Body as Portal

Bringing the Body into Practice

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ABSTRACT

This article offers a synthesis of practice; a conceptual integration of theory-informed right brain (RB) to RB (Schore, 2012), body-to-body, somatic and relational practice, interfaced with affect regulation theory and attachment repair. It exemplifies the diverse potential of right hemispheric processing and explores and explains the theoretical underpinnings of this body-centered or somatic practice, showcasing the body as a portal to the unconscious, and to the immobilized relational material that hinders the psyche and dysregulates the body. Through a composite clinical excerpt, I present an in-session experience of my integrative practice, a multi-layered rendering of the therapist's internal clinical experience, which identifies layers of tracking the body in practice.

Keywords: somatic; affect regulation; right hemisphere; attachment repair; body-centered psychotherapy

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> ***...the threshold of consciousness is a bodily threshold.***
>
> van Loben Sels

Inhabiting the body – the ways in which we indwell, respond to, and are in relationship with our bodies, with their myriad of complex systems and drives – is deeply impacted by trauma and the fragmenting nature of the modern world. Many of us in the 21st century live a disembodied existence – a split between body and mind that traps us in the narrow focus of the brain's left hemisphere (LH), separated from our bodily knowledge. The roots of dualistic living, introduced by Descartes (1596-1650), called for a separation of body and mind that co-opted rationality, reason, and objectivity as the superlative mode. With this shift, an over-reliance on the LH was established, and the body lost its legitimacy as an epistemological site (Clark, 2001), over time creating fragmented and disembodied ways of living on a mass scale that persists today.

Despite society's fixation on intellect and logic, focus on the body continues to grow in clinical practice, and clinicians have a wider range of interdisciplinary knowledge to facilitate the remembering and re-integration of embodied knowledge and somatic processing. However, many therapists who work with the body lack a clear understanding of the expansive and varied processes that the body and right hemisphere (RH) avail. Such narrow focus maintains the misnomer that somatic or body-centered practice is limited solely to the sensate experience. Often, the result is that their body-based attention lacks depth and nuance; they attend merely to the sensate body, unaware of the diverse potential RH processing offers in metabolizing and re-organizing traumatic material. Through the RH, the therapeutic dyad has access to the unconscious, and is able to work with specific aspects of experience, including sensations, gestures, sensory motor movements, emotions, images, metaphor, and the symbolic or archetypal realm to process and metabolize material that can then be integrated into the client's explicit narrative or knowing.

This article offers a synthesis of practice, a conceptual integration of theory- informed right brain (RB) to RB (Schore, 2012), body-to body, relational practice, interfaced with affect regulation theory and attachment repair-oriented body-centered or somatic practice (i.e., the clinical application of working directly with the body's innate ability to process traumatic material), which I call *Somatic Attachment Psychotherapy*. I present an in-session experience of integrative practice, a multi-layered rendering of my internal clinical experience, which identifies layers of tracking both the client's and therapist's body in practice. In the vignette, I intentionally use physicality as a portal to the unconscious and immobilized relational material that hinders the psyche and dysregulates the body.

My orientation to body-centered relational psychotherapy is based on Merleau-Ponty's "introceptive philosophy," which states that "embodied awareness is the prima facie of self-knowledge, and healing happens through experience" (Tantia, 2015, p. 4) and through relationship (Stanley, 2016). In this body-centered relational approach, psychotherapy is done seated, face-to-face, without physical touch, yet oriented to emotional connective touch, utilizing the eyes (gaze) and ears (prosody) as primary modes of communication, in concert with the client's awareness of their felt sense and adult witness to somatically and relationally process trauma. Sessions often unfold with back-and-forth dialogue as in talk therapy, however, depart from traditional LH therapy and relational practice in the following ways:

- the primacy of the RH within (RB) relational psychotherapy;
- the focus on embodiment of the therapist and client; and
- the orientation towards the RH, the congruency between the narrative and the body, and the direct engagement with the body and RH processing as I consistently utilize and attune to both body and mind.

My body, my primary tool of perception, attunes to the neurophysiological underpinnings in the client's body (somatic countertransference), using right-hemispheric processing to help regulate their autonomic nervous system (ANS) and metabolize implicit and explicit traumatic material. In this article, I use a composite clinical excerpt to illustrate somatic relational work, and show how engagement of right hemispheric processing can unearth unconscious material and aid in the expression, reorganization, and integration of dysregulated experience in the ANS, thereby facilitating relational and psychological change. Additionally, I offer an insider experience about what I am seeing or feeling in my body to elucidate nuanced somatic practice.

The Body in Clinical Practice

When we bring the body into practice, we connect body to body, RB to RB (Schore 2012), aware that our nervous systems are carrying on a conversation below our verbal interaction. We "situate the body at the heart" of practice (Johnson, 1998, p. 8), recognizing that "the basis of our psychic life is the construction of bodily states, gestures, and ways of moving which have social and emotional meaning" (Grand, 1998, p. 172). We enter into relationship by being deeply somatically and affectively attuned to the experience of the other, allowing our bodies to authentically meet and resonate. Conscious attunement to our felt experience aligns us with the body's wisdom (Fisher, 2006), and, as therapists, we can use the body as our "primary text and starting point for knowledge" (Rountree, 2006, p. 98). In "reading the body as one would read a text" (Gustafson, 1998, p. 52), we can use both client and therapist's bodies to track, inform, and guide clinical practice. We *"behold"* our client, prioritizing "the tactile, kinesthetic, rhythmic, and musical dimensions" (van Loben Sels, 2005, p. 221) of the body, in the content, and in the dyadic experience, offering our "somatic empathy" to "accept, appreciate, legitimize, inquire, cherish, and explore the unique configuration of another's inner world" (Stanley, 2016, p. 106). This way of entry "breaks through defensive fixed-action patterns of the body and mind" (p. 106), slipping "beneath the words" (Mark-Goldstein and Ogden, 2013, p. 123) and allowing dysregulated material, both psychological and physiological, to emerge, to be digested, and to be integrated.

