

# Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

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## Abstract

Research has consistently demonstrated a connection between affect dysregulation and experiences of early childhood neglect, trauma and attachment failure (Van der Kolk, 2015; Courtois & Ford, 2009; Ford et al, 2005; Siegel, 1999). Without adequate regulation of infant distress states, the autonomic nervous system and affect-regulating brain structures fail to develop optimally (Schoore, 2003). Affect dysregulation is a component of all mood disorders, anxiety disorders, post-traumatic stress disorder, and borderline personality disorder as well as a contributor to addictive and self-injurious, and suicidal behavior. Methods to increase self-regulation are crucial to the effectiveness of any treatment for these issues. Traditional therapeutic modalities that address distorted cognitions, focus on emotional expression, or expose individuals to traumatic memories often fail to modify autonomic dysregulation in response to present day experience. Sensorimotor Psychotherapy (Ogden & Fisher, 2016; Ogden et al, 2006), a somatically-oriented talking therapy, approaches affect dysregulation as a subcortical physiological issue central to the treatment of traumatic stress.

## Keywords

Trauma, abuse, neglect, post-traumatic stress disorder, attachment, affect dysregulation, somatic interventions, trauma treatment

This paper describes Sensorimotor Psychotherapy, a psychotherapy method focused on addressing the physiological as well as psychological effects of traumatic experience. Twenty-five years of research has substantiated the relationship between Post-traumatic Stress Disorder and autonomic dysregulation and unresolved physical responses, creating a need for somatic

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approaches that address these effects and can be integrated into traditional trauma treatment modalities.

In the aftermath of traumatic events, individuals are left with a host of easily re-activated neurobiological responses and an inadequate memory record (Van der Kolk, 2015; Van der Kolk, McFarlane & Weisaeth, 1996). They report intense emotional responses without words and with no apparent connection to any precipitant or past experience. Long after the events have ended, traumatized individuals can continue to experience flashbacks and nightmares, intense emotions of fear, shame and rage, numbing of feelings and body sensation, and a loss of initiative and energy, reflecting a body that has experienced allostasis and consequent development of Posttraumatic Stress Disorder (PTSD). Painful negative beliefs about the self often further intensify the distressing emotions and physical responses (van der Kolk, 2015; Courtois & Ford, 2009), affecting posture, breathing, freedom to move, even heart rate and respiration.

### **Autonomic Effects of Trauma**

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It is now well established (Van der Kolk, 2015; Van der Kolk et al, 1996, Levine, 1997, LeDoux, 2002, Porges, 2011, Ogden et al, 2006) that exposure to threat or danger stimulates autonomic nervous system activity governing the animal defense survival responses of fight, flight, freezing and total submission or ‘feigned death.’ Fight and flight responses are driven by the sympathetic branch of the autonomic nervous system via the release of norepinephrine to increase heartrate and respiration and maximize oxygen flow to muscle tissue. The parasympathetic branch of the autonomic nervous system, stimulated concurrently in response to threat, then inhibits sympathetic arousal and active defensive responses. Via the rapid metabolization of adrenergic neurochemicals, decreased heart rate and respiration, and sudden loss of energy, the parasympathetic system facilitates total submission or “feigned death” responses (Porges, 2011), exhaustion, and numbing (LeDoux, 2002; Scaer, 2014). Freeze responses are characterized by high sympathetic activation coupled with physical immobility and are often implicated in date rapes when freezing prevents the victim from speaking or resisting (Ogden, Minton & Pain, 2006). Heightened sympathetic and parasympathetic arousal are both associated with inhibited cortical activity to facilitate instinctual responding (LeDoux, 2002). This automatic engagement of ‘bottom-up’ defensive responses compromises the individual’s ability to stay conscious and fully aware, inhibits

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hippocampal activity, and therefore interferes with memory encoding and cause-effect perception.

