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Touch and affect regulation

Skills and tools for body oriented psychotherapy in trauma therapeutic context - Particularly in relation to methods of postural integration

Abstract

On the basis of new neuro physiological research this article explores how touch influences different areas of our brain via nerve receptors, and how different techniques of touch support a client's need for affect regulation.
It demonstrates, how not to avoid emotional expression, following A. F. Schore's proposal concerning affect regulation, and the development of a resilient inner self for the clients; it is useful to work with the affect cycle to understand in a more profound way difficulties of handling emotions-traumatized clients are suffering from and how the understanding of the „window of tolerance"-frame will support both: Those clients who are suffering from too strong and painful emotions as well as those who are suffering from too little contact to any emotional reaction.

Keywords:

Touch and affect regulation, skin-mechano-receptors, affect-cycle-charts, window of tolerance

The beginning situation: Let's have a look into the first contact between client and therapist: Before, we had email- or phone contact. We read lines written by the other, we heard the voice of the other, and we always start to relate to the signals we received:

- How did the client express his interest in therapy: Was it mostly in technical terms?; Was it more in terms of needs and desires, or did the client have difficulties to make

him/herself understood because of interfering emotions?;

- Or on the telephone: What in the sound of the client’s voice resonates within ourselves as therapists: Do you/we remember that, due to our „social engagement system‟ (Porges 2001), we often associate a face and body of a person just by hearing their voice: What feelings do arise about the other person - even if you are not trained in „sensing the primary Chinese element in that voice‟ (Ohashi, 1992; chapter 3);
- Or where in your own body the client’s voice resonate as you are listening to it?;
- Which channels of sense do clients use: Are they more into „visualization‟, into „inner voice dialogue‟ or do they talk about their senses and body sensations!? Lots and lots of information you may perceive from your clients in the situation before actually meeting.

And than **the initial scene**: The first live interaction: The relation between the inner vision you may have created from your client and the reality; which facial expressions does the new client show in this contact: Is he smiling!? Or is she close to tears? Or does the face to face contact feel like there is a great distance between you with skeptical eyes watching you!? How is the quality of the handshake? Strong as if a bulldog squeezes your bones...or limp, like a duster!? And how does this relate to the overall tension of the person in front of you!?

This initial scene is full of detailed sensorial information about your clients style of interaction. And in body psychotherapy we use our own body as an interactive, psychobiological regulator for all the emotions that may come up in this situation (Diamond et .al 1963; shore 2001b). Courtois (1999) describes, that particularly traumatized clients, due to their painful experiences, have great difficulties to establish less fearful communication in therapeutic relation. Therefore, therapists do have a need for creativity concerning conscious as well as unconscious patterns of interaction.

On a basic level, we sense f .i. that there is no feeling. Just a mask of more or less friendly interaction, the emotions are in a hypo arousal (about hyper-/hypo arousal see: Post et. al. 1997), there is nothing to really relate to; or even less: Maybe a silence we cannot understand; or something like a deep black

hole/void that opens itself in contact, but cannot be touched in any way; or the opposite is the case: The basic level of interaction is in a hyper arousal state: Much pain is coming up in this first contact with the client: Tears caused by something that has happened on the way to the practice; or in the last days before our meeting; or the clients have fantasies concerning your skills as therapist: They read something in the internet that has deeply touched them; or they see something in your eyes that causes their basic distrust to come up...

How, as therapist, do you relate to this bonding situation!? Do you take the emotional feedback personally f. i. as being a result of your good or bad marketing strategies!? Do you lean back with „a calm face‟(Hornak et. al. 1996), merely observing what you sense!? Do you use several interactive patterns to find out how to cope with this situation: Are you aware of the change in your voice while talking in this first contact!?