Inviting a confluence of mind and body into the therapeutic space builds an embodied narrative with a high degree of coherence between explicit and implicit memory systems. Explicit memory is constructed, revised, and edited throughout the lifespan, whereas implicit memory is represented "in the form of perceptual, emotional, and physiological experience" (Prince, 2009, p. 282). Working with implicit memory has the capacity to shift underlying neurophysiology to establish more regulation and open the system and self to healthier relational patterns.

My Body in Practice

I liken my body to a tuning fork (Marks-Tarlow, 2012) rather than a shield, whereby my body *resonates* with the client and the co-created intersubjective relational field, giving me direct, immediate feedback. The information is varied and can include several phenomena: the dysregulation or immobilization of another's ANS; a client's disavowed emotions; tension in the field – when something is unspoken or needs attention; the pull of intergenerational patterning, almost like a haunting; and intuited information in the form of words, awarenesses, or images. This sensitivity to the "somatopsychological arousal" (Montgomery, 2013, p. 35) and nuanced attunement to the "intersubjective somatic dance" (Pickles, 2015, p. 13) intimately guides my clinical perception moment to moment, enabling more finely-tuned interventions (Montgomery, 2013).

The Body-Centered/Somatic Therapist

Skillfully utilizing the body in clinical practice requires therapists to have a strong capacity to dwell in their RH, decipher information that arises in self and other, and possess considerable body literacy to sense and interpret their own bodily shifts as well as the other's, moment to moment. These requirements call for the clinician to be grounded and regulated, and able to return to this state if or when dysregulation occurs. The body-oriented therapist witnesses dysregulated material, facilitates up- and down-regulation of the ANS, supports the client's body to process undigested traumatic material, and opens the dyad to access sites of knowledge in and through the body. In order to engage in this way, therapists need to understand the body's innate (re)organizational capacities, and interrupt the existing adaptational rhythm so that the body can "feel" the dissonance, process the disruptive material through the RH and body, and organize it into a new rhythm. Clinically, it is necessary to invite a slowing of the pace of the verbal dialogue and prioritize bodily experience over content, allowing (mal)adaptive patterns (relational/attachment and/or regulatory) to emerge into consciousness.

Body-centered psychotherapists use their bodily knowledge to:

- facilitate staying in the present moment and track shifts in the intersubjective field;
- track bodily-based shifts, non-verbal cues, and subtle changes in affect regulation;
- decipher, regulate, and process affective material, dissociated or otherwise;
- regulate the therapeutic dyad by being the "psychobiological regulator" of the client (Carroll and Schore, 2001, cited in Gill, 2009, p. 362);
- reveal countertransference information that is present in the therapeutic dyad;
- gather information for self-disclosure that aids in reparation of relational ruptures, enactments, and attachment patterning; and
- engage the mirror neuron system to facilitate completion of a client's thwarted impulses. The mirror neuron system, premotor neurons, fire through observation, activating the same neural substrates in the observer as the one who executed the movement (Gallese, 2009).

A body-centered orientation offers numerous advantages in clinical practice:

- It facilitates immediacy and authenticity, deepening intimacy in the dyad.
- Information translates faster and more efficiently in embodied practice.
- Congruence or incongruence is experienced in the body.
- Subtle breaches in attunement register physiologically in the moment, albeit sometimes unconsciously.
- It allows access to immobilized impulses of protection and defense, and to impaired attachment patterns that are implicitly and explicitly held in the body.
- It facilitates working within the window of tolerance (Siegel, 1999) and fosters application of the polyvagal theory (Porges, 2011), both theoretical frameworks explaining ANS functioning.
- Embodied presence offers the client a multilayered experience in the present moment of being relationally held.

The body-centered therapist is faithful to the body – their own and the client's – in that they attend and often prioritize the messages conveyed by the body over the narrative. This is not to say that verbal content is dissuaded, rather that the story of the body is integral to gathering the *whole* story, and ultimately organizing, integrating, and transforming traumatic material, as the body holds disavowed and unconscious material that is not integrated into the explicit narrative. The role of the body in processing traumatic experiences is demonstrated in the following composite clinical vignette.

Clinical Case Study

Jane

Before I can sit in my chair, Jane, 38, launches into her story. Her eyes are glued to me, and her speech is tight and unusually low in tone, as if she is working hard to control her emotion. I sit, feel my body land, and orient towards her, and I meet her, body to body. In a brief moment of eye contact and non-lexical vocalization (uh huh), there is a slight down-regulation in her ANS. She can feel me with her; our seventeen months of work steady her.

Jane is bright and fiery. Highly educated and successful in the corporate world, she carries an air of guarded sophistication, and is always immaculately put together but understated in her expensive attire. She is personable but shies away from emotional intimacy, is driven and primarily work-focused to the detriment of her interpersonal relationships. She struggles with low mood, is adept at auto-regulation, and tends toward being guarded in relationship. She sought therapy after being passed over for a promotion at work, which felt like a betrayal by her mentor.

Our relationship began with much relational negotiation. Initially she had wanted me to "push her," because this was her familiar way of relating and being recognized. She had the misconception that therapy needed to be grueling, confrontational, and intellectual. It was difficult for her to access her internal experience; she once noted that "my body has been a machine." Finding

common ground was a delicate dance. In the beginning, our work centered on her feeling safe enough to be met without having to perform, succeed, or push; to experience relationship on her own terms, including renegotiating a relationship with her body and becoming more embodied.

In the interaction depicted in this case study, Jane was agitated about a recent visit with her father. Their relationship has been characterized by a long history of invalidation. Over the past several years, she had limited contact with him, set clearer boundaries, and looked elsewhere for connection and acceptance. Despite these attempts, she continues to be relationally hooked by his demoralizing and hurtful behavior. During the following scenario, she recounts his most recent infraction. Feeling anger, she was ready to process it through her body.

