Hakomi Mindfulness-Centered Somatic Psychotherapy

A Comprehensive Guide to Theory and Practice

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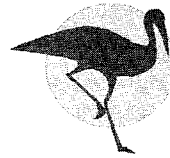

CHAPTER 24

Mindfulness and Trauma States

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EXPERIENCING TRAUMA IS not only a shock in the life of clients, but also an event that alters how they see themselves. Clients categorize their lives in terms of before and after the trauma experience (Herman, 1992; van der Kolk, 2014). "Before my accident I was able to run and go everywhere. Now I am afraid to leave my house." Traumatic events can mark distinctive chapters in one's life or have an ongoing chronic impact on a person's psychoemotional and physical life (van der Kolk, McFarlane, & Weisaeth, 1996).

Much has been written and discovered about trauma, especially since the 1990s. Somatic psychotherapy has been greatly enhanced by the works of Bessel van der Kolk (1987, 1994), Peter Levine (with Frederick, 1997), Pat Ogden (Ogden et al., 2006), Babette Rothschild (2000, 2003), and many others in the field who have advanced our understanding that traumatic events are experienced through the body. Treatment modalities need to include a deep understanding and methodology for resolving trauma on a psychophysiological basis (van der Kolk, 2002, 2014).

We now understand in somatic psychotherapy that work with traumatized clients needs to include working with the sensory experience of the body. Traumatic events cannot be talked away through top-down processing, but need to be carefully renegotiated in the memory and nervous systems of the body through bottom-up processing. The activation levels of the limbic structures of the brain need to be held in an optimum range of neither

nder- or overactivation, so that the client is able to take in new information on a neocor-cal level (Ogden et al., 2006). Clients must be able to be alert and focused enough that ey can feel, sense, and comprehend what is occurring inside of them, and how they are aking sense of their trauma events through a cohesive narrative (Siegel, 2007), so that ere is coherent comprehension of what has happened to them.

Like a good story, the event must be understood on all levels of human experience to ake sense. Part of trauma is the senselessness of what has occurred. The more loss or life reat clients have experienced, the more they are faced with the senselessness of it all. laking sense requires an intellectual comprehension along with a physical one, with the ippocampus functioning to weave meaning from implicit memory (Schacter, 1992).

Many traumatized clients are not able to mobilize these intellectual and physical require-ents for addressing the senselessness of their trauma. They cannot operate within what gden and colleagues (2006) term the "window of tolerance," where Porges (2003) says e ventral vagal nerve facilitates our capacity for social engagement, with ourselves (Sie-el, 2007) or others. These clients display signs of either hyperarousal (increased sensa-on, emotional reactivity, hypervigilance, intrusive imagery, and disorganized cognitive rocessing) or hypoarousal (relative absence of sensation, numbing of emotions, disabled ognitive processing, and reduced physical movement). When these signs are present, it eans the person is dissociated to a degree and not really present to the therapy in an ffective way (Ogden et al., 2006). Therapists without specific training in working with ch indicators of trauma should consider referral or seek the requisite training through e Hakomi Institute, Sensorimotor Psychotherapy Institute, or other qualified training roviders.

In this chapter, the focus is mainly on neurological development and trauma therapy om a Hakomi perspective, and how mindfulness can help mediate the comprehension d integration of traumatic experiences. Trauma therapy is a vast topic and here only a w aspects of our unfolding understanding of how to treat trauma symptoms are high-ghted. Please see the references for a more in-depth study of this subject.

Meeting the Client, Meeting the Brain

kson (1963) helps us understand the trauma to veterans of Vietnam by explaining that y developmental issues such as identity formation happen in late adolescence and early lthood. However, it also remains true, as object-relations and self-psychologists have earched (Stolorow et al., 1987), that our earliest levels of development leave a foun-ional footprint that influences how we process later difficulties. Newborn babies are uisitely sensitive when they arrive in the world. The organ of their skin is taking in ry touch as a new experience to be processed throughout their whole body and brain hwartz & Begley, 2002). Touch and early sensory stimulations are strong excitations r the young nervous system. They are stressful in the sense that the developing brain of e infant has to process and organize these previously unknown experiences (Siegel, 99).

The loving orientation of a warm and consistent caregiver provides containment for these arousing experiences. The attuned attention of the caregiver is key as the child learns how to incorporate these strong sensorial activations into an organized pattern of relationship style. For instance, the mother's soft voice and repetitive, gentle strokes along the baby's back as he is crying and arching give rise to a rhythmic and intuitive dance, evolving between caregiver and infant through matching voice tone, eye gazing, smiles, and gentle touch. Over time, the child begins to perceive touch and such stimuli as a nonthreat (Cozolino, 2006).

