## Certified Clinical Trauma Specialist-Family
## Child and Family Trauma Transformation

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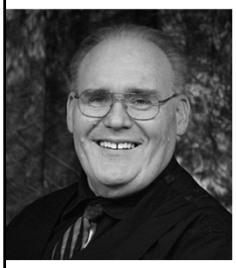

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## Resources

- Manual with PowerPoint
- The Arizona Trauma Institute YouTube page additional training videos.
- **Here is the link to** Dr. Rhoton's Resource page -- https://aztrauma.org/rhoton/ You will need to sign up for a user account to view the pages, but there is no fee or cost.



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## Contents

- You will see the value of working with families
- You will know why you have to think differently to help children and families
- Explain trauma's impact and effects
- Predictable changes in behavior, emotion and thinking are biology not pathology
- Helping others to communicate more effectively
- Help families create high quality family relationships



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## Contents

- Respect, engage and like your most challenging clients
- Co-create a growth minded family environment
- Lead and champion positive change for the families you work with



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**Section #1**

**The thought process needed for family trauma work!**

1. Why is a different thought process needed for family trauma work?
2. Dualism's impact on treatment and healing
3. Pathology focus
4. Structure of mental health system
5. Complexity versus simplicity
6. Attributes of Pathological approach
7. Attributes of Salutogenic approach
8. Example of Salutogenic thinking (be Mr. Jensen)



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## Why does Family and Child Trauma Treatment require a different thought process?

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## Dualism's impact on healing

- Separated the body from the emotions, thinking and behavior.
- Inadvertently promoted a pathogenic approach to resolving problems.
- Pathogenic focuses on acute symptoms, which in medical terms is great if the problem is localized in one organ or system of the body. This led to specializations to deal with acute disease.
- **Pathogenic approaches do not address environmental, whole person, life-style or prevention.** It is laser **focused problems** and **deficits**.
- What emerged in the culture of mental health was a pathogenic view of emotions, thinking and behavior. Overly focused on **problems** and **deficits**

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## Dualism's impact on healing 2nd slide

- The Salutagenic approach looks at the person as a multiple systemic functioning being.
- Salutagenic is not designed for acute pathology (symptoms) it is designed for dealing with whole person.
- Salutagenic approaches are necessary when the acuity is not centered in one part or system. Most situations we deal with in the mental health culture are Salutagenic, not pathogenic.
- Truly trauma-informed approaches are salutagenic not pathogenic in nature.

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## Economic structure of mental health culture

- **Diagnostic system (DSM)**
- **The Pharmaceutic Industry**
- **Medical Insurance**
- **Most traditional treatment models**
- **Most agencies and programs**

**Tend to be strongly Pathogenic, looking for acute causes**

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People with histories of trauma, toxic stress, and adversity are not generally dealing with the consequences of acuity

**Instead they are dealing with the consequences of having multiple systems effecting each other, creating changes in body, behavior, social/emotional, and spiritual aspects of life**.

Most of us were trained from a Pathogenic ***not*** Salutagonic prospective in college programs

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## Attributes of Pathogenesis

- **Disease-centric**
- **Paternalistic (power and control from the top down)**
- **Curative (fixing a problem)**
- **Fixing discrete "broken" parts**
- **Authority figures, professionals possess a sense of entitlement**
- **Lower levels of collaboration and transparency about process or expectation**
- **Business and billing efficiency-minded**
- **Absence of pain is equal to good health**

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## Attributes of being Salutogenic

- Thriving
- Self-efficacy
- Hardiness
- Locus of control
- Gratitude
- Social and emotional intelligence
- Connectedness
- Attachment
- Empowerment
- Learned optimism
- Coping skills
- Quality of life
- Flourishing
- Resilience



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## Be Mr Jensen



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## Why work with trauma from a Salutogenic prospective?

- The symptoms labeled as dysfunctional family behavior are frequently the consequences of accumulated/layered circumstances, stressors and reactive responses **(*normal reactive physiology)*** rather than **volitional acts.**
- Children have ***little to NO*** capacity to be more regulated than the environment, or the adults in charge of their world.
- When families are overwhelmed by stressful circumstances it disrupts development in all domains.



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## Rules for good clinical work

- Your patients will be your best teachers.
- No meeting with any patient is ever routine for them, so it should never be routine for you.
- Focus on establishing a strong therapeutic alliance and healing relationship. This is the most important initial goal.
- Validate that your patients are currently trying to do their best, but also possess a strong belief in their ability to grown and be increasingly competent.
- Always inspire realistic hope and always reverse unrealistic demoralization.
- Follow your patient—not your preconceived notions, a supervisor, or a manual.
- There are no bad or boring patients, but there are some bad and boring therapists.
- Be as empathic, as caring, as involved, and as alert for the 10th patient each day as you did for the first.
- Never lose sight of the practical struggles each patient faces in the real world and try to help them find practical solutions.
- Do not give advice when the patient can find his or her own way.
- Include family, friends, other informants, and potential co-therapists whenever possible.
- Be open ended enough in your questions to let patients tell their life stories and structured enough in your questions to get the specific information you need.
- Try to create rare magic moments—things you say to patients that they will remember always and use in changing their lives.
- Take your time and be careful. Small mistakes can have major consequences.
- Know the patient, not just the diagnosis.
- Diagnosis should almost always be written in pencil—especially in the young and the old. And, always err on the side of underdiagnosis—it is easy to later up-diagnose and almost impossible to erase a diagnostic error that can haunt the patient for life.
- Use DSM, ***but do not worship it***. Equally distrust clinicians who do not know DSM and those who only know DSM.
- Educate patients about their symptoms, diagnosis, course, and the risks and benefits of plausible treatments.
- Negotiate, do not dictate, the treatment plan: allow patients to pick whichever plausible treatment most suits them with awareness that no one size fits all.
- Do not join the bandwagon of diagnostic fads. Whenever everyone seems to suddenly have a diagnosis, it is surely being way overdone (e.g., attention deficit hyperactivity disorder, autism, bipolar disorder).
- Watchful waiting is the best treatment whenever there is doubt or the symptoms are mild.
- Placebo is the ***best "medicine"*** ever invented and responsible for most of what appears to be drug effect when milder symptoms improve.
- Always rule out the real possibility that symptoms are caused by medications, alcohol, street drugs, or medical illness.
- Do not be a careless pill-pusher, but do understand the great value of medications used wisely for proper indications
- Know the risks, not just the benefits, of medications.
- Avoid the current tendency toward irrational poly-polypharmacy.

- Read the scientific literature with great skepticism and awareness that most studies do not replicate, positive results are always exaggerated, and negative results are usually buried. Do not be wowed by genetic findings—so far, they have flopped in finding causes and have no place in planning treatments.
- Uncertainty sure beats false certainty. Accept its inevitability; do not jump to conclusions, and help your patients deal with the anxiety it provokes.
- Learn statistics, especially as they apply to medical decision making and think probable not rigid yes/no categories.
- Have a rich, varied, and satisfying personal life.
- Embark on a personal psychotherapy to help understand yourself better, solve any problems you may have, correct biases based on your personality and experiences, and discover what it is like to be a patient.
- Learn from your supervisors, but do not follow them slavishly.
- Read widely, especially the great classic novels, and see psychologically astute movies and plays.
- Read history and try to deduce its recurring patterns.
- Do not impose your cultural biases, your religious beliefs (or non-beliefs), or personal values on your patients.
- For every complex question, there is a simple, reductionistic answer—and it is **WRONG.** Do not expect or believe simple answers to complex questions, such as "What causes mental illness and how best to treat it?" Instead, do have a well-rounded, four-dimensional bio/psycho/social/spiritual approach to understanding mental disorders and selecting treatments for them.
- Be a vocal advocate for our patients. We must do all in our power to reverse the shameless neglect of the severely ill that has relegated 600,000 of them to jail or homelessness.
- Be yourself—and grow into an even better version of yourself as you enjoy the special privilege of helping others also better themselves.
- DO NO HARM!

Dr Frances is Professor Emeritus and former Chair, Department of Psychiatry, Duke University;

## Summary of this section

- Dealing with Families and children require a Salutogenic thought process.
- A focus on pathology and acuity are going to consistently underserve family and child well-being
- Most systems (schools, juvenile probation, child protective services, and courts) that counselors and therapists work with are going to be Pathogenic focused on immediate acute resolution than in long-term well-being.



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**Section #1**

**The thought process needed for family trauma work!**

1. Why is a different thought process needed for family trauma work?
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**Section #2**

Trauma Introduced and explained

1. Trauma is a body and nervous system response that is natural and predictable
2. Trauma, toxic stress and adversity
3. What happens when the Central Nervous System Shifts
4. Changes in biology create changes in emotion thinking and action
4. What is 100% correct response to trauma and toxic stress.
5. Stop seeing behavior, emotion and thinking as a purely volitional choice



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## A thought in starting our journey

- It takes tremendous courage to confront childhood trauma. Often it is like searching through a stygian darkness for the source of pain and misery.
- Most children with histories of trauma, toxic stress and adversity will **NOT** be strong enough on their own to resolve and work through early life experiences. They require the support of a caregiving system.
- The caregiving system that is essential to help a child to resolve trauma is one were the parents and emotionally balanced, intentional and deliberate, not reactive, punitive, aggressive or shaming. The parent must already be living the healthy life that the child is being asked to live.



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## Vwduwlqj#sr lqw

The state of the body influences behavior, emotions and thinking

Z kdw#grhv#kdw#hdo|#p hdqB

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## It is not a choice, it is biology

What is a large increase

| 4 Changes in metabolism | 2 Emotional/behavioral change |
|---|---|
| Large increase in Noradrenalin | Anger, Aggression and Hostility |
| Large increase in adrenalin | Fear, Withdrawal, flight, |

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**What can cause these large increases in Hormone and biochemistry**

- If the child was neglected or abused the child is likely to develop a primary world view that the world is a threatening, fearful and unhappy place.
- Often because of lack a of safety, the adult figures in a child's life are seen as being untrustworthy which is stressful
- Fear, feeling unsafe, family conflict, unstable adults drive hypervigilance, and stress
- Avoidance and making one's self small and striving to be invisible are also triggers for biochemical changes in the body.
- Being criticized, difficulty in relationships with adults, feeling shame are also triggers of biological



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## Why is this point important

The state of the body influences behavior, emotions and thinking

What are the bodies of your clients experiencing?

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## Why is this point important to you!

***How would it change you and the way you look at things:***

- **You would always give people the benefit of the doubt**
- **Realize that when you are angry that is *you* failing to manage you well, not anything to do with other people's actions**
- **Most often annoying behavior is not planned, or done with forethought**

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## The body's excitatory process

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## The Body has a Balance System

- Which regulates body processes
- Works automatically (autonomously), without a person's conscious effort.
- When out of balance the body ***ADAPTS*** or ***MITIGATES***
- Behavioral symptoms result from the over-use of the threat/stress response system and the body is struggling to have balance



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## Adaptation (how the body self corrects)

- **Hemostasis Phase** is the process of the wound being closed by clotting
- **Inflammatory Phase** is the stage of wound healing causing localized swelling. Inflammation both controls bleeding and prevents infection.
- **Proliferative Phase** is when the wound is rebuilt with new tissue.
- **Maturation Phase** also called the remodeling is when the wound fully closes.



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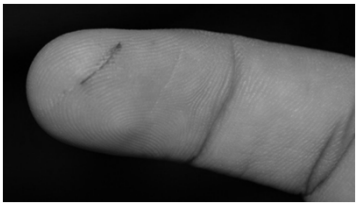
# Ouch!!!!





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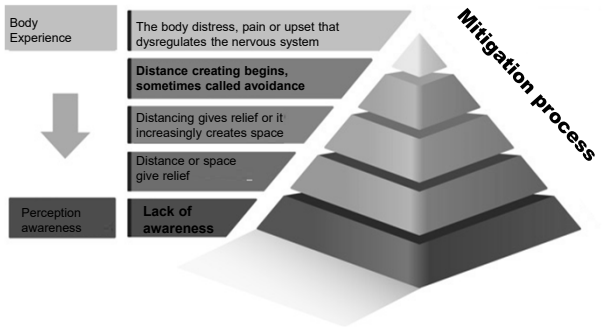
Body Experience
The body distress, pain or upset that dysregulates the nervous system
Distance creating begins, sometimes called avoidance
Distancing gives relief or it increasingly creates space
Distance or space give relief
Perception awareness
Lack of awareness
Mitigation process

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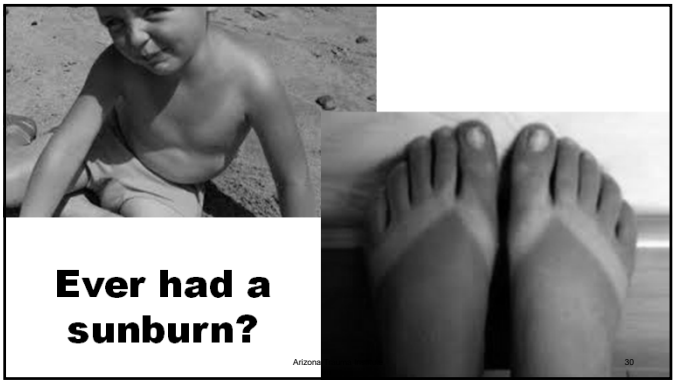
Ever had a sunburn?



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## If you have had a Sun Burn have you mitigated?

**Do you change your behavior?**

- ✓ Staying out of the sun
- ✓ The clothes you wear
- ✓ How much physical contact with others you will tolerate
- ✓ How you sit comfortably

**Do you notice that you get angry more easily?**

**If someone looks like they might touch you are you more reactive?**

**Do you get a little extra snappish with people, even loved ones?**




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## If you have had a Sun Burn have you mitigated?

**Did you put something on the sunburn to reduce the pain?**

- ✓ Aloe vera?
- ✓ Aloe vera with lidocaine (topical analgesic)?
- ✓ Vinegar?
- ✓ Hemorrhoid cream?
- ✓ hydrocortisone cream?
- ✓ Tea bags?
- ✓ Aspirin, Ibuprofen ?

**Did you use some substance to give you relief from pain and distress?**

**Mitigating reduces the risk of further distress and pain!!!**



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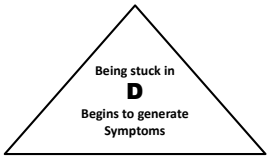
## Trauma/adversity cycle

**R** ⟹ **D** ⟹ **RR**

| Regulated | Dysregulated | Re-Regulated |
|---|---|---|
| Bruce Banner Brain | Hulk brain | Bruce Banner Brain |



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## Trauma/adversity cycle

**R** ⟹ **D** ⟹ **RR**

**Regulated**
Bruce Banner Brain

**Dysregulated**
Hulk brain

**Re-Regulated**
Bruce Banner Brain



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## Traditional Types of Trauma

Natural disasters
Mass interpersonal violence
Domestic fires
Motor vehicle accidents
Rape & sexual assault
Physical assault
Partner/Family battery
Torture
War
Child Abuse
Emergency worker exposure



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Most clients are not working with a single incident trauma!

They struggle because of multiple stressors



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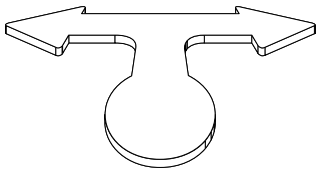
## Please Understand

**SALUTOGENIC**

You see behavior, emotion and thinking as a form of communication that reflects people's movement through different environments

**You must choose!**



**PATHOGENIC**

That the problem is some acute single cause that is within the person and if that can be patched or fixed then everything will be better. Acuity and problem focused

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## What are the absolutely correct biological responses you should see?

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## Nature of the sympathetic system

- Immediate
- No future
- Impulsive
- Irrational/illogical
- Little self reflection
- Little evaluation
- Poor ability to evaluate rewards



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## Change or transformation requires Bruce Banner not the HULK

**A metaphor to use when thinking about how the body changes thinking, emoting and behaving**



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**Perhaps a different way of looking at this might be nice kitty and mean kitty**



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1. The idea of a window or range of tolerance
2. Resilience is living within the range of tolerance
3. Hormonal and biochemical changes push us above the threshold
4. When move past the window of tolerance we are no longer intentional, but reactive
5. Metabolism overload
6. Hippocampal function
7. What should be seen behaviorally, emotionally, and in thinking when outside the window of tolerance

**Section #3**
Window of tolerance and stress responses

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## How does trauma get created?

# OR

**How does the body get "pushed" to the point that it must adapt or mitigate?**

Arizona Trauma Institute 44

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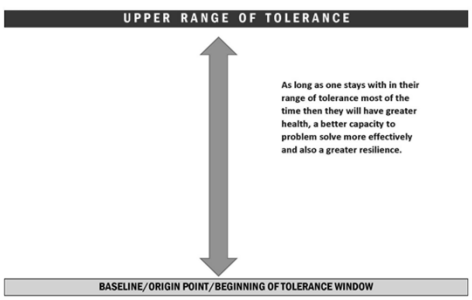
**Range of Tolerance Graphic**

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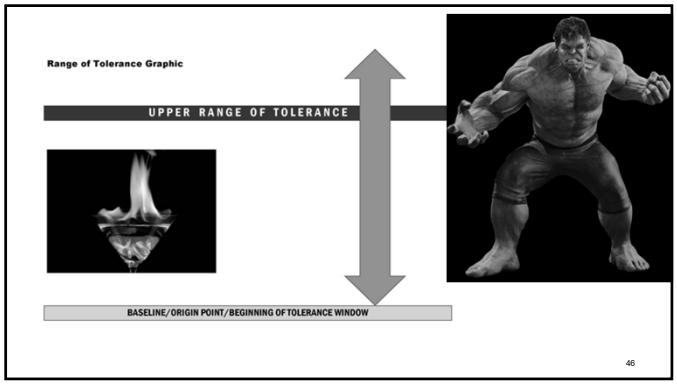
Range of Tolerance Graphic
UPPER RANGE OF TOLERANCE
BASELINE/ORIGIN POINT/BEGINNING OF TOLERANCE WINDOW
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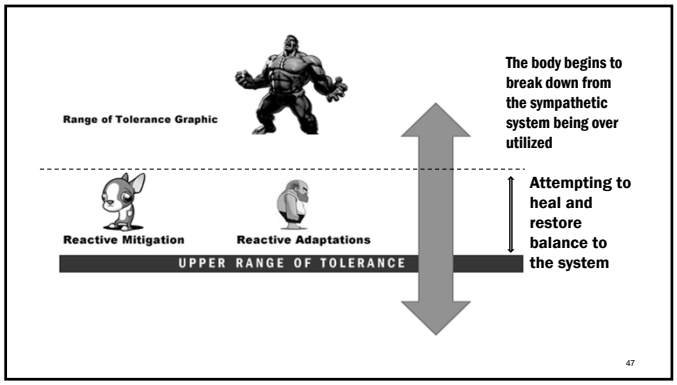
Range of Tolerance Graphic
The body begins to break down from the sympathetic system being over utilized
Attempting to heal and restore balance to the system
Reactive Mitigation
Reactive Adaptations
UPPER RANGE OF TOLERANCE
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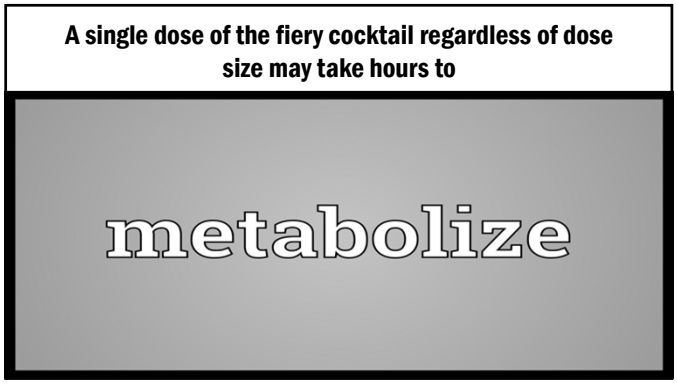
A single dose of the fiery cocktail regardless of dose size may take hours to
metabolize

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## Impact of 2 ingredients of the fiery cocktail! There are many more

- **CORTISOL**

**a. Reduces**
- ✓ Hippocampal activity
- ✓ Executive functioning
- ✓ The ability to create sequential memory
- ✓ Ability to see differences or distinctions (reality checking)

**b. Restricts access to the (impulse control center)**

**c. Can act as a neurotoxin**

- **ADRENALIN**

**a. Increases**
- ✓ Emotional memory
- ✓ Sensory memory
- ✓ Fear, anxiety, phobias, hallucinations, depression, agitation

**b. Reduces**
- ✓ ability to focus
- ✓ sleep patterns
- ✓ problem solving
- ✓ goal follow through and attainment



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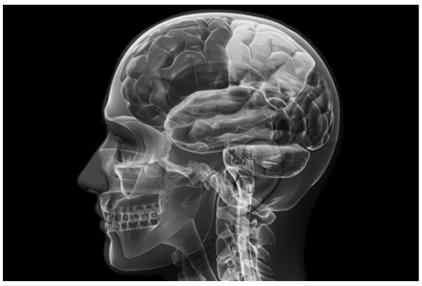
## When the whole brain works together





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## Hippocampal function

- Creates discrete/distinct elements from experience
- Necessary for reality checking
- Modifies and governs Amygdala function
- Serialize and/or sequence time within a context
- Connect separate brain regions as part of active integration
- Enhance executive functioning
- Enhances cognitive flexibility
- Increases ability to inhibit behavior
- Greater sequential memory
- Logic
- Reason
- Reward Evaluation
- Planning



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## When the brain isn't regulated multiple areas are adversely impacted

Areas Impacted:

**Biological**
**Emotional**
**Cognitive**
**Social**



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## So are big bad events necessary to have the symptoms of trauma?




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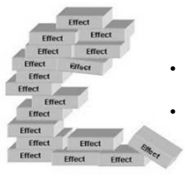
## Small repeated events: The cumulative harm effect




- **Chaotic environments**
  - **What are chaotic environments**
- **Aggressive environments**
  - **What is an aggressive environment (anytime rules come before relationship)**
- **Punitive environments**
  - **Where there is a demand for performance that is valued more highly than attachment or relationship**
  - **When the rules for operating constantly flux based on the annoyance of those in charge**
- **Inconsistent practices**
  - **What doe this look like**
- **Instability**
  - **Lack of predictability**
  - **Inability to trust situation**



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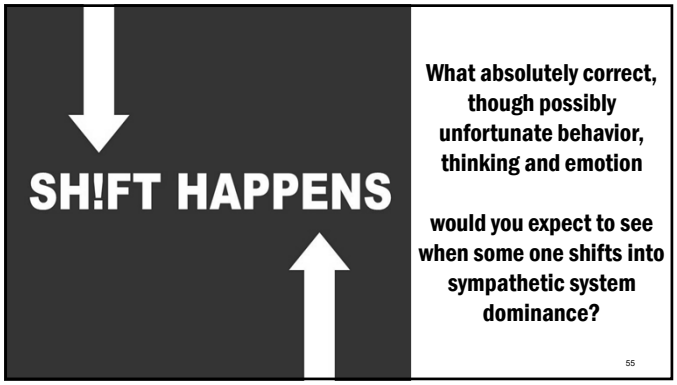


What absolutely correct, though possibly unfortunate behavior, thinking and emotion

would you expect to see when some one shifts into sympathetic system dominance?

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## What are the absolutely correct biological responses you should see?

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## These are not bad behaviors –just proof of the system in use

**(action oriented behaviors fight or flight)**

- Angry
- Aggressive
- Defensive
- Reactive
- Impulsive
- Hostile
- Irrational
- Self-centered
- Poor focus
- Inattention
- Sleep disturbances
- Fidgety
- hyperactive
- anxiety
- Irritability
- Delays in reaching physical, language, or other milestones on time

**Physiological congruent and predictable behaviors**



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**These are not bad behaviors just proof of the system is in use**

**(passivity oriented behaviors related to mitigating behaviors)**

- Freezing, stuck, paralysis of action
- ***Dissociation***
- Emotional numbing
- ***Distraction***
- Self-soothing
- ***Addictions***
- ***Self-injury***
- ***Suicidality***
- ***Compulsive behavior***
- Reactive
- Impulsive
- Emotional and psychological distancing
- Self-centered
- Sad
- Withdrawn
- Difficulty attaching securely
- reluctance to explore the world

**Physiological congruent and predictable behaviors**



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1. The idea of a window or range of tolerance
2. Resilience is living within the range of tolerance
3. Hormonal and biochemical changes push us above the threshold
4. When move past the window of tolerance we are no longer intentional, but reactive
5. Metabolism overload
6. Hippocampal function
7. What should be seen behaviorally, emotionally, and in thinking when outside the window of tolerance

**Section #3**

Window of tolerance and stress responses



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1. What is PolyVagal
2. The function of the ACC or the Anterior Cingulate of the Cortex
3. How binary thinking is created
4. Memory distortions are based on relevance
5. An explanation of potentiated reactivity
6. Calm and balanced CNS (Bruce Banner) need to sustain any change
7. Unmet needs drive arousal and dysregulation like threat and danger do
8. Dysautonomia which is more accurately what we are dealing with

**Section #4**

Introduction to the Polyvagal function



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## Threat/Stress Response System of the Body

## The Poly Vagal System

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## Truth #1

- **The job of the autonomic nervous system is to ensure we survive in moments of danger and thrive in times of safety.**
  - Surviving requires that we have a sophisticated threat detection and an activation/reactive survival response.
  - Thriving requires the inhibition of the survival system activation/reactive responses so that social engagement can happen.
  - When we have a reduction in our capacity/capability for activation, inhibition and flexible (intentional) responses; suffering emerges
  - Rather that consider trauma as an event instead think of trauma as "an overwhelming demand placed upon the physiology of the human system" **(Polyvagal theory in therapy, D. Dana 2018, p17)**



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## The survival system

- Humans have two mobilization systems:
  - A. (SAM) the sympathetic adrenal medullary system
    - ✓ (SAM) provides a fast response (the burst of energy) which is a (hormonal) adrenal response
    - ✓ Increased heart rate, circulation of blood flow changes, change in carbohydrate metabolism, muscle activation.
  - B. (HPA) the hypothalamic-pituitary-adrenal axis
    - ✓ Activates when the (SAM)response doesn't lead to resolution of demand. HPA triggers the release of the (hormone) Cortisol. This release is much slower than the SAM system, and takes much longer for the body to metabolize after releasing.



