Minding the Body: Somatic Interventions for Enhancing EMDR Effectiveness

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Challenges to EMDR Processing: Why We Need Somatic Interventions:

• The patient gets sleepy, spacy, numb, "nothing happens"
• The patient dissociates during processing
• The patient gets flooded: goes into flashback or becomes overwhelmed just setting up the protocol
• The patient reports flooding after the session, even when processing was apparently successful
• The patient “loops” endlessly, returning over and over to the same negative belief
• The patient becomes “EMDR phobic”
• Or becomes more symptomatic, not less!  
  
Fisher, 2009

Depression
Irritability
Decreased interest
Numbing
Decreased concentration
Insomnia
Physiological hyperarousal
Psychomotor agitation

Foreshortened future
Hopelessness
Dissociative symptoms and disorders
Substance abuse
Eating disorders
Generalized anxiety
Panic attacks
Self-destructive behavior
Dissociative symptoms and disorders
Amnesia
Self-destructive behavior

"Trauma survivors have symptoms instead of memories"  
[Harvey, 1990]

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The Triune Brain [McLean, 1967]

**Reptilian Brain:**
- Autonomic arousal, instinctive responses
- Speaks the language of sensation and impulse

**Mammalian Brain:**
- the Limbic System: somatosensory, emotional, and relational memory
- Speaks the language of emotion

**Frontal Cortex:**
- Regulatory abilities, cognitive and executive functioning
- Uses verbal language and analytical reasoning

**Why do trauma survivors have symptoms instead of memories?**

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How we remember trauma

**Hippocampus:**
- Inhibited during threat response, it is unable to process trauma

**Amygdala:**
- the unprocessed traumatic event is encoded as implicit memories without words, easily activated by triggers

**Threat**

"Under conditions of extreme stress, there is failure of hippocampal memory processing, which results in an inability to integrate incoming input into a coherent autobiographical narrative, leaving the sensory elements of the experience unIntegrated and unattached. These sensory elements are then prone to return, when a sufficient number of [them] are activated by current reminders."

Van der Kolk, Hopper & Osterman, 2001

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Sensory elements without words = implicit memory

• The survivor is left with a host of overwhelming implicit memories: automatic emotional, physical, and somato-sensory responses—disconnected from the event

• These implicit memories do not “carry with them the internal sensation that something is being recalled. . . . we act, feel, and imagine without recognition of the influence of past experience on present reality.” (Siegel, 1999)

“Emotional memory converts the past into an expectation of the future, without our awareness [and] makes the worst experiences in our past persist as felt realities” (Ecker et al., 2012, p. 6) (Fisher, 2015)

Non-verbal memories don’t feel like memory—they feel like “me”

“When the images and sensations of experience remain in ‘implicit-only’ form . . ., they remain in unassembled neural disarray, not tagged as representations derived from the past . . . Such implicit-only memories continue the shape the subjective feeling we have of our here-and-now realities, the sense of who we are moment to moment . . .” (Siegel, 2010, p. 154)

Phobia of Traumatic Memory

• “It’s too dangerous for me to put these things into words. I am afraid they might become gigantic and I be no longer able to master them.”
  • E.M. Remarque (1929/82, p. 103)

“The moment any memory or shred of a memory was about to float upwards, we would fight against it as though against evil spirits.”
• A. Appelfeld (1993, 1994, p. 18)

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Implicit memories take many different forms

- **Intrusive emotions disproportional to the stimulus:** fear, anger, shame, dread
- **Thoughts the predict threat or failure,** especially when intrusive, contradictory, or ruminative
- **Impulses:** to run, to hurt the body, drink or drug, hide under the bed, avoid going out
- **Somatic sensations:** spinning, dizziness, pain, heaviness, floating, tingling, numbing, ‘noise’ in the head, loss of hearing or vision
- **Attachment symptoms:** yearning for contact, painful loneliness, and a felt sense of abandonment

*Fisher, 2015*

The Body and Nervous System Adapt to Conditions of Danger

“When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over.”

