Psychoanalytic Dialogues, 22:606–615, 2012

ISSN: 1048-1885 print / 1940-9222 online
DOI: 10.1080/10481885.2012.719451

Routledge
Taylor & Francis Group

Commentary on Paper by Ellen F. Fries

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In *Perchance to Sleep: Minding the Unworded Body in Psychoanalysis*, Ellen F. Fries masterfully articulates the complexities of right-brain to right-brain, body-to-body interactions between herself and her patient. Her work highlights the dominance of the nonverbal implicit self over the verbal, explicit self and provides an excellent example of clinical work in which she thoughtfully attends to the unspoken, bodily based communication that takes place within the therapeutic dyad. In this discussion, I offer perspectives from Sensorimotor Psychotherapy on the impact of early attachment on the procedural organization of action sequences that reflect and sustain the implicit self, and embody unconscious relational expectations. The following topics are addressed: (a) Physical actions that provide avenues of exploration into the implicit self, especially actions such as reaching out, making eye contact, or maintaining an upright posture that are abandoned or distorted when they are ineffective in eliciting the desired response from attachment figures; (b) Body-oriented interventions that target the involuntary physical spasms that Fries' patient experiences, which are associated with unresolved physiological arousal originally stimulated in the face of trauma; and (c) The nonverbal manifestation and negotiation of enactments that emerge from the body-to-body dialogue between the implicit selves of patient and therapist.

In this beautifully written paper, Fries describes the complexity of the patient/analyst relationship, vividly articulating the impact of her patient, Andres, on her body, mind, and emotional state. As I read what she wrote, so rich with imagery and feeling, I could viscerally *sense* the nature of their developing connection, not simply as a result of communication that takes place between two individuals but as the creation through the dyad of something larger, made up of conscious and unconscious elements of human experience. Fries' descriptions of Andres' deadness and hopelessness catalyzed traces of similar states in my own body and I could sense in myself the familiarity of the myriad physical sensations and emotions that Andres evoked in his analyst. I believe this "felt sense" of one another, which comes through loud and clear in Fries' writing, is the essence of all relationships, including those of author/reader and patient/analyst. At the core, it is what happens within the relationship that facilitates change in any method of psychotherapy.

Although psychoanalytic theory has greatly influenced my work, I am not an analyst but a body psychotherapist, founder, director, and faculty of the Sensorimotor Psychotherapy Institute, an school I founded over thirty years ago. We teach a cognitive/somatic approach for the treatment of trauma and attachment disturbances. But Fries' description of her work as an analyst and of

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her own process in relationship to her patient is very familiar to me as a therapist. In what follows I try to elaborate her case study through the lens of Sensorimotor Psychotherapy, and hopefully add another dimension to understanding the right-brain to right-brain, body-to-body interaction that is so richly described in this paper.

Fries, quite successfully, tackles a challenge well known to me in my own writing: how to articulate what occurs within the therapeutic dyad as each tunes in to elements of an internal world that cannot be seen or consciously understood but are communicated and enacted beyond technique and beneath the words. This level of communication comprises an affectively laden, body-to-body dialogue involving the implicit selves of both parties.

Highlighting the dominance of the nonverbal implicit self over the verbal, explicit self in her relationship with Andres, Fries inquires into the roles of both conscious and nonconscious communications. I imagine she hopes, as I would, that the interwoven explicit and implicit journeys that take place within the therapeutic dyad will create a context that can facilitate the development of the patient's unconscious and immature regulatory mechanisms (A. Schore, 2009, in press; J. Schore & Schore, 2008).

The body speaks in a variety of languages: visceral sensations, rhythm, prosody, movement, gesture, arousal states, scents, posture, facial expression, tension, breath, physical symptoms, and so forth. Many patterns of nonverbal language have their formative roots in infancy and early childhood. Immature affect regulatory capacities are developed as attachment figures match, attune, and respond to the infant's ever-changing arousal states (Beebe & Lachmann, 1998), and these nonverbal interactions shape the infant's right brain as wall as influence his or her physical movements and structure. Infants learn to repeat the actions that evoke the desired response from their attachment figures, becoming increasingly effective at nonverbally signaling, engaging, and responding to others (Brazelton, 1989; A. Schore, 1994; Siegel, 1999; Stern, 1985, Tronick 2007). However, when certain actions are consistently ineffective in eliciting the desired response, they are abandoned or distorted. We learn to slump and keep our heads down if standing upright with our heads held high brought unwanted attention, abuse, or shame. We stop reaching out if no one is there to reach back; we cease proximity seeking behavior, such as eye contact, if such overtures were not responded to in an attuned manner.