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## Three biological parts in action #1

- **The parasympathetic system (two primary processes)**
  A. Relational and social connection systems (attachment & relationship pleasure)
  B. Immobilization and anesthesia systems (freezing & feigned death)
- **The pathway of the Parasympathetic system is the VAGUS cranial nerve which branches into distinct actions:**
  A. Dorsal Vagus (most primitive) takes the body out of social/relational connection into immobilization. It actively creates space between visceral experience and perceptual awareness
  B. Ventral Vagus (most modern) takes the body into social/relational connection or social engagement and co-regulation of the nervous system. ***Human thriving requires frequent and prolonged ventral vagus activity***



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## Three biological parts in action #2

- Through the three systems (sympathetic, ventral Vagal, and dorsal vagal) our autonomic nervous system (ANS) is constantly in service to survival.
- Regardless of situation (Traumatic event, living and/or working is a toxic stress environment, and repeated adversity), the ANS is linked and functioning for survival.
- **If we do not get regular opportunities to experience safety (physically, emotionally, and psychologically) then the ability to activate or inhibit the ANS appropriately WILL lead to difficulties engaging, disengaging and re-engaging relationally with others, increasing our difficulty to meet our needs.**



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## Lack of adequate activation and inhibition

- Attachment difficulties
- Problems with relational stability
- Increasing levels of family distress as parents and children fail to regulate which allows them to appropriately activate or inhibit the operation of the ANS
- Learning and memory challenges
- Reactive and emotional responses rather than intentionality and deliberateness.



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## Three Types of Nervous System Activation

- **REAL DANGER**
  Facing actual danger, threat, being unsafe is imminent
- **PERCEIVED THREAT**
  Inability to distinguish between past painful learning and the present
- **IMAGINED FEAR**
  Failure to regulate the arousal system

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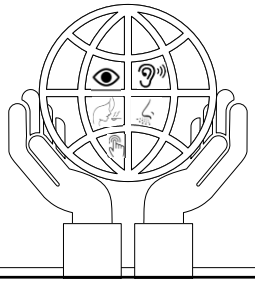
## We learn through experience

OUTER

We always start here exposures, experiences… what happens to us and around us

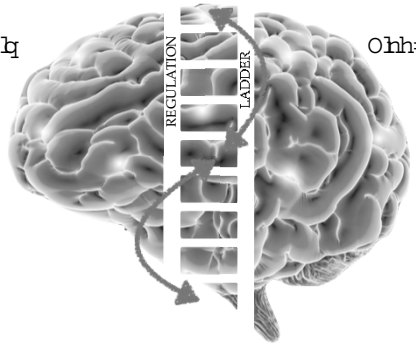


INNER

Our perceptions, interpretations, beliefs, what we know, and our assigned meanings

68

## Wkh#Eudlq

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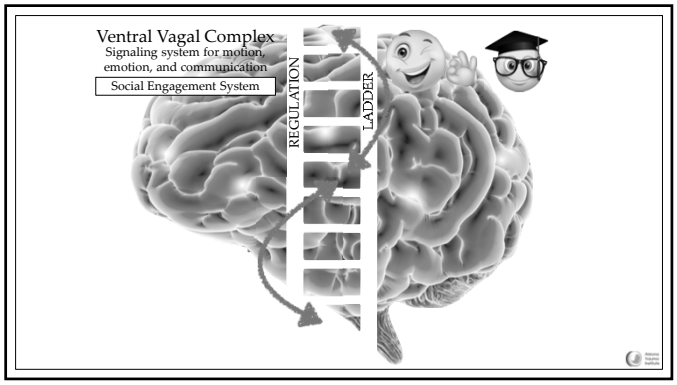
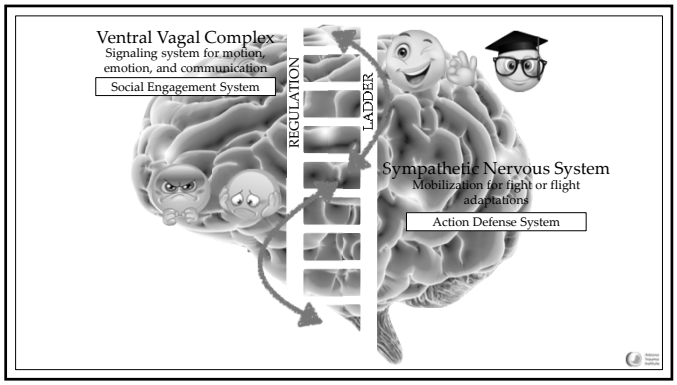
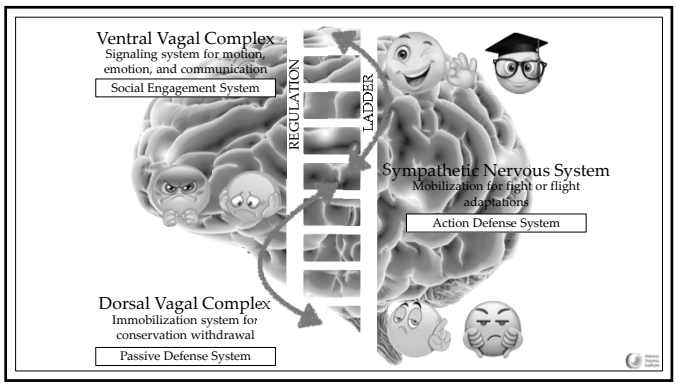

Ventral Vagal Complex
Signaling system for motion, emotion, and communication
Social Engagement System
REGULATION
LADDER

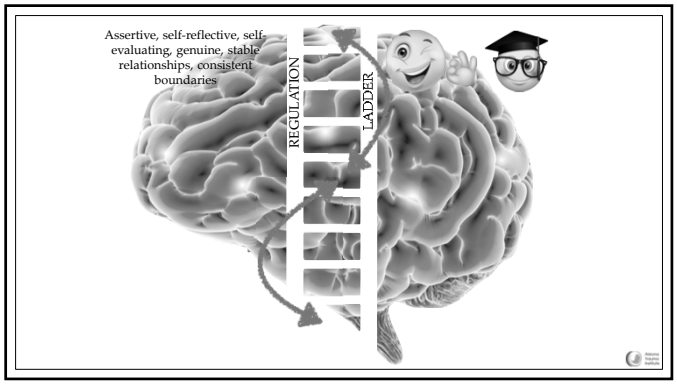
70


Ventral Vagal Complex
Signaling system for motion, emotion, and communication
Social Engagement System
REGULATION
LADDER
Sympathetic Nervous System
Mobilization for fight or flight adaptations
Action Defense System

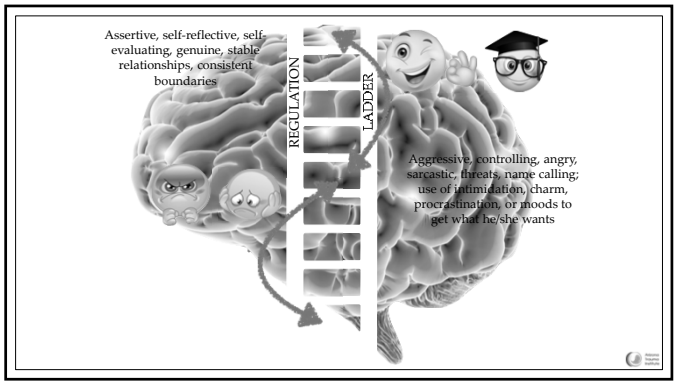
71


Ventral Vagal Complex
Signaling system for motion, emotion, and communication
Social Engagement System
REGULATION
LADDER
Sympathetic Nervous System
Mobilization for fight or flight adaptations
Action Defense System
Dorsal Vagal Complex
Immobilization system for conservation withdrawal
Passive Defense System

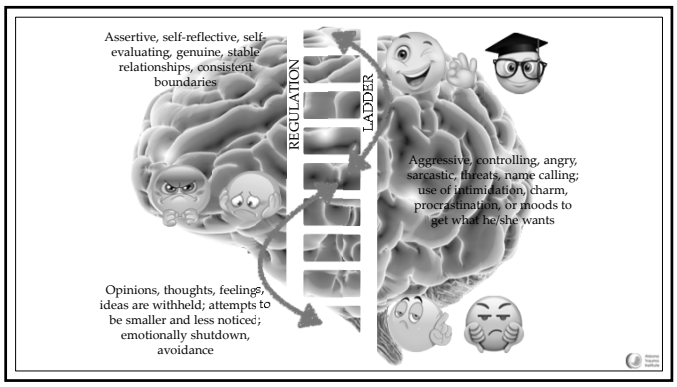
72


Assertive, self-reflective, self-evaluating, genuine, stable relationships, consistent boundaries
REGULATION
LADDER

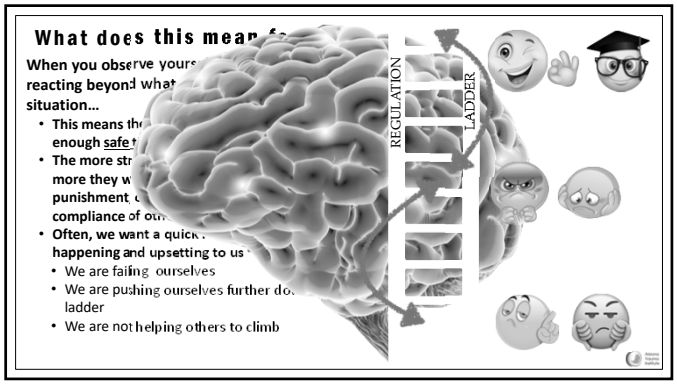
73


Assertive, self-reflective, self-evaluating, genuine, stable relationships, consistent boundaries
REGULATION
LADDER
Aggressive, controlling, angry, sarcastic, threats, name calling; use of intimidation, charm, procrastination, or moods to get what he/she wants

74


Assertive, self-reflective, self-evaluating, genuine, stable relationships, consistent boundaries
REGULATION
LADDER
Aggressive, controlling, angry, sarcastic, threats, name calling; use of intimidation, charm, procrastination, or moods to get what he/she wants
Opinions, thoughts, feelings, ideas are withheld; attempts to be smaller and less noticed; emotionally shutdown, avoidance

75


What does this mean f
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reacting beyond what
situation…
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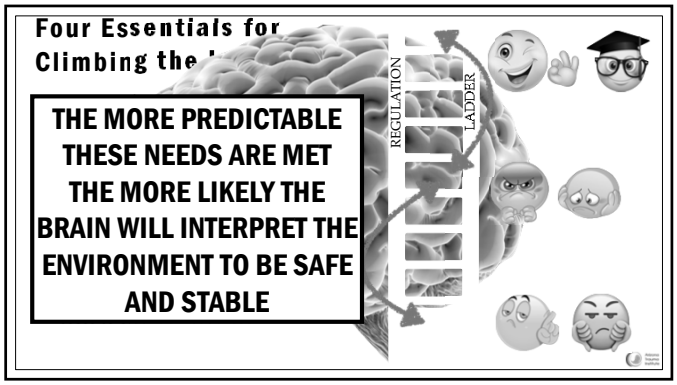
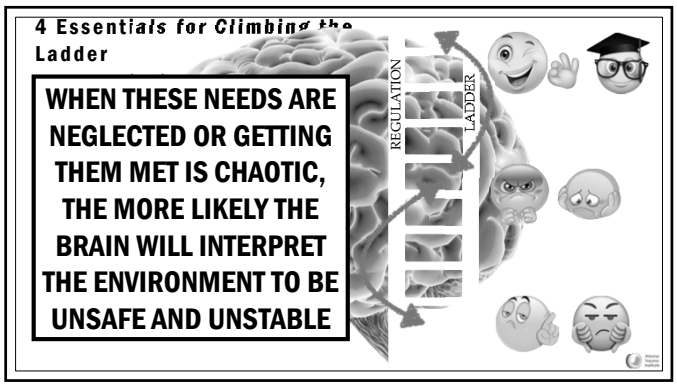
• Often, we want a quic
happening and upsetting to us
• We are failing ourselves
• We are pushing ourselves further do
ladder
• We are not helping others to climb
REGULATION
LADDER

76


Four Essentials for
Climbing the
THE MORE PREDICTABLE THESE NEEDS ARE MET THE MORE LIKELY THE BRAIN WILL INTERPRET THE ENVIRONMENT TO BE SAFE AND STABLE
REGULATION
LADDER

77


4 Essentials for Climbing the
Ladder
WHEN THESE NEEDS ARE NEGLECTED OR GETTING THEM MET IS CHAOTIC, THE MORE LIKELY THE BRAIN WILL INTERPRET THE ENVIRONMENT TO BE UNSAFE AND UNSTABLE
REGULATION
LADDER

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# Healing Trauma And Pain Through Polyvagal Science

Peter Levine, Ph.D., Stephen Porges, Ph.D., and Maggie Phillips, Ph.D

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# HEALING TRAUMA AND PAIN THROUGH POLYVAGAL SCIENCE: AN E-BOOK

**Peter Levine, Ph.D., Stephen Porges, Ph.D. and Maggie Phillips Ph.D**

## Introduction

The genesis of this e-book was a 3-session webinar that was recorded and broadcast in November, 2014. Each chapter represents the material of one of the three sessions; the question and answer session transcripts of all 3 are included as an appendix at the end of the book.

Stephen Porges and Peter Levine met back in the late 1960's. As Peter says, "We went to kindergarten together." They have been study partners in the emerging field of polyvagal science, which has revolutionized how we conceptualize and treat trauma.

One of the leading proponents of the Polyvagal Theory of nervous system evolution, and author of *The Polyvagal Theory (2011),* Stephen Porges has made groundbreaking shifts in our understanding of neurophysiological foundations of emotions, attachment, communication, and self-regulation. Peter Levine, is one of the world authorities in somatic approaches to the treatment of trauma, and creator of Somatic Experiencing,™ a gentle, highly effective model for the treatment of trauma and restoration of balance and wholeness. He is well-known for his applications of polyvagal science in his work.

Peter and I have taught together for more than 30 years on various topics related to the treatment of trauma and more recently to that of pain. Our recent explorations led to the creation of *Freedom From Pain: Discover Your Body's Power to Overcome Physical Pain (2007), a book with a CD of audio exercises published by Sounds True.*

The three of us first worked together in the Innovations in Trauma Treatment, an online conference presented live and on-demand between January – August, 2014 (for more information, write peggy@maggiephillipsphd.com). The three of

us were presenters in the conference and I had the great pleasure of interviewing both of them about the essence of their work.

We decided that our next project would be the November webinar on how polyvagal science and theory actually hold the answers to the best practices in healing and resolving pain, as one of the most challenging forms of trauma which has been locked into the nervous system, sometimes since early life. We are proud of the results and are happy that you are joining us. The e-books offer a more integrative version of the audio/video versions with edited manuscripts. You might be interested in the other formats as well to enhance your learning visit http://maggiephillipsphd.com/.

We hope you will find this an exciting addition to your resource library as we extend the "cutting edge" connections between trauma, neuroscience, social engagement and the defensive functions of the nervous system, and the creative applications of polyvagal neuroscience, Somatic Experiencing,™ and other body-focused approaches to successful healing and integration.

### The Sympathetic/Adrenal (Fight/Flight) System and Effective Interventions

Peter Levine and Maggie Phillips

# Chapter One

The concepts underlying the Polyvagal Theory are relatively basic, but they have been elusive for decades if not centuries. The clue to framing the Polyvagal Theory has been to understand and appreciate that our nervous system responds to challenges in a very adaptive way.

**The Sympathetic/Adrenal system, which we will explore first in this course, has to do with mobilizing**. Its actions are known best in the form of fight or flight reactions and behaviors.

The autonomic nervous system used to be seen as something that just goes on autonomously and had nothing to do with how we feel, certainly nothing to do with our consciousness. In reality, it's a reflex, like when the doctor takes the hammer and gives you a little tap below the knee, the leg kicks. That is an autonomic reflex.

Experts now are trying to bring forth the idea that what goes on in the basements of our nervous systems, the autonomic nervous system, really affects the entirety of consciousness and feeling. When you are talking about the autonomic nervous system, you are not talking about an *autonomous* system. It is a highly integrated system. Integrated somatically, perceptually and cognitively, it's a profound regulator of our energy systems. Here is where we can bring together the different systems that comprise the ***polyvagal*** system, which is the primal core regulatory system.

## The Polyvagal as an Integrated Regulatory System

There are three primary systems involved. The first most recent system is related to the mammalian system—i.e., this system only exists in mammals and becomes more elaborated, more refined in higher mammals and primates. It is called the social engagement system, or the ventral vagal system. It's a system that is 100 – 160 million years old. Mammalians go back 160 million years. Its key function has

to do with the fact that we are social animals. Our survival depends on our ability to connect socially and communicate socially. This is the most refined system.

Hypothetically, if you are angry with a person, you don't go and try to strangle them, as in the fight or flight reflex. You will most likely go to the person and say "there's something we need to talk about." We engage face to face. This should be our default system because we are not living in the jungle any more.

There's a second system that that goes back probably about 280 million years and this goes back to the reptilian period, and actually even to fish. From the reptilian period forward there is the sympathetic adrenal system. This has evolved over a period of about 300 million years, perhaps a bit more. ***This system has to do with mobilizing fight and flight responses but also has to do with bracing, holding, protecting and flexing.*** This is the sympathetic /adrenal system. From reptiles upwards, it has the dual function of the sympathetic nervous system and secretion of the adrenal glands. So the adrenals have only really occurred in the reptilian era 280 million years ago.

Once the sympathetic has evolved, it's not so easy to bring things back to equilibrium, because the organism has become "wired up" rather than used to down-regulate activation.

Here's an example: A person is sitting in their car when someone hits them from behind. Both drivers get out. Both are angry and get out their licenses, insurance, etc. Then they begin to discuss the situation and they're actually feeling really good, actually kind of high, thinking that they're really getting a lot accomplished. Yet, others are noticing that their behavior is really strange. It's a manic kind of experience, and again it's something that takes time to come down from. We really don't want to go into that system unless we really have a high probability that we need it. That's where the *ventral vagal system, the social engagement system*, which we'll review later in this course, also plays an important function in down regulating, or slowing down the sympathetic nervous system fight or flight responses.

These two systems, the ventral vagal and sympathetic adrenal, were followed by what Stephen Porges calls the *dorsal vegal* or the *myelinated vegas nerve*. This is the nerve that goes from the back of the brain stem, down into the body and

connects to all the viscera. Many believe all the viscera, especially the heart, lungs and guts, stomach and intestines – this system has to do with shutting down. It goes back 500 – 600 million years, very primitive.

One principle of evolution is that *we don't outgrow one system and go to the next.* That early system gets carried forth. Looking at that system at the very beginning of its evolutionary development, we find the jawless fishes that we see in National Geographic and Cousteau programs. The function of the vegal system is to shut down metabolism. You can see that in sharks and rays. If there's not enough oxygen the organism doesn't want to use it up. We shut down. It's called "energy conversation withdrawal." We have that system and if it takes over, that system shuts down the more recent system or suppresses it in some way.

***The dorsal vagal*** **system suppresses the sympathetic system**, especially the social engagement system, **just as the sympathetic system inhibits the social engagement system, and the social engagement system has the capacity to down-regulate the sympathetic system**.

What happens when we perceive a threat in our environment? We go into these primitive self-protective and defensive responses of fighting or fleeing. The first choice usually is to remove ourselves from the situation if that is possible.

But if we need to stay, if that's the only choice, or if the individual perceives that it is much stronger than the threatening animal, then he or she responds with a fight. But in order to do this, we mobilize tremendous amounts of energy. All of our muscles are tuned to a high pitch, like a violin string. We tune it to the highest pitch, ready for action, and when we're ready for action, the autonomic nervous system, that is to say the sympathetic system, prepares the metabolism, and our muscles for action.

Let's first give an example that shows how powerful the sympathetic effect can be. There are many cases that document mothers who weigh 90 pounds lifting a car to save their child. A car! Think of the energy that takes. If we perceive threat and we don't go through it, we don't mobilize and then express and discharge, the defensive energy continues to grow and grow.

So the muscles are tense, the sympathetic nervous system is pumping, the heart is pumping, the blood vessels in the extremities, the hands constrict, so our hands become cold, and the same with the belly. This has tremendous value in survival; for example, if injured, we are less likely to bleed to death.

When we become chronic in the sympathetic state, we don't regulate ourselves downward, because the sympathetic continues to get the muscles activated and they act – the muscles tense in the sympathetic system and result in a positive feedback with negative consequences.

Here's an example: You and your spouse have an argument around bedtime. You go to bed but neither of you will have a good night's sleep. The sympathetic system gets going and tends to roll like a rock rolling down a hill.

When working with clients who are in a chronic sympathetic state, it's difficult to help them begin to regulate. Our own presence and "settledness" actually provides a bit of a container for the client to be able to feel, to sense those activated sensations. When they feel and sense them, and don't fight against them, the sympathetic arousal normally starts to come down.

It's a combination of an innate system for an action and de-action, or activation and deactivation, charge and discharge, and also the fact that the social engagement system has a regulatory effect in itself. As therapists we want to bring those together because that is really what helps clients who are in sympathetically dominated states begin to re-regulate.

In order to regulate high sympathetic activation states, we need to be with another person who is able to help contain us and co-regulate with us. There are two approaches to get self-regulated. That's why it is so important for therapists to have a regular practice. Whether it's yoga, Tai Chi, biofeedback, neurofeedback, anything that really helps us settle so that we can become the containers that our clients need us to be to be able to regulate the sympathetic arousal, to bring the heart rate down, to let the hands become warm again. It's essential for any therapist working with trauma to be able to regulate themselves. At times you must regulate yourself in the moment when the client is most dysregulated.

As a therapist, when you're working with someone in whom the distress, the emotional and physical pain they are experiencing is really related to some kind of trauma that has gotten locked in the system and not released, it's difficult to determine what clues to look for. When the pain in itself, particularly when pain that's not going away is so profound a stressor, we often think, "what came first – the trauma or the pain?" In a way it really doesn't matter.

Looking at the sympathetic system again, every muscle in our body is prepared for action. We normally move our hands and they gesture and so forth, that's controlled by what is called the alpha motor neuro system or the voluntary motor system. The gamma system has to do with the involuntary. We don't have control over that, or at least conscious control. That's the system that prepares every muscle in the body by tightening, literally from head to toe.

This condition can become chronic, which it does if one does not resolve the acute stress response. When it becomes chronic, one starts to experience more and more pain. Consider the person who goes to see his doctor or chiropractor and his back is just in unbelievable pain. The person is convinced that he's going to need to have back surgery. The Doctor asks what happened and he says "absolutely nothing – I went to pick up a piece of paper and my back went out." The Doctor then asks if the patient was having problems before and hears "no."

This person has been experiencing such muscle tenseness that when they went to pick up the paper, everything went into spasm. One piece of the camel's hair broke the camel's back. That's the state we find people in. It's really easy to see how when you go into pain, acute and then chronic pain, that pain also causes fear. This pain the causes more sympathetic arousal. It's a vicious circle.

Many doctors are realizing this situation is one that cannot be fixed surgically. More are advising their patients that they don't need surgery that time will resolve the issue, and those that really care about their patients often send them to therapists to work out the stress. People are often not aware of how their whole body is in lockdown, because they've gotten so used to it, it's just the way it is for them.
An example is fibromyalgia. It does not have any kind of causation. It's not like you can see something out of this pathology that is now the cause of the pain. Although there are certainly hereditary susceptibilities, as there are for most

everything, it's a stress related response. The most important thing therapists can do is to look at what's happening.

If the person is in pain and they have a higher heart rate, you could say they are in sympathetic arousal. This is trauma-related, though most don't even prefer to use the word "trauma." It's a whole spectrum and we just have to find a way to break the vicious cycle.

Let's work with that tip of the iceberg that's underneath the water which includes bracing patterns, the holding patterns, and perpetual arousal patterns and find a way to regulate them. When regulated, the pain will go down. It's not unusual in an SE session to see a person move on a pain scale of 0 to 10, from a seven, even eight, down to a four, three, and two, even sometimes to a one or a zero where zero is no pain.

An example of this is Peter's work with Ray, an Iraqi soldier. He was in extreme pain and after the first session; a good amount of that pain was gone. He was able to find the right pathways, the right discharge pathways to discharge the trauma energy, and the pathways to regulate that high sympathetic arousal. It made all the difference for his life.

As therapists, people come to see us every day. We know, but they don't, that sympathetic/adrenal responses are perpetual patterns. Our job is to help find a portal into it, so that we can begin to slow them down and regulate.