### **Psychiatric Consequences of Traumatic Exposure**

Subsequently, the brain and body become sensitized to perceptual stimuli associated with each traumatic experience, presumably to increase muscular and autonomic hypervigilance in anticipation of threat. When traumatized individuals later face a reminder of that event (i.e., a potential danger cue or similar stimulus), the brain and body respond with the same emergency stress and animal defense responses, whether or not they are currently appropriate (Van der Kolk, 2015; Van der Kolk et al, 1996). In the aftermath of trauma, it is common for individuals to experience chronic alterations in attention and reactivity, especially autonomic nervous system responsiveness to daily life stress and especially to any subtle or obvious reminder of the traumatic events. With a nervous system that does not easily recover from heightened states of emotion or from states of depression and numbing, survivors of trauma frequently report difficulty with affect regulation (van der Kolk, 2015; Ogden et al, 2006). Autonomically-driven emotional arousal may feel overwhelming and unmanageable at times while blunting or

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disconnection from affect may result in numbing of sensation and emotion, and a sense of detachment. The former is often accompanied by impulsive action-taking, the latter by passivity and loss of energy and initiative.

Maintaining a state of well-being is often challenged by this heightened vigilance and sensitivity to trauma-related stimuli. Non-threatening situational cues reminiscent of the traumatic event or its context may activate sympathetic nervous system activity and fight-flight responses, while dangerous situations paradoxically elicit parasympathetic non-responsiveness and obliviousness to personal safety (Herman, 1992). When the traumatic experiences have occurred repeatedly and have been chronic over many years or when they have occurred in the context of “enduring conditions” (Saakvitne, 2002) (such as is the case with physical, emotional or sexual abuse, domestic violence, and combat), the body and nervous system develop habitual responses (e.g., automatic obedience, hyperactive fight/flight responses, hypervigilance, loss of sensation, heightened tolerance for pain) once adaptive in a traumatogenic environment but now maladaptive or even dangerous. Clients report being driven by powerful impulses seemingly beyond their control, finding themselves frozen in terror, inexplicably collapsed and passive, or alternatively over-reactive or responsive.

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Repeated activation of the autonomic nervous system in response to trauma-related stimuli interferes with subsequent development of affect regulation and predisposes traumatized individuals to a number of mental disorders: chronic depression (Thabet et al, 2004), anxiety disorders, chronic PTSD, and borderline personality disorder (Fisher, 2017; Courtois & Ford, 2009). When clients with these disorders present with a past history of trauma, neglect and/or attachment failure, treatment is often complicated by their sensitivity to trauma-related stimuli and autonomic dysregulation and related vulnerability to decompensation and regression under stress. The treatment of trauma-related depressive disorders, anxiety disorders and PTSD is further complicated by the array of secondary symptoms associated with these disorders that provide chemically- or behaviorally-induced autonomic regulation (Fisher, 2017; Ogden et al, 2006). These include addictive disorders (Min et al, 2007), eating disorders (Kong & Bernstein, 2009), obsessive-compulsive disorder (Dykschoorn, 2014), risk-taking, self-destructive behavior, and suicidality (Krysinka & Lester, 2010; Khoury et al, 2010). Traditional talk therapies (including psychodynamic psychotherapy, psychoanalytic methods, cognitive-behavioral treatment, and prolonged exposure techniques) can often sufficiently manage the secondary symptoms to ensure patient safety, desensitize individuals to the traumatic memories, and help them process the resulting emotions, but traditional psychotherapy

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models generally lack techniques that directly treat the autonomic and somatic effects that perpetuate the psychophysiological symptoms.

## **Introduction to Sensorimotor Psychotherapy**

It is in this arena that the use of Sensorimotor Psychotherapy can be invaluable in treating the autonomic and affective dysregulation that underlies the symptomatic legacy (both intrusive and numbing responses) of traumatic events. Developed in the 1980s by Pat Ogden, Ph.D. as a body-centered talking therapy, Sensorimotor Psychotherapy (Ogden & Fisher, 2015; Ogden et al, 2006; Ogden & Minton, 1999) is designed to specifically address the bodily and autonomic symptoms of traumatic stress disorders and the cognitive-emotional aspects. Because it does not require the use of hands-on interventions, it is a somatic approach easily integrated into all traditional inpatient and outpatient talking therapies for trauma-related disorders. Sensorimotor Psychotherapy incorporates treatment techniques derived from psychodynamic psychotherapy, gestalt therapy, cognitive-behavioral therapies, and the Hakomi method of body psychotherapy (Kurtz, 1972). Its theoretical principles are based upon a number of well-established theoretical models and the neuroscience research findings on the effects of traumatic



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experience on the brain and body (Van der Kolk, 2015; Van der Hart et al, 2006; Van der Kolk et al, 1996).

