 2012, p. 6)

Fisher, 2015

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Triggers and triggering

•The human body is self-protective: it automatically reacts to any cue indicating the **possibility** of danger.

•**The brain is biased to respond to any danger signal it has known before:** times of day, days of the week. times of year, gender and age, facial expression, colors, smells or sounds, weather conditions, a tone of voice or body language, touch, even our own emotions and body sensations

•When we get triggered, we experience **sudden and overwhelming feelings, sensations, and impulses that convey, "I AM in danger—right now!"** not "I was in danger then" Fisher, 2015

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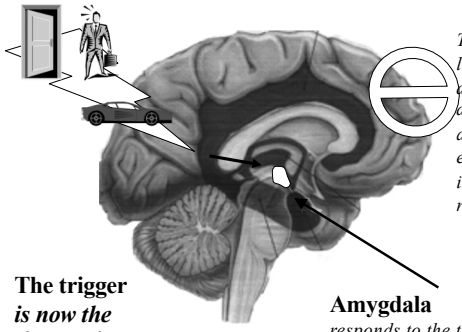
Triggering supports a sense of threat



The frontal lobes shut down or decrease activity to ensure instinctive responding

The trigger ***is now the threatening stimulus!***

Amygdala
responds to the threat cue by activating emergency stress response

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Triggered implicit memories take many different forms

•**"Feeling flashbacks"** of desperation, despair, shame and self-loathing, hopelessness and helplessness, rage

•**Chronic expectation of danger:** hypervigilance and mistrust, fear and terror, "post-traumatic paranoia"

•**"Body memories:"** numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking

•**Impulses and movements:** motor restlessness, 'hang-dog' posture, frozen states, impulses to "get out," violence turned against the body, huddling or hunkering down

•**Symptoms:** vegetative symptoms of depression, anxiety disorders, somatization disorder, OCD, addictive disorders, and Borderline Personality Disorder Fisher, 2014

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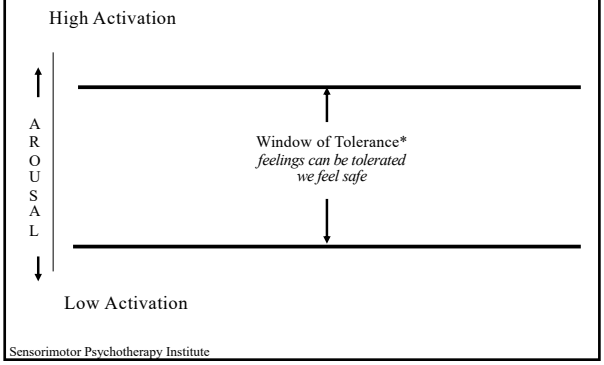
Autonomic nervous system is shaped by parental attachment behavior



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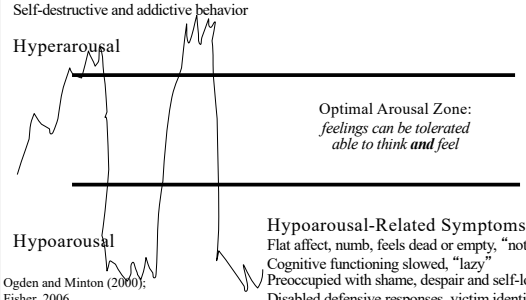
Autonomic Adaptation to a Threatening World

Hyperarousal-Related Symptoms:
Impulsivity, risk-taking, poor judgment, racing thoughts
Perceptual and muscular hypervigilance, post-traumatic paranoia, states of frozen terror
Intrusive images, sensations, emotions; flashbacks and nightmares
Self-destructive and addictive behavior



Hypoarousal-Related Symptoms:
Flat affect, numb, feels dead or empty, "not there"
Cognitive functioning slowed, "lazy"
Preoccupied with shame, despair and self-loathing
Disabled defensive responses, victim identity

Ogden and Minton (2000); Fisher, 2006
*Siegel (1999)

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"Long-lasting responses to trauma result *not simply from the experience of fear and helplessness but* ***from how our bodies [hold and] interpret those experiences."***

Yehuda, 2004

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Parts reflect the body's defensive responses

". . . We have to understand that our body, in going into certain types of responses when we are traumatized, is acting in a very heroic way. The body is helping us, it is saving us, and our body is not failing us—it is doing something special."