Learning the source of their trauma is essential. When someone is highly traumatized, getting a history may take two or three sessions. And again, there's no question that there's a high correlation between childhood trauma and all kinds of chronic pain syndromes, including fibromyalgia. We have to be careful however. For many patients, if you say they are having this pain because they are traumatized, it somehow negates the person's suffering and brings up shame with a sense of shame. Then we have shame perpetuating the pain. Some even go into denial saying, "No, I had a perfectly wonderful childhood."

This is one reason Somatic Experiencing™ is so effective. It's gentle. You take a little bite size piece at a time. It could be nothing more than just asking what's happening in their body when they talk about this incident that brought them

here. You may hear their heartbeat is elevated, their breathing is shallow and rapid. These are the clues we work with. Many therapists will jump on board and say "Oh, okay, let's get your heartbeat down; or "Let's work with your breathing." This is not always the best idea.

When a person is in chronic pain due to sympathetic arousal, we normally do something like biofeedback to just bring the heartbeat down. This will have some positive effects, bit it misses the organismic response. **The sympathetic nervous system is just one part of this whole mobilization system that is meant to function as an integrated organismic whole. It must run through its cycles of regulation in order to really down regulate the whole system.** Doing just one component that is trying to bring the heart rate down or during a relaxation exercise with the muscles, which can also be of some value, is not enough.

It also depends on timing. Yet deciding "let's fix it, this is the problem, let's fix it this way" misses the point. This has a biologically meaningful course of action that must be completed in a titrated way. This is what Somatic Experiencing is all about. It's very much about rhythms. Many people no longer know what slow means. Working with a client, you might say "Okay, go ahead and move a little bit; now pause and breathe. Go ahead and move just a little bit more, pause and breathe." By the time they are finished with several rounds of that practice, regulation is there. Not only that, they've integrated it. They don't have that same constellation again. It doesn't have to be that breathing/pausing pattern, but there needs to be some effective way of titrating.

Often, clients will find pain in a movement. Even with the smallest movement, the pain may increase for a moment. But then it decreases, as part of that cycle of charging and discharging. That is titration. Most people don't really understand the difference between voluntary movement, or even slow voluntary movement, and inner, involuntary movement. Sometimes the way to help, or the language to help with, is something like "…when you slow it down so much that it really feels like it's almost not moving at all, like it's really actually moving from inside of you", that can bring the person into that level in which they begin to get titrated, discharged.

## Pendulation as Regulation

Sometimes it's hard to get the person to focus on their pain because that's the last place the want to be. This is where ***pendulation*** comes in. This is probably one of the most basic concepts of Somatic Experience. Perhaps it's also a quality of many, many indigenous and other healing systems over thousands of years. It must be. But the idea is when a person has chronic pain, he/she obviously doesn't want to feel that more. Often what happens is their nervous system then goes into the dorsal vagal system, where massive shutdown occurs.

Later, where they really just numb out, yet assuming that the pain is still available enough, the moment they actually experience the pain, just touching into the pain, it will feel worse. It will seem worse. But just for the moment because for every contraction, there's an expansion. Here's the pain, trauma, sympathetic gamma system locked in and then what happens is we open, expand and then contract, and then expand and contract. When people get the sense of that rhythm, that's the key. When you are in the rhythm, moving with the flow, the pain cannot exist.

This is a very simple tool that anyone can do with their clients and with themselves, family members and friends. Sometimes it really helps to have the person identify some part of their body where they are not feeling pain or where they are feeling some pleasure and first shift back and forth, from painful areas to the less painful areas. That's actually not the pendulation. Some believe it is. It's the shifting between the two, which then allows pendulation. It can sometimes be staggeringly effective in working with pain. It's all about moving from pain, and noticing some element of it. When the person eventually experiences pendulation, their organism will naturally do what we are describing. At the beginning, you have to prime the pump. You have to give them experience of what it's like to go into the pain, feel it briefly and then have a plan to escape out of the pain and focus on somewhere else in the body that feels different. This is something therapists can do, and it helps to have some kind of a mindfulness emphasis in your work. SE training™ can be a valuable start.

One thing that happens when people start pendulating is what they will describe as trembling and shaking. It's not a spasm. The patient may get scared and think "Oh, my God, I'm having a spasm." You need to know what it is and how to work with it***. The shaking and trembling is how the organism down-regulates itself.*** People, especially the first time, are often freaked out. Then they brace against

that, which results in the pain becoming worse. Just educating our clients with this one piece of knowledge can help them release so much of their trauma because they've stopped fighting.

Not all shaking and trembling is effective; it has to go through cycles. Trembling occurs then settles. There's the deep spontaneous easy breath. Fingers get warmer, their color changes. The carotid pulse, you can see the heart rate slowing down. You do that one little bit of titration.

## Containing Activation through the Social Engagement System

How do we help people contain trembling and shaking when they have had some other kind of therapy where they were encouraged to enhance it or even suppress it? First we need to realize that neither is a good solution. The person needs professional guidance. **Sometimes you can make a really big difference when you put your hands on their upper arm and shoulder with, not a heavy pressure, but a firm, noticeable touch. Don't use a very light touch, because that also stimulates fear receptors.** This is one way if you work with bodies and allow touch in your practice. It can be very helpful. But again, the thing the therapist must rely on most is their own centering, regulation, their capacity to engage socially, not to demand that of our clients, but to engage and to be there, and to offer eye contact, when the client is able to receive it.

The voice is also important. A lullaby voice, "rock-a-bye baby' tone. You are sending a message that they are not alone; you are there with them.

Peter shares his own personal story of being hit by a car when crossing the street. He's lying on the pavement, having shattered the window of the car and thrown to the road. Peter recalls he was in a highly dissociated state. He felt "out of body" looking down at himself. A woman came by and said "I'm a doctor, I'm a doctor, actually a pediatrician." He felt such relief. She asked if there was anything that he needed and his response was to ask the doctor to just stay and be with him. She sat by his side instead of standing, held his hand and with that touch, Peter was able to go inside. He could not do it before because he was dissociated. Gone. Terrified actually and he truly needed that contact. Peter recalls that he's been teaching how to handle trauma for 40 years, but without

that contact, the physical touch, he doesn't know if he would have been able to survive. There's no doubt he would have been traumatized, and he would have known to get help, but the simple touch of another made all the difference. You cannot overstate the salubrious function of presence.

A very important way to repair pain is through the relationship, whatever you've got, whether it's an EMT, doctor that happens on the scene, or your therapist. If you can't create a regulatory relationship in therapy, that's not going to help with your trauma.

It's essential that we have tools to help ourselves. A therapist can help a client regulate, but when the person is alone and dysregulated, it can be because the co-regulator is not there with them, which is a problem because often people haven't really developed object constancy. It is so important to guide and give people tools to use when needed.

It makes a difference when the pain has been chronic. The first time one experiences less pain, perhaps the pain is gone, they go out to the mall, clean their houses, because they haven't been able to do anything. They overdo. It's guaranteed to happen to your client. Think ahead and say "Look, I know how great that feels and you're probably going to overdo it physically. But know that it may bring back some of the pain. It's wonderful that you want to celebrate – go and spend the whole day in the mall."

Maggie once worked with a woman that was in a car accident and broke her pelvis. She shared pictures of the car she'd been driving and it was unbelievable that she was alive, let alone injured with only a broken pelvis. She's doing very well. But one of the things that happened as we started doing some of this very gentle titration and release and pendulation, is that she was feeling so much better. She said "you know I don't even think I felt this good before the accident." Maggie's first thought was "uh oh." The next week she was talking about going to a Bikram yoga. Maggie asked if she had attended yet and the client said "No, I thought I better talk it over with you." Maggie said "I'm so glad you did. I think it's great that you want to, that the desire is there, that's a good sign. But you may want to start with a very gentle restorative yoga. Maybe five or ten minutes at a time. That is where you need to start." She could not believe it, but that's the way it is. We don't learn to walk again in a few weeks, it's no

different from the way babies learn. That's the only way that we can incorporate learning.

## Coupling Dynamics

Another more advanced application is **work with coupling dynamics**. Therapists need to at least have an understanding as a professional, even if they don't work directly with these dynamics. There's a distinct relation to pain.

With a high sympathetic state, gamma system activated, our muscles are in a preparatory state. What happens if one muscle goes into spasm? With all the muscles at this hair trigger point, one goes into spasm and the rest follow. Let's say it was the jaw, which is for people with TMJ. The jaw gets in spasm, then the neck contracts, then the contraction in the neck causes shoulders to contract. This is over coupling. The way we resolve that is by working with one tension at a time, using, again, principles of titration and/or pendulation.

Here's an exercise. Let's say you are experiencing temporomandibular jaw (TMJ) pain. Allow your jaw to open the smallest amount until you feel the first bit of resistance, not even more pain. Then let it close a little teeny bit and then just let it open a little bit more. That's it. You feel a resistance and then let it close. Do it a little bit more. How do you feel? Are your muscles starting to let go? **This is decoupling**.

Returning to Peter's experience with Ray, the Iraqi Veteran, Ray was blown up by two IED's in Iraq. When Peter saw him he'd been diagnosed as having Tourette's. The problem was *overcoupling* because of the bomb blast. The head and the eyes are trying to move in that direction to orient where the blast is coming from. It's too late because before you even start to do this, you are blown up. So all the contraction, all the flexing muscles contract to go into a ball. You are locked into that. Just by doing that exercise and one little other exercise, after the first session, 80% of his Tourette's was gone. By the end of the fifth session, it was completely gone. What could have been seen as a hopeless case, was improved by using this concept of over coupling, boom, he was able to really make this leap. Many experience a high degree of overcoupling because of the way our organism is created. Everything is interconnected. It's like a Calder mobile. If one part is moving and in spasm, then the whole thing is going to move somehow. You have

to think that way and help people understand about pain pathways. You could call them that. "Oh, I see where you are moving through a pain pathway right now. Can you tell me what comes next?" That is a way that people can accept it, if it's got a name. Sometimes names are the best containers. The language of whatever happens next indicates that *there is a next*. When a person is highly traumatized and in pain, they don't see a different future. They just see the same suffering.

During Peter's third session with Ray, the Iraqi veteran, Peter had him look at where he was "now", in terms of feeling good about his life. Where does he see himself in the future? Then, again the same question when his pain goes from 4.4 to 4.25. You could see his response, "Okay, I can see myself opening up." Language is so important.

When a client is in a shutdown state, social engagements are not online at all. They shut off. Your presence is minimal compared to working with someone who's in a sympathetically dominated state. We should not feel like we're being inferior, **but we should realize that we're in that state that can't make contact**. The contact has to again be apart from our presence and our containing, and to help them actually move out of that shutdown state.

Here's an example, almost a trivial example, but it actually is valuable. When you work with a client who's in a shutdown state, they are collapsed around the diaphragm, leaning over. You ask them, "Okay, close your eyes and tell me what you're experiencing." When you're in the shutdown state, you have to do something first to get them out. <u>One of the simpler ways is to have that person –</u> because in therapy, most of the time you're sitting <u>– get up and walk together with you at their side so they know you're there.</u> You are not forced to make social engagement, which often causes even more shutdown. Just walk beside them. This is called walking meditation. Then describe a little bit how it feels in their bodies when they are walking together with you. That can often be enough to help a person out of the shutdown.

<u>There is also the special trampoline technique that helps connect with this rhythm</u>. When you are sitting, you are not getting much proprioceptive information. When you stand, the anti-gravity muscles require you to get this proprioceptive information. Now you are getting even more enhanced

proprioceptive information. This is what takes people out of the shutdown. When they come out of the shutdown, they tend to go into hyper-mobilization. You don't want the person to come out of the shutdown too quickly because they'll likely go into a very high hyper arousal, and it will be difficult to regulate them. This is the wisdom of titration, the utilization of titration.

Another example is working with a therapy ball. When sitting on the ball, you can't collapse or you're going to fall off the ball. You have to have some organized proprioceptive feedback in order to stay on the ball. You can play a bit with moving back and forth so you're getting a wave, a flow of stimulation. You can try slowly lifting one foot off the ground, and then the other foot, and try to stay balanced with that. It's amazing when this spontaneous movement comes.

**Sanchez' tuning board is another example of a very simple device that brings these kinesthetic, proprioceptive channels online to take the person enough out of the shutdown to work the underlying sympathetic arousal.**

## Moving Out of the Shutdown and Into Activation

When people come out of the more shutdown response, and immediately and naturally move into this hugely activated response, what's the best way to help them contain that feeling without feeling like they're doing something wrong? Without being overwhelmed? The answer is: Titration, pendulation and education.

Some years ago, many people were presenting with anxiety. Those that were more shut down, were really depressed. In an experiment, they were asked "would you be willing, at least temporarily, to switch your depression for anxiety?" We examined all the implications of that, not just giving an answer. It's kind of a rhetorical question. If I felt more anxiety, what would happen? How would I deal with it? What would my life be like? LIFE! With depression, you're not feeling, people don't expect very much of you and you don't expect very much from yourself. It helps to see the value of depression, but also the challenge of learning to live with anxiety. Anxiety can resolve and does resolve. Depression doesn't resolve. It doesn't help in most cases. It depends on the nature of depression. But in chronic depression, going into the totality of it,

saying "Okay, just let's go into the depression and see what it's like…" is terrible. It's a black hole. One more part of you gets swallowed up in that black hole. At the same time that person who is depressed for long periods of time will experience anxiety for a period of time. Other times it may be rage they express. Very often it is rage and the fear of the rage. "If I feel rage then I might hurt someone. I might want to hurt somebody and myself." You have to really prepare the client for all of these kinds of possibilities, so when they come, they at least can say, "Okay, I understand this is expected as part of the healing process."

Maggie once worked with a client who had had a bad bike accident. Once they started thawing the freeze and the shock, the client started feeling itching sensations. Even before I even said anything, she said "Oh, itching is supposed to be part of the healing process. Isn't it?" Yes! Congratulations, there it is!

For those professionals working with someone who's in chronic pain and just struggling and not getting anywhere it's often good to turn to your resources for a refresher. When one thing that you try in the session doesn't work, you can turn that into a positive thing and say, "Okay, so this didn't work, but that's really important, because some things are going to work and some things will not. Some will work a little bit. If we can find something that works just a little bit – we're headed in the right direction. This gives a sense that there is a future, that there is something beyond the pain. There are many times, with this bit of hope for the future, people actually find their pain simply goes away. They forget about it, a truly amazing thing to witness.

The pain subsides, but is often replaced with a shift to emotional pain and anxiety. The therapist must be ready. Often, the person will say "Well, is there any reason for me to continue to work with you?" And you can say, "You know, I really think it does make sense to do a few more sessions because sometimes there are feelings that are locked in with the pain and it takes tools to resolve them." It takes time for those feelings to unlock and resolve.

Remember, for most people, pain is probably one of the scariest things in the world. We really have to appreciate how much fear there frequently is behind chronic pain and be very respectful of that.

## Sympathetic Activation in Medical Trauma

**Consider surgery and medical trauma as well as abuse.** Emotions can definitely get locked and produce a sympathetic like hyperactivity. Anger and fear – but anger that's suppressed, results in a high level of sympathetic activity and a suppression of the mobility. You are leaving the ANS, and the sympathetic system "all dressed up with nowhere to go"… it's really important to remember that many times chronic pain is related to anger and aggression issues.

Being able to move forward in life is so important. Let's say you are undergoing surgery and you're really frightened and when you're really frightened what happens? Sympathetic arousal. Now the sympathetic adrenal system is an antagonist for the anesthesia. The person who's in a sympathetic adrenal state will need more anesthesia to go under. They are in this hyper aroused state. Their heartbeat is going crazy, and of course in surgery, you're measuring all of that so you can see it. The surgeon and anesthesiologist then increase the depth of anesthesia, and the patient finally goes under. But this time too deep, and they go into a shutdown state, and you see the heartbeat is very low. This results in a lowering of the anesthesia level, and again the person goes into a sympathetic adrenal state. You can see how the sympathetic adrenal system gets really coupled, exactly, with a surgical trauma, with medical trauma. If you are aware during or even partially awakened during this period, you go into this super sympathetic adrenal state. Bouncing up and down. Anesthesiologists are becoming a little more aware of what's happening when this happens, but they don't see the fear that the nurses do when working with the patient.

Peter has observed many of his patients who've had surgeries in the last 10-15 years have an almost like psychosis, like a post-psychosis. You can work with these patients, but there are usually pieces that are out in the ether, and it really becomes quite a challenge. When Peter asked if he could talk with the doctors of these patients, one thing that seemed to really correlate was the use of a benzodiazepine called Versed rather than an anesthetic. It's used a lot. It seems about one third of the people had a basically neutral experience with Versed. They felt relaxed. Another third flipped out completely. They experienced severe PTSD, and a profound difficulty in sleeping. **We are finding that if someone is not**

**traumatized, Versed usually works okay**. But the solution for traumatized people? It may be to have those people list Versed under allergies. Thankfully, more and more anesthesiologists are recognizing this condition and acting accordingly.

Touching upon emotions again, emotional pain is very much as important as physical elements. Both use the same brain system, same pathways, etc. People who are locked into the physical system don't have or are not aware of anger and fear, and that's one of the reasons why we encourage this group of clients to explore through the body. If you just ask the person as a curiosity the question "What is your relation to anger like? How would you describe the relationship?" or "How is anger handled in your family?" you will likely see their reaction through movement.

Another example is Maggie's work with the patient who had been in a severe bike accident. He would go into dissociation as he was talking about something that happened to him. This is not related to the accident directly, it was related to his trying to get his life back. He's attending classes and finds he can't sit in the position that they want you to be in the classrooms like everybody else in the class, and he doesn't raise his needs. When asked why he didn't take this issue up with the teacher, he dissociated. He said "I don't know why but I feel really dizzy and confused right now." You need to bring the person back… I said "Well, what I know in the past has been true, is that you've felt shame if you aren't like everyone else, if you feel like you are disabled." Then it clicked for him. He said, "That's it! That's why I could not ask, instead of going with what I needed, I dropped down into confusion and being in lockdown."

Therapists need to work hard to be able to recognize when someone is in severe pain. Those experiencing a nine – ten on the scale. They are very preoccupied by pain. **This is a situation where they're flooded versus dissociated. That tells us that they're in a sympathetic arousal, because they are so overwhelmed.** How do we get them to connect with their experience? When they are in that overwhelm state, it's to connect more from a place of compassionate observer.

## Awareness of Bracing and Other Muscular Patterns

The thing that does seem to relieve and be effective, because it gets at the root of the pain, is to be able to have the person gradually become aware of the muscular pattern, the bracing pattern or the retracting pattern, that's underneath the pain. When they focus on that, it's kind of like a figure ground relationship. At first the pain is the only thing – that's in the figure. And then the tension pattern is way in the background, almost imperceptible. But then when they're able to bring the tension pattern out and observe the tension pattern, the pain tends to move into the background. An example is the figure/ground card, the one where you either see a vase or you see two ladies' faces looking at each other.

Because we talk about bracing patterns, yet if you haven't, for example, done some kind of somatic training – including somatic experiencing, you may not know what that really means. Is it more than muscular tension and if so, what else is there in bracing?

***Bracing is a muscular pattern with purpose.*** Let's say we injure our arm back in the day of the early hunger-gatherers or the cave people. If you broke your arm, there was nobody to set it. Basically you would die because you wouldn't be able to use the arm. But perhaps, it makes sense evolutionarily, that the muscles actually formed like a cast, formed like a brace to keep the bones in place to get some kind of knitting. Afterwards, this bracing pattern may remain a little bit, but at least you've survived.

When we've been immobilized for a period of time, we tend to stay immobilized. Most of us have had a cast on, so if it's been on for six weeks and then comes off, you notice you're not having that same range of movement. That's the residual bracing. It appears that the bracing is meant to, in a way, reduce the pain, but now it's actually causing the pain. If the person is having pain in their forearm, you can very gently extend the hand at the wrist and then move it a very little bit in the opposite direction and do it back and forth very slowly. Then boom, all of a sudden, there's a release of energy, of heat, of vibration when that bracing pattern releases. By just playing with the passive movements that are around the area of the pain, again the person has learned not to move to prevent more of the pain, so you have to encourage them to move, and to explain that this is different. This is a mini-movement, a micro-movement. When it's done this way, it may increase the pain, but it's only momentary. Then the pain almost always becomes

less after that, sometimes quite significantly, with just a very simple intervention like that.

The point is that many people think that bracing has to be something striking, that you're going to see, but that's not the case. It's much more subtle than that. People will report tightness and tension that will give you some clue, but it's the micro-movements that are related and maybe help the person come out of that bracing pattern.

## The Presence of the Therapist

How do we handle someone who has multiple, fairly serious traumatic events? They tend to want to stay in the story and the interpretation of what happened and really resist slowing down and taking one step in the event at a time. It's really frustrating when we're unable to get a person to slow down. It's important to take a few minutes to center and to collect yourself. Then you have the possibility of joining, of getting some kind of alliance with the person. Once you have that alliance, then you get more traction when you say something like, "Well look, this has been there for a long time and I know you're really wanting to get at this stuff because it's been troubling you. It's been interfering with your whole life, maybe even ruining your life." When working in this way, less is often more. Just hearing those words, you see the person go "Ahh… - relief" We need to touch into the experience. Whether it's a particular memory or just what's going on inside of you, which is even better, right now in the here and now. Just to touch it and then work with it. Clients want to be tricked by us, because they know at some level what they've been doing hasn't been working. First we form a presence and an alliance. Just saying, "Let's just try this and see what happens and lets just give it a whirl and see if we can get some results that you'll find helpful."

## Simplicity as a Tool

Not only is less more, but so is *simplicity*. A simple tool can be so much better for people than something that is so complex that they just can't do it. Try the approach of asking the client to pause, wherever they are, **and take just one**

**normal breath**, with no intention to change anything. Just breathe in and out and just notice what that's like. In most cases those results result in the person having the space to feel more, and that will include sensations beyond pain.

## Chapter One Summary

This chapter examines the Sympathetic/Adrenal branch of the polyvagal system and some of its interlocking patterns with dorsal vagal shutdown and social engagement. The Questions and Answers session manuscript that occurred after this webinar session is included at the end of this book, which may give you further understanding and answer some of the questions that came up in your reading.

In the next two chapters we explore the ventral vagal/social engagement system with Stephen Porges and then the dorsal vagal system with Peter Levine, Ph.D., Stephen Porges, and Maggie Phillips.

**Social Engagement/Ventral Vagal System, Pain and Relevant Interventions**

**Stephen Porges and Maggie Phillips**

# Chapter Two

In this chapter, we use the polyvagal system as a kind of neural map to explore pain in a very different way than it is usually discussed. The polyvagal theory is an obvious way of organizing information. But with that way of organizing information, it creates a decoding method to understand the human experience and to help start treating pain and trauma.

## Evolution of Polyvagal Theory: Hierarchical Patterns

The polyvagal theory is really an understanding of the recapitulation of our own evolutionary history. For mammals the evolutionary history is actually called *phylogeny,* which considers the nervous systems (or their features) that we've inherited from our ancestors. In this case, he ancestors are reptiles, amphibian, and fish. As vertebrates we have inherited a lot of circuits. As these circuits change, they resulted in functional neuro-platforms for many of the behaviors we as humans express. ***One thing we have forgotten or didn't understand until the polyvagal theory enabled us to have the reconceptualization, was our unique transition from reptiles to mammals.***

***In that transition from ancient reptiles to even the primitive mammals, there are certain things that occurred. Those things are about enabling co-regulation*** in a sense, enabling one mammal to help regulate the physiological state of another mammal. That required cueing, or the social engagement, of another with signals of safety and the, with those signals of safety, to enable two of the species to be comfortable in each other's presence.

The whole history of mammals is about being comfortable in the presence of another or another appropriate mammal. It's really what gets disrupted with trauma. When trauma occurs, people are no longer able to co-regulate with

another, since often the trauma has been inflicted by another human being and their nervous system now does not invite the other person into their presence.

The polyvagal model really has three polyvagal states, including the most primitive system that we've inherited, which is shared with virtually all vertebrates. It goes back to cartilage that fish have, that is related to the ability to immobilize with fear, and to use immobility as a defense system. This becomes one of the critical points – that is, individuals who have gone into a collapse or a death feigning, have changed because they've acquired access to this very, very ancient circuit.

Genetically, the next stage that evolved was the mobilization system, which we all know as fight-flight. But fight-flight also has certain wonderful advantages, because as long as we keep moving, we're not going to be vulnerable to shut down or collapse. You see those symptoms in many people who have trauma histories.

Being in a physiological state of fight-flight, is not very good for one's body. It leads to diseases. It's also horrible for social interactions, because we want to cue others to, in a sense, stay calm, co-regulate, and share experiences. We could use the term inter-subjective experiences. We want to share thoughts and ideas and actually be present with another.

**With the advent of mammals, a newer circuit came on, and this is what we're labeling either the ventral vagal circuit, or the social engagement system.** The social engagement system was actually linking the neuro-regulation of all the muscles, the strident muscles that control the face and head – including the muscles of vocalization, the muscles of listening, the muscles of cueing in the face, and the muscles of how we articulate the prosodic features in our voice with the vagal regulation of the heart.

We basically are always wearing our face on our heart and we're conveying our physiological state in our voice. We are detecting the physiological state of others, through their voices and with their faces.

When we watch someone, we pick up cues on the speaker's face, listening to their voice and deciding, is this a comfortable person to hear? Or should I just

think about the words or should I think about the feelings that the words convey? So the social engagement system is really what makes humans human, or actually makes mammal's mammal.

