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On safe ground: using sensorimotor approaches in trauma

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Abstract: Drawing on insights from neuroscience research, particularly in respect of autonomic arousal, brain structures, and neural plasticity, this article considers the impact of recent developments in the treatment of trauma, and ways of integrating new understanding with current Gestalt methodology. Sensorimotor trauma therapy offers some new concepts through which safe and effective trauma treatment can be reconsidered. Through the use of clinical examples, the article discusses the application of three sensorimotor concepts, integrating them with Gestalt practice. There is also a brief description of the role of defensive systems in trauma work from a sensorimotor perspective. Relational aspects of this way of working are integrated into the text.

Key words: trauma, sensorimotor, resources, window of tolerance, ANS arousal, defensive systems, figure formation, fixed gestalts, creative adjustment.

Introduction

Sensorimotor trauma therapy was developed as an offspring of Hakomi therapy (Kurtz, 1990/2007) which was in turn greatly influenced by Fritz Perls and Wilhelm Reich. Although its theoretical base is quite different from Gestalt therapy, drawing on trauma research, there is much in common in terms of its approach. Sensorimotor therapy brings together a number of strands from neuroscience research and weaves them into a coherent methodology for working with trauma (Ogden, Minton and Pain, 2006). It provides a number of interlinked theoretical, diagnostic and methodological frameworks, four of which are discussed in this article. Sensorimotor psychotherapy emphasises the role of the body in the maintenance of and recovery from trauma (see also van der Kolk, 1994). A failure to integrate experience is implicit in trauma work (Janet, in Ogden, Minton and Pain, 2006, p. 36). While there are some challenges for Gestalt therapists, I have found sensorimotor methods to be invaluable and effective when integrated with my Gestalt practice. A first impression may be that sensorimotor psychotherapy has little to offer Gestalt therapists because of the numerous commonalities. Sensorimotor psychotherapy speaks the language of tracking, experiment, contact and mindfulness. However, there is a clarity and a precision about how and why these approaches support trauma therapy that is not made explicit in Gestalt literature. The sensorimotor therapist is more selective about the figures to attend to, more repetitive about applying techniques, and has a different intent in working with trauma. Much of this can be translated into Gestalt terminology, but it is in the attention to the minutiae of experience that the difference really lies. Sensorimotor psychotherapy could be critiqued as being too technical and formulaic, too I-It, but the skills it offers require mastery in order to become fluid, and to be 'incorporated within relational spontaneity' (Bromberg, 2011, p. 123). In the hands of an experienced relational therapist it becomes a highly flexible, responsive, and singular approach.

Neuroscientific research challenges us to find new rules to explain the nature of change and the ways in which we organise experience. It draws attention to the functions of different areas of the brain in specific situations, to the concept of neural plasticity and to the complex neural and chemical reactions that serve to ensure the equilibrium of the whole organism and survival under threat. Fundamental to all contemporary treatment approaches is the need for stabilisation in the early stages of therapy with trauma clients. This meshes with the first two stages of Kepner's Healing Tasks model – safety and self-functions (1995). Sensorimotor trauma work emphasises stabilisation more than other approaches, in order to restructure the ground from which the figure of trauma emerges. It also offers a methodology similar to that of Gestalt, in attending to process, awareness, sensation, and mobilisation in the here-and-now. But it differs crucially in providing an alternative formulation of the client's difficulties and proposes that the therapist needs at times to be more directive in choosing which figures to work with and which to avoid at all costs. There is an emphasis on

experimentation in sensorimotor trauma therapy which tends to be guided by the therapist rather than co-created in the classical Gestalt sense, the reason for this being that there is often not enough time in traumatically laden moments to build the experimental ground, and action must be taken, as the clinical examples below illustrate. Later, time is taken to engage in a shared, reflective, phenomenologically-based dialogue.

The paradoxical theory of change is to some extent challenged by the sensorimotor approach. Beisser's theory (1970) is predicated on the availability of choice, but there is ample evidence from neuroscience that for trauma clients, choices are simply not available. I agree with Philippson's comments (2011, p. 89) that the paradoxical theory of change relies on the capacity for organismic self-regulation, and that this condition cannot initially be met in the case of trauma. Primitive survival-based defences and adjustments are at play, driven by sub-cortical regions of the brain. The complex interplay of neural networks and neurochemicals creates predictable loops of reaction and behaviour, fixed gestalts that can only loosen when alternative pathways are established. It is in the early stages of trauma therapy that it is particularly important to take account of the limitations of the client's functioning and of a purely Gestalt approach. This is when it is necessary to establish the ground from which the paradoxical theory can later emerge. I include full discussions of the paradoxical theory of change and relational implications in trauma work in my forthcoming book.[1]