Porges, 2013, p. 20 (NICABM interview)

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Sensorimotor Psychotherapy

•Sensorimotor Psychotherapy is a body-oriented therapy developed by Pat Ogden, Ph.D. and enriched by contributions from Alan Schore, Bessel van der Kolk, Daniel Siegel, Onno van der Hart, and Ellert Nijenhuis.

•**Sensorimotor work combines traditional talking therapy techniques with body-centered interventions that directly address the somatic legacy of trauma.**

•Using the narrative only to evoke the trauma-related bodily experience, **we attend first to discovering how the body has "remembered" the trauma and then to providing the somatic experiences needed for resolution**

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"Small gestures and changes in breathing are at times more significant than the family tree"

(Christine Caldwell, 1997)

- Sensorimotor Psychotherapy is ***not focused on what happened then***
- The narrative is used to evoke the ***nonverbal implicit memories***: the autonomic responses, movements, postural changes, emotions, beliefs, etc.
- ***The therapist looks for patterns***, for habits of response: too much or too little affect, movement or stillness, negative cognitions, patterns of gesture or movement
- ***Therapist and client explore "right here, right now:"*** how is the client organizing internally in response to triggers? ***How is the memory being expressed somatically?***

Sensorimotor Psychotherapy Institute — Fay, 2004; Fisher, 2018

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Observing the client's habitual patterns of response

"In collaboration, therapist and client "study what is going on [for the client], not as disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded. The whole endeavor is more fun and play rather than work and is motivated by curiosity, rather than fear."

Kurtz, 1990, p. 11

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To stabilize, frontal lobe Inhibition must be reversed

"In order for the amygdala to respond to fear reactions, the prefrontal region has to be shut down. . . . ***[Treatment] of pathologic fear may require that the patient learn to increase activity in the prefrontal region*** *so that the amygdala is less free to express fear."*

LeDoux, 2003

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Mindfulness = noticing experience instead of talking about it

- **Awareness** or recognition of sensation, thought, emotion, movement, external stimulus (medial prefrontal cortex)
- **Detachment:** noticing it but 'not participating' in it or getting swept away by it (medial prefrontal cortex)
- **Labeling:** putting neutral language to what is noticed (e.g., "I'm having a thought—some emotion is coming up")
- **Mindfulness can be directed or directionless:** following the flow of thoughts, feelings and body experience as it unfolds or deliberately focused on an aspect of experience (e.g., the breath) Fisher, 2009

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Facilitating mindful awareness

- **Mindfulness in therapy depends upon the therapist becoming more mindful**: slowing the pace, refraining from interpretation or direction in favor of neutral observation, helping the client begin to focus on the flow of thoughts, feelings, & body sensations
- **Mindful attention is present moment attention**. We use "retrospective mindfulness" to bring the client into present time: "As you talk about what happened then, what do you notice happening inside you now?"
- **Curiosity is cultivated because of its role as an entrée into mindfulness**: "Perhaps by binging and purging, you were trying to help yourself get to the wedding. . ."

Fisher, 2009

19

Mindfulness skills

- "Notice . . ."
- "Be curious, not judgmental. . . "
- "Let's just notice that reaction you're having inside as we talk about your boy friend"
- "Notice the sequence: you were home alone, bored and lonely, then you started to get agitated and feel trapped, and then you just **had** to get out of the house"
- "What might have been the trigger? Let's be curious—go back to the start of the day and retrace your steps" Fisher, 2004

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Distinguishing thoughts, feelings, and body sensations

In traditional talking treatments, we do not always clearly differentiate cognition, emotion, and body responses:

For example, when we say, "I feel unsafe,"

- It could reflect a **cognition**: "I am never safe," "The world is not a safe place"
- It could mean an **emotion**: "I'm feeling frightened"
- It could mean **bodily sensation**: "My chest is tight; my heart is racing; it's hard to take a breath"
- It could mean **action**: "I want to hurt myself"

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Introducing mindful attention to somatic experience

Because somatic awareness can be threatening for trauma survivors, as well as helpful, **we introduce attention to the body slowly and carefully and track the patient's response:**

- "When you talk about feeling scared, how does that feel inside?"
- "That's the thought that goes with that scared feeling: what's the visceral sensation that goes with it?"
- "What sensations tell you that you're scared? How does your body tell you that?"

