Rich: Welcome, everyone. Welcome to this installment of "21st-Century Trauma Treatment - State of the Art." My name is Rich Simon. I'm editor of *Psychotherapy Networker*. And I'm your host for this series. I think most people who are listening to this series understand that working with trauma, with traumatized clients, the whole range of the kinds of traumas that clients bring into therapy is challenging. And one of the things that makes it especially challenging is the degree to which there is a physiological dysregulation. People feel out of control.

And it's the talking cure, which is the tool most of us have, can very often seem insufficient in trying to help these clients deal with whatever the range of experiences in life that are traumatized. So we have today someone with us who really has been a pioneer in expanding the vocabulary of psychotherapy and adding to the repertoire of therapists the ability to work somatically. So it is my great pleasure to welcome one of the innovators in our field, Pat Ogden, who has developed an approach called sensory motor psychotherapy. Pat, welcome. How are you?

Pat: Yes, Rich. Good to be here.

Rich: So as we just as before we move into talking about the particular way that you work therapeutically, let's talk a little bit about your background. What is it your – I know that your background outside of the therapy field has been very instrumental giving you the awareness and the tools to work the way you do. Describe that a little bit. Where were you before you became a psychotherapist?

Pat: What I immediately think of is when I was 7 years old, and my mother put me in a dance class because she knew I was going to be tall. And I remember going to this modern dance class as a little child. And she talked about this poise that dancers had in their bodies. And I just got it immediately as a child. And I grew up very active physically, dancing for my whole childhood until I left home and beyond. And I worked in the inner city in the '60s with traumatized kids. I taught in the first integrated school in Kentucky. So I was exposed to a lot of trauma in the children that I worked with. I got interested in it.

And in the '70s, I started teaching yoga and dance at a psychiatric hospital. And that really piqued my interest about the body because I found that the patients who did the yoga classes seemed to improve. And maybe they would have improved anyway. Or maybe they were already on that trajectory, and so that's why they

came to the classes. But it really piqued my interest. And now, Bessel van der Kolk is doing research on yoga and trauma and really proving how valuable yoga is.

Rich: Yeah.

Pat: A big turning point for me was meeting Ron Kurtz in the early '70s. And he was the first person that I had met who had this idea that the body is very important in psychotherapy. That just changed my world. And I quit social work school, and I moved out here to apprentice with Ron. And we founded the Hakomi Institute in 1980. And in 1981, I started my first branch – my first training of my own work, which was called Hakomi Bodywork back then.

Rich: So I want to give people a very concrete sense of how you work and how you work with the body. And let's get into that just a moment. But what is it that working with the body, particularly with trauma clients, what does that address? What does that enable you as a therapist to get at, to access that just words alone cannot do?

Pat: Well, trauma, first and foremost, it affects the body and the nervous system. If you're falling down the stairs, for example, you grab to the railing instinctively before the information even gets to your thinking brain. So in sensory mode of psychotherapy, we think about how we can incorporate bottom up interventions and approaches and integrate them with top down, so that we're really addressing the trauma on the level where it impacts the most, which is the nervous system and the movement of the body.

Rich: Let's take a moment because the terms that you just used I think is something that you talk about a lot. I think people who work somatically talk about. And let's just make sure people understand. Bottom up/top down.

Pat: Well, there are a couple of ways to think of it. In terms of the brain, we're thinking top down is really affecting the cortex working with thinking, and insight and understanding is how it relates them to psychotherapy in the hopes that that will affect strong emotions that live in the limbic system primarily and also the subcortical reptilian brain that is the seed of so many of our instincts. And the bottom up approach, we're working more directly with movements, posture, body sensation to facilitate processing at that level with the idea that that will help shift the upper level.

And that sensory motor level of processing is really foundational to the others. The cortex develops over time. So we're looking at the bottom up addressing that subcortical level and helping shift the upper. And sensory motor psychotherapy, we're really going in both directions. We work a lot with insight as well.

Rich: Yeah. Okay. So let's make this very concrete so people, by the time our time is done with each other, people really get a concrete and visceral experience of the kind of way you work. So I'm coming in to see you for a first session. And let's – I've had a car accident. Let's keep it simple for the moment, and we'll talk about variations on that as we move through it. And I can't get over it. This is several months now. And every time my heart starts pounding every time I get into the car because it affected my whole life. And I've heard about Pat Ogden and working somatically. It's my first session with you.

Give us a flavor for how would you work with a client like me?

Pat: Well, as you come in not understanding the benefit of what I do, I would want to help you really understand that, first of all, because many clients come to therapy thinking it's just talk therapy. They don't understand how the body is. So I would talk to you about how when we have a trauma like that, it stimulates our nervous system, and sympathetic arousal really goes up. And we become like anxious like this. And initially, that is to prepare us for protective action. But often, the nervous system just doesn't calm down again. But it lives in the body. It lives in that panicky feeling, that rapid heart rate.

And it also lives in our movement and posture because trauma stimulates fight, flight, and freeze and feign death responses that often aren't fully effective, like in a car accident. So I would say to you, let's start finding out how we can help your body resolve the stimulation that so impacted you in that car accident. And then if you say yes, okay, great, that sounds good, then we would find a way to begin. And often, we don't want to go right to the accident. So I might ask you well, what starts to happen in your body is you just start to think about that accident.