Drawing upon Fisher & Murray's theoretical model of Hierarchical Information Processing (HIP) (1991), Sensorimotor Psychotherapy makes a clear distinction between cognitive, emotional, and sensorimotor or subcortical processing, differentiating "higher level" integration from "lower level" or somatic processing on which it depends. "Lower parts of the brain are conceptualized as developing and maturing before higher-level structures; development and optimal functioning of higher-level structures are thought to be dependent, in part, on the development and optimal functioning of lower-level structures (Fisher & Murray, 1991, p. 16)."

It was Pat Ogden's belief that addressing subcortical areas of the brain was necessary to regulate the autonomic nervous systems of traumatized clients prior to narrative processing or prolonged exposure. In addition, Sensorimotor Psychotherapy incorporates techniques similar to those used in Focusing (Gendlin, 1981) in which clients are asked to observe moment-by-moment the physical and emotional 'felt-sense' of their experience rather than simply "talk about it." In Sensorimotor Psychotherapy, this practice of asking the client to focus on the minute details of cognitions, emotions, internal body sensations, movements, and sensory perceptions he or she is experiencing is defined as "directed mindfulness" (Ogden & Fisher, 2016). Although the

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effectiveness of these somatosensory techniques has not been formally researched using a control group paradigm, the effects of mindful concentration on brain function have been studied. Brain scan research on meditation shows increased activity in the brains of experienced meditators in areas governing attentional processes (i.e., the medial prefrontal cortex and anterior cingulate) and in areas regulating arousal and autonomic control, (i.e., the amygdala and hypothalamus [Lazar et al, 2000; Davidson et al, 2003; Creswell et al, 2007]). Because activity in these brain areas has been found to be compromised in subjects with PTSD, it is a promising finding that meditation and associated mindfulness techniques can counteract trauma-related physiological responses.

### **Evidence Base for Sensorimotor Psychotherapy**

Currently, no formal control group effectiveness research has been conducted to attest to the efficacy of Sensorimotor Psychotherapy as a general treatment strategy or one that is specific to the treatment of trauma. Two studies have been published, however, on the results of research on a Sensorimotor Psychotherapy time-limited group therapy protocol. Langmuir et al (2012) reported on a pilot study of subjects receiving weekly Sensorimotor Psychotherapy-informed group treatment focused on regulating autonomic arousal and stabilizing PTSD symptoms. Ten subjects in a hospital-based outpatient group reported

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improvement in dissociative symptoms, internal awareness, and receptivity to soothing at the end of the group treatment and at six-month follow-up. Gene-Cos et al (2016) used a twelve session Sensorimotor Psychotherapy group protocol (Fisher & Ogden, unpublished manuscript) incorporating psychoeducation, body awareness, and skills for regulating autonomic arousal. Following the 12-week inpatient group, the 20 subjects reported decreases in depressive symptoms and PTSD symptoms and increased scores on measures of overall health and social/vocational adjustment. Most were able to move on to a less restrictive level of care.

Sensorimotor Psychotherapy for the treatment of trauma has been developed primarily from clinical practice, guided by research findings and theoretical developments in the areas of sensory integration, trauma, and neuroscience, which have then been integrated with techniques derived from other therapeutic methods. In single case studies, subjects have reported satisfaction with the effectiveness of the Sensorimotor techniques in resolving symptoms and in increasing feelings of mastery and well-being (Riley, 2015). Clinical observations and experiences, as well as feedback from clients, have been utilized to develop and modify specific interventions. Until formal efficacy research is undertaken, however, the effectiveness of the Sensorimotor Psychotherapy method is not substantiated,

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although the mechanisms underlying its principles and interventions have been . Currently, research studies are being planned but are not yet underway.

### **Treatment Methods and Rationale**

Sensorimotor Psychotherapy interventions emphasize attention to modulation of autonomic arousal and re-instatement of adaptive responses. A typical session begins as would most psychotherapy sessions: with a client narrative. However, rather than using narrative techniques to ‘talk about’ the experience, the Sensorimotor psychotherapist instead directs the client’s focus to the habitual patterns evoked by the recollection. As the patient speaks of the traumatic event, the therapist observes his or her emotional and bodily responses to ascertain how these experiences have been encoded nonverbally and autonomically (Ogden et al, 2006). Even when different individuals are exposed to the same traumatic event, their psychophysiological organization of it will differ (Terr, 1992). Each traumatized individual uniquely encodes an event or events as some combination of images, smells, sounds, autonomic responses, visceral and muscular sensations, movements and impulses, emotions, and cognitive and narrative components. This phenomenon accounts for the difficulty many traumatized patients report in recounting their traumatic experiences: the narrative memories are fragmented rather