•Throughout, attention is paid to signs that the patient is becoming more, rather than less, dysregulated

Sensorimotor Psychotherapy Institute Fisher, 2004

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Increasing frontal lobe activity: offer a menu of possibilities

- "When you feel the panic come up, what happens? Do you feel more tense? More jittery? Or do you want to run?
- "As you feel that anger, is it more like energy? Or muscle tension? Or does it want to **do** something?"
- "When you talk about feeling 'nothing,' what does 'nothing' feel like? Is it more like calm? Or numbing? Or like freezing? " Ogden 2004

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Making it even easier: ask contrasting questions

- "Does that sensation feel good or bad? Is it more pleasurable or unpleasurable?"
- "Does it feel like something that will hurt you from the inside or the outside?"
- "When you say those words, 'I'm a loser,' does the shame get better or worse?"

Ogden 2004; Fisher, 2005

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On what should we focus?

•Trauma patients generally come to treatment because of post-traumatic triggering: trauma-related stimuli have stimulated anxiety symptoms, intrusive memories, overwhelming emotions, depression, and/or suicidality

•**The first goal of trauma treatment is to help clients recognize the role of triggering in causing and perpetuating their symptoms in order to empower them**

•With greater understanding comes decreased fear and shame when these responses are triggered. With more self-awareness and a language to describe what is happening, the capacity for self-regulation in the face of triggering can potentially increase

Fisher, 2008

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Pierre Janet 1859-1947

"[Traumatized] 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."

1919/25, p. 663

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Fisher, 2004

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Tracking the body: what story is the body telling?

As clients talk about "what happened," the narrative telling simultaneously evokes the thoughts, emotions, physical movements and body sensations associated with the event. The therapist uses this information along with the narrative to inform the treatment:

foot jiggling	trembling	slumping of the spine
rigidity	holding breath	hyperventilation
gestures	head down	blunted affect
gross motor	signs of autonomic	repeated words
movements	arousal	patterns of emotion

Sensorimotor Psychotherapy Institute Ogden, 2000; Fisher, 2003

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Keeping an "experimental attitude" Kurtz 1990; Ogden 2005

- **Heightened curiosity and interest: de-investment in the outcome.** We want to discover, not solve
- **Openness** to the client's experience, whatever it is
- **Mindful data collection:** "Let's see what happens if you _____. Notice what shifts—or doesn't shift."
- Everything that happens as a result of experiments is seen as useful information and therefore grist for the therapeutic mill. What doesn't work is of equal interest
- Therefore, **there are no "right" or "wrong" answers, no failures.**

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Expanding the Window of Tolerance

"*Our brains will continue to take in new information and construct new realities* ***as long as our bodies feel safe.*** *But if we become fixated on the trauma, then our ability to take in new information is lost, and we continue to construct and re-construct the old realities."* *van der Kolk, 2003*

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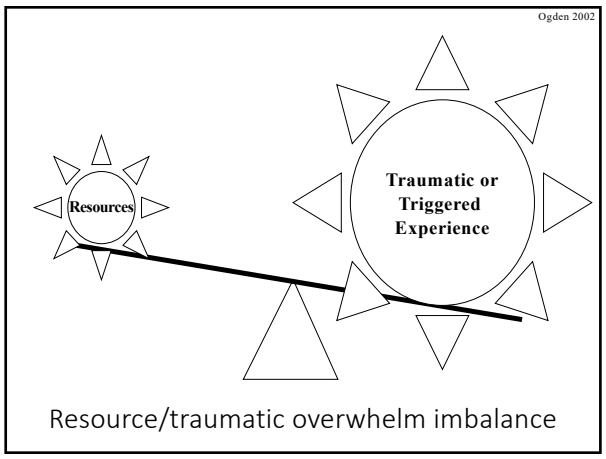

