Touch and Affect Regulation

Postural Integration, Trauma Skills, and Tools for Body-Oriented Psychotherapy

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ABSTRACT

Based on new neurophysiological 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. Following Allan Schore's proposed approach to affect regulation, the article demonstrates what supports emotional expression and the development of a resilient inner self. It details how to work with the affect cycle and trauma and deepen our understanding of the window of tolerance concept in order to support clients who suffer from overly strong and painful emotions, as well as those who struggle with a general lack of emotions.

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

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In the Beginning

Let's start by considering the very first contact between a client and therapist. Let's suppose that we get in touch with a new client via phone; the client, a woman, introduces herself, and we hear each other's voices.

As usual, we begin to relate through the signals sent and received:

- How does the client express their interest in therapy? Is it primarily in technical terms? Is it in terms of needs and desires? Do they have difficulty making themselves understood because of emotions that arise?
- How does the client's voice resonate within us as a therapist? Our social engagement system (Porges 2001) often associates faces and bodies with people simply by hearing their voices. What feelings arise about the other person, even if we are not trained in sensing the "primary Chinese element" in their voice (Ohashi, 1992)?
- Where in our own body does the client's voice resonate while we listen to them?
- Which sensory language does the client use? Do they visualize? Do they refer to their senses and body sensations? Do they use an inner voice dialogue?

We perceive an abundance of information from clients before we physically meet them.

> ***In this final phase, therapists need to view their clients in a new light. They must stop seeing them through deficit-oriented diagnosing eyes, and instead look at their human potential.***

PHASE 1
How Bonding Regulates Touch Possibilities

In our first live interaction, we address the relationship between the inner image we may have created and the reality of the client. Which facial expressions does the new client show in this first

contact? Smiling or close to tears? Does the face-to-face contact feel like there is great distance between us? Are we faced with skeptical eyes watching us? What is the quality of the handshake? Is it heavy, like a bulldog squeezing our bones, or limp, like a duster? And how does this relate to the overall tension of the person in front of us?

This initial scene is full of detailed sensorial information about your client's style of interaction. As body psychotherapists, we use our own body as an interactive psychobiological regulator for the emotions that arise in our client (Diamond et al., 1963; Schore, 2001b). Courtois (1999) describes how a traumatized client, because of their painful past experience, can have difficulty feeling at ease communicating in a therapeutic relationship. Therefore, we as therapists are called upon to be creative regarding conscious, as well as unconscious, patterns of interaction.

On a fundamental level, we can sense if a client lacks feeling, and presents a more or less friendly mask. Their emotions may be in hypo-arousal (for a description of hyper- and hypo-arousal, see Post et al., 1997), and it may seem there is nothing to relate to. Possibly, there is even less – a silence we do not understand; something like a deep black hole, a void that opens when in contact, but cannot be touched in any way. Perhaps it is the opposite. The basic level of interaction is hyperaroused, with a great deal of pain coming up during our first contact – tears caused by something that has happened on the way to the session, or in the days before our meeting. Possibly, a client has fantasies concerning our skills as therapist. They have perhaps read something on the internet that was deeply touching, or seen something in our eyes that triggers distrust.

How, as therapists, do we relate to this bonding situation? Do we take the emotional feedback personally; for example, as being a result of our good or bad marketing? Do we lean back with a calm face (Hornak et al., 1996), merely observing what we sense? Do we try a variety of interactive actions to explore how to cope with the situation? Are we aware of the change in our voice during this first contact?

What about the self-organization of our own body during client contact? Are we feeling comfortable? Are our arms crossed... our legs? Is our reaction to our client one of ease, of open gestures? Do we sit facing them with relaxed arms, mirroring and adopting their facial expressions? Are we able to follow their gestures to get closer to grasping their meaning? Do we give them feedback about their facial expression and gestures? Do we begin regulating their emotions during this first contact, or do we feel overwhelmed by their emotions? (For the endogenous intent of the human brain to stay in relationship, see Dunn, 1995, p.724.)