And what we have to remember is that we can have many traumas, many car accidents, fall, war trauma, whatever, but we only have one body. So we develop these patterns of response. So the

accident that you had can tap into these patterns. So we're really working with the patterns, not the event itself.

Rich: Okay. Now, as we begin to work, and let's say I'm presenting something that's quite circumscribed just for simplicity's sake, and we all know that I think for most clinicians that's probably the exception. But let's stay with it for now. How much about me do you need to know if I'm presenting in this way before we begin to do our work?

Pat: I don't need to know really anything, but clients often need to tell me.

Rich: Okay.

Pat: And part of my job is to be that person that can hold it and listen and not go away and be really present with it. But in terms of what I really need to know, it's all there.

Rich: So it's all there, yeah.

Pat: Yeah. It's all there. I mean, as soon as I say what happens inside when you think about that accident? What happens in your body, your heart rate, your shoulders come up. And then we just go with that and help with massage. So we're always working with the effects of the trauma. We're never working with the actual events. Memory is such a reconstructive phenomena anyway. I think of content as catalyzing incomplete responses: physical, emotional, and cognitive as well.

Rich: What you just said, so talk a little bit about this idea, because as I understand it, that's really central to your work. This idea of incomplete responses.

Pat: Okay. Well, we can think of it in so many ways. If we're just talking trauma, we're talking about those fight or flight or seeking help responses, attachment cry responses. So if you're working with a trauma that someone has had, we're tracking the body through those kinds of responses. Like can you see my hands like this? I can't see them, so I don't know.

Rich: Yeah, I can see your hands now.

Pat: So a patient's hands might just lift a tiny bit like that as they're saying something like when my uncle came into my room, and

their hands go like that. And then we can view that as a preparatory movement. And often, it's almost imperceptible. I'm exaggerating here. But it might just be so slight. But all animals make these preparatory movements before the full execution of a movement. So we're tracking for those actions that are kind of incipients in that trauma but never got executed. And then when they start to emerge, we're encouraging the patient to find out how the body wants to execute the motion and then complete that.

But it can be so many. Like I was working with a Vietnam vet who was really so overwhelmed. It's been years and years and years, but many of our returning veterans are having the same experience now very currently. And he had years of panic and rapid heart rate, etc., etc., and despair, just terrible despair. And he was getting really hyper aroused. And his fingers, his hands just kept going like this. This tiny, little movement. And when we stayed with he, what he wanted was to reach out and hold on to somebody. And what he said was – because I did. I'm not shy of working with touch because I've had tons of training in touch.

So it's a potent technique, and I don't advise it unless people have training. But I've had a lot of training in body work and touch. And so as I met his hand, he said he felt like he was going to collapse into nothingness without contact. And I think that's an illustration of how there can be incomplete actions that can go way back. I mean, that sounded very almost infantile to me when he said that. So actions can be reaching. They can be pushing. They can be running, turning away, almost anything to learn to track the body for those actions that didn't happen. Just still waiting to happen.

Rich: So this is part of what you say about this. I know this is another thing you talk about is there's a wisdom in the body. A person is cut off or there's a sort of somatic wisdom. Talk about that. What is this – so it's as if the body has a direction for you, but people in their panic and their freeze are resisting it?

Pat: Well, I wouldn't use the word resisting. I think the body adapts to situations in context. I think our bodies, for example, they shape themselves around our early attachment environment. So if you're in an environment where your parents want you to be tough and strong, you might have a body that literally takes on that posture. Yeah. Like that. But if you're in an environment where your parents are more accessible if you collapse and be little, your body might take on this stance. If you have to keep everything in, your

body might look more like this. And so that's adaptive in that context.

Rich: Yes, I see.

Pat: Just like with sexual abuse. Freeze response or a collapse and a feign death response, it's adaptive in that context because fight or flight would make it worse. So we don't want to say that the people are resistant to that wisdom. I feel like we all develop patterns then that have been adapted. And over time, they take hold. But then it limits our options because if your body is like this that both reflects and sustains a thing like I have to be tough. I have to be strong. I can't be vulnerable. So what we want to do in therapy is help bring awareness to those patterns.

But we want to go beyond that to help a person learn to process differently in their bodies. Does that make sense?

Rich: That makes a lot of sense. So what I'm getting from that is we're coming in with our containers, and our bodies are often out, as you say, out of context. Literally, out of context of our present lives. And we're trapped in a pattern that made sense at one point. It doesn't make sense, and we don't – but the kind of sad thing and also the hopeful thing is that we don't realize.

Pat: Yeah. And these are procedural patterns, ways of being that become habitual that happen physically, but they also happen emotionally and cognitively. It's not just body. But we want to look at how it all goes together. So if you have a traumatized patient who is frozen in fear like this. You're going to get limited affect talking about it. I think you're going to get more if you integrate the bottom up work as well where you can start to let that down, find the responses that help him or her feel empowered.

Rich: So it's almost like we're wearing our unconscious or issues outward, and we're pretending as if people can't see it. And this is something that you've devoted your life to being able to read this. But I guess you call this the implicit self? Is this part of what you mean by implicit self?