Your dog has a really well developed social engagement system and many cats do as well; they convey their feelings in their vocalizations, in their facial expressions, in their gestures, and even how they move their heads.

The social engagement system is this wonderful ability to convey to another what our physiological state is. **What the polyvagal theory puts together is the view that these circuits are hierarchical. Hierarchical means that newer circuits have the capacity to inhibit the older ones.** What that means is social engagement can down-regulate fight-flight and can calm us down just as fight-flight can keep us out of shutting down.

There are three levels and each one inhibits the more primitive system below it. The word that was used to describe this is a word called "dissolution," which comes from scientist John Hughlings Jackson, who was very interested in brain processes and in this inhibition of brain circuits, so that they become more primitive and reactive when we have brain damage or illness. So the autonomic nervous system works the same way. **Our newest circuit calms us, our older circuits can be used for defense.**

What allows social engagement to occur while the defensive mechanisms of fight-flight are being disabled? Stephen uses the term ***"feature detectors"*** **that basically assumes that our nervous system evolved to detect features in the other, to help us identify safety and to calm us down. So those feature detectors are part of the construct he calls "neuroception."** You cannot talk about the social engagement system without talking about ***neuroception*****.** ***Neuroception*** is the mechanism through which our nervous system detects safety and then enables the social engagement system to work. It detects this without awareness. It is a very special system because it is not the cognitive awareness we are in safe surroundings.

**Our nervous system is detecting the level of safety, then the physiology responds.** One can be very aware of their physiology. Much like going to a lecture, we go in and we say "Well, the words sound good or at least if I were to

read it, it would be good, but you know, there's something about that person that I don't really feel comfortable with." Everyone has had those issues. It is hard to label, but we feel uncomfortable, maybe it's a lack of prosody in that person's voice, the lack of engagement. We could say it is the lack of being really sensitive or having the sense that the other is being a valid person. It's really that the words are there but the feelings underneath the words may not be. That is what our bodies are responding to. *We respond more profoundly to attenuation of voice, than we do to what is said by the person. When our body responds, we feel it and then develop our own personal narrative. That's how we either feel that we can be close to people or we feel that we should be really distancing.* ***The underlying theme here is, there is no social engagement, unless our neuroception picks up the features of safety.***

## How the Nervous System Detects Safety: Prosody

Specifically, how does the nervous system detect these elements of safety? It's far more specific than we give our nervous system credit for. We think it's a complex process--you need to go to school to learn it, you need to look about micro-features in the inner parts of the eyes, or you need to do frame-by-frame analysis.

But in general, our body's picking up profound things like the intonation of voice. The best example used is Bill Clinton. Clinton's voice was extremely prosodic. There used to be these stories going around Capitol Hill that, not about the women, more interesting is actually the **stories that came back from the Republicans who had come to the White House. They would have a good time, they would be interacting with Bill Clinton and they would leave not knowing what they had agreed to. They were picking up these cues and they had totally down regulated their defenses.** This becomes a real interesting thing.

The other alternative is **George W. Bush. He did not modulate the frequency of the intonation. He modulated loudness. So, he appeared to be barking at you and talking with emphasis. This had the effect of pushing people away. For both of them, it had little to do with the content.** As intellectuals, we say it had everything to do with the content, but really it had a lot to do with how they were able to communicate.

Our nervous system is detecting the prosodic features (the set of speech variables including rhythm, speed, pitch, and relative emphasis that distinguishes vocal patterns), and this is powerful. Although we can close our eyes when we don't want to look at something, we have difficulty closing our ears. This portal is so powerful especially for people with trauma histories. They have difficulty making eye-to-eye contact looking at someone, but **they can't turn off their nervous system's ability to interpret prosodic features of voice. It's hardwired in.**

For a person with trauma history, a hand gesture can be misinterpreted. If you have a dog, and a stranger comes and puts a hand over the line of eyesight, the dog is going to respond. We have to think that humans have some of these features. We want to see what's in front of us. We don't want to see things behind us. If we become at all uncomfortable in the physical situation, we come hyper-vigilant about what's going on behind us and we're uncomfortable with the interaction.

Social engagement is dependent on the way we regulate muscles of our faces and heads. If we say that if we're physically and physiologically processing information as safety, our face becomes spontaneously engaging. As opposed to a false smile, which emphasizes the lower part of the face. But it's the upper part of our face that's giving us the cues to safety.

We're reminded by the contemporary culture that people use Botox to dampen their wrinkles, but the wrinkles are a way of telling us that people are really interested in what we are saying. The Botox may get rid of the wrinkles, but it also creates a problem.

As an aside, if you deal with parents or children or adults who have autism, one of the comments that we hear is "Well, my son he looks so young he doesn't have a wrinkle." What they are misunderstanding is that many of the wrinkles are really a manifestation of neuro regulation of the muscles there below the skin, especially the orbital muscle called the *orbicularis oculi*. So, the first principle is not merely that we can stage our muscles, but if we're in this physiological state then the spontaneity occurs and there's a big difference between spontaneous smiles and forced smiles. Our nervous system detects this rapidly and that's part of why we don't feel comfortable with certain types of people. Just like during

election time, the false smiles of individuals really is a big turn-off to our nervous system.

Stephen uses a slide in his talks that shows an ancient Chinese mask and one of the pictures is a picture of the mask of happiness. The way you know that its happiness is that it has really big crow's feet on the side. So, this was used as an unambiguous cue to the audience of happiness. The dermatologists are not schooled in this information and people don't want their wrinkles. In fact, if we think about it, people put make-up on, especially women, and I guess men do some of this now too, in a very static mode, they hold their face up. But it's not the static mode of the face that's attractive. It's the dynamic aspect of the face. That gets lost in the culture.

## The Role of Oxytocin in Safety

There are so many ways to approach this issue. One of them is the role of *Oxytocin* and what role it has both in social engagement and in the inhibition of pain.

Stephen is always cautious about talking about Oxytocin because of the other part of his family – his wife Sue Carter is the one who discovered the importance of Oxytocin in terms of social behavior. He explains that his interpretation of Oxytocin is not always identical with what Sue says, and offers his own interpretation.

Oxytocin is a neuropeptide. It's very common throughout the body. What's important is what areas of the brain stem it influences. Oxytocin influences the area of the brain stem where ***the source nucleus***, the source of the dorsal vagus, is. So it actually influences even the *vagus*, or the *ventral vagus.*

The dorsal vagal complex contains many different receptors. We can cope without collapsing. So the dorsal vagal complex co-opted the ability of the dorsal vagus to be used, not as an immobilization with fear, but as an immobilization strategy without fear. If you think about ***reproductive behavior, which involves Oxytocin, it's the ability to immobilize without fear,*** which is very critical. Whether you're an active sexual participant or you're fall asleep afterwards, is not

the issue. ***It is that you're safe in the arms of the other. It's the ability to immobilize without fear.*** So the linkage of Oxytocin first is with the immobilization bit. However, research has demonstrated that *if people have reasonably functional ventral vagal systems, they tend to respond to Oxytocin by increasing the social engagement system in the ventral vagus.*

It's not that Oxytocin affects everyone uniformly. Paradoxically, one might say for those who don't really need it, it's more effective. So in a sense the system is more organized to use it. There are some studies with a typical clinical population that show if you give participants Oxytocin, they don't become more social, they become more defensive. And part of it may be linked to the fact that Oxytocin may end up enhancing *selective* relationships, not generalized relationships.

We have to be very careful when we try to use drugs or chemicals to think that we are helping social behavior, because that model would be making people promiscuous and that's not really what the goal was. The answer is the body is smarter than the people doing the research and the body is really saying, "I like you, then Oxytocin will help me to like you more and I will be more pah, pah, pah…"

But if you have difficulty liking people, if you feel unsafe with people, Oxytocin may not work at all. In my conceptualization, I use the term, "expanded autonomic nervous system," which I think includes, not merely the autonomics, but what people call the endocrine, and others the immune system.

## The Expanded Autonomic System

***The expanded autonomic nervous system*** *is* a more complex system that really enables us to either be safe or be defensive. The polyvagal theory demonstrates that you can have two different defensive strategies: you can mobilize and fight – metabolically costly – or you can just shut down and conserve whatever resources you have. Both are defense. But Oxytocin is going to be related to always reducing metabolic output in safe situations.

However, Oxytocin has everything to do with safety and trust. Yet, it's a complex system and ***here is where it gets really tricky, because under fear-induced***

***stressful situations, where you normally would want mobilization and fight-flight, there's a surge in Oxytocin as well***.

There are two possible interpretations of Oxytocin from this perspective. It could protect the dorsal vagal complex from having a surge and shutting down, so that we can continue to mobilize without going into collapse. Then, the other idea, is consistent with and true to the polyvagal theory, where we have our older circuits and our newer circuits. Since we co-opt older circuits, we may have a receptor in our brainstems that is both sensitive to Oxytocin and to vasopressin, because that's what reptiles have.

***Vasopressin in the brain helps us mobilize.*** It literally keeps our sympathetic nervous system driving at a higher rate before we have natural feedback to help us calm down and shut down. It's called the ***baroreceptor reflex***. You get your blood pressure up. If it goes too high, we get it down. *But vasopressin allows blood pressure to get higher and higher, so we can fight more.* I think Oxytocin, being a mammalian neuropeptide, can affect those older receptors.

Actually, no one has studied this, but we believe those receptors may be sensitive to both Oxytocin and vasopressin, depending on the context of what's going on. So the short of the story is there's no such thing as a biomarker for love and trust. We are a biological system. Biological systems have adaptive functions. Under certain settings, our nervous system will try to do whatever it can to calm and be safe and to co-regulate with another. It will utilize what other mechanisms it has, so it's not a one-to-one relationship. ***I think there is where the literature and the expectations and understanding have been confusing. We also have a similar issue with the concept of cortisol, where people have basically operationally been defining cortisol as a measure of stress. It's far from that.*** It's a very important hormone of our body that enables us to efficiently mobilize. It doesn't mean that we're mobilizing out of fear. We have to understand the biology of the system to make better interpretations of the neural or physiological platforms upon which behavior is super-imposed.

## Faulty Neuroception of Danger and Pain

Let's discuss how neuroception of danger can occur, both in terms of external environment as well as to the internal environment. *How can faulty neuroception contribute to pain in both those cases?*

It takes three levels: External, internal and then the pain level. So from the external perspective, our bodies literally are tuned for certain physical cues in the external environment, like low frequency sounds or rumbles, which are embedded in our nervous system to detect predators. When we are in environments that have noise, primarily low frequency sounds like shopping malls, restaurants, sounds of vacuum cleaners, airplanes or trucks, our body has difficulty relaxing.

We see this literally amplified in any psychopathology. If we look at autism, kids just can't deal with acoustics at all. But if we talk about *people with trauma histories, they will try to restrict their social environment, based upon the acoustic environment that they have to enter. They don't want to be in noisy environments and they'll even have difficulty processing human voice.* That's because the nervous system changes in neural regulation of the striated muscles of the face in the head, including the muscles regulating the middle ear. And when those muscles become relaxed, they become basically amplifiers of low frequency sound which is really adaptive for predators, but we can't hear human voice.

The issue is that sound really is extraordinarily important. When we get into a physiological state that facilitates hearing a predator, our body becomes tactically defensive and we become hyper-vigilant, which is really the appropriate adaptive behavior in that state. Because if we are hyper vigilant, we're already prepared for fight or flight. So, that's the external context.

Now, *internal context becomes a little bit more complicated in understanding, but most of the sensory information that we get is actually below our level of consciousness. Much of it comes from below our diaphragm* - comes through the sensory part of the vagus, really representing how our body feels. And **now we get to your question, is that when we start getting those visceral feelings of pain, are those feelings often coming up through vagal pathways that we're not supposed to be feeling?** In a sense, the body is supposed to be doing its job. In a

way*, **that job is not feeling, especially sub-diaphragmatic pain**,* and it's often sometimes in the chest but primarily sub-diaphragmatic, pains. It's supposed to be automatic when that starts coming through, with gastric distention and all these issues, which I'm sure most the therapists are familiar with, because clients are going to come into therapy with it; that sub-diaphragmatic area is really representing the old, shutting down, collapsed, vagal system, now being used as defensive system.

If we put it all together, ***sub diaphragmatic, visceral pain is really related to pelvic floor areas*.** Even symptoms like irritable bowel, gastric distention, oscillation between diarrhea and constipation, are related to a gut that is really communicating to the person--a signal saying, "Hey, I'm not safe, because if I were safe, I would be really running your factory real well. Things would be simple- you take the food in, it comes out. You wouldn't worry about it."

But something has happened and so the system now is "out of balance." But in a physiological state of defense, using an autonomic system is supposed to be supporting health, growth, and restoration. So, to re-conceptualize this - ***it's only when we feel safe that we can utilize the spontaneous features of the social engagement system. It's only under those conditions that the sympathetic nervous system and the unmyelinated sub-diaphragmatic vagus work to support health, growth and restoration.***

We lose our social engagement systems, which is usually the outcome of illness, whether it's physical or mental illness. And this is constantly the case with trauma cases. Then other autonomic circuits, the sympathetic and the sub-diaphragmatic dorsal vagus, become used as defense. ***One of the consequences is that all the sub-diaphragmatic problems including visceral pain, are used as defense.*** **What implications are there for treatment in that case?**

The obvious answer is, "Of course, if you don't utilize the sympathetic and dorsal vagus as defense systems, then you don't have a problem." Now, if we reverse this into a treatment model, the treatment model would say, "***How do I engage the social engagement system? How do I give the nervous system features of safety, and if I do that what will happen to the defense strategies of both sympathetic and dorsal vagus***?" And the answer is that they should be *dampened*. ***The secret in treatment models, is to utilize an understanding of the***

***nervous system including, the feature detectors, which we talked a lot about in terms of prosodic features, as being a profound way of triggering the nervous system out of defense.*** I mean, think of a mother calming a baby who doesn't have the tools of language, and even think of an older child who's terrified and the words aren't going to calm the child, but the soothing voice will. Here's an interesting aside - autistic children often are fearful of the father's voices. While their mother's voices may be calming, the father's voices may trigger a sense - a biological sense - of predator. So, the answer here is, can we engage the social engagement system and what effect will that have?

## How to Engage the Social System to Dampen Defense

I'm going to talk about two other things now to give you and listeners another set of hints. One is the power of breath, respiration or breathing. And breathing is a wonderful neuro-biological system, because it's not only automatic but it's also voluntary so you're breathing as we're talking. I'm breathing while I'm talking. I'm not thinking about, "Wow, I'm going to have to take a breath because my phrase was too many words. I'm going to pass out." No, our body is automatically calibrating and adjusting to this. However, we can regulate our breathing. We can push our diaphragm down. We can inhale with deeper breaths. We can modulate the ratio of inspiration to expiration. So all these parts of breathing have been parts of ancient practices. They're incorporated now into Somatic Experiencing.™

But they're also part of pranayama yoga. They're part of Japanese traditions. They're part of continuum. Even mindfulness meditation has some of this. There's a biology to this, and if you understand the biology, then you can kind of rephrase it and you can use it for your own use as a therapist or even as a client. And that is the vagal brake, the mileaid vagus, the calming vagus, your friend... your friendly vagus.

**The effect of breathing is amplified during exhalation, and is attenuated during inhalation**. So one of the exercises that I do, when I do workshops, is basically have people breathe with different styles. And look at each other and try to evaluate their perception of the world. *So if you extend the duration of your inspirations and reduce the duration of expirations - so you shift the inspiration-expiration ratio to an inspiration bias - you'll see the world as being very*

*evaluative and critical*. Because what you've done is dampen the vagus, which now functionally allows the sympathetics to express themselves more. So suddenly you come into an evaluative, aggressive world. But as a therapist if you look at people breathing, if they start breathing in the upper part of the chest, you know that they are getting into a very high state of anxiety. Another way of viewing is that they are unconsciously manipulating their body to be in a physiological state that will dampen their ability to understand what you are saying. They're basically blocking the connection and they are mobilizing their defenses.

I mean you can't just say to a client, "Hey, look, the way you're breathing you are not going to learn anything, we are not going to get anywhere..." **But the issue is you can help them see it so they can learn to use soothing, calming strategies. So as you extend the duration of your exhalations, the world becomes seen as more positive.**

So I was looking at the literature on pain perception and on types of pain, and there's a mixture in there, but there is a predominant finding. ***And that is that this visceral pain is reduced during slow exhalations.*** So now, the answer to that is really very simple: ***During the slow exhalation you're increasing the myelinated vagus activity and that's basically calming you down.***

There are different theories about pain. One is that if your muscles and your body are tight, you're going to feel more pain and the idea is **how do you relax the body?** Even if you're getting surgery, how do you make the tissue relax so that - you literally can be cut without bleeding as much and not fighting it?

**The answer is slow exhalations will help if you're feeling safe and comfortable.** So slow exhalations have been within part of the history of humanity for hundreds of years. Whether we call it religious traditions or folk medicine, it was always part of it.

The other part of breathing where people inhale, and when you inhale, you can immediately see your hands going like this, if you hold it. Now, that's a very powerful defense method, but it doesn't deal with tissue injury in the same way.

***For example, if you want to get an injection in your arm, tensing the muscles makes that injection more painful.***
Stephen is now reviewing the literature because there may be sensory systems that are reduced during inhalation. So there may actually be two different processes acting. He comments, "it's a good challenge to be honest, to be interviewed on something you're still working on." ***It's clear that relaxing people by extending the duration of exhalations will help chronic conditions. And so from a medical point of view anything that enables a person to relax and reduce the muscle tension will be very helpful. So, slow exhalations will work.*** However, with the issue of acute reactions, even this notion of tensing when we get the needle may have some adaptive function which has yet to be discovered.

***One important caveat for therapists who want to use the slow exhalation technique is make sure that it truly is relaxing to the individual client.*** There are ways that people teach breathing that are just so mechanistic that it robs the person of the value.

We will be moving further into the practice of breathing in the next and last chapter of this ebook.

## Chapter Two Summary

This chapter explores the hierarchical patterns of the polyvagal system and how the newest system, the ventral vagal system, calms us and creates safety while the older circuits provide for defense. Porges discusses how *neuroception* helps us to detect safety in multiple ways that we are unaware of. One example is voice prosody that includes pitch, rhythm, high tones of intonation. Another is the muscles of the head and face that indicate a spontaneous, trustworthy smile. Porges also indicates the importance of neuropeptides, especially oxytocin and vasopressin, in the creation of safety through the ventral vagal system. The slow exhalation breathing approach is offered as a way to dampen the defense systems and increase myelinated ventral vagal activity.

## Dorsal Vagal, Freeze, and Dissociative Pain and Effective Polyvagal Solutions

Peter Levine, Stephen Porges, and Maggie Phillips

# Chapter Three

As we discussed in chapter 2, the primary role of the dorsal vagal system, in humans, is to regulate organs below the diaphragm. However, that's not the only role. Let's put it in perspective. Genetically, the dorsal vagal pathway of the autonomic nervous system is basically very similar to what's been seen in bony fish and even cartilaginous fish. By the time it evolved to mammals, its role was really relegated primarily to below the diaphragm. This means it regulates basically all those visceral organs that we are really not aware of. However, there are some tracks, or pathways, that are still, in a sense vestigial, old systems that go to the heart and to areas like the esophagus. If you were to stimulate the furthest, deepest part of your esophagus, that would be regulated by the dorsal vagus. Of course, what happens if you stimulate that part of the esophagus? You regurgitate.

Regurgitation is, in a sense is a dorsal vagal response. The system is really going down and this is a very adaptive strategy for getting rid of toxins and other things that may be occurring. To begin with, when we talk about the dorsal vagal system it originates in the brain stem area called the *dorsal motor nucleus of the vagus* or more commonly now known as the **dorsal nucleus of the vagus**.

Some of the pathways actually migrate through the nucleus ambiguous and then come back down through the vagus and some of those that migrated actually end up being part of the nucleus ambiguous or the ventral vagus. By the time you see it coming from the brain stem you basically have a unified integrated nerve. A lot of people think that they're two separate nerves, the ventral vagus and the dorsal vagus; however, they're really all in one conduit and we have to visualize that.

There are only about 15% of the fibers in that conduit. 15% to 20% of those fibers are actually efferent fibers meaning going down from the brain. Of that 15%, actually 80% of those are going to the dorsal vagus, and very few are going to the

ventral vagus. So really, the predominant features of our vagal system are actually dealing with sub-diaphragmatic organs. **The important part that we really want to get to when we start discussing pain, is this role of the afferents, of these systems, being the sensory part going back to the brain.** So the dorsal vagus comes from an area that is dorsal to the nucleus ambiguous, which is ventral to the dorsal.

## The Role of the Dorsal Vagal and Pain

Retaining those specific details is really not important because they're really irrelevant to understanding the function. The function that we start understanding is that ***the nucleus ambigus vagal fibers are linked with the face and affect that we normally have, while the dorsal vagal fibers are more predominantly linked to areas below the diaphragm***. Gastric pain, irritable bowel, all these things that are really symptoms of other syndromes that many people who suffer trauma have, are really indicators of atypical regulation of the dorsal vagus. This becomes really important because within the model of the Polyvagal Theory, both the sympathetic nervous system and the dorsal vagus can be recruited as defense systems***. When the ventral vagus is really functioning at a high level and regulating well, then the sympathetics are merely part of the homeostatic processes. They support health, growth, and restoration. They also support movement without being a defense system.***

## Importance of Ventral Vagal Activity to prevent Defense and Shutdown

Similarly the same metaphor works for the dorsal vagus. The dorsal vagus is critical; it's not a bad system but ***it's not healthy for that system to be used or recruited as defense. That becomes really, the primary issue and the Polyvagal Theory gives you the hierarchical model. It says, as long as the ventral vagus is literally in command or running, then your sympathetics can dance any way they want in a more homeostatic way*** to promote blood flow and promote healthy growth and restoration. *It's only when the ventral vagus gets retracted that we then get into this vulnerability of a sympathetic defense system.* When

that doesn't work, well, then the dorsal vagus is the only thing you have left and that shuts you down. You start seeing the hierarchical way that things work.

What is really important is the role of the vagal afferents from the gut, from the sub diaphragm. Their role in the modulation of pain is part of this chapter's emphasis. Peter notes the fact that the vegas nerve, the largest nerve in the whole human body is 80% afferent, when we look at what happens when people get stuck in the dorsal vagal system*. Steve has emphasized its regulatory function, both the dorsal vagal and the sympathetic, and of course the ventral vagal. But there are many situations, particularly trauma and pain - where this regulation is not really homeostatic, where it's maladaptive.*

## Strategies to Shift out of Maladaptive Defense States

*One of the ways that we can switch out of those maladaptive states, due to trauma or pain, is through stimulating these afferents*. There are several ways--one, for example, is the use for example, of vibrating a sound, right from the visceral area where you seem to be stimulating those afferents. Sometimes you'll see a person go from shut down and into equilibrium.

Sympathetic hyper arousal is part and parcel of this autonomic somatic pattern of bracing, of constricting, of holding. This leads to pain and that pain itself causes further bracing and further activation of the sympathetic system. *When the bracing pattern and the pain itself have become more and more acute, the body shuts down more into what Steve has talked about as a metabolic retreat, a state of energy conservation. At the same time, presumably, that enhances the release of endorphins, which are the body's own opioid pain relieving system.*

## Moving out of Shutdown and Working with the Sympathetic Responses Underneath

In a sense, a person shifts from acute pain, to acute moving towards chronic, and that's the **sympathetic arousal/bracing pattern**. Then, over time, it goes into the shutdown. In order to help people, once they've been in the shutdown, **we have to find a way to help get them a little bit out of the shut down and then use the sympathetic reaction under that**.  As Steve was saying, a lot of that regulation

comes from that *ventral vagal social engagement system, by the therapist really being present and being able to guide them through those arousal sensations.*

Stephen and Peter agree on the ***important intervention of belly breathing or abdominal breathing.*** Many of the very powerful afferents related to breathing for the ventral vagal system, are actually embedded in the diaphragm. The issue is, we can use a voluntary system, meaning control of the diaphragm and breathing, or at least voluntary breathing, to push the diaphragm down and to extend the duration of exhalations as well as to improve or increase abdominal breathing. That, in a sense, increases the ventral vagal flow. Again, the basic underlying theme here is that the sympathetics in the dorsal vagal system will work in a wonderful homeostatic way as long as the ventral vagus is really functioning. ***Peter has shown in a very concrete way that you can get some of this control back through a voluntary breathing strategy.***

Because what that is doing is functionally triggering the ventral vagus to enable the dorsal vagus and the sympathetics to go back into a homeostatic situation. Bracing, which of course, is increase in in motor tone, is a sympathetic mobilization and that has short-term effects. As Peter suggests, "If I'm clenching my fists and preparing, I am basically saying to my ventral vagal system, 'Go away because I'm in a defense mode.' Now, if this doesn't get rid of the pain, since I'm in a hierarchical system, or I *am* a hierarchical system, I've already thrown away, discarded the ventral vagus as an option. If this doesn't work, what does my nervous system do? It goes down to its lowest level."

We cannot say that all the dorsal vagal responses are negative because there is a degree of analgesia and sometimes there is dissociation and no feeling of pain. But the cost to social interaction is a catastrophic price to pay.

As Peter notes, when working with a client, it's important to honor and respect the need for that particular defense system and then gradually help the client to move out of it to a less, more hierarchically contemporary system, a here and now system.