*Judith Herman, 1992*

Autonomic Adaptation to a Threatening World

**Hyperarousal-Related Symptoms:**
- Impulsivity, risk-taking, poor judgment, racing thoughts
- Hypervigilance, post-traumatic paranoia, phobias and panic symptoms
- Overwhelming emotions, flashbacks, flooding
- Self-destructive and acting out behavior

**Hyperarousal**

[Graph showing hyperarousal]

*Ogden and Minton (2006)*

**Hyporarousal**

[Graph showing hyporarousal]

- Flat affect, numb, feels dead or empty, "not there"
- Cognitive functioning slowed, "lazy"
- Preoccupied with shame, despair and self-loathing
- Disabled defensive responses, victim identity

*Siegel  (1999)*

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Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from the work of Alan Schore, Bessel van der Kolk, Daniel Siegel, Onno van der Hart, and Ellert Nijenhuis. Sensorimotor work combines traditional talking therapy with body-centered interventions that directly address the neurobiological effects of trauma. By using the narrative specifically to evoke the trauma-related bodily experience and making that the primary entry point in therapy, we attend first to how the body has "remembered" the trauma and then to cognitive and emotional meaning-making

Sensorimotor Psychotherapy

Triune Brain = "Triune Processing"

**COGNITIVE PROCESSING**
Capacity for conceptual information processing, reason, cognitive schemas, meaning-making, and decision making.

**EMOTIONAL PROCESSING**
Capacity for expression and articulation of feeling and affect. Emotional processing adds motivation and "color".

**SENSORIMOTOR PROCESSING**
Capacity for processing through the body. Sensorimotor processing involves physiological and motor sequences associated with impulses, movement, postural changes, orienting responses, physical defensive responses and ANS arousal

Information Processing in EMDR

**COGNITIVE PROCESSING**
What makes the picture so disturbing right now? What belief?
What belief would you prefer to have about yourself?
On a 1-7 scale, how true does that belief feel to you now?
On a 0-10 scale, how intense are those feelings?

**EMOTIONAL PROCESSING**
What emotions do you feel when you see the picture and say the words of the negative cognition?

**SENSORIMOTOR PROCESSING**
What is the most disturbing picture to look at? The worst moment in the memory?
Where in your body do you feel this disturbance the most?
How EMDR and Sensorimotor Therapy Challenge Implicit Learning

• Both challenge or disrupt "talking about" the events in ordinary consciousness
• Both focus just on single framed images of the experience, not the narrative of a whole event, to elicit the implicit memories associated with it
• Both emphasize awareness of each component of experience separately: thoughts, feelings, perceptual and bodily sensation

How EMDR and Sensorimotor Therapy Challenge Implicit Learning, cont.

• Both are mindfulness-based. Focus on the bilateral stimulation or on the body responses help clients stay focused in a mindful, witnessing state of dual awareness and just report what is noticed in present time
• Time is either speeded up [EMDR] or slowed down and expanded [Sensorimotor Psychotherapy]
• There is an explicit assumption that movement will happen under the right conditions: neither the therapist nor the patient has to try to make it happen

Both facilitate neuralplasticity

• "Neuralplasticity refers to the ability of neurons to forge new connections, to blaze new paths through the cortex, even to assume new roles." (Schwartz & Begley, 2002, p. 15)
• "Neuralplasticity is fostered by inhibition of old responses coupled with repetition of new, more adaptive responses. "Attending to one sense . . . does not simply kick up the activity in that region of the brain. It also reduces activity in regions responsible for other senses." (p. 333)
• "The way an individual willfully focuses attention has systematic effects on brain function, amplifying activity in [those] brain circuits." (p. 334)
Deepening Mindfulness of Sensorimotor Experience

The therapist asks questions that focus the client’s attention specifically on body experience:

• “Notice what is happening right now... your thoughts, your feelings, sensations in your body...”

• “Where exactly do you experience that tension?” Can you describe the qualities of the tension?

• “When you have that thought, ‘There is no one there for me,’ what happens inside?”

• “When you feel that anger, is there a movement that your body wants to make? Stay with that impulse...”

Giving a choice of possibilities facilitates mindful awareness

When you feel the panic come up, what happens in your body? Do you feel more tense? More jittery? More frozen?

“When you say those words, ‘I’d like to kill him,’” what does your body want to do?? Does it want to push away? Or pull in? Or strike out??


Ogden 2004

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Making it Even Easier:
Asking Contrasting Questions

• “Does that feeling feel good or bad? Is it more pleasurable or unpleasurable?”

• “Does that danger feel like something that will hurt you from the inside or the outside?”

• “When you say those words, ‘It was my fault—there must be something wrong with me,’ do you feel better or worse?”

Ogden 2004; Fisher, 2005

How does Mindfulness Treat Trauma?

From van der Kolk, 2009

Experiments Replace Suggestions
[Ogden, 1999]

Sometimes, mindfulness spontaneously leads to the transformation of a habitual pattern. But when the client is stuck, the sensorimotor therapist challenges implicit learning and facilitates processing by conducting small mindful “experiments” that gather new information or offer new options.

The experimental attitude encourages thoughtful “trials” of small new responses and non-biased observation of their impact. Experiments are conducted with openness and curiosity, without investment in any particular outcome, with no "right" and "wrong" answers.