What about your self organization of your own body during clients contact: Are you feeling comfortable!? Are your arms crossed!? Your legs!? Or is your reaction to this client one of easy, of open gestures: You relax your arms, sit facing the client and mirror their and adopt to their facial expression? Are you able to follow her/his gestures to get closer to grasping their meaning? Do you give feedback to your client about their facial and gesturing expression!? Do you start to regulate emotions during this first contact, or do you feel over whelmed by the emotions!? (About the endogen directed intent of human brain to stay in relation see: Dunn, 1995, p.724)

During this **first phase** you support your and your client’s **social engagement system** (Porges 2001) to find regulations for a good interaction that allow both a situation of sharing inner core feelings as well as supporting the need for clear borders or regulations which is a necessity for both of you as adult human beings. To accomplish this we do need only little hierarchy and a reliable reciprocal feedback system in a setting of nearly symmetric relationship. This differs completely from the old therapeutic paradigm of the therapist as a „white paper‟ who views the client’s transference-problems from an objective perspective. „The observer of a situation is part of the situation‟ (Greene 2004; chapter 4: Heisenberg and the vagueness). And our social

engagement system is a good internal regulator for all these questions of contact and interaction that may arise.

In this first phase we start giving feedback on body interaction with clients: On those both of us are conscious of: Like the sound of their voice, the strength or speed of their movements, or about our feelings in this bonding situation while we are sharing space and time in the therapeutic setting. We try to nourish the client's ability of receiving and giving feedback in a body wise way. In the same way good parents interact with their children: Giving feedback about existence with all their physical presence. Later, we also will include the unconscious components of interaction as well. Especially „body reading" (Prestera/Kurtz 1976) will follow in a phase, when a reliable foundation of trust has grown, which cannot be the case in the beginning situation of a therapeutic setting.

Later you may oscillate between these regulations and the following self regulation methods you use, to recreate again and again a therapeutical situation of trust and self development for both parts of the therapeutic contact.

In this early situation of therapy you have the opportunity to decide if you can go on with your kind of body psychotherapy, or if there is a necessity to work with trauma therapeutic strategies. We forgot/may not forget that even though there is, since the 90ies of the last century, a cultural background suggesting that „all clients are traumatized", there are some who just have had experiences in their life strong anxiety and need help to cope with these, and that only some of our clients are traumatized in a way it has been defined as:

- There is a subjective understanding of a life threatening situation;
- For the client there has been no way for fight- or flight activities
- After the situation, there is no way to receive good, nurturing bonding to calm down the autonomic nervous reaction (correspondingly: Levine; 2010; chapter 1)

In the **second phase**, tracking (Ogden et al; 2010; chapter 9) „body wise" is the main goal. To support clients' resources of finding

good and safe places, their sense for a better centering/improve their sense of being centered in their body and especially strengthen their ability to differentiate between an emotional interpretation of a body signal and the body sensation itself. This later will support their ability to calm down emotional hyper arousal; or, if they find themselves in a hypo arousal situation, support self activation of their emotional activity.

What ever type of body psychotherapy you are specialized in, from now on you have to handle all details of the initial scene in the bonding situation with the clients - for example:

- The distance you choose working with a client,
- Support of gesturing: What kind do you find meaningful for the work ahead of you: Maybe you want to encourage a client to enlarge a gesture in order to find out its meaning...
- Or you start playing with unconscious body signals you have perceived in the initial scene.
- Or you may bring more awareness into a certain body area of the client where they feel comfortable.
- Invite them to breathe into that area.
- Bring their attention to small changes there: Differences of temperature or perception of colours under the skin.

All this can also be described in terms of „grounding‟, which is a term originating in bioenergetics (Lowen 1975; Ogden et al 2010, chapter 10) and later has been developed into the concept of „embodiment‟ of experience (Hüther 2011). It is not merely a term, it is a basket full of techniques, each allowing to track good, strong somatic resources, alongside or beneath the traumatic memories clients may have.

During this phase, relation gives the chance to train both: The therapist in choosing their interventions and the clients to keep the emotional arousal in an optimum range within the „window of tolerance‟ (Ogden, et. al.; 2010; p. 67) in their memory work: Enough emotion is evoked to work with (Quote from Breuer/Freud about the fact, that memories without sufficient affect have no impact on the healing process 1895; GW1; p. 85); enough regulation happens because of the social engagement system to keep the charge of emotions in a degree of intensity which allows both to regulate the process, even if some first „rapids‟ (Levine 1997) may have to

pass. The social engagement system teaches both: The therapist about the choice of techniques that support regulation with this client, and the clients, how to handle emotional arousal without falling into the post-traumatic cascades of reactions they had experienced in the past.