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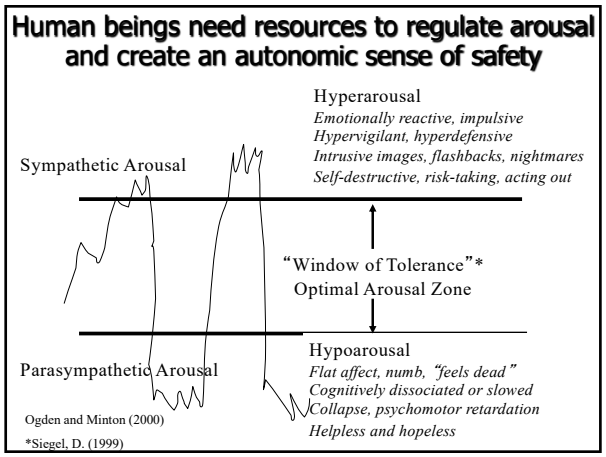

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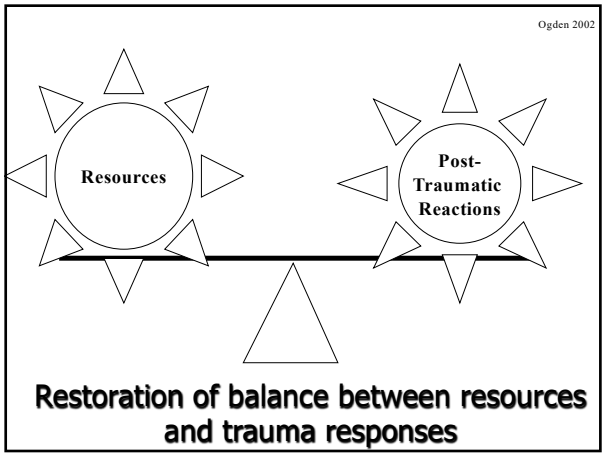

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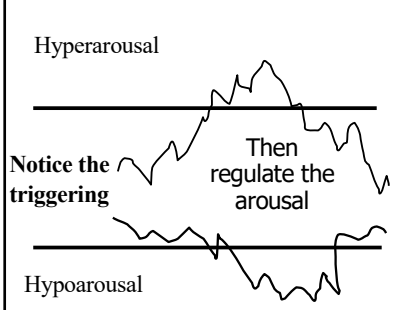
Teaching the skills to regulate arousal within the Window of Tolerance



Interventions

- Psychoeducation
- Curiosity
- Reframing
- Mindfulness
- Differentiating body, thoughts, feelings,
- Identifying triggers
- Tracking patterns
- Breathing or sighing
- DBT skills
- Somatic skills

Ogden 2006; Fisher, 2009

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Capitalizing on the body's "library" of resources

- When a client's frontal lobes go "off line," using somatic resources is often more effective because there is no requirement to "think," only to practice movements
- **The body is a rich source of resources:** movement, muscular tension and relaxation, breathing, balance, flexibility, alignment, musculoskeletal support
- **Many somatic resources support psychological capacities:** eg, musculoskeletal support enhances sense of emotional support, muscular relaxation supports relaxing anxiety, bodily flexibility supports psychological flexibility

Fisher, 2008

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Experimenting with somatic resources for traumatic reactions

Traumatic Reactions:	Resources:
Shaking, trembling	Deep breath or sigh
Numb, dazed	Grounding
Wanting to run	Lengthening the spine
Mobilized for "fight"	Slowing pace
Collapsed, helpless	Making a movement
Armoring, "on guard"	Hand on the heart
Pulling back, pushing away	Clenching/unclenching

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Learning to "drop the content"

- When triggered, **clients are often bombarded with thoughts that stimulate unresolved trauma responses**, further dysregulating an already fragile nervous system
- A sensorimotor skill to address triggering thoughts, images, or memories is the ability to **"drop the content:"** to "let go" of any distressing thoughts, images, and feelings and to choose the direction of attention
- **Dropping the content changes the client's focus:** from the dysregulating thoughts to the feeling of the feet on the floor, or to sensations in the body, or to a new belief, such as "I' m doing the best I can" or "I' m triggered—that' s all it is—just triggering"

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Establishing calm in the body

- **Restoring calm** to the body is a means of **sending the somatic message: "You are safe now."**
- If the therapy focuses primarily on the traumatic memories or on problems caused by triggering, clients will have difficulty achieving states of bodily calm in the therapy. **Any relief from 'talking about' will be offset by the autonomic dysregulation stimulated by memory**
- Teaching clients the importance of **learning to tolerate calm**, as well as how to achieve states of calm or to restore calmness after being triggered, will help to 're-calibrate' the autonomic nervous system to adjust to 'peacetime conditions' Fisher, 2007

