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Playing with Possibilities

Sensorimotor Psychotherapy with Younger Clients in Individual, Family, and Group Psychotherapy[1]

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All children will experience trauma and attachment challenges to varying degrees. Bromberg (2011) writes:

> If we accept that developmental trauma is a core phenomenon in the shaping of personality then we also accept that it exists for everyone and is always a matter of degree. If that is so, then the stability achieved by even secure attachment is also a matter of degree. That is to say, everyone is vulnerable... (p.14)

Each child's development, vitality, and well-being are impacted by the accumulation of both positive and adverse experiences at home, with peers, and at school. The personal meaning children make of these experiences is revealed not only through words but also through physical actions. Even infants express the meaning of their interactions with others through physical action and especially through the procedural organization of their posture and action sequences (Beebe, 2006; Tronick, 2006). When particular actions are consistently ineffective in eliciting the desired response from the people important to them, children will abandon such actions – for example, they will stop reaching out if no one is there to reach back or such overtures were not responded to in an attuned manner; they will slump and keep their heads down if standing upright with heads held high brought unwanted attention, criticism, abuse, or shame (Ogden, 2013).

1 The authors wish to thank Deb Banowetz for her contribution to this chapter.

By the time a child reaches the age at which emotions and meanings can be verbalized, such procedural habits are already well established. A child's patterns of physical tension, movement, gesture, posture, physiological arousal, gait, and other action sequences form a 'somatic narrative' that tells a story of both trauma and attachment inadequacy. These physical habits, in turn, constrain a child's 'capacity to make new meaning and respond flexibly to the here and now and turn the future into a version of the past' (Ogden and Fisher, 2015).

Sensorimotor Psychotherapy utilizes both verbal and somatic interventions to treat younger clients, aiming to identify and understand the somatic narrative, in addition to any available verbal narrative, so that the non-conscious procedural patterns can be directly addressed. It should be noted that many children are unable to discuss what has happened for a variety of reasons: language centers of the brain are not developed; they cannot formulate the words, they are ashamed, they fear retribution, and so on (Ogden, Goldstein and Fisher, 2012). By not relying solely on language for its efficacy, a Sensorimotor Psychotherapy approach can directly target the non-verbal legacy of childhood trauma and relational difficulties (Ogden, Goldstein and Fisher, 2012; Ogden, Minton and Pain, 2006).

Through the focus of Dr. Goldstein's work, clients learn to navigate life's complexities addressing relationship and developmental challenges as well as trauma, grief, and loss issues. She has co-authored various papers with Dr. Ogden applying this treatment modality, and has a private practice in West Los Angeles offering individual, group, and family therapy.

Dr. Pat Ogden, Founder and Educational Director of the Sensorimotor Psychotherapy Institute, was an elementary school teacher at a low-income inner city school in the 1960s. She also worked at a local day care center, where the children taught her the chants and dances that so clearly helped them regulate arousal and cope with community, family, and individual traumatic experiences. During the desegregation of American schools in 1970, she taught at one of the first integrated elementary schools in Louisville, Kentucky, addressing the challenges of racial diversity. Pat left teaching to pursue a career in psychotherapy, beginning by working with psychiatric in-patients, where her duties included conducting groups for adolescents and adults in art therapy, yoga, and dance. These pursuits reinforced her interest in the importance of physical action in regulating arousal and

recovering from trauma and attachment inadequacies. Her experience with these children, families and patients, was the early inspiration for Sensorimotor Psychotherapy.

This chapter describes a Sensorimotor Psychotherapy approach implemented during a long-term therapeutic journey with David, who was 5 years old at the beginning of treatment with the author (Bonnie Goldstein). David's treatment included individual therapy, family therapy, and eventually weekly group therapy. We will illustrate how addressing David's physical sensations and actions led to significant shifts in the context of child/therapist, child/child, child/group and family interactions, positively influencing his social engagement. The analysis of symptoms and somatic interventions described herein will help to educate teachers about the difficulties that children, and especially children diagnosed with an autism spectrum disorder (ASD), face that can lead to undesirable behavior in the classroom. These children often experience difficulty integrating sensory stimuli and regulating their impulses. The source of such difficulties typically lies in an inability to regulate physiological and emotional arousal, rather than in intent to misbehave, which highlights the limitations of typical classroom discipline and provides an explanation for why such discipline is sometimes ineffective. This chapter emphasizes basic somatic skills that help children take action to regulate their arousal. Although we do not directly address how teachers might integrate regulatory skills into their daily schoolroom activities, we hope that it will spark curiosity as to how simple breathing, movement, and other somatic exercises might assist children to regulate their arousal and thus promote adaptive behavior in the classroom.