Maggie points out that a lot of therapists devalue the freeze response and are almost phobic about it. They don't want the client to be in a freeze state. It's

important to know what kind of psycho-education we can give clients about how the freeze has been valuable to them.

Peter adds that the freeze is an adaptive response, meaning that it has adaptive function and that's part of the psycho educational component. When people start to understand that their body has reacted, literally, in a predictable and adaptive way, it's not voluntary behavior. You can say "Gee whiz, I if I didn't want to shut down, I shouldn't have shut down." But shut down is not a voluntary system. The body is doing things outside the realms of awareness. Even though we are not aware of the triggers that put us into these physiological states, the afferent feedback of our physiological shifts certainly are within the realm of our awareness.

The issue is how do we label those physiological responses? Do we tell ourselves that we did something wrong or do we try to say, "Look, my body's doing something. It may have been very effective for an acute adaptive response, but obviously in the chronic one, the body needs to be reeducated to say 'Hey, it's safe, come out of there.' Another important factor is that when someone comes out of the shutdown, you typically hear, "I didn't hurt that much before." When the dissociation and the analgesia dissolve, there's pain both physically and emotionally. As professionals, we have to use education that basically explains it that way. Then we have to be present and available to help them then work through the pain. Nothing is resolved – ***pain and trauma issues do not resolve when the person's in the shutdown--that will only happen if they have to come out enough to be allow them to be energetically accessible.***

Peter agrees that therapists are often uncomfortable with the shutdown stage. This is likely due to a few factors. One is if therapists are frightened of the freeze in themselves, of their own internal state. Another is that they simply do not know what to do. Most therapists are compassionate, they're caring and generally well-tuned in for the clients. If that's all they do, however, it's not going to be sufficient for someone who's in a shutdown state.

## The Importance of Breathing and Movement

There are different ways to work with that, through the voo sound and immobilizing the jaw. For example, the type of breathing that Stephen and Peter are talking about, is to use something like “Voooooooo.” When the client is asked to make the "voo" sound with you, you’re connecting the gut and then mobilizing the jaw to help release the shutdown and freeze. Often in therapy, the clients are basically slumped over like this. Even if the therapist says “Let’s just walk around the room together”, sometimes that’s enough to ship them out of their shutdown enough to start making contact again. Stephen was talking about getting regulation that’s supposed to be a harmonious by shifting between sympathetic and dorsal vagal and ventral vagal. To say it another way, we help clients to have the experience of being in the now.

Stephen adds another dimension, which is working with facial muscles. This is a part of what he calls the integrated social engagement system, which is giving tremendous sensory feedback to the brain stem area, regulating the ventral vagus. It involves using laryngeal, pharyngeal, trigeminal, and facial muscles plus listening. It’s a very integrated system.

## Breathing

Stephen explains that what is really wonderful about breathing is that we don’t think about it when we do it. "We can think and do it differently, so it’s like a system that we can literally reach into our body and change a spontaneous physiological system. If you watch client’s breath, or watch an anxious person, or a depressed person or a person who is totally dissociative, you can actually see different breathing patterns. Peter has actually spent his lifetime observing these types of things. We can watch as a person gets anxious, the breathing moves up their chest and so they’re really getting very shallow breaths, but what happens is losing the opportunity of getting the significant influence of the abdominal afferents going upwards to the ribs. More importantly, the person is reducing the duration of the exhalation in the breath. It is during that exhalation that the ventral vagus can have a soothing effect.

When Peter's doing his breathing using voo sounds, he is emphasizing the exhale because otherwise you would not have the sound; he's not sounding on the inhalation, he's sounding on the exhalation and he's encouraging his clients and the therapists who use this technique to extend the duration of their sounds. Extended duration of the exhalation means from a polyvagal perspective, we extend the impact of the ventral vagus."

## Afferents

Peter explains the difference between afferents and efferents by explaining that the term "efferent" means that these are the nerves that are going from the brain, the brain stem in this case, down to the viscera. "For example, if I voluntarily tell this hand to go into a fist, I'm doing that through *efference.* Now I'm closing my eyes and I'm conducting Beethoven's Fifth Symphony and then boom, 'Please help me God,' I could not do that without afferents. Afferents are sending information from my muscles and my joints and also from the viscera that informs me of my internal state. This cannot be over emphasized in feelings of goodness and wholeness – how profoundly they are related to our internal state. These receptors that are in the organs, that are in the muscles that are in the joints they are coming back from the periphery into the centrum, the brain and the brain stem. This gives us knowledge of who we are inside ourselves."

Stephen adds that the afferents from the sub diaphragmatic area are rarely recognized. "We are aware of it when it tends to be on the negative side. Sub-diaphragmatically, when things are going great and the afferents and efferents are doing the appropriate regulation, we're unaware of it. Our awareness comes with pain and discomfort. The part that I really want to emphasize is where we have a wonderful vocabulary of external sensation, we have a very limited vocabulary for the viscera because we don't have the specificity of the visceral receptors. It's not really that we don't have all the words, we don't have all the discreet feelings. When we say 'I feel full after eating,' some of that is not even a visceral response. Some of it is actually the stretch on the skin of our abdomen which is not coming from inside our guts, it's coming from the outside."

"The first year of Somatic Experiencing is learning about those hundred, or thousands of different kinds of internal sensations and what they mean," Peter responds. "We're learning to navigate them in the inner landscape and of course

pain and trauma and shutdown profoundly moves you away from that process. It gives you this one experience of distress in the gut instead of the hundreds of nuance sensation based feelings that emanate from a core visceral sense of ourselves."

## Inflammation

Inflammation plays a big role in pain. This section of our presentation considers how the autonomic nervous system regulates pain and inflammation.

Stephen starts by asking participants to think about the vagus nerve having receptors, some of which are affected by *cytokines,* the immune system for inflammatory activity. When some of the receptors triggered by localized cytokines, release, this actually informs the brain to release those same types of chemicals centrally. It's kind of a switchboard, so you have a receptor down below to pick up something and it sends the message "upstairs." It doesn't actually travel up the nerve in the sense of the chemical traveling up there. It's actually a code.

When talking about inflammation in the autonomic nervous system, the term "ANS" may be too restrictive. Stephen now uses what he calls the ***expanded autonomic nervous system*** (see chapter 2). That term incorporates neuroendocrine and immune and even the constructs that people use in terms of neuropeptides, like oxytocin and vasopressin. The reason these structures are included in the expanded ANS is that they're utilizing similar brain stem areas for regulation. The partitioning of these disciplines, whether through psychoneural immunology or psychoendocrinology or psychophysiology indicate separation with separate dependent variables, but if you look at the regulations systems, they're all overlapping.

## The HPA (Hypothalamic Pituitary Adrenal Axis)

Peter reminds us that the part of the brain that's a kind of driver of all of these autonomic and endocrine systems is what has previously been called the *hypothalamic pituitary adrenal axis (HPA)*. When you have shifts in autonomic activity, you also get parallel shifts in this hypothalamic pituitary adrenal axis

(HPA), which affects not only inflammation through the corticosteroid system for example, but almost all of the internal metabolic and endocronological activities. It's really important to understand this clinically. When you work with a client and you're working primarily with their autonomic signs. When they get regulation there, very often people with autoimmune diseases or weak immune responses will shift. Once we work with this central axis all kinds of things can happen. W.R. Hess, who won the Nobel Prize in 1949, showed that the hypothalamus actually affects virtually every part of the brain and the nervous system in the body. It is astonishing that people don't talk much about that anymore.

Hess won the Nobel Prize in 1949 for his work on the central regulation of the viscera. In the first paragraph of his speech, he describes how everything is interrelated to everything else in the body. What he is saying is that the interaction among the components is much more than the sum of the little components. Peter and I are big believers in his work.

## The Dorsal Vagas and Nociception as a Cause of Pain

Stephen explains there's a lot of embedded research floating around in neurophysiology on the relationship between the afferents of the dorsal vagus and *nociception* (the encoding and processing of harmful stimuli in the nervous system, and therefore the body's ability to sense potential harm). One of the things uncovered in the literature is that ***the sensory part of the vagus interacts with a spinal pathway that's involved with nociception***. That becomes interesting in terms of constructs or concepts like fibromyalgia, which tends to be linked very much with people who have experienced profound shutdown and are literally floating between a dorsal state and a sympathetic state. They're shutting down. If you only tracked their colon you'd probably see the same phenomenon. In a sense going between constipation and diarrhea, you'd find the same metaphor at a lower level. What you want to understand is that a couple of things get really triggered due to the changing in the afferent regulation of the autonomic nervous system while in a dorsal vagal state.

That means that the system that regulates blood pressure regulation, the *baroreceptors,* gets disrupted. People often get dizzy and pass out. They become "vasovagal sympathetic," they fall, and this is due to vagal afferents. It's a system

that is not linked, so only part of it is working. People exhibiting these problems often may have *posterial hypotension or hypertension.* It's the blood pressure regulation. *Hess found the link between chronic fatigue syndrome and blood pressure regulation problems, that they are part of the same system.*

We may have three syndromes linked together in terms of symptomatology. ***One is chronic fatigue*** which is going to be a symptom of many people who have trauma or who have experienced prolonged periods in dorsal vagal states. ***The second is blood pressure regulation***, not hypertension, but literally getting dizzy when standing up. This is not the kind of dizziness where things are spinning but where the person really starts hitting the ground. ***The third link is fibromyalgia.*** These are all the same system---fibromyalgia, chronic fatigue, and blood pressure regulation--- that has gone hypotensive. This is all part of the dorsal vagus system, in the sense, being the last resort and being used in a defensive mode.

These 3 difficulties are facets of the same syndrome. A psychiatrist from the U.K. sent Stephen a letter regarding a client whom he said "appears to have a polyvagal syndrome." Stephen decided to deconstruct these symptoms so that we can talk about all these symptoms and how they would be describing fibromyalgia, blood pressure regulation, and chronic fatigue. If the person is spending too much of their neuro-regulation time in a dorsal vagal state that is not protected with the features of safety we cannot immobilize without fear.

## Fear and Depression, Polyvagal Science, and Pain

Peter wants to emphasize fear and depression in terms of polyvagal science and pain. Very often when the pain becomes chronic, the adaptation to *allostatic load* (the wear and tear on the body due to chronic stress) is to shift towards shutdown. This occurs because there is fear associated with the load and depression that tends to reinforce itself. Normally in animals that are threatened, or under life threat won't move. They appear to be dead. Just like a gazelle that's going to be taken down by a cheetah. There's no movement but then moments later the animal just hops up and goes off on its way. Because those states are normally time limited. But when you introduce fear into the immobility circuit, it not only maintains immobility or freeze, but maintains it robustly.

Let's take a guinea pig for an example. When you take the guinea pig and hold it in your hand, it becomes immobile. Then in a few moments, seconds to minutes, it pops up and goes off. But if you frighten it each time it goes in, it stays longer. What could be five minutes or seven seconds, with the fear added on, can virtually keep it indefinitely. Peter did an experiment like that in Brazil and had the animal stay in that state for 24 hours. Sometimes animals will actually die.

## Risks and Benefits in Coming Out of Immobility

When a human being begins to come out of immobility, clinically, there's a rush of hyper arousal. Stephen was talking about the sympathetic and dorsal vagal system being in this kind of flip-flop. ***What you have to do is help the person contain the sympathetic system, by keeping them engaged socially in the here and now.*** Then, there is regulation and the immobile person is able to come out of the immobility, out of the dorsal vagal shut down, because they're not reactivating themselves. If the pain becomes more acute, you have to say "Okay. If that pain becomes more acute and you just begin to notice that a little more, you notice if it's continuing to increase, if it's starting to decrease or if it remains the same or if it changes to something else". With this kind of invitation, clients get the sense that time moves along and boom, before they know it, they've exited from the immobility state.

Stephen goes on to explain that some mammals, through phylogenetic development, are able to go in and out of polyvagal reactions as adaptive functions. Small rodents also do this: however, even in going into the dorsal vagal response for a small rodent, there's a risk of dropping dead. The same is true with the guinea pig, *there is a chance just dropping dead from the immobilization response.* This likelihood tends to occur with mice and other small rodents. ***What appears to be adaptive can also be lethal***; as mammals, we need lots of oxygen, and when we go into shutdown states, we're not supporting our life needs as well as our body needs.

Another part to remember is the notion of *when the animals come out of dorsal vagal states, they shut down and they get highly immobilized*. There is also a sense of a highly mobilized state for many adaptive reasons, and one is merely to escape. They are trying to get the blood back into their muscles, back into their bodies so that they now have the appropriate metabolic resources to move the muscles. You have these twitches and other things that are occur4ing as you

refuel the body. Then, the regulation starts occurring. As long as individuals who have previously experienced shut down are mobilized, which means that they are in a state of panic or chaos, they are not going to shut down. You have to see these reactions as having adaptive features. They are not really features of good social interaction, but they keep them out of shutting down. Our nervous system has evolved, exquisitely and eloquently to shift between mobilization and social interaction. That defines how mammals function and evolve and survive, because they had to identify rapidly, who was safe and who was not safe.

## The Dorsal Vagus, Goodness, and Help with Pain

Peter follows up earlier discussion to talk more specifically about the fact that many therapists, when they learn about the dorsal vagal system, and its central role in trauma and in chronic pain, will see it as the enemy. It's almost like "well, if we could cut it out, why wouldn't you just cut it out?" Why not cut out those afferent and efferent connections? The reason is that the dorsal vagal system in mammals or humans is really central to basic feelings of goodness and also supports feelings of connection through the ventral vagal system. When you feel warm and happy, you can get a longing "God, it'd be wonderful if we could get back to our walks on the beach and so forth." Feelings of gladness and those feelings, they come from the gut. They come from the diaphragm and they come from the heart. What we're talking about is a system that is so vital for our own functioning, yet can so readily become maladaptive and therapists have to understand and hold together both sides of this.

Similarly, Stephen has had therapists ask "Can't we ablate it? Can't we depress it?" He believes that they are missing the whole understanding of what's going on and that's why if that system is used as a defensive system, it cannot be a system that supports our homeostatic needs.

The same is true for the sympathetics. To conceptualize this, there's a term that wasn't liked much called "Autonomic Balance." Autonomic Balance referred to the fact that in a sense you have enough sympathetics, and enough parasympathetic. Instead Stephen emphasizes that "If the ventral vagal circuit is really functioning well, then subdiaphramatically you have [organically] autonomic balance between the sympathetics and the dorsal vagus." This is is the kind of balance you want to be having and this promotes good feelings. He notes

what Peter was emphasizing was a feeling of well-being and how that moves up the afferent vagus from the gut and really dominates our ability to access different areas of our brain. We must not forget this massive flow of sensory information that is primarily coming from below the diaphragm that is actually changing the accessibility to various parts of our brain. It's a monitor.

**The real issue is the ability to keep the sympathetic and dorsal systems out of defensive roles.** They're going to be used for defense at various times as well as for their adaptive functions and if they're acute the balance probably will be just fine especially the sympathetics. If it's prolonged, and if the sympathetics don't work to get us out of danger, we get into this dorsal defense system. That is really where we get into problems.

**Maggie raises the question of how dorsal vagal responses, when they're not being used defensively, can be used to help with pain?**

Peter explains that our anatomy automatically shuts things down. If we're not in a defensive mode, the pain is not caused by something organic. That very often is when you can have the person connect with some visceral feelings of goodness, of okay-ness of wellbeing, to shift back and forth between those sensations and the area of the body where the pain is. *"Ah, so you feel that pain in your shoulder, in your right shoulder, but then you also feel that feeling of warmth and expansion in your belly. If you let yourself shift between these two sensations, notice what happens, what changes, and then what happens next?*" You can definitely enlist those good feelings. But again, if the body is really in severe pain and it becomes chronic, the client going to be in a shutdown state.

Stephen wonders if there's a science behind this because there are quite a few studies that view the stimulation of vagal afferents as moderators or modulators of somatic pain. What Peter is suggesting is that we can shift our visceral feelings to deal with the pain. Let's take a feeling that involves a sub diaphragmatic gut response that changes the afferent flow, changing our bodily state to make it easier to deal with the pain. Just as if we were going to get surgery (I'm sharing my own set of experiences here) in a very trusting way, our tissue is really much more pliable. We won't scar as much and we'll heal sooner.

The issue is trusting and feeling comfortable, having good feelings. Using those psychological constructs in specific physiological states, different sensory afferents are modulating our pain receptors and modulating the receptors of defense on the tissue level. We have defense on multiple levels. The body reacts hierarchically from, in a sense, social communication of components of the body, just like the polyvagal theory. Then it goes down as it protects its elements and then finally it implodes. It goes into a life threat mode and implodes.
Stephen shares that his friend, Bob Naviaux, who is a physician who runs the metabolic mitochondrial clinic at U.C. San Diego, introduced himself by calling me and saying "Look, bacteria follow the Polyvagal Theory." He says, "When things are good and when it's all clear" is the metaphor he uses. "They talk to each other, they're interactive. They are socially engaging." Now present a threat to the system, and it basically creates its own defenses. Then you can shut them down, then they implode and they die off. **The metaphor of safety socialization is in a sense a metaphor of the human body in all levels.**

What Bob is doing is part of his studies of the micro bile. This gets us back to the gut and the afferents. If you signal that the digestive system is going to shut down, animals start dropping their heart rates, and go into a shutdown reaction – this happens with mice. The signal of the gut is now conveyed up the vagus to the brain stem saying "Hey, this is a bad situation!" Now we're discussing methods of reversing acute trauma, by basically sending signals up the gut saying "Hey, everything's clear." There are pharmaceutical or pharmacological methods of sending an "all clear" response through the gut, through the receptors of the gut.

We're going to literally do a study that applies an acute trauma to the prairie vole, through restraint and predator. We basically put him in a restraint, which is bad enough. Then we put his natural predator, a ferret in front of them. Some of their basal heart rates are 400, some of them just get tachycardia. They go up to 600. But others go down to 150 beats per minute. Some shutdown and look like they're dead. But there is also species diversity.

In a sense, this creates the adaptivity of a species to survive, notes Peter. The issue of what we want to study is once that vole has gone into shutdown, what happens to their social behavior, their parenting behavior? We want to reverse it by sending a gut response up to the brain, "Say, hey, your gut's all good." Will that be sufficient to turn them around?

Stephen remarks that there is a drug that stimulates the normal signaling of the gut that everything is okay, yet that's not the sole solution because it's a multi-faceted problem as trauma is. He's also using features of treatments that he has developed with acoustic stimulation giving cues to the vole because the voles are vocal and they vocalize as a signal of their own autonomic state. If they're stressed out, the prosodic feature of the vole vocalization demonstrates that.

## Practical Ways of Shifting Out of the Freeze

Peter has found that sometimes it's possible to do different things with mobilizing. He has a device that looks like a small trampoline, yet it's completely different. It doesn't use any springs and it has elastic bungee cords. Now when someone stands on this, one gets to a place where he/she starts to, in a way, have an interaction with the trampoline. It feels like, between the two of you, that the trampoline wants to move you a little bit, to bounce you a little teeny bit and as you feel that bouncing, you're getting new proprioceptive information, mobilizing information from the joints, from the muscles. Peter works with people in severe shut down, and believes that doing verbal therapy could go on until the next century! Just getting these little movements on this trampoline takes them out enough so that they're accessible to mobility and you can work with them. It's good to remember that there are non-verbal and movement oriented ways of doing this.

Stephens's perspective is always to deconstruct what seems to be working to give it a physiological validation. Where intuitions seem really on target, can we give a reason why? There are two things***. One is rocking. A lot of individuals who have these experiences will often do things like this, and they have to understand that they are stimulating vagal afferents and trying to regulate blood pressure through the movement of their body in space. It's not just body and space. They are actually stimulating the carotid baroreceptors.*** It's soothing for people to rock. We have to see it as a neural exercise, as an attempt to rehabilitate a system that has been down regulated.

Another way raises the whole question of the pelvic floor. A lot of individuals who have trauma experiences realize that many of these trauma experiences are going to be surgically related, especially abdominal surgery or sub-diaphragm surgery. The pelvic floor is going to, in a sense, stop working. We have to

understand that the pelvic floor is, as a metaphor, a diaphragm. Just as our diaphragm is to our lungs, the pelvic floor is to our bladder and colon. It creates a negative pressure. The pelvic floor contracts, so everyone who has had pelvic floor issues is told, “Do Kegel exercises.” But Kegel exercises are sphincter muscles. The pelvic floor is not a sphincter muscle, it has sphincter muscles traversing it. The issue is how do you get the pelvic floor to adjust and work? You do that through shifting balance or balance challengers. This is like the approach with the trampoline. We might also use the BOSU which is half of an exercise ball.

Peter agrees that just sitting on a gymnastic ball and making little movements, and then getting help to find the feeling of surrendering the pelvic floor into the ball can really shift things. If the person allows the ball to support the pelvic diaphragm, then the diaphragm just relaxes into the ball. You see this often with sexual trauma, abdominal surgeries, and so forth.

Stephen noticed that Peter closed his eyes when describing this process. His eyes started to droop and close. That reminded Stephen of the fact that he had had surgery and I did not like what they told him to do, to deal with the pelvic floor issues, so he created his own model. He also realized that if he closed his eyes it was more difficult and challenging, and it was working better because he was not using the visual cues. It’s best to work with clients with their eyes open and something to hold on to. It creates a connectedness if you are with another person. You can even give them your arm to hold on to so that when they come out of shut down, there you are.

## Somatic Resources of the Dorsal Vagal

From Stephen's perspective it’s a difficult question. In a sense, it’s our core or our base of being alive and the issue is that when we try to use it as a resource, it’s almost like using it as a defense. Instead, we have to, in a sense nurture it. When we nurture it, it serves us and this is where the afferents are coming back saying, "all clear". The “all clear” afferents are the same afferents that support our ability to engage others and our ability to access other areas of the brain that are both social and creative. If the signal from the dorsal vagus is, “I’m in trouble” it’s going to down regulate everything else. It’s a support system, a resource system, where by giving, we get, as opposed to a sense of exploitation from it.

Maggie suggests going back to Peter's suggestion of standing on one half of an exercise ball and having something to hold on to and having someone there. Doesn't bringing in safety change everything?

Stephen agrees: ***safety and trust change into a neural exercise of growth as opposed to a shutting down defensive reaction.***

## Getting Started with the Dorsal Vagal Shutdown

The final topic for this dialogue is, what advice would you give to therapists who are working with clients with chronic severe pain that appears to be related to the dorsal vagal shutdown defensive response? Where would you suggest they begin?

Peter comments that clients in the dorsal-vagal shut down response are looking down, looking anywhere else. You can just tell they are going into a freeze because they are rigid, and very de-focused, we all know what it looks like.

Peter suggests saying "It seems like it's really difficult for you to talk right now. If that's true, how about the two of us just walk around the room a little." When I lived in Colorado full time, and on the river, I would take clients out into the yard on the property and walk around the river. You could just see things shift. *Movement also evokes curiosity. But even if they can become curious about the shutdown then you've enlisted them as an ally. They observe themselves as an ally. If someone is in a shutdown, it's not just freeze.*

It's a bit more related to the sympathetic although it has components of both. I think the critical thing here is ***that when the person is in collapse, as soon as you can't use your cleverness to get the person to move, or breathe,*** and many times when a person has been very traumatized, especially sexually, to make a voo sound at the beginning would be too much. ***Walking around the room is likely to be okay.*** Maybe even jumping a little bit on that trampoline that I spoke about. Again, you can be there and hold their hand while they're doing it and then when they show excitement, say "Wow, that's wonderful, seems like you are really feeling more energy." You need to make contact. If it's worries they have, they want to talk about their worries. If its pain and what effect it has on their life,

then let them talk about that for a while and then get to "Okay, so now let's begin to do something about that; are you on board with me?"

Stephen notes that it's easiest for him to deconstruct from Peter's clinical insights. *As long as you get them moving in a way that is not a fight-flight movement, they are going to stay out of deep dissociation or shutting down because, as we've said, there's a hierarchy in physiological states and* ***if you move you can't shut down.***
If you can move now in a socially supportive environment, you're now performing a type of neural exercise, and one where the person is gaining the ability to move more in the context of play than they were in fight or flight. ***As long as you can stay in a moving state, without going into flight/flight, then there is the opportunity of recruiting the social engagement systems and the ventral vagus, because that's the portal we have***. We don't have a good portal of going directly out of dorsal vagus. What we have is a portal that if we're mildly mobilized, we can push people or trigger people into more social engagements.

Maggie points out that without the social vagal system being online in some way, at least in relation to you as a professional, then the client may not be able to move out of the dorsal vagal response, especially since there is no direct portal to come directly out of shutdown and immobility defenses.

Stephen reminds us that the other point that's really critical is that when people are in defensive states, they're going to read neutral cues in your face and in your behavior as negative. ***You have to be very careful about losing contact, not being present and turning away, doing trivial things that normally would not matter***. Clients may, in a sense, overact and become highly reactive and then disappear again on the psychological level.

Peter mentions that everything is kind of biased towards false positives**.** That's why perceived threat is a survival response. You always have your perception. I was just writing about this, on the memory book. Laura and I were editing this section of the book and we took a break, walking around. We were in Zurich, one of the most beautiful of parks. We're walking and holding hands, and all of a sudden, we're poised to alertness. We're not enjoying each other's company, No more holding hands and walking, now, both of us are looking and scanning – it's as though there is some fearful threat. Then we noticed about 20 bamboo

branches; the kids are waving them around and not obeying the normal Swiss norms.

