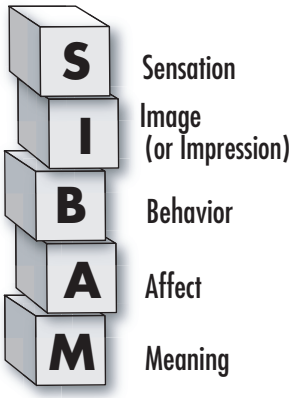
Somatic Experiencing®

Beginning Year

Module 3

SIBAM



SIBAM is a term coined by Peter Levine to denote the elements that form the gestalt of our experience. Understanding each element gives us a reference point for how flexible or rigid a client is in her responses to stimuli. It also gives us an understanding for which channels of perception are more or less available, and where there is traumatic coupling (and how it manifests). SIBAM is important because it helps us recognize what a client presents with most predominantly, and what is absent. For example, if a client comes in with a lot of emotion, but can't feel her body, then we know that she leads with Affect, but is less resourced, comfortable or familiar with the Sensation element. Or, if a client has a lot of symptoms (Sensation or Behavior) and beliefs (Meaning), but is cut off emotionally (Affect), this can help us see where we may need to build range, resource and resiliency. Our long-term goal is for people to be able to live a rich and full life with access to all SIBAM elements.

Sensation

Beginning 1 and 2 were spent primarily working with Sensation using the felt sense, tracking, and observing movement. All elements of SIBAM need, eventually, to be anchored or connected with sensation through the felt sense. Sensations relate to experiences that originate from inside the body.

Sensation comes from:

- Kinesthetic awareness
  - Muscle tension, constriction, bracing, bound energy
  - Movement impulses
- Autonomic nervous system, involuntary sensations
  - Temperature-hot, cold, warm, flushed, sweat, chills
  - Digestion- fullness, hunger, nausea, tension
  - Heart-rate- normal, rapid, relaxed
  - Viscera (organs)-intuition, gut feelings, tension, space, complex sensations
  - Eye movements
  - Respiration
- Proprioception (self-perception)
  - Where one part of our body is in relation to another and how fast we are moving
  - Joints
  - Helps us notice where we are in space
  - What our position is, information to brain about how to stabilize
- Vestibular
  - Inner ear
  - Relationship, orientation to gravity
  - Uprightness, balance, equilibrium
  - Sense of acceleration and de-acceleration

Note: Vestibular disturbances can present as nausea, dizziness, or vertigo. Often shows up when there have been falls, motor vehicle, skiing, biking accidents. This can mimic structural or medical problems and should also be evaluated by health care provider specializing in vestibular dysfunction.

When working with Sensation:

- Learn to speak in "sensation language" to access the involuntary functioning of the reptilian brain. Examples of descriptive sensation language: warm, tingly, electric, flowing, smooth, static, soft, tense, relaxed, dense, light, fuzzy, sharp, achy, dull, permeable, porous, liquid, light, bubbly, deadness, numbing, chilly, cold, hot, foggy, clear, etc.
- Help the client stay focused on sensation by carefully asking sensation-oriented questions. It takes practice to resist the impulse to get cognitively or emotionally oriented in your questioning. "Is there anything else you notice about the sensation? vs. "Why do you think you felt that way?" This latter question leads the client back into thought and emotion-oriented processing.
- Get curious about the sensation, and encourage the client to be curious about it.
- Aid the client in broadening, staying with, and savoring the sensation. "You might want to let yourself allow…explore…indulge in…"
- Expand the client's awareness of sensation: "Is there anything else that you notice about it?" "Do you notice it intensifying, lessening, or no change at all?" "Does it have a size, shape, density, location, or sense of direction or substance?"
- Build the capacity to tolerate it.
- Track how it changes and releases.
- Move things along in time. Ask questions that sequence through time and build a sense of continuity of experience. "And when you allow yourself to explore that sensation, what happens next?"
- In trauma resolution work, sensation is the central organizer of integration after the damage and disruption caused by undercoupling and overcoupling, which are inherent in trauma dynamics.

Image (or Impression)

- That which (seemingly) comes from the outside.
- An **internal** representation of an **external** sensory stimulus. Image is a translation of an outside experience to an internal one.
- External image: input from the five primary senses.
- Internal image: includes visions, dreams, metaphors, symbols – perceptions derived from internal stimuli. These images capture overwhelming aspects of experience and connect them with cortical functions, where they can be manipulated and integrated into present states. This can minimize overwhelm, and help create some resolution and reorganization (although this reorganization may only be temporary and incomplete, or dissociated from other elements of SIBAM).
- Behavior → Impulse → Image
- When external images aren't available, we move to internal ones.
- Every perceptual image has a sensory-motor experience associated with it.
- Each image corresponds to another element of SIBAM.
- Images include all perceptual information from external and internal stimuli that is not proprioceptive or kinesthetic.

The sensorium includes the five primary senses:

- Auditory-sounds
- Tactile- touch
- Olfactory- smells
- Gustatory- tastes
- Visual- sights

Memory

Parts of the brain more specifically involved in memory:

Amygdala: integrates the **memory image** of an event with emotional experience.

Hippocampus: (verbal memory) forms a **cognitive matrix** for that memory image. Not fully developed until 16-18 months, thus no explicit memory before that age.

Orbitofrontal cortex: sends messages to the **cerebral cortex**, which organizes **more complex memory**, and to the **brainstem** and **motor centers**, where survival defenses are organized. If successful, the motor behavior will be stored, for future threat use, in the brainstem centers, which retain **unconscious motor** and **conditioned procedural memories** *(Scaer).*

In working with image, it's helpful to understand variations in types of memory and the way memories are processed in traumatically-stressing situations.

Declarative or Explicit Memory: This refers to conscious learning, and information learned that can be put into words, thought about, analyzed and integrated into the larger gestalt of life. Conscious; intentional; explicit; verbal and semantic memory for facts, places, events and information (i.e., knowing *what*).

Non-declarative or Implicit Memory: (**also called procedural memory**) The long-term memory of skills and procedures. This is often not easily verbalized, and emerges without conscious recognition. Unconscious; stores acquired skills, conditioned responses, and emotional associations (i.e., knowing *how*). In charge of automatic/instinctual daily activities; relies on past experiences.

Under activated trauma states, a client may be able to function only on a procedural level without access to higher cortical, abstract or integrative/ analytical strategies.

Memory Mechanisms in Trauma

With trauma, memory will be disorganized or distorted as a result of trying to utilize present knowledge to understand or match up with stored images. This makes accurate associations difficult. Complete memories may not be available, and need to be 'pieced' together. The content or story of a remembered experience can be affected by hearing others talk about the event — such as observers, healthcare providers, family and friends, lawyers, etc.

Since the hippocampus does not come on line until about 18 months, an infant does not have the neurological capacity to store external images, even though the experiences are being perceived and imprinted in other ways. This is why early memory is implicit and more motor-sensory than image-based.

Retention of procedural memory in the freeze may well serve as recurring internal cues for recurring patterns of activation, which alternate with numbing and dissociation, showing PTSD as self-perpetuating.

Damage to the hippocampus, typically associated with PTSD, can lead to an inability to store new conscious information. It can also produce hypersensitive responsiveness to environmental stimuli.

