

# 32

## Multiple Levels of Meaning-Making

### *The First Principles of Changing Meanings in Development and Therapy*

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### Introduction

We see meaning about one’s self in relation to the world of people and things, and in relation to one’s own self, as a core organizing concept in approaches as varied and contentious as Body Psychotherapies, psychoanalysis, psychodynamics, Cognitive Behavioral Therapy, dialectical

cognitive therapies, dyadic therapies, attachment therapies, relational therapies, and others (Tronick, 2007; Harrison, 2003; Ogden, 1997; Modell, 1993). Meanings about one’s self are made continuously and simultaneously, in real time, at multiple levels, and by multiple body and brain systems. Loss of any of these meanings—the meaning about one’s self to one’s self, or one’s self to the world—leads to serious psychopathology. Indeed, a failure to “make meaning” is a psychic catastrophe: a trauma (Modell, 1993). More common than failures are the meanings made about more mundane events that distort one’s sense of the world and one’s self. Such meanings often generate further distortions and increasingly insidious debilitations. Critical to our view is the idea that these endogenous meaning-making processes demand real-time seeking of information through active engagement by the individual with the world of people, things, and the individual’s own self in order to apprehend, in both body and mind, the information that is integrated with past meaning into the meaning of the relation of the self to the world. Moreover, and often under-appreciated, meaning-making is a psycho-biological process that involves not only the brain, but other somatic systems that generate implicit meanings and memories that shape our ways of being in the world. Thus, the process of making sense of the world inherently involves the whole individual in an endless and continuous process.

### A Neurodevelopmental Perspective: In Brief

Understanding this meaning-making is no easy task; multiple theoretical perspectives attempt to understand how it is actually carried out; what systems are involved; how meaning-making is distorted, even destroyed; what

happens in its aftermath—and, most critically, if the meanings made make for psychic health or illness and how therapy can change the meanings of an ill individual. These different theoretical perspectives all approach these issues from different places. A neurodevelopmental perspective emerges from research on the neurochemical, structural, and organizational view of the functioning brain and the distorting effects of maltreatment and trauma on it (Perry, 1999, 2008). One example emerging from this work is a treatment model of embodied multilevel brain processes, the Neurosequential Model of Therapeutics (NMT) (Perry, 2009). The NMT incorporates a functional assessment of the brain and the individual's developmental experience that sculpted it, which leads to a set of approaches for treatment of areas of brain dysfunction that distort the individual's meaning-making. The neurodevelopmental perspective, because of its focus on developmental experiential processes that sculpt the formation of somatic and neurological systems, holds to a view that *all* current experience, rather than the fifty-minute therapy hour, has to become part of therapy, and to the extent possible the individual should have the choice to determine her engagement with the world and with others on a moment-by-moment basis. In this context, the individual can take hold of information to endogenously create new meanings and ways of being in the world.

### A Developmental-Psychological Perspective: In Brief

The developmental perspective has focused on the infant's and young child's capacity to engage the world, especially the world of people (Tronick, 2007; Tronick and Beeghly, 2011). Researchers have tried to understand the kinds of meanings that even the youngest infants make about themselves in the world. Tronick (2007), for example, emphasizes that the infant does not have explicit processes, but nonetheless makes sense of the world with implicit processes. The approach is to microanalyze infant socioemotional behavior, with the goal of seeing the organization of infant behavior and the relation of that organization to events and their context. This approach reveals that that

organization makes it possible to infer the meaning that the child has made about the world, and how that meaning changes with experience and development. Tronick (2007), for example, sees these psycho-biological implicit meanings as assembled into a biopsychological state of consciousness that guides the individual's engagement with the world. His still-face experiment, in which the mother and the infant are face-to-face, but the mother does not respond to her infant, demonstrates that the infant has organized and varied ways to get the mother to change her behavior back to normal and to fulfill his intention to interact with her—"I want you to play with me." And when she does resume her interaction, his behavior changes to smiles and playfulness—"This is fun."