Now remember, we are feeling that Zurich is the safest place in the world. A park like this is probably about the safest park in the safest place in the entire world. Nevertheless, we are programmed to expect the worst. We are programmed to expect threats. As soon as we realized what it was, we laughed and went back along our way. But if you've been threatened and hurt by an individual, any teeny little thing about their face that reminds you, even remotely is going to trigger them. You can't avoid it completely so you may sometimes ask, "It seems like something I said or didn't say, seemed to get in the way, or affect you?" Again, you're helping them articulate some of this, which also is a way of helping to bring the frontal brain online and the social engagement system online.

Stephen notes another part of Peter's experience is the acoustic environment. People tend not to emphasize that. When you're in a hyper-vigilant state, your hearing gets biased towards low frequency sounds or high pitched ones. It loses its acuity in the range of prosodic features of human voice. We lose in understanding, or we dampen our ability to understand other people's affect around us because the low frequencies are triggers of predators. The high frequencies are triggers of someone in pain. When those bamboo grasses, which weren't grass but 20 feet high – when they were moving Peter, there was probably a low frequency hum that was coming from them. That, to all mammals, is predatorial. The body is programmed to react automatically to predators.

## Chapter Three Summary

This chapter has presented a dynamic discussion of the dorsal vagal component of the polyvagal system and its complex interactions with the ventral vagal social engagement system and with the sympathetic/adrenal fight-flight system of defense and regulation.

One of the most important principles that was emphasized multiple times in different ways is the importance of bringing in safety through ventral vagal social engagement. In the treatment of trauma and pain, this must be accomplished by

steering the healing relationship through what Stephen has termed “biological rudeness” as social cues are misinterpreted, acoustical sounds are perceived as dangerous and predatorial, and both members of the relationship are triggered to withdraw.

Although this is extremely challenging work, there is much hope in the strategies offered here. The gift of simple presence can help defense and shutdown shift to connection and healing. Belly breathing and “voo” sounding extends the exhalation and the soothing feeling of ventral vagal engagement. Simple movement like walking around the office can help clients who have great difficulty with social engagement through eye contact and other connection. We can help sympathetic containment by teaching vocabulary to our clients so they can stay connected to their own body experience and to us. Encouraging movement on an exercise ball or special trampoline that is safe and increases social engagement is hugely healing. Gentle rocking movements can similarly be a safe and enjoyable way to enter the ventral vagal system while beginning to move out of shutdown. Finally, tending to the acoustic environment and enhancing prosodic qualities of the therapist’s voice can also expand the ventral vagal engagement so that all 3 branches help move the organism into homeostasis and wholeness.

# Appendix

## Chapter 1 Q&A

| | |
|---|---|
| MAGGIE | Let me get that going. There we go. So, welcome you to the questions and answers now about the sympathetic adrenal system, pain and interventions. Peter, I hope you enjoyed our dialogue as much as I did. I thought it was-- |
| PETER | I did. I thought it was fun. |
| MAGGIE | A lot of fun, yes. Who would think you could have fun with the sympathetic adrenal system [laughter]? |
| PETER | I wish that somebody told my physiology professor that. |
| MAGGIE | Exactly. There is hope. There is hope. So, those of you on webcast, we are counting on you to type in what you want to ask us. |
| PETER | To spur us on. |
| MAGGIE | Hopefully you can ask us about things we did not go far enough in to. You can ask us about working with clients. We are very open to that. In fact, we like those kinds of questions. Those of you who would like to talk with us directly, you can at any time switch over to the phone. You can stay connected through the webcast and ask your question on the phone, and then jump off again and go back to the webcast. So, there are lots of choices here. I think while we're waiting-- Here we go. We have a few more coming on now. While we're waiting for someone to type in, whatever they would like to ask or any comment you would like to make about the video that you saw, why don't, Peter, you and I-- I'd like to revisit one of the questions that I didn't think we got to go quite far enough. And if you feel like there's something we didn't really talk about that you feel belongs with the sympathetic adrenal, then this is your chance to add on. |
| PETER | I do. I do have some thoughts. |
| MAGGIE | Good. You have something? |
| PETER | Yeah. Well, I mean, a couple of things. |
| MAGGIE | All right. Good. |
| PETER | They're both sort of related to the question about after surgery and medical trauma as well as abuse, but also about emotions. Emotions can definitely get locked and produce a sympathetic like hyperactivity. Because remember anger and fear-- but anger that's suppressed, again you have a high level of sympathetic activity and a suppression of the |

mobility. So again, you're leaving the ANS, the sympathetic system all dressed up but with nowhere to go [chuckles]. I think that that's really important because a lot, a lot of times chronic pain are related to anger and aggression issues.

MAGGIE Yeah, that's right

PETER [The forwarding?] of being able to move forward in life, so that's important. And then the other thing about surgery-- I haven't presented it quite like this before, so bear with me, bear with me. You're undergoing surgery and you're really frightened, and when you're really frightened what happens? Sympathetic arousal. Now, the sympathetic adrenal system is an antagonist for the anesthesia. In other words, the person who's in a sympathetic adrenal state, will need more anesthesia to go under. So there they are in this hyper aroused state. Their heartbeat is going a mile-- and of course in the surgery, you're measuring all of that, so you can see it. And I have. I've been in surgery and just seeing exactly that. And so then what happens, the surgeon, the anesthesiologist then increases the depth of anesthesia, and the patient finally goes under. But this time they go too deep, and they go into a shut-down state, and you see the heartbeat is very, very low. And so, what do they do? They have to again release some of the anesthesia level, and again the person goes into a sympathetic adrenal state. You can see how the sympathetic adrenal system gets really coupled, exactly, with a surgical trauma, with medical trauma. And of course, if you are awake during or even a partial awakening, you go into this super sympathetic adrenal state.

MAGGIE That's awful.

PETER Yeah, exactly. It's bouncing up and down. And I think that anesthesiologists are becoming a little bit more aware of that, but they're not aware when a person is terrified often, though the nurses frequently are.

MAGGIE Yeah, the nurses tend pick up on that.

PETER Right. I think this could make a big difference in surgical outcome, if there was more attention paid to that. But what do I know?

MAGGIE You know a lot as it turns out [chuckles]. Yeah, but I'm glad you mentioned that because we didn't really have as much time as we would have liked to talk about the sort of medical trauma issues. Because I think they still get overlooked - there's more awareness - but we're still not where we should be on those. I don't think.

PETER Yeah, no absolutely not.

MAGGIE While we're at it--

PETER There's a lot to go.

MAGGIE --you have some strong feelings about a certain anesthetic as falling more into that kind of trap. Do you want to say anything about that?

PETER Well, this is not specifically for the sympathetic adrenal. Well, but it could be.

MAGGIE Could be?

PETER It could be. Well, I observed a lot of people I would work with. They've had surgeries in the last 10 or 15 years, 10 years. It's almost like a psychosis, like a post-psychosis. I would work with the person to stitch the things together, but there were pieces that were just out in the ether, and it really became quite a challenge. I started to ask and find out and ask them to ask their doctors. The one thing that seemed to really correlate was the use of-- it's not an anesthetic. It's actually sort of a benzodiazepine, called Versed. It's very, very, very common. It's used a lot. If you go to some of these - what do you call them? - Blog posts, where people talk about their experiences-- I thought, "Is this just me?" And then somebody said, "You know, there's such a thing as the Internet." So I went on and I found one that had hundreds of entries. About a third of the people had a basically neutral experience with the Versed. About a third of the people had a really positive experience. They felt really relaxed. And another third flipped out. They had severe PTSD, severe pain, a profound difficulty in sleeping after that. So, if somebody's not traumatized, probably Versed is okay. But the compilation that we're talking about are largely traumatized people. So, what I'd do and what I suggest to my friends to do, is to just list - as under allergies - list Versed.

MAGGIE Yeah, that's right. And, certainly, I think if you do have a trauma history - and many, of course, of people we see do - I usually try to help the person find a way to bring that up to either the anesthesiologist or the surgeon or both. And even if the surgeons and anesthesiologist aren't actively going after that information - they won't initiate, in other words - but it's gotten to the point, in my experience, where if they're given information they will use it wisely.

PETER I think so. I talk to many anesthesiologists that are recognizing it, that some people just do very poorly.

MAGGIE Absolutely.

PETER And the medication that works really, quite well, especially to this kind of twilight is this [crosstalk], which has recently got a little bit of a bad name.

MAGGIE I was going to say.

PETER No, it's an excellent, excellent alternative.

MAGGIE All right. Good, I'm glad. I hope all of you will take that to heart and mind. We have now a couple more people still coming on, so I want to

remind you, people on the webcast, please type in your questions and comments. We really welcome these. It makes such a big difference to Peter and me when we get your input. Also, we have some people on the phone now, so if you want to call in - let's see - I will repeat the phone number. I should have it right here somewhere. Shoot. It's one of those times when things are moving slowly in a technical world. Hopefully you've got it on your email or you wouldn't be here. Please, please, join us, please. Give us ways to help you apply some of the things we talked about. We're standing by, hopeful to the end [chuckles]. The other thing, I want to go back to the emotions for a minute, because I think we said this, but emotional pain is every much as important as physical elements.

PETER They use basically the same brain system.

MAGGIE Same pathways, yeah, the same system. A lot of people who are really locked into the physical system they don't have or they're not aware of anger and fear, and that's one of the reasons why we encourage you to explore through the body. Because sooner or later-- and I gave this example of a woman who just all of a sudden shot her arm out as if to strike someone. She hadn't even mentioned the word anger, but it was in her body experience.

PETER Often if you just ask the person as a curiosity question, "What is your relation to anger like? How would you describe the relationship?

MAGGIE Yeah, that's good.

PETER Or even, "How is anger handled in your family?"

MAGGIE Same with fear.

PETER Because a lot of times if you're just tracking, you're not going to get that information.

MAGGIE Yeah, you may not. My experience is you'll get it mainly through movement.

PETER Through movement, but also from questioning.

MAGGIE And questioning, right, what they say. I think you want to have an awareness about how you're going to move back and forth between emotional and physical pain. I had somebody who - I'd been working with him for a while - had a very bad bicycle accident. I don't know why, but I have multiple bicycle cases right now. They really can be awful because there is so little protection. And so, what happened with him is that he would go into dissociation as he was talking about something that happened to him. This is not related to the accident directly, it was related to he's trying to get his life back now. He's going to some classes, and he finds he can't sit in the position that they want you to be in - to be in a regular class, where you're sitting in these uncomfortable chairs. His issue is, there's so much shame involved in

not being able to be like everybody else in the class, that he doesn't raise his needs. When I started to talk with him about this, about why he didn't ask the teacher about getting into a more comfortable situation, he dissociated. He said, "I don't know why but I feel really dizzy and confused right now." You kind of have to bring the person back and sometimes guess. I said, "Well, what I know in the past has been true, is that you've felt shame if you aren't like everyone else, if you feel like you're disabled." Then it clicked in for him. He said, "That's it. That's why, I couldn't-- instead of going with what I needed, I dropped down into confusion and just being in lock-down."

MAGGIE Again, we welcome your comments and questions about anything we're saying. I think we have to learn how to go on a campaign to elicit questions on Saturday morning, Peter [chuckles]. People I guess would rather be listening to us, I think, rather than--

PETER Well...

MAGGIE Maybe. I don't know. But your questions are valuable. I really do want to encourage you along those lines.

PETER Yeah, yeah, yeah, it's important. I think you mentioned it, but also if there are things from the webinar you just saw that you didn't understand, and you want to have clarified, please ask that.

MAGGIE Please ask.

PETER We're not getting any questions. We either did a fantastic job, or we did a terrible job [laughter].

MAGGIE Yeah, there is not much in between usually. But, anyway, I'm pulling up the questions here. We can take a look at them. I know everybody was sent these questions as the study guide. So, I would still say - let's see here - if I were going to have questions, they would be about how do we recognize when somebody is in severe pain. And by severe pain, I'm-- you know, they're reporting, and you can sense it from them, a nine to a ten on a scale. And they're very preoccupied by pain. This would be a situation where they're flooded versus dissociated. And so, that tells me right there that they're in a sympathetic arousal, because they're so overwhelmed. And so, how do we get them to connect with their experience? But I would say, when they're in that overwhelm, it's more from a place of compassionate observer. Do you know what I mean, Peter?

PETER Of course, absolutely. I mean, in a way that's the only stance to pain that really helps significantly, is to be able to-- but of course--

MAGGIE So can you talk about how do you get--? Go ahead.

PETER Well, I mean, somebody who is in pain almost to even suggest that, can conceal the meaning.

MAGGIE Yes.

PETER What do you mean just observe it? You try this pain and see if you can just observe it. Point well made.

MAGGIE Right [chuckles]. Then you'll get some anger. You'll get to work with that probably.

PETER The thing that does seem to relieve, be effective, because it gets at the root of the pain often, is to be able to have the person gradually become aware of the muscular pattern - the bracing pattern or the retracting pattern - that's underneath the pain. When they focus on that, it's kind of like a figure ground relationship. At first the pain is the only thing - that's in the figure. And then the tension pattern is way in the background, almost imperceptible. But then when they're are able to bring the tension pattern out and observe the tension pattern, then the pain tends to move into the background. That's in the ground, the one where you either see a vase or you see two ladies' faces looking at each other.

MAGGIE Yeah, right. I remember that one.

PETER We've all seen that one.

MAGGIE Yeah, indeed. This might be a good one to talk about a little bit, because I think people may need a step-by-step. Because we talk a lot about bracing patterns, but yet if you haven't, for example, done some kind of somatic training - including somatic experiencing - you may not know what that really means. What does it mean? Is it more than muscular tension, and if so, what else is there in that? Can you add something to that, Peter?

PETER Well, it's muscular tension with a particular purpose. Let's just say we injure our arm. Let's just say this was back in the times of the early hunter-gatherers or the cave people. If you broke your arm, there was nobody to set it, and basically you would die because you wouldn't be able to use the arm. What I think happens - it makes sense evolutionary - is that the muscles actually formed like a cast, formed like a brace to keep the bones in place to get some kind of knitting. Afterwards, this bracing pattern may remain a little bit, but at least you've survived. And I think one of the-- really, I'd love to do a study on this sometime. I have talked to some of the, for example, the Navajo because they have a tradition, they call them bone-setters. And what they'll do is they'll actually put their hands around on both sides of the break, and probably generate some kind of electric field. And then they'll also, out of bark and reed, they'll make some kind of a brace. But how that slowly came in.

PETER Then of course, when you've been immobilized for a period of time - we all know this - when you have been immobilized, then you tend to stay immobilized. Think about it. Most of us have had a cast on, so if

it's-- especially if an adult. So let's say it's been on for six weeks, and then it comes off, you notice you're not having that same range of movement. That's the residual bracing. Now, you hopefully see a physical therapist or a SC person or a [?] person or a [?] or whatever. And then they help restore the tissue to it's previous setting. So, I think again that the bracing is meant to, in a way, reduce the pain, but now it's actually what's causing the pain. Very often these little movements-- and you can just try that. So if the person, for example, is having pain in their forearm, you can very, very gently extend the hand at the wrist and then move it a little teeny bit in the opposite direction and do it back and forth very, very slowly. I think we talked a little bit about that before. Then boom, all of a sudden, there's a release of energy, of heat, of vibration when that bracing pattern releases. By just playing with the passable movements that are around the area of the pain-- again the person's learned to not move to prevent more of the pain, so you have to encourage them to move, but to explain that this is different. This is a mini-movement, a micro-movement, a mini-movement.

MAGGIE Micro-movement.

PETER Yeah. And when it's done that way, it may increase the pain, but it's only momentarily. And then the pain almost always becomes less after that, sometimes quite significantly, with just a very simple intervention like that.

MAGGIE Yeah, that's great. I think the point I want to make is that a lot of people think that bracing has to be something very striking, that you're going to see in the-- that's not true. It's much more subtle than that. People will report about tightness and tension and that will give you some clue, but really as Peter was saying, it's the micro-movements that are related and maybe nearby, that help the person come out of that. So, hopefully we'll be able to get to that in some part of the rest of the webcast, is how to work with those micro-movements. We have more people on the phone now, so I'm going to suggest if you want to ask us a question - and we only have time for about one question from you at this point - would you please press *7. It works best if you're on a landline, and just start talking. Just tell us your name, "This is Mike," and blah, blah, blah, blah.

PETER "I'm from... and here's my question."

MAGGIE Exactly, that's what would help us. We have one while we're waiting for that. We have one person, Christine, who called in and said she didn't get the video. I'm not sure if you meant you weren't able to access it. I'm not sure what happened for you that it didn't work, because I tested it several times and it seemed to be working fine. Can you catch up afterwards? Absolutely. This material will be available at least through the end of January, February. So, it'll be up there long enough so that you can go back to it again and again.

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| PETER | Exactly, review it. |
| MAGGIE | Yeah, because there's a lot there, and that may be another reason why we're not getting questions this morning Peter, is just that there's so much material there. |
| Caller 1 | Can you guys hear me? |
| PETER | Yes. |
| MAGGIE | Yes, now we can. Who are you? |
| PETER | My name is Alex. Hi, how you doing? |
| MAGGIE | Hi, Alex. Great to hear from you. |
| PETER 24:58 | Where you from? |
| Caller 1 | Santa Barbara area in California. |
| PETER | Right. |
| Caller 1 | Hi. I have a question, can you talk about-- I'm working with somebody who has multiple traumatic events, fairly serious. They tend to want to stay in the story and the interpretation of what happened, and really resist slowing down and taking one step in the event at a time. So I'd love if you can talk a little bit about ways of approaching that. That would be fantastic. |
| PETER | Sure. Well, I think the first thing is your presence. Because you might be feeling frustrated that you're unable to get the person to slow down. So it's really important to take a few moments to center and to collect yourself. And then, you have the possibility of joining, of getting some kind of alliance with the person. |
| MAGGIE | Yes, that just what I was thinking, right. |
| PETER | And then once you have that alliance, then I think you get more traction when you say something like, "Well look, this has been there for a long time and I know you're really wanting to get at this stuff. Of course because it's been troubling you. It's been interfering with your whole life, maybe even ruining your life." But you know that my experience particularly in working with this approach is that less is more. Sometimes just hearing those words, you see the person go, "Ahh" - relief. What I mean by that, is that the important thing is to just to touch into the experience. Whether it's a particular memory or just what's going on inside of you, which is even better, right now in the here and now. Just to touch it and then we'll work with that. I think basically, our clients want to be tricked by us, because they know at some level [chuckles] what they've been doing hasn't been working for themselves. So again, I say first your presence, because again there's a frustration. There's a helplessness - how can I help this person? We all want to help our clients. Then the second is presence. And then |

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| | developing an alliance, and just saying, "Let's just try this and see what happens, and lets just give it a whirl and see if we can get some results that you'll find helpful." |
| MAGGIE | I would add to that, that I think sometimes, not only is less more, but so is simplicity-- can be much better for people than something that is so complex, they really just cannot do it. So one of the approaches that I use is what I call Just One Breath, and I'll ask them to just pause, wherever they are, and take one normal breath, not changing anything. Just breathe in and out and just notice what that's like. If you did that right now, what do you think you might answer? That would be my question to you, the caller. |
| Caller 1 | Yeah, that's a great-- |
| MAGGIE | What happened for you? |
| Caller 1 | Yeah, it just, it pauses the momentum and the stream, and it gives you the space to feel more. |
| MAGGIE | Right, but if you just take that breath right now, Alex. |
| Caller 1 | Right. |
| MAGGIE | Tell us what changes. |
| Caller 1 | Well, what I just described is the-- because I was thinking about the situation, and instead of feeling the impetus of the treadmill of the story, it was being in the present, right now. |
| MAGGIE | There we go. |
| Caller 1 | Which makes a lot of sense. I think that for the-- |
| PETER | That's right, that's right. |
| Caller 1 | And I think that for this individual, it was so new for this person to be able to tell the story - they had never been able to tell this story before - that I think that for the first pass, they just needed to get it out. I tried to slow it down as it was happening, but it was so-- |
| MAGGIE | Compelling. |
| Caller 1 | -compelling, in the sense, and the freedom of being able to actually tell this story was so major, that he just had to do that. I think that probably in future sessions and work they will now have that baseline from which they can probably slow down. I think that these ideas make a lot of sense. |
| MAGGIE | Also maybe just saying to them the magic question, which is, "As you tell me that, let's have you pause and see if you can go inside in some way and find out how your body's responding." |
| Caller 1 | Right. |

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| PETER | Even for just a moment, even just a moment. |
| MAGGIE | Right, just a moment. Even just a moment. |
| Caller 1 | Yeah, and we did that and that was definitely helpful, because it finally connected to... |
| MAGGIE | Yeah, some things there. So thank you, Alex. If you would press *6. We have a couple of more calls we'll take in from the webcast quickly, before we sign off. It seems like people had to get warmed up a little bit. Are you familiar with the work of Dr. Hamer and German New Medicine? He talks about two phases of disease, following the trauma, or trigger we run in the sympathetic fight/flight. And only when there's a resolution or turning point, can we go into the second phase of healing, which is where we would experience musculoskeletal pain in regeneration, Hamer describes as the parasympathetic phase. And he's saying, "I'm interested in understanding how you see the pain of muscle happening in regeneration, such as a bodybuilder might heal during a rest period." So he's interested in that whole model. I don't know anything about it, Peter, do you? |
| PETER | No. I have heard of-- he's considered to be controversial. I think it's-- one time somebody even gave me an article of his. I think it does fit in with the work we do and with our static load, and so forth, accumulated stress. He's a very interesting guy, actually somebody was supposed to try to set up a-- was it a meeting with him or with one of his protégé? |
| MAGGIE | Well, we might want to follow up on that. |
| PETER | Yeah. |
| MAGGIE | But Sammy, who asked the question, I think there are a lot of models of disease. I think it makes some sense that he's saying you'll go from the sympathetic fight/flight, and then when there's a resolution or turning point, the issue is resolved, then you can go to the restorative part which is-- |
| PETER | That's right. |
| MAGGIE | --where you feel the pain and be able to resolve that. So I think we're in agreement with that. I think it's a little bit different, in that we don't believe that you have to get a resolution in the fight and flight - the sympathetic adrenal system - in order to move on into the next phase of healing. I would say, for me, it's much more of a interactive, interlocking method, model, where you [crosstalk]. |
| PETER | Right, but still the general movement is from sympathetic to the resolution. Or when we'll be talking next week from the vagal shutdown to the sympathetic, to the arousal. But I think when you're young-- especially I mean pain because it's a chronic thing, the first reaction again is more of a fight or flight sympathetic adrenal. But then |

as that becomes chronic the nervous system and the body goes into what's called an energy conservation withdrawal, which is probably the same thing as dorsal vagal system, and I think you have a similar parallel in different diseases.

MAGGIE — Yeah, and true that if you're still bouncing, as Peter was saying earlier with the sympathetic fight/flight responses, it is hard to feel much of anything in the body unless you're guided back there some time. It makes sense to me, what I read here, is that you go from sympathetic fight/flight, then there's some kind of resolution, and we go to a place where we experience pain, and then the para-sympathetic phase where there's restorative and regeneration. Yeah, it's roughly the same, but somewhat different. And we're going to have to stop there in terms of the time, but I want to thank you all for your question, Alex and Sammy. And I hope the rest of you will remember that the next webinar session is with Steven Porges on ventral vagal, and that is on Wednesday. You'll be sent a separate email about that, so you'll know how to access it. In the email that you get the day before-- and a lot of times we don't send it sooner, because we try to catch everybody in one email blast as much as we can. So that we send one out the night before and one that morning. In that email, you will get access to the video and you will get the link for the question and answer. So keep that email handy so you won't miss anything. And thank you so much for joining us this morning. And thank you, Peter Any last words?

PETER — Okay, Mag. No, just, hey, that's right, as usual, enjoyable, and again just really appreciate folks logging on to this and expanding their knowledge base, their clinical skills. That's great.

MAGGIE — Yes, thank you so much for everybody, and those listening later, we thank you too. Take care and we hope to see you Wednesday. Bye, bye.

