DOI: 10.17689/psy-2019.2.7

УДК 378.4

Sensorimotor Psychotherapy: A Body-Oriented Form of Talk Therapy

© 2019 Lynne H. Harris*,

* MA, MPH, a Licensed Professional Counselor (LPC) / Licensed Mental Health Counselor (LMHC) in the United States (Saint Marys, USA),

lynneharris.lpc@gmail.com

Annotation: Sensorimotor psychotherapy is a body-oriented form of talk therapy that was developed in the 1980s by Pat Ogden, PhD, and informed by the works of Ron Kurtz (1990) and the Rolf method of body work. It draws on, and incorporates, the contributions from the research on attachment, trauma, neuroscience and dissociation. Sensorimotor Psychotherapy blends cognitive and emotional approaches with physical interventions to address the implicit memories and neurobiological impact of trauma. Implicit memories are different than explicit or narrative memories in that they are stored in the body as emotional states and procedurally learned patterns of thinking and feeling. They are often not recalled as memories at all, but rather show up as intrusive experiences that feel like "now". Sensorimotor psychotherapy is particularly effective at addressing the implicit memories because in Sensorimotor psychotherapy the route of access is the body and not the person's story about what happened. As many practitioners have found, talking with patients about what happened often does not result in resolving the trauma, and, in fact, can make symptoms worse because talking will bring up what is stored as implicit memory.

Key words: body, trauma, sensorimotor psychotherapy

Сенсомоторная психотерапия: ориентированная на тело форма разговорной терапии

© 2019 Линн Х. Харрис*,

* МА, МРН, лицензированный профессиональный консультант (LPC) / лицензированный консультант по психическому здоровью (LMHC) в США (Сан-Мэрис, США), lynneharris.lpc@gmail.com

Аннотация: Сенсомоторная психотерапия – это телесно-ориентированная форма вербальной терапии, которая была разработана в 1980-х годах Пэт Огден, и, основана на работах Рона Курца (1990) и метода работы тела И. Рольф. Данная форма терапии ориентирована на исследования привязанности, травмы, неврологии и диссоциации. Сенсомоторная психотерапия сочетает когнитивный и эмоциональный подходы с физическими вмешательствами для устранения неявных воспоминаний и нейробиологического воздействия травмы. Неявные воспоминания отличаются от явных или повествовательных воспоминаний тем, что они хранятся в теле в виде эмоциональных состояний и процедурно выученных моделей мышления и чувств. Они часто вообще не вспоминаются как воспоминания, а скорее проявляются как навязчивые переживания, возникающие в «моменте». Сенсомоторная психотерапия особенно эффективна для устранения неявных воспоминаний, потому что в сенсомоторной психотерапии путь доступа - это тело, а не история человека о том, что произошло. Как выяснили многие практикующие врачи, разговоры с пациентами о том, что произошло часто, не приводят к устранению травмы и, фактически, могут усугубить симптомы, потому что разговор поднимает то, что хранится как неявная память.

Ключевые слова: тело, травма, сенсомоторная психотерапия.

Top Down vs Bottom Up Approaches to Therapy

Sensorimotor Psychotherapy might be thought of as a “bottom up” approach to therapy vs. a “top down” approach to therapy such as in more cognitively-based approaches. In a top down approach, we are looking to effect change in cognitions and emotions as the way to bring about symptom relief, and the point of entry through which change is made is through the patient’s narrative, their words. In a bottom up approach, we focus on effecting change in a patient’s interpretation of physical sensation as the route of change/symptom relief. The point of entry is the body, not words.

Examples of top down interventions in therapy might be clarifying meaning, addressing cognitive distortions, telling the story of what happened, connecting affect to past experience, gaining insight, putting words to feelings. Examples of bottom up interventions are tracking and regulating repetitive or intrusive body sensation related to trauma, somatic grounding and resourcing, and orienting to the present using one’s senses.

Top down approaches that people are generally familiar with are Cognitive Behavioral Therapy, Dialectical Behavior Therapy, or psychodynamic psychotherapy.

Types of bottom up approaches include Sensorimotor Psychotherapy, Somatic Experiencing, and Eye Movement Desenstization and Reprocessing.

Ideally, in the option of this writer, therapists want to use use a mix of cognitive and body oriented approaches for the best results in the resolution of trauma.