It may seem odd to think of the infant as making meaning, but the infant could not survive in the world if it did not have a way of organizing itself in relation to the world; that means that successfully fitting into the world requires knowing something about the world (see Sander, 1977, for a full explication of fittedness). Rooting to find the nipple of the breast, latching on, and sucking may be labeled as reflexes, but their organization contains powerful meaning about the nipple, the infant, and the world. A ten-week-old covering his face with his hands and ducking away when his mother makes an angry face at him shows us that he has made meaning of the display—threat or danger (we don't know exactly), which has a clearly different meaning from when they engage in mutual smiles. And of course, the meanings made by infants are not the same as the meanings made by adults, and in many ways they are mysteries to us. But when meanings are communicated and shared between an infant and an adult (an amazing accomplishment, given that they are so different developmentally from one another, almost like different species), a *dyadic* state of consciousness is formed such that the infant's as well as the adult's sense of self in the world expands.

### Commonalities of the Two Approaches

Despite the differences of these two approaches, there are commonalities in these neurodevelopmental and

developmental-psychological perspectives. The commonalities include the agency of the individual; the multilevel psycho-biological structures and processes involved in organizing the whole individual's (all bodily processes and levels) engagement with the world; the importance of development and past history; the embeddedness of the individual in context; and the critical effects of what goes on in relationships. Both approaches see the infant and the child as able to share meanings with others. Additionally, both approaches see development and therapy as operating similarly: repeated patterned, rhythmic experiences (Perry, 2008, 2009) or chronic, reiterated experiences play a critical role. These commonalities, which organize the individual during development and in therapy, and especially the role of reoccurring experience, are the focus of this chapter.

### Reoccurring Experiences

What do we mean by the reoccurrence of experience? Start with a clinically relevant example of a child getting slapped. The first slap a child receives is not experienced the same way as the tenth; it is unique. It changes the child's state of consciousness about the world—his or her psychic landscape—forever. But so does, and so may, the tenth slap. Moreover, the slaps are not the same, but depend on the motivational state of the child—for example, if she is slapped when she is concentrating on a game and feeling safe; or if she is hiding and in a fearful state; or if she is in an angry state. And any slap is experienced differently at two years of age, than at five years, or at ten years; and differently if, at ten years, it was last experienced at two years, or five years, or never experienced before. Furthermore, whatever actions the child chooses to take—fighting back, running away, freezing, crying—will change the nature of the experience of the slap. So, it is not just the event, but the event as grappled with by the individual in their state of consciousness, and in the context, that makes its meaning.

### Peekaboo

Let's pursue our commonalities in relation to the slap as a way of understanding how it affects the individual and

what it suggests for therapy. Because the meaning made of slapping has not been studied, though it is likely that many readers will have had the experience of being slapped, think about how a child comes to learn the game of peekaboo, a recurrent event that has been studied (Bruner and Sherwood, 1976; Commons et al., 1998). Peekaboo may seem quite far away from being slapped, and it is, but—for our purposes—it is not. The game of peekaboo is a dynamic interplay of actions and information between a child and an adult. The game is rule-governed, but flexible in its enactment. Often there are unique individual and familial variations. Despite our saying that a four-month-old plays peekaboo, please recognize that young infants do not actually play peekaboo. It is played “at” the infant, by an adult, who initially plays all the sides of the game. The infant exhibits a large number, and variety, of behaviors and has lots of varying intentions and apprehensions of what is going on, many of which are unrelated to the adult's game-playing actions. The infant looks away when she “should” be looking toward, or she raises her shoe, or looks at her hand. What she is doing is messy—variable, unstable, disorganized. Yet, with reoccurrence, the infant attends, and begins to anticipate the coming “boo,” and some of the messiness is pared away. With more reoccurrences and development, the infant begins to become agenic and to control some of the elements and the pace of the game. She comes to signal the timing of the “boo,” and her reactions become more complex. As the game is acquired, the infant begins to learn pieces of how to be the “surprised” and then the “peekabooer.” Sequences and rhythms emerge. While all that is going on, the adult continuously makes adjustments (e.g., holding positions longer) in relation to the infant's actions and the adult's intent—what Bruner calls “scaffolding” (Bruner, 1990).