When working with Image GENERAL

- Ask questions to gather details.
- Anchor images in the felt sense, the physiology, or bodily experience. Often image suggests a direction. Track for what the body wants to do in response to the stimulus. The client reports a tension pattern of feeling as though his head is in a vice grip or he sees the vice grip: "What might your body like to have happen with the vice grip?" "If anything were possible what would you like to have happen?"
- Move between image and sensation. By asking a client to connect an image to a sensation, you are creating some distance from the sensation, which makes it more tolerable.
- Direct the client's attention back and forth between the image perceived and the client's body sensation. "As you see the image, what happens in your body?"
- Determine whether image is a resource, or is activating. Is the image comforting, or unpleasant?
- Search for more pleasurable images to use as resources.
- Help the client integrate or connect images, behaviors and affect, and take them to the body experience or felt sense.
- Dreams, visions, fantasies, imaginings come from the "inside". These are internal images. Connect these to sensation and behavior as clients report them.
- Memories are state-dependent, so you can work with symptoms if no image is available. An image may then emerge. In this case you would be working with the internal imprint manifesting the "hidden" image as a symptom – often in the form of constriction.
- Image can be used to help with titration. For example, looking at a scene through backwards binoculars helps distance a client from the intensity of overwhelm.

When working with Image

- Intrusive images related to traumatic events are highly charged, constricted, and compacted.
- In general, it is important to expand the image - working center to periphery. "What else do you see?" "Is there anything else you notice about the image?"
- Often the image may start out fixed or frozen when working with an intrusive or recurrent trauma-related image. Does the image change or unfold?
- Invite the opposite image by suggesting the opposite image jump out without thinking about it. This technique is especially useful when the image is strongly fixated or stuck. "As you see the image of the fierce, bloodthirsty monster…without thinking…what's the opposite image?"
- Visual disturbances may arise related to the activation associated with the trauma itself, and may resolve as the event is worked through. Symptoms may include avoidance of looking a certain direction, temporary blindness, blurry vision, non-convergent eye coordination, aches in or around the eyes or occipital region in the back of the lower skull.
- A significant image may be obviously lacking. This indicates dissociation and intense activation. Do not push restoration of the image. It will come back as the associated activation is lessened.

When working with Image

- Create a competing or neutralizing sound experience. When working with intrusively loud or harsh sounds such as the crash of automobiles colliding, or an angry parent yelling, it may be helpful to have the client switch focus to a sound that he or she finds comforting or soothing such as a babbling brook or children laughing. Bring the client's awareness of the anchoring sound into the body experience.
- Loud, shrill, harsh sounds or unpleasant associations fused with certain sounds can flood the system and cause a breach in the stimulus barrier. Later, similar sounds can act as triggers to activate trauma-related arousal and threat responses. The typical example is the Vietnam vet, formerly exposed to the excessive decibel level of heavy artillery in combat, who now instinctively dives for the safety of the ditch when a car backfires nearby.
- Soften the excessive sound through imaginary resources such as earmuffs, soundproof glass, shields, etc. This strategy enhances the client's sense of control through the use of a buffer or shield for sound.
- The client may experience directly how the ears attempt to block out the sound in the Eustachian tubes. Often a crackling sound will be heard as quite loud inside the client's head as the tubes reopen and gradually relax. Ringing in the ears, or loss of hearing in one or both ears, may become symptoms.
- Lessen the impact of the undesirable sound through suggesting the client determine the distance they need. You might also suggest the possibility of a volume control dial. These possibilities provide resources of control and space.
- Due to flooding during boundary rupture caused by trauma, "in" and "out" can become confused. A client may have heard a surgeon express: "He's not going to make it." during an operation and the client might hear the sentence aloud inside afterward. "I'm not going to make it."…and experience the accompanying terror of death, even though he has already successfully survived the surgery.

When working with Image  TACTILE

- It is important to help the client distinguish between inside and outside. "When he grabbed your arm on the outside, what did you feel inside your body?" Note: If the client is dissociated, do not ask what they feel in their body.
- The client may need to re-experience the type of touch that was disturbing in small doses and within his or her state of readiness. Sensations might include a sense of pressure applied, skin temperature or condition such as cool, warm, hot, sweaty, slimy, dirty, gritty, smooth, clean, soft, rough, etc. It is useful to move back and forth between the activating touch and other experiences of soothing touch and to experience both in the inner felt sense. This aids the constricted sensation related to the trauma to expand, neutralize, and dissipate.
- Aid the client in developing an appropriate desire to touch or a sense of discrimination between safe and unsafe touch when appropriate. "And when you feel the desire to reach out and touch your friend, what happens in you?" "And when you felt the gentle touch of your partner that felt safe, how did you know in your body that it was safe?" (If the client is a child, have the child focus on the adult's behavior instead.)
- Help the client become receptive to safe, nurturing touch if it is a missing resource. "Remember a time when someone you like touched you in a comforting way. What was that like for you? Imagine that safe person here with you now…what happens in your body?"
- Distinguish where and how the client feels safe having personal physical contact. "If your partner that you feel safe with could touch you in a gentle and reassuring way, where or how would he or she make contact? As you imagine that possibility, what happens?"

When working with Image  OLFACTORY (Smell and Taste)

- Contrast desirable and undesirable examples of smells and/or tastes. Switching back and forth while tracking sensation helps the client move through the distasteful experience and complete it.
- Tease apart overcoupled smells and/or tastes from traumatic experience one at a time. Proceed slowly and titrate as needed to discharge the activation.
- Pleasant tastes and smells vary with the individual. Useful possibilities might include essential oils, flower and fruit fragrances, favorite foods and/or the freshness of outdoors.

Behavior

Behavior is any activity observable from the outside of the client, including verbal and non-verbal activity.

Verbal—words, sounds, vocalizations, expressions, tone of voice, cadence and inflection of speech, pitch and rapidity, etc.,

Non-verbal—includes movement (gross motor and micro-movements, voluntary and involuntary), posture, gestures, facial expressions, character structure, muscle tone, eye movements, breath, skin color, gait, motor tics, etc.

Types of behaviors:

(Starting with the most conscious, to those that are generally unconscious)

- **Voluntary movements**
  - Movements that are controlled by will
  - Gestures, rocking
  - Voluntary movements can become habituated over time and become unconscious. These are not exactly involuntary, but happen without volitional or cognitive recognition. These gestures are often important to work with.
- **Emotional expressions**
  - Includes facial and bodily expressions of anger, fear, shock, joy, relaxation and settling, etc.
- **Postural shifts**
  - Intentional movements, slouching, collapsing, bracing, tilting of head, etc.
  - Preparatory movements for flight or fight. Readiness – the intentional movement prior to the gross movement.
  - Stiffening into freeze
  - Posture expresses affect
  - From gestures, the impulse can be inferred
- **ANS responses**
  - What is observable: yawning, sweating, burping, tears, tummy gurglings, goosebumps, swallowing, change in skin color, shaking, trembling, acceleration of heart rate, shift in breathing pattern, pupil dilation, limp limbs, stillness
- **Archetypal gestures, mudras**
  Symbolic behavior is that which unfolds organismically as if from the collective unconscious. These behaviors appear to be mostly involuntary, and have a unique quality. They are recognizable when pointed out, but often the client is initially unaware of moving into a symbolic gesture or pose. Bring your client's awareness to the gesture when appropriate, as these are very deep resources that often reflect completion of renegotiation.
  - Spiritual mudras: include hands with fingers touching in prayer, open palms facing upward receptively, etc.
  - Archetypal movements or gestures: Classical archetypes that are recognized across all cultures ("warrior stance", "mother holding baby", etc.).