Introduction to David

David's journey learning to self-regulate, develop self-awareness and shift consciousness began after his preschool director and his kindergarten teachers voiced their concerns about the following aspects of his behavior: not sitting in class; walking around the room; standing on one leg; not following or understanding directions; talking back to the teacher and otherwise challenging her; and asking multiple questions before figuring out an assigned task. Interpersonally, David's poor boundaries manifested as his touching and hugging other kids

on the playground and in class, following classmates around against their wishes, and responding inappropriately when asked to stop.

David's school counselor recommended psychological testing, and David was evaluated by a neuropsychologist who identified the first indications of a probable ASD. The assessment indicated that although his schoolwork was on track for his age, his social and emotional difficulties rendered him unable to continue at his current kindergarten without therapeutic intervention. Because of his aptitude (testing suggested that he was in the gifted range), he was not a candidate to repeat kindergarten. Hence, in order to move forward in school, which required a remediation of his disruptive behavior, he started intensive twice-weekly individual therapy and bi-monthly family therapy in the spring of his kindergarten year, with the addition of group therapy several months later.

David experienced several early attachment disruptions. His mother's week-long hospitalization due to an emergency C-section occurred when David was almost 2 years old. Both his mother and his baby sister were hospitalized for a week following her premature birth. Additionally, his mother returned to hospital due to post-partum depression, leaving David with a caretaker. Following years of marital conflict, his parents divorced when he was 2½ years old. David experienced the divorce as a profound loss and frequently asked his parents when they would be getting back together. These early-childhood disruptions, combined with his diagnosis of high-functioning ASD, affected David's capacity to engage well in relationships, as evinced by his problematic behavior at home and at school.

David's parents had hoped that he would outgrow his behavioral and developmental difficulties, and grappled with the limitations indicated by his diagnosis. They reluctantly realized that they, and David, needed help. An initial family therapy session illuminated the impact of myriad family struggles on David, and his parents began to understand that David's difficulties are characteristic of children who have early attachment disruptions as well as diagnosis of ASD. David started weekly individual therapy, adding additional family sessions every other week. Family treatment was essential to David's progress. Through psychoeducation during family sessions, his parents became part of the treatment process, helping to integrate therapeutic

goals, validate large and small steps achieved, and aid in their son's improving participation in the family milieu.

After seven months of individual and family therapy, David joined a newly formed weekly children's group, continuing his individual sessions as well. Over the year of individual and group therapy, family sessions were intermittent, usually scheduled when David was having difficulty at home or at school. David continued in a group for a second year, with his individual sessions becoming less frequent (at first every other week, then monthly 'check-ins') and with family meetings as needed.

David's first therapy session

David's therapist first met with him after a playground conflict in which he was sent home mid-day and subsequently brought to therapy under duress. David promptly told his mother how sorry he was about pushing his classmate; he even apologized to the therapist, to which his mother replied in an exasperated tone, 'David, you're the Apology King, always saying 'I'm sorry'...but it's not OK unless you change your behavior.' David looked at his therapist and woefully said, 'I'm the Apology King.' Unfortunately, for David, his peers, and his parents, he had learned to say that he was sorry without understanding how his behavior needed to change. He was able to apologize, and genuinely felt distress when his behavior displeased others, but he was unable to change his behavior at school or at home.

David's inability to connect his actions with consequences or pair his apology with a new action is characteristic of ASD. Neurobiological studies on the autistic brain suggest an 'underconnectivity' between its parts. For example, the mammalian brain (responsible for feelings of empathy or guilt when apologizing) does not work well with the neocortex (responsible for understanding when apologetic words are necessary to maintain social engagement). In addition, children with ASD commonly demonstrate difficulty in planning, controlling impulses, focusing attention, and problem-solving, executive functions of the neocortex (Kunzig, 2004; Russell, 1997), all of which worked against David in his social interaction at school. David's mother's plea to him to change his behavior, attempts to help him, and the punishments he received at school made little impact on his impulsivity. Without the ability to integrate information from different regions of

his brain, and without the tools to help mitigate his impulses and problem-solve, David's disruptive behavior surfaced again and again.

Learning to pay attention to his experience – that is, to understand his own impulses, physical sensations, and non-conscious procedural action patterns – and develop skills to self-regulate in interactions with others were David's challenges. The following treatment goals were established collaboratively with the family and carried out across individual, family, and group therapy:

- developing greater awareness and sensitivity to other children
- becoming more 'in tune' with himself and his peers
- establishing and following through on appropriate boundaries regarding self and other
- learning ways to self-regulate impulsive and disruptive behavior
- engaging his own natural curiosity, playfulness, present moment awareness, and drive for mastery.