During this first phase, we tend to our own and our client's social engagement system (Porges, 2001) to find attuned interactions that allow both of us to share inner core feelings as well as to support clear boundaries and co-regulation. This is necessary for both of us. To accomplish this, we need a setting of near symmetrical connection, with only a small amount of hierarchy and a reliable reciprocal feedback system. This altogether differs from the old therapeutic paradigm of the therapist as a blank slate viewing the client's transference struggles from an objective perspective. "The observer of a situation is part of the situation" (Greene 2004, about Heisenberg's "uncertainty relation theory") Above all, our social engagement system is a good internal regulator for the questions of contact and interaction that may arise.

In this first phase, as we share space and time within the therapeutic relationship, we begin to give feedback about our experience in the here-and-now. We consider feelings that both of us may or may not be conscious of, such as the sound, strength, or rhythm of the voice, tiny bodily movements or gestures, or how we feel about the bonding in process. We train our client's ability to receive and give feedback in a body-wise way in the same way good parents interact with their children – by giving feedback, by being present with all human aspects of being – body expression, posture, attention, and bonding information. Later, we include the unconscious components of interactions as well. And when a reliable therapeutic base has been established, we add body reading (Prestera & Kurtz, 1976).

Later, we may switch between these early regulation strategies and the following self-regulation methods to continue recreating therapeutic situations of trust and safety. We provide the space that enables a learning environment for both client and therapist.

In this early phase, we can decide whether to proceed with our specific body psychotherapy modality or focus on trauma-oriented therapeutic strategies. Even though, since the 90s, there has been a cultural ground suggesting that all clients are traumatized, some clients seek help only to cope with strong experiences of anxiety. Only some of our clients present with the type of trauma defined as the subjective experience of a life-threatening situation without the possibility of fight or flight, and leading to the experience, following the traumatizing situation, of a lack of nurturing bonding to calm the autonomic nervous reaction (Levine, 2010).

PHASE 2
How the Body Regulates the Quality of Touch

In the second phase, the intention is to track the body in order to resource clients (Ogden, et al., 2010). This means supporting them to imagine a good and safe place, improving their sense of being centered in the body, and in particular, strengthening their ability to differentiate between a body sensation and the emo-

tional interpretation of a body sensation. This will later support their ability to calm emotional hyperarousal, or, if they find themselves hypo-aroused, to support emotional self-activation.

Whatever our body psychotherapy specialization, from the initial meeting on, we must take into consideration the details of our initial experience of the bonding situation:

- The distance we choose when working with a client.
- How we support their gestures, and the kind of gesture we find meaningful for the work ahead – for example, we may want to encourage a client to expand a gesture in order to discover its meaning.
- Playing with the unconscious body signals we perceived in the initial meeting.
- Bringing more awareness into a certain body area where they feel comfortable and inviting them to breathe more deeply into that area.
- Bringing their attention to small changes in that area – differences in temperature or perception of color under the skin.

This list describes *grounding*, a term originating in Bioenergetics (Lowen, 1975; Ogden et al., 2010), and later developed into the concept of *embodiment of experience* (Hüther, 2011). Grounding is not merely a term; it is a basketful of techniques, each allowing us to track good, strong somatic resources alongside, or beneath, traumatic memories.

During this second phase, it is the client-therapist connection that teaches therapists to choose their interventions, and clients to keep emotional arousal in an optimum range within the *window of tolerance* (Ogden et al., 2010, p. 67). On the one hand, there is a need for enough emotion to work with (Breuer & Freud, 1955, GW1; p. 85); on the other hand, there is a need for enough emotional regulation for the social engagement system to stay in charge of emotions, and within a degree of intensity that allows for a regulated process – even if some initial *rapids* must be crossed (Levine, 1997). The social engagement system teaches the therapist about the choice of techniques that support regulation with a particular client, and the client about how to handle emotional arousal without falling into the post-traumatic cascades of reactions they have experienced in the past.