None of the theoretical concepts presented in this article is a discrete entity; it is for the sake of clarity that I attempt here to separate them out. The window of tolerance is a key concept in sensorimotor trauma work and the one which I single out as the most useful. It rests on the concept of optimal autonomic arousal first described by Siegel (1999), and can be related to the cycle of experience. This is an invaluable diagnostic tool from which specific ways of working emerge. The concept of somatic resources focuses attention on creative adjustments to trauma, and on developing new and more adaptive ones. The orienting response is another diagnostic tool which opens up new ways of understanding how trauma manifests in clients' bodies, and of working creatively with them. Each concept is illustrated by a clinical example, with a commentary. The clients' stories are composites of several individuals to preserve confidentiality; what happened in the session is more or less faithful to process as it happened, and only the clients themselves might recognise it.

The window of tolerance

I sit with my client, Rose, at the start of a session. She tells me about the events of her week in some detail. I feel welcoming of her, quietly observing her whole being, taking her in. She sits a little forward in the chair, hands resting on her thighs, gesturing occasionally. She talks a little fast, is breathy. I note her energy which flares a little at first and gradually settles. I make enquiries, follow up on some points, check my understanding, letting her know that I am with her.

Commentary: Rose has a long journey to the trauma service in which I work, and I know that she struggles to 'arrive' in the session and is often anxious to get things off her chest. After some months of working together Rose continues to find her inner experience difficult to attend to and she perceives her difficulties as originating in the external field. There is truth in this; she was held hostage in a locked room and raped. We have been working on boundaries and she has taken the courageous and risky step of leaving an abusive situation, so it is relevant that I keep up to date with changing circumstances. I use this time early in the session to assess her developing self-functions. We have plenty of time; an hour and a half is often more containing for trauma clients. I wait for a figure to emerge.

Rose tells me about something she found troublesome this week. She had given a lift to a man, a friend of her father. As she speaks I notice her hands move in a wringing, fluttery way. She makes a familiar gesture, touching her head with her hand. Her breathing tightens and she looks away. I tighten very slightly in my chest in response, and remember to check my seat in my chair.

Commentary: Over many times, Rose and I have learnt together to spot these specific changes and to pay attention to them as indications of her escalating arousal. The Gestalt cycle of experience can be seen as a model of healthy arousal of the nervous system (Stauffer, 2010, p. 54). The nervous system is prepared for action by the sympathetic nervous system, and when action is complete the parasympathetic branch rebalances the system.

Figure 1 illustrates how figure formation is linked to the biological processes of the Autonomic Nervous System (ANS). Important in understanding trauma, there seems to be a threshold beyond which a return to a regulated state is no longer automatic, in which figure formation is interrupted and contact functions are compromised. During states of highly dysregulated arousal a client is 'estranged from present reality' and therefore a healthy cycle of contact is not achievable (Ogden, Minton and Pain, 2006, p. 34).

I focus my attention closely on the process, mindful of supporting Rose to calibrate her arousal. Importantly, the emerging figure in my mind is not the story but her cycle of