Client: *"I'm so mad that I let him in. I told him about this opportunity not so he could support me, but just so he could be happy for me… there was no room for criticism, NO ROOM, it's good, just all goodness."*

Therapist: I am aware that there is a lot of bodily-based material creating dysregulation in her ANS that needs to be processed before she continues with her verbal story, so I interrupt her. *"And if we just take a moment here and check in with your body, what do you notice?"* I note the sympathetic arousal in her system has increased; there is intensity in her voice, and constriction in her facial muscles. I can see that she is angry. I am also aware of some sadness in my body. Through my practiced awareness of self, I am able to decipher this as somatic countertransference, reflecting Jane's disavowed sadness. It feels like she has not quite landed in the deepest part of her experience. It's as if she is suspended in the anger, hovering over her bodily experience, which I suspect is early relational material. Instead of calling attention to the sadness, I remain curious and aware while continuing to track her conscious process. I trust the wisdom of the unfolding. As she pauses, I see an up-regulation of her ANS, a narrowing of her gaze and tension in her musculature.

C: *"Okay, I feel so mad, he always does this AND I always do this, get sucked in and cave."* Jane continues her highly charged narrative, her speech is pressured, and she is unable to drop into her bodily experience. This reminds me of Quillman's (2018) description of ventilating emotional and physiological pressure through disembodied speech. I recognize the need to slow the pace of our work, as it is outside of the window of optimal arousal where we have full access to our psychological functioning. This indicates to me the need to down-regulate her ANS.

T: *"I can feel how intense this is for you. Can you feel me here with you?"* I use the vagal brake (Porges, 2011) of social engagement to down-regulate her system. She makes visual contact with me, and then looks away. *"That's right, let your eyes orient to the room."* Again, another somatic intervention to down-regulate her ANS. She begins visually orienting around the room as we have done many times before. Twenty seconds pass. *"Taking your time to notice where your eyes want to linger, and how your body is shifting."*

C: She pauses, her body orienting to the stimuli in the room. After 45 seconds, I notice an expansion in her breath, indicating a settling and lowering of the intensity of the sympathetic arousal. She closes her eyes, and redirects her awareness internally. Ten seconds pass. Opening them, she says, *"I feel a lot of energy in my body; it's uncomfortable. I feel agitated… and I'm hard and immoveable inside."* Ten seconds pass, *"Like a cement mountain."*

T: I hear the immobility of the relational violation in the *cement mountain* that I suspect is under the agitation. I recognize this as a familiar relational pattern Jane has with her father, with her anger firing to keep her out of the deeper wound of hurt and rejection that orients her ANS towards the collapse of self and hypo-arousal. I see a slight drain of color from her face, and her body shifts, sinking inward like an implosion. Her shoulders roll slightly forward, which I regard as a collapse of self, as her ANS moves from high to low/hypo-arousal as she touches into her interrupted bid for connection with her father, and her inhibited protective relational response. Wanting to stave off the lure of immobility, I say, *"Uh huh. And where do you feel the energy in your body?"*

C: *"Mostly on the edges of the mountain."*

T: I can feel a heaviness in my body, and I am aware of sadness; again, my somatic countertransference guides me. I note this, and slowly alternate pushing my feet into the ground, a regulation technique to keep rhythm in my body and stay grounded, as hypo-arousal has a strong contagion effect (Brantbjerg, 2021). The immobility has emerged in her ANS, and I attempt to up-regulate her by asking for a counter to the cement mountain. *"I wonder what the opposite of a cement mountain might be?"*

C: Fifteen seconds pass. I can see a little color move up her face. Ten seconds pass. *"A bed of seaweed, bull kelp."*

T: *"Uh huh, tell me about the bull kelp."* I use image to help her regulate her ANS.

C: *"It's thick and strong… it moves with the ocean from swaying to… always holding on."* She meets my gaze and says, *"Fiercely grounded."* Her ANS is shifting, and there is some vitality moving. Her eyes are clear and I can see she is engaged in the present moment. The heaviness and sadness in my body is diminishing. Before she can access her own sadness, there needs to be enough mobility to process it.

T: *"Uh huh, and can you feel that fierce grounding?"*

C: I see her thigh muscles contract as she pushes into the floor with her feet. She gives a slight nod and carries on, closing her eyes to connect more deeply within herself. *"It doesn't matter what the ocean does; the kelp moves with it."*

T: *"That's right"* I validate. *"I wonder what it would be like to get a sense of that movement, watching how the kelp moves."* Ten seconds pass. *"That's right, just watching how it moves... and then noticing the fierce grounding... and feeling the sway of the kelp."* I invite her to oscillate between RH processes – the movement, her felt sense of the fierce grounding, and the image of the kelp. Her spine begins to straighten, her shoulders are less slumped, and some color returns to her face, indicating an up-regulation of her ANS. Twenty seconds pass. *"What's happening now?"*

C: *"I still feel heavy in my body, but I can feel the kelp moving."* She lifts her face, her eyes still closed, and responds. Her ANS is shifting, though the heaviness tells me we are still in the low/hypo arousal zone.