Such scaffolding is intuitive and implicit. The selective assembling of the infant's self-organized actions and intentions *and* her apprehension of the adult's actions and intentions *and* the adult's reciprocal apprehension become incrementally more coherent. And so on, through endless repetitions, until the game is fully “within” the child and at the same time fully within the child-adult dyad. And none

of this being within—knowing—is explicit. It is simultaneously embodied in multiple systems at multiple levels.

### Critical Elements in Knowing

#### How to Play a Game

A few points about the process of acquiring the game: the acquisition of a game depends on the infant being with someone who knows the game and who must be willing to “teach” her the game. Infants cannot teach themselves the game. At any age, the learning of the game is dependent on the repetition of the game, and the development of different capacities, at multiple levels (neurological, regulatory, motor, emotional), that make the acquisition of a game possible; a three-month-old baby does not have the capacities to learn the game no matter how often its reoccurrence. The game is individualized. The adult who is playing it with the infant plays the game in a unique way, and the infant acquires that unique way. Better said, they co-create a unique way of doing the game together. In an important sense, they co-create a unique game of their own. The game, like all children’s games, is arbitrary, in the sense that it has a history in a cultural context. It is not built in by evolution. It is a canonical cultural artifact, played in the way it is played in a particular culture (Ibid.). Other cultures play other games in their own cultural form.

More generally and importantly, we see the acquisition of a game by an infant as no different from the infant learning any other cultural form of behavior, or any form of procedural knowing that involves spontaneous—“natural”—interaction; that is their way of being with others. The infant learns the “game” of cuddling, the “game” of feeding, and the “game” of greeting a stranger. They learn the “game” of being demanding; the “game” of the bath; and changing, and nursing, and going to sleep. Each of these “games” reoccurs tens, even hundreds, of times a month. Each has a form that is individualized and culturated. Each changes with development. Each involves learning the “game” with another person. And though hardly a game, these features of learning any game will also apply to learning the “game” of being slapped.

### Systems of Meaning-Making

From a neurodevelopmental perspective, the primary mechanism in meaning-making is the capacity to create associations. When patterns of neural activity co-occur with sufficient frequency, intensity, or pattern, these patterns become “connected” at a synaptic level. The capacity to weave the complex array of sensory, somatic, and cerebro-modulatory patterns of activity into a form of coherence is one of the remarkable qualities of development. Indeed, development requires the sequential creation of associations—essentially, sequential meaning-making—from body to brainstem to cortex (see Figure 32.1). Beginning *in utero*, the meaning-making systems (typically, but artificially, referred to as “body and brain,” which is a linguistic dichotomy, not a physiological reality) weave together seamless, multiple, interactive, dynamic systems through multiple molecular mechanisms, including the creation of “activity-organized” synaptic nets that begin to create meaning for the developing organism. In the sensory and somatic rhythms of neural activation, created by the intrauterine environment (warm, fluid, and embracing), the fetus (see Figure 32.1) and the mother (including her ever-beating heart) become associated through the neural activation created when the fetus is “safe and regulated” (i.e., not hungry, thirsty, cold, or threatened). Reoccurring rhythms of somato-sensory activation gain meaning. At the level of the brainstem and diencephalon, then, meaning is made of various patterns of somato-sensory bodily activity; the somatic signals of fetal posture(s) and the somato-sensory signals from rhythmic rocking, for example, have a primordial meaning of “safe,” a meaning inherent in coherent somato-sensory organization; and when the frightened or overwhelmed child self-soothes by rocking in the fetal position, it is an attempt to recapture, or may actually create, the primordial meaning of “safe.”

Neurodevelopment progresses from the lower (i.e., brainstem and diencephalon) to the higher (i.e., limbic and cortical) area. The timing and pattern of activation of key regulatory neural networks play a crucial role in

shaping the functional capacity in all the areas of the brain and body, better thought of as subsystems of the whole individual (see Figure 32.1; Perry, 2001). Perry's neuro-developmental model provides an understanding of the multiple levels of organization of the embodied processes by which the child comes to learn the "slapping" game. We will start with a two- or three-month-old and then move up the developmental ladder. After we have a picture of how the event's meaning is made at different developmental levels, we will then go on to think about how reoccurrence affects the outcome of being slapped.