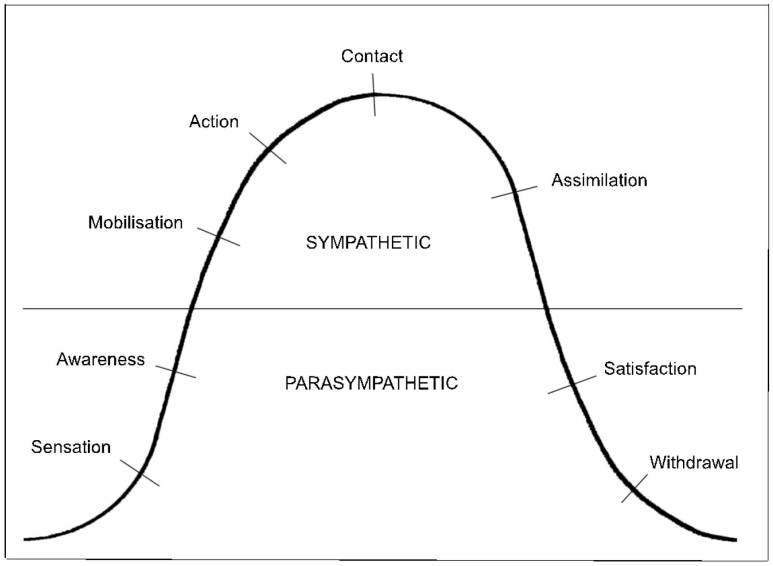

Figure 1: The cycle of autonomic arousal

arousal. My thinking rests on the theoretical concept known as the window of tolerance (Siegel, 1999, p. 253; Ogden, Minton and Pain, 2006, p. 26) which corresponds to the cycle of experience. Based on the survival function of the ANS the concept proposes that this window of optimal arousal lies between states of hyper- and hypoarousal. Hyper- and hypoarousal of the ANS are experienced as panic, overwhelm, or chaotic sensations and thoughts on the one hand, and as numbing, disconnecting and shutting down on the other. In states of overwhelm, both branches of the ANS cease to operate; they are 'maximally active and temporarily stuck in that position' (Stauffer, 2010, p. 56). Therefore a return to balance is not possible, and extreme, paralysed distress can follow. Hyper- and hypoarousal can occur concurrently (ibid., p. 51), and switches between the two states can happen in a fraction of a second. It is for this reason that the therapist needs at such moments to be more directive and cannot build relational or experimental ground.

Trauma survivors' ability to access this window of tolerance is compromised during hyper- or hypoaroused episodes. For clients such as Rose, this space may barely exist. She told me, 'My tolerance levels are paper-thin'. Studies have demonstrated that while trauma responses

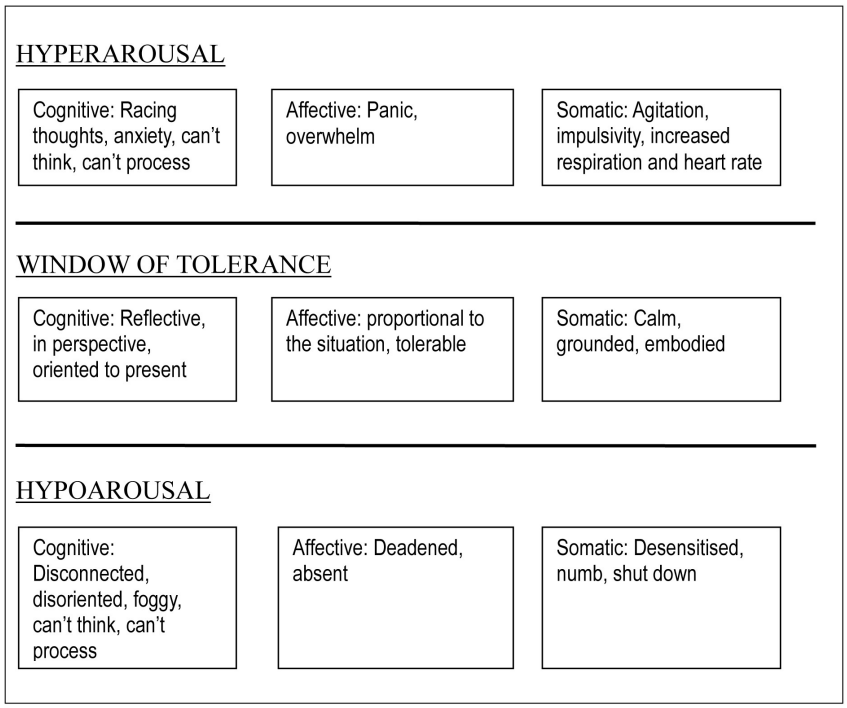

Figure 2: The window of tolerance model

are driven by the limbic system in the brain, the cortex becomes active when the individual returns to their window of tolerance, and more integrated functioning becomes possible (ibid., p. 29). Rose's capacity to calibrate her levels of arousal represents such specialised function. Right now, I don't know whether Rose can stay in her window of tolerance, as she is at the edge of hyperarousal. What she cannot tolerate she cannot assimilate and it would be counter-therapeutic to let her go too far outside. I want therefore to support Rose to stay present and 'in the therapy'. When hyperarousal is incipient it is necessary to slow things down. I think it is crucially important in clinical practice not to treat this science as a fact, but as a model to inform interventions.

My energy has changed too in adjusting my attention from open focus to a narrow aperture. I slow myself down, my thinking helping to keep me grounded as I gently ask Rose if she is willing to tell me what it was about giving this old man the lift that upset her. She pauses briefly and says quietly and hesitantly that it was his aftershave. We make eye contact briefly and exchange a small nod of understanding.

Commentary: Rose does not need to use words for me to realise that she is in touch with a memory. I make a mental note that we will at some stage in the future have to de-couple the association she seems to be making between aftershave and the trauma. Although there are times now when she can approach traumatic memories without going out of her window of tolerance, this fragment of memory has a raw and intimate quality which is new and I need to learn how close she can come to it in this moment. My question is 'Does this figure have enough support?'

I want Rose to choose. I ask her to pay attention to her inner experience and to let her body tell her whether it would be helpful or unhelpful to work with this. Her muscle tone in her upper body releases. Rose inhales and exhales and says 'I want to lie down'.