Pat: That's one way you can call it. And you're right, this is nothing new. Wilhelm Reich said the body is the manifestation of the unconscious. Pierre Janet was working with it in the 1800's changing people's, what did he call it, automatisms or automatic behavior. So implicit self is one word that many people are using

now. But in trauma, we often – we can have many dissociative parts of the personality, not just one, depending on the severity of the trauma and how the person adapted to it.

Rich: Okay. So just – this is great. You've laid the groundwork with some of these concepts here. So let's come back to our traffic accident here. And so you've explained to me the way some of your thinking and the way you worked. And you've let me understand something about the role of the body when these kinds of unfortunate things happen. Take us from there. So how do we proceed from there?

Pat: Well then, I would explore with you. So what's a good starting point? Like maybe we can become aware of what happens in your body as you just begin to think of the accident. What starts to shift? What starts to change? Just take a little, tiny piece of it. Because you don't want to take a big, huge – you don't want to go to the core of the trauma. Just take a little piece and see what happens. Does your heart rate go up? Do you have an impulse in your body? So we use the content in this case because you have a memory to stimulate physiology and other somatic responses.

Rich: How do you make sure with me that I can titrate it in that way? Is there some language you use? That seems like a fairly key issue at that point.

Pat: Oh, it is. Well, we want to, again, just take a sliver of the memory, and then see what happens in your body. Many times I've even – like I'm thinking of a guy I worked with who had a terrible car accident in San Francisco going down that steep hill. And we started out, okay, let's find out what's going on in your body, even before you got in the car. Like do you remember that morning and how you felt in your body? And then how it shifts as you go through the sequence of events. And with each shift, we'll pause then, and we'll drop the content. We won't talk about the memory or the content or the emotion. We'll just go with the body.

Rich: Okay. So I mean, it feels – I must say just as you're describing it, it feels very cozy. Here I am. Who of us ever does this that we have this opportunity to share with another person these little, subtle nuances of being inside our own skin. So that seems like, for many people I would think, that's quite a remarkable experience just to begin with in its own way a very intimate experience.

Pat: Yes. Exactly. That's what I was going to say. It's very intimate. It's very intimate because who tracks our bodies like that? Who is going to say wow, when you said that, you sat up a little taller. Your eyes widened. Did you feel that? Let's find out about that. It's so intimate.

Rich: Yeah. Okay. So stay with it. So you're slowly getting me to sample a bit of that really just distressing and difficult experience. And I'm coping with you. And so take us to the next step.

Pat: Okay. So you say I'm remembering that morning, and I felt good, and my body was relaxed. And I was excited about my day. I might say well, let's pause there and feel how that feels in your body that excitement. And you say oh yeah, I sit up a little taller. I'm breathing deeply, and I feel good. And my body feels good. And so we get a sense of positive feeling in the body, which is very important in trauma survivors. You always capitalize on any positive feeling and take it to that body level. And then once you've hung out with that, then we move on a little bit. And then you say okay, now I'm in my car.

And I'm driving along. And I start to have this funny feeling. And I'm starting to feel anxious. It's interesting because people – and with accidents like this, people often will have that funny feeling before the accident happens. They just have that. And so then, I might say okay, let's pause right there. Can you describe that funny feeling in your body? And you say well, my arms are tingling. My heart is getting a little bit faster. And then I say okay, let's just stay with that. Stay with that. Your heart beat, feel that tingling in your arms, and let's see what happens next just in your body.

And you say the tingling is getting stronger, and I'm shaking a little. And then you just stay with it. What happens next? And what will happen almost always is that the sensations will increase, and then they'll start to just resolve in the body by themselves. And we want that resolution before we go onto the next piece of memory. So it's almost like if you're working with a client who has this unresolved grief. And the grief starts to come up. And you help them stay with it. And you say yeah, just feel that. It's so important for you to feel this. And it has its development and its peak, and then it resolves.

And it's like ah, you know. And it's the same as sensory motor processing.

Rich: So if you don't activate – so two things stand out about that piece of it. One is this lovely, little thing kind of like the pause button. It's giving you a pause button. Life suddenly becomes – it wouldn't be great if we had this in life – TiVo – this pause button.

Pat: If we used it in life.

Rich: If we could use it, too. We do have it if we become aware of it. But most of us don't have it automatically. So I like the pause button. And then if we don't go towards that avoidance response, if somehow we can stay with the original response and not the response that steers us away from it and, in a sense, and this is a gross simplification, let nature take its course.

Pat: That's exactly right.

Rich: Something different happens.

Pat: Exactly. And usually, the reason we want to stay away from it is because it's coupled with panic and terror. And so we say forget the emotions. Let's just let your body work with this. Your body knows what to do.

Rich: With the sensation.

Pat: With the sensations and the heartbeat and the shaking and trembling. I mean, animals tremble after trauma. They don't inhibit it. They let it resolve. They let it run through the body. So we're looking – go ahead.

Rich: I'm staying with you. So you're taking us through the flow.

Pat: Yeah. So there's really two basic, physical things we're looking at. One is those involuntary movements like the heartbeat and the shaking and the tingling and all of that. And we want to allow those sensations and the trembling and those movements to kind of run their course in the body. So that's one level. And then the other level is we're tracking any impulses that you might have. Like you might say I'm driving along, and I'm feeling good. And I might track your body turning or your head turning like that a little bit. A beginning, just a slight, little motion.