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Tolerating states of calm

- For many trauma patients, **states of calm feel threatening rather than a relief.**
- For torture and cult survivors, procedurally learned hyperarousal, post-traumatic paranoia, and expectations of danger are "normal" states. **When calmness decreases hypervigilance, it increases the sense of danger.**
- For the hypoaroused client, calm states within the window of tolerance can result in increased connection to emotions and bodily experience that overwhelms rather than informs
- Often the therapist has to work toward achieving "calm but alert" states before "calm and relaxed" is possible

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Experiments for regulating hyperarousal and impulsivity

The client is asked to **do** something:

1. Breathe: take a deep breath or sigh and breathe out
2. Ground: feel the floor under the feet, push down against the floor with the feet, feel the support of the chair
3. Orient: slowly look all the way around the room and notice selected objects, colors, familiar things
4. Lengthen the spine: gently lengthen the lower back
5. Stand up: stand up, walk around, feel legs and feet
6. Create a boundary: with hands, energetic boundary

Fisher, 2008

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"When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over."

Judith Herman, 1992

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Being trapped in "ordinary responses to danger"

- Chronic expectation of danger: still feeling unsafe, the client remains hypervigilant, isolated and avoidant, phobic of many aspects of normal life
- Chronic self-destructiveness: decades after the trauma, the client is still fighting but now against her/himself
- Chronic despair and self-loathing: still trapped in a submissive, helpless state, she feels degraded, defeated, and powerless to help herself
- Chronically searching for rescue: though the client desperately searches for help, the 'right' help is never there

Fisher, 2013

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"Even when immobilization is the only survival option, the impulses to actively defend remain as urges concealed within the body long after the original trauma, often going unrecognized as manifestations of the legacy of trauma."

Ogden, Minton & Pain, in press

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"[The therapist must act as an 'auxiliary cortex'] and affect regulator of the patient's dysregulated states in order to provide a growth-facilitating environment for the patient's immature affect-regulating structures."

Schore, 2001

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Minimizing Negative Affect and Maximizing Positive

". . . The earliest phase of [attachment formation] involves calibrating the infant-caregiver relationship in regard to maintaining a positive state for the infant. **The parent's role in regulating negative arousal** during the first year **is not simply to respond with comfort when the infant is disturbed, but to avert distress** by maintaining the infant's interest and engagement in a positively toned dialog with the social and physical environment."

Hennighausen & Lyons-Ruth, 2005

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"Not only is the therapist . . . unconsciously influenced by a series of slight and, in some cases, subliminal signals, so also is the patient. Details of the therapist's posture, gaze, tone of voice, even respiration, are [unconsciously] recorded and processed. A sophisticated therapist may use this processing in a beneficial way, potentiating a change in the patient's state without, or in addition to, the use of words."

Meares, 2005, p. 124

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Strategies for neurobiologically regulating clients

- Varying voice tone and pace: soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- Energy level: very "there" and energetic versus more passive
- Empathy vs. challenge: how does the patient respond to empathy vs. challenge? Does s/he need limits or permission?
- Amount of information provided: noting the effect of psychoeducation or therapist self-disclosure vs. neutrality
- Titrating vs. encouraging affective expression: "too much" affect or shame-based ruminating can be dysregulating
- Speaking in ways that connect client to his/her resources: intellectual, spiritual, relational or emotional

Fisher, 2008.

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"The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

P = playfulness

A = acceptance

C = curiosity

E = empathy

Hughes, 2006

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"Leavening" Distress States with Positive States

"Playful interactions, focused on positive affective experiences, are never forgotten . . . Shame is always met with empathy, followed by curiosity. . . . All communication is 'embodied' within the nonverbal. . . . All resistance is met with [playfulness, acceptance, curiosity, and empathy], rather than being confronted."

Hughes, 2006

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Trauma is overcome through practice, not redemption

*"I believe that **we learn by practice**. Whether it means to learn to dance by practicing dancing or to learn to live by practicing living, the principles are the same. . . . Practice means to perform over and over again in the face of all obstacles, some act of vision, of faith, of desire. **Practice is a means of inviting what is desired."***

Martha Graham

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