Working with behavior:

- Slow movements down, so intentional movements have a chance to organize and become more apparent. Look for subtle signs of significant movements.
- Bring awareness to the impulse to move. Learn to track the intentional movements of orienting and protection.
- Bring awareness to non-verbal cues (don't do this too much, or the client will start feeling too observed and may inhibit themselves).
- Slow the vocalizations.
- The tone and expressiveness of the voice can tell you how connected to the self the client is.
- Exaggerate micro-movements, or encourage a client to allow the body to move itself. This uncouples fear from immobility.
- Tension and intention: The tension pattern related to intentional or preparatory movement precedes the impulse. You could think of tension as a suspended action or an underlying impulse with the brake on. Tease out the impulse. As tension is released, the joints are freed up to express hidden movement. The covert becomes overt.
- The intentional "rehearsal" pre-movements become overwhelmed in trauma and, due to the extreme nature of the event, often are stored in somatic memory as internal cues that were unsuccessful. Therefore, they will not be called upon to deal with future threat. The organism is always attempting to learn what worked and what may have caused harm. "You were doing this, and caused that to happen, which caused that to happen…so don't do that again." This information, which may in part be accurate, gets stored in the hippocampus and amygdala inhibition system, and patterns that were tagged as dangerous will not be chosen again. These become behavioral deficits for future threat.
- Many autonomic shifts are observable to the experienced physiological tracker.Notice skin tone changes, pupil dilation, goose bumps, sweating, breathing pattern, pulse, posture settling, etc.
- Autonomic shifts allow for effective mapping back and forth from behavior to sensation. Then there can be communication and joining at a deep, reptilian level.
- Goal: bring to consciousness that which isn't yet conscious.

Affect (Emotions)

Types of Affect:

- **Categorical emotions** (Darwin)
  - Fear, sadness, anger, joy, disgust
  - Rage, terror, shame, helplessness- these are common to trauma
  - Love, connection, support- often missing in trauma
  - Strong emotions can become addictive, especially if their expression functions as a release for excess charge cathartically – whether acted out in the client's personal life or inappropriately induced in the therapeutic environment.
- **Nuances or contours of feeling**
  - Subtle shifts in our internal landscape
  - Pleasures, soft moods, warmth, agitation, elation
  - Awareness of the subtlety of experience of affect can have a titrating and integrating effect on traumatic renegotiation.
- **Primary Emotion:** A fresh emotional response to something, even though it may be related to a trauma that happened 20 years ago. The primary emotion response reveals a new feeling about it. It has a fresh, new, spontaneous quality.
- **Secondary Emotion:** Describes stuck sequences of emotion. The pattern of response remains recurrent and un-evolving. There is the feeling of sameness and re-enactment. It feels repetitive, fixed, old.

Other Considerations in Working with Affect

- The ability to feel and express emotions can become affected by ANS disorganization. The ANS is a mediator of feeling states and can compromise emotional resiliency. When the ANS is disorganized or dysregulated, the experience of helplessness, panic and confusion is heightened.
- Changes in hormones (in the endocrine system), neurotransmitter levels, and in postural shifts (in the neuromuscular system) all have an impact on emotions.
- Hormonal shifts during puberty, the menstrual cycle, and around menopause obviously affect emotions. Anxiety is one of the most common symptoms experienced during peri-menopause and menopause.
- Changes in muscles, caused by postural shifts or in the overall tone (flaccid vs. rigid) of the muscles, can determine how safe someone feels. Consider how the posture of standing or sitting, slouching or lying down changes feeling states.
- Being overly tired or stressed also affects emotional states.
- Medications, recreational drugs and addictive substances can all have profound effects on emotional states.
- Changes in the endocrine system and brain function due to prolonged stress, illness, or phases of lifespan development can bring fragmentation or undercoupling (and associated symptoms) to the surface.

- When there have been problems with early attachment, or physical or sexual abuse in the family, love, fear, hate and survival needs all get very confused. We need to separate each feeling from the survival responses and get to the impulses underneath. There will be the biological need for closeness and connection that is disrupted by the need to run away or protect. These involuntary survival impulses are overridden when a loved one is the perpetrator, and need to be teased out. Rebuilding the person's faith in their ability to protect themselves, even with a family member, helps restore a sense of personal power and safety.
- There is also likely to be grief, disappointment, rage and shame. A survivor may go into denial about love or about having wants or needs; sometimes hatred is easier to feel. The need for love may need to be teased out so that healthy relationships can occur. Getting in touch with love can restore a person's capacity to trust and connect. We move between all of these complex layers while tracking the physiological reactions in order to increase the client's ability to tolerate all feeling states without overreacting, making false meaning or dissociating.
- The viscera have a significant influence on affect through the polyvagal system. This will be explored in greater depth in the Advanced year of the SE training.
- Infants make facial expressions for fight and flight, including biting, snarling, grimacing, turning away, spitting, etc. This can be especially evident with attachment disorders that emerge as symptoms as the infant grows and develops around the disorder. Or, we may see a freeze in the face and social engagement system, with little facial expression.

Working with Affect

- Tracking and resonance—a client might be too dysregulated to track their felt sense. Using your resonance and tracking them through physical observation (visually and by what they say) can help your biofeedback (offering them information about changes you perceive).
- Uncouple fear/terror from immobility.
- Sensations may or may not emerge logically, sequentially or linearly.
- Slow the vocalizations.
- A client might get lost or stuck in sensation (overcoupling sensations) and you can find yourself chasing symptoms (often this happens with chronic pain). Image can help increase their ability to track.
- Anchor affect in the physiology. Break the emotion down into its components and return to sensation. "When you feel the fear, where do you feel it? And, when you feel the fear in the pit of your stomach, how do you notice it physically?...cold?...dry?"
- Most often it is suggested to avoid cathartic processing in order to reduce the risk of flooding.
- When the client's emotional expression is shut down almost entirely (alexythymia), do not push for emotional response. Most likely emotional impulses will appear first and it is a good idea to suggest to the client to proceed slowly and at the body's pace. Much like the development of intentional movements, as the impulse itself has time to re-establish itself gradually and the arousal can disperse, the related emotional expression will return.
- Goal: to connect to sensation and to track the physiological shifts that occur when an emotion arises or changes.
- We look to restore basic survival responses through basic affect. Remember that the reptilian brain communicates in "feels like" and is not often meant to be literal. Be careful that you do not make suggestions to the client that could introduce the possibility of false memories. "Feels like" may take you to an image or another sensation, and in either case, gives you more valuable information along the way toward reintegration and renegotiation.
- When working with a felt sense affect, such as feeling tones, encourage the client to deepen and settle into the experience rather than going back to sensation immediately.
- It's important to have an emphasis on expansion and to develop the client's sense of, and capacity for, containment.

Meaning

- The attempt to label or make sense of experience, rather than just having it.
- Strong emotions or sensations lead to meaning making.
- Beliefs, ideas, judgments, thoughts, analysis, interpretations, symbols, etc.
- Meaning is often expressed through words.
- Sensory-motor disorganization is put into words and thoughts as a strategy for distancing oneself from the overwhelm, and to avoid activation and fragmentation.
- Meaning is often "fixed" or limited and constricted.
- With a dysregulated ANS, it is common to have the internal experience, and consequently the belief, that "I am bad". We don't naturally distinguish between "my body feels bad" and "I am bad". Children are particularly susceptible to making this type of meaning.