T: *"As you feel into the movement, can you get a sense of how your body wants to move, wants to be the kelp?"*

C: She takes a moment and then nods. *"From my sit bones, up my spine."*

T: *"Uh huh,"* I validate. *"Slowly move a trace of that movement, just a trace."* I know the potency of adding movement, and I use traces of it to awaken mobility. Larger movements can override the ability to attune in the nuanced way that is necessary to process immobility in the implicit memory system. Experienced in this kind of internal work, Jane takes her time to engage the movement in her spine, and experiments with how the movement works. After some time, it becomes more fluid, wavelike. As she opens her body to the movement of the kelp, I can feel energy moving up the front of my shins, thighs, and in my face, telling me there is a significant shift happening in her ANS. I see energy moving through her face, and her eyelashes flutter intermittently, again confirming neurophysiological shifting. *"That's right,"* I encourage, *"the movement and watching the kelp... back and forth,"* wanting her to maintain the oscillation, the rhythm, to help her body process the immobility. We work in this way for a few minutes, with me watching and murmuring my support, and Jane's body slowly undulating, then pausing until the undulation begins again. We trust that her body has its own wisdom to organize and metabolize. I can see and feel the vitality coming alive in her system as energy moves her body in minute ways, and color moves through her face. At times, the front of my legs tingle.

C: *"I feel a lot of heat moving through my legs and torso,"* she reports, eyes closed.

T: *"That's good, it's a little reorganization of your nervous system... let's give your body time to catch up."* I offer some psycho-education around what is happening (her shifting ANS), and what needs to happen (her body needs time to reorganize the immobile energy that has been mobilized) in order to reassure her and keep her LH at bay. We sit, both tracking her shifting internal state. About 25 seconds pass, and I notice her shift in her chair. On the next pause of the undulating movement, she lingers. *"And, what's happening now?"* She begins talking about her father, and how this recent interaction began differently, about how things felt different relationally with him. She told him how excited she was that she had been offered an interesting work project abroad. But he could not share in her excitement. Instead, his critical lens emerged. She talked about how hurtful it was that he was her only family and couldn't be happy for her. I can feel sadness once again in my body, a tightening in my chest up into my throat, and I can feel energy moving in the back of my mouth and behind my eyes. I pick up a short phrase from her words. *"He hurt you,"* I state. She meets my steady gaze. Energy moves through her body up into her face.

C: *"Yes."* Tears come into her eyes but they don't fall. She continues to hold my gaze, and silently we track the shifting in her body.

T: As this happens, the feeling of sadness diminishes in my body. I can see color moving through her face, and I feel it in my body as a slight upward pressure. I hold her gaze. I can see she is feeling the edges of her sadness; it is coming into consciousness, her disavowed emotional experience. I want to support her in regulating this emotion, and moving the energy into organized coherency to avoid having her collapse under the weight of the chronic invalidating relational pattern with her father. The energy settles a bit. About 20 seconds pass. Tentatively, I ask, *"What would it be like to feel the movement of the kelp, and listen for the sound that would go with it?"*

C: Her eyes close briefly. More emotional energy moves through her system up through her face. Fifteen seconds pass. Her body begins its slow undulation from the bottom of her spine.

T: *"That's right,"* I encourage. *"Is there a sound that goes with it?"* She looks at me and nods. *"And if you could just make a trace of that sound, either inside, or very softly out loud."* Again, we are using a trace to open the system but not overwhelm it, which could push her to the edges of hyper- or hypo-arousal. Knowing how potent the combination of movement and sound are, particularly the use of voice when it has been silenced, I heighten my focused attention, my holding of the space, to help steady her ANS as she prepares to engage her voice. Her eyes close. At first, there is nothing audible as her body moves like the kelp. I can see color coming into her face, but not necessarily moving through. I can feel tension in my chest, a tightening on the edges of my eyes. Ten seconds pass, I begin to hear a whisper of sound as she

exhales. The movement in her body lacks the fluidity it had before, so I suspect we are working with a deeper piece of the immobility, the historical relational trauma. I notice a slight nausea in my stomach which informs me she is coming out of the immobility. *"That's right; is there a little nausea happening?"* I ask this question to confirm my tracking, and keep her from worrying about the sensation, to keep her LH from interrupting the process. She nods, opening her eyes for a moment to make contact. *"That's right, it's just a little immobility moving."* Her eyes close again, she knows I know what's happening, which heightens her safety. *"Is it tolerable?"* She nods. The undulating and vocalization pause, and she sits quietly. The nausea subsides in my system. Her head and neck gently nod in a slow rhythm. Her body breathes a deep breath, and once again the movement begins. I can hear the whisper accompany her exhale, nausea again in my body, which is also moving of its own accord in a slight rocking from my mid-back through my neck, telling me of our deep co-regulation and the metabolization happening in her system. *"That's right, at your own pace."* Her body is in process, and my role is to not interrupt it, to help her stay steady in her RH and body, and allow the shifting ANS the regulation to mobilize and metabolize the immobility. On her next exhale, she sounds a little louder. Color rushes into her face, and I can see a tremble move through what I imagine is her spine. Tears stream from her closed eyes and flow down her face; she begins crying aloud. *"Uh huh… I know"*, I soothe. About 45 seconds pass.

C: She reaches for a tissue and wipes her face. *"My body is shaking inside,"* she tells me. I notice that her spine has become more erect, her shoulders sit back, no longer rolled forward.

T: *"That's a good sign,"* I reassure her. *"In your core?"* She nods. *"It's just the energy moving and finding its way."* I explain in simple terms how the immobilization is moving out of a frozen/collapsed state, so she will not shift to her intellect (LH) to figure it out. I want to give her body as much time as it needs for the immobilization, now mobilized, to reorganize the vitality that has been bound in her system.

C: She nods. *"And heat, lots of heat… in my face, too"* she laughs. The heat moving through her face, the ventral vagal, tells me the deep relational immobility has opened in a new way. *"I'm sweating."* She lifts her legs one at a time as if unsticking them from the chair. Our eyes meet, and we break into laughter, a deep belly laugh – a little play that helps metabolize and organize, the play linking the parasympathetic ventral vagal, or social engagement, with the sympathetic system. Our laughter slows, and then erupts again as she plays, *"More heat,"* she says, and pretends to wipe her brow. A minute passes as we sit, in connection, her body settling, the color normalizing in her face. *"It's slowing down, the shaking inside."* Ten seconds pass. Jane's eyes slightly narrow. *"He hurt me… again."* Her truth resonates through the field, and I see a quiver move through her system like an aftershock.