## Chapter 2 Q&A

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| MAGGIE | Hi, this is Maggie Phillips, and I'm with Stephen, and we are so happy to welcome you to our live question and answer session on the social engagement ventral-vagal system pain that is related to that system and relevant interventions. And we hope you enjoyed the video webcast, and Stephen and I are here, ready to take your questions and comments. Those of you on the phone, what you need to do is to press *7 on your touch tone phone. It works best if you have a land line. If you don't, you can try it anyway. And those of you on the webcast, you can type in your comments and questions at any time. We really, really appreciate them. I can't tell you how important it is for us to be able to tailor our comments to those of you who are listening, and we can't do it if we don't have feedback from you. So, Stephen welcome, again. |
| STEPHEN | Thank you, Maggie. It's a pleasure to be here, and looking forward to some interesting and challenging comments. |
| MAGGIE | I hope so. What's what we like, we really do. So far, we haven't gotten anything, so I think we will start us off. One thing that actually has come up when I have been teaching recently on the ventral-vagal system, is that some people don't understand why you may have changed that to social engagement. You're emphasizing that term more now. Can you say something about that? |
| STEPHEN | Certainly. The muscles of the face and head - the striated muscles that we use to engage others - the muscles that we use for facial expression, the muscles of vocalization, and the muscles even of the middle to listen to, are regulated in the brain stem in the area that regulates the myelinated vagus. In fact, it's an integrated system, so the use of those muscles of the face and head influence the vagal activity to the heart. And when the vagal activity of the heart is low, then those muscles tend not to be used at all, meaning that people have flat face, flat affect, and have difficulty hearing voice. |
| MAGGIE | I think what you're saying is that social engagement - I'm going to go a little bit broader here - social engagement is essential for attachment, and I think most people think of the ventral vagal system sort of globally as attachment. But you have made the point that no, it's really - in terms of the science which you just described - it's really about, can the person use their natural, organic prophecies-- |
| STEPHEN | Let me even kind of-- |
| MAGGIE | Yeah, go further. |
| STEPHEN | It's basically, the evolution of mammalian species, was all about the ability to convey that visceral state, and if that ventral-vagal system that was on board was acting, then the individual was safe to come |

close to. So, the whole notion is not merely of receptive; it's also expressive in a system that's bi-directional. So, when we think about an integrated - and I'll use that word - integrated social engagement system, is the use of queuing, the ability to receive signals, and also the regulation of physiological state. This becomes critical in the clinical domain, because people tend to separate things like flat affect, difficulty with processing auditory signals, hypersensitivity to noise, high pitched voices as if they're independent or orthogonal to an ergonomic state, when really they can be a manifestation of that ergonomic state. And the other part, it gives you a portal of intervention. So the exercising, breathing, facial expressivity, and laryngeal of singing are functionally interventions in themselves that form neural exercising; exercising that vagal regulation of the heart.

MAGGIE I'm glad you mentioned that, because recently I've done something with a chronic pain patient that I haven't done before. It's been an edge that I haven't crept out into, but she loves to sing. So, we are using singing and she's experimenting to find out what types of pitches and what types of rhythms really are able to help her connect with herself better, and then to engage with her partner, for example, when she is in some difficulty with pain. And so far, it's been fascinating. It's been really interesting.

STEPHEN Well, I'm sure she'll discover some basic laws of nature, meaning that if she's prosodic or uses melodies like a mother's lullaby, it will have a functional regulation of the pain; she'll feel better. So she may start off with higher pitched tones, holding and then by modulating she'll start seeing the functional impact of this ventral system working.

MAGGIE It's so exciting to me, because that is already happening for her. That's her sensibility toward music anyway, but it's exciting because, goodness, we could be using this with almost every type of patient that we work with.

STEPHEN Yes. And in the singing, she'll also learn that if she extends the duration of her phrasing while singing, then the vagal break is more functional. So, she'll find out that longer phrases are more effective.

MAGGIE Wow. That's just fantastic. I wanted to-- go ahead.

STEPHEN Well, you'll let me know, because I need to be informed when some of these ideas actually start working.

MAGGIE I will certainly will. I'll be glad to do that. I want to talk to the people on the phone here for a second, because there are more of you than there are in the webcast, which is a little bit different. So please, we want to encourage you to just-- all you have to do seriously, press *7, give us your name - your first name - and we'll be right there with you for questions or comments. So, please do not hesitate, don't be shy. We really want to hear from you. Steve and I are happy to talk to each

other of course [chuckles], but we would rather talk to you in this portion of the program. So, please get ready for that.

MAGGIE — Now we have something. This is from Sylvia. How do you recognize facial features when an individual dissociates, other than feeling that one is staring into space? For example, the eyes aren't in the here and now. That's a good question.

STEPHEN — Well, I think you picked up immediately on what the features are. Basically, the upper part of the face, especially the muscles that go around the eye socket - it's an orbital muscle called the orbicularis oculi - and that's where crow's feet and exuberance, and that's what we look at when we look at people, that goes flat. And then the eyes goes someplace else; they may roll up or they just gaze forward. But look at the upper part of the face and look at the neural tone to the orbicularis oculi in that said orbital muscle around the eye socket. And of course, that's the one where people go to have Botox remove all the cues. But when the cues are gone, people will have difficulty responding to them.

MAGGIE — That's exactly right, yeah.

STEPHEN — The second part of the comment is that, the reaction to the dissociate person is a reaction that can often be anger as well to the person dissociating, because the upper part of the face is no longer engaging. They have basically offended, in a sense, what I call biological rudeness. So if someone is engaging and they just dissociate, they're basically turning away and walking away. In a way, they're doing that, but they're also doing it to the person who's doing the engagement behavior.

MAGGIE — Fascinating. That explains a lot, of course, why it's hard to work with highly dissociative people.

STEPHEN — Well, from a clinical perspective, it's difficult because it's very difficult as a therapist to be present with the person who is disengaging to you. So, our biology is to react to that type of cue, is for us to also walk away, or to get angry.

MAGGIE — That's right. And instead, I think what you're suggesting - this is not the only thing you're suggesting - but one strategy, is instead to focus on the sound of your own voice at that particular moment. I think a lot of therapists look for the eye contact as part of being able to do therapy, and in this kind of situation, you're not going to get that. I think what you've said is, well, focus on other ways of connecting. And the voice, it turns out in your research, has been hugely effective, right?

STEPHEN — Yeah. The prosodic features are going to get into the nervous system, and they bring the person back. Again, what I say is that the cue of a flat face to the person who's engaging the person with the flat face, is to become more defensive and reactive, because our biology views this

as insulting. But now, we as insightful individuals have to say, "Wow, we can't allow that to happen, because that will just create a cycle of chaos in the interaction." We have to now be like the mother, and basically speak as if we're singing a lullaby, and that will have the calming features and hopefully make the person feel safe enough to come back and re-engage.

MAGGIE — Right. I was working with a dissociative client - I think it was on Monday - and I noticed that this is not necessarily true of all people who are dissociative, but she was talking very, very rapidly and not looking at me, which is sort of-- it's a similar kind of challenge to stay connected.

STEPHEN — Well, I will tell you, she was also probably talking in a higher pitch voice, and her phrases, although they were running on each other, were probably gasped of breath. So, it's very short phrases with breathing, and so what she was really saying to you was, "Hey, I'm in a stay of fight flight. I'm being dominated by my [inaudible] nervous system, and if you engage with me with any cue of danger, I will dissociate." That's what she's saying to you.

MAGGIE — Exactly. I can really see that. What I did was, I focused only on my voice. Of course, I was looking at her as if she were looking at me, but I really focused on that quality and I slowed down and my voice was softer and a higher, more melodic pitch. And that did seem to help bring her back. I'd say ten minutes or 15 into the session, she was making very good contact. I want people listening to understand that that is just a really important strategy when you're working with people who have emotional and/or physical pain. We have to really work hard at this engagement piece.

STEPHEN — And we have to remember that the engagement is not a voluntary reaction. It's a spontaneous reaction of the reciprocal engagement. It's spontaneous, but based on the physiological state of the other and whether that nervous system can react as if the other person in the environment is safe. And that is picking the most profound and potent cues that happen to be the prosodic parts of the voice. I mean, the intonation, the melodic aspect of voice.

MAGGIE — That's right. And I think we have to be careful. Some patients would be, I would say, probably a little sensitive or wary at first if the therapist is changing your voice pitch, but it doesn't have to be-- I guess what I'm getting from this is that I think, I am thinking to myself like a mother singing a lullaby. And it doesn't necessarily mean that what comes out of my mouth is going to be a song or a lullaby.

STEPHEN — That's right. And actually people with higher pitched voices that are melodic have an advantage in this therapeutic setting with the types of people we're describing. So, a male with a big, bass voice is going to be very difficult. It's a bad fit. And so, what [inaudible] form a melodic voice.

MAGGIE Gosh, maybe we should be screening people with-- take their psychologist exam or some other exam and see what kind of voice quality they have. It's not a bad idea.

STEPHEN Or teach them to--

MAGGIE Or teach them, you're right.

STEPHEN So, what I was saying in the webinar was that when I talk publicly, I notice that my voice goes to a higher pitch and is quite melodic, compared to when I'm really talking one-on-one. It tends to go a little bit lower. And I'm really bouncing off the social engagement of the people in the audience. I'm looking at them, and I'm responding to them.

MAGGIE That's right. We have a very good question here from Irene. Her question is: You have spoken about prosody and facial expression in helping people feel safe, but what about movement, body posture, gesture, the rhythm and quality of movement, etcetera?

STEPHEN I think those are excellent questions, and often I don't talk much about that, because I almost view them as implicit. So the issue is, the parts of the brain that are picking up facial expressivity and intonation of voice are also picking up the movement of the head, the leaning forward, and even hand gestures. And those areas of the brain, in the temporal cortex, are actually the centers that evaluate the features to down-regulate our defenses. So, her points are actually excellent. We can see the gesture in clients or in therapists, whether or not it's truly-- let's use the word 'functionally engaging', meaning are they leaning forward, are they functionally engaging? Are they using their hands not as a defense - autistic children might put their hands up to block - but their hands are gesturing 'come closer', engaging gentleness of the hands. So, posture, hand movements, head movement are all critical features of engagement.

MAGGIE That's important. I'm glad, Irene, that you asked that question to give him a chance to be explicit, rather than implicit. We still haven't heard from anybody from the phone. *7 is all it takes to get to us. Let's see if we have another question here from the webcast people. So far, not.

STEPHEN And remember, every question is a good question.

MAGGIE Every question is a good question, and every question usually is something that other people are wondering about and they may not have gotten it to consciousness yet or they may be a little shy, so you will be helping not only yourself, but all of us to learn more. I want to go back to - since we're talking about face a bit, as well as voice - we talked about the pain face in the webinar, and you explained that there's a brain/heart face system, and it also is part of, of course, the ventral-vagal system. Do you want to say anything more about the pain face? What I'm getting at is, when people are in pain, I'm thinking

about how they express it, and this is usually unconsciously, facially. A lot of partners of pain patients will say, "I don't understand why she acts this way. I never know when she is in pain and when she isn't." Do you want to say anything at all about that?

STEPHEN I'll say a couple of things, that often pain is linked with a type of grimace, or at least a type of facial expression that is far from inviting in terms of social interaction. So, the narrative that individual comes up with who sees or experiences interaction with a person in pain can have different meanings. But let's think about it for a moment, and let's think if we're in pain, we generally do not want to interact with the world, whether it's physical or even mental pain. The issue is, it's a retraction-- you've been pricked, and the system pulls back. And it has to be respected for its own defensive approaches. So, if you're in physical pain and you have the grimace, you have chronic pain, it's certainly going to compromise your social interaction. It's going to compromise your access, literally, to different areas of your brain. It's going to affect your cognitive functioning, your ability to extrapolate that could be created and interactive. The body evolved, the nervous system evolved with this complex agenda, which was protect itself. And that's part of the response when the face pulls back.

MAGGIE Exactly. Thank you. I have two more excellent questions, so let's move on. Julie asked, what do you suggest in working with people who rapidly switch - this is not really appropriate for this call, but if you can say something briefly - who rapidly switch between sympathetic arousal and dorsal shutdown?

STEPHEN Yeah. I actually--

MAGGIE Do you want to save that one?

STEPHEN No, I saw that one coming [laughter]. I think this is really the metaphor for those of you who are trauma people, is really part of the shifting from aggressor to victim, and it's a destabilized situation. I have actually start conceptualize that as a specific stage within what I call polyvagal syndrome. And you get that moving back and forth when the ventral-vagal system is not functioning. It's just not functioning, so you're disinhibiting the sympathetics. And you get the shutting down effect when the sympathetics don't win the war, they don't win the battle. So you come out with swinging and fighting, and then you're supposed to stop swinging and fighting, but you don't have a social system. It's just not there. So, you lose the fight and your body says, 'What else do I have in it?' And that is disappear, to dissociate. So, it's a functional hierarchy, and that's part of what the polyvagal theory is about. But the vulnerability occurs when there's a predominance of the sympathetic nervous system being used as defense and not swinging back between defensiveness and social behavior, which is really in a sense, what we used to characterize as neurotic behavior.

MAGGIE Yes. And so now, I guess one point is to use our observational skills certainly, but also to - I think this is where psycho-education comes in a certain way - teaching clients to track, in SE terms, their own process when this is happening; to catch it when it's in the therapy room with you, if you can.

STEPHEN If you can. You see, this is what I think is really challenging for the client. Because I think the client is oscillating between two states that don't provide really good awareness of one's own behavior. So, when you're in sense mobilizing fighting, you don't have a true sense of body, and when you shut down, you don't even have a sense of context. So, the awareness bit. And again, the history of therapy was always concepts of insight: you should know this, you should understand this. I think you hit on what I view as the most important point of any form of therapy, and that's the psycho-educational component. And that is the understanding by the client, that the body will go into these defensive modes, and not to be so embarrassed by it. I think there's so much personal shame that people have when they go into these states.

MAGGIE That's right. I think it's the biggest obstacle we have really, in treating trauma.

STEPHEN Yeah. And then, they go through a world of denial, or at least a process of denial, which is how literally their personal narrative helps to protect them from their shame. I'm learning about this as I travel and talk and get informed and actually interact with many clients and people and therapists: being informed about the creative aspects of how we try to make sense out of these disruptions in our lives, and I think the whole goal of therapy - and even of life - is to try to make sense out of it. What the polyvagal theory is attempting to do, is to provide another set of constructs, another set of metaphors that we can understand what our body is doing without having to say, "I am personally responsible for that specific act at this time. But as I get informed, the responsibility is now shifting. I need to have a better understanding of what triggers it and how I can then control it."

MAGGIE I think you'd agree with me, but part of how you can help the person get the ventral-vagal system online when they're in that place of rapid switching between sympathetic and dorsal shutdown, is psycho-education. In other words, if you are offering information, I have found that it is so reassuring to clients. I can watch them and their facial expression will change, everything will change. All of a sudden, they're online again with me. So, I think we really do want to emphasize that piece.

STEPHEN Maggie, I totally agree. What I've also learned over the years, is that when people get informed through a psycho-educational model that tells them what their body can do, then those top-down processes, rather than focusing on denial and fixing it by-- actually starts understanding it and seeing both the advantage and disadvantage;

meaning that there may have been an advantage for an acute use of those strategies, but they can now see the disadvantage of when it becomes chronic.

MAGGIE — Exactly. We have one more question I'd like to get to, because again, it's a good one. This is from Serra. As a therapist, I'm constantly working to bring clients into greater regulation using our own ventral-vagal social engagement system, and of course, this is what we were just talking about. Yet as humans, we're sensitive to the limits of our attempts to control the situation through co-regulation, and inevitably there may be a moment when we're overwhelmed, such as in compassion, fatigue, and burn out. Would you say then, that our dorsal vagal complex has kicked in and overridden the ventral-vagal, because we've attempted to down-regulate ourselves too much? How would you explain this?

STEPHEN — I think it's a path, meaning that the first thing is to really be highly mobilized, irritable, and unable to literally be present and help regulate the other. Because physiologically and neurophysiological, the client has basically been biologically rude to our nervous system by disengaging. And each time a person disengages when we engage, it gets to us; we feel bad. And our nervous system is literally telling us, 'Why are we doing this? It's so uncomfortable. Why should I experience this discomfort?' So, the first reaction is to get the hell out of there. And a lot of therapists and a lot of parents and a lot of spouses disengage. However, you still need to make a living, you still need to take care of-- there's all these other, what we call cultural constraints. I think she's absolutely right. Then the system may just shut itself down, because that's all it has left. You didn't listen to the getaway response, you didn't respect that, and now what it's going to do is going to ride everything, and is just going to make you limit your capacity to interact.

MAGGIE — Right. I'm thinking about a woman that I just worked with a couple of weeks ago, actually. I was getting ready to go to Europe for my teaching trip. She just came in, I would say, loaded for bear. She was really in a sympathetic response. She was angry, very angry toward me. She didn't say anything at all about what she saw in me that might be going on in a system between us. I asked her directly, "You seem a little unsettled today. Is there anything that you are aware of coming from me that you're reacting to?" And she said, "No." It took us the next session to go back into it. In fact, what she had been doing while she was sitting waiting for me to come in, she had had this conversation with her father - very, very abusive father - and she said, "I'm not going to let you run my world anymore, and I'm sick of this," so she really was standing up to him in - I think - a very good way. And I was able to explain this to her, that there may be parts of her inside that became very scared, because of what would happen in the past when she stood up to her father, which was, she'd usually get beaten.

MAGGIE — We were able to work through that, but I think it was because - and I want to emphasize this too - it's staying in a place of curiosity. If you can't do anything else-- and sometimes - I completely agree with the question that was asked - is that, yes, this is when we do feel compassion, fatigue, and burnout. We've had it. We just can't respond anymore. But what brings me out of it more is curiosity. What could be going on here?

STEPHEN — Once you're in the state of asking the question, 'What could be?', and you're curious, you're no longer defensive. So, we have to understand that if we feel like we're being attacked - which is really what she was doing - if we feel that it's personal, then we shift physiological state, and we'll say, "Why am I being attacked?" And our response is - we have two of them - either we fight, argue, try to get out of there, or we just dissociate or shut down. And the part the therapist has a responsibility here in that, is to understand that the therapist isn't really the target. The person is functionally trying to regulate their state by expressing how they feel. Even if it feels to be abusive, it's really allowing that person to say things that they never felt they could say before to anyone.

MAGGIE — That's well said, Steve. I like the way you put that. We're going to have to stop. I wish we could go on. It seems like we get warmed up and the time is over. But certainly, all of you, thank you for joining us so much. I do want to remind you that we will be back. Peter, Stephen, and I will be with you on Friday morning. We look forward to seeing you again, those of you who can make the time to be with us live. But we also want to thank those of you who are joining us later when it's convenient for you. We hope you find this useful and helpful, and that you'll listen to it and watch it again and again if that's what you want to do, because I think it's very valuable material. And I thank you so much, Steve, for lending, as usual, your wonderfully informative and sensitive assets to what we're discussing.

STEPHEN — Thank you, Maggie. And thank you for everyone who's tuned in and who's watching. As I usually say, it's important to reach and translate the science into practice. And it's because people like you, Maggie, and people like those who are on the webinar that enable me to use a real sense, a sense of personal validation by being able to go beyond the frustration of basic laboratory science and see it have positive impact on humanity. So, thank you.

MAGGIE — Yes. Thank you so much. And we'll see you all, hopefully on Friday. Take care. Thanks. Bye-bye.

## Chapter 3 QUA

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|---|---|
| Peter: | Particularly, when it comes to the shutting down - the energy withdrawal system. I think that's the one that therapists have the most confusion about. |
| Maggie: | I think that's great. I love the way you said it too, "The marriage between the theory and the clinical." |
| Stephen: | I'd like to add, there is both a theory and there's also empirical neurophysiological basis. We flowed, literally, among those three points of a triad - from biological basis, to theory, to clinical application. We also flowed with different ways we use in the way we speak. So often, when we speak in terms of biology, it's really a deconstruction without much feeling. But I want to make sure that people who have listened to us talk understand that if I go into a deconstruction on the biology, I haven't lost my sense of feeling or my sense of compassion for those who are experiencing those things. It just provides a language of explanation. |
| Maggie: | Right. My comment would be, as a therapist listening to this, that's one of the things that I most admire about you, Stephen. You never lose, as far as I've ever seen, any aspect of your humanity and your sensitivity to what's going on. So I think your attempts to integrate all of that as you deliver the theory or the science, you are right on. So thank you for that. |
| Stephen: | Thank you, Maggie. |
| Maggie: | You bet. |
| Peter: | I couldn't disagree with that [laughter]. |
| Stephen: | The other thing-- |
| Peter: | I said, "Couldn't, couldn't disagree with that [chuckles]." |
| Stephen: | But there's one other point that I didn't really elaborate on, and that is… |
| Maggie: | Please, yeah. |
| Stephen: | That is that my entry into this whole area of trauma was through Peter, was through his persistence, his… |
| Maggie: | Wow. |
| Stephen: | …actually his boldness in terms of engaging me in the 1970s, and basically confronting me with some of his questions. So I never appropriately thanked him during the dialogue in the webinar session, and this is, in a sense, the start of an amazing dialogue for both of us. |
| Maggie: | For both of you, I am sure. |

Peter: Thank you so much, and I really look forward to continuing that and exploring different ways that we can feed each other.

Maggie: I think that the world will more than benefit from that, so I'm urging you on too [chuckles].

So let's inform people so they know, if they haven't done this before. When you're on the phone, you need to press star seven and immediately start talking. Just give us your name, then we'll get your question or comment, and we'll be glad to receive it - in fact, more than glad. We really welcome all comments. And those of you on the webcast, please, all you have to do is type in a comment or question on the screen. It's very clear. You can see it on the page that you were sent to with the link. So we're glad you're all here. We know there'll be many more people coming later.

I think, for me, going back to the questions that we covered. One of the ones, that I think is so important, is where we got to with how the dorsal vagal system is implicated in pain and also in feeling. Can either of you elaborate on that?

Peter: I'm glad to start. Review: Pain in itself, regardless of what originally caused it, when it becomes chronic, the nervous system experiences that prolonged stress, very much the way it processes trauma.

The origin of pain, and this is my belief -- When people originally have pain, the pain is usually due to an injury. And then, the bracing pattern - the body's biological bracing pattern, the innate bracing pattern - which then actually causes more pain. Then that causes more fear, which causes more contractions, which causes more pain. So when people get into that loop - that negative feedback loop, what can you do?

People will, of course, take pain medication. And then, the body starts to generate, in the absence of pain medication, its own mechanism of pain relief - of analgesia. And that has to do, largely with the shutdown system. So in other words, you're in pain. You want to do something about it, but then you're in pain, and in pain, and in pain. And the only out really that the nervous system has, is to just anesthetize, to shut things down, to increase numbness. So the dorsal vagal system then is, I believe, and Steve can probably say much more about that, that the dorsal vagal system function with pain is, in a sense, pain relief.

Now, once you're in this immobile state, with this energy withdrawal - energy conservation state, especially when there's pain on the other side of it and coming out - people tend to go deeper and deeper into the dorsal vagal, into the shutdown system. And then, when they come to see the therapist, often it's with this sense of despair and helplessness. They're kind of crushed between pain on one side, and then helplessness and despair on the other.

As we're able to help clients move out of the shutdown - out of the dorsal vagal mediated system. It's really important that we support them. Because as they move out into arousal, into the pain, we have to be able to have already taught them something about pendulation. So when they experience the pain, they can experience the increase in pain, but then open to the decrease in the pain. And when that rhythm gets established, and I really think it is a rhythm, then the nervous system automatically moves towards social engagement, towards connection. So again, I think of it as a stage process, where you work with a person who has had chronic pain, who has shut down. You help them find ways to move out of the shutdown, just the smallest amount - just what I call the titrated exposure, more is not less, less is more.

Then as they move into the sympathetic state, into the pain, to help them to open into the pain. Maybe that would be a good term to use, to open into the pain. And then, as the pain diminishes, you have, "My god, the pain can change." Very often, working in this way, if the person experiences, for example, they're not in the shutdown and the pain is at an eight, they often will come down to a four. And that gives hope. Because really, you have to help contradict the hopelessness. Because when a person is feeling hopeless, They're not even feeling. They're being swallowed, being drowned in hopelessness.

They start to experience hope. They start to experience the energy that's underneath the bracing pattern, that's underneath the pain. So again, it's a gradual process. It's a step-wise process. It's one of education. Also, it's one of helping the client when something happened, and it appears like they've gone back to square one.

Maggie: I think one of the things that we emphasize, and I'm sure you'd agree, is that through this whole process that you just described, it's hugely important for the therapist to be fully present - as present as he or she can be. Because that brings in the ventral vagal system. There are other ways of doing it too, but you want to make sure that that is very much online - as much as it can be.

Peter: Yes. You're absolutely right, absolutely right.

Maggie: Stephen, you want to add something?

Stephen: Sure. I would deconstruct it into the sense that - keep thinking about the autonomic nervous system and the Polyvagal Theory as being hierarchical. Once you're suffering pain, you're in defense. It's operational. You're there. And when you're in a defensive state, you compromise social engagement. But also, when you're in that defensive state, you only have one other option, and that is to shut down. So if the pain becomes too intense for too long a period of time, the system goes into this conservation and shuts down.

This raises a whole variety of thresholds, so there are a lot of adaptive functions to it. But it also ends up with a different cluster of emotions, feelings. Feelings of hopelessness, particularly, as Peter was saying.

And that's why what Peter is saying that you get the client to move a little. You're basically putting him back into a sympathetic state, and that is dampening that hopelessness in that dorsal vagal state, which never evolved to be your primary defense system. And if you get into a mobilized state, then you have opportunities to down regulate that with social engagement, with prosodic voice, because that's what we evolved to, to deal with. But we never evolve to deal well with this shutting down, so someone has to help us regulate, has to give us the features of safety, so that we get out of the defensive realm.

Maggie: That is it in a nutshell.

Again, now that more people are on the phone, I want to emphasize please press star seven. You can ask us questions about clients, how you would apply this. That's what we're looking for in the questions and answers, mainly. And if something wasn't clear to you in the webcast and the video cast, then please, please ask the question. Because somebody else will want to know it too, and just won't have the confidence to put it out there.

Just again, we're reflecting on this current webcast for a little bit more time, and then I want to move toward synthesizing and bringing together all of the presentation, so that we can give people a summary of what we hope they have learned. Then, of course, once they have that it'll be easy for participants to go back through and review the webinars and some of the other questions and answers in a way that will bring it more into integration for them. So does that make sense as a plan for us, for this time?

Stephen: Yeah.

Gina: Yes.

Maggie: Is somebody on the phone?

Maggie: Please, give us your name.

Gina: Hi, I'm Gina.

Maggie: Gina, great.