To support clients' awareness means at first to establish body areas where clients can feel safe and comfortable, where later they can balance their fear of traumatic memories even if they feel separate from their body (if they have a tendency to get a hyper arousal) or to establish something like a sensual presence in a body area which later can be developed into an emotional reaction (if they have a tendency to stay in their hypo arousal). You now have to establish several **aspects of clients self-regulation.**

And mind the following: If you have a client with eating disorder, fasting is not part of the solution! If your client belongs to those twenty percent of Europeans suffering from sleeping problems, just not to sleep definitely is not part of the solution! And the same is true with touch: If you have a client who has been traumatized by violence, or even sexual abuse, avoiding touch is part of the problem and does not lead to any relief of the client's trauma. Any way, as a body psychotherapist, after making your client aware of the physical part of interaction, you develop ways to come into closer contact with the client and this also involves touch. **Touch is part of the client's self regulation process**. (See also concepts from Bion 2004: „containment"; and Winnicott: 1990: „holding environment") –

Some years before Bandler/Grinder(1976; p. 37f; Ogden 2010, chapter 8) found out during videotaping the works of Virginia Satir, Fritz Pearls and Milton Erikson that the unconscious body dialogue between therapist and client is a main factor for the success of therapy, Bowlby (1995) demonstrates the part our bodies play in regulation of contact and therapeutic healing. Gelder (2004) explains later too that mirror postures activate similar parts of the brain in all participants in a situation and this has been called „postural resonance". And finally Rizzolati (et. al. 1996) found out the activity of the „mirror neurons" as part of our brain activity to adapt to the feelings of people we communicate with.

In this phase, we implicitly start doing something else that we later, in the third phase of work, start doing explicitly: For the clients, we start to **develop a history of good touch**, touch our clients receive and are competent in. Some of the traumatized clients have fragments of memory about the „original situation" (Rosenberg 1985) of their traumatic experience. Others learned by another source that something must, have happened, or during the anamnestic interview at the beginning of work, you found out that some of the criteria for an unresolved traumatic situation could be found with this client. However, often the „original situation" cannot be recalled... In fact, the opposite is the case: Clients are suffering from lack of memory of long spans of life time or especially memories of early childhood.

Therefore we start making clients sensitive to the history / experience of touch they may have received: F. i. The mothers touch during nursing; the contact of the mother/ grandmother hands with the baby while changing diapers; the sensation on the skin of their „stuffed animal"; hand- or body contact with their brothers and sisters; memories of pets' paws if there were any in their childhood surrounding, like guinea pigs...rabbits...dogs, or cats; body contact with relatives in family while being read fairytales or watching TV; experiences of body contact while doing sports, or dancing; or last not least good bonding contact clients may remember from former or actual relationships.

In doing so, the therapist gradually develops a map of good/beneficial body contact clients have received - f. i. the gallery of sensations of touch by their relatives. You start to create a memory puzzle; at the beginning there may be little memory at all; but step by step, some isles of memory will develop about a special place in their childhood; around a photography they have; of a certain age... sometimes it is only a small detail: The color of a wallpaper, the smell in a room...not even knowing where it originates. What we start doing is both: To reactivate the forebrain-memory activity (von der Kolk 1996) and also to break the pattern of amygdala dominated traumatic reactions (Brewin 2001; p. 381), while activating more and other areas of brain activity in this phase of work.

This is achieved not only by talking: In a parallel process, while we start awakening the clients' interest for different kinds of

touch and body areas that feel safe, we are also looking forward to a new kind of „tracking": The tracking of touch itself and the clients' sensing of different qualities of touch. This may happen actively: They remember the skin of their mother's hands... and we invite them to explore the skin on their own, or by the therapist's hands. Or it may happen in passively: They receive different qualities of touch by the therapist. At the beginning, it is touch without any intention: Like doing Reiki, or pressing an acupressure point, or melting a part of fascia... none of that. Only to put the hand on a specific area where clients feel comfortable with and to bring awareness to this contact.