Beginning somatic resources

It is critical that children diagnosed with ASD be allowed the time to develop a connection with their therapist, without too much emotional intensity, which can cause further dysregulation (Turkington, Davidson, and Carson-DeWitt, 2012). Thus, David's earliest individual sessions focused on developing rapport with his therapist and learning resources for regulating the arousal and frustration that he experienced on the playground during recess and lunch times, which often led to disruptive behavior.

At school, the play-yard tetherball game was a constant source of interpersonal conflict for David, who would throw his entire body into other players, landing upon them or stepping over them in order to win the game. When his foot landed on the windpipe of a classmate, who screamed at David to get off, he shouted, 'I won, I won,' apparently not registering that his classmate was writhing in pain. On one occasion, when his shoulder hit the nose of another classmate, it was only the deep red color of the blood that oriented him to the pain he had inflicted, as his goal – to master the game – superseded awareness of the distress of his peers. Many children with a diagnosis of ASD can be described as 'systemizers' (Kunzig, 2004) who become obsessed

empathy (Kunzig, 2004). Indeed, David had been focused on the game and how to win it, at the expense of empathizing with his peers. Because of his behavior, David was reprimanded, punished, placed on a 'reward' system, and provided with a behavioral shadow (a teacher who would accompany him during play time), with little result. In fact, David often lashed out verbally and physically in response to these interventions.

While describing these incidents to his therapist, his breath became more staccato (short and quick) as his arousal and anxiety mounted. Often, children with ASD have an overactive amygdala, which is the part of the brain associated with anxiety. Clearly, David needed to learn skills that would help him both improve his social awareness and calm his arousal. As David's anxiety increased and his breathing became ragged, he was encouraged to bring his attention to his breath, which he willingly did, taking a huge breath. Working with breath can be particularly useful for regulating dysregulated arousal, decreasing emotional intensity, or providing energy or fostering relaxation (Caldwell and Victora, 2011; Ogden *et al.*, 2006). David was able to notice that after breathing deeply, he could better discuss his distress.

In fact, deep breathing became a resource on which David came to rely, particularly when he was triggered to act out. Learning to pause and breathe deeply proved particularly helpful in shifting states of consciousness, calming himself and containing the uncontrolled outbursts that were ill-suited to a particular situation, difficulties typical of children with ASD (Turkington, *et al.*, 2012).

During one of the monthly family sessions that paralleled his individual therapy, David's therapist encouraged him to model deep breathing for his parents. He assumed his favorite position, with hands resting on his lap, legs crossed, sitting aligned with spine elongated, then moving his hands in an arc with elaborate upper body movement; his hand gestures spontaneously emerged as he encouraged his parents to follow his guidance. As David instructed his parents, who attentively mirrored his movements, his enjoyment of his role as teacher instead of as the target of disapproval was obvious in his big smile and eager participation. Additionally, as he taught the movement and explained its effect, his own learning about his resources of using breath was enhanced.

At a subsequent family session discussing a previous conflict David had with his younger brother during which David became physically aggressive and was punished, breathing again was useful in regulating David's arousal. As he retold the conflict, he grew quite agitated, repeatedly kicking his foot against the back of the couch, wiggling and squirming. He paced the room, expressing his outrage at his mother for 'unfairly' doling out consequences, unable to settle himself. He then stated how exhausted he felt in our session and collapsed onto the couch. In a short period of time, David's arousal escalated to hyperarousal and then plummeted into hypoarousal, as illustrated in Figure 9.1.

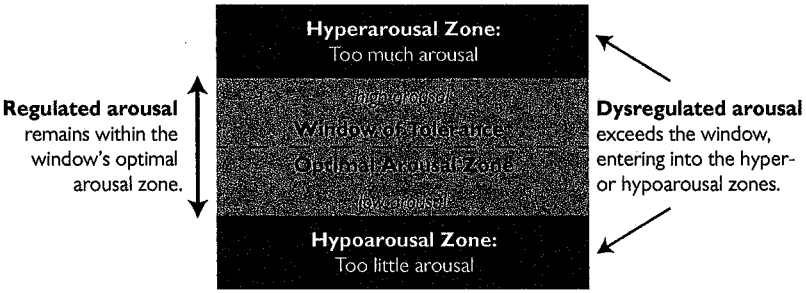

***Figure 9.1:** Window of Tolerance*
(Ogden and Minton, 2000)

David's therapist reminded him of how much he had been helped in previous sessions by deep breathing, and encouraged him to select a small stuffed animal from those available in the office, and to place it on his belly as he lay on the couch, watching it gently go up and down as he breathed in and out. David enjoyed the playful nature of balancing the animal on his belly and felt a sense of satisfaction when he succeeded in doing so. This intervention immediately helped his arousal return to a window of tolerance so that he could participate in the discussion of the conflict without undue dysregulation.