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than sequential and evoke the intense physical and emotional non-verbal components of the experience rather than contributing to its resolution (Van der Kolk et al, 2001). Moreover, they are often so aversive that clients avoid them, exacerbating the post-traumatic irresolution that renders individuals vulnerable to being autonomically triggered, a quite common vicious cycle for trauma survivors. It is not until these experiences are faced to some degree and the response and reactivity are quelled that they can become more coherent and integrated and thus less subject to unregulated autonomic stimulation.

Therefore, the Sensorimotor psychotherapist focuses on increasing the client's non-judgmental awareness of persistent physical, cognitive and emotional responses evoked by the narrative or by trauma-related stimuli. Rather than the focus of treatment being the event itself, the client is asked to mindfully notice rather than interpret or analyze the succession of thoughts, feelings and body sensations or movements that occur when thinking or talking about the event. This emphasis on mindful noticing of thoughts and feelings is often affectively and autonomically regulating in itself. Narrative re-telling of distressing experiences or over-learned interpretations of what happened (such as 'It was my fault') activate left hemisphere long-term memory areas and associated affects,

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resulting in emotional and autonomic reactivity. The Sensorimotor Psychotherapy focus on observing what takes place with curiosity and mindful attention activates the medial prefrontal cortex (Davidson et al, 2003) thought to be an integrative center and the part of the brain responsible for interoception or internal awareness. The medial prefrontal cortex has deep connections to both cortical and subcortical areas including the amygdala, the brain structure regulating threat perception and autonomic arousal (van der Kolk, 2006). Numerous brain scan studies of subjects practicing mindfulness meditation (Creswell et al, 2007) demonstrate a reciprocal relationship between activation of the medial prefrontal cortex and de-activation of the amygdala.

### **Innovative Techniques and Interventions**

A significant clinical feature of Sensorimotor Psychotherapy is its emphasis on the fostering of “dual awareness (Ogden & Fisher, 2016; Ogden et al, 2006).” Dual awareness is a term from the mindfulness meditation world that describes attending to multiple states of consciousness simultaneously. In a state of dual awareness, the client is able to observe images of a past experience while feeling simultaneously the associated emotions or physical reactions, all the while observing them as emotions, thoughts,

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sensations, or movements. Long after clients have reached the intellectual conclusion that they are safe in their current lives, the body's post-traumatic responses re-create an internal experience of threat (Van der Kolk, 2015; Ogden et al, 2006; Courtois & Ford, 2009), adversely affecting reality-testing. Dual awareness allows them to 'hover above' the intense images and emotions, increases the ability to differentiate past from present, and supports awareness of feeling endangered rather than misinterpreting their responses as immediate threat. Effective resolution of post-traumatic symptoms and prevention of inadvertent re-traumatization, both during psychotherapy and in the context of normal life, requires the ability to maintain dual awareness in the face of post-traumatic dysregulation.

In a mindful state that encourages observation rather than reactivity, traumatized individuals learn to become more curious rather than fearful as they notice their emerging thoughts, emotions, sense perceptions, internal body sensations and movements. Under the guidance of the therapist, they are asked to pause periodically as they speak about distressing or traumatic experiences to observe the interplay of thoughts, feelings and visceral responses that arise moment-to-moment and/or to regulate their autonomic or emotional arousal. The goal is to process and re-organize the experience so that it no

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longer has an overwhelming or debilitating effect. In Sensorimotor Psychotherapy treatment, psychoeducational input is utilized to educate clients about trauma's effect on body experience and to increase their capacity to sustain 'dual awareness' in the face of traumatic activation. Mindful observation requires practice but also education as well: the therapist may need to teach clients how to mindfully observe trauma-related emotions and sensations, how to understand the role of autonomic activation in what they are experiencing, and how to regulate their bodies' defensive responses of fight-flight-freeze and submission in the present moment with the active support of the therapist. Cognitive understanding of how their symptoms preserved physical and psychological integrity under threat or the role of autonomic arousal in driving current symptomatology (van der Kolk, 2006) is usually helpful to clients, often facilitating treatment compliance, lessening self-judgment and self-blame, and increasing curiosity.