Working with Meaning

- When meaning becomes locked in with the threat response and the possibility of danger, it can become fixed and limiting. This is a time when the client needs to be maximally open to options that might enhance safety or escape.
- Talking cognitively about meaning that is associated with trauma will be minimally useful. At times, it is important to point out a client's misinterpretations point blank. "It was not your fault that you were assaulted." "You were a child then and could not know the options you know now as an adult."
- It is essential to work with meaning in a way that connects it to sensation. "And you have the thought that…What happens in your body when you have that thought…"
- It is best when new meanings spontaneously emerge from direct sensory experience, i.e., "I can tolerate this sensation".
- When meanings shift into new insights, this reflects a sign of healing. This usually happens in stages, not all at one time. New meanings are life affirming, fluid and flexible experiences in the body, without denial of the danger and difficulties inherent in life.
- Many times, reframing meaning can un-fixate a trauma-induced phobia or belief.
- Usually, the new resilient perspective occurs after working the material through sensation, which is generative and facilitates self re-organization. New meaning will emerge naturally out of reorganizing the SIBAM elements.

Coupling Dynamics

Coupling refers to an association between a stimulus and a response.

In SE, coupling dynamics refers to the relationship that different aspects of SIBAM have with one another. It also refers to the response of the nervous system to a stimulus that it perceives as similar to a prior trauma experience.

Healthy Coupling Dynamics

Healthy coupling between different elements of SIBAM can be defined as flexible, variable, congruent, and non-fixated in relation to arousal and activation. While elements of SIBAM may link together, they are not stuck together. This allows for curiosity, multiple possible outcomes, creativity and staying within the range of resiliency of the ANS. Healthy coupling dynamics do not produce trauma, since they can be uncoupled, deactivated and discharged.

For example, a person is walking across a street, hears the screech of brakes, and has a surge of ANS activation. Her entire body tenses as her movement briefly arrests; she orients toward the sound by turning her head, and she darts across to the sidewalk. She stops, stares, feels her heart racing, becomes very warm and clammy, begins to shake and breathe heavily, and realizes she feels scared and relieved simultaneously. She begins to have tremors, feels wobbly in the knees, sits down and shakes for several minutes. After crying, her body relaxes, she lies on a bus stop bench and rests. When she gets up she says to herself, "Wow, that was a close call." With that thought she calls her boyfriend, who is supportive, and says he'll meet her at the café. She feels better, her ANS and physiology normalize, and she walks to the café feeling fine. When she retells the story to her boyfriend she is able to chuckle about it and doesn't feel activated for more than a brief moment. The elements of SIBAM (physical behaviors, affects, sensations and image) have uncoupled.

Traumatic Coupling

Traumatic coupling refers to activation due to a trigger that leads to traumatic symptoms. There is not flexibility, choice or variability in response to the stimuli, and responses are not congruent with the stimuli. Any element of SIBAM has the potential to trigger symptoms of traumatic activation through coupling. This is like a well-worn loop, or a record that skips.

Trigger/cue/perceived threat ➡ arousal ➡ activation ➡ symptoms

Triggers are perceptual cues from the five basic senses: sight, sound, olfaction (smell), gustatory (taste) and touch, in the form of images, thoughts, beliefs, movement, memories (conscious or without content).

Usually, traumatic coupling is a mix of overcoupling (over-association) and undercoupling (disconnection/dissociation) in which elements of SIBAM become either fused/disrupted or split apart/disorganized. Disorganization occurs at the reptilian brain level. Traumatic coupling can happen locally or globally. The purpose of both overcoupling and undercoupling is to keep activation down in the system in order to avoid or minimize overwhelm. Energy is released when two or more undercoupled parts are brought together, and energy is released when two or more overcoupled parts are taken apart.

Overcoupling

Overcoupling is a fixated pattern or sequence of two or more elements in SIBAM in response to activation. It is the result of elements of SIBAM rapidly associating with one another without choice. The elements become bound together and over-associated. The overcoupling binds survival energy, so is associated with high levels of arousal. It is often the first response that happens in trauma: parts stick together in rapid succession.

A stimulus leads to a whole series of reactions:

This overcoupling may occur within elements of SIBAM:

- Image: "Every time I see that place in the road, I see my son getting hit by the truck."
- Behavior: You notice that each time your client begins to work with completing a specific defensive movement, she begins to rock and tilt her head from side to side.

Or it may occur across different elements of SIBAM:

- Meaning and Sensation: A person may think, "It's my fault" (meaning); then there is a constriction in the diaphragm (sensation).
- Affect and Behavior: The client feels frightened by his symptoms, which express as anger (affect). He is unable to contain the anger and lashes out at a friend (behavior).
- Sensation and Behavior: The client feels constriction in her arms and spine (possibly as a signal of thwarted defensive gestures), but keeps clenching and unclenching her fists as a way to limit the sensation of tightness.

The pattern of overcoupling becomes fixated and predictable, but the overcoupling typically happens so rapidly that most people are completely unaware of these overcoupled elements, and how complex they are. As you slow down the overcoupling, activation increases, so it is often (but not always) followed by undercoupling.

Signs of Overcoupling:

- "All roads lead to Rome" phenomenon: *This* is always followed by *that*, so it seems as though there is no way out.
- Constriction: Overcoupling always goes with constriction. When there is arousal, some part of the body may automatically constrict. These constriction patterns may be global or local.
- Multiple responses or symptoms are so linked that they seem to be one thing.
- There is limited differentiation. It may be difficult for the client to differentiate elements of SIBAM — a feeling is the same as a sensation; one sensation is the same as another.

Working with Overcoupling

- Uncouple fear from immobility.
- Help the client gain awareness of the sequence of overcoupled responses.
- Track the first trigger and catch it before it "couples" to the next part of the sequence.
- Stretch out the response; slow it down; ask for details.
- Backtrack: Educate the client; let him know the body can remember the sequence: "What happened before that happened; and what happened before that", and so on.
- Separate (uncouple), name, and notice each element as a way of breaking up the sequence/pattern. When this happens, a little of the energy bound in the overcoupling gets released. This allows new options, choices and meanings to become possible. Allow time for settling and integration before going to the next titration (ideally).
- Change to another "channel", or element of SIBAM: "Let's come back to this later."
- Physical constrictions may also contain thwarted defensive and orienting responses. Watch for the emergence of intentional orienting and defensive responses, and support these as the constriction eases.
- Support with one's hands where the overcoupling is, where the constriction is, if it is manifesting as a physical pattern.
- Bodywork: Anything that gives a slight expansion through movement is usually helpful.
- Invite movement, or suggest a specific movement.
- There is often a predictable sequence of sensations that occur before the onset of overcoupled symptoms, such as migraines, seizures or panic attacks. Observe the sequence carefully, and work to deactivate the charge early in order to interrupt the sequence and keep the symptoms from progressing to their full-blown expression.
- Reassure, educate, and normalize the client's experience. This helps to uncouple the fear from the discharge state, and helps the discharge to complete.