Commentary: Rose appears to know what she wants, but her range of choices is not yet sufficiently developed. What she says seems to be based more on her knowing what she doesn't want – to stay agitated and over-aroused. I have a different idea of what could help. Gestalt practice would present me with a wide range of choices at this point. However, with the window of tolerance concept as a guide, I am able to recognise that something physiological is happening over which Rose has no control. This focuses my choice of interventions quite specifically. There is now only one thing that I am seeking to support, and that is Rose's return to a regulated state. It is sensorimotor psychotherapy that has given me the ways of conceptualising this and the means of working with it. I have come to rely on this thinking repeatedly in sessions, intentionally treading over and again a new neural pathway; and this practice is not yet embraced in Gestalt.

I say lightly and warmly, 'Oooh, perhaps something different would be better?' Rose smiles and nods.

Commentary: I made a light comment in order to support her to stay present and engaged with me, and again inviting her to think and decide for herself. I want to try to keep her thinking capacity, her cortex, engaged so she can stay present. Rose can have an almost irresistible pull towards collapsing in a state of extreme hypoarousal, and it happens very fast indeed. That she has learnt to spot it herself and let me know shows great progress, but the situation is nevertheless urgent. I decide not to support the apparent choice that Rose has made, but to go with a more contactful option based on the window of tolerance which I hope will hold more potential for Rose. I choose to support her to resist this pull, to provide an alternative, as in collapse she can be completely out of contact and unresponsive for some time. I understand her collapse as a re-enactment of the trauma, representing a survival-based response to a life-threatening situation. It is usually very hard work to bring Rose back from such a state, and if I'm honest, I dread it; it's a tough place for both of us. This is why we have longer sessions. But I know we can do it together so I have no need to panic.

I urge Rose, 'Look at me', but she can't sustain the contact. I suggest she presses her feet into the floor, lengthens her spine a little, interventions which sensorimotor therapy teaches to bring a client into their embodied experience. She says 'I feel so heavy'. I ask her to use her eyes to check around and see if anything bad is happening right here, in this room – further sensorimotor interventions. She doesn't move her eyes, which look blank to me, she feels less present. I notice that my breathing is steady and that my eyes feel tight as I attend to her. I find an anchor for myself in my spine.

Commentary: I don't know if Rose has registered and my interventions don't seem to have improved things although she has not lain down. The heavy feeling Rose reports is her pull towards collapse. Her lack of response to my last intervention informs the next.

'Do you think it would help to bring some movement in?' I ask Rose, who nods. I demonstrate a simple exercise using my arms (Emerson, 2008. p. 21). Rose knows this one and copies me, as I invite her to pay attention to the sensations of the muscles, the touch of her hand on her shoulder and the movement of her clothes against her skin. I keep my movements in sync with my breathing which I find helpful. Rose starts to slow the movement down, and I encourage her to keep going. She struggles with this, and is almost grinding to

a halt. We stop making this movement. I enquire whether she is willing to get to her feet. With effort, Rose stands, and we begin to move around the room together as we have done a number of times before, Rose following my movements. I invite her to pay close attention to the soles of her feet and to the transfer of weight from one foot to the other, very slowly and gently. I give a running commentary first on my experience and then describing her steps as she takes them. After a few minutes walking and tracking in this way Rose tells me that she can sit down now. I ask her what's telling her this and she says her limbs feel less heavy. Her breathing is steady, her muscle tone somewhat clearer and as we sit she makes eye contact with me.

Commentary: I first try to orient Rose to stay with various aspects of her present situation. Her traumatically driven experience is causing her to relive some aspect of past experience and she cannot distinguish the here-and-now from the there-and-then. What I am inviting, or at least strengthening, is the self-function of dual awareness (Rothschild, 2000, p. 129), whereby someone can stay aware of the past from a present orientation. In this instance, my strategy merely prevents a further decline into collapse. When Rose did not show a response to my invitation to look around her I took this as a signal that I was losing her. When someone is becoming hypoaroused as Rose was, you need to introduce more energy into the process rather than to slow things down. It could be argued that I am falling back on technique here but it is clear that my presence alone is not enough to support the needed recovery. My first intervention using movement does not succeed either and in stopping the arm movements I sense the strength of her pull downwards again. Therefore I increase the energy by standing and walking together. I don't want to rush this as that might startle Rose's system and trigger further dysregulation. Lest Rose is on the verge of collapse again I make a phenomenological enquiry about her changing experience before we sit down.

I ask Rose how she is doing now. She says that her head still feels a bit woolly and her hands are shaky but she is feeling better. I tell her that it's okay to let her hands shake if they need to, and to allow it if she can. She looks down at her hands. I allow my focus to open again, feeling an expansion in my chest and a softening in my eyes. I know where my spine is, how my body receives the support of the chair once more. We sit quietly together and begin to reflect on what has happened.