In a Sensorimotor Psychotherapy approach, physical habits are viewed as statements of psychological history that reflects "implicit relational knowing" (Lyons-Ruth 1998)—what to expect and how to "be" in relationship. Beebe (2006) asserted, "Early interaction patterns are represented pre-symbolically, through the procedural organization of action sequences. . . . Infants form expectancies of how these interactions go, whether they are positive or negative, and these expectancies set a trajectory for development (which can nevertheless transform)" (p. 160). Potential trajectories are clearly illustrated in Tronick's (2007) Still Face experiments, where the attachment figure is directed to be unresponsive to the infant. Initially, the infant desperately seeks proximity with eyes, arms, vocalizations, and even the whole body, only to cease such actions, falling silent and slumping in the highchair, when the mother does not respond. Tronick (2006) clarified,

> The infants disengage, look away, become sad, and engage in self-organized regulatory behaviors such as thumb sucking to maintain their coherence and complexity and to avoid dissipation of . . . their state of consciousness . . . there is meaning and certitude made by and expressed in his or her posture, actions and affects. (pp. 16–17)

If nonresponsiveness recurs, the infant repeats such actions and affects are over and over, gradually developing persistent procedural tendencies and meanings that both reflect and sustain the implicit self.

Procedural tendencies of our adult patients can be inroads into troubled early histories during which interactive negotiations had been unsatisfactory and often painful. As I read about Fries' work with Andres, I was curious about the story his physical habits might tell. Perhaps he had given up standing proudly upright with a straightforward gaze into the eyes of another for a collapsed posture and averted gaze that kept him from intimate engagement with others, or prevented his being seen fully by them, or both. Given his mother's early death and his troubled relationship with his father, I imagine that proximity-seeking actions such as eye contact, reaching out, or decreasing distance were conflicted, emotionally painful actions for him, filled with meaning. Perhaps as the relationship with his analyst developed, suggestions of such actions emerged in his sessions but were truncated before they were fully executed because they were implicitly fraught with pain and fear of what might happen if proximity were achieved. Examples might be a slight opening of his hand, the beginning attempt to reach out: fleeting, inconsistent eye contact; or an almost imperceptible leaning forward toward his analyst, subtly decreasing the physical distance between them. Or did Andres demonstrate proximity-distancing actions such as physically leaning away from his analyst, flat prosody devoid of affect, absence of eye contact, or habitual gestures that convey a "keep back" or "stay away" message, such as lifting of his fingers or hands, palms facing outward?

The movements, gestures, and postures of a patient implicitly impact those of the therapist, and vice versa, eliciting corresponding actions in the other in an ongoing nonverbal conversation (Ogden, in press-a, in press-b). Fries emphasizes that the nature of bodily states is often intersubjective—we have a "feeling" or "know in our gut" certain things that we might find hard to articulate. These intuitions are, at least in part, a product of the unconscious encoding and decoding of both chronic procedural habits and the time-limited nonverbal actions and that regulate the relationship, moment by moment. A chronically puffed-up chest may reflect a need to keep one's distance or create safety by intimidating others, and such a pattern might be exacerbated when the individual implicitly perceives a breach of proximity within a relationship. This could simulate actions in the other that signal compliance or submission, such as lowering of the head or crouching of the body posture. A childlike hanging of the head or pout of the lower lip might be an invitation for care or empathy. Tensing around the eyes might convey a message of suspicion that could reflect a chronic distrust of others, or a response within the present moment interaction.