Other Considerations in Working with Overcoupling:

- It is possible that multiple overcoupled sequences, or elements with no apparent sequence, may emerge simultaneously. In this case, choose one part or sequence with which to work, otherwise the client may be overwhelmed. As you pick apart various components involved in the overcoupling, there may be a reassociation of those elements in the client's awareness. That awareness alone can bring a new level of charge into play.
- In negotiating the overcoupled elements of SIBAM, the client may "dive" or spin off into places in which s/he is overwhelmed or not anchored. The secret to working with overcoupling is to slow the process down to limit the possibility of the client moving rapidly into overwhelm. If this progression into overwhelmed states happens, apply whatever first aid techniques are needed to calm the client and use his/her resources to decrease the overwhelm and anchor him/her. (e.g., open her eyes, invite slower breathing, instruct to slow down and take it easy.)

- As you work with uncoupling the elements of SIBAM, activation will emerge because the constriction associated with it binds survival energy. As the constriction begins to ease, the bound activation will reappear.
- In the trauma renegotiation process, it is common to move from overcoupled responses to undercoupled responses and back again, so you will often see a mixture of indicators of both types of coping strategies.

Undercoupling

Undercoupling is a lack of coherent connectedness among and within the elements of SIBAM. The psyche distances the elements away from each other in order to handle the overwhelming experience. SIBAM elements are fragmented. This may include a full-body dissociation, or absence in one part of the body, in a certain sensory channel, or a memory, etc.

Undercoupling is adaptive, but lack of sensory integration drives PTSD. The intense arousal interferes with information processing and memory storage. The person may look calm, but undercoupling/dissociation is actually a state with extremely high levels of bound energy. Undercoupling is preceded by overcoupling and constriction in an attempt to not fragment and hold oneself together. As undercoupled elements reassociate, activation increases, so undercoupling is often (but not always) followed by overcoupling.

Levels of Dissociation/Undercoupling: (Per Bessel Van der Kolk in Traumatic Stress)

Primary: Here the elements of experience separate. This may manifest as one part of the body, as discussed above, or one element of the experience being undercoupled. Examples: The memory is there, but affect is missing. The emotion is present, but there's no actual memory. The scene of an accident may play over and over in one's mind, with accompanying emotions, but the bodily sensations may be absent/undercoupled/dissociated. It's common for trauma survivors to have undercoupled, absent memories, and these sometimes express as nightmares, flashbacks, or strange bodily sensations.

Secondary: De-realization, depersonalization, sense of "not me".

Leaving the body and observing it from a distance. Depersonalization in which perception of the environment seems unreal. This allows the person to observe the event as a spectator. It limits pain, suffering and distress, and protects the nervous system from the full emotional and physical impact of the event. The perception of the world is unreal; people may report that things are waving in front of them; the room starts to close in; there may be colored hazes; hearing becomes distorted; the perception of others is distorted.

You can dissociate in or out. Babies and even adults may go "way deep inside" to withdraw from the environment. They're not dissociated from themselves, but they are separated from the outside world and often numb emotionally. They may find refuge inside.

Tertiary: DID, distinct ego states that contain the traumatic experience. Generally a more fragmented state of dissociation than primary and secondary states. It represents a failed attempt to prevent fragmentation and is a very disorganized and dysregulated state of the ANS.

Signs of Undercoupling:

- The client often will seem at least slightly dissociated, spacey, foggy. Physical or emotional numbness. Dissociation is an aspect of undercoupling in which there is a high level of stress response and stress hormones, as well as both sympathetic and parasympathetic tone.
- There is fragmentation – aspects of SIBAM do not seem to go together. There is no sense of coherence. There is no discernible pattern. Example: Pain that jumps around to different locations.
- Feelings may be undercoupled: you may see fear in a client's face but they have no awareness of it.
- The client may feel energy in their body, but the impulse to flee may be undercoupled or unavailable.
- There may be a disconnection, or walling off, of any element of SIBAM: it may be almost completely unavailable to the client. Examples: Body feels numb, cannot even feel when you are touching them; has trouble tracking sensation at all; when asked to provide a word or image that matches their experience, they cannot find one.
- There may be disorientation in time and space.
- Client may have poor boundaries and read social cues inaccurately.
- The cognitive presentation can be quite confused and difficult to follow.
- Body looks collapsed, muscles seem to have little tone – this can be local or global.
- Again, undercoupling may be followed by overcoupling, so you may see symptoms of both.

Working with Undercoupling

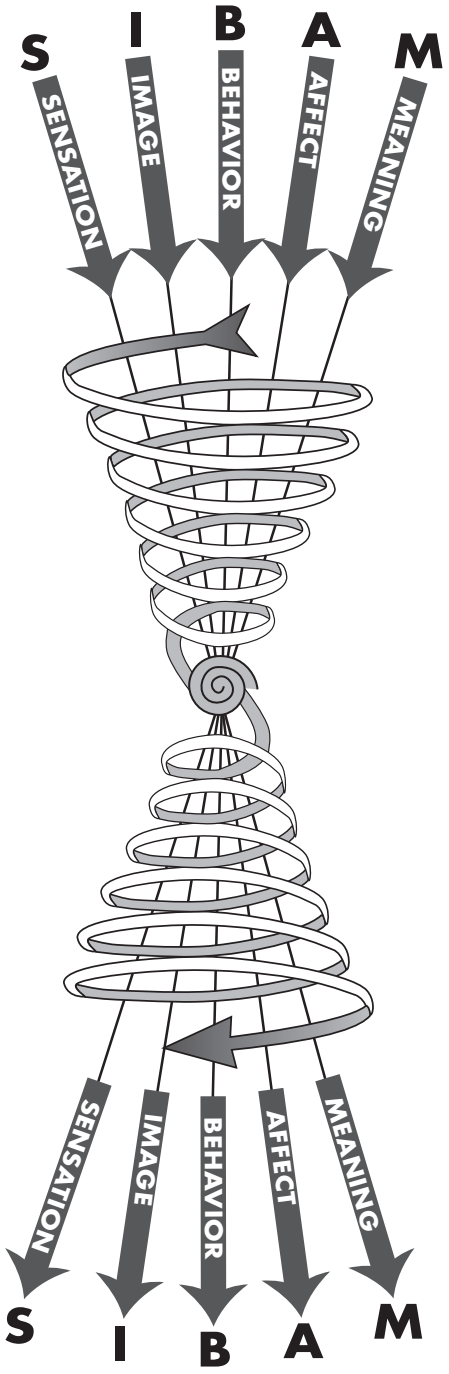
- Build connections; bring the pieces together; re-associate. Like putting together a jigsaw puzzle: build the edges, borders, container. Work to re-associate one or more pieces that make some sense to you as a possible connection. Associate elements that are presented in the current session with pieces that were presented in past sessions.
- Notice connectedness through similarity. Track for connections.
    - Think of different elements of SIBAM as being *complementary* or *similar* to each other. A feeling, for example, may be associated with an image that expresses the same experience. Help the client notice these similarities between different elements of SIBAM.
    - Think of *different* pieces of the *same element* of SIBAM as being *complementary* or *similar* to each other.
    - The client may not notice the connection between these elements, but if both can be held in their attention, they will sometimes cohere and re-associate.