Commentary: The shakiness in Rose's hands is a sign of a parasympathetic response, a natural recovery process. Therefore I offer support for this. The window of tolerance concept has provided me with a new understanding of my client's process, a way of diagnosing in the here-and-now and has pointed me towards intervening in specific and focussed ways. Its value is in part the knowledge and relative confidence that it offers me, and in the ways in which my client and I have formed an alliance and can co-create the therapeutic dance around it. Fundamentally, I believe there is an underlying ethical principle involved, that of recognising the risks of re-traumatising my client and knowing how to prevent that to the best of my ability. The window of tolerance does not offer a fixed state, but a space in which resources can be developed. Furthermore, the model is presented as a one-person phenomenon, but I recognise that I have a part in the process of my client's dysregulation, and in their subsequent recovery, and thus see it as a model of available contact.

Somatic resources

At the Trauma Service I meet Nick for the first time. He seems defensive, edgy; he's got his eye on me. I know that he's just come back from Afghanistan and has been drinking heavily. A doctor has mentioned PTSD to him. I know also that he has chosen to come here rather than seek help from the armed forces; I imagine this is safer for him. I feel under fire with his questions about my experience and how the sessions might go. I feel quite tense, anxiety in my stomach, and also defensive. But as I explain a bit about how trauma affects people and talk him through the window of tolerance concept, Nick's pace slows, he seems less defensive. He tells me he can recognise himself in what I describe.

Commentary: I sense that Nick needs answers before he will engage, and I feel anxious that he might not. I don't want to push this guy because I imagine he can be easily triggered into a trauma response. Actually, I like that he has questions, because he's doing what he knows best to make himself safe, though I don't like the way he asks them. I choose to meet him where he can be met. By thinking about something together we begin to make an alliance. Psycho-education has an important role in trauma work because 'it teaches the patient about the symptoms: how to recognize them, how to anticipate them, what they mean, how to manage them' (Fisher, 1999).

'So I don't need to talk about what happened?' he asks. 'No, I don't need to hear the story, and I don't believe it will help you to tell it until we both know that you can do so without you feeling too distressed. We need to first find ways of making that possible so that we can trust that you are steady enough to face it', I tell him. He begins to soften, his breath deepens and he settles back in the chair. More questions follow; he seems disbelieving, but he is listening more attentively. I ask him, 'Is it helpful to be asking me questions?' 'Yes,' he says, 'I want to know if I can trust this'. I say 'It seems like you don't

know how to feel safe at the moment'. Nick nods in agreement while I continue. 'You won't really get it until you do it. We can work on this a bit now, if you're interested.'

Commentary: My insistence that Nick does not tell his story at this stage is a key point. It is my firm belief and experience that to retell is to relive a trauma and I am determined to avoid this with him as far as I am able. Trauma clients are often quite phobic of their body sensations because they remind them of their distress (Ogden, Minton and Pain, p. 199). 'Being in their heads' is protective. But I mean what I tell him; safety isn't a concept, it is a felt sense that I want to encourage here. So I'm interested in exploring this before I lose him with more words. Although I believe fundamentally that safety is a relational function, it will take a long time for the kind of trust that enables this to develop; in the meantime I think we need to build our initial alliance around the issue of safety. I sense that this is the right moment because he has some curiosity. I guess curiosity is my best ally in this moment.

I ask Nick to think of a place as safe as possible, real or imagined. I make some conditions for it – he must be able to feel fully himself there, no one will make any demands or have any expectations of him, and that nothing bad can happen there. Nick thinks of a mountain in the Himalayas, where he has climbed previously. I encourage him to take himself back there, by recalling all his senses, his kinaesthetic and inner experience. We really take our time over this, lingering, savouring the experience to support his growing felt sense. Nick's breathing is slow and easy, his energy is higher and he has released some muscles in his face. His skin tone is more vibrant. I share my observations: 'Did you notice that too?' – heightening his attention and awareness further. I am aware that my own body is soft and receptive, more settled than at the start of the session.

Commentary: I think of the integrative capacity of our bodies (Kepner, 1987/1999, p. 41), and many potential layers of connection and meaning. To support this sense of integration it is necessary to access as many modalities as possible (Grigsby and Osuch, 2007, p. 50), and to linger in the less familiar satisfaction and assimilation stages of the cycle of experience (Rothschild, 2002, p. 95; Shapiro, 1995, p. 122). This allows the figure to develop fully and to subside uninterrupted. Sensorimotor psychotherapy places great emphasis on lingering with, basking in, luxuriating in positive experiences because it allows necessary integration to take place. Neurologically it likely supports the growth of alternative neural networks and reduces the influence of stress hormones. The longer someone can stay in their window of tolerance, the more likely they can access it in future. This can't happen alone, for the more this regulation takes place in the between of relationship the more embedded it will become.