And then I might say okay, let's stop a minute and just sense what's happening in your body because trauma will stimulate

orienting as well as any defensive movement, which could be a twist away, push, anything. And we want to trust those preparatory movements that occur almost always when somebody is talking about their trauma. We trust those movements. And again, then we pause and say let's find out from your body the movement your body wants to make. Don't think about it. Let it really come from your awareness of your body.

Rich: Bottom up, bottom up.

Pat: Yeah.

Rich: So now at this point, I haven't actually gotten to my experience of the actual accident yet? Or just orient me on here –

Pat: Well, we're going – if you think of the memory as, like, this is the memory. And right in the middle is the core of it. We're going to start at the edges and slowly move in so that you can titrate it, so it's not overwhelming. And sometimes, a patient will come in and they're already overwhelmed, in which case we do follow up phase oriented treatment approach that was pioneered by Pierre Janet in 1898, and we'll work with stabilization first. Like let's find some somatic skills that can keep you grounded, that can help you relax, that can help you not be so panicked. We might do that before we even adress the memory.

Rich: Okay. So in this case, we just had me feel the vitality I felt when I got in that morning. And that was a bit of that. But if somebody is really distraught and extremely dysregulated, you want to spend more time in establishing their ability to do that.

Pat: Absolutely. Absolutely. It's just simple things like the hand on the chest and a hand on the belly. Some contact with the torso. Can you feel that? I mean, I can feel it just doing it. It helps you settle a little bit, right? So help people find these actions in their own body that will kind of help them calm down.

Rich: And they're nothing fancy. They're very natural, very implicit, very subtle.

Pat: Totally, but they're very powerful.

Rich: Yeah. Okay, Pat. So let's go back to this midpoint in this cycle in this pattern of traumatic experience. So we've moved into – we've come from the periphery of the experience. And we've had our

pause button. And you've had me really focus on my sensations. At each stage along the way. And now, I'm getting into the experience, which, at this point, I've had – I've been rear ended in San Francisco, since you mentioned that experience. I was at a stop light on a hill. Somebody lost control of their car. They rear ended me. I got jolted. I had whiplash. I had a whole bunch of reactions. It was a very frightening experience.

And now every time I stop at a stop light or even get in my car, my body is reacting like, oh my God. This is going to happen again.

Pat: Well, again, it's the same thing all the way through. We are looking at how your body wants to respond and helping it complete those actions. So we would trust your body. I'm thinking of a man I worked with who was in a terrible pile up on a freeway. There was horrible fog. And he managed to get out of the car, and he managed to get his wife out. But there was a lot of fire, and a teenage girl died screaming. She burned. And he had terrible pain in his neck. He got activated every time he was on the freeway. And this is part of I think the wisdom of the body. As we were working with this, he felt this burning sensation in his neck on the same side as where the girl had died.

Not that that came up in the session again, because it wasn't important. He felt this burning, and he felt an impulse to move his head like this. And he felt a lot of heat. He said a lot of electricity in his body. But he couldn't finish the movement. His head just got stuck. And so I put my hand there like this so he could continue that movement against the pressure of my hand, not that his head went really far like that. And it just had its own intelligence. And he pushed for quite a while. And then he felt like it was enough, and it was complete, and the pain had gone. And this was a man who had never had a body driven session.

A business man in a suit and tie, very stayed type person. But his body knew what needed to happen. So we just take it one step at a time. Whatever your body comes up with by itself is what needs to happen.

Rich: So there really is wisdom in that. The therapist is trying to – needs to teach a coping response or some other way to think about the experience or anything like that.

Pat: No. You want to illicit that intelligence and help actions complete. And again, this is nothing new. Janet talked about incomplete

actions long ago. But we want to find ways to help the body follow its natural course to completion, whether it's something involuntary like the rapid heart rate and the shaking or the impulse to turn the head or reach out or push away or run away. We want to evoke that from the individual's body.

Rich: So in this kind of thing where I've had the whiplash, and maybe I'm – what you're reminding us of, these things can be quite subtle. Sometimes, they're exaggerated. But an exaggerated version would be something like this I think. You've been in an accident like this. So something where there is this whiplash, what might – and also, you're saying that you discover this with that particular client.

Pat: That's right. Yeah. I beg your pardon?

Rich: What's the possible – in your experience and working with this kind of thing, so where might this –

Pat: There might be an orienting like with this guy that needed to happen when his head wanted to turn. Sometimes, it's just an extreme tension and freezing in the neck. We might work with just micro movements deep inside the neck and see what happens. It totally depends on what's coming up for that person. If their shoulders are also braced like this, there's probably some movement that wants to happen to the arms and shoulders as well. And again, we have to remember that we're never working with that event. We're working with the cumulative effect of all the traumas the person has ever had and all the attachment, everything.

So we have to find out from that specific situation that individual's body what wants to happen.