The use of mindfulness

Children's internal reactions to stimuli happen rapidly and unconsciously, and are often translated immediately into action. Teaching mindfulness and developing consciousness of internal reactions

can help them identify the somatic precursors to action, giving them tools to notice the indicators of dysregulation prior to action. Most definitions of mindfulness include an attitude of openness and receptivity to present moment experience, as a 'quality of attention which notices without choosing, without preference' (Goldstein and Kornfield, 1987, p.19). Sensorimotor Psychotherapy uses particular mindfulness techniques to provide specific tools for helping children become aware of their bodies, emotions, and thoughts within the context of the therapeutic relationship. Specific 'directed mindfulness' (Ogden, 2007, 2009; Ogden, 2014) interventions guide children's awareness toward particular elements of present-moment experience considered important to therapeutic goals. Siegel (2010) notes: 'When we focus our attention in specific ways, we create neural firing patterns that permit previously separated areas to become linked an integrated. The synaptic linkages are strengthened, the brain becomes more integrated, and the mind becomes more adaptive' (p.43). With the use of focused mindful attention toward new elements of internal experience, we hope to help children develop new mental capacities that can interrupt old patterns of reaction.

From the initial session using Sensorimotor Psychotherapy, David began to acquire the skill of directed mindfulness. To clarify, non-directed mindfulness would be a general question: 'What do you notice?' An example of directed mindfulness might be: 'What do you notice in your chest right now as you tell me about being punished?' The second question is based upon the therapist's specific tracking of the child's physical response (i.e. tightening in his chest that restricts his breathing) to the verbal narrative. David learned to identify several somatic signals (e.g. his heart beating faster, a knot in his stomach, tension around his heart, short and shallow breathing) that indicated distress and increased arousal related to interactions with others.

Critically, mindfulness in Sensorimotor Psychotherapy is not a solitary activity, but is firmly embedded in what occurs within the therapeutic dyad. In conversation, children tell their story by 'talking about' rather than noticing their bodies. With the use of embedded relational mindfulness™, therapist and client both notice how the experience of the story unfolds in the present moment, through changes in the body, emotions, and thoughts. This is not a solitary endeavor; both parties are attending to the ebb and flow of the child's

present-moment experience. Taking place within an attuned dyad and group, mindfulness activates not only the child's experience of the effects of trauma and attachment inadequacies but also increases the engagement and connection between the child, therapist and other group members.

It is imperative that mindfulness is employed in a way that increases patients' experience of relational safety and fosters their ability to connect to and engage with others. A significant element of this process in individual therapy was that David and his therapist worked together, as she helped him become mindful of his body. Utilizing such collaborative, mindful suggestions as 'It is as though we can sense the sound of our breath' and 'Let's feel our breath together as it comes in and goes out' helped David learn to sense his breath and subsequently shift his energetic state while staying in close contact with his therapist.

In school, David often had difficulty regulating his arousal during transitions, especially from play-yard to 'quiet time'. Through the use of mindfulness, he learned to recognize 'wiggles that had no place to go', which often occurred right after play-yard, when the children were instructed to get their mats and pillows for a short break. Invariably, he was the one who was admonished by his teachers for not settling down. As he spoke of this in therapy, his agitation emerged anew, expressed with wiggling feet, one leg bobbing up and down before he abruptly stood upright with his fist clenched. He and his therapist capitalized on this moment to help David pay attention to these bodily signals that would otherwise go unrecognized, signals that often led to admonishment and punishment. With instruction from his therapist, he scanned his body from top to bottom, starting with the top of his head, then down toward his shoulders, arms, hands, heart, tummy, legs, and feet, noticing what thoughts and feelings accompanied his sensations. David soon discovered that his aggressive impulse was connected with his fists, and his impulse to bolt was preceded by a tingling in his feet, expressed in wiggling movements. David learned to describe the sensations in his body, using words like 'tingling', 'pulsing', 'throbbing', and 'jarring'.