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

As therapists, we must be aware that if we have a client with an eating disorder, fasting is not part of the solution! If our client belongs to the twenty percent of Europeans suffering from sleeping problems, not sleeping is definitely not part of the solution! And the same is true with touch: If we have a client who has been traumatized by violence or sexual abuse, their avoidance of touch is part of the problem, and does not lead to any relief of the client's trauma. As a body psychotherapist, after making our client aware of the physical part of the interaction, we develop ways to come into closer contact with them, and this involves touch. Touch is part of the client's self-regulation process (Bion, 2004; Winnicott, 1990).

During this second phase, touch is not a one-way medical palpation, or a physio-therapeutic training exercise. This is often misunderstood by clients who have not experienced body psychotherapy and are not familiar with therapeutic kinds of touch. Touch in body psychotherapy and in Postural Integration is embedded in the therapeutic process. Touch is part of the *holding environment* of the therapeutic relationship. How to touch and where to touch is not a prescribed, fixed, theoretical protocol. This kind of touch originates in sensing and feeling the therapeutic issues. Where to touch, the quality of holding, leading, activating, or releasing while touching is embedded in the therapeutic connection between therapist and client. Of course, touch should be done according to the EABP ethical guidelines (see principle 7 at https://eabp.org/ethics). In the clinical treatment of touch dysfunctions such as depression or schizophrenia, the manuals Röhricht created for touch studies in psychotherapy in Great Britain can be consulted (Röhricht, 2009).

Some years ago, while videotaping Virginia Satir, Fritz Perls, and Milton Erickson, Bandler and Grinder (1976, p. 37f; Ogden, 2010) discovered that the unconscious body dialogue between therapist and client is a key factor in the success of therapy. Bowlby (1988) demonstrates the role our body plays in the regulation of contact and therapeutic healing. Gelder (2015) explains that mirroring posture – called *postural resonance* – activates the same parts of the brain in all participants. Rizzolati (Rizzolati et. al., 1996) figured out that mirror neuron activity is part of our brain's response when attuning to people with whom we are in communication.

In this second phase, we implicitly start doing something new that later, in the third phase of the work, we will do explicitly. We begin to develop a history of the comfortable touch our clients received and feel comfortable with. Some traumatized clients have fragments of memory about their original traumatic experience (Rosenberg, 1989). Others discover, through other sources, that something must have happened. Or, during the interview at the beginning of the work, we may have noticed our client showed some signs pointing to an unresolved traumatic situation. Often, the original situation cannot be recalled. In fact, the opposite is the case. Clients often lack any memory of long spans of life, and especially a lack of memory about early childhood.

Therefore, we start making clients sensitive to their personal touch history; for example, their mother's touch during nursing, the contact of caregivers' 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 a pet's paws, if they had, for example, a cat, dog, guinea pig, or rabbit; body contact with family relatives while being read fairy tales or watching TV, experiences of physical contact while doing sports or dancing, or, last but not least, good bonding contact through touch in previous or current relationships.

In these ways, we gradually help our clients develop a map of the comfortable body contact they have received – a gallery of touch sensations. We begin to create a memory puzzle. Initially, there may not be much memory at all, but step by step, some islands of memory will arise about a special time in childhood, perhaps associated with a photo or a certain age. Sometimes, without knowing its origin, a small detail appears, such as a wallpaper color or the smell of a room. We begin to reactivate the forebrain memory (van der Kolk, 1996) and we break the pattern of amygdala-dominated traumatic reactions (Brewin, 2001, p. 381) while increasing the activity of other brain areas.

This is achieved not only by talking. In a parallel process, we awaken a client's interest for different kinds of touch and body areas that feel safe, while we also look ahead to a new kind of tracking – the tracking of touch itself, and the sensing of different qualities of touch. This may happen actively, as in remembering the skin of a mother's hands, and inviting the exploration of the skin on one's own hands, or of the therapist's hands. It may happen passively, as therapists offer, and clients receive, different qualities of touch. In the beginning, touch is without intention. It is not a technique, like Reiki, or pressing an acupressure point, or melting an area of fascia. It is simply placing a hand on a specific area where clients feel comfortable, and bringing awareness to this contact.