### **Infant Meaning-Making Systems/Processes**

Even though the young infant's somatic and neurophysiological systems are far from fully developed, she can make meaning. She has states of consciousness, though with no implication of awareness. As such, the infant can fully organize a motivated and embodied state of distress, perhaps even an emotionally fearful state, or a motivated state of pleasure that organize her actions in the world: one state leads to withdrawal and demands for regulatory support; the other to engagement and self-directed action on some object, or communication with another. The process of meaning-making begins with the first experience to create the primary associations (i.e., neural connections) that will organize the infant's world.

During development, this sequential process of meaning-making recruits more complex neural networks in increasingly "higher" areas of the brain, essentially organizing the brain's capacity for increasingly complex and "executive" functions, whereas the lower areas mediate the simpler, more regulatory functions (see Figure 32.1). The bedrock of primary associations that help the infant create meaning is those derived from the somato-sensory and regulatory experiences from intrauterine and early postnatal experiences, as well as from ways in which those experiences organize the operation of the regulatory processes that, in their operation, embed meaning. These associations involve a set of crucial regulatory neural networks involved in the stress response (and multiple other functions; see Figure 32.1). These regulatory networks

are, themselves, modulated through patterned, repetitive, and rhythmic input from both "bottom-up" (i.e., somato-sensory) as well as "top-down" (i.e., cerebro-modulatory) systems. The brain processes (and acts on) incoming input at multiple levels; although the brain is essentially an open and interactive system, this multilevel process of sensing, processing, and acting on the world basically "begins" at the site of initial input of sensory, somatic, or cerebral input to the lower areas of the brain. It is in these lower systems that prenatal and perinatal experiences shape associations that will influence meaning-making throughout development, as the sequential process of development proceeds. Incoming modulatory input provides a direct route to these crucial regulatory neural networks and can influence the organization, reorganization, and functional status of these key systems. As these regulatory networks (e.g., NE, DA, SER in Figure 32.1) are altered and sensitized by developmental trauma, attachment disruption, and chronic derailing experiences, any therapeutic efforts must be directed at these systems.

As the somato-sensory input from the "experience" enters the brain (see Figure 32.1), there will be an iterative process that involves the sequential processing of this input from the lower neural networks (where all primary somato-sensory input enters the brain) to the higher neural networks and regions. At each level of the different systems, there are opportunities to process, store, and act on the neural "activations" that result from this experience. This complex cascade echoes through the open, interactive, dynamic neural and somatic systems. In other words, the experience of being slapped will result in stored associations—i.e., memory—in all levels of the brain, and there will be an interrelated set of memories of what others often refer to as visceral, sensory-motor, precognitive memory. All networks in the brain involved in processing any experience will be affected. It is, therefore, nearly impossible to experience a meaningful human interaction—especially in infancy—without creating implicit somato-sensory memory components.

In the case of a slap, the first time that the infant is slapped, the image of a hand moving swiftly across the