These experiences are internalized not only as sensory-emotional memory but also as a perception of how the child is being received into the first relationship template. These experiences translate into deep belief structures in the psyche of how one is loved and cared for, and influence one's capacity for loving another (Kurtz, 1990a).

When the touch-care continuum is internalized negatively, many years later, life is perceived and felt as a threat—just as the early template of sensorial stimulation was not matched with the experience of love and care. These deep sensate templates become compounded when trauma is present, and provide a confusing and overwhelming landscape for the trauma client (LeDoux, 1996). The capacity of the trauma client for self-reflection, self-soothing, and basic hope in the face of despair (Shaver et al., 2007) is based on how she is resourced in her foundational years when establishing safety in early relationships is crucial. There is a serious difference between chronic developmental trauma and event-centered trauma such as an accident or war experience.

I am reminded of a Nicaraguan client who was politically tortured, whose capacity for overcoming the most horrific events was admirable. Her reply in one of our sessions to a comment on how well she was doing despite those tragedies was, "They can break my bones, but they can't take my spirit," an idea that could evoke endless hours of contemplation. What we know of trauma survivors, especially those who have been tortured, is that a refugee's unfaltering faith in his or her cause can be a psychological savior in face of such horrifying experiences.

However, there was another truth about this person. As we referenced her statement in the months to come, I discovered in this client's history a very loving and warm family with a mother who was attuned and caring to my client as a young child. Her foundational relational matrix was intact—despite her injured body, the tragedy of having lost every person she had loved including her child, and the trials of living in a foreign country and having few skills in her new country's language. Still, her internalized mother provided palpable hope in the process of healing her trauma symptoms.

Learning the internalized skill of self-soothing is a delicate exchange between the mother and the infant (Tronick, 1989). The internal state of the mother regulates much of the baby's state and vice versa (Schore, 1994). A colicky baby's cries and fussing can begin to exhaust an already tired parent, setting up an internal chain reaction in the mother (caregiver) and escalating the chain of stimulus until she is overwhelmed. The baby may then experience parental patterns of withdrawal, anger, helplessness, and emotional distancing. Selma Freiberg's famous term "ghosts in the nursery" reflects the

entrenched emotional patterns generated in the subtle, moment-to-moment exchange between caregiver and child (Doidge, 2007).

Babies who learn that their cues of distress are not responded to as needed develop a high-activation continuum in the brain stem, diencephalon, and limbic regions of the brain whenever stressful moments are experienced (Perry et al., 1995) and become dysregulated when there is no mediation by the caregiver. The dysregulated internal states of the baby can in turn further dysregulate the mother's internal states, which further dysregulate her infant in a problematic cycle. Infants in this arousal continuum are at great risk for abuse and continuous high stress levels. A prolonged exposure to these high stress levels in the brain can have lasting impact on the developing brain's memory system and capacity for emotional range (Lewis et al., 2000; Schacter, 1996).

The intricate exchange that takes place between mother and child on a moment-to-moment basis is largely nonverbal—gestures, facial expressions, and whole body expressions convey the message of the emotional state. The child becomes masterful in reading these cues and responding to them in ways that preserve and enhance the relationship. These exchanges of subtle cues are, I believe, the same in an in-depth psychodynamic approach to psychotherapy (Lewis et al., 2000; Tronick, 1998).

Psychotherapy as Potentially Overstimulating

The internal states of clients impact psychotherapists a great deal. If a client is highly dysregulated and not making eye contact with the therapist, this can be met in various ways. How therapists respond to the lack of an empathic relationship depends on their own momentary state and their history, as well as their training (Roy, 2007).

For instance, Gerald was unable to look me in the eyes at any time. In fact, he constantly diverted his eyes away from me, staring at the carpet, as if lost in a distant dream. Over time, such somatically embedded behaviors of the client, as well as the basic needs of the therapist, can make even the most compassionate therapist uneasy (this is assuming a Western therapist, and I recognize the cultural bias here; see Foster et al., 1996; Johanson, 1992; Lewis et al., 2000; Sue & Sue, 1990). A subtle rejection might begin to form in the therapist who feels she cannot relate to this client or understand him on a deep level. Feelings of resentment or failure might arise. The loving presence of the therapist begins to alter. This, in turn, fuels the worst fears of the trauma client. Instead of experiencing the delight and consistency of the therapist, he once more experiences a caregiving person not seeing or understanding him, and withdrawing (Feinstein, 1990). The internal arousal of stress is exacerbated.