When changes are beginning in the **third phase** of the therapeutic process, we now support clients' resources to receive touch:

Keep them in the „here and now" (Stern 2004);to be aware of the difference between body sensation and their emotional interpretation (emotion); to sense the quality of touch it self: Is it warm/cold; does the surface of their skin melt beneath the touch, or does the clients' ability to be separate from/inability to connect with the touch remain; do they feel a need to relate to the warmth of the therapist's hands – or the contrary, do they fear that something is intruding their body by this hand!? (see also proposals for different kinds of hand-contact in: Busch 2006)

With pain clients you often find an unconscious pattern to use the touch of someone as a „lightning rod" to discharge their pain, and what happens when the therapist gives them feedback about this pattern. This process trains awareness of the difference between clients' interpretation of the therapist's intention of touch and their own emotional reaction to the quality of touch. Change the quality: Bring in some slight movement, change warmth or pressure of the hand (Schlage 2016) and again and again support the self regulation of clients, or regulations by the therapist's social engagement system with strategies which both have learned in former phases of work. Establishing somatic resources (Hermann 2003; Bundy, Lane & Murray 2002), identifying peritraumatic memory (Janet 1925) and mapping qualities of touch (Sollier 1897; Lowen 1967, chapter 3) are the main goals in the beginning of this phase.

And remember, memories can be visual, can be auditory (the sound

of mother’s voice; the sound of the motor of father’s car or the sound of voices of clients’ inner dialogues...), some clients may focus on memories of smell and, especially in body psychotherapy, many clients have kinesthetic memories: From former osteopathic, or Shiatsu sessions they received; feelings of being repelled; getting manipulated by touch. Therapists support the tracking of these touching experiences, or the sense of autonomic micro movements to reestablish body awareness in areas where they feel stiff or dull...it is possible to track while clients are moving body parts themselves/maybe under continuous touch. We explore this in different areas of the body: Center/periphery; front backside; legs, arms; face or head...and there for therapists can use maps of wisdom about what could be the emotional background in these areas (Marcher 2010; Painter 1987) influence of sensoric input for the regulation of the dyadic arousal and affect regulation to establish a more secure relation for both: Therapist and client. The stabilization of the neuro physiological pattern of „orbito frontal cortex‟ is basic upon a better self regulation of the client, upon a more differentiated social engagement system, and the client’s more secure bonding-pattern. It is the sensorial input that makes the development possible, he describes. (Schore, 2003, p. 219)

In the beginning of the third phase therapists are not focusing on the trauma. They just open up accumulation of memories. Therapists’ interpreting memories too early does influence the kind of memories especially concerning sexual abuse, it takes some time for client and therapist both to find out the difference between a memory

- Of unconscious fantasies of the client having sex with an adult or close relative indicating an unresolved conflict in the oedipal phase of normal psychosexual development;
- Or if the memories follow an induced „false memory syndrome‟ (Stevens et. al. 2007);
- Or if clients offer a memory to a sexual abuse that really has happend.

Even if normally clients in this phase of work are ambivalent with such memories, therapists themselves must hold back any interpretation until both have collected enough pieces of the puzzle of the „original situation‟ to decide: What did happen,

when, where, and who was involved.

It is a question clients ask again and again: „How much details of memories are needed, to come out of the traumatic emotional cascade pattern?" And there are different ways to answer: Of course, some clients have a need to really identify what exactly did happen; f. i. if perpetrators are still alive, if clients have to stay in continuous contact with these relatives in their families. Other clients remain in the ambivalent phase of realization and need to become more curious, or more brave, to follow where the memories are pointing to. But in the end it is sufficient, if both, client and therapist, realize that emotions find new ways and can be released more easily; and acknowledge that the ability of the client to self regulate her / his emotional reactions as well as their memory-reactions in a way more aligned to the natural affect cycle is increasing.

While keeping active the somatic resources we have developed in the client / therapist relation, or by the client's self regulation, in **the third phase** we are continuing to work on the more specific traumatic sequences by touching

- Different areas of the body (f. i. front side of the legs, arms, shoulders...),
- Different layers of that areas (f. i. superficially in the areas of meridians and acupuncture points, into the memories of muscles, in between fascia of organs or deeper to the periosteum at the bones)
- With different qualities of touch (f. i. following the contact; invite micro movements; evoke deeper emotions; covering something...).