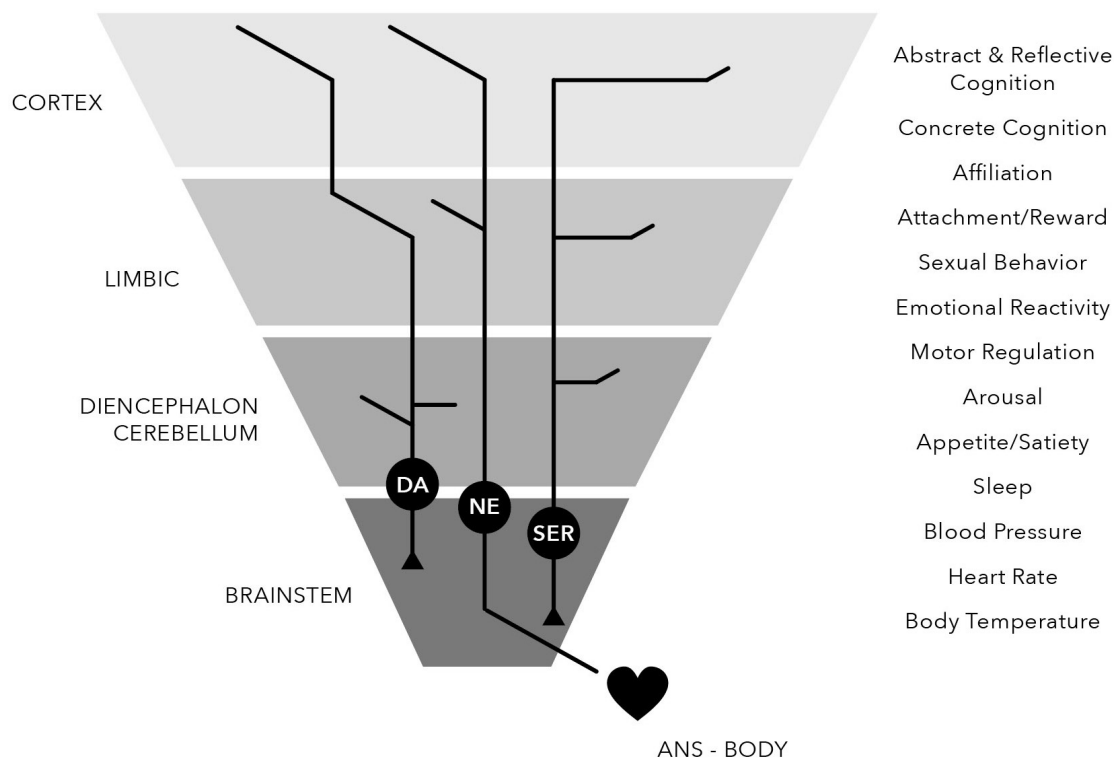


Figure 32.1. The Efferent Distribution of Key (Primary) Regulatory Networks

Human meaning-making systems are organized in a hierarchy that develops in a sequential manner. As the body—including the brain—begins to develop *in utero*, meaning-making begins. At the level of the brain, this process involves the creation of associations (literally, synaptic connections) between neural networks that are simultaneously activated with sufficient pattern, intensity, and duration. Four developmentally distinct regions (brainstem, diencephalon, limbic, and cortical) are woven together by multiple neural networks. These networks, like the monoamine systems (i.e., NE: norepinephrine, DA: dopamine) and other related systems (e.g., SER: serotonin), as well as others like ACH: acetylcholine (not shown in Figure 32.1), originate in lower brain areas and have a widespread impact on widely distributed “upstream” systems in the brain and the “downstream” systems of the body. These regulatory networks play a role in integrating, processing, and acting on incoming patterns of neural activity (Figure 32.1) from the primary sensory networks (such as touch, vision, and sound, which monitor the external environment), somatic networks (such as motor-vestibular, cardiovascular, and respiratory, which monitor the internal environment), and cerebral networks (such as cortical-modulating networks, which monitor the brain’s internal environment). This continuous input from the brain, body, and world must be integrated, processed, sorted, associated, and stored to create coherent states of consciousness for the developing infant. Then they can respond to the outside world—“meaningfully.”

visual field has not yet been associated with pain. If the slapper is always the same person, and others never slap the child, the set of somato-sensory associations may generalize to the properties of that person, or the place

where the slapping occurs (i.e., the bedroom); the child may begin to feel fearful with the sound of the slapper’s voice, the smell of his aftershave, the image of his face, the sound of a door closing, etc. And the child will then

generalize, from the slapper's hand, to all hands moving quickly near his face—even if the person is a nurturing caregiver, moving to gently wipe the child's nose. These associations and the resulting threat-related behaviors are mediated by the simpler, lower somato-sensory and action (motor) systems involved in stress and the threat response (see Figure 32.1).