In each session, clients are asked to practice observing and naming, without judgment or interpretation, any thoughts, feelings, body sensations, and movement impulses that arise as they discuss traumatic or other events. In the course of these observations, clients typically begin to notice patterns of response. Guided by the therapist, the client might observe how a trauma-related body sensation immediately leads to a thought, how that



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thought evokes a negative emotional response which in turn evokes a body response, leading to another negative thought, all evoking increased emotional overwhelm. Clients then learn how to interrupt this pattern and how to manage and increasingly regulate their responses. Through the practice of mindful observation, clients gradually develop increased ability to become aware of their inner experience without becoming overwhelmed by it and to choose to what they wish to attend and what they wish to put aside for the time being. As individuals experience increased ability to maintain a relationship to their distress and its symptoms, rather than becoming overwhelmed or responding impulsively, their confidence in addressing their traumatic experience grows. When they learn next to deliberately shift focus away from disturbing material and on neutral or pleasurable stimuli until the autonomic arousal subsides, they begin to feel a sense of mastery in relationship to the trauma, countering the sense of powerlessness they previously experienced. In those moments, the relationship to the memory or event is ‘re-organized.’ Clients report feeling less helpless and hopeless, less anxious, more ‘here’ and in personal control. An ability to recall the event as distressing without becoming overwhelmed, to feel emotions without flooding or acting out in some way, represents a transformation of the memory from ‘danger now’ to ‘finally over,’ from overwhelming to manageable.

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In addition to increasing the client's capacity to maintain dual awareness and states of optimal arousal, the Sensorimotor psychotherapist also teaches clients how to use somatic 'skills' that prevent overwhelm, increase ability to recover from traumatic reminders, and restore states of calm. For example, the therapist may help a patient to notice that, each time he has the thought, 'It was my fault,' he experiences the acute flooding of shame leading to a slump in his spine, collapse in the chest, and averting of the head and eyes down and away. Having noticed the pattern, the therapist then begins a process of helping the patient to reorganize it, first by noticing it and becoming curious, then by exploring how a physical intervention (such as lengthening the spine or lifting the head) affects this habitual organization of response. If the patient lengthens his spine and raises his head slightly, what happens? And what happens if he exaggerates the collapse and gaze aversion? Does the fear increase or decrease? Interventions for increasing somatic and ego functioning are termed "somatic resources" (Ogden et al, 2006) and many (such as feeling the ground under one's feet, placing a hand over the heart, lengthening the spine, turning toward or away, moving closer or farther away) impact psychological functioning. Conversely, many psychological resources have somatic correlates: confidence is often experienced somatically as a feeling of being taller, physically

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stronger, more solid, or more flexible. Acceptance or compassion are often accompanied by a warmth in the chest, sense of opening, and relaxation of the musculature. The English language includes many expressions that capture this relationship between body and psyche: ‘keep your head held high,’ ‘stiff upper lip,’ ‘hang-dog,’ ‘having a backbone,’ ‘weak in the knees,’ or ‘having a warm heart.’

### **Regulation of Autonomic Arousal**

Diagnostic criteria for PTSD (and associated post-traumatic stress responses and disorders) reflect the role of dysregulated arousal in the symptom picture. The intrusive symptoms that have become the hallmark for PTSD are driven by sympathetic hyperarousal, while the numbing symptoms are the result of parasympathetic hypoarousal. Easy startle, difficulty sleeping, dissociation, loss of interest and hypervigilance also reflect dysregulated arousal. Autonomic alarm responses occurring both situationally and internally are easily interpreted as a sign of threat in the here-and-now environment. For traumatized clients to experience a somatic sense of safety, the autonomic nervous system must be stabilized and the capacity for optimal arousal cultivated. Allowing clients simply to access traumatic reactions of fear, horror and helplessness in treatment without relief or ability to process or contain it is usually of

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little therapeutic benefit. In Sensorimotor Psychotherapy practice, *the therapist's goal is re-organization rather than re-experiencing* the trauma and its aftermath. Without the ability to regulate their intense emotional states, many clients are unable to resolve their post-traumatic symptoms. Thus, *attention to the regulation of arousal must be a key feature of any effective treatment for trauma.*