David began to recognize that these sensations indicated an escalation in arousal, coupled with emotional reactions that were the precursors to his impulsive behaviors (e.g. impulses to step on another's foot, kick someone, or grab items that aren't his). Learning

to recognize these signs, and learning to implement his deep breathing resource at those times to calm himself, were primary treatment goals throughout the course of individual and group therapy.

When teaching children to become mindful of their bodies, a playful atmosphere becomes an important element that not only facilitates mindfulness, but also activates the child's play and the social engagement systems (Ogden *et al.*, 2006). In group work, mindfulness was included spontaneously as incidents occurred. For example, when David apologized to the group for his behavior, his therapist said to the group, 'Let's find out what comes up when you hear David say the words, "I'm sorry".' This was followed by the question: 'Maybe you feel relieved or happy or mad. I'll bet something changes in your body – can you tell us what changes? Maybe your body tightens up or relaxes, or maybe your breathing changes.' Directing mindfulness in this way helped the children notice things like muscle relaxation and tension, changes in facial expression, movements such as backing away or turning toward, changes in breathing, and so forth. Playfully saying, 'Let's all be like Dora the Explorer, and see what happens inside our bodies' led to robust conversations wherein the children were able to enliven each other's burgeoning self-awareness.

Group therapy

As David gained awareness of his body, developed self-regulation skills, and gained confidence in his relationship with his therapist, expanding from individual and family therapy to a weekly group experience became possible. David, like many children diagnosed with ASD, had difficulty making friends (Frey and Carson-Dewitt, 2012), Although he wanted friendships very much, he did not seem to comprehend that basic implicit social cues are necessary for interacting with other children, a characteristic difficulty of children with his diagnosis (Turkington *et al.*, 2012). Group therapy using Sensorimotor Psychotherapy offered David another theater in which to explore social engagement, increase his self-esteem, challenge his newly developing body awareness and somatic self-regulation skills, and learn how to recognize and respect his own and others' boundaries. Group Psychotherapy offers a particularly effective format for treating the multifaceted issues of children, especially those with ASD who typically have difficulty reading social cues. Group experiences help

such children to explore how they react to social situations and to begin to understand that others have perspectives different from theirs.

At school, as at home, David was given the message, both overtly and covertly, that he was a problem. He came to believe that 'there's something wrong with me' and change felt insurmountable because he deeply believed he was defective. Due to David's history, particularly his experience in school, shame became a deep assault on his developing psyche, and one goal of group work was to ensure that further shame was not elicited. Thus, shame was an important emotion to identify for David early in the group experience because his underlying fears made it hard for him to feel comfortable and safe with others. David learned to identify his feelings of fear and shame and their ensuing sensorimotor correlates. Because David keenly felt that he was flawed, reframing his difficulties while fostering self-compassion and empathy along with enhancing awareness of others were all necessary. In group therapy, opportunities arose for David's peers to model the type of reciprocal social support that David needed both to experience, and to learn how to provide to others.

David's introduction to the ongoing weekly first-grade co-ed group was set up carefully to minimize any shame and maximize the chances for him to feel empowered and gain the respect and admiration of the other members. He was encouraged to take a role as a kind of co-leader, directing other group members to experience and discuss the breath work he had mastered. He modeled deep breathing, as he had already done with his parents, and the other children were instructed to mimic his actions of opening his chest by spreading his arms and straightening his posture. Teaching his fellow group members to do this enhanced his own self-understanding of the breath and offered an opportunity for him to experience pride and empowerment in interaction with others.

David's group therapy also included listening to the echoing reverberations of a gong or a singing bowl. Children with ASDs often exhibit hypersensitivity to sound (Stiegler and Davis, 2010), although studies showing that the physiology of hearing of this group does not differs from that of those who are not sensitive to sounds (Stiegler and Davis, 2010). Koegel, Openden, and Koegel (2004) demonstrated success in treating this sensitivity through exposing children with ASD to disturbing sounds over time. Similarly, in the group, as each child took a turn tapping the gong, they were guided with prompts to

what happens inside each our bodies' or 'Let's see how long you can hear the sound as it rings, listening to the sound as the ringing fades.' As the children listened, they also practiced the deep breathing somatic resource that David had taught them. Adding the breathing helped David in particular regulate his arousal so that he could remain calm as he listened to the gong.

He loved the breathing exercise and gradually began to request it, particularly when interpersonal conflict arose in the group. Thus, breathing exercises were used often, not only when David's arousal increased, but also when group members spoke about themselves, which helped David become more centered, reflective, open, and curious about his peers' perspectives and experience. By using breath to quiet the anxiety-driven sensations and movements that had caused him strife with peers in the past, he was able to increase his interest in others and maintain social engagement even in times of conflict. It can be surmised that through these exercises the three levels of his brain – cortex, mammalian, and reptilian – began to work together in a more integrative way, rather than his subcortical brain hijacking his cortex.