These more generalized and undifferentiated responses can be quite troubling and mystifying, even when the formative experiences are part of the “known but unremembered” aspects of a person's life. Though unavailable in conscious memory, they are nonetheless stored in the brain and in the body's holding patterns, activation preferences, etc., throughout the body and are encoded by implicit neural processes that are remarkably durable. As suggested earlier, traditional talk therapy may not be sufficient to access these subcortical organizers of experience. Directing attentional processes to the body, a core feature of Somatic Psychotherapy, can stimulate neural circuits associated with these memories, providing opportunities to encode new experiences that support a shift in meaning and, subsequently, a shift in experience.

### **The Robustness of Early Meanings**

This picture of what is going on gives us a critical idea of why early experience has such long-term effects. The meaning-making process in infancy is developmentally robust, because so many meanings are connected to the fundamental regulatory needs and capacities of the child. Thus, many of the associations created early in life are directly linked with these primary regulatory neural networks and primary somatic processes that continue to shape and influence function throughout life (Figure 32.1). Moreover, the infant has less capacity to modulate or shift the meaning, because the higher areas of the brain are not yet fully organized. For example, the infant does not yet have complex time-telling capabilities, or abstract cognition, to allow her to make a more “abstract” or differentiated meaning about the one abusive slapper in relation to other nurturing caregivers.

### **Developmental Changes of Meaning-Making**

As the child becomes older, and as the limbic and cortical areas of the brain become more organized, the meaning of the slap, the slapper, and the toddler's potential to act in relation to the slapper with behaviors that appear to increase or decrease the probability of slapping change. The infant “learns” (comes to know at implicit, preconscious levels), for example, that crying (a “fight-or-flight,” stress-related behavior that should bring a caregiver to ameliorate the infant's distress: i.e., hunger, thirst, cold, pain, etc.) will actually increase the slapping, whereas dissociating (and not crying) will decrease the slapping. As a toddler, she may also learn that overly compliant, almost seductive, behavior will decrease slapping. And she may modify her meaning about slapping. Let's say her mother—a loving but overwhelmed, frustrated caregiver, who never slapped before—slaps her in frustration when she is noncompliant (noncompliance is *not* possible for her with the slapper, but is with the mother). Almost immediately, there will be a physically nurturing and intimate interaction as the guilty mother attempts to repair the empathic rupture (not an unusual dynamic with an overwhelmed mother and an abusive partner—the initial slapper). This change in meaning is now possible because of the development of neural systems previously unavailable to the infant. The “meaning” of the slap evolves.

### **Meaning-Making and Therapy**

How does the evolution of the complex archaeology of the meaning of the slap, or of peekaboo, or of being with another, or of any way of being, relate to therapy? For us, therapy is about changing meanings. How do we see the change process? Obviously, there are a myriad of driving forces and systems involved that are inherent to making and changing meaning, including somatic and regulatory systems, neural systems, and action systems; the list goes on and on. Our view of therapeutics is very much Vygotskian (1978): optimal development in any domain (e.g., neural, regulatory, motor, sensory, etc.) occurs when

the individual is given opportunities and expectations, usually by or with another person, that are neither too familiar and simple, nor too unfamiliar and complex (Perry, 2009; Tronick, 2007). For the individual with a psychic dysfunction, she has to be allowed to select or guide the information that she is presented with, so that it fits to, and can be worked on by, her meaning-making capacities to make new meanings. Tronick (Tronick and Beeghly, 2011) emphasizes that therapeutic work with infants and young children must aim to understand their intentions more deeply and especially the multilevel meanings that children are making about themselves, and how they are making meaning within themselves, and by themselves, with objects and, most importantly, with others. In adults, it is critical to determine where their sense of meaning “resides.” It may reside in the prefrontal cortex (as is presumed by cognitive therapies), but we believe that much of it also resides lower down and more unconsciously, in the brainstem and diencephalon, where regulatory and somato-sensory processes tend to operate. These processes will therefore demand forms of therapy that help to reorganize them through reoccurrent (more positive or coherent) experiences that may eventually make the distorting experience available to awareness.