- Release the activation slowly, as there's a lot of charge in each fragment. There's a risk of rapid overwhelm and activation as pieces come back into awareness. Ensure that the client is not reassociating too quickly and therefore releasing too much bound energy at once. Undercoupling exists to avoid overwhelm, so you need to pay close attention to working with very small and manageable levels of activation. Expect increased activation as undercoupled elements reunite. As constriction that is concurrent with or underlies the undercoupling emerges, further activation is likely – as is fragmentation. Sometimes, the felt sense is unavailable, and other channels of SIBAM need to be emphasized. However, anchoring experience in the physiology is imperative to provide context, containment and cohesion.
- Educate: Help the client understand the need for reassociation and restoration of the relationship between undercoupled elements. Also help them understand that activation will reappear as undercoupled elements reassociate.
- Establish the here and now, present time, present age. Orient to the room, to the chair, to the floor.
- Look for what is missing.
- Track the areas where there is sensation. Stay in the felt sense through sensation; this helps to reestablish continuity.
- Re-establish body boundaries
- Work backwards to the constriction (overcoupling) that triggered the splitting off
- Sense into the numbness, move between that and an area of sensation.
- Change channels (elements of SIBAM).
- Procedural memory helps to connect the fragments.
- If the client begins to focus on the story, or the emotions related to the story, invite them back to the felt sense: "What happens in your body when you feel that?"
- As a client re-associates, they may experience pain, anxiety, constriction and other symptoms that have been disconnected from their awareness. It is important to normalize this. It happens because you are working with survival states, and the terror that accompanies these states. Uncouple the terror from the immobility/freeze.
- Help to contain using imagery, touch, slow micro-movements. Classical and other types of music can be recommended for use at home.
- Distance the disorganization using images that give it a higher cortical function, and decrease the engagement of the reptilian brain (or give it a chance to develop new meaning as re-organization and integration take place). Work very small amounts by bringing elements of SIBAM together slowly.

  For example: Ask the client to allow only 5% of himself to sense the area to his left where the car came from, or to sense only 5% of the area to his left. Or, "If you look at the scene through a backwards set of binoculars-----".

Undercoupling, Overcoupling and Resolution

It should be clear by now that there is no such thing as working only with overcoupling, or undercoupling. Both are simply opposite ends of the spectrum of managing high levels of activation. Clients who have at least a minimal capacity for self-regulation will tend to move between over- and undercoupling as a part of the natural process of trauma renegotiation. Some clients are more frightened by overcoupling, others by undercoupling. Educating them about this natural process helps to remove, or at least lessen, the fear when these sudden changes occur.



Again, remember that in working with both overcoupling and undercoupling, there is release of bound survival energy. After each titration, care has to be taken that this released bound energy is discharged, and that time for integration is provided. Ideally, in the process of trauma resolution, one piece after another enters conscious awareness, activates the organism, and with adequate resources and support, is integrated in such a way that the organism moves toward more wholeness, capacity, and resilience.

Not all altered states are dissociative. People can use altered states to go away from something, they are not necessarily dissociating in the classical sense of the term. Some of these altered states are much better than dissociated states. They're just removed from a certain experience, and it's perhaps better for them. We're defining dissociation as an attempt to manage an overwhelming experience. Often it is associated with the freeze, which means there is a high level of stress and stress hormones in the body, and the sympathetic/parasympathetic systems are maximally engaged, and/or there is a great deal of cortical motor inhibition manifesting as constriction or flaccidity in the muscles. In meditative states, people are very relaxed, including in the ANS. Not all altered states will be this way. If you bring some people into the body out of the altered state of meditation, they go into a freeze/dissociated state. In freeze, there are three components: high levels of stress hormones, engagement of both branches of the ANS, and motor rigidity or flaccidity.

So you can see that the body would rather move out of this freeze state toward an altered state that regulates the body toward health. That is why sometimes people who habitually use altered states to regulate their traumatized physiology find it very difficult not to go into the altered state in the face of traumatic activation. They are moving toward health by going into the altered state, but they are not necessarily embodied in relation to the trauma. They're only embodied to the extent that the altered state has regulated them back to some health outside the traumatic freeze, but they have very limited ANS resiliency.

Joining vs Merging: The Empathic Process

Merging touches our own unresolved issues, our counter transference. Our unconscious takes over. We are susceptible to merging when the client comes with need and no boundaries. Merging is an unconscious process.

Edith Stein describes the Empathic Process (as opposed to empathy) as a 3-stage process "in which foreign experience is comprehended." *(Stein, E. "The Problem of Empathy", 1916)*

The diagram below demonstrates the difference in relationships:

1- separate individuals with clear distance between them, such as when a practitioner and a client are just starting to work together;

2-unconsciously merged;

3-the individuals are clearly in connection, but have distinct boundaries.

This is not a consciously controlled process, but it can and does occur. Bodyworkers may need to be particularly aware of this.

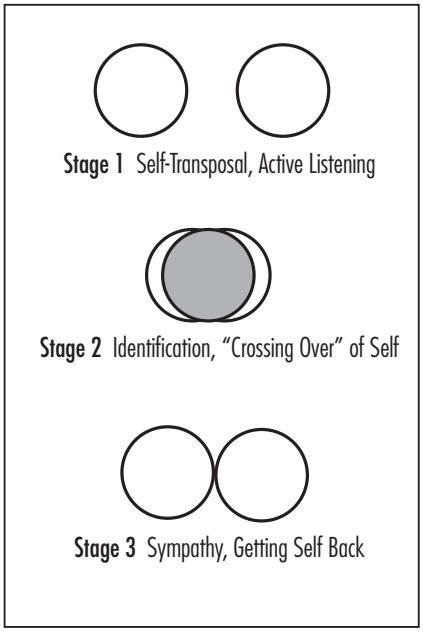
The empathic process is not necessarily unhealthy, but a practitioner must be aware of it and have clear boundaries.

1: Interacting or attuning with a client

2: Merging

3: Joined but not inappropriately merged in a sympathetic state

(Diagram from Davis, C. Patient Practitioner Interaction: An Experiential Manual for Developing the Art of Health Care, 3rd Edition, SLACK Incorporated. 1998)



Three stages of empathy as described by Stein.

Merging can happen with:

- Clients whose boundaries have been so abused or ruptured that it is nearly impossible for them to maintain appropriate boundaries. It is essential that we have (or develop) healthy boundaries.
- Clients with strong borderline characteristics. They will tend to merge easily, violate boundaries frequently, or ask us to violate our boundaries.
- Clients who come with tremendous needs and limited boundary function.
- Clients who place the primary responsibility of recovery on the therapist, or who are unwilling or unable to monitor their own progress.

Red Flags or Signs of Merging:

- Something will happen in our system to decrease our contact with our own felt sense.
- We feel uncomfortable with a client who is leaving her body. It is unsettling to interact with somebody who is out of touch with her body.
- We feel unsettled. We feel unclear, tired, not in the present.
- We think about a client outside of sessions more often than our comfort level.
- We feel the need to prove to clients that we are doing a good job.
- The thought of a session with a particular client makes us feel uncomfortable.
- We think we are indispensable, or the only person who can help a particular client.
- Our boundaries become fuzzy: We go over time with the person, stay too late; we are still doing therapy while going out the door; we start taking on their stuff, thinking about it; we have dreams about them; we think of them while "off-duty".
- We are pulled in by their stuff.
- We may not be able to differentiate a client's issues from our own.

What do we need to do?