Setting and respecting boundaries

A somatic sense of boundaries is an essential resource that many children need help to embody (Kepner, 1987, 1995; Levine and Frederick, 1997; Macnaughton, 2004; Ogden *et al.*, 2006; Rosenberg, Rand and Assay, 1989; Rothschild, 2000; Scaer, 2001). Our younger clients often have difficulties appropriately setting boundaries for themselves and respecting those of others, and David was no exception. His 'under-bounded' style manifested in difficulty saying 'no', identifying his own needs and desires, and invading the boundaries of others. He found that the boundaries he had set ineffectively were often violated, and he was unaware that his body frequently was collapsed and his posture slumped, often signs of weak boundaries (Ogden *et al.*, 2006; Ogden and Fisher, 2015).

Sensorimotor Psychotherapy can help children establish non-verbal boundary setting through exploring simple physical actions, including:

- the use of facial expressions like frowning or grimacing
- crossing arms in front of the chest

- making a 'stop' sign with the hands
- building a tangible boundary through the use of rope, pillows, or other objects
- integrating proximity seeking actions (e.g. reaching out or beckoning another person to come closer).

(Ogden *et al.*, 2006; Ogden and Fisher, 2015)

David often provoked interpersonal conflict by physically disrespecting the boundaries of others – stepping purposely on a group member's foot, taking chairs or sitting on laps without permission, following and poking classmates even after they asked him to stop, and, in one session, stealing another child's private diary to read selections aloud (much to her consternation). To help David learn more about his own boundaries and the boundaries of others, he and another group member explored physical distance and proximity. Guided by the therapist, Tami and David, both 6 years old at the time of this session, stood facing one another on opposite sides of the room, with the other group members quietly observing. David was instructed to ask Tami to come forward towards him, using both words and gesture, until he felt that she was 'just the right distance' from his body, at which point he was to ask her to stop. As he said the words, 'come closer,' he made a beckoning motion with both hands. When he felt that she was at the right degree of closeness and that she should not come any closer, he indicated this with a 'stop' gesture by placing his hands in front of his chest, palms facing outward, along with verbally asking Tami to stop.

Characteristic of weak boundaries, David did not experience Tami as too close until she was nearly on top of his toes. Then he finally said, 'OK, stop there.' His therapist asked, 'What happens in your body that lets you know that this is just the right distance?' David pointed to his tummy, his feet, and the top of his head, saying, 'My tummy knows and my feet, they say it, and they tell my brain the same.' These words and gestures illuminated his growing capacity for self-reflection and also reflected the collaborative work that had transpired in both his individual and group sessions in which David had been guided to acquire skills to scan his body in order to gain insight about himself.

When it was Tami's turn to beckon David closer, he failed to heed her words or body language indicating that he had reached 'just the right' distance for Tami, and instead ran impulsively very close to

her, causing Tami to move backward, and cry out, 'Too close!' As the exercise was repeated, David was instructed to look for somatic cues from Tami (leaning back, movements such as making a small 'stop' gesture, facial expression of discomfort, looking away, a downward tilt of the head) that indicated she did not want him to come any closer to her. As he noted these cues, he gradually began to gain the insight that Tami's boundaries were different than his own.

In order to foster David's ability to look, listen, and become curious about Tami's experience, his therapist instructed him to approach her 'much slower, as if making a slow motion movie.' As David again moved closer to Tami in response to her beckoning gesture from across the room, he heartily engaged in this activity, saying, 'I must move very, very slowly' and he made large, slow movement of his arms and legs. This slow movement, coupled with reminders to pause and notice Tami's non-verbal communications and hear her words, such as 'stop', 'wait', or 'back up', allowed the time for David to respond appropriately. David's drive for connection was powerful, and he eagerly complied with exercises such as these; but repetition is key to developing a felt understanding of boundaries, so this exercise was repeated many times, in a variety of contexts.

In subsequent sessions, the group members explored boundaries in other ways, with leaders reiterating the importance of setting one's own boundaries and noticing and honoring the boundaries that others established. In one such exercise, each child took a turn to establish his or her own personal space by using pillows, jump-ropes, and other props to mark a tangible boundary. They were guided to find the words that represented their boundary, such as 'This is my space' or 'Don't come here' or 'Please ask before you cross my boundary'. Similar to his interactions with Tami, David would impulsively invade others' physical boundaries, despite their words or signaling with a 'stop sign' that they were not receptive to his proximity and wanted him to maintain distance. It is important to note that in Sensorimotor Psychotherapy, the times that David did not respect a boundary were communicated to him and to the group as opportunities to practice skills, rather than as failures. Since David often found it challenging to honor these tangible boundaries of the other children, he was provided myriad opportunities to practice this essential skill.