One implication, of multiple levels and different kinds of meaning-making systems, is that therapy cannot simply or solely focus on just one system or another—be it the somatic, or neural, or action, or cognitive, or emotional systems. What development tells us about meaning-making and change is that it involves all these systems, simultaneously operating as a messily organized ensemble. More specifically, change involves an individual who has agency to organize her engagement with the world, especially the world of people, with every level and every meaning-making system she possesses. But development also tells us that therapeutically induced changes in meaning must enact the first principle of reoccurrence. The individual must have the opportunity to engage and reengage in experiences that can change and generate new associations at the core of their meaning.

As the reader can see from this handbook, Body Psychotherapy interventions focus on including the somatic aspects of self-organization. They work with the felt sense of the body, with movement, gesture, posture, etc., to reach those (lower) levels of self-organization(s) and meaning-making that cannot be accessed by explicit mental processes alone. They pay attention to how implicit meanings are held in the body. From this perspective, meaning—for instance, that “the world is a dangerous place”—is held by bodily processes, such as those of the autonomic nervous system (ANS), that were organized or structured by such early experiences, even though the conscious mind does not have access to the early experiences that created that meaning. Work with the body can therefore bring into awareness how the somatic processes—hypothalamic-pituitary-adrenal (HPA) axis, ANS, brainstem—operated during the prior experience, which has biased the individual’s view of the world, and makes them desirous of therapeutic work.

This process of changing and creating new associations requires plasticity of neural networks. Fortunately, neurons and neural networks are not only capable of change; they are specifically constructed to change in response to experience. This plasticity underlying both developmental and therapeutic change has conditions that will enhance, and others that inhibit, meaningful change (Kleim and Jones, 2008). Two primary principles of plasticity are specificity and pattern. Simply stated, neural networks that are not being activated with sufficient repetition in a meaningful pattern will not change.

The demand for enough experiences to allow for change is especially critical when we consider early meanings that are interwoven with fundamental somatic and regulatory processes. Admittedly, we don’t know what “enough” is, but we do know that there is seldom enough reoccurrent experience in the right systems (i.e., the bedrock associations created by our earliest somato-sensory experiences in the lower areas of the brain). Most targeted therapeutic efforts do not adhere to the core principle of specificity; nonsomatic therapies will not directly and repetitively acti-



vate the foundational somato-sensory systems (and related associations) made in early life, and localized in the lowest systems in the brain. This is where somatic and sensory experiences (and somato-therapeutic approaches) can provide direct and nondiffused patterns of neural activity that can play a primary role in reshaping systems that had been negatively impacted by earlier development experience. Yet, somato-sensory repair is, in and of itself, not capable of permeating therapeutic change. The “in and of itself” indeed applies to all therapies, but somato-sensory repair may be most effective in reaching foundational systems. Thus, as we have argued from the beginning, meaning-making and therapeutic change involve systems at all levels of the hierarchical organization of the brain and body simultaneously.

It must now be obvious why we find the idea of bringing the body more fully into therapy to be highly important. We feel treatment will remain needlessly limited, in most clinical contexts, if it cannot reach beyond the domain of the verbal. To the extent that meaning-making capacities, on multiple levels, can be reorganized, therapeutic effectiveness will be increased, we expect. What we find attractive about Body Psychotherapy is how it has embraced this basic insight. By saying this, we are not proposing that Body Psychotherapy is somehow better than other methods. We are not here taking a position about the comparative value of different approaches. Our suggestion is a more modest one, if radical enough: we suspect that there likely exist some types of techniques in the Body Psychotherapy tradition that could be profitably incorporated into, or