T: My body resonates in response to this witnessing of deep truth. I hold her gaze, *"Uh huh."* My head nods.

C: *"It's normal that I want him to be part of my life, and want him to support me,"* she states as she looks me in the eyes. This statement, emerging from the RH processing, a bottom-up process – from the body up – tells me that the immobility is shifting and a new sense of herself is emerging.

T: *"Of course it is,"* I validate.

After a few minutes, Jane goes on to talk about her internal conflict, wanting her relationship with her father to be different than it is. She speaks of the devastation that she feels in the face of invalidation, hurt, or rejection. She articulates how her anger flares to keep her from feeling devastated, and how, despite her knowing, the anger fires unconsciously, as if wired to protect (which it is). We talk about healing being in the tracking and attending to those fragments that have been disavowed in order to maintain relationship, specifically with her father. As we near the end of the session, she is able to feel and name the grief that companions this recognition, holding the awareness that while her father loves her, he is unable to engage with her in consistently loving ways. With support, Jane reflects and integrates her awarenesses that have emerged into a deeper understanding, and integrates and organize it into her explicit narrative, now bridging the right and left hemispheres.

In the weeks and months that followed, Jane continued to unravel the relational immobility that has held her captive in invalidating relationships, particularly with her father. The gains she made were built on months of previous work that allowed her to access and metabolize some deep relational immobility. This shift opened her to deepen some of her existing relationships and make new connections. The imaginal (the cement mountain, the bull kelp, and its sound) and her embodied movement were able to ultimately mobilize and contain the intense energies of the chronic relational injury so that she could bring the unconscious material forth, and regulate and process it through her body. "Repressed emotions and memory are held in the musculature and can be released… through expression of the body" (Espenak, 1981; Koch, Fuchs, Summa, and Miller, 2012; Lowen, 1967 cited in Tantia, 2015, p. 4). Further, the impact on her psyche, her internal working models (IWMs – a framework for beliefs about oneself and how the world and relationships work), from repeated relational violations, was challenged, and the seeds of internal repair were planted: "a retearing and restitching of the fabric of the self can occur within the safety of relatedness" (Marks-Tarlow, 2014, p. 400). The important aspects of effectively working with the body touched on in this clinical example include the following:

- use of short, directive, and validating phrases to avoid activating LH content processing;
- oscillation between different RH processes to differentiate and link (movement, image, felt sense, sound);
- a slow pace to engage the implicit memory system; and
- use of traces of movement and sound to make contact with the underlying immobilization of the relational rupture – in this case, her father's chronic invalidation.

I also relied on our relationship to act as a vagal brake (social engagement system) through eye gaze and validation, offered psycho-education about what her body was doing in terms of processing the traumatic material, maintained a slow pace to allow her ANS time to process, and tracked my internal experience and somatic countertransference to inform and guide our journey.

Linking the Vignette to Theory

Bringing the body into practice rests upon several theoretical and conceptual understandings that are exemplified in this case study: embodiment, the hemispheric brain, the polyvagal theory, the window of tolerance, affect regulation, attachment and attachment repair, trauma, and trauma repair – all through the lens of interpersonal neurobiology. The implications of trauma, both incidental and relational, to the ANS underscores the fruitful nature of body-centered work that regulates affect, and facilitates integration and digestion of physiological traumatic material that is immobilized in the body. This underpins psychological and attachment/relational capacities and patterns of relating, which are neurophysiologically wired and scaffolded onto physiological structures of the body, establishing the IWMs. A comprehensive understanding of these theories provides the terra firma of this body-centered psychotherapeutic approach. I will now present relevant theory for this body-centered practice.

Embodiment

Embodiment, the conscious inhabiting of the corporeal body, is the bedrock of body-centered psychotherapy. It is our phenomenological experience in the body that anchors us and becomes the navigational instrument in guiding clinical practice. Totton (2014) recognizes embodiment as "the matrix for human relationship," noting that "psychotherapy is perhaps the place where this can be brought most clearly into awareness" (p. 93). Embodiment is a widely-used term that lacks an agreed-upon definition across therapeutic orientations in psychotherapy, ultimately inhibiting our ability to cross-pollinate ideas and applications for clinical practice. From my perspective, embodiment means to *consciously inhabit* one's physical body: "to live in a fluid yet consistent state of inhabiting one's body and utilizing the body as a site of knowledge whereby one's awareness is consciously engaged in an intimate relationship with the internal self as it concurrently attends" (Mortimore, 2013, p. 174) to other(s), including the animate, sentient earth. Embodiment is a state of being where we are attuned to the present moment, wherein "the body is an intentional body, primordially relational, and co-arising with its situation that is not just fleshy perceptual but also full of implicit meanings and relational understandings" (Todres, 2007, p. 21). In this way, the body is purposeful in its functioning and relational at its core, serving as information gatherer, receiver, and messenger; embodying is "where knowing and being meet" (p. 20).

Body-centered clinical orientations understand embodiment as:

- flesh, blood, organs, tissues, and bones – the matter of the self that serves as container for the life force;
- receiver/transmitter of information – we experience the world through our bodies (Merleau-Ponty, 2002);
- an integral part of the ecosystem including our felt sense of relationship to earth;
- being continually shaped and reshaped through relationship(s);
- being sculpted by language and culture;
- holding the story of one's life in both conscious and unconscious realms, implicit and explicit memory;
- not being amenable to comprehension as a decontextualized entity; and
- a site of, and a conduit for, knowledge (Mortimore, 2013).

Acting as an access point, the body serves as an entry to the psyche, whereby the varied and expansive inner landscape of the body reaches both in and beyond the world of matter to interface with another. This embodied relational experience (intra- and inter-, conscious and unconscious) brings knowledge from the ground up – from the body up through the RH and across to the LH. In this way, it is a living inquiry (Burstein, 1998), a phenomenological pursuit.