Lasting Impact of Trauma

The recent research on trauma, especially in the Sensorimotor Psychotherapy literature, demonstrates the lasting impact of trauma long after the traumatic events themselves are over. Ogden (2006, 2009), Van der Kolk (1991, 2005), Siegel (1999), Herman (1992), Fisher (2003), among others all describe the process by which the neurobiological effects of trauma drive the symptoms. The same responses that help preserve us physically and psychologically under threat also drive the symptoms of

Post Traumatic Stress Disorder. The literature on complex trauma shows that If an environment is chronically traumatizing, (e,g, chronic abuse or neglect, a mentally ill or addicted parent, violence in the home, lack of attunement between caretaker and child, etc.) the survival response will become chronically activated. This means that the human nervous system remains “stuck” in either hyperarousal or hypoarousal, or oscillates between the two, often using hypoarousal as the “brake” on chronic hyperarousal. This is represented in Dan Siegel’s discussion of the Window of Tolerance.

Children have an additional risk factor in that the person who would provide safety in the moment of danger, e.g. a care taking adult, is often the source of danger or non-protection from danger. This results in the biological drive to attach being in direct conflict with biological survival responses. This leads often to a disorganized attachment pattern (cite sources).

Common presenting behaviors among people with complex trauma resulting from early onset, chronic maltreatment are self-injury and suicidality, risk taking, re-enactment behavior, self-sacrificing or overly caretaking, re-victimization, and addictive behavior. Van der Kolk, et al (2005) has developed clinical terminology that goes beyond the existing clinical diagnostic description of PTSD to incorporate, and more accurately capture, the symptomology and neurobiolgical adaptations caused by chronic trauma in the term Disorders of Extreme Stress, or DESNOS. In any case, when a therapist is working with a patient who presents with this cluster of symptoms, it is very difficult to treat.

Sensorimotor Psychotherapy in Practice

The following is an example of what using Sensorimotor Psychotherapy in a session can look like. It is based on a case study published in Trauma Psychology News, 2019, 14(1), pp. 19-20. A client with complex trauma and dissociative disorder, with whom I have worked for over two years, was telling me in a session about a recent episode of intense dysregulation based on a very mundane event (she was buying donuts in a store and could not get her usual order). My client describes

that her immediate reaction was one of utter terror in her body, heart rate racing, couldn't talk, dissociated on the spot. She went home in what she described as a state of terror and fear and it took into the next day to calm it down. She reported this to me in our session almost a week later. We mindfully studied the body response evoked in the session by her retelling of the events, and focused on noticing the hyperarousal in her CNS as "just sensation" without attending to the contents of any thoughts or distorted cognitive schemas that were attached to it (e.g. I'm going to die, I'm in trouble, something bad is going to happen, etc.). While noticing the sensation of fear in her body, I asked her to locate where she felt it the most (in her chest) and somatically resourced that part of her body by asking if it felt ok to put a hand to chest where she felt it. I asked her to try to notice if the *intensity* of the feeling fit the situation at hand ("just you and me talking in my boring office"), or if it was a better fit for something that may have happened another time. My client was able to identify it was more congruent with past situations. I reframed it as a "body memory" or "sensory memory", a form of a flashback. Then I encouraged her to cognitively explore what the *actual* consequence might be when she came home without the preferred donut. We discussed how in the donut situation the worst case scenario was that her partner might be disappointed, or possibly angry, or that she was frustrated with the Dunkin Donut staff, but, I pointed out, none of those possibilities were life or death situations, and yet that is what her body was signaling to her. "It is just a donut", I said, "It is not life or death", "we are just in my office, talking". She looked at me, clearly back in her adult self and back in the room and laughed out loud and repeated "It's just a donut! It's not life or death!". We repeated it laughing.

So now, when she feels the old sensation of fear escalate in her body when we are working on something that triggers the sympathetic nervous system defensive response, she recognizes it, puts a hand on her chest and one on her belly and says, "This is fear. This is where it lives". I sometimes do it with her. I place a hand on my chest and one on my belly. Together we say "It's just a donut. Nothing is happening now". Sometimes, I ask her to notice specific objects in the room to help reorient and

reground. A favorite is to guess the stylistic era of the fabric on the couches (we think late 1980's, early 1990's). We somatically track the reduction of nervous system arousal as the re-orientation to safety in the present moment allows the amygdala to turn off and nervous system to return to baseline functioning.

In conclusion, Sensorimotor Psychotherapy is a highly effective form of therapy for working with trauma, dissociation, anxiety, depression or with any client who would benefit from being more connected with their body. Without that, a lot of information is missed and the symptoms are not so readily resolved resulting in misdiagnosis and prolonged treatment, as well as poor treatment outcomes.

References:

1. Fisher, J. (2017). Healing the fragmented selves of trauma survivors: Overcoming self alienation. New York: Routledge.
2. Herman, J. L. (1992). Trauma and recovery. New York: Basic Books.
3. Siegel, D. J. (1999). The developing mind: Toward a neurobiology of interpersonal experience. New York: Guilford Press.
4. Van der Hart, O., Nijenhuis, E. R.S., & Steele, K. (2006). The haunted self: structural dissociation and the treatment of chronic traumatization. New York: W.W. Norton.