Verbal and nonverbal messages might contradict each other and can seek to hide aspects of internal experience as well as make them known. A patient's shoulders may tighten and a furrow may appear on her brow as she reports a positive experience. We often see the signs of dissociative parts of the self in conflicting simultaneous or sequential actions of distance- and proximity-seeking, as when a patient reached out to shake hands as her upper body pulled away. Andres seemed to have several parts of himself that would each be accompanied by their own postures and movements: for example the "childishly needy" part of him might collapse helplessly, while the part of him that challenges his analyst on her cultural and literary knowledge would be embodied in a very different manner.

Bromberg (2006) stated, the "road to the patient's unconscious is always created nonlinearly by the analyst's own unconscious participation in its construction while he is consciously engaged in one way or another with a different part of the patient's self" (p. 43). Both chronic procedural

tendencies and moment-to-moment physical movements and adjustments are visible reflections of this unconscious participation. Each party implicitly interprets the others' cues, and responds with his or her own, nonverbal, often nonconscious, behaviors: leaning forward, averting or holding gaze, tightening, relaxing, a deep breath or a holding of the breath—the possibilities are endless. This affective, body-to-body call and response is an ongoing implicit dialogue that exerts a powerful influence on what takes place within therapist and patient, arguably more potent than the explicit verbal exchange.

Kurtz (2010) stated that psychotherapists ought to be on the lookout for nonverbal cues he calls "indicators"—"a piece of behavior or an element of style or anything that suggests . . . a connection to character, early memories, or particular [unconscious] emotions," especially those that reflect and sustain predictions that are "protective, over-generalized and outmoded" (p. 110). In a Sensorimotor Psychotherapy approach, indicators that register consciously for therapist or patient can provide an avenue of exploration into the implicit self. Among the most fruitful indicators to explore are proximity-seeking actions, which, as mentioned before, are surely altered in some way for Andres. The simple act of reaching out to another person can be executed in a variety of styles that reflect and sustain un-symbolized meaning: palm up, palm down, full arm extension or bent elbow held close to the body, relaxed or rigid musculature, shoulders curved in or pulled back, upper body leaning forward or pulling away. Often I ask patients to simply reach out with one or both arms as a diagnostic experiment as well as an avenue for working through relational issues. One patient reached out with a stiff arm, palm down, braced shoulders and a rigid spine, while another patient reached out weakly, shoulders rounded, keeping her elbow by her waist rather than fully extending her arm. Yet another, always preoccupied with my availability, reached out eagerly, with intense need, leaning forward, both arms fully extended. All these movements reflect a childhood devoid of adequate regulation and support and the abandonment of an integrated, regulated reaching with the expectation of someone reaching appropriately back.

The following example provides an illustration of how to use the physical act of reaching out as an avenue of exploration and change.

> I was drawn to the tension in Robert's arms and shoulders that seemed to increase when he discussed his girlfriend's complaints that he was emotionally withdrawn. I asked if he would be interested in noticing what happened as he reached out with his arm as if to reach for another person. He said he immediately felt suspicious of my suggestion but was willing to try it. As he reached out with his left arm, his body reflected his words in its tension, slight leaning back, stiff movement, locked elbow, palm down. His non-verbal message conveyed his discomfort and lack of expectation of a safe, empathic reception. Robert's affect transitioned from suspicion to defensiveness as he stayed with the gesture, saying angrily there was no point in reaching out: "Why bother?" Over time, together we explored his emotionally painful early memories of a father who could abide no weakness or need in his son. Robert had learned to abandon this gesture because it had evoked disgust and criticism from his father. His therapy included learning to reach out to me in an integrated manner, arm relaxed, fully engaged, with eye contact and intent to authentically connect with me. (Ogden, in press-b)

Robert's simple proximity seeking action first evoked anger, then great sadness and grief, and finally a feeling of vulnerability leading to the beginning receptivity to trust and closeness in his relationship with me, which began to carry over to his relationship with his wife.

It is important to note that our procedural tendencies not only profoundly influence our interactions with others but also determine our sense of ourselves. A variety of studies have demonstrated

the impact of posture and other physical actions upon self-perception and experience. Stepper and Strack (1993) illustrated that subjects who received good news in slumped postures reported feeling less proud of themselves than subjects who received the same news in an upright posture. Schnall and Laird (2003) showed that subjects who practiced postures and facial expressions associated with sadness, happiness, or anger were more likely to recall past events that contained a similar emotional valence as that of the one they had rehearsed, even though they were no longer practicing the posture. Similarly, Dijkstra, Kaschak, and Zwann (2006) demonstrated that when subjects embodied a particular posture, they were likely to recall memories and emotions in which that posture had been operational.