The intimacy of psychotherapy, and especially somatic psychotherapy such as Hakomi, can easily travel into the terrain of sensory experience (Heckler & Johanson, 2015). This means that although clients might want to discover and transform the core beliefs that are holding them back by impacting their relationships with self and others, the very process of psychotherapy might be adding to their feeling of overwhelm. Activated clients cannot

process their core material. The activation level itself prevents clients from bringing the experienced material into the rational and logical part of their brains (the neocortex) for comprehension and processing. The actual experience of the therapy backfires and is experienced as too activating and arousing (Ogden et al., 2006).

This is a crucial point that is often missed by well-meaning verbal and body-inclusive therapists who feel their unconditional positive regard can automatically create a safe place. The arousal states of clients need to be brought down in specific ways in order for them to witness and comprehend what is occurring. Just beginning to experience a high arousal level can bring up learned defense mechanisms, as well as triggering basic survival mechanisms of protection (Morgan, 2006). This is a delicate balance, as the therapist wants to allow and facilitate the client's emotional processing, which in a particular moment can escalate into an activation level or trauma vortex that the client cannot manage. It is often important to begin working on the multiple ways a person can resource herself mentally and somatically before beginning to address the trauma directly. Then client and therapist together can track the ability to go back and forth from the resourced position to a piece of trauma small enough to be titrated and digested by the nervous system.

For more information on how to titrate triggering sensations and how to work without promoting a trauma vortex that can retraumatize a client, we can refer at minimum to the work of Levine (with Frederick, 1997), Ogden and colleagues (2006), and Rothschild (2000, 2003). All somatic psychotherapy that aims to negotiate the arousal of the nervous system in elegant ways seeks to track and address activations and dissociations beyond the client's window of tolerance, so clients can actually be present with their experience and find new ways of relating to their triggers.

Mindfulness and Interruption of Nervous System Patterns

Mindfulness is a state of being, as well as an inner reflection on moment-to-moment experience (Chapter 10). As discussed throughout this book, the use of mindfulness plays a central role in Hakomi therapy in the discovery of internally held beliefs and experiences. The predicament of clients with trauma is that it is a state of disruption of their life force that renders them unable to handle the arousal levels in their body. The coping mechanisms vary with each person according to his or her capacity for self-regulation and function. Nevertheless, in a general sense, the trauma client has lost the capacity for being with himself in a calm, resourced way. Trauma states can be viewed as uninterrupted states of mindlessness. Lower brain functions are in charge as opposed to the thinking brain.

Hakomi therapy can provide a beginning place for meeting the trauma survivor's brain and treating it in a multifaceted way. In Hakomi, we pay attention to present-moment, direct experience, and how the client is relating to it. This direct relationship with time and history has an important function (Pert, 1999). Clients can experience their traumatic past in relationship to multiple parts of themselves (Rowan & Cooper, 1999), as well as to the therapeutic relationship. That the therapist calls the client's attention to what is occurring

for him in the moment offers the client the awareness and self-control to interrupt automatic patterns and experience himself in a new way (Siegel, 2007).

> *This might occur in minuscule moments, such as with Sylvia when she glanced up at her therapist with a look worn down by many years of rejection and the chronic emotional pain of trauma. The therapist received her with acceptance and positive regard. She startled. His eyes widened. The Hakomi therapist tracked this and used this moment to gently contact and guide her to noticing that she was surprised not to find the expected hostility. Sylvia's crying deepened as she nodded. A mixture of recognition, pain past and present, were all mixed in a soup of gratitude and aliveness. She had been seen, received, and led into a new state of aware wakefulness. The past did not matter in that moment. The authentic connection with her own pain and the acceptance by another provided a new experience in which her symptoms took a break. She could let in a ray of hope that life need not be as bleak as she had perceived it to be.*

The case above is an example of relating to developmental or chronic trauma, as opposed to the single-incident trauma (accidents, rape, or events related to first-responder work, war, gangs, and so forth, where life is literally at risk) normally diagnosed as PTSD. Though chronic or complex developmental trauma has been identified as a different syndrome than PTSD, it has not yet been included in the diagnostics of the *Diagnostic and Statistical Manual of Mental Disorders* (van der Kolk, 2005).