However, the safe place isn't enough for Nick; he takes a second helping of calmness. He tells me about the first time he abseiled down a cliff as a cadet. He had been sleepless with anxiety the night before. Approaching the cliff top he felt very sick and his legs were shaky. I ask him to slow down and try to remember what helped him to let go. He replies that it was the thought that the officer leading the exercise, a man he looked up to, had done this many times himself. 'How did that make you feel; what went with that thought?' I ask him. 'I had a feeling in my stomach that I'd survive, so I just went over the edge.' Nick recalls that as he felt the harness take his weight and he made his way down the cliff face he began to feel steadier and more trusting. He remembers the exhilaration of reaching the bottom and I ask him to tell me more about this. Again we linger with the sensations that he is drawn to in the present. Nick notices pulsing and feeling alive; his eyes are bright and I can sense and share his satisfaction. I ask Nick how this memory might help him now and he tells me that he has a sense of overcoming. We linger with these thoughts, feelings, and sensations. As he leaves the session Nick says with a wry smile, 'Yeah, I can do this. See you next week.'

Commentary: These events seem to be linked in his memory system. They have some features in common and may be state dependent (Philippson, 2001, p. 65). The concept of resources can probably be traced to the NLP notion of anchors; Kepner refers to self-functions as resources (1995, p. 59). Resources represent the disowned functional polarity (Kepner, 1995, p. 97) to dysregulated ANS arousal. They are the 'glue' of trauma treatment, paradoxically by dissolving some of the fixity of the trauma experience (Stratford and Brallier, 1979), loosening fixed gestalts. The deliberate use of resources serves to re-structure the ground of trauma. Resources can take myriad forms, from the natural world to the creative, from the cognitive to evoked companions, and are commonly used in contemporary trauma therapies (e.g. EMDR: see Parnell, 2007, p. 79). Building a wide range of resources is a major task of stabilisation in trauma work, developing and strengthening the capacity for exercising choice; there can never be too many resources. I propose that it is not so much the range of resources that is the factor that promotes change, although the variety adds interest and keeps the client engaged. Clients tend naturally to revisit, review and refine their resources and it is more likely to be this repetition, supported relationally, that builds strong neural connections. Conversely, attempting to move towards processing of trauma, Kepner's stage of undoing,

redoing and mourning, when there are too few resources in place, is potentially very risky, and worryingly common practice. The idea of the safe place is often the first port of call for trauma therapists (Rothschild, 2002; Shapiro, 1995). These different modalities share a common embodied approach to developing resources as described above.

Unique to sensorimotor trauma psychotherapy, as far as I am aware, is the concept of somatic resources. 'Somatic resources comprise the category of abilities that emerge from physical experience yet influence psychological health' (Ogden, Minton and Pain, 2006, p. 207). Myriad such resources are possible and can be grouped into different categories, including boundaries (see also Kepner, 1995, p. 71), containment, grounding, centring, and movement. As the above examples suggest, once a client can relate to their body in a way that can restore a sense of mastery their body is less feared, and the highly charged affective states of traumatic origin that it holds become more tolerable. Resources can also be triggers to positive affective and somatic states (Boon, Steele and van der Hart, 2011, p. 170).

Seventeen-year-old Jimmy is a fighter and came for therapy via a Youth Offending Team. He was brought up in a violent household and even when mum escaped with her children, his father tracked them down to their safe house. His whole life is organised around fights. He has his crew who protect him when he's with them, but when alone he is constantly alert for trouble. He admits to being frightened. At home, Jimmy's preoccupation is weight training to maintain the strength he needs to defend himself. We've done some work on breathing and stabilisation and Jimmy has times of being able to drop his guard with me. Now we study his awareness of what happens just before he pulls the first punch, and track backwards. Jimmy notices that he starts to salivate more under threat, having taken what he calls his 'fight breath'.

Commentary: My thinking is that by stepping back and studying his process, Jimmy can take a more reflective stance in relation to activating situations. I imagine that this will be more integrating because he will be able to attend to a range of sensory, cognitive, and behavioural modalities. By tracking backwards, my intention is to help Jimmy spot the signs of escalating arousal more quickly. He is usually so reactive that he needs to learn to slow down so that he can assess situations more accurately, and act appropriately. I want to support Jimmy to expand his range of available choices through increased awareness.

The following week Jimmy tells me about an incident. He saw an old adversary from another gang in town and approached him. It was then that he recognised his fight breath, and thought 'He's just a kid'. Jimmy shrugged his shoulders and walked away.