I found myself curious about how Andre embodied his relational patterns, his view of himself, and his emotional states, because such physical indicators could be targets for interventions designed to explore the procedural tendencies related to his issues. For example, since Andres complained of depression, his torso might habitually curve forward in a typical physical pattern of depression easily detected among depressed humans and even many animals. Exaggerating this posture slightly usually stimulates associations that then can be directly worked through in therapy. Or, embodying a more aligned posture could be explored, along with all the emotions, thoughts, memories, and relational dynamics that would then spontaneously ensue. Andres' propensity to "drag himself through life" would have its physical correlate; perhaps his gait and pace of movement is slowed and plodding. Yet he is "bright and engaging," which might manifest though increased eye contact, animated prosody, or in how he gestures. I'm interested in how his body literally "hold[s] on to the nutriment he has taken in" not only through his digestive tract, but also through tension patterns, posture, and movements. Any of these physical indicators might prove productive avenues of discovery within the relationship, with the ultimate intention of helping Andres develop insight into his patterns of interaction, and cultivate new procedural tendencies that would reflect and sustain the changes that occur within the therapeutic dyad.

It takes intention, experience, and practice for the therapist to "know" which nonverbal cues are salient indicators and which are not. Indicators that we would explore would be the ones that are laden with attachment-related affect. This "knowing" is not cognitive; rather the therapist finds him- or herself being drawn to specific nonverbal cues, just as Fries describes noticing Andres' avoidance of eye contact, or that he forcefully holds himself in. It is important for the reader to entertain the idea that specific interventions of working with indicators emerge spontaneously from what transpires experientially and implicitly within the therapeutic dyad. Philip Bromberg (personal communication, December 21, 2010) stated that most characteristically he does not "plan" in advance what to do or say in the therapy hour, but rather "finds himself" doing or saying certain things that arise spontaneously from within the relationship. His words and actions are not premeditated or generic techniques, but rather are emerging responses to what transpires in the here-and-now between him and his patient. Similarly the somatic interventions I describe in this discussion "come to me" unbidden in the therapy hour. Although I can explain the theoretical rationale behind the interventions, they were neither premeditated nor consciously thought out. While these interventions are in principle "techniques," they are not generic. They never happen the same way twice, but come forth naturally and unexpectedly while both therapist and patient are subjectively experiencing each other. In other words, they are communicating their affective and somatic responsiveness to an experience of what is taking place within their relationship that is not processed cognitively but is known implicitly.

Fries writes about her own visceral responses to Andres' "uncontrollable wrenching spasms." I completely agree with her view that these reflect the "unthinkable, unspeakable anxieties" that relate to early childhood trauma, such as Andres' witnessing the prolonged death of his mother. From the perspective of Sensorimotor Psychotherapy, such involuntary spasms are conceptualized on a physiological and somatic level as having to do with the immense arousal stimulated in traumatic conditions, like Andres' early loss. Animals, including humans, typically experience uncontrollable shaking and trembling following trauma, thought to discharge the immense arousal mobilized by danger (cf. Ogden, Minton, & Pain, 2006). When we are threatened, primitive animal defenses are catalyzed. Initially, sympathetic nervous system arousal increases, designed to mobilize the "attachment cry," a desperate seeking of a safe and protective attachment figure, and/or fight-or-flight responses. If these mobilizing, active defenses fail to assure safety, immobility defenses, such as freezing and feigned death, emerge. These animal defenses are accompanied by extremes of physiological arousal. When past trauma is explicitly or implicitly touched upon in therapy, increased arousal may emerge in the form of rapid heart rate, trembling, shaking or jerky movements, which is viewed as a "discharge" of the immense energy that was initially mobilized to fuel survival behavior (Levine, 2005; Ogden et al., 2006). Patients usually experience these sensations and jerky movements as frightening and out-of-control, coupled with the terror they had felt in the original incident. In a Sensorimotor Psychotherapy approach, they learn that these involuntary movements are normal reactions after traumatic experience and can be effectively and resolved through addressing them physically.