Hakomi embraces the various ways in which we experience ourselves. No single way is the right one. The discovery of what works organically for a particular person is deeply honored (Germer, 2006). This goes beyond just being respectful of people and their processing preferences. It also includes the way our brains function to come to terms with a traumatic assault of stimuli and sensory inflation that is often hard to decipher (Rothschild, 2000; van der Kolk et al., 1996).

Through my work with trauma clients with many different trauma histories, I have come to view meeting them where their brains are as the best possibility. For instance, new babies need that eye gaze of delight and the gentle adjustable touch that activates the right orbital prefrontal cortex, or joy center, and teaches them that touch and relationship can be a safe haven and a nurturing template for all relationships to come (Doidge, 2007).

Trauma clients, likewise, need that same recognition and understanding of their arousal and fear contingencies—of how their brains have been affected. They also need the initial limbic restructuring experiences with the therapist to help them regulate parts of themselves lost in their instinctual-level coping with traumatic events (Schore, 2003). Or as one of my first clients put it when I was a beginning therapist, "I thought I came here for therapy, but what I really came for was feeling safe and understood and loved." This occurred just as I was taking pride in graduating, complete with my newly acquired therapy skills. It helped me realize that the magic ingredient had not simply been my advanced techniques, but rather the quality of the bond that had developed with my client over time.

Now we had an opening to work directly with her fear, and with how she was managing herself in that state. This was a precursor to exploring how she was dealing with her trauma experiences, namely pushing through them while excluding feeling. If we had not created a safe atmosphere, with a slowed-down environment for curious, open-ended exploring (Kurtz, 1990a), we would not have had the opportunity to befriend her experience and see it unfold in new psychosomatic patterns.

Another important aspect of introducing mindfulness is interrupting habitual unconscious patterns in favor of providing an emotional holding space where clients can safely experience their high-affect states without spinning off into a trauma vortex. The mindfulness of therapists is also a crucial element, as they become the temporary nervous system that holds the disorganized states of clients—also true in parenting (Siegel & Hartzell, 2003).

Here are some ways to use aspects of mindfulness to interrupt habitual patterns of managing trauma-based states of fear:

1. Therapists actively engage to calm their own levels of racing or triggered thoughts by slowing down and getting mindful distance on their parts being evoked.
2. As therapists become aware of their own "speediness," they calm their own body movements. They then employ simple ways to slow down clients physically. Interventions can include bringing awareness to the quality and rhythm of the breath and introducing a slower, more deliberate breath. Or clients can be encouraged to bring their awareness to the immediate knowledge that they are sitting on a chair, and their attention can be guided to the physical contact points with the chair and their feet on the ground. This attention to breath and to grounding the body helps to bring down the activation levels of the nervous system.
3. If they have not done so already, therapists engage their clients in mindful awareness of multiple ways they can resource themselves through body, images, colors, memories, self-state centeredness, and such (Ogden et al., 2006). This is always a first stage of treatment of trauma issues to ensure that clients always go back into traumatic material resourced, and have resources readily available to counterbalance activation outside their window of tolerance.
4. Therapists use their abilities to track and contact (Chapter 14) to stay closely attuned to the client's experience as it is occurring, thereby enabling the client to bring awareness to the present-moment experience. Trauma is very much about not being congruent with one's own experience, but rather with the past or the future.
5. Therapists support clients in increasing their ability to feel, sense, taste, and experience what is happening directly through the body. Connecting with the here and now enables clients to put thoughts and feelings into perspective. Therapists continually track clients for signs of hyper- or hypoarousal, and move to center, ground, resource, or titrate sensations when signs of dissociation arise indicating the process is going too far, too fast.
6. Therapists can bring mindfulness to bear on the quality of the therapeutic relation-

ship (Fosha, 2000). This can enable the client to become aware of and enriched by the support, understanding, and empathy the therapist is offering, thus breaking the trance of traumatic isolation (Wolinsky, 1991). Directing the client to notice the therapist in the moment can also help break the trancelike quality clients can fall into when recalling traumatic events.

Again, traumatic experiences involve lower regions of the tripartite brain that work before and outside of the influence of the neocortex, thus making clients susceptible to experiencing trauma vortexes that manifest in terms of hyper- or hypoactivation of the nervous system. Hakomi therapists can become skilled in employing mindfulness in the service of bottom-up as opposed to top-down processing to deal with such situations. However, supervision, referral, and further specialized trauma training are all important to avoid putting clients at risk of retraumatization.