The orienting response

Maria walks up the stairs dragging her coat behind her on the steps. A very young child with her security blanket comes to mind. She is disorientated although she has been here several times before. I feel sad and troubled by this client. Once in the room she glances around, but doesn't seem to be with me. 'What's up?' I ask her gently. She is distressed that she woke this morning to find some ornaments in her flat destroyed; she lives alone and doesn't remember doing it. Yesterday, she tells me, she had caught sight of her abuser from a distance and she was later picked up by the police. She had driven out of town without knowing how she got there. Incidents such as these are quite common for Maria and she finds them deeply, deeply distressing.

Commentary: Maria is describing episodes of dissociative fugue and amnesia (van der Kolk, McFarlane and Weiseath, 1996/2007, p. 283; Ross, 1997, p. 99) in response to a seriously triggering event. I can only guess her history at this stage of our work, but the fact that I am willing to 'feel into' her trauma forms a bridge between us. She is far too traumatised to be able to tell her story, and my only focus is to support Maria to be safer in the present. Unfortunately, there are multiple triggers for Maria even in the therapy setting which she is constantly alert to.

The sound of an emergency siren outside startles Maria, and she gets up to look out of the window. She always needs to move when she is triggered by something. I quietly go and stand by her and tell her that I am there. She is very agitated and I observe her head and eyes turned slightly to the right. I comment on this and suggest that she looks to the left. Something small shifts and she engages with me more directly for a moment, saying 'When I was a child my bedroom door was on the right'.

Commentary: This vignette illustrates the somatic basis of the orienting response. This is a creative adjustment whereby 'individuals unconsciously and reflexively narrow the field of consciousness to reminders of the trauma' (Ogden, Minton and Pain, 2006, p. 65). I understand Maria to be telling me about something stored in implicit memory on a somatic level (Siegel, 1999, p. 28), and I am responding mostly to body-to-body communication. Had I chosen to explore the figure of the door, as my Gestalt training might have suggested, I imagine that Maria's dissociative difficulties would have been compounded and there would have been no ther-

apeutic value in this. The orienting response goes hand in hand with hyper-vigilance, keeping the perception of threat and the sense of danger in the foreground of the trauma survivor's experience.

The following session, Maria is on her feet again. Her head is turned to the right and remembering her comment last week I suggest that she looks to the left again. She does so and then shuffles her feet round, so that while looking in a new direction, her head is again to her right. We repeat this little dance a couple of times before I finally understand something. I wait until Maria is seated again, so that she can't move her feet. She is looking at something on her right, and I imagine that she is seeing the door again. I use different words. 'Turn your head to the left, Maria, and see if you can hold it there for a moment.' She does so and says with a tone of surprise, 'Oh, I feel calmer now, more stable'. She's engaged with me now, much more present, and we linger with this better experience for some time, to help her integrate it and process what she has learnt.

Commentary: Maria is organising her whole body position in reference to the memory of her bedroom door. This is a somatic fixed gestalt, held in the relationship between her head and her shoulders, which begins to loosen by this intervention.

Defensive systems

The orienting response is related to the need to defend against danger. Instinctive defensive systems related to trauma can often be observed in therapy. I want to return briefly to two clients discussed earlier. Maria's tendency to walk around in sessions occurs at times of heightened arousal, while at such times Rose collapses. Fight, flight, and freeze are commonly understood reactions to threat. In addition, Nijenhuis, van der Hart and Steele (2006, p. 60) propose 'Submit' and 'Attach' as survival based defences. A more user-friendly mnemonic for this is Friend, Fight, Flight, Freeze and Flop – the five 'F's'. [2] Maria's reaction can be related to the flight response, and Rose's to submit. In these responses can be seen the somatic re-enactment of traumatic memory. Submission makes sense in cases of extreme danger where anything else might escalate the violence, like the mouse playing dead in the cat's jaws. Attach(ment) represents a common instinct on the part of people under threat, such as screaming for help. Sensorimotor trauma therapy views 'fight', 'flight' and 'attach' as active, mobilised responses, and 'freeze' and 'submit' as passive, immobilised response (Ogden, Minton and Pain, 2006, p. 92). This is useful for therapists who can support a hierarchical progression from immobilised responses to more mobilised responses. This does much to mitigate the experience of helplessness and completes defensive actions (Levine, 1997, p. 110; Ogden, Minton and Pain, 2006, p. 87). Notice that with Rose, in addressing her extreme hypo-arousal I brought in movement, supporting a more active engagement which she needs in multiple areas of her life.