If patients are taught to "uncouple" trauma-related emotions (i.e., panic, terror, or rage) and traumatic content from the bodily responses, their fear of being out of control often diminishes. In a Sensorimotor Psychotherapy approach, patients learn to temporarily disregard emotions and thoughts that arise in favor of focusing their attention on their physical sensations. When involuntary spasms occur, they might be encouraged to hover over their physical experience, observing it and reporting it to the therapist, following the therapist's example of becoming curious about the movements that "happen by themselves." Patients learn to "follow" their sensations and movements with mindful attention as they sequence through the body without trying to control them. The slow pace of this microprocessing, within the context of an attuned therapeutic relationship, keeps the experience manageable and safe for the patient. Usually they then find that movements resolve and settle by themselves and the body becomes calm (cf. Ogden et al., 2006).

For example, Jeanie, sexually abused as a child, came to therapy to "get rid of" feelings of being chronically overwhelmed. She stated that her body was out of control, and reported accelerated heart rate, trembling, and jerky movements similar to those of Andres. When these movements emerged spontaneously in therapy as she talked about her early experiences, Jeanie learned to set her fear and the traumatic memories aside to describe her bodily sensations and movements. As she noted the slight acceleration in her heart rate and the tingling in her arms that occurred prior to the shaking and jerky movements, I instructed her to simply notice these movements and how they changed, and little by little she learned to accept and allow these sensations without trying to control them. To her surprise, Jeanie became aware that the disturbing movements naturally and gradually settled down on their own. Rather than becoming frightened and confused by the movements of her body, Jeanie, like countless other patients, learned to mindfully observe and describe her physical sensations and movements, and found that eventually the movements resolved on their own and diminished over time.

These involuntary movements of course can resolve by other processes too, as illustrated in Andres' treatment. His jerky movements seemed to transform into more soothing and comforting movements through what transpired over time in his relationship with his analyst. Fries wrote movingly about her own impulse to place her hands on Andres' chest as his body jerked, in an attempt to calm him, which stimulated him to touch his own chest. This touch seemed to calm him down and the jerky movements diminished. I suspect unsymbolized meaning was conveyed to his implicit self through his own touch (and Fries' symbolic touch), perhaps conveying a message to him of not being alone, of someone willing and able to be in contact with him in his distress, thus providing a "missing experience" (Kurtz, 1990). If attachment figures are neglectful, children may cease reaching out for contact or help, and may also fail to connect with themselves in a nurturing or soothing manner. In this example, Andres seemed to do both—to reach for another, his therapist, (although not literally) and to physically contact himself.

Bromberg (2006) emphasized that the environment in which change can take place must be "safe but not too safe" for both therapist and patient, and this concept was well illustrated in this paper. Therapist and patient alike often find themselves at the regulatory boundaries (A. Schore, 2009) of their own "windows of tolerance" (Siegel, 1999). By working at the regulatory boundaries for both patient and therapist, the windows of both can be expanded. See Figure 1.

Therapeutic enactments, when negotiated, can also serve to expand the window of tolerance for therapist and patient. Affectively laden collision and enactments that take place at these edges of the window of tolerance occur in the realms where interactive regulation had failed in the past for both parties. The implicit selves of each may have different predictions and intentions in relationship. A session with my patient, Linda, illustrates how nonverbal actions can herald an enactment, and also can help to negotiate it. When Linda talked about her invasive alcoholic mother, her shoulders became tense, and she reported feeling "frozen" and unable to move, which increased to the point of discomfort and emotionally distress at "not being able to move." Linda had closed her eyes as she reported the tension, and at one point in the therapy hour, I leaned forward and asked her if she could make eye contact with me, hoping that this proximity-seeking action would provide the safety and relational contact that would allow her shoulders to relax and quiet her emotional distress. However, eye contact had the opposite effect; she reported, "Nothing changes in the freezing" and became more frozen, numb, and detached.

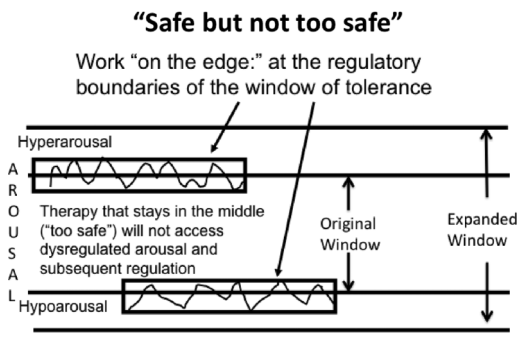

FIGURE 1 Mutual regulation of arousal within the therapeutic dyad expands the window of tolerance.

Upon reflection after the session, I realized that my leaning forward and suggesting eye contact came from the needs of my own implicit self, which had its origins in childhood when I was anxious to reach my rather withdrawn and reserved mother. Linda had grown up with an invasive mother who did not allow her daughter the freedom to set distance between them. I implicitly experienced Linda as "not letting me in," while she implicitly experienced me as intrusive like her own mother. None of this was reflectively available to either of us during the session itself, but it was clear in our physical communications. Our two histories had collided in a hand-in-glove, body-to-body enactment.

Processing these collisions of the implicit selves is possible when the therapist "'wakes up' and *feels* that something is going on between himself and his patient (a here-and-now experience), rather than continuing to *believe* that the phenomenon is located solely in his patient, who is 'doing the same thing again'" (Bromberg, 2006, p. 34). Eventually, I intuitively realized that Linda's freezing, numbing, and withdrawal was a response to my proximity seeking, such as leaning forward and even my questions, both of which she implicitly experienced as intrusive, reminiscent her mother's behavior. A few minutes after I asked Linda to open her eyes, I asked her to notice what happened if I closed my eyes. This intervention emerged intuitively, without reflection, from what transpired experientially and implicitly from within the "relational unconscious" that Linda and I had created together. As A. Schore (2011) stated, "the therapist's moment-to-moment navigation through these heightened affective moments [occurs] not by left brain explicit secondary process cognition but right brain implicit primary process affectively driven clinical intuition" (p. 1). When I closed my eyes, Linda immediately took a deep breath and at last her frozen arms began to relax, and her arousal began to return to a window of tolerance. I found myself moving my chair back away from her while keeping my eyes closed, conveying recognition of the part of Linda that needed distance, and Linda's demeanor soon became engaging and even playful. It is important to note that if Linda had not experienced my being intrusive, interactive repair could not have occurred at the depth at which it did. It is the repair and working-through of the inevitable enacted experience between implicit selves of patient and therapist that often result in the most beneficial therapeutic gain.

The processing of each person's implicit self within the relationship provides the raw material for new experiences, new actions, and new meanings for both parties. Andres would not be able to expand his window of tolerance if he did not contact the disturbing issues from his past in the here-and-now of the therapy hour or if his emotional and physiological arousal consistently remained in the middle of the window (e.g., at levels typical of low fear and anxiety states). Similarly, therapists are also challenged by what is evoked in them by their patients, often the residue of their own past histories that they thought were already resolved. This intersubjective process cannot be defined, identified, or predicted ahead of time, because it occurs within the context of what transpires within the dyad and thus requires a leap into the unknown for patient and therapist. Fries (this issue) writes that her work with Andres,

> pushes me to locate some newfound faith in the mutually moving process of feeding and being nourished. For me, this leap of faith still entails a most perilous gamble; it is a leap across a chasm of potential disappointment, yet a risk worth taking for the profoundly deep rewards available when patient and analyst together touch the vulnerabilities inherent in interdependent relatedness. (p. 589)

Indeed, this leap is risky and frightening for all of us who, by engaging deeply with our patients, open ourselves to navigating the inevitable frustrations, collusions, collisions and enactments,

often accompanied by the emotional pain reminiscent of the disappointments of our own early attachments. But, as Fries describes, these emotionally rich encounters between the explicit and implicit selves of patient and therapist take both on a mysterious roller coaster journey that is immensely rewarding in the long run. Fries and I both believe that the intimacy of this journey is enhanced by thoughtful attention not only to the verbal exchange but also to the body-to-body conversation of the implicit selves that takes place between patient and therapist.

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