While doing so, we continue to map clients' biographic history and also start to track traumatic sequences of memory. Doing this, we are aware of changes in certain body areas during emotional arousal, and change of orientation and awareness, and we activate the clients' somatic resources to tolerate these changes. we interrupt posttraumatic stress cascades by the „basket of techniques" of grounding and embodiment we have established in former phases of work, and we start looking for unfinished defense reactions: Especially traumatized clients have „frozen" motor activities which can be recognized by experienced therapists in

small movements at the periphery of clients' activities: F. i. notice movements of fingers, or feet. These can be tracked to find out which kind of defensive reactions, or reactions of beginning fight- or- flight-activity are there to re-activate. Being aware of the fact of about 700 nervous receptors in 1 square meter of skin (Juhan 1987, chapter 2), body psychotherapists also choose different kinds of touch to stimulate via these receptors the basic regulation of the autonomic nervous system: F. i. the Golgi-organs, to decrease muscles motor fibers; Pacini-receptors to increase clients' proprioceptive feedback and especially the Ruffini-receptors for the inhabitation of sympathetic activity. (Rywerant 1983; Schleip 2012; p. 151)

Possibly, by doing this, emotional inhabitations of the limbic system will come up and contrary to the old therapeutic paradigm of „acting out‟ (van der Hart et. al. 1993, p. 165), we now are aware of different emotional charging phases: We are working with the model of affect cycle (Schlage et. al.; 2012; pp. 209-223) which shows that every emotion can be seen in different phases and that there are some phases where you have to be especially watchful dealing with traumatized clients: F. i. some of them are in a hyper arousal and possibly they are overrun by feelings before sufficient grounding of experience has been achieved: The ability to track the place in their body, to differentiate between emotional interpretation of a body sensation and the sensation itself: In this case, we reactivate strategies of former phases of work to slow down the arousal, or if they are running very fast from one excitement to the next without being sufficiently capable to separate themselves from the triggering signal / relation. In these cases we need to use more techniques to enhance centering and detachment in order to regulate the emotional arousal. Or if the opposite is the case and clients can not charge their emotion enough to work with the affects that relate to their memories: In this case we use different ways to charge clients' breath and motor activity to reestablish their emotional energy in body areas which are blocked, or feel frozen or stiff / rigid.

To assume touch in postural integration processes emotions by the so called „rapids". (Levine 1997) we support a process of „melting the frozen energy‟ which is a metaphor for reactivation of micro movements and we develop clients' trust in emotional waves: From self regulation to reactivating the fight- or flight pattern. This

way we continue to use auto regulation strategies and those of the social engagement system which have been trained in former phases.

There are specific phenomena with traumatized client that will arise and have to be transformed into another choreography: Let us remember: Clients, in these specific situations, felt themselves to be in a live-threatening situation: This means that a lot of the brain’s activities running in survival patterns. This again means that a great amount of normal brain capacities not available to the clients; early amygdala induced reactions like very high emotional arousal to get reactions, or the opposite: Hypo arousal: The absence of any emotional contact, contraction of muscles or even collapse of muscle tonus and blood circulation. Therapists often observe this in hyper arousal states of clients suffering by posttraumatic stress reactions.

We can support reactions of orientation and better grounding of body sensation in areas where client feel safe; when clients can not activate their fight- or flight-pattern of the nervous system: We support body resources we buildup in former phases of work; we track micro movements and support their self regulative activity to bring them out of those „blocked‟ or „dissociated‟ states of body awareness; we support clients’ ability to handle even deeper or more powerful emotions while at the same time being conscious of what is happening. In accordance with the basic characterological conflict we choose different types of affect cycle-choreography for the re-design for a healthier , well adjusted client.(http://icpit.org/philosophical-backgrounds/ - see chapter „bodymind intergration defined from several angels‟; Marivoet 2016) and finally, we support the creation of close bonding situations, thereby supporting the final re-organization of clients. (see fourth phase of work) Ogden (2010) describes the need for correlation between deep inner muscles and the muscles of the surface of body (quoted in Kurtz/ Prestera 1979). The development of unfinished defensive reactions also is needed: If clients have impulses of fight- or flight, indicated f. i. by the way the arms are used to gain more distance, or the legs are stepping on something or show the desire to run away, we now are looking for ways to complete these unfinished movements.