I discriminate between embodied practice, where therapists and clients use their bodies as a tool of perception, and body-centered practice, where we engage the body and RH processing to up- and down-regulate the ANS, and to process implicit and explicit traumatic material. I assert that embodiment is needed for both. The clinical excerpt demonstrates how I relied on my embodiment and utilized my body to gather information, including Jane's unconscious emotion, regulate myself and the therapeutic dyad, track ANS changes, and aid in processing the traumatic material. This case study highlights the process of Jane re-inhabiting her body in association to the relational injury. This reorganizational capacity, spanning the brain, body, and psyche, shifted her ANS over time, processed the traumatic ma-

terial, and further reorganized her sense of self and self in relationship, her IWMs.

The Left and Right Hemispheres

Understanding the hemispheric brain is essential for clinical practice. However, there is considerable misunderstanding regarding how the hemispheres function. McGilchrist's seminal work (2009) clarifies that the hemispheres do not do different tasks (emotion, reason, language), as previously simplified explanations suggested. Rather, they approach these same tasks in radically different ways. The narrow focus of the LH allows for precise, detailed concentration. It disembodies the self and distorts the holistic and nuanced nature of issues, simplifies and decontextualizes complex relationships, is best utilized for local, short-term assessment, and is "relatively untroubled by the complexity of empathy, emotion, and human significance" (McGilchrist, 2016, p. 201). It seeks power (Hecht, 2014), and its fragmentary nature and lack of insight can distort reality and be manipulated.

Conversely, the RH allows for complexity, uncertainty, and a united worldview (McGilchrist, 2016). Life is experienced as alive, emotionally rich and nuanced, embedded in context, and reliant on our emotional sensibilities to make sense of the world (McGilchrist, 2016). The RH builds affiliation (Hecht, 2014) using a long, wide lens to engage the world, and allows one to be in connection, to live in community, and to hold the values of equality and justice (McGilchrist, 2009). The RH is primary in the experience of self (McGilchrist, 2009; Schore, 2014), and central for the recognition, expression, and communication of both verbal and nonverbal emotion (Schore, 2012). The implicit self, located in the RB, represents "the biological substrate of the human unconscious mind and is intimately involved in the processing of bodily based affective information" (p. 73), particularly traumatic material as it remains undigested in the right. This understanding is critical in regulating the ANS, and renegotiating trauma and attachment patterns held in the body.

Ideally, the LH should rely upon and take direction from the RH (McGilchrist, 2009). However, that is not the case for most people of Western cultures. Instead, they tend to over-rely on the LH, disavowing bodily (and emotional) knowledge to maintain safety, finding comfort in and accepting guidance from the intellect. This backward approach to processing experience renders us ill-equipped for living in a complex relational world. This predisposition accompanies therapists into practice and clients into therapy. Both parties tend to subjugate the body and embodied knowledge, identifying intellect (logic, cognition) as the avenue to change, rather than engaging in the wisdom of the body. "The mind-body clash has disguised the truth that psychotherapy *is* physiology. When a person starts therapy, he isn't beginning a pale conversation; he is stepping into a somatic state of relatedness" (Lewis, Amini and Lannon, 2000, p. 168). Therapists must "find a way past the busy, defended left brain to negotiate a relationship with the patient's right brain" (Quillman, 2012, p. 5) in order to process dysregulated material through the body.

Most clinicians have been trained to track and give primacy to the narrative content in session. However, in the clinical exchange presented, I focused on *how* her story was held in her body. "Effective interactive psychobiological regulation requires paying more attention to how interventions affect autonomic arousal than to the content of the client's narrative" (Ogden, Minton and Pain, 2006, p. 216). When Jane told me she was mad that she had let her father in, I interrupted the story, shifting her from her LH into her RH by asking her to attend to what was happening in her body. This shift in focus allowed us to first regulate the high arousal of her recent interaction, opening the way for her implicit memory of the unconscious (historical) relational injury to emerge and mobilize the collapsed self, digesting the immobilized material and allowing her protective response – her voice – that had been suppressed, likely to maintain relationship in her early life, to both aid in that process and speak her embodied truth: *"He hurt me."* We used the body as a source of living knowledge, and worked with right hemispheric processing to reorganize, process, and integrate dysregulated energy and make psychological shifts.

Working with Right Hemispheric Processing

Traumatic experience (incident trauma or relational trauma) impacts the RH in creating over- or under-bound connections between the different hemispheric processes. This fragmenting of experience and/or self protects the psyche from intolerable pain through dissociative processes, and "different aspects of the traumatic experience (sensation, affect, image) are fragmented, divided into compartments" (Kalsched, 2013, p. 23). This underscores the necessity to connect and organize the over- or under-bound fragments of experience, and bring unconscious material into consciousness, digesting, organizing, integrating, and finding new meanings from the bottom up as the ANS regulates. Stanley (2016) explains, "Differentiating fused brain circuits and their neural networks allows linkage, a natural process of growth and development, to utilize the most adaptive brain circuits and create new neural networks" (p. 137).

To land in one's body through the RH brings experience to life, which, in the case of re-inhabiting the traumatized body, must be done slowly and carefully so as to prevent further overwhelming the ANS and creating more dissociated pathways. The varied processes of the RH include:

- tracking and listening to the sensations of the body to witness and guide further somatic intervention;
- activating sensory motor processes (gestures and movement) to tell a story, or part of a story, and guide us;

- using sensory motor information or relational gestures to complete thwarted protective/defensive impulses;
- regulating affective expression;
- processing images – auditory, visual, tactile, metaphors, myths, or dreams; and
- exploring archetypal or symbolic realms.