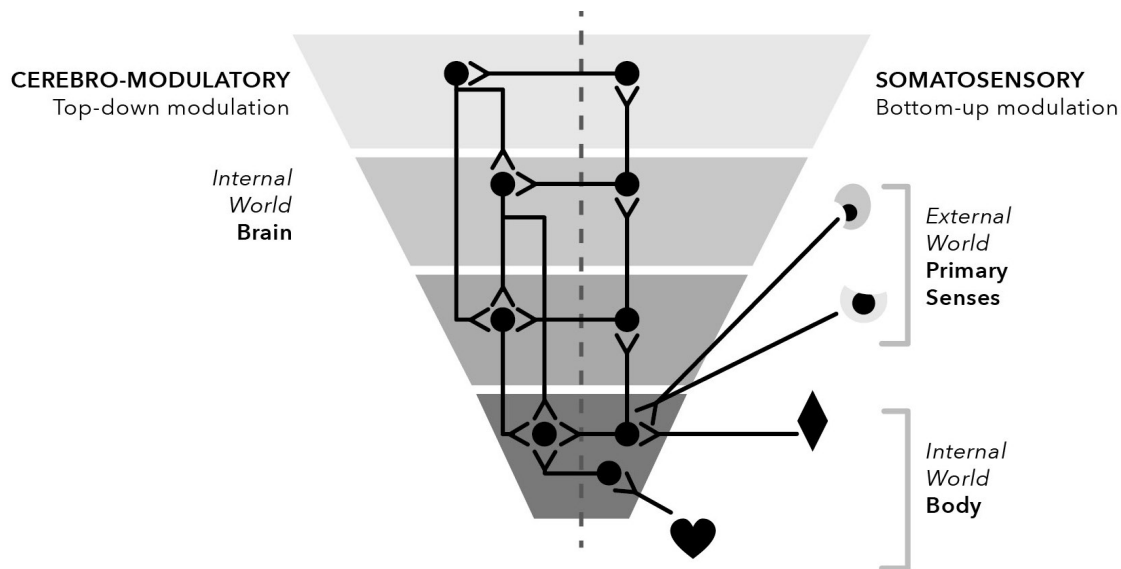


Figure 32.2. Afferent Modulatory “Pathways” of the Primary Regulatory Networks

Figure 32.2 illustrates the afferent (incoming) neural networks that provide input to the set of regulatory neural networks that are in the lower regions of the brain (e.g., NE, DA, SER, etc.). Cognitive behavioral interventions use the cerebro-modulatory routes, whereas somato-sensory interventions (e.g., music, dance, therapeutic massage, physical therapy, occupational therapy, etc.) tend to use primary sensory or somatic routes. In the case of a poorly organized cortex (e.g., due to complex trauma or neglect), or an “unavailable” cortex (e.g., due to high arousal/anxiety), cerebro-modulatory routes will be less effective. Some therapeutic efforts try to use all three routes (e.g., play therapy that integrates somato-sensory activities; EMDR; and the traditional healing rituals of many indigenous cultures).

added to, many treatment modalities (cognitive behavioral, psychodynamic, systemic, etc.).

We also think that the point of view that we have sketched out here might be of use to Body Psychotherapists themselves. It is interesting with respect to this tradition how many theoretical attempts there have been to define what “to reach beyond the verbal” should mean. Notoriously, some of these accounts—e.g., ones positing an esoteric “energy”—ring strange to psychotherapists of other persuasions. However, we sympathize with the motivation for such attempts, even if the results are other than our own way to construe matters. Perhaps a viable alternative might be a theoretical framework that gives more extensive attention to what we have called the various diencephalon and brainstem systems of meaning-making. More generally, our emphasis is on the multilevel psycho-biological nature of meaning-making. This might create a space for plenty of further thinking about what “to reach beyond the verbal” might signify, yet remain within a standard science viewpoint.

The child lives in a world where an hour of any kind of therapy is lost in the welter of all the other hours. If the people in the child’s life are not part of the process of change, then change will not occur. Traumatized children face the same dilution, even with weekly hours in therapy. They need an immersion with therapeutic Others. Adults, at some point, may be able to do much work on their own; nonetheless, additional scaffolding of their self-organized work with more contact (sessions) and “work” will enhance their own work. Thus, what makes sense for us as a guide for therapy—for children and adults—is to take our cue from the developmental meaning: Approach therapeutic change like learning peekaboo. Do it often, do it in multiple ways that fully engage every level of the individual, and let the individual agentially control the process.

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