In Sensorimotor Psychotherapy practice, the therapist addresses this issue by helping clients observe their trauma-related tendencies toward either hyper- or hypoarousal moment-by-moment long before they cause dysregulation. For example, a therapist might notice that as the client begins to speak about a traumatic event, her body musculature and posture tighten and her breath becomes shallow. Using dual awareness, the client is asked to practice orienting away from the event itself and toward the body sensations, physical impulses or movements that have been evoked by the memory. By continually observing the client's body for signs of increasing regulation versus dysregulation, the therapist monitors the activity of the autonomic nervous system. The client is frequently reminded to maintain a curious observational attitude rather than becoming frightened by the activation and to notice the physical signs that indicate dysregulated arousal. Simultaneously and repeatedly, the therapist teaches the client

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how to make use of somatic resources, such as body posture, gesture, and movement, to regulate autonomic arousal. As clients learn to notice their habitual reactions and to practice alternative somatic interventions (i.e., changes in posture) or to engage defensive responses inhibited at the time of the traumatic experience, a sense of greater control over both autonomic arousal and impulsive behavior is facilitated. Indications of unresolved and incomplete defensive responses are noted (“Notice how your fist is curling into a ball as you talk about your father,” “Stay with that jigging in your foot and notice what impulses you feel . . .”), and clients are encouraged to mindfully repeat or complete defensive movements arrested at the time. These simple interventions generally result in a sense of what Pierre Janet (1925) labeled an “act of triumph,” eliciting pleasurable feelings of power, control and mastery, counteracting the client’s post-traumatic sense of vulnerability, powerlessness, and shame. With practice of these skills and increasing ability to self-regulate, clients may also be able to become less reliant on psychotropic medications for autonomic regulation or may require smaller dosages.

### **Over-association of Neutral and Trauma-related Stimuli**

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Traumatic experience often results in conditioned “over-association” or “coupling” of unrelated stimuli: for example, the stimulus of a male person might become associated with autonomic hyperarousal in clients who were physically assaulted, sexually or incestuously abused, tortured, or have been in combat. Increases in heart rate may become over-associated with the belief that something bad is going to happen. The result is that normal or even positive experiences (for example, enjoyment of being in male company or increased sympathetic tone resulting from excitement or enjoyment) are experienced as threatening. Utilizing interventions that ‘uncouple’ traumatic memories from their intense emotional and somatic responses, Sensorimotor Psychotherapy clients are helped to experience a sense of safety in their body even when faced with reminders of past psychological trauma. The process of uncoupling over-associating stimuli involves the dual awareness technique of directing the focus of attention. The client is asked to shift focus from a memory or description of a distressing event to the way in which their body and mind respond during the remembering. For example, as a client recalls being beaten by his father as a child, what is his internal experience of that event? Does the recall trigger increased arousal or body sensations? A thought or belief? Some feelings or emotions? Or impulses to move in some way? With the guidance of the therapist, he is asked to notice, ‘What is happening right here, right now?’ One of the

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characteristics of trauma-related disorders is the loss of present time orientation, and Sensorimotor Psychotherapy addresses that issue by helping clients to differentiate past and present: “When you remember that experience then, what happens here and now inside you?”

### **Developing a “Window of Tolerance”**

Affect tolerance develops in the context of attachment relationships in early childhood (Ogden et al, 2006, Fisher, 2011) as caregivers respond to the infant’s distress with attuned “repair” efforts (feeding, rocking, changing of diapers, soothing or stimulation) until it is relieved. With repeated regulation of the child’s immature nervous system, children gradually develop a “Window of Tolerance” (Siegel, 1999; Ogden et al, 2006), i.e., increased capacity for both positive and negative stimuli and more ability to recover easily from states of distress. In Sensorimotor Psychotherapy, clients are taught to identify signs of autonomic dysregulation and to expand their windows of tolerance by practicing habits of self-regulation. The psychoeducational language combats shame and self-blame and helps the individual focus on achieving more control over the trauma-related overwhelm or numbing.