In working with right hemispheric processes such as sensation, affect, or image, one can see how they are intricately linked. Greene (2005) aptly describes this linkage. Awareness often "begins with a physical sensation, it often transforms that sensation into a feeling or image so that the border between imaginal and embodied modes of experience is blurred, at which point their reciprocal relationship becomes apparent" (p. 202). Recall in the vignette how Jane started with an emotion, anger, and moved to the sensate experience of energy and agitation. In moving into the felt sense of the cement mountain, the underlying immobility emerged. We used the bull kelp (her resourcing image) to regulate, and invited traces of movement (sensory motor) and sound (imaginal) to mobilize, digest, integrate, and ultimately shift her ANS and IWMs.

Trauma and the Body

The legacy of trauma has far-reaching implications for the neurophysiological body and psychological self. The body holds the story of one's life. "Nothing in a body's life goes unregistered, so wholeness enters through the body's door" (van Loben Sels, 2005, p. 230). The body holds the immobilized energies of fear, terror, and anger deep in the ANS, often in frozen or collapsed states. Traumatic experiences can disrupt the cohesiveness of people's lives (Kalsched, 2013), fragmenting the self psychically, and wreaking havoc in the coherence of the body and bodily-based functions by dysregulating the ANS. Such impacts can create insecure attachment, interrupt development, impair affect regulation, create physical and psychological symptoms, and make people vulnerable to further traumatization. The traumatic energy remains undigested, often impeding a unified sense of self and hindering an organized internal experience. Trauma "disrupts or threatens to disrupt the continuity of self-experience" (Bromberg, 2011, p. 13). The narrative lacks fluidity and coherent meaning, and "we no longer make sense to ourselves" (Kalsched, 2013, p. 23). Confusion, chaos within the system, and an incongruence between the implicit and explicit narrative often accompany this disruption of the continuity of the self.

From a neurobiological perspective, the polyvagal theory explains how trauma incites hierarchical behavioral strategies that correlate with specific ANS states and psychological feelings. Further, it explains the acute and lasting physiological dysregulation in the ANS (Porges, 2011). When trauma is left unprocessed, the ANS does not return to homeostasis. Rather, it remains dysregulated, creating havoc within the body and psyche. The hierarchical cascade of response to the overwhelming experience of trauma creates high (anger/fear) and then hyper-arousal (rage/terror) of the sympathetic nervous system, and often moves into hypo-arousal (dissociation/immbolization/collapse). Our first line of defense to mitigate threat is relationship (ventral vagal) (Porges, 2011). If this is insufficient or is not appropriate to safely meet the situation, the flight or fight/engage or disengage response (sympathetic) will instinctively initiate (Porges, 2011). If these protective, defensive strategies are not enough to shift the trauma experience, they are thwarted. The ANS then moves into a parasympathetic dominant state of immobility with fear – a hypo-aroused state of the dorsal vagal (Porges, 2011). At this point, "there is a freeze response or a collapsed state" (Schore, 2012, p. 159) in and of the self. This lasting dysregulation in the ANS generates a propensity to operate with a bias toward either high/hyper-arousal (anxiety/panic) or low/hypo-arousal (depression/dissociation), creating activated or immobilized/collapsed parts of self that inhibit the self's overall capacity and functioning, including the capacity to mentalize (Brantbjerg, 2021), and distorts accurate perception of safety (Porges, 2011). We use neuroception, unconscious neural processes, to evaluate risk/safety in our environment, and guide our responses. If our ANS is dysregulated, our perceptual and neuroceptual capacities are impaired, and we are unable to accurately assess safety and employ the most adaptive survival response. This underscores Levine's (1997) assertion that the key to healing trauma is through our physiology, the body.

In linking Jane's experience to the polyvagal theory and window of tolerance, her struggle with low mood indicates a bias towards low arousal in her ANS, and tells of earlier unresolved traumatic experience. We can deduce that the underlying immobility in her system points to previous traumatic truncating of her protective relational responses due to a chronic and historical silencing of self in order to maintain relationship with her father – a dynamic that was established in early life, and unconsciously enacted. She entered the session in a highly aroused sympathetic state, indicated by the intensity of her speech and the energy and agitation she described in her body. However, as we regulated her ANS, the underlying immobility, a hypo-aroused state (from chronic relational injuries, leading to a distorted IWMs and a collapsed self) revealed itself, interrupting the processing of her anger and deep sadness (disavowed and contained in the cement mountain), both historical and current, and ultimately impairing her relational capacities. Through processing in the RH, Jane was able to access her vitality and regulate her ANS as the immobility was processed physiologically – seen in the shaking, heat, sweat, fluttering lashes, bodily shifts/energy, and tears. Processing the immobility shifted her physiological terrain, opening a new experience of self and her IWMs.

Relational Trauma and the Body

For people with a history and body formed in the wake of relational trauma – as with insecure attachment, where the primary caregiver was unpredictably available for relational and regulatory contact, leaving the infant in high/hyper-aroused or low/hypo-aroused states without regulatory and relational repair for long periods of time, the cumulative impact of chronic misattunement and extended periods of affect dysregulation impair the regulatory and integrative capacities of the growing child (Siegel, 1999; Schore, 2012, 2014). Unconscious patterns are established, both relational and neurophysiological, that endure and underlie IWMs, and "are nonconsciously accessed at later points of interpersonal emotional stress" (Schore, 2014, p. 390) and in the therapeutic relationship. The relationship with the body is often conflicted, arising through abuse in the form of neglect and/or violence, or as an internalized response to invalidated emotional needs by the caregiver. In order to maintain relationship, the developing child disavows their bodily sensations signaling need, ultimately disavowing parts of self. These thwarted seeking and caring motivational states become wired into the affect-regulating system and corresponding relational strategies as well as into one's sense of self, ultimately impeding regulation, health, and healthy functioning and relational capacity. "The body unconsciously expresses – is the site of – the reciprocal and mutual stimulations of caregiver and child" (Grand, 1998, p. 176). It houses relational impulses to merge and withdraw in the IWMs, and is home to deeply frozen/collapsed/disavowed self-states. Attachment experiences are "affectively burnt in" (Schore, 2014, p. 390), establishing "nonconscious strategies of affect regulation" (p. 389) and imprinting, encoding, or wiring the self with specific affect management and attachment strategies that shape the RB, a process integral to emotional processing in the limbic system and ANS (Schore, 1994).