Gina: I came in late because I had a client, so I am probably going to repeat something here. But we could all use - I mean, I could use repetition [chuckles].

Maggie: Sure.

Gina: What I wanted to ask was a general problem I have with my clients. They will come in and they will have some physical pain. Because I'm also a body worker and a counselor, I see the pain could be solved by

osteopathic work, cranial sacral work, myofascial release work. I want to tell them, "Here are some recommended people to go to." I don't want to deal with those pains. Is that the proper thing to do, because sometimes it's just that they walked the wrong way, or they fell down the steps or...? That's not the same kind of thing as a chronic pain issue.

Maggie: Gentlemen.

Peter: I'm not sure I fully understand the question. So a client comes in with acute pain, is that what you're saying?

Gina: Yeah, acute pain like their neck feels out, or they have some back pain that I know an osteopath or chiropractor could fix.

Peter: I think, of course, if you have a good referral to help somebody with a particular problem, a particular issue, by all means. The only thing that I would add is that usually chronic pain is quite different than acute pain. First of all, with acute pain, you may want to have them evaluated by a physician, if there is some kind of actual injury. So yes, it's a first-aid kind of thing. They come in. They have pain because they've had a whiplash or something like that.

Most osteopaths tend to work very gently, which is important. And most cranial therapists, the same. Myofascial release, for many people that could be too much. They could be overwhelmed. And when you're overwhelmed - the person is overwhelmed - the nervous system almost doesn't know the difference between that overwhelmed and the overwhelmed that caused the trauma in the first place.

So I think it's really important to do. Now again, if you had somebody-- they're really monomorphic body, and they really need somebody to help release some of the muscle, then-- I don't know if the term "aggressive body work" might be helpful. But I really appreciate your interest in referring, because I think very often, therapists don't refer. And in that way, they're not delivering the best care.

Maggie: What I would add to that, Gina, is that as a therapist, I think you want to monitor the progress that your client is making with whomever you refer them to. That's really important to be checking in on that.

Gina: Okay.

Stephen: I have another point, and that is - I think, Peter was really emphasizing the difference between acute and chronic. Because sometimes with chronic pain, you can't identify the cause. And you don't know really, whether the client wants to give up that pain. Pain becomes part of who they are, and they're going to protect it. But acute, I think you should take care of that first.

Gina: All right, thank you.

Maggie: Thank you for the question.

Gina: Certainly.

Maggie: Thank you very much. So, to keep the noise minimal, press star six. Great. Anyone else? I agree, Peter; most people, most therapists want to jump in to try to help the patient, even if they're not sure what's going on. And it is important to have good referral sources - people whose work you know and it's stood the test of time, and they're open to working with you on behalf of the client.

Peter: Right.

Maggie: I would urge Gina and some of the rest of you listening - another possibility is to get training so that you know how to recognize acute versus chronic pain, and that you can learn more about chronic pain and how you - in particular - can intervene in that.

Let's see. What do we have here from the webcast? Do we have any questions from you coming in? I don't see any yet. I'm looking at the time. I'm thinking, unless there are more from the phone - and we'll find out as we go along, it might be good to look at how each of you see the hierarchical system - Polyvagal system - and how it interweaves with branch to branch, and what that suggests for our treatment of people who have pain.

Peter: I'll let you start, Steve.

Stephen: The first part is that we know that once a person is feeling acute pain or is going through even chronic pain and bracing, we know that that is a down-regulating potential vagus, and it's actually a physiological part of a defense system starting with sympathetic activation. When it gets prolonged, you start moving now into that dorsal vagal issue. Now, the real question here is that both the sympathetic nervous system and the dorsal vagal are very important for our homeostatic function - for basically, our vitality, health, growth and restoration. But when they're recruited as defense, that's when we get into trouble. The only way that they're not vulnerable to defense is when we get that ventral vagal system on board. It's a hierarchical system, and once - we have to visualize the ventral vagal system literally, as a state modulator or state regulator that enables the rest of the autonomic nervous system to functionally do its job - to optimize your health, growth, and restoration.

When you have pain - whether it is acute or chronic - it is telling the body, "Go into that defensive mode, or go into one of your defensive modes." So the way of getting individuals out - and this is really what our dialogue was about with Peter and me - and that is literally, utilize behaviors that trigger the ventral vagus. Peter has the vocalization. I emphasize breathing and expiration. There's also rocking or movement - the body back and forth, from head to toe which triggers the baroreceptors. These are mechanical methods of getting that ventral vagal system triggered. You can see these. Actually, this is a personal

story for a moment. I've had kidney stones twice in my life - not recently, not in the past 20 years or so. But they are painful - kidney stones - and you understand the word "writhing" once you have a kidney stone.

What you also understand is that **movement helps mitigate some of that pain**. This goes back to this whole understanding of movement. So if you get on the floor and literally, writhe with that kidney stone, the pain is not as bad as just going supine or sitting. The movement has an effect on the modulation of the pain. So what we're both saying is that an understanding of the hierarchy of the autonomic nervous system, in terms of how it reacts to challenges, give us insights into how to down regulate the defensive modes. Pain is operationally a defensive reaction.

Peter: I would add to that because you mentioned the kidney stone. This is an example. Somebody could come in to you with a severe backache, and you work with them. Maybe there's a little bit of a change, but then it goes back to just as bad. And if it's something like a kidney stone, we're wasting time that really should use addressing the proper treatment.

So it's really so important to have a relationship with, not only alternatives, I use that term to cover many, many different modalities, but you also need to have a good relationship with an internist and possibly with specialists, neurologists, gastroenterologists, and so forth. One thing in the Somatic Experiencing advanced level training, when we discuss syndrome, I talked to the students by saying, "Trauma can mimic almost anything in the Merck manual. Any disease can be mimicked by trauma. However, somebody can have trauma and also have a disease. Especially around pain, it's important to have that referral option in place, and also, if for nothing else, to cover yourself. If the person is experiencing pain and you're not really seeing the possibility that it could be something medical, then you're doing incompetent work."

Peter: So I'm just saying that it's so important. And then, begin breaking down the homeostatic functions of the trivariate (ie polyvagal) system. Really, it's the balance of those systems that gives us health, growth, and vitality. The idea that we should completely suppress or meditate out our arousal system, that really takes away our capacity to really engage in life. So we need to be able to mobilize. We need to not go into the sympathetic adrenal system all the time, but to be regulated by arousal systems. So the person with all systems operating in a coherent way, in a synergistic way, really gives rise to the experience that the person has when they contact themselves.

In a way, I think trauma is a profound portal to spiritual experience. I've said that in many different ways. But I think what Steve is saying really gives us that here-and-now entry into grounded, embodied spiritual experience because we feel in ourselves the help, the growth, the

restoration, the vitality. When we experience that, in a way, that's the basis of many, many spiritual experiences.

I think a lot of times in the West, notable, notable teachers accepting that there is an emphasis is in blandness, in being seduced by these interstates of consciousness and moving the cooperative residents of health, vitality, growth, and goodness - the feeling of goodness, the feeling of wholeness. Maybe I make a risky statement, but I think that's really the basis of all spiritual experience. Steve has said this. We both really notice this. The immobility response, in the absence of fear - the dorsal vagal system, in the absence of fear, can be quite illuminating. People report experiences like what you can ascribe as the eternal now. The now just expands in all directions, like a pebble dropped into a pond. And the wave goes on and on and on, even in a positive way. So that was the point I was trying to make.

So you can have these mystical kinds of experiences. But at the same time, you want to help the person move towards being able to feel what they're feeling inside and, at the same time, the outside.

So interact with the therapist, or if it's in a group, interact with other people in the group to use the social engagement system to bring in. Sometimes I also use the image of a magnet. The experiment that the teachers would do in junior high school, where you have a plate of glass and you put the iron filings on it. And then, you had the magnet underneath the glass. You move the magnet, and the iron filings follow the magnet. The magnet draws the filings towards it. And when people are able to feel these deep, internal states related to immobility, quite frequently, and be able to socially engage at the same time, I think is maybe the spiritual challenge for Western culture.

Stephen: Peter, may I add - so the immobilization without fear is really the loving state.

Peter: That's right.

Stephen: This is the ability to be still in the arms - I use the term, "safe in the arms of another," where your bodies comforted and there's no muscle tension. That immobilization, it's recruiting some of those same neural pathways that are used in shutting down, but they're being modulated - often, by neural peptides such as oxytocin, that enables the body to be compliant and flexible.

The other part of what you were saying, Peter, is that in craniosacral work, people talk about stillness. And that's really what we're talking about in immobilization without fear. The assumption with some of these other alternative strategies is that when you get into that state, your body does its recuperation. It starts working, taking care of itself - reorganizing. This is part of what we're saying. When the sympathetic and dorsal vagal are not defensive, then they're recuperative.

The final point I wanted to mention was with my own personal experience with kidney stones. I didn't tell you that I had it for 49 days. I didn't just have one experience of kidney stones. I learned the waxing and the waning of the pain, because it's not chronic. I was actually able to drive in and go to work. I could also sense when it was starting to get renal colic. So I could understand all the features. Some of them were periodic, and I could understand the time course of them. When pain becomes predictable, which it frequently is not, but when it becomes predictable, then some of that uncertainly and hopelessness is removed. I was continually being monitored by a urologist. Basically, how long I could take this before he'd go in. But the idea was, would it move on its own? And after seven weeks, it moved.

Maggie: Wow.

Stephen: Most people aren't that patient. And my view was, my body will reject it. What I started to learn from the X-rays was that I could start using gravity to help the stone move. So I started to sleep on my side, and then it, basically, passed within a week. But the point I'm really making on that is both in understanding of those visceral feelings, to take those visceral feelings and not be so afraid of them.

I think that's part of what's going on. And what Peter is saying, that through pain and often through trauma, we can bridge into literally another level of understanding. For me, going through the seven weeks of this gave me another understanding of pain and how to deal with it, and also to understand the biological significance of it.

So I think in understanding and predicting various outcomes from our own bodily cues, understanding of those biological processes, being informed by the biology empowers us to understand what's happening, and takes away a lot of the uncertainty that leads to this hopelessness.

Maggie: Right. And just to add one more piece to this or summarize it, what we're talking about is, as we've said, balance in the Polyvagal system. That's worth working for. That's what we're focusing on and - go ahead.

Stephen: But I want to make sure that the word "balance" only occurs when the ventral vagal circuit is there, because it is your balancer. It inhibits the defensive strategies of the other systems. So you can talk about balance, but you're really focusing on sub-diaphragmatic balance. What you're focusing really on is the power of that ventral vagal system and its linkage with all the attributes of human interaction and connectedness - the social engagement, the listening, prosodic voice, the facial expressivity and the response to gesture, whether they're hand or head gestures. How that helps to calm the physiology, to take the physiology out of defense and move it back to a more homeostatic level.

Maggie: Thank you for saying that. So really, all of you listening, there has to be that focus on ventral vagal response, how you are online in your connection with a client, and how you can help them also to move into that. We've mentioned a number of ways throughout the series. Let's name a few of them. Peter, what are some of the ones that you talked about?

Peter: I'm sorry. Name what?

Maggie: Ways of helping the pain patient come into the ventral vagal system and to contact.

Peter: Again, I was mentioning the analogy of the iron filings and the magnet. So when a person feels, even for a moment - for the first time, feels the homeostatic state. Instead of just leaving them in that - it would be meditation, some meditation - you have the person then make as much eye contact as they're comfortable with. With the idea - often, this is in a group. With the idea that instead of the people looking at you, you are not only looking at them, but you are drawing them in, the way a magnet draws them to the filings. You're drawing them into you, into that now, more open, visceral state. And then, that in itself opens the visceral state even more, which allows the social engagement. So when you get this thing going in a good way, the positive feelings tend to add and add to themselves. And it contextualized it in terms of the governor, which is - as Steve described - the ventral vagal state.

One of the things that I've noticed is sometimes - Steve, you're talking about the movement. One of the exercises I do in my training is that I I demonstrate it by just putting my hand on the person, with their permission, of course, on their upper arm on both sides. And then, just waiting there. Then what will happen is the body will tend to just almost imperceptibly move in one direction or the other, and then I just support that and maybe accent it a little bit. I think again, what's happening is - Steve, I don't know if it's baroreceptors, but it's certainly the vestibular system. And this gentle movement tends very often into helping the person move into this state of balance.

One other thing I wanted to add was sometimes the mistake the therapists make. They try to get the client to engage socially. Maybe they've heard some seminar or just Steve speaking, and they have the idea, "So we want to get the person into the social engaging, into the ventral vagal system." So what do you do? You want to engage them.

But a person who's in shutdown hasn't spent the mechanism, especially if they are unable to make contact. And if you force that in any way, they go deeper into the shutdown. I think Lewis has demonstrated this very same thing with the very high, high, high power brain scan. So even though this is, in a sense, the ideal state, if you try

to make it happen, rather than creating this possibility for it to happen, then you may get exactly the opposite result.

Maggie: That's right--

Stephen: Let me add a little more to that. That is eye contact and facial expression to a stranger is viewed as a threat. And depending on the physiological state that the individual is in, your facial expression, your engagement, will be viewed as either a threat or something that is positively engaging. The portal that is the most flexible is the use of prosody, the intonation of voice.

So even if people aren't looking at you, you can, in a sense, cue them. This goes back to what mothers do with tantruming babies, singing lullabies or talking to them. Fathers, historically, have not been as good because their voices are lower. And of course, reprimanding someone in a tantrum is certainly not going to take them out of it. So the issue is, how can you trigger the physiological state by your behavior as a therapist? And socially engaging, making eye contact, facial gesture, and hand gesture, might literally, frighten the person out and, in a sense, force a disassociation.

The other part that you can work on is, you want to give instruction set. This is what the client can do, that you could teach the client certain breathing methods in which they would extend the duration of exhalations, based on what they could tolerate and report their feelings as they change those breathing patterns. You could have them, in a sense, extend the duration of their vocalization.

Peter does work with that, with the voo sound. Not only does he do duration of exhalations with the sounds, he also modulates the frequencies. This is very, very profound because it's stimulating many of the neural features of the social engagement system. The laryngeal-pharyngeal nerves, also the oral cavity, and the facial muscles are being stimulated. The other one is, basically, posture. And posture is simple. People can, in a sense, as an exercise, have people lean forward, or sit up straight and lean backwards, and do some self-report of their perception of you as a therapist.

Maggie: Also, I would add to that, you can experiment with leaning forward. You have to be careful about this, but watching, of course, for their responses. Because sometimes that will make a huge difference. Not even, really, saying anything about it. Just moving forward with your interests. The other thing I wanted to say is that I think what is helpful to me is to have in my mind and my intentions, the metaphor of engaging a baby. When you're engaging a baby, the last thing you want to do is to make any sudden movements. You don't place any demands on them, "Look at me." Some of those things that we're talking about would be obvious in that context. If that's helpful to you, I would just offer that as well.

Maggie: We have one question that I'd like to finish with. I think it's a good question. This is from Sarah. “I wasn't clear on the issue, actually, from the second webinar. So that would be the sympathetic adrenal. I'd like to hear more about the vagal brake. How does it work, and what does it mean as a caregiver to get the timing right?”

Stephen: It's my construct. I'll talk first.

Maggie: Go for it.

Stephen: The vagal brake is really the effective component of that myelinated ventral vagus on the sinoatrial node. Basically, it's an inhibitor on your pacemaker. And it's chronically there because our heart rates are much slower than our intrinsic heart rate, meaning that if you took the nerves away from our heart, both sympathetic and vagal, the heart rate would be over 100 beats per minute, but most of us have slower heart rates than that. That's because we have a chronic inhibition of our pacemaker through the vagus, and that's the vagal brake. The vagal brake enables us to retract it - take it away - and raise our heart rate very, very rapidly without recruiting sympathetic activation. So we can, in a sense, get up, walk around, do things, raise our heart rate, sit back down, and the vagal brake will come back on board. It will calm us down immediately.

If we had to recruit the sympathetics, we would have more difficulties - a more generalized arousal type response, harder to control. But just by manipulating the vagal brake, we can increase the cardiac output necessary to move. So the vagal brake is really our personal governor to keep us from overheating, from overreacting. We can recruit it through simple things like extending the duration of exhalation. People used to say, "If you're really upset, take a deep breath," but they weren't phrasing it correctly. It was, "Take a breath, and exhale slowly." So if you want to calm down, don't take that deep breath. Take a breath and exhale slowly. What you're doing is, you're allowing the vagal brake to come back on board.

Maggie: Great. Peter, you want to add something?

Peter: Just one thing. Maybe we don't want to use the word "chronic" for the vagal brake, but maybe something like - what would be a good word? Because I confuse that with the chronic pain.

Stephen: It's a dynamic adjustment of our heart-rate output. We can see that on a breath-by-breath basis, and that gives us what's called Respiratory Sinus Arrhythmia. But then, you have to really expand or empower the brake more. You just exhale slower, because the vagal effect on the sinoatrial node is optimized and maximized during exhalation.

Peter: I think maybe the term I would use is the vagal brake is - oh, God [chuckles]. I had it a minute ago. It's a modulator of the sympathetic arousal state. If you think about it this way, you're sitting in a room and

somebody - they don't knock, but they just open the door and walk in. You're not really looking in their direction, so there's a shadow. You see that shadow, and then your heart rate goes up. Now, you look and you see, '"Oh, my goodness. This is Jeff somebody who's coming to clean the room," or something like that. So the great advantage of the vagal modulation is that you then say, "Okay, it was only this person coming in," and you don't go into full sympathetic arousal state.

But you do go into an arousal state, in case you would need to go into a sympathetic arousal state. But then, you're able to. That is because it's a myelinated system in part of the fact that it's a myelinated system, then allows you to say, "Okay, we don't need to have the heart rate up." So you say hello to the person, they say hello to you, and your heart rate goes back to baseline.

Stephen: I think the last part - being myelinated - is tied into our control. It's literally a cleaner signal, a more efficient signal, goes more rapidly, and that part is absolutely correct. The part of - in the sense - retracting that vagal brake and allowing heart rate to go up, I call that literally, an anticipatory precautionary state. Because now, without the inhibitory aspect of the vagus on the sinoatrial node, if you need to go into a fight-flight, there's no competition. The sympathetic will just take charge.

Maggie: Her last comment was, "How can the caregiver or the therapist get the timing right?" I'm not even sure I understand that part.

Peter: Well, I think this is very, very important because-- so the person has shut down, shut down, they come out just a little bit, and then you see a sympathetic state. That's when you know to intervene. As you feel that tingling or as you feel that rush of energy, what do you begin to notice next or what else do you begin to notice? So it's really important because as a therapist-- that you get that the client has just come out of the shutdown, or that they've just regulated the sympathetic arousal - down regulated the sympathetic arousal. Then the client doesn't get the input they need to know that they've switched states, and that this is a positive thing. So the ability to monitor where the person is in terms of the Polyvagal theory. To monitor where they're in, and then to be able to see that often, just with - Steve, the term you used - prosody.

Peter: As you notice that or as you start to feel your heartbeat going up, I just want to know, "Have you noticed if it continues to go up? If it goes down? If the sensation changes in any way?" so forth and so on. So really, the timing is absolutely critical. When the therapists say, "That's it," well, that's not it. You lose [chuckles] that ability and really, what allows for that resonance in interpersonal space to evolve, to both support the clients in-- both the therapist's and the client's internal state of balance.

Stephen: I'd like to add one point. Our nervous system detects the lack of reciprocity, the lack of the synchronous, smooth interaction of one to the other. It basically responds with a very defensive reaction, and I call this biological rudeness. Even when we're trying to encourage our children when they're young to behave appropriately, we give them two magic words, "Please" and "Thank you." And they are merely words that enable an engagement, and also the completion of a behavioral response. So enables a loop to be completed. Because if you ask for something, you get it, and walk away, it's a neural violation to the person who handed that to you.

And when you're talking about a mother or a therapist dealing with a client or a child, there is a timing component of where they have to engage or that client's body will think of it as being biologically rude. Because they have made themselves vulnerable for that moment they've engaged. And if you don't immediately or appropriately respond in the appropriate time window, which is merely, relatively - it's like within a second or so. You have to be present, and you can't just say, "A few moments ago, I think you were looking at me. You really rejected me," because they're now already gone.

Maggie: Well said. Well, thank you all. I wish we could go on, but we really do need to stop so that the recording will be complete for people who listen later. I would just say this. I really feel that this has been an excellent series. I hope those of you listening do. And certainly, it would help to send us feedback. We would really benefit from that. I, of course, will forward that to Peter and to Stephen. We thank you all for being with us. Stephen and Peter, the two of you are nothing short of amazing, and I'm so glad for the privilege to be working with you. Thank you so much.

Peter: Thank you, Maggie…

Stephen: Thank You Maggie, and thank you Peter.

Peter: Thanks, really--

Maggie: Take care. Goodbye.

Peter: …it's great to reconnect to all. Bye-bye.

Maggie: Yes, bye-bye. Take care.

## Recommendations

**We hope you have enjoyed this e-book. As further steps in learning, we recommend the following reading and online searches.**

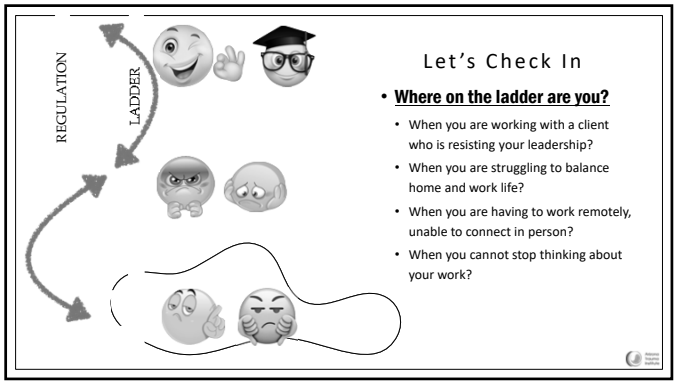
***Peter Levine:*** To learn about Peter and view his books, articles, and videos, please visit http://traumahealing.org/peter-a-levine-phd.php. To learn about Peter's Somatic Experiencing training, visit http://traumahealing.org/se-professional-training.php

***Stephen Porges:*** Stephen's website is a primary way to connect with Stephen's landmark book, articles, videos and podcasts, research studies, interviews and other news. Visit him at www.stephenporges.com.

***Maggie Phillips:*** To learn about Maggie and view her books, audio and online programs, and other information, visit http://www.maggiephillipsphd.com/about.html, http://www.maggiephillipsphd.com/products.html, and http://www.maggiephillipsphd.com/interviews.html.

These three references will give you a good foundation in polyvagal theory and its somatic applications. Of course, there are many more helpful materials and we hope you will dig deeper. We wish you well on your journey!

Maggie Phillips
Maggie Phillips, PhD
Oakland, CA. USA,
Published 2015

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## ANTERIOR CINGULATE OF THE CORTEX (ACC)

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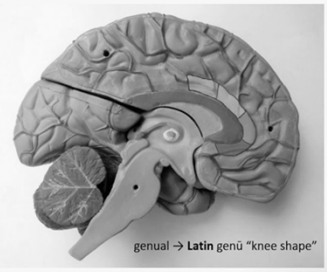
## Activated by emotion




- **Posterior ACC** (Dorsal ACC)
  - Action selection, fear associated with faces, and learned fear (Pessoa, 2008; Stevens et al., 2011)
- **Anterior ACC** (Dorsal ACC)
  - Emotional appraisals, cognitive control, error conflict (Pessoa, 2008; Stevens et al., 2011)
- **Pregenual ACC** (Ventral ACC)
  - Affective processing, emotion regulation, and universal emotions (Pessoa, 2008; Stevens et al., 2011)
- **Subgenual ACC** (Ventral ACC)
  - Emotional reward value, emotional conflict evaluation, and universal emotions (Allman et al., 2006; Stevens et al., 2011)

**Universal emotions** → surprise, disgust, sadness, anger, fear, and happiness

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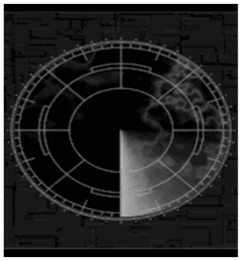
**The Body's Radar System:**
**Anterior Cingulate of the Cortex (ACC)**



- ***An active relevancy system that is totally individualized based on one's history.***
- ***Arousal impacts the relevancy process***
- ***Those things that activate arousal create attentional competition based on the relevancy***

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**Repeated Activation of the *Relevancy System* (ACC)**

**This system that distinguishes the relevant and important in the here and now gets distorted by trauma, toxic stress and adversity**

**Attentional competition, having one's attention always focused on the immediate relevancy or salience of a thing. Relevance/salience is always based on our history of experience and meaning making!**

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**The natural Consequences of having repeated categories collapsed is that we begin to look at everything through a binary or two dimensional mental lens.**

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What beliefs systems do we each carry that is binary because of stress

- Standing in front of an audience
- The role of parent or partner
- The role of a worker
- Binary thinking is efficient, but false because it divide most things in life as either-or situations.
- The more dysregulated (HULK System) you are, the blacker and whiter the world becomes, and people become less and less likely to think before they act.

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## Repeated Activation of the *Relevancy System* (ACC)

**Is Memory reliable?**

- Where Salience is high (significance energy in the brain) it is focused on attending to what is of ***(personal significance)*** and little else in the environment.
- Attention is always focused on the relevant, memory is built on the foundation of relevance.
- Energy competition in the brain is high in sympathetic dominant states, meaning that only a few