- We need to ground, come back into our own body, and resource ourselves. Track our own sensations, clearly noting that we are a different individual than your client. Ability to stay in our own chair (instead of merging or distancing).
- We need to reset our boundaries. It is not possible to prevent ourselves from ever merging. We can't always prevent it from happening. Check what happened in our system that made us decrease our contact with the felt sense we have to go back to who we are.
- We need to look at how merging touches our own unresolved issues and our countertransference. Do we believe that we are the only one who can get through her blockage? We might end up kind of succeeding through emotional attachment, while not really cultivating our SE skills.
- We need to do our own work to renegotiate our personal trauma.
- We need to remember that someone who feels like a perpetrator finds a victim, and someone who feels like a victim finds a perpetrator. This will help us understand the inevitable victim-perpetrator dynamics that can sometimes occur in the transference and countertransference when working with trauma.
- We need to attend to traumatic transference and countertransference (Judith Herman's *Trauma and Recovery* has an excellent chapter on this).
- Not letting ourselves be too caught up by the story (merging, which is what we also do with our own stories).
- Going back to process. Going back to the felt sense (re-establishing the felt sense by using the five channels of communication, and bringing them into sensation). Moving through SIBAM in a very congruent way.
- Avoid engaging as the object of transference. We are hooked if we feel we want to fix them or fight them.
- Staying present within our boundaries without withdrawing, and behaving in alignment with our professional role and ethics. This helps the client to feel safer and begin to develop trust.
- Come back to our belief in the client's own ability to heal, and the knowledge that they have taken care of themselves for many years without us, and will continue to do so.
- Respect their need for boundaries – on both sides of the relationship.

The Use of Touch in SE

Somatic Experiencing, by name and by nature, is a body-oriented process. Its successful practice relies heavily on the practitioner's skill at understanding the client's somatic communication. The most obvious form of this communication used in SE is that of the client tracking his or her sensation. Although we cannot directly experience our client's somatic states, we can rely on a kind of translation of those states into language that we can understand. Sometimes that translation takes place at a verbal level, such as when clients are tracking their sensations and verbally reporting to us what they are experiencing. We listen to their descriptions, noting what types of words are used, what is said, as well as what is not said. Sometimes our clients translate their internal experiences to us in forms other than verbal: Gestures, postures, breathing cadence, trembling, weight shifts, subtle circulation changes – all may have meaning in helping us understand the client's process of renegotiation of trauma. As a result, SE practitioners need to be highly skilled in their capacities to understand as many of the body's forms of communication as possible.

A keen awareness of subtle shifts within the client's somatic state can use all of the practitioner's senses: hearing, vision, kinesthetic sense, smell, tactile sense. In this context, the use of touch is simply another possible tool that SE practitioners might use to enhance their observations of the client's renegotiation process. Sometimes the client's communication of her inner experience takes place through subtle tissue changes, which may not be observable in any other way than through contact with those tissues. This type of direct tissue observation may be understood by a skilled touch therapist in much the same way as the client's verbal cues may be understood. The essential SE process remains the same, only the form of observation changes. The use of touch is not essential in the practice of SE, but when used appropriately it adds another possible option to the list of tools available to the practitioner during a session.

Touch in an SE session is to be done consciously and with clear purpose. The types of touch that are used in the SE context have the specific purpose of supporting the SE process as a whole. The touch should match the focus of the session or process at that point in time.

Different types of touch common in SE sessions:

Containing: Touch which helps to stabilize the client; helps stabilize and integrate the change process; helps the client manage high levels of charge or energy in a system or body region; helps define the body boundary.

Listening: Hearing with the hands. Tracking what is happening in body systems through physical contact. What do I feel, sense, perceive?

Directing: Intentionally directing movement or facilitating movement. This might include initiating gentle physical pulsations as a stimulus for pendulation.

Following: Letting your hands be invited to a particular area, structure or region. Letting your hands explore a pattern of movement or constriction.

Stimulating: Touching in a way that facilitates increased sensory input and awareness.

Inhibitory: Touching in a way that slows down or stops a movement or escalation of a process.

Integrative: Touch which helps fragmented aspects of awareness cohere into more organized attention to the whole.

Non-physical touch: "Touch awareness" – being aware of the sensory field and using directed attention to gather information about that field and to give the client the sense of being joined in the awareness of a specific sensation or state.

You might notice that all of the forms of touch described above could also be descriptions of different interventions or methods you might use in an SE session. Touch simply offers another possible way to apply the same tools you have already learned in SE.

Scope of Practice

"Ultimately, if local licensing laws exist where you practice, they govern your Scope and determine what you can and cannot do. Even if laws exist, however, many of them are very general and make no mention of specific modalities. So, while the laws serve as a guide, two practitioners governed by the same laws may have significant differences in their scopes of practice based on their education and unique knowledge base. Beyond the law's watchful eye, educational training individualizes Scope and it becomes a personal issue rather than a collective one. Ethical practitioners must be mindful about the limitations of their training, regardless of what they are lawfully permitted to do." *The Ethics of Touch*, Benjamin and Sohnen-Moe, page 149

Somatic Experiencing stands on its own as an approach to healing trauma. It is neither a psychotherapy nor a bodywork technique, but lends itself well to being integrated into either of those modalities. That integration requires an awareness on the part of the practitioner of the effect that the blending of SE methods will have on his or her Scope of Practice.

Defining Your Scope of Practice

In a community such as the SE community, where there is great diversity in training, background, and experience, it is not possible to define a single Scope of Practice. Different professional and certifying organizations have guidelines which may contradict each other, or the law. You will need to account for a variety of factors in order to define your applicable Scope:

- Your education, experience, competency and willingness to provide specific services
- The law governing your form of practice
- The professional codes of ethics, standards of practice and scope of practice guidelines of the organizations to which you belong
- The standards established by your malpractice/liability insurer
- The professional and social community standards in the community in which you practice
- Your capacity for self-evaluation and accountability

Touch as Adjunct, Touch as Primary Intervention

The training needed to do "repair" work for someone who has experienced physical injury or dramatic physical effect (such as surgery), from a traumatic experience is different than the training needed to use simple touch appropriately in an SE context. If touch is your primary intervention, especially if you are working with clients who have physical injuries or challenges, you need training in a system of body therapy that gives you the necessary palpation, assessment and repair skills, as well as knowledge of contraindications. If you are using touch primarily as an adjunct to other forms of therapy, you don't necessarily need to know detailed anatomy, palpation skills and so forth. You ***do*** need to know about using touch appropriately and have an understanding of its implications for the therapeutic relationship.

Likewise, if you are trained primarily as a bodyworker or other tactile therapist, you need to maintain appropriate boundaries in your Scope of Practice and not engage in psychotherapeutic interventions in the process of integrating SE into your practice.

Keeping the Appropriate Focus on Scope While Integrating SE into Your Practice

The following questions can be used to assess whether or not a bodywork or psychotherapy context is most appropriate, or whether a referral or team approach is needed for a particular client:

- What are the primary dynamics of the client's symptoms: physical, emotional, developmental, psychological, relational, or a mix?
- Does your Scope appropriately include the needed elements to effectively deal with these dynamics? Could it include some of the elements if you have supervision or other practitioners involved? How will you and the client determine the boundaries of appropriate Scope?
- Can you access the symptoms through the:
    - Body (for bodyworkers)
    - Psychotherapeutic relationship (for therapists)

  or will understanding of other forms of intervention be needed?
- Can the client's symptoms and responses be adequately discussed using:
    - Body therapy language rather than psychotherapeutic language (for bodyworkers)?
    - Psychotherapeutic, somatic language (for therapists) - or is the language of physical repair needed?
- Are the client's resources adequate to maintain appropriate Scope boundaries as the SE work proceeds?