Exploring proximity and distance through exercises such as those described above provides a venue for discussion about boundaries and

promotes understanding, empathy, cooperation, and consideration of others. Each participant's ability to sense the other's experience is increased. Over time, with practice and reinforcement, David became better at both reading and respecting the somatic and verbal boundaries of his peers. He learned to track and appropriately interpret non-verbal cues, and take those cues into account; this limited his impulsive actions, helped him remain connected with the other person, and led to less reprimand for upsetting others. His progress continued outside of group therapy, as evidenced by subsequent reports from his school teachers of his improved behavior.

Use of video

Group sessions were often videotaped and reviewed by the group later so that all members could learn from observing their own behavior and the behavior of their peers. Because viewing oneself in conflict-laden or high arousal moments in group therapy, especially in the presence of that group, has the potential to be upsetting, frustrating, or shaming, group members were shown short, edited clips, followed by empathetically attuned discussion. Hearing from peers that they too have felt embarrassed or ashamed at times helps to ameliorate these potentially negative feelings, and enhances the safety and learning possibilities. Video segments can thus provide transformative opportunities by highlighting critical moments and observing and discussing inevitable interpersonal challenges. David's initial response when he saw the video playback of the group therapy in which he stole the diary was to laugh; however, his body appeared tense and anxious, his posture rigidly upright, but with his feet wiggling rapidly. Viewing the moments before stealing the diary, he and group members noticed that his body lurched upward and that there was an almost imperceptible shaking of his arm – somatic signs had gone unnoticed during the session but were evident as the session was viewed. The group explored early indicators of arousal in their discussion, noticing together in a playful, interactive, and collaborative dialogue. Some members recognized and shared similar experiences of getting in trouble for taking something (e.g. stealing cookies before dinner even though they knew they were off limits, or grabbing their sister's pillow at bedtime) and the children collaboratively brainstormed about the somatic resources they might use to curb such impulses. For

example, one member said that when he tried to stop himself 'doing something naughty' he would 'suck in my breath', which he then demonstrated by taking in a very large gulp of air. David said that he could take a 'super big breath' and he then demonstrated as well, his arms extending widely, his mouth opening and closing, and a chorus of laughter broke out as fellow group members mimicked him to take their own big breaths.

Following the conversation, playful opportunities for practicing were created in the group. A few members role-played having an object that David might want to grab, and David took his 'super big breath' as a regulating action to curb his impulse to take the object. There was much laughter as David role-played with his peers, taking many large gulps of breath, adding a hand movement of drawing large circles with his arms in the air.

All members experienced encouragement and support throughout David's practicing of his 'super big breath'. Others group members also were afforded opportunities to share times that they got in trouble or broke a rule and to find resources that might help them inhibit impulsive behavior. These discussions, accompanied by members role-playing their experiences, allowed David and all the members to learn together and experience safety in the commonality of sharing. For David, this was evidenced by his posture visibly relaxing, his breathing spontaneously deepening, and his wiggling feet becoming still.

An important element of this exercise was to discover and practice new resources the children could use to curb the impulses that got them into trouble. Each child was encouraged to find gestures or movements that were their own, perhaps inspired by one another, yet germinating from their own experience. During each member's role-play, mindfulness questions such as 'What happened in your body the moments before...' and 'Let's notice what's happening right now, as you describe this...', or 'What can you do first to help you calm down or curb your impulse...' led to collaborative brainstorming of somatic resources to self-regulate. One child said, 'I can stretch my arms widely, reaching way up to the sky like David did,' while another reported, 'I can melt into the chair and relax,' and yet another said, 'I can feel my feet plant onto the floor like glue.' Together, the children tried out each other's resources, learning new regulatory skills from each other.

During individual therapy, other opportunities for therapeutic integration unfolded as David was able to deepen his understanding of

the rich array of movements and gestures and postures available, and we discussed what he had seen from his fellow group members. David was encouraged to reflect upon insights about his group members' actions, as they might be useful to him. For example, David said that he could try on Sammy's 'sticky feet' as he reflected on his peer's use of 'foot glued to the ground' as his way of curbing impulsive behavior. David then role-played a scenario where he would forgo taking a toy in the office that was deemed off limits. David placed his feet firmly on the ground (sticky feet), his body posture shifting to upright and purposefully rigid, saying, 'See, just like Sammy, I'm not going to take the toy.'