PHASE 3
Supporting Clients to Receive Touch

While keeping clients in the here and now (Stern, 2004) and supporting the awareness of the difference between a body sensation and an emotional interpretation of the sensation, body psychotherapists support tracking a variety of touch experiences:

- Sensing the quality of the touch itself – is it warm or cold; does the surface of the skin melt beneath the touch, or does the sense of separation and inability to connect with the touch remain?
- Do clients feel a need to relate to the warmth of the therapist's hands, or on the contrary, do they fear the hand is an intrusion upon their body? (See also suggestions for different kinds of hand contact in Busch, 2006.)
- Pain clients often have an unconscious pattern of using touch as a *lightning rod* to discharge their pain. What happens when therapists give them feedback about this pattern? This process trains clients to be aware of the difference between the interpretation of a therapist's touch intention, and their own emotional reaction to the quality of touch.
- Vary the quality of touch by bringing in slight movement, or changing warmth or hand pressure (Schlage, 2016). Again and again, use the strategies client and therapist learned together in the earlier phases of the work to support the client's capacity for self-regulation, or apply the therapist's capacity for co-regulation through social engagement. In the beginning of phase 3, the main goals are to establish somatic resources (Hermann, 2003; Bundy, Lane, & Murray, 2002), identify peritraumatic memory (Janet, 1925), and map the qualities of touch (Lowen, 1976).

Memories can be auditory as well as visual – the sound of a mother's voice, the engine of a father's car, or the voice of a client's inner dialogues. Some clients may focus on memories of smells and, especially in body psychotherapy, many have kinesthetic memories of past osteopathic or Shiatsu sessions. They may have feelings of being repelled by touch manipulations, or they may sense autonomic micromovements reestablishing body awareness in areas where they feel stiff or dull.

It is possible to track clients as they are moving their body, even while they receive continuous touch. We can explore different areas of the body: center to periphery, front to back, legs and arms, face, or head. Therapists can use emotional maps of these areas (Marcher, 2010; Painter, 1987), influence sensory input to regulate dyadic arousal, and regulate affect to establish a more secure relationship between therapist and client. Schore (2003, p. 219) wrote that stabilization of the neurophysiological patterns of the orbitofrontal cortex is based on better self-regulation by the client, on a more differentiated social engagement system, and on the client's more secure bonding pattern. He describes how sensory input makes development possible.

In the beginning of the third phase, therapists do not focus on trauma. They only work with accessing memories. If a therapist interprets memories too soon, it will influence what is remembered, especially when it concerns sexual abuse. It takes time for client and therapist to understand the differences between a memory:

- that is a client's unconscious sexual fantasy with an adult or close relative indicating an unresolved conflict in the oedipal phase of normal psychosexual development,
- that follows an induced false memory syndrome (Steffens, et al., 2007),
- that is a remembering of sexual abuse that really happened.

Even though clients in this phase of the work may be ambivalent about trauma memories, therapists must hold back any interpretation until both have collected enough pieces of the puzzle about the original situation to decide what did happen, when, where, and who was involved.

A question clients ask again and again is: "How much detail of the event do I need to recall in order to be free of the traumatic emotional cascade?" There are various answers to this question. Some clients need to identify what exactly happened, and whether the perpetrators are still alive. Others are in continuous contact with these family relatives, while yet others remain in an ambivalent phase and need to become more curious or courageous in order to follow where their memories will take them. In the end, it is sufficient for both client and therapist to realize that emotions find new ways of expression, and can be released more easily, when the client's ability to self-regulate their emotional reactions and their memory-reactions are more aligned with their growing natural affect cycle.

Regulating Emotional Processes

In this third phase, while keeping the somatic resources developed in phase 1 active within the client-therapist relationship and in the client's own sense of self-regulation, the therapist continues to work on more specific traumatic sequences by touching:

- different areas of the body – for example, the front sides of the legs, arms, and shoulders;
- different layers of those areas – for example, superficially in the areas of meridians and acupuncture points, into the memories of muscles, in between the fascia of organs, or deeper to the periosteum;
- with different qualities of touch – for example, by following the contact, inviting micromovements, evoking deeper emotions, or covering something.