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As Pat Ogden writes,

The therapist's task is to "hold" the client's arousal at the optimal limits of the Modulation Model, accessing enough traumatic material to process but not so much that clients become too dissociated for processing to occur. When arousal reaches either the upper or lower limit, clients are asked to temporarily disregard their feelings and thoughts and instead follow the development of physical sensations and movements in detail until these sensations settle and the movements complete themselves. In this way, the therapist acts as an auxiliary cortex, interactively modulating clients' levels of arousal, keeping them from going too far outside the optimum arousal zone, where it becomes difficult or impossible to process information without dissociating. At the same time, [through repetition,] clients develop their capacity to self-regulate as they learn to limit the amount of information they must process at any given moment, which develops the capacity for self-regulation independent of their relationship with the therapist and prevents their being overwhelmed with an overload of information coming from within. (Ogden & Minton, 2000)



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## **Key Benefits and Disadvantages**

The development of abilities that foster improved affect regulation is perhaps the most significant benefit of the use of Sensorimotor Psychotherapy. The use of dual awareness can increase the ability to think clearly and reality-test appropriately and thereby reduce impulsivity in traumatized clients. Use of somatic resources as alternatives to such self-injurious attempts to regulate as cutting, acting out sexually, or substance use contributes to stabilization of high-risk behavior. In clients without clear memories of traumatic events (such as in drug-induced date rape or children under the age of nine), Sensorimotor Psychotherapy provides a method for treating the trauma without the necessity for remembering the details of events. Because of its emphasis on autonomic self-regulation, it avoids many of the pitfalls associated with other trauma treatments such as high dropout rates and potential flooding and exacerbation of symptoms (Ogden et al, 2006).

## **Conclusion**

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Historically, psychotherapeutic treatments for trauma and attachment failure have focused on the task of creating a narrative in order to access and express the affects connected to it (Herman, 1992). In recent years, treatment focus has shifted to cognitive-behavioral treatments, psychopharmacological symptom management, and other present-centered and trauma-focused techniques. In Sensorimotor Psychotherapy, exposure to the details of the event is used primarily to access the unresolved somatic and affective components of the memory. As the client relates a traumatic experience, the therapist pays equal attention to the narrative and to the body responses until signs of unresolved emotional, muscular, postural, visceral or autonomic activity are observed. Therapeutic interruption of the trauma-related reactions and re-focusing the patient's attention to the somatic responses facilitates their being recognized simply as sensations and emotions rather than experienced as signals of danger. With the client's growing ability to maintain dual awareness, reactivity diminishes, and arousal gradually comes under greater control. Re-organization of the experience results not only in improved affect regulation but also improvements in mood, energy, interest, and present-day reality-testing, along with the lessening of impulsivity. The client now has a narrative that places the events in the past and a body that experiences these events as 'over.' The body and thus the client now have

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the “know how” and the capacity to appropriately respond to environmental stimuli as either stressful or pleasurable but not dangerous and threatening.

### References

Courtois, C. & Ford, J. (Eds) (2009). *Treating complex traumatic stress disorders: an evidence-based guide.* Wiley & Sons.

Creswell, J.D. et al (2007). Neural correlates of dispositional mindfulness during affect labeling. *Psychosomatic medicine* 69: 560-565.

Davidson, R. et al (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, 65, 564-570.

Dykschoorn, K.L. (2014). Trauma-related obsessive-compulsive behavior: a review. *Health psychology and behavioural medicine*, 2(1), 517-528.

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Published in *Practice Innovations*, 4:3, 156-165, 2019

Fisher, A., Murray, E. & Brundy, A. (1991). Sensory integration: theory and practice. Philadelphia, PA: Davis.

Fisher, J. & Ogden, P. (2009). Sensorimotor psychotherapy. In Courtois & Ford, *Treating complex traumatic stress disorders: an evidence-based guide*. Wiley & Sons.

Ford, J. et al (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of traumatic stress*, 18:5, 437-447.

Gendlin, E. T. (1981). *Focusing*. New York: Random House.

Gene-Cos, N., Fisher, J., Ogden, P. & Cantrell, A. (2016). Sensorimotor group therapy in the treatment of complex PTSD. *Annals of psychiatry and mental health*, 4(6), 1080.

Hennighausen, K.H. & Lyons-Ruth, K. (2005). Disorganization of behavioral and attentional strategies toward primary attachment figures. In Carter, C.S. et al. *Attachment and bonding: a new synthesis*. Cambridge, MA: MIT Press.

Herman, J. (1992). *Trauma and recovery*. New York: W.W. Norton.

## Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

Published in *Practice Innovations*, 4:3, 156-165, 2019

Khoury, L., Tang, Y.L., Beck, B., Kubells, J. F., & Ressler, K.J. (2010). Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. *Depress anxiety*, 27(12), 1077-1086.