"Informed consent also entails informing clients of what professional services you can legally and ethically provide as well as any limitations. Under the best of ethical conditions informed consent is a twofold agreement in which the client and practitioner share an objective for the treatment or procedure and its outcome. The objective is explained, discussed, fully understood and agreed upon by both the client and the practitioner before the treatment begins. Ethically speaking, the client needs to be well-informed, not merely, informed." *The Ethics of Touch,* Benjamin and Sohnen-Moe, page 166

SE, Touch, and Psychotherapy

If touch is one of the tools being used in the SE mix, its effect must be accounted for. The integration of touch into the psychotherapeutic and counseling environment continues to be a developing, and sometimes controversial, process. Because of this, if touch is used by an SE practitioner who is licensed as a psychotherapist or counselor, care must be taken to ensure that all legal and ethical boundaries are respected. Laws and community standards regarding the use of touch in psychotherapy vary from region to region.

The amount and type of touch that any SE practitioner uses will be based on many different factors: licensure, practice setting, type of clients, practice style of the practitioner, and so forth. The guidelines presented on pages 31-32 are simple rules of thumb that apply to the use of touch in the psychotherapeutic or counseling setting when it has been determined that the use of touch is allowed within your Scope of Practice.

If you will be using touch in more than an incidental way, it is strongly recommended that you include a separate section of your informed consent document specific to the use of touch. Clinical notes should include information on the purpose of the touch that was used in sessions, and how it supports the overall treatment plan.

Even when touch is legally and ethically allowed, there are times when it should not be used, or when it should be used only with caution and forethought. Likewise, there are times when touch is especially helpful in assisting the client's change process. The following material provides some general guidelines to help in your decision-making in the use of touch.

In general, in the psychotherapeutic or counseling setting, touch should not be used under the following circumstances:

- To treat or repair physical injury. The exception to this is simple forms of touch which are used in the context of working with the psychological or traumatic stress symptoms associated with the injury, but are not specifically for the treatment of the injury itself.
- For the purpose of sexual arousal.
- For the purpose of causing harm to the client
- If the practitioner is unclear on the purpose of the touch being used, and cannot articulate its purpose to the client.
- If the client has not explicitly agreed to the use of touch in the session and to the specific purpose of the touch being used.
- If the practitioner is feeling confused or overwhelmed by the transference or countertransference dynamics which are occurring in the therapeutic relationship.
- If the client habitually uses touch work to avoid, rather than engage, the change process.
- If the practitioner is using touch work to avoid engaging the client's change process, particularly if that process is uncomfortable for the practitioner and touch work is being used to set the practitioner at ease, rather than for the benefit of the client.
- Simply because the practitioner can't think of anything else to do.
- If the practitioner's level of skill does not match the level of complexity of the client's needs related to touch. The more complex and subtle the client's symptoms, the more experience and training the practitioner needs.

Caution should be used in deciding to use touch under the following circumstances:

- When the client has a history of negative experiences with touch, particularly from caregivers.
- When the client has such limited experience of appropriate touch that he or she is at high risk of misunderstanding its purpose.
- When the client lacks enough developmental maturity to adequately manage the necessary contract related to touch – this may include otherwise mature clients who are engaging developmental issues in the therapeutic relationship and are temporarily lacking in their usual resources.
- When the client is struggling to identify appropriate boundaries.
- If touch causes the client to be overwhelmed or over-activated by the sensations resulting from touch.
- When cultural difference may make it difficult to know how touch will be interpreted.

Appropriate touch can often be especially useful under the following circumstances:

- In working with early shock trauma that has a primarily physical origin (particularly when this occurs in the child/infant's pre-verbal development phase). This is especially true when the client's symptoms are manifesting as primarily somatic complaints.
- In working with developmental disturbances that have a primarily physical origin, such as extended hospitalizations, particularly if the client's symptoms are manifesting somatically.
- When it is helpful to the client to learn to differentiate between appropriate, caring touch and inappropriate, harmful touch.
- When touch helps the client integrate his or her change process more fully through all layers of self.
- When touch helps the client remain resourceful in managing his or her activation levels.
- When the use of verbal language is limited, either due to disability or language barriers.

(Thanks to Kathy Kain for the material on touch and Scope of Practice.)

Student Self-Assessment Questionnaire
Beginning: Module 3

This self-assessment questionnaire is intended as a review of the concepts and practical skills covered in each module, and as guidance for focusing your consultation sessions, and review questions of faculty in future modules. The concepts and skills listed below are those that you are expected to have learned in this module. For each of the listed skills or concepts, if you do not have at least a basic understanding, or feel at least somewhat proficient in being able to apply those skills, you should consider focusing more specifically on those topics in your consultations with faculty or approved consultation providers. Each module builds upon the knowledge gained in previous modules, so any gaps in your understanding will only make future material more challenging to learn.

You may want to return to the questionnaires for previous modules as you progress in the training, since your understanding of basic concepts will change as you gain in experience.

Part 1

Circle one of the numbers on the scale to indicate your depth of understanding of each of the concepts listed below.

	Don't Understand	Still Unclear on Some Aspects	Basic Understanding	Good Understanding	Understand Well
SIBAM					
Sensation	1	2	3	4	5
Image	1	2	3	4	5
Behavior	1	2	3	4	5
Affect	1	2	3	4	5
Meaning	1	2	3	4	5
Implicit memory	1	2	3	4	5
Explicit memory	1	2	3	4	5
Coupling Dynamics					
Healthy coupling	1	2	3	4	5
Traumatic coupling	1	2	3	4	5
Over-coupling	1	2	3	4	5
Under-coupling	1	2	3	4	5
Joining vs. merging	1	2	3	4	5
Different types of touch used in SE	1	2	3	4	5
Scope of Practice	1	2	3	4	5
Other _____	1	2	3	4	5

Part 2

Circle one of the numbers on the scale to indicate how proficient you feel about being able to apply each of the skills or concepts listed below.

	Not at all Proficient	Lacking Proficiency	In the Middle	Somewhat Proficient	Very Proficient
Working with sensation	1	2	3	4	5
Working with image	1	2	3	4	5
Working with behavior	1	2	3	4	5
Working with affect	1	2	3	4	5
Working with meaning	1	2	3	4	5
Working with SIBAM in an integrated way	1	2	3	4	5
Observing and recognizing overcoupling	1	2	3	4	5
Observing and recognizing undercoupling	1	2	3	4	5
Facilitating uncoupling	1	2	3	4	5
Facilitating re-association of undercoupled elements	1	2	3	4	5
Using touch appropriately for containment and support	1	2	3	4	5
Use of touch for increased resonance	1	2	3	4	5
Ability to stay within appropriate scope of practice when using SE	1	2	3	4	5
Ability to stay within appropriate scope of practice when using touch	1	2	3	4	5
Ability to conduct a session using material from all Beginning modules	1	2	3	4	5
Other _____	1	2	3	4	5

Part 3

Based on your responses above, on what areas would you like to focus during consultations? (These, of course, do not have to be the only areas on which you will work in consultations.)

_____

_____

_____

_____

_____

_____

_____