Conclusion

For relational Gestalt therapists, there is an inherent paradox in sensorimotor work about needing to be more directive at the start of therapy. The approach at times of heightened arousal is far more therapist-led than we are usually comfortable with, although this is never my primary relational stance. Furthermore, the sensorimotor approach calls into question the paradoxical theory of change, or at least suggests that there are limits to it with trauma clients. When working from a Gestalt perspective, I assume that the client can return to a state of organismic self-regulation and that contact is possible. When the work takes a more sensorimotor turn, I no longer make these assumptions. Sensorimotor trauma practice is not for the most part different to Gestalt, it is in some respects 'more than'. The sensorimotor strength is that it adds something important in its well-defined and accessible rationale for working in particular ways with traumatised clients. The concepts considered in this article are all deeply embodied, relating to somatic creative adjustments to trauma. Sensorimotor trauma work seeks to facilitate the emergence of choice, to support the client's self-directedness and helps prepare the ground for the paradoxical theory of change.

As the above examples illustrate, the detailed observation of the client and the regulating capacity of a present and embodied therapist make this work fundamentally relational. I cannot emphasise enough the grounding effect that sensorimotor concepts and methods have on me. I propose that this in itself is enough to establish a radically different field in trauma work, which Kepner calls the Embodied Field (2003). The non-verbal communication of an embodied, present and mindfully attentive therapist can powerfully convey that the therapist, for one, is not afraid of the work. Setting up the work to use therapist-guided interventions to prevent arousal escalating from the outset configures the whole relational dynamics in a profoundly different way. It immediately provides a container for the uncontainable by setting the parameters within which the work will take place. By such incremental steps, the legacy of trauma can be transformed.

Notes

1. Taylor, M., *Trauma Therapy and Clinical Practice: Neuroscience, Gestalt and the Body*. Open University Press; publication expected Spring 2014.
2. My thanks to Kim Hosier for this idea.

References

Boon, S., Steele, K. and van der Hart, O. (2011). *Coping With Trauma-Related Dissociation*. New York: Norton.

Bromberg, P. (2011). *The Shadow of the Tsunami*. New York: Routledge.

Buchholz, C. (2008). *Complexity of Self-Reflection*. Saarbrucken: VDM Verlag Dr. Muller Aktiengesellschaft and Co. KG.

Emerson, D. (2008). *Yoga for Peace of Body and Mind – a Clinician's Manual*. Boston, MA: The Trauma Center.

Fisher, J. (1999). 'Stabilisation in Trauma Treatment'. Unpublished paper: www.janinafisher.com/resources Accessed 3 April 2012.

Grigsby, J. and Osuch, E. (2007). Neurodynamics, State, Agency and Psychological Functioning. In Piers, C., Muller, J. P. and Brent, J. (eds.) *Self-Organizing Complexity in Psychological Systems*. Maryland: Aronson, Lanhan.

Kepner, J. (1987/1999). *Body Process*. Cambridge, MA: Gestalt Institute of Cleveland Press.

Kepner, J. (1995). *Healing Tasks*. San Fransisco: Jossey-Bass Inc.

Kepner, J. (2003). The Embodied Field. *British Gestalt Journal*, 12, 1, pp. 6–14.

Kurtz, R. (1990/2007). *Body-Centered Psychotherapy: The Hakomi Method*. Mendocino, CA: Life Rhythm.

Levine, P. (1997). *Waking the Tiger*. Berkeley, CA: North Atlantic Books.

Nijenhuis, E., van der Hart, O. and Steele, K. (2006). *The Haunted Self*. New York: Norton.

Ogden, P., Minton, K. and Pain, C. (2006). *Trauma and the Body*. New York: Norton.

Parnell, L. (2007). *A Therapist's Guide to EMDR*. New York: Norton.

Philippson, P. (2001). *Self in Relation*. Highland, New York: Gestalt Journal Press.

Philippson, P. (2011). Mind and Matter: the implications of neuroscience research for Gestalt psychotherapy. In Bar-Yoseph Levine, T. (ed.) *Gestalt Therapy: Advances in Theory and Practice*, pp. 83–92. Hove: Routledge.

Polster, E. (1995). *A Population of Selves*. San Fransisco: Jossey-Bass.

Ross, C. (1997). *Dissociative Identity Disorder*. New York: Wiley and Sons.

Rothschild, B. (2002). *The Body Remembers*. New York: Norton.

Siegel, D. (1999). *The Developing Mind*. New York: Guilford Press.

Stauffer, K. (2010). *Anatomy and Physiology for Psychotherapists*. New York: Norton.

van der Hart, O., Nijenhuis, E. R. S. and Steele, K. (2006). *The Haunted Self*. New York: Norton.

van der Kolk, B., McFarlane, A. and Weisaeth, L. (eds.) (1996/2007). *Traumatic Stress*. New York: Guilford Press.

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