Rich: So as you're working with me, someone like myself here in that situation. And they really begin go get a strong reaction, they get too much into the content of their experience. They're back in it. It's not titrated anymore. How do you respond to make sure that they don't move too quickly back into their –

Pat: Yeah. Well, hopefully, you can prevent that as you go along because you're really tracking the body. And if they start to get aroused, you say you know what, let's stop. And I'll often say to people if they really are into the story, I'll say I want to hear the story. I do. But there's so much happening in your body right now. Could we pause just for a couple of minutes, and then we'll get

back to the story. Because otherwise, you're letting the arousal go way over window of tolerance, and it's going to make things worse not better. So hopefully, you can prevent it. But if you have gone way over, then you've got to come back to resources.

And sometimes, especially with childhood trauma, not so much with a single incident, a person will have an unexpected flashback. I remember one patient who was abused out of childhood. Suddenly, in our work, she got the image of the blood on the sheet, and she just – her arousal went way up. And so then you take charge and say stand up. Feel your legs. Can you see me? Come back into the room. You're very directive in helping the person come back into that window of tolerance. But that doesn't happen very often.

Rich: And the key of what certainly you're talking about, but this is the hallmark of all trauma work, is that attunement and not rushing people and getting them into this hot zone of response and not retraumatizing people.

Pat: Yeah.

Rich: And so at this point, you're working with me, and you've gotten a sense of what the thwarted response is. You're helping me to do the movement or whatever it is. You have a sense of what – and you've helped me to experience where my body is telling me where it wants to go. So take us to the – so how do we go? We're moving through therapy really fast here. Warp speed therapy.

Pat: Usually, when people come, you've got an hour or less to work. And so there's this kind of rhythm that happens. And it's really the – there's no rocket science here, especially a situation like this. You take a piece of the memory. You find out the body's response. You come back to the memory. Often, other memories will be catalyzed that also might have some trauma like a fall or abuse or whatever. So you take whatever comes up. But you're always using that content to see what is unfinished in the body, and you just keep moving in that way.

And it usually has, again, its own completion even for the session.

Rich: So this is kind of a natural rhythm to it. Once as you begin to tune to people's body, sensation, response, there's a kind of natural rhythm to what happens.

Pat: Yeah. I think so. And I mean, you have to manage the process so that it has a completion. It might take several sessions to work through one memory. But you work with that. You get as far as is right, and then you really stay with the shifts that had happened in that session. And I often almost always encourage some sort of homework to help shift the procedural tendencies in the body. Because even if it's a single car accident, you're going to be working with habits of response.

Rich: So say more about the homework. Let's say this is the end of my first session with you, and we've worked this through. And I am sort of feeling a bit more comfortable, but it's not as if I'm ready to get back in my car without being very panicked by it. How might we end a session like that?

Pat: Well, I would want to say how do you feel more comfortable? What shifted for you? And maybe say my shoulders are more relaxed. I feel fuller in my chest. I feel a little bit more aligned. I don't feel so collapsed or whatever. And then we take those gains and capitalize on them. So if you say I feel a little more aligned in my body, I'll say why don't you pay attention to that this week, and see if you can just pay attention to that alignment, and notice when you start to collapse again. Because this is a real different way of being in the world than this.

Of if they come like this, and you get some relaxation, again, it's a big shift. Just these little changes in the body. They're huge in terms of their psychological importance.

Rich: Yeah. And so the way you work – and so you're perfectly comfortable particularly with somebody coming in with this kind of presentation of what we've been calling in the series small T trauma – or not small T trauma. But this is a distinct –

Pat: Single incident, yeah.

Rich: Single incident trauma. There isn't a lot of history. It will come out. What you need to know about me is going to come out. And if I need to tell you a story that you'll listen, you'll tune to that. But you'll stay with it, but you're going to be guided by this response. The sensation, my report on the sensation and this –

Pat: And your impulses. Sensation and impulses, right, yeah.

Rich: Okay. So now – and then come back, keep going at it. And at some point, I'm – something shifts for me, and I come back. And I feel more comfortable. Or maybe this reminds me of something else. I might get into more complex territory. But that's the flow.

Pat: And that's what often happens is the trauma also stimulates attachment issues. So somebody gets rear ended – like I remember one woman that I worked with, she had a bad accident actually and was actually disabled. She had a brain injury and everything. And it wasn't only she had PTSD that we had to work with, but we also had to work with the collapse of her modus operandi that she had learned in a very high achieving family that she always had to produce and do things and be productive and all of that collapsed, too, which really threatened her sense of self. And so that's another whole arena that needs attention as well.

Rich: So talk a little bit about – because I know you're very interested in emotion and more broad speaking attachment issues and working with emotion in the consulting room. So in addition to what you've already laid out for us, what else – so if I'm dealing with the more relationship issue and the attachment injury, how is that any different than what we've been describing with a distinct trauma experience?

Pat: Well, if you think of this woman that I was just describing, we can look at the parts of her that were not recognized by her attachment figures and, therefore, never had a home. Never had a place to grow up in. And for her, it was her neediness and her – mostly just her need. She had, in her family, pushed away the need because it wasn't really recognized in her very high achieving family. They just wanted her to be productive. Not to be needy or weak or helpless or lazy, so-called lazy. Not to just relax.

Rich: By their definition, yeah.