Fourth phase of work is the establishing of **triumphatic embodiment experiences and integration into daily life relations.**

Although this article describes body psychotherapeutic trauma work with clients in a phase model, real therapeutic relations are not running this way. Often during the fourth phase some unknown memories are coming up, or it is possible that, with the prospect of ending the therapy, some new trauma memories come up which clients or therapist's have not been conscious of before. (Steele 2005b)

In this phase of work, the main goal is to support clients to transfer the learned/acquired tools of self regulation and of social engagement system into daily life situations. (Brown et. al. 1998)

Also in the bonding situation we take time to establish good ways to stabilize self defending and self authorization patterns which we have created in former phases of work. Now we also try to support the clients' need to gain more intimacy in contact with other people or relatives (Brown 1998). Often after traumatic life experiences, the bonding system gets damaged in a way that clients suffer from their inability to have satisfactory relations. Some, for instance, may get too fast into a setting of taking care of someone else (Sable 2000), or into intimacy without regulation of distance and self awareness, or they fall into so called „paradox", or „parentificated" relation patterns (Minuchin 1974) where they take care of those relatives who, in a healthy family pattern, actually ought to be the ones to take care of the client's well being.

Clients have to learn that grounding, centering, bonding, sounding, and eye contact, and our social engagement system, make it possible to variate contact and intimacy in relation to a given situation and the kind of relationship they are in. There is a difference to regulating yourself in relation to a colleague at work or to a close friend or to a family member to whom more distance keeping is advisable.

Juhan (1987; p. XXIX) wrote that therapists create a wave of sensory and motoric information to clients' minds which does not come from goes beyond the limited repertoire of their life experience. New information filling up their sensory lack of knowing their bodies' possibilities of sensitivity and movement will support clients to cope in new ways of relating to nature,

environment and relations.

Janet wrote (1925, p. 988) that the main characteristic of a successful therapeutic treatment is clients' improved ability to experience happiness and joy. For traumatized clients this is difficult to reach even though they have a need for these life experiences. We know that - possibly due to neurotransmitter problems with the dopaminerg system - (Cabib & Puglisi-Allegra 1996) it is difficult to release clients into this kind of feeling, after the work with „affect cycle‟ and „rapids‟. Due to the fact that these feelings have a tendency to open people for situations and relationships, these clients naturally are deeply afraid of this opening process. Frijda (1986, p. 368) describes that „enjoyable sensations will unconsciously form the body itself to open up to possibilities of new patterns of habit". So, in this phase of work we have to invite clients to create more positive sensations in relationships as well as in auto regulation.

This may lead to new hobbies like dancing, doing sports, hearing good music, choosing new colors of clothes, or create changes in their environment. We will support them in whatever we discovered is supporting them to follow this new wave of energy, the new orientation of brain functions, and the intentions of the clients' personal self.

In the final phase of work, therapists also need to develop a new view at their clients: To stop looking at them through the deficit-oriented diagnostic eyes, instead start looking in the direction of human potential (Dychtwald 1977; chapter 9) and the realization of an archetypal pattern of their soul. (Jung 1978)

Final work: From tragedy to triumph

It is an old question also religions are struggling with: Why do people suffer from life experiences!? Even though we know that some of the world-wide-problems are the result of peoples' habits of commercial interests, we also know that people relate differently to the same situation of life experience. Some are able to look at what they have experienced with a soft heart later on and realize that by this problem they have grown personally in a good way. But especially with traumatized people it is evident that they are repeating their pattern of suffering again and

again–to them it seems that there is no way out.

Body psychotherapy offers solutions which seems to be natural: Even though we use techniques acquired by learning, we do use our voices to calm down, we do use our social engagement system to regulate relation with our body presence, and we do use touch to support containment of what has happened. Schlage (2017) wrote about special effects somatic transference have in the final situation, especial to the therapist. We can say that we change alienation from natural life and try to re-establish basic life-functions like feeling well in the own body, having good relations and living in a healthy environment.

For this process, this article perhaps can give hints to both, clients and body psychotherapeutic working colleagues as well.

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Biography

Bernhard Schlage has given workshops since 1980 in most European countries and has run a private body psychotherapy practice since 1984. He has given lectures at international congresses including San Francisco, Paris and Sydney. In 1986 he co-founded an adult education centre for health care in northern Germany and later was in charge of a mental health centre until 2008. He has been a trainer for Postural Integration since 1999 and an ECP-holder since 2001. Specialised in treating psychosomatic disorders, he is now focusing his work on training the next generation of health care practitioners in body psychotherapy. Bernhard is author of more than 100 articles about body psychotherapy and has written four books.

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