While doing so, we continue to map a client's history and track traumatic memory sequences. All the while, we note changes in areas of the body during emotional arousal, as well as changes in orientation and awareness. We activate the client's somatic resources to support their capacity to tolerate these changes.

We interrupt post-traumatic stress cascades by using the basket of grounding and embodiment techniques established in phases 1 and 2 of the work, and we look for incomplete defense reactions. Traumatized clients have frozen motor patterns that can be recognized in the small peripheral movements of the body, such as movements in the fingers or feet. These can be tracked to explore if defensive reactions or beginning fight-or-flight activity are there to reactivate. As there are about 700 nerve receptors in a square centimeter of skin (Juhan, 1987), body psychotherapists use various kinds of touch to stimulate those receptors that regulate the autonomic nervous system. For example, Golgi organs decrease reactions in muscle motor fibers, Pacini receptors increase proprioceptive feedback, and Ruffini receptors help embody sympathetic activity (Rywerant, 1983; Schleip, 2012; McGlone, 2017).

When using these approaches, emotions suppressed by the limbic system may come up. Contrary to the old therapeutic paradigm that encouraged acting out (van der Hart et al., 1993, p. 165), we now recognize different emotionally charged phases. We work with the affect cycle model (Schlage et. al., 2012; pp. 209-223), which shows that every emotion goes through different phases, and in some phases, we must be particularly watchful when dealing with traumatized clients. For example:

- Some clients can be hyperaroused and overwhelmed by feelings before they have achieved a sufficient capacity to ground their experience. They may not yet be capable of tracking activated body areas, or differentiating between the emotional interpretation of a body sensation and the sensation itself, or they may be running from one activation to the next without being sufficiently capable of separating themselves from the triggering signal. In such cases, we reactivate strategies from former phases of the work to slow down the arousal. We need to focus on using techniques that enhance centering and detachment in order to regulate emotional arousal.
- In the opposite case, if clients cannot connect with their emotions enough to work with affect related to their memories, we use techniques to charge their breath and motor activity to reestablish their emotional energy in body areas that are blocked, frozen, stiff, or rigid.

A Brief Case Study Working with Blocked and Frozen Feelings

This client had received a total of 42 body psychotherapy sessions over a period of three years. During a workshop on shamanic dreams, several childhood memories emerged. After working with shamanic techniques, we suspected sexual abuse in early childhood, which prompted her to seek a female therapist. While focusing on tracking the original scenario (Rosenberg, Rand, & Asay, 1985) and analyzing transferences, they found muscular tensions in her torso, and encountered symptoms such as trembling and feeling cold, especially in emotional situations (Reich, 1967; Levine, 1997). Now in touch with these symptoms, she decided to work with me again on clearly defined goals.

First Experiences with Touch and Being Touched

Safety and trust. Usually, we started sessions by talking, and then turned to role play, which allowed her to express her need for separation and distance, and trained her capacity for self-regulation. During a particular role play, she marked her personal space with a rope on the floor, and I encouraged her to allow herself to feel different emotions at different places within the circle. We

explored various positions: What did she feel when she was closer to the center, or at its periphery? What happened when I came closer to the rope, or kept more at a distance?

Experiences with different kinds of touch. We went on to explore her reactions touching herself or being touched at different areas of her body. We began with areas she chose herself, and this later changed to other parts of the body that were chosen by me.

We took time to explore her inner reactions to different types of touch – such as feeling warm or cold, tense or relaxed, and we engaged in dialogue about the quality of touch and her experience of these qualities. Additionally, she allowed herself to sense the touch itself – did the skin of the therapist's hand feel separate from her skin, or did it feel like a fusion of both? What was the quality of the temperature at the point of touch, and did some of the sensation from the therapist's hand flow into her body, or vice versa? Could the tension or pain be felt with the touch of the therapist's hand, or by the therapist through his hand? Did this happen by itself, or was she able to regulate the direction or amount of sensation? We also tracked the reactions she felt in the core of her body, depending on the place of touch (Ogden et al., 2006; pp. 262-264) – closer to the periphery, or on distant parts – in order to explore the different (or even at times paradoxical) body reactions she experienced in response to the type and location of the touch.