The legacy of insecure attachment includes affect-regulation issues, relational impairment, and a distorted sense of self, essentially an injury to RB functioning (Kalsched, 2013). Logically, we understand that "what has been broken relationally must be repaired relationally" (p. 13), and note the need for *"affectively focused treatment"* (p. 13). Because "Implicit right brain-to-right brain intersubjective transactions lie at the core of the therapeutic relationship" (Schore and Schore, 2008, p. 15) psychotherapy that activates and optimizes implicit RB communication, can, over time, repair caregiver-infant attachment injuries.

By bringing the body into practice, the body takes the lead role in signaling the emergence of underlying attachment patterns and concurrent (un)conscious affect. At the core of therapeutic work and the reparative process is regulation of unconscious and conscious bodily-based material and affective and physiological overwhelm through explicit processing in the RH. Through the co-regulation of this chaotic material, new neural pathways are established, and new relational experiences and options for interaction emerge. In this way, the body acts as a broker between the IWMs and new attachment experiences that build these emerging neural pathways.

The clinical excerpt demonstrated this sequence in Jane's initial conflict of listening to her body as she had learned to prioritize relationship (with her father) over self-protection via silencing of her hurt: "Individuals who suffered chronic abuse as children, especially during a developmentally vulnerable period, and who may not have been able to capitalize on social engagement, attachment, or mobilizing defenses for survival, generally have come to rely on immobilizing defenses" (Ogden et al., 2006, p. 97). Jane's chronically invalidating relationship with her father, stretching back into her early life, created an internalized conflict where her relational need superseded her need to protect herself, resulting in a collapse of the self – "the survivor kills his or her own truth to save a bond with the other" (Mucci, 2018, p. 180). This collapse was seen physically in the slumping posture of her shoulders and emerged symbolically in the cement mountain. Her sensate experiences, lying "at the heart of emotions" (Stanley, 2010, p. 8) were disembodied as we began therapy: "these dead zones remain(ed) unverbalized and out of awareness. Thoughts, feeling, and memories lay frozen in time" (Gill, 2009, p. 263).

Seventeen months in, Jane was able to use the security of the therapeutic relationship, safety that had been earned over time, to steady herself and act as a vagal brake (Porges, 2011) to down-regulate her ANS. She demonstrated a new pattern of using relationship and her body (orienting, grounding) to shift her state so she was able to access her embodied experience, stay within the window of optimal arousal, and bring her disavowed emotion and instinctual protective responses to consciousness for processing.

Trauma, the Body, and a Body-Centered Orientation

In bringing the body into practice, body-centered therapists attune to their clients and to the intersubjective field, tracking nonverbal cues in themselves and their clients. The therapist's regulated ANS offers a prototype with which to align and fall into rhythm. The entrainment of nervous systems requires the therapist's regulation capacities to be strong, and reliable enough to establish co-regulation and maintain rhythm in the most chaotic of moments. This resonant circuitry allows for the client's brain to rewire "regulation in parallel with the neural firing in the therapist's more integrated brain" (Mark-Goldstein and Ogden, 2013, p. 128). The focus and direct engagement with RH processing allow the dyad to work directly with the ANS and with implicit memory in the body. However, a body-centered focus must go beyond simply paying cursory attention

to the body – "Where do you notice that?" or "What's happening in your body?" – in order to decipher what bodily information is present, and determine what is needed to facilitate optimal processing and reparation in the ANS. Because consciousness arises from the body (Wirtz, 2014), therapists need to bring awareness and curiosity to what is revealed physiologically and symbolically, and where those revelations may lead.

In order to go beyond mere attention to the sensate body, body-centered therapists need to engage, explore, and expand other processes of the RH (the imaginal, sensory motor gestures, affect, and symbolic representations), and weave aspects of an experience into present moment time. For example, when working with an experience in the past, the clinician should inquire about what is happening in the here and now, as demonstrated in the case study. Focusing on the present moment provides the opportunity to process chaotic undigested material, regulate and increase safety, and re-inhabit the body, all which must be done slowly and carefully to prevent further overwhelming of the ANS as "the threshold of consciousness is a bodily threshold" (van Loben Sels, 2005, p. 230).

Conclusion

To heal a body wounded by trauma, particularly relational trauma, is a tall order. Its legacy has deep roots into the psyche and the neurophysiological body. The implicit regulation and attachment patterns emerging from traumatic histories establish familiar ways of being in the world and in relationship that maintain a sense of safety at the expense of healthy relationships and a regulated ANS. The experience of being somatically attuned to, and resonated with, is a starting point from which to enter into relationship and begin the process of re-inhabiting the body, trusting it as a guide, and entering relationship on one's own terms. In this process, the embodied body-centered therapist intentionally and actively engages in right-hemispheric processes that bring the body and implicit knowledge into the therapeutic dyad to be digested and integrated neurophysiologically and relationally, and, ultimately, to be embodied and integrated into the IWMs. As the clinical dyad processes up and down the RH while engaging with sensations, sensory-motor aspects of the body, emotions, images, and/or the symbolic, and attending to regulation of the ANS in the present moment, the body and psyche digest experiences and patterning held in the body – the activated, immobilized, or collapsed states – and make subtle shifts in the regulatory pattern of the ANS (as illustrated in the clinical excerpt). Over time, these shifts culminate by offering a change in the overall regulatory capacity, opening new avenues for relational patterns and new ways of experiencing and inhabiting self and the body.

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