Kong, S. & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of clinical nursing*, 18, 1897–1907.

Krysinska, K. & Lester, D. (2010). Post-traumatic stress disorder and suicide risk: a systematic review. *Archives of suicide research*, 14(1), 1-23.

Langmuir, J., Kirsh, S., & Classen, C. (2012). A pilot study of body-oriented group psychotherapy: adapting Sensorimotor Psychotherapy for the group treatment of trauma. *Psychological Trauma: Theory, Research, Practice and Policy*, 4(2), 145-151.

LeDoux, J. (2002). *The synaptic self: how our brains become who we are*. Guilford Press.

## Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

Published in *Practice Innovations*, 4:3, 156-165, 2019

Levine, P. & Fredericks, A. (1997). *Waking the tiger: healing trauma*. Berkeley: North Atlantic Books.

Min, M., Farkas, K., Minnes, S., & Singer, L.T. (2007). Impact of childhood abuse and neglect on substance abuse and psychological distress in adulthood. *Journal of traumatic stress*, 20(5), 833-844.

Ogden, P. & Fisher, J. (2016). *Sensorimotor psychotherapy: interventions for trauma and attachment*. New York: W.W Norton.

Ogden, P., Minton, K. & Pain, C. (2006). *Trauma and the body: a sensorimotor approach to psychotherapy*. W.W. Norton.

Ogden, P., Pain, C. & Fisher, J. (2006). A sensorimotor approach to the treatment of trauma and dissociation. *Psychiatric Clinics of North America*, 29, 263-279.

Ogden, P. & Minton, K. (2000). Sensorimotor psychotherapy: one method for processing traumatic memory. *Traumatology*, 3 (3), 1-20.

## Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

Published in *Practice Innovations*, 4:3, 156-165, 2019

Porges, S.W. (2011). *The Polyvagal theory: neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York: Norton.

Riley, S. (2015). *The effectiveness of Sensorimotor Psychotherapy on post-traumatic stress disorder*. Unpublished doctoral dissertation. The Chicago School of Professional Psychology.

Saakvitne, K. (2002). Shared trauma: the therapist's increased vulnerability. *Psychoanal. Dial.*, 12:443-449.

Scaer, R.W. (2014). *The body bears the burden: trauma, dissociation, and disease*. Third edition. New York: Routledge.

Schore, A. (2003). *Affect regulation and the repair of the self*. W.W. Norton

Siegel, D. (1999). *The developing mind: toward a neurobiology of interpersonal experience*. New York: Guilford Press.

## Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

Published in *Practice Innovations*, 4:3, 156-165, 2019

Terr, L. (1989) *Too scared to cry*. New York: Basic Books.

Thabet, A.A.M., Abed, Y., & Vostanis, P. (2004). Comorbidity of PTSD and depression among refugee children during war conflict. *Journal of child psychology and psychiatry*, 45(3), 533-542.

Van der Hart, O., Nijenhuis, E.R.S. & Steele, K. (2006). *The haunted self: Structural dissociation of the personality and the treatment of chronic traumatization*. New York: W. W. Norton.

Van der Kolk, B.A. (2015). *The body keeps the score: brain, mind and body in the treatment of trauma*. New York: Viking Press.

Van der Kolk, B.A. (2006). Clinical implications of the neuroscience research in PTSD. *New York Annals of Science*: 1-17

Van der Kolk, B. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F Shapiro (ed) *EMDR as an integrative*



## Sensorimotor Psychotherapy in the Treatment of Trauma

Janina Fisher, Ph.D.

Published in *Practice Innovations*, 4:3, 156-165, 2019

*psychotherapy approach: experts of diverse orientations explore the paradigm prism.* APA Press.

Van der Kolk, B., McFarlane, A. & Weisaeth, L. (eds) (1996). *Traumatic stress: the effects of overwhelming experience on mind, body, and society.* Guilford Press.

Van der Kolk, B. & Fisler, R. (1995) Dissociation & the fragmentary nature of traumatic memories: overview & exploratory study. *Journal of Traumatic Stress*, 1995, 8(4), 505-525

Van der Kolk, B.A., Hopper, J.W. & Osterman, J.E. (2001). Exploring the nature of traumatic memory: combining clinical knowledge with laboratory methods. *Journal of aggression, maltreatment & trauma*, 4, 33-71.