Pat: So that part of her wasn't recognized by them. And we all have parts that weren't really nourished and recognized by our attachment figures, and so we push them aside. We have to. These are like sort of not-me parts of us. So that's also held in the body. Her mobilizing, she was mobilized for action. She was an executive, and let's go. Let's get a lot done. And very fast talking. Her body had shaped itself around that environment. So for her, part of therapy – well, it was forced on her by her trauma, to deal with that not-me self that her parents hadn't acknowledged.

So in attachment related work, we start recognizing those parts of the patient, and we welcome them into the therapy hour also by helping them shift their bodies to welcome them. For her, all that mobilization and that speed and all is really denying a big part of her. So we find out how her body reflects and sustains that learning from her attachment figures. And we help that start to shift. Maybe we help her chest – help her become aware of her chest and softening through here to allow room for another more yielding part of her.

Rich: So that puts a different – so as you're describing this, it's one thing if you're helping me sense the innate wisdom of my body in response to physical injury and that kind of trauma. In here, you're inviting this smaller part of me, this dependent part, this little girl and boy, maybe the little girl in me, to come out. And then so how does that play out in therapy? What's that like? What does that sound like, and what does the relationship go to in that context?

Pat: Well, there are a couple of ways to go with the body in terms of what we're talking about. You can either exaggerate the pattern, or you can go the opposite way and challenge the pattern. So with her or him who has that particular I got to achieve a lot, I got to get a lot done, we might say if you go into that, what starts to happen in your body? How do you feel it? And they say I feel this lift in my chest. Yeah, you demonstrated it, too. It's immobilization. And so we stay with that. We find the words that go with it, the belief. And it leads to tremendous pain because you start to feel that you're so disconnected from what's deeper in there.

So we can go that direction. But then we can also go the other direction like what starts to happen if you soften your chest, soften your breathing, just start to melt a little bit? That's often very frightening.

Rich: Yeah. Almost crying. You may have seen that response once or twice in your practice.

Pat: Yeah. I can't see you very well on the screen, but yeah.

Rich: Yeah.

Pat: So shifting the pattern can help contact those places that were denied and not recognized. And just like you say, there's tremendous emotion that comes with that.

Rich: And then what happens? What happens between you and I when I go into that place? And I am tearing or I'm sobbing. I'm this little child who wasn't loved and seen for who he was and that whole experience. And then how do you see your role as the therapist in that situation?

Pat: Well, my role then – one of the ways we think about it is the sensory motor processing. There's emotional processing. And of course, it's cognitive processing, too. And we want to look at which level we're going to get the most mileage out of on all three levels. So if you were sobbing, but you're not dissociated, you're still at the edge of your window, I'm going to make a lot of contact. How painful and hard. Oh, it hurts so much, etc., until those emotions, just like with the sensory motor processing, until those emotions have found their completion. And then we're going to work with the hopeful transformation of that in your body and your beliefs and your emotions.

Like then I might say can you sense that needy part of you right now? And how do you sense that in your body? And you say yeah, I can feel it because this has kind of opened up, and I don't feel that bracing anymore. And then we just stay with that. And you might make contact with it, etc.

Rich: In your heart, like you were saying earlier.

Pat: Yeah. Wherever you feel it, yeah. And we also might work with any gestures that you've abandoned because your parents didn't respond to them. I mean, just the simple act of reaching, exactly. So I might say let's play that. What happens when you reach out now? That's such a simple act that brings tremendous information, especially if somebody didn't have anybody to reach back in the right way. You can imagine the incredible pain that they felt the last time they tried it and nobody responded. So these little proximity seeking actions of eye contact, reaching out, can be so potent in the body approach. Yeah.

Rich: So now, as we move into complex trauma, where we're headed here, and we move into dissociation. We're moving into people who have really had a very, very difficult time. And there are attachment injuries. And there are very extreme – describe what is it about the process that you've been describing so far that shifts? In some basic ways, I think people understand this is the foundation of what you do. Move into that level of dysregulation for folks. What happens?

Pat: Well, I think one of the things that we certainly didn't understand in the '60s and early '70s was that you don't want to stimulate more attachment needs than the person can integrate. So with really intense emotional attachment trauma, complex trauma. We want to track very carefully that window of tolerance and titrate the experience so that the person doesn't find these overwhelming attachment needs now coming up. And the intent is always integration. If there's complex trauma, there's going to be some degree of dissociation. So we're working with these dissociative parts of the self, helping them communicate, but also communicate in the body.

So we're working with defensive responses, for example, that might have become more isolated, more a part to take over the functioning of the person. So they might go into a dorsal vagal collapse type of arousal and not be able to –

Rich: So they go – dorsal vagal, just explain the language for a moment.

Pat: Well, if we look at Steve Porges's polyvagal theory where he's redefined the nervous system in terms of a hierarchy where social engagement involves the ventral vagal complex, which involves facial muscles. Eyes, we're looking at each other and listening to each other. It regulates the larynx for speaking. But if social engagement fails to keep you safe, then a sympathetic system is arousal fight or flight. And if that fails, then the dorsal vagal system, which is known as the feigned death response that is the unmyelinated vagus that slows everything down, that's stimulated.