At a family meeting one week later, David's parents learned about the targeted goal of preempting impulsive or problematic behaviors and actions through David's sharing of the events, the antecedents, and the outcomes. David talked about his initial anxiety when he viewed the videotape of his taking the diary, speaking about noticing how his foot or arm wiggled, his body posture tensed, and so forth. He spoke of the regulatory resources of the 'super big breath' and 'sticky feet' that were co-created through the group process. The coherence of self-understanding as he described these sessions offered yet another 'teachable moment'. There was a shift wherein David was no longer the problem but rather part of the solution, a certain self-esteem builder. This shift was confirmed in the following weeks, as his teachers reported David's behavior on the playground had improved markedly with fewer conflicts and no reports of physical skirmishes or violations of personal property. David's parents reported that David often practiced 'gulping super big breaths' and 'sticky feet' and, with the reminder of his parents, would be able to utilize these resources to help regulate his arousal and behavior.

Integrating therapy into David's school and home life

David, his therapists, and other group members learned to recognize the somatic signs of David's escalating arousal, and were able to remind him to implement resources, such as deep breathing, to great success. However eliciting his parents' or school teachers' full support for his newfound skill proved challenging. At home, his parents easily slipped into old patterns of shaming admonishment and punishment, failing

to help David assess his behavior or use his resources. At school, once David grew flustered or frustrated at an interpersonal challenge, he had difficulty accessing the skills that he had been learning in therapy. He needed the initial support of his teachers to help him to recognize the somatic signs of his dysregulation and remind him to breathe, until, over time, he was able to internalize these skills on a more consistent basis.

As a result, violating boundaries and the personal space of others continued to be a challenge for David. The tetherball game at school, in particular, was a consistent source of interpersonal conflict in which David had difficulty drawing upon the skills he had learned in therapy to regulate his disruptive behavior. However, over time he attained better awareness and his impulsivity diminished. At one group session, David proudly reported that he played tetherball for an entire period: 'No one got hurt... My teacher gave me a happy face sticker that I got to wear all day on my shirt...and when my mom picked me up, she told me how proud she was.' These positive responses to his success on the play-yard, and the support and compliments of the group members as he reported his success, were encouraging to David in his efforts to change problematic behaviors. As he reported his successes in subsequent therapy sessions, his pleasure was evident by his huge beaming smile. As he looked in the full-length mirror in the office, he could see remarkable differences in his body and posture. Enthusiasm and self-confidence seemed to bubble from his tall, elongated stance, replacing the slumped posture that had been his norm.

Though David had made marked progress in reading social cues and resonating empathetically with others, it remained one of his biggest challenges. Seeing himself through the eyes of another remained especially problematic and he often seemed confused about why his behavior had 'hurt' another child. He desperately wanted to be accepted and was very willing to say 'I'm sorry,' but increasing his understanding of how his behavior affected his parents, teachers, classmates, and group members continued to be a goal of treatment. Slowly, over time, both maturation and practice led to increasing success. His progress report at the end of his first-grade year stated 'consistent attempts to regulate behavior with increasing success; room for improvement.' Those simple remarks held both a sense of achievement and hope for David. Not only had he taken conscious

effort to change his behavior, he now had at his disposal a set of resources and skills that would help him to continue improving.

Conclusions

Patterns of behavior may become so familiar and habitual that they interfere with the establishment of new neural pathways and subsequent novel patterns of behavior. Working with younger clients early in life provides an opportunity to teach self-regulation skills that can mitigate problematic behaviors (and before they become ingrained). Through the use of directed mindfulness, embedded in relationships, we hope to capitalize on the neuroplasticity of the brain by teaching children to notice the internal somatic indicators that comprise their automatic reactions, and then purposefully direct mindful attention to something they typically do not notice, like deep breathing, thereby creating a new experience.

A Sensorimotor Psychotherapeutic approach to working with younger clients aims to integrate mind and body through teaching body awareness, helping children understand procedural learning, and enhancing existing regulatory skills and teaching new ones. Through the mind–body integration that developed in individual, family, and group treatment, David was afforded an opportunity to engage his natural curiosity and playful nature in the service of these aims. His own and his peers' capacity to listen to one another, establish and respect boundaries, to 'feel felt' as each of the members was changed, for the better, by the others, grew as therapy progressed. By learning somatic resources to quiet his anxiety and high arousal, and with practice reading and responding to social cues, David gradually began to develop self awareness and form stronger and more satisfying relationships with others.

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