Later, for about five sessions, we practiced various freeing or unlocking techniques used in body psychotherapy – making use of breath, movement, and sound to deepen contact with chosen body parts (Rothschild, 2000). By changing her awareness of touch, by focusing on her breath, by tracking micromovements, and by trying to amplify or diminish the intensity of these experiences, we gave her expression of movement a wider radius, greater strength, or more speed through the use of movement expression. We encouraged her to make sounds to support her expression, if needed. This detailed work was intended to support her so that she could deepen her trust in her own abilities for self-regulation and self-encouragement (Schoenaker, 2011). She began to practice these with some members of her family.

Reaching deeper layers and releasing deeper tensions. Moving forward, we focused on deeper muscular tensions, particularly those she felt in her upper torso. After a while, although she felt the need to honor her personal boundaries, especially around her upper chest area (not including her breasts), we managed to find ways of touching her ribcage directly.

As described in my previous article (Schlage, 2016), we were now using fairly deep and strong physical touch accompanied by deep breathing, and exploring awareness of any internal movement. Peter Levine (1997) describes how the counter-pulsation – what he called tension in certain areas – tends to increase initially. At first, the client found herself with a strong muscular resistance against "something:" her inhalation became fixed, her posture defensive, she pressed her wrists to the front of her chest, made fists, and sensed an unknown scream in her throat.

Because of our preparatory work, she was increasingly able to transform this frozen gesture into movement, and finally tried different kinds of voice work, even screaming, to bring relief to this area. This was the emotional climax (Erken et al., 2012; p. 209) that we approached several times, until she developed some trust in this process.

While following this path of contact, movement, and sound – probably for the first time in her adult life – the client was able to gradually reconnect with her traumatic memories, and associate these with her bodily experience. She often found deep relaxation after these sessions. Liberation was a step-by-step-process in which she reconnected to her body, emotions, and movements, and to her growing confidence. She occasionally passed through phases of deep shame as well as – paradoxically – deep laughter, which emerged several times when repeating this body-oriented process.

Finally, she felt much more relaxed, especially in her upper chest, and her ability to breathe and the capacity for movement in her shoulders significantly increased. She then decided to continue therapy with her Gestalt therapist (Schlage 2018; the client gave an informed written consent for publication.)

Summary

Postural Integration uses touch to process emotions as they shift into what Peter Levine calls "rapids," and to support a process of "melting the frozen energy," a metaphor for reactivating micromovements. We develop our clients' trust in their capacity to hold and contain emotional waves – those processed internally as self-regulation, and those visible externally, such as fight-or-flight patterns. Throughout treatment, we continue to use autonomic social engagement regulation, which we help clients develop in the early phases of treatment.

Usually most human schemata follow the affect cycle described above – stimulus, expansion through nourishing, climax, and relaxation. When working with traumatized clients, we consider specific phenomena; we might be faced with sudden interruptions or jumps within the affect cycle, such as a jump from a small stimulus to a climax, or an absence of relaxation. We help clients transform these phenomena into appropriate choreography. We remember that clients in these specific situations feel they are in life-threatening situations. This means that a lot of brain activity is channelled toward survival responses such that a significant amount of normal brain capacity is not available.

Early amygdala hyperarousal is identifiable by high emotional load, or by its opposite hypo-arousal – the

absence of emotional contact, contraction of muscles, and even the collapse of muscle tonus and blood circulation.

We support orientation and grounding of body sensation in areas where clients feel safe, or when they cannot activate their fight-or-flight responses; we support body resources built up in early phases of the work; we track micromovements and support clients' self-regulative activity to move out of blocked or dissociated states. We support the ability to handle ever deeper and more powerful emotions while at the same time encouraging clients to remain conscious of the present. In accordance with their characterological conflict, we choose different types of affect cycle choreography to support clients in becoming healthier and better adjusted – see Marivoet (2016) on bodymind integration defined from several angles: (http://icpit.org/philosophical-backgrounds/).