And with many of our patients with complex trauma, childhood trauma, they just collapse in the face of threat. They find they can't function sometimes, they can't move. But when they're not triggered, they can be very successful and very engaged and everything. So we want to help those parts start to make a bridge to each other and communicate with each other.

Rich: That integration – because as we both know, there are models, I mean, going back to Gestalt therapy and having the different parts talk to each other, and it's on that probably more sophisticated variations on that that have evolved over the years. So how does this integration take place in the way that you work?

Pat: Oh gosh, there are so many ways to think of it.

Rich: Give us some flavor of some things that will happen.

Pat: Yeah. I'm thinking of a woman that I worked with who was just severely dissociated. Just terrible, terrible trauma. And she talked about how her mother abused her, would call her a pig and all these awful things. And when she thought about all of this, she had the impulse to go like this. So there was some anger that was coming up, which she was very afraid of, which she wanted to take a pillow, and she just shook it like this. But she had a very difficult time now switching into another part. She said it's hard for me to just stay with this as a physical action. But you know what?

As she did it, and we just stayed with that action, which you can also think of as a fight defensive response, which she had never, ever executed, her body started to shift. And what she reported afterwards that when she had gone to visit her mother who was in a nursing home by that time, and she said she could tell her mother was going to spit at her. I think her mother was starting to have early Alzheimer as well. And she said, I said to my mother, don't you dare spit at me. And she said, my mother just settled right down. And she said, I've never done that before. So in terms of integration of parts, we're taking this part and the physical action that was a defensive response that she never executed.

But she's also staying in social engagement with me in the room responding to me. And those two parts are integrating through the body. And I think when you can get two parts communicating physically like that or lots of other ways, then we're looking for how does that change the behavior and the life? I mean, that's – the proof in the pudding is always in what happens after. It's not in what happens in the session.

Rich: That's right. So it's how people take it into their life.

Pat: Yeah.

Rich: So okay. So now, I mean, we're moving quickly through this territory, but I'm just really getting this very immediate sense of how you work and also the impact you would have on somebody in how you're doing this. Now, I know one of the things that you've done recently, and this is a big interest of yours, is working with kids. And this working would seem to me, in the talking cure, whatever its limits with adults, it seems like it has a huge, huge disadvantage with kids and small kids.

Pat: Yeah.

Rich: So talk a little bit about how you've adapted this in working with children.

Pat: Okay. Well, I've been developing sensory motor psychotherapy for children and adolescence with Dr. Bonnie Goldstein, who is a child psychologist, which I am not. So we've been really working together both in individual work and group work. And the kids are so beautifully receptive to doing anything physical. They have none of the awkwardness that adults often have in their bodies. So it's so delightful. For example, a little boy who was molested at school by an older kid would not speak of it at all.

Rich: How old was this child?

Pat: Seven. And he was sent to Bonnie. They didn't know what to do with him. He wouldn't go to school. He would not talk about it. And so in our collaboration, I said to Bonnie, well, get a drum and have him talk with the drum. And she taped it for me, which is wonderful because you see him drumming, and his hands are drumming like this. There's no power. And so you know right away. And you can see it in his collapsed posture as well. But you can see his lack of boundary and defense.

Rich: Vitality. His vital energy.

Pat: Exactly. So in the first session, he just talked with the drum, found a few words. You can see him dissociate. He stops drumming and he goes I was really scared, and he's looking around, and then he goes what was the question? His cortex just shut down. So then we come back to the drumming. And at one point, he can't breathe. He's going like this. And Bonnie beautifully says well, a trick that I do is I go like this when I can't breathe. And he does it. And of course, it opens the chest, and he takes a big breath. And so in the first session, he's drummed the memory. He hasn't talked about it. But the physical responses have come up, and she's worked with them.

And then in the second section, he starts to work with – he brings his older sister with him, and he makes a boundary around himself with a rope. And then as she comes into his boundary, Bonnie starts to help the boy find his defensive response. And at first, when the sister comes in, he's just like this. He just gets frightened, and he moves back. He doesn't do anything. But

eventually, he finds from his own body he pushes her out. And yeah, so after the first session, he went back to school, actually. And then after the second and third and fourth sessions, he started to have more – his posture started to get more aligned.

He's having more of a sense of his own ability to protect himself. And see, that's not a cognitive ability. That's body. If you're like this, you feel like a victim.

Rich: And also, you invite victimization.

Pat: Yes, yeah.

Rich: You're easy pickings. And so the boy never – none of this requires this young boy to talk about this horrible experience.

Pat: No. But he does talk about it more as he gets more empowered.

Rich: He can if he wants to.

Pat: Yeah.

Rich: And that's entirely the flow of it. So it's conceivable from what you're saying, he could go through this whole process, he never has to go back and talk about this incident.

Pat: Absolutely. I work with so many people who have early trauma they never remember. But the imprint is left on the body, and the emotions and the mind and all. And so, but you don't have to remember because it's all right there.

Rich: Whether you talk about it – relive it with your therapist or any of that.

Pat: No. Although it is relived in the current life, of course, like you're saying.

Rich: And in that other mode, you're always reliving it in some sense.

Pat: Right.