Fisher, 2003
### Cognitive Interweaves are Experiments

- Sensorimotor Psychotherapy uses the term “experiment” for what EMDR calls a “cognitive interweave” to emphasize curiosity and decrease investment in a particular outcome.
- A verbal experiment or interweave affects the body in the same way that a core belief does: “It's my fault” or “I am worthless” produce certain body sensations, postural changes, fluctuations in arousal, emotional responses, and changes in energy flow.
- A successful interweave (such as “Imagine that this is your child speaking—what would you say to her?”) also changes body experience and thus changes belief. 

Fisher, 2015

### Using Somatic Experiments as Interweaves

- Sometimes, verbal/emotional experiments are not effective: the client rejects one after another or ends up in the same place despite our best efforts.
- Cognitive interweaves can be dysregulating: they may be too big a jump for the client or inadvertently triggering, or client is so dysregulated already that it cannot be ‘heard’.
- Somatic interweaves have two purposes: they specifically regulate the nervous system, making possible cognitive reprocessing as well as challenge core beliefs. Remember: cognitive reprocessing requires prefrontal activation and enable witnessing to be effective.

Fisher, 2015

### Experiments = Somatic Interweaves

- **Patient is “looping” or stuck:** “Let's notice what happens when you say the words, ‘Right now, right here, I'm doing the best I can . . . ’” "Let's see what happens if you drop the words, 'It's my fault,' and just concentrate on your body. . .”
- **Patient is having trouble staying present:** “Notice what happens if we both stand up. . .” “Notice what happens when you ground yourself by pushing against the floor with your feet. . .”
- **Patient is too hyperaroused to process:** “I wonder what would happen if you just noticed the sensation of the fear . . .”
- **Patient is too hypoaroused to process:** “Let's study what happens if you exaggerate that movement . . . If you make that gesture again . . ” "If you say those words a little louder.”

Fisher, 2003
**Experimenting with Somatic Resources for Traumatic Reactions**

<table>
<thead>
<tr>
<th>Traumatic Reactions</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaking, trembling</td>
<td>Deep breath, sigh</td>
</tr>
<tr>
<td>Numb, dazed</td>
<td>Tensing, relaxing muscles</td>
</tr>
<tr>
<td>Wanting to run</td>
<td>Movement: standing up</td>
</tr>
<tr>
<td>Fear of abandonment</td>
<td>Hand on the heart</td>
</tr>
<tr>
<td>Collapsed, helpless</td>
<td>Lengthening the spine</td>
</tr>
<tr>
<td>Hypervigilent, &quot;on guard&quot;</td>
<td>Tensing &amp; relaxing</td>
</tr>
<tr>
<td>Pulling back, pushing away</td>
<td>Grounding</td>
</tr>
</tbody>
</table>

**(Ogden, 2000; Fisher, 2005)**

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**Counteracting “Looping”**

**Client statement**

- Loop: "If my father and I are going to have a relationship, it has to have boundaries” [BLS]
- "I need to be able to stand up and stand my ground”
- "It’s better, but I can feel myself pulling back with my lower body and leaning forward with my upper body”
- "It’s OK to want what I want”

**Therapist statement**

- "Notice what happens inside if you reach out with one hand and make ‘Stop’ gesture with the other”
- "Just allow your body to express that wish to stand your ground” [client stands up]
- "Notice what happens when you lengthen your spine . . . and then reach out with your hand”
- "Go with that . . . ” [BLS]

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**Installing Boundaries Established Somatically**

**Therapist**

- "Just notice what happens when you put up your hands to make a boundary . . .”
- “Notice what happens if you create an energetic boundary around you instead . . .”

**Client**

- "It feels like pushing someone away—like rejecting them . . .”
- “This feels like it’s about me—I have space around me now—feel calmer inside—I don’t have to be what they want me to be”

**(Fisher, 2007)**

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Installing Boundaries Set Somatically, cont.

**Therapist**
- "Go with that sense of your boundary and the calm feeling inside..." [Bilateral stimulation]
- "As you say those words, 'I can choose,' what happens inside? Go with that" [Bilateral stimulation]

**Client**
- "It's OK for them to want me to do or be things for them, but I can choose what's best for me."
- "I don't have to get defensive or resentful—I can just say 'No.'"

Fisher, 2007

Installing Boundaries Set Somatically, p. 3

**Therapist**
- "Imagine bringing that sense of boundary into your parents’ home..." [Bilateral stimulation]
- "Notice his face and that feeling of the energetic boundary around you..." [BLS]

**Client**
- "I can see my father looking grim and tense—he wants something...I'm starting to feel guilty and afraid..."
- "I feel calm as I feel my boundary around me...It's his tension, not mine."

Fisher, 2007

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