Finally, we support developing close bonding connections, thereby supporting our clients' final reorganization. Ogden (2010) describes the need for correlation between the muscles of the surface of the body and the deep inner musculature (quoted in Kurtz & Prestera 1979). The completion of unfinished defensive responses is also needed; if clients show impulses of fight or flight, indicated by the way the arms are mobilized to gain more distance, or the legs to step on something or show the desire to run away, we seek ways to complete these unfinished movements.

PHASE 4
Embodying Therapeutic Experiences

The fourth phase of the work establishes successful embodiment experiences and integration in daily life.

Although this article describes body psychotherapy work with trauma in a phase model, therapeutic relations may not unfold this way. Often, during the fourth phase, unknown memories may emerge, or at the prospect of ending therapy, new trauma memories may come up that had previously remained unconscious (Steele 2005).

In this fourth phase, the goal is to support clients to use the self-regulation and social engagement tools they have learned in therapy in their daily lives (Brown et al., 1998). Additionally, we take time to stabilize their bonding capacities with the protective and self-empowerment patterns developed in the early phases of work. We also support their need to expand intimacy to include other people or relatives (Brown, 1998). Often, after traumatic life experiences, the bonding system is damaged so that clients are unable to have satisfying relationships. Some may move too quickly to take care of someone else (Sable, 2004) or become intimate too quickly without regulating distance and self-awareness. They may be drawn into parentification patterns (Minuchin,1975) in which they take care of relatives who, in a healthy family, ought to be the ones taking care of them. Clients must learn that grounding, centering, bonding, sounding, eye contact/facing, and their social engagement system make it possible for them to diversify their need for contact and intimacy. They must learn appropriate self-regulation and distance to keep in various relationships – for example, with work colleagues, close friends, or family members.

Juhan (1987, p. XXIX) writes that therapists create new waves of sensory and motor information in their clients' brains that takes them beyond the limited repertoire of their life experience. The new possibilities for sensitivity and movement that informs their body's sensory lack of experience supports clients to relate in new ways to nature, their environment, and their relationships.

Janet wrote (1925, p. 988) that the main characteristic of a successful therapeutic treatment is to improve a client's ability to be happy and joyful. We should consider that particularly traumatized clients, because of painful bonding experiences, and possibly due to dopaminergic neurotransmitter problems (Cabib & Puglisi-Allegra 1996), are naturally deeply afraid of this opening process. On the other hand, Frijda (1986, p. 368) describes how "enjoyable sensations will unconsciously form in the body to open to possibilities of new habit patterns." Consequently, in this fourth phase of the work, we need to invite clients to create more positive sensations in their relationships as well as through self-regulation. This may lead to new hobbies such as dancing, engaging in sports, listening to good music, choosing new colors to wear, or creating changes in their environment. We support them to follow the new waves of energy, the new orientation in brain function, and the new desires of the personal self.

In this final phase, therapists need to view their clients in a new light. They must stop seeing them through deficit-oriented diagnosing eyes, and instead look at their human potential (Dychtwald, 1977; chapter 9) and realize the archetypal pattern of their soul. (Jung, 1978).

From Tragedy to Triumph *(Ogden, 2010)*

Religions struggle with this age-old question: Why do people suffer from life experience? Even though we know that some of the world's problems result from people's commercial interests, we also know that people relate differently to similar life experiences. Some can reflect on what they have experienced with a soft heart, and realize that, through struggle, they have personally grown in a good way. On the other hand, traumatized people repeat the patterns that cause them suffering again and again. It seems that they do not find a way out.

Body psychotherapists offer solutions that seem natural. Even though we use learned techniques, we also use our voice to calm, we use our social engagement system to regulate our capacity for embodied presence, and we use touch to support containment of what has happened. I believe that we can transform alienation from

life and re-establish basic life functions, such as feeling good in our own body, having satisfying relationships, and living in a healthy environment.

I hope this article offers clues to both clients and body psychotherapy colleagues.

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