Rich: So how much does language – how much of the talking cure is relevant in this process that you're describing where you –

Pat: Well, it's very relevant, especially with complex trauma. Rick **Cluff** talks about the rule of thirds with complex trauma where the first third of the session you spend integrating what happened during the week and talking about that. And then the second third, you're working with new material. And the third third, you're integrating that. And of course, when we say integration, we're talking about also integrating through the body. Like if your homework is to pay attention to your alignment or whatever it is, we're going to find out about that. But there's a lot of helping it make sense and insight that does come up.

So and even with when we're working more bottom up, we're still really engaging the frontal lobes because we're asking people to be mindful when we're directing their mindfulness of particular elements of their experience. So there's hopefully an integration. Dan Siegel calls that vertical integration in the brain going on. So language – I don't mean to say language isn't important. But we want to integrate top down with bottom up.

Rich: And language – maybe the important concept is language is the tool of integration. Language not just people narrating their problems, but language as this tool. That's this marvelous way we have – different parts of the brain do come **[inaudible]** doesn't always require this. But at its best, that's what language **[inaudible]**.

Rich: And in our work, we want to listen not only to the verbal language but the language of the body because the body speaks so vibrantly and profoundly.

Rich: Yeah. Well, as we're doing this I'm just really experiencing this both watching you and because we're violating the normal rules of human interaction here. This is dance, and I'm just – I have permission in this particular exchange to do things I wouldn't normally do, and we're near each other. And this is always happening. But it's minimalized.

Pat: Yeah. That's right, yeah. That's another thing. Do I have time to say something else? Well, it's so interesting. I just wrote a paper on this. Like what is happening explicitly between patient and therapist in contrast about what is happening implicitly with this kind of body to body dialogue that's going on between the two that's not conscious for either. It's so fascinating. Yeah.

Rich: Remember Edward Hall – 50 years ago now – the *Hidden Dimension*. And he was one of the pioneers in beginning this heighten of somatic awareness. So we have just a little bit of time here. So the last piece here, and then I want to make sure people are aware of different resources and things that you've written that they might want to consult and training opportunities. So if I'm a talk therapist, as I assume most people watching this are primarily talk therapists, and they're interested in doing this, how do I move into this domain here? What's the next step for me?

Even if I don't want to learn sensory motor psychotherapy or some of the other models, or Hakomi or other kinds of models, somatic experiencing. How can I expand my repertoire as a therapist?

Pat: I would say just be curious about the body, your own body, and your clients' bodies. Just be curious. I mean, honestly, the way I got so interested was back in the early '70s, Ron Kurtz and I used to just watch bodies. We'd go to any public place, and we'd just watch people walk. And we'd make up these stories about their lives because their walks were all so different, the movements and all that. It's fascinating. It's like watching – it's as interesting as a really great movie. So just get interested. Get curious. There is a bit of a caveat about some people will hear us talking about this, and they'll just want to help their clients be aware of their bodies.

You just have to be careful because if you take a traumatized person into their body, and all this stuff comes up, and you don't know how to work with it, then it's not a good idea.

Rich: And you've really emphasized throughout for us this whole thing of attunement, titration, of just jumping into an intense experience. So Pat, as we have just a few more minutes. So talk to us about the different kinds of training resources for people who are interested in working in the way that you're describing and other kinds of materials that people might access.

Pat: Okay. Well, Sensorimotor Psychotherapy Institute conducts training throughout the world from Australia, Europe, starting to open up some of the oriental places as well, Canada, United States. And we teach how to work with trauma, that's our first level of training. We teach then our second level is how to work with attachment and trauma and their interface, and then we have a third level, that's our certification program, which is the most advanced.

And we do various conference presentations and workshops, like the *Networker* that's coming up. People can read our book from 2006 called *Trauma the Body: A Sensorimotor Approach to Psychotherapy*. And I'm writing a new one with Janina Fisher that's going to be a little bit more practical, giving therapists and patients some interventions through all three phases of treatment. Lots of chapters and books. Contact our institute. A lot of it's just on our website.

Rich: And people can have their – if you – on the fulfillment page, for those of you who take the enhanced learning track, you can just have a link directly to Pat's website. You'll see a listing of the training opportunities and different things you can read. And also, Janina and Pat did a terrific case study for the *Networker* just a few issues ago, and that's one of the bonus readings that you'll have as part of this course. So there's plenty of opportunities for those people who want to deepen their familiarity with this way that Pat works.

And let me invite those of you listening to – and particularly because we've been emphasizing the hidden dimension here so much in this conversation. Good old fashioned written language, the comment board. Good tool for integration. Good tool for helping your focus on what you've taken in from this conversation. So please for your own sake, in terms of just crystalizing the questions you've had, the learnings you've had, the connections you've made with Pat's work over the course of the conversation, and also for all of us to extend the conversation that Pat has begun with us today. And Pat has graciously agreed to take a look at the comment board and, maybe, as the spirit moves her, respond to questions or comments.

Pat, what an enlivening experience, and an embodying experience to be in this dance with you. And it really felt like a dance to be in this conversation here. I really enjoyed it.

Pat: Yeah. It's fun. Thanks.

Rich: Take care.

Pat: Yeah, you too. Thank you.

Rich: Good-bye to all of you from the *Networker*'s "21st Century Trauma Treatment" webcast. See you next time. Bye-bye.

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Duration: 69 minutes