Advances in the Treatment of Trauma

How to Work with Trauma That’s Trapped in the Body

with Ruth Buczynski, PhD and Pat Ogden, PhD

National Institute for the Clinical Application of Behavioral Medicine
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Advances in the Treatment of Trauma: Pat Ogden, PhD

How to Work with Trauma That’s Trapped in the Body

**Dr. Buczynski:** Hi everyone. I’m Dr. Ruth Buczynski, a licensed psychologist in the state of Connecticut and the President of the National Institute for the Clinical Application of Behavioral Medicine. And I’m so glad that you’re here with us.

It’s such an important topic and we’re very lucky today because we’re going to spend an hour with Pat Ogden. Pat has a PhD and is the founder and director of the Sensorimotor Psychotherapy Institute, an internationally recognized school that provides training in somatic and cognitive approaches to the treatment of trauma, and developmental and attachment issues.

She is the co-author of a book *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. She is also the co-founder of the Hakomi Institute.

Pat, welcome.

**Dr. Ogden:** Thank you.

**Dr. Buczynski:** Thanks for being here. Let’s jump right in because we’ve got a lot to talk about.

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### Uncovering the Root Cause: Long-Term Affects of Attachment Issues

**Dr. Buczynski:** I’d like to start by talking about the long-term effects that early attachment issues have.

**Dr. Ogden:** This is the way I think of it; both the brain and the body shape themselves according to early attachment dynamics. Even as an infant interacts with their primary attachment figures, you can see their bodies start to make implicit meaning out of what’s going on. You’ll see an infant hunch their shoulders, make a grimace, or pull back; if those actions are repeated over time, the body will start to conform to those actions.

“As an infant interacts with their primary attachment figures, you can see their bodies start to make implicit meaning out of what’s going on.”

For example, if a child is raised in a fearful state, a natural response to fear is to pull in and have their
shoulders come up. If that is consistent throughout childhood, a person might have this shape to the body in adulthood. What’s fascinating and helpful as a therapist is that those patterns in the body both *reflect* the internal state and serve to *sustain* it.

If you put your shoulders up, you start to feel a little anxious, right? You can feel it. For somebody who does this as a habit, the anxiety or fear becomes chronic.

**Dr. Buczynski:** I was reading that some of the developmental issues that result from disturbed early attachment can result in *limiting beliefs* later in life. Can you tell us if *limiting beliefs* are a frequent symptom and your thoughts on how that happens?

**Dr. Ogden:** I think we all have *limiting beliefs* because none of us had a perfect childhood. Even if parents are really conscientious and we’re securely attached, there are still beliefs in there that might not be as expansive as possible.

For example, someone might feel like they have to perform for love because they grew up in a family that valued higher education, good grades and achievement. That will start to shape the body; if your body is geared for action and performance, there might be a little more readiness to the body.

If you grew up in a family where there wasn’t enough of the right kind of support, you might have beliefs like *I don’t deserve to get all the support I want,* or *My needs aren’t okay,* or *I can’t ask for what I want.* The body might hold back, reach out or even collapse a little bit. I’ve never met anybody who didn’t have some of those left over from childhood.

**Dr. Buczynski:** How frequent are attachment issues in people that have PTSD?

**Dr. Ogden:** We know that a secure attachment is the strongest inoculation you can have against future PTSD but then as Ross said of World War II combat, “Every man has his breaking point.” Even with a secure attachment, if there is enough trauma, PTSD will be the outcome.

We know that the people who are most vulnerable to PTSD are those with insecure attachment patterns, especially
disorganized/disoriented attachment. Often a client will come in with a recent trauma, but you’ll find that their habits of response have roots in their past.

The Styles of Attachment

Dr. Buczynski: Could you briefly go over the styles of attachment and whether one of them is more related to trauma?

Dr. Ogden: Unresolved trauma in adulthood is typically connected with type D, disorganized/disoriented attachment. It’s an interesting attachment pattern in terms of the body because if an attachment figure is also the perpetrator, the child is in conflict on a somatic and biological level. The evolutionarily prepared systems of defense and proximity-seeking that go with the attachment are in conflict.

If the attachment figure is the perpetrator, a child’s body is conflicted between proximity-seeking action, seeking that attachment figure, and defending or getting away from the attachment figure. You see that in the organization of the body because you’ll see those conflicting patterns.

One action I worked with a lot for a recent patient is just reaching out, which is diagnostic because it’s a proximity-seeking action and you can get a lot of information by how somebody reaches out. She would reach out and pull back at the same time instead of just a clear seeking of proximity.

In sensorimotor psychotherapy, we want to work with those patterns and all of the issues that prevent clear seeking of another person in adulthood.

Dr. Buczynski: What are the other attachment styles? Let’s flesh them out for people that are taking notes.

Dr. Ogden: We know about secure attachment, the one we hope our children have, in which we’re able to form intimate relationships with others and depend on them and we’re able to receive their support and give support. Then there’s the avoidant pattern, with the tendency to avoid intimacy in relationships.
The hallmark of the *ambivalent attachment* pattern is when the mother is not consistently present or there for the child. The child may seek the attachment figure but be unable to take in the nourishment from them, for example. And then there’s also the *disoriented/disorganized attachment* we’ve spoken about.

**Dr. Buczynski:** Is any one of them more frequent than the others?

**Dr. Ogden:** I don’t know if any are more frequent or if any studies that have shown that there is prevalent style in certain areas.

### How Attachment Patterns Influence the Body

**Dr. Buczynski:** Let’s talk about how attachment and the body are related, because it sounds like attachment is more connected interpersonally between the child or infant and the parent.

Where does the body come in?

**Dr. Ogden:** I call it the *body-to-body* conversation between a mother and a child or any two people in a relationship. This is what’s happening beneath the words, underneath the content, in terms of how the bodies are relating. On a micro-tracking level, you see implicit meanings that are made all the time through *body-to-body*.

Even with us, right now; you’re leaning forward and there’s a lot of interest in your face, which is drawing me out. If you were leaning back a little, that would cause me to have a very different reaction in my body that would be based on my implicit *meaning-making* from my attachment figures. Based on my history, I would probably think you were being critical.

Somebody else might think, *Well, she just doesn’t understand* or *I’m a terrible communicator and I’m not getting my point across* — and all of those implicit beliefs have their root in one’s own attachment history.

In the body, you can often see underneath, beyond what is being talked about and beyond the explicit. We’re looking at how the person responds physically in relationship then reveals the implicit self.

**Dr. Buczynski:** Are there particular questions that you ask when you...
start to see someone or do you mostly watch and observe? Can you articulate how you generally start an interview?

Dr. Ogden: We’re definitely watching, observing, and listening to the presenting problem that the client comes in with, but the important point is to watch how the body participates in that problem, because it will. It has to.

I was working with a man recently, the son of a very famous Hollywood actor. He’s very depressed. He’s not able to find himself professionally or in his marriage and as he talked about that, there was a collapse in his body. This tension in his rectus abdominis that pulled his body down.

You can see how the body reflects and sustains those difficulties and we can use the body as an avenue to explore.

Dr. Buczynski: Give us a sense of how you did that with him.

Dr. Ogden: First, I named what I saw. I said, “As you’re talking about this, your body is collapsing. Do you sense that?” and he said, “Yeah, I can really feel it.” I asked him to go into that pattern and — although I didn’t say to use mindfulness, it was mindfulness — to notice what happens as he goes into that pattern. He started to get sad and memories emerged of him being alone and not having connection as a child.

The body is a quick avenue into those early memories. There’s research that says that if you embody a certain posture, you’ll start to associate with memories of when you were in that posture. There was a lot of emotional pain that we worked with; we wanted to help him find this new stance.

Dr. Buczynski: Let’s talk a little bit about disorganized/disoriented attachment.

Dr. Ogden: Think of a person in conflict between defense and seeking relationship and imagine what that does psychologically, emotionally and physically; that encapsulates the conflict between the attachment system and the defense system.
With that pattern, the trauma they experienced as a child continues to be regenerated in their brain and body. It becomes unresolved trauma and, as an adult, you have this conflict between attachment and defense. Arousal is often at the edges and out of the window of tolerance; very easily triggered and hard to self-regulate.

Don’t Fit the Person to the Theory: Respecting Your Client’s Uniqueness

Dr. Buczynski: You mentioned before that very few of us have a perfect attachment history. If you have a propensity towards a certain style, will it affect your therapy or your work as any other kind of practitioner?

Dr. Ogden: It’s a tough question because you know nobody has one particular pattern. For example, a child can have different attachment patterns with different parents. There are categories of attachment—but, in my work, you can’t fit the person into the category.

You can use attachment history and research to help understand the patterns, but I’ve worked with many people where they’re securely attached with one parent, insecurely attached with the other, and they might have a disorganized/disoriented pattern with an uncle who abused them.

I don’t think it’s clear and there’s always danger when trying to fit the person to the theory; every person is unique and the way they manifest their attachment is unique, it’s hard for me to generalize. I often ask people about their attachment history: who they feel comfortable and safe with and who they didn’t. You start to tease out these different dynamics.

For example, I had one traumatized client who felt completely secure and safe with animals in her life. She bonded to them like an attachment figure and that was a secure attachment for her. She knew what it felt like to be securely attached, just not with her parents. Her brother and father were abusive and her mother was neglectful.

How to Treat Insecure Attachment

Dr. Buczynski: Can we talk about how to treat insecure attachment?
Dr. Ogden: I’ll give you examples because it’s hard to analyze and I don’t use the AAI (Adult Attachment Interview) to categorize my clients in terms of their attachment pattern. I think that we work with the tendencies that a person has.

For example, I work with a young woman who cannot ask anybody for support and as soon as she thinks about it, her body tightens up. We could say that she has some avoidant tendencies. I wouldn’t say that she is avoidantly attached, but she has tendencies when there is a need for them. She finds reaching out aversive; she didn’t want to do it and she pulled back.

We have to remember that those patterns are learned very early on and she could just reach her arm out, but to reach out with a real need was frightening to her because she implicitly remembered what it was like when she really did reach out and nobody met her need.

“We start to work with that through the body, very delicately, because these memories are not conscious. She hates to be a child and finds it distasteful. When I ask her, “What happens when you just think about reaching out?” she starts to feel tightness in her body and wants to pull back and we’ve started to explore it. I think sensorimotor psychotherapy is of the real delights of body therapy because you don’t need the content; it’s all in the body. It all lives there and there are procedural tendencies.

Dr. Buczynski: Would you ask her to reach out in the hour you’re working with her?

Dr. Ogden: I like to work up to that. When I did ask her, she was like, “Oh no, no, no” and we just slowed down and I just asked what happened when she thought about reaching out. She started to get jittery and nervous and she didn’t want people to see her weakness and how weak she was deep inside. We worked with how she carries the sense that she’s weak and what that weak part needs.

Dr. Buczynski: Pat, can you give me a sense of what you worked on a few sessions later and how it turned out?
Dr. Ogden: Her homework was to go to her ex-stepdaughter’s performance. They had just gotten divorced, she was nervous to go and her homework was to reach out and ask a friend to go with her. She actually did it, which surprised me; that was a big step and she was surprised herself that her friend didn’t seem to think any less of her for that and was happy to go with her. This happened recently and we haven’t had another session since then.

Dr. Buczynski: How much do you use psychoeducation with the patient? How much do you actually discuss it the way you and I are talking about it now?

Dr. Ogden: Just enough so that they can understand the intelligence of working through the body.

I was working with an abused young man recently who can’t talk to girls at all; he said he had never asked a girl out, because he’s too terrified.

“... Use just enough psychoeducation so the intelligence of working through the body is understood ...”

I said “It’s like you can’t reach out and call somebody in.” He said “Right, it’s really hard for me.” We played with that and we tried a little experiment where I asked him to make a gesture to beckon me over from across the room. He could only do it as a defense; he said this is what he would do if he was provoking somebody for a fight. He couldn’t make that motion, but there wasn’t much psycho-education to it because the intelligence of it was so obvious.

Secure Ambient Attachment: Unlearning Relationship Patterns

Dr. Buczynski: Can we spend a moment talking about secure ambivalent attachment?

Dr. Ogden: I’m thinking of a woman who had these tendencies, but again, I don’t use the AAI; I don’t categorize my clients in this way.

This was actually a couple’s session where her husband was complaining about her neediness. When we worked with them, as she spoke to him she was leaning forward and clinging with her eyes and her energy. He found himself moving back away from her because there was too much intensity for him, but that was unconscious for her.
We played with it and had her back off a little bit and we saw how he reacted as she talked from a leaning back stance; he didn’t feel the need to defend against her. We do little experiments like that.

Dr. Buczynski: Did you send them home with any homework?

Dr. Ogden: She was to practice not leaning forward and living in her body when she spoke; to practice living in her back, being aware of her back and resting back in her own body and he was to practice not automatically defending. They had developed that pattern over the years.

**Drawing the Window of Tolerance: Managing Hyper– and Hypo–Arousal States**

Dr. Buczynski: You write a lot about the *window of tolerance* and how important keeping the client within the *window of tolerance* is. I think we should define that and put it in the context of the treatment of trauma.

Dr. Ogden: The phrase *window of tolerance* is from Dan Siegel’s 1999 book *The Developing Mind* and I think John Briere used it before then. I started looking at modulation of arousal in the late 80s and how, in music, you modulate from one key to another, with different dynamics and pacing — because I play a lot of music.

We first called it this *modulation model*, which has edges. If arousal is within a certain zone, not too high or too low, you are within a *window of tolerance* within which you can process information effectively without dissociating information, both from inside and from the outside.

The first step of treatment with trauma is to help patients learn how to bring their arousal into the window. If it’s too high, to help it come down; if it’s too low, to help it come up.

Dr. Buczynski: What would you do to help the patient understand that they want to do that and how they might do it?

Dr. Ogden: I always think of connecting the treatment and interventions into the goals they have. If a patient comes in with panic attacks and says that they’re revved up all the time, they can’t sleep and they’re anxious, their arousal is over the edge of the window.
So I’ll often draw the window for them and say “It seems like your arousal is up here.” And if they say yes, then I say “Let’s see how we can bring it back down into the window.” Here again, we have to look at how their body participates in that high arousal.

**Trauma: The Failure of Integration**

**Dr. Buczynski:** Pat, you’ve said that trauma is a failure of integration. What do you mean by that?

**Dr. Ogden:** That was a statement from Pierre Janet, one of my heroes, who was a contemporary of Freud’s, who worked with trauma and is considered the father of dissociation. Janet said, “Trauma is a failure of integrative capacity,” meaning that trauma is too overwhelming, too fast and it’s too intense for a person to really integrate it all. It shocks the system.

Over time, many people will integrate what happened, especially if they’ve had a secure history with attachment figures and they don’t have previous trauma. If they don’t integrate what happened, it develops into PTSD. Janet’s prospective, which I agree with, is that trauma outweighs the person’s capacity for integration.

To integrate all the emotions, feelings, images, and the meaning of all that happened is not possible. There’s a fragmentation which leads to dissociation.

**Dr. Buczynski:** Can you always see dissociation in cases of trauma?

**Dr. Ogden:** How to define dissociation is a big debate in the field.

**Dr. Buczynski:** Tell us more.

**Dr. Ogden:** Some people define it as a strong *dorsal vagal propensity* that causes a person to space out and not be there, which would be at the low end of the window of tolerance. To me, on a practical level, it makes more sense to think about dissociation as states or parts of the self that *live* outside that window.

There can be a part of a person that is constantly in a hyper-aroused zone that holds the past trauma and
tends to relive that past trauma. There could also be a part that is hypo-aroused and tends to collapse in a version of the *feign death response*.

**Dr. Buczynski:** *Feigned death response* is a concept that I associate with Peter Levine, the person who introduced it.

**Dr. Ogden:** *Feigned death* is what all animals do as a last resort response to trauma; it’s wired in our nervous system. Peter definitely talks about feign death, but it’s biological. All ethologists talk about animals that have a feign death response because it makes the body go limp and you look like you’re dead. In the wild, this prevents the predator from eating you because the predator won’t eat a dead animal for their own survival.

This is important because animal defensive responses are what’s triggered in human beings in trauma. If you experience danger, the fight or flight systems start to kick in; but if you experience a life threat that you can’t escape from or get away from, then the feign death response, which is mitigated by the dorsal vagal branch of the parasympathetic system, starts to kick in.

We see remnants of these responses in our traumatized clients. One of the ways to think about dissociation is that when a person is triggered by present day reminders of past trauma, one or more of those animal defense responses are also triggered; but if they’re just going along in life and they’re not triggered by reminders, then they’re in that *window of tolerance*.

As soon as they’re triggered, they go out of the window. That’s why I think dissociation has to do with both hyper-arousal and hypo-arousal.

**How to Expand the Window of Tolerance**

**Dr. Buczynski:** Let’s talk about how to expand the *window of tolerance*.

**Dr. Ogden:** Most traumatized patients have a very narrow window and they can only tolerate a certain kind of information or stimuli without their arousal going outside the window. So when we expand that window, they’re
learning to integrate the kinds of information that they previously couldn’t and it will begin to take more and more stimuli to get them out of their window.

There are many ways to work with them, such as helping a person learn to stay grounded or helping someone who goes into panic or hyperarousal to learn to breathe or relax their shoulders. All those interventions have to be particularly tailored to that individual. To me, there’s no one size fits all; it’s got to be particularly tailored for that person.

I worked with one woman and I never would’ve come up with this. She tended to get very hyper-aroused and as we started exploring that in her body, I was tracking ways that her body would automatically try to calm her. If you see that in the body, you can capitalize on it and they can have meaning for the person.

Her hands kept coming together; I asked her about that and it was so touching because as she felt her hands and experienced that, she was reminded of her mother who had passed away. It was a terrible death from alcoholism, alone in a slum, but her hands took her to a very positive experience of her mother.

She loved her mother’s hands, her mother had very beautiful hands and she remembered her mother’s hands holding hers. This became a gesture that she could do consciously to calm her down and implicitly trigger those positive attachment memories of her mother. I mean, who would’ve thought of that?

Dr. Buczynski: How did you come upon it?

Dr. Ogden: Because she was doing it anyway and I wondered why, so I brought her attention to it and as she stayed with it those memories are what started to emerge. The body is so wise and we can have a person really rediscover the wisdom of their own body.

Dr. Buczynski: You spend a lot of time in the present, rather than spending time talking about what happened. You stay in the present, watch someone and get curious about things like what they do with their hands.

Dr. Ogden: I do that because we’re looking for the patterns in a person that really drive the content. Of course it’s necessary to listen to the story and talk about it, but we’re more interested in how they’re
organizing that past experience to make it so present in the moment. We’re trying to get underneath the content to those patterns that hold that past in place.

Exploring Hypo-Arousal: The Last Resort Response

Dr. Buczynski: A lot of us think about going outside the window of tolerance as a hyperarousal experience, not so much a hypo-arousal. Where does the hypo-arousal come in, what does it look like and what to do with that?

Dr. Ogden: The hypo-arousal is a last resort response to trauma if there’s no escape and it has features of that feign death response. Instead of being mobilized and wanting to fight or get away, the body collapses, the muscles collapse, the face loses expression and the eyes go blank. There’s no feeling of real engagement and we see versions of that in our patients in a flaccid posture that often feels like depression.

If that immobility persists over time, it gets hard to get out of bed and I think many people feel depressed when it’s actually a consistent hyper-aroused pattern that they’ve developed from trauma.

If immobilizing defense doesn’t work, if you can’t fight and you can’t get away, as in childhood trauma, the best thing you can do is to freeze, which is a sympathetic response but it’s still immobile. Or you can just give up and that’s the hypo-arousal feign death response.

Dr. Buczynski: How do you work with that?

Dr. Ogden: One important thing is movement because this is an immobilizing response in which you’ve given up all movement. Any way to stimulate some kind of movement; just standing up can mitigate that response.

I worked with a woman who had suffered very early sexual abuse and although she didn’t remember it, she’d never had a sexual relationship in her life or really dated.

She was in her 40s when I saw her and she remembered being attracted to a boy when she was in high
school but she kept thinking, “What would happen in the dark afterwards?” She didn’t know where it came from, but the more she talked about, the more she went into this response and she said she couldn’t feel her body and she wasn’t present.

I asked her if she’d stand up and when she stood up, that is a more of resource position for your body. You have your legs under you and it stimulates being in the world and then from that posture, everything started to emerge. She felt an impulse to push, which of course she couldn’t have executed as a young child.

Then instinctual animal defense of protection came up for her and I think that’s so important to remember because we want to find those defensive pattern responses that a person has given up on and we want to elicit them from the body.

With this hypo-arousal, she had not been able to push away, but to bring that response back to her body was very empowering for her. It came from her body and I didn’t even have to suggest it; she just felt it.

**Dr. Buczynski:** Do you ever experience yourself feeling tired or less interested when you’re with a patient who is in a hypo-arousal?

**Dr. Ogden:** Yes. Fritz Perls used to talk about using our bodies as an instrument because with contagion and mirror neurons around us, we can start feeling what our client is feeling and that can be a cue for the therapist as well.

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**Using the Polyvagal Theory to Expand the Window of Tolerance**

**Dr. Buczynski:** I’d like to talk about the polyvagal hierarchy and how it can help us increase the window of tolerance.

**Dr. Ogden:** I think this was such a gift from Steve Porges.

**Dr. Buczynski:** He’s a fascinating person.

**Dr. Ogden:** I highly recommend his book, *The Polyvagal Theory*. He’s redefined the nervous system as a hierarchy instead of a balance. He talks about this phylogenetically as well.
The last to develop is the ventral vagal complex of the social engagement system, which is the myelinated vagus. It governs our facial muscles, eyes, middle ear, and larynx. Steve calls it social engagement because it’s highly engaged with others through our voice, listening, seeing, and facial expression.

If social engagement is lost in childhood, say because your attachment figure didn’t protect you or was themselves the threat, you can’t rely on it for security and the sympathetic nervous system (the fight or flight response) kicks in. But if that fails to assure safety, the dorsal vagal system, the unmyelinated branch of the vagus nerve, will take over. When there’s increased dorsal vagal tone, it leads to that feign death response and slows everything down as the last defense.

It’s important in therapy to remember that it progresses from social engagement to the sympathetic system and then there’s the dorsal vagal branch of the parasympathetic system that will lead to feign death.

The first order of business with a client is to find a way to stimulate social engagement. You’ve got to have that ventral vagal complex online to start to regulate arousal and work with those animal defensive responses.

Dr. Buczynski: How do you do that?

Dr. Ogden: It depends on the patient. When I asked the woman with early trauma to stand up, she wanted me to sit very close to her because as soon as I backed away, she experienced that I wasn’t there. Our chairs were close in that case, but with another client I had to be across the room before she felt safe and the social engagement system could kick in.

In therapy, one of the first things we work with is simple proximity and what helps the social engagement system kick in. When a traumatized person is in control of how close or far you sit, that immediately gives them a sense of safety.

Dr. Buczynski: Do you have people sit in a chair that has wheels on it? How do you do that?

Dr. Ogden: Wheels are a nice idea because you can slide in and out, but you don’t have to have wheels, just a chair that moves and that you can scoot forward or back.
Dr. Buczynski: Do you move or do you have the patient move?

Dr. Ogden: It really depends on the patient.

We might experiment with both ways. Traumatized people are so sensitive to your movements that just leaning forward can raise anxiety and being too far away or breaking eye contact can make some people feel you’re not really with them.

The Importance of Mindfulness in Trauma Treatment

Dr. Buczynski: Let’s spend a little time talking about mindfulness. Why is mindfulness important in the treatment of trauma?

Dr. Ogden: I feel very lucky because I met Ron Kurtz in the early 70s. Ron Kurtz is the founder of the Hakomi method and he taught me how to use mindfulness before anybody was even talking about it.

“We’re studying the organization of experience — the habits that keep the maladaptive patterns in place.”

We’re studying what Ron would call the organization of experience, or the habits that keep the maladaptive patterns in place; we’re not studying the contents—we’re not talking about.

If you think of mindfulness as paying attention to the present moment without judgment and with curiosity, that helps a patient study the workings of their procedural tendencies.

One of my friends who likes cars says, “You can’t take the engine apart while it’s running.” If you’re just talking and having a conversation, you can’t really study what’s happening inside.

I work with a young woman—I’ve only worked with her twice and haven’t uncovered her trauma -- who has really severe symptoms. She hasn’t been speaking in school for two years and her parents didn’t even know that she wasn’t talking.

When she came to me, her body was literally like this; her head was way over to the side and she would hardly speak. Instead of just talking about her history, we started to notice the effects of it.

She said that she’d been humiliated since she was a little girl and that she felt she had lost all of her confidence. When I asked her if she could sense that inside herself, this lack of confidence, this pattern
became exaggerated.

Through *mindfulness*, she started to realize that this held in place that lack of confidence. She would *mindfully* put her head up straight and feel what that was like, but it was too scary so she had to put it back.

It was through *mindfulness* that we worked through the pattern, not just talking about what had happened.

**Dr. Buczynski:** Do you often ask your patients to meditate?

**Dr. Ogden:** Never. I’ve taught at Naropa University, a Buddhist university, since 1985 and I think meditation can be very helpful. But when I’m speaking of mindfulness and therapy, I’m talking more about shifting attention from having a conversation to studying what’s going on in your body, your thoughts, your feelings and seeing what images come up by themselves. It’s a different way of using mindfulness and therapy than meditating is.

**Dr. Buczynski:** We don’t have any more time, but I just want to say, thanks for your work. I know you’ve been at it for a long time and you’ve explored many different avenues and done some very creative things. I just want to say thank you for all that you’ve contributed and thank you for being on this call.

**Dr. Ogden:** You’re welcome. It’s a pleasure.
About the speakers . . .

**Pat Ogden, PhD**, is the founder and director of the Sensorimotor Psychotherapy Institute, an internationally recognized school that specializes in training psychotherapists in somatic and cognitive approaches for the treatment of trauma, as well as developmental and attachment issues.

She is a co-founder of the Hakomi Institute, served on the faculty of the Naropa University in the Somatic Psychology and Contemplative Psychology departments from 1985 to 2005, and lectures internationally.

She is the first author of the groundbreaking book, *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*, which was published in the fall of 2006.

**Ruth Buczynski, PhD**, has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she’s been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she’s expanded into the ‘cloud,’ where she’s developed intelligent and thoughtfully researched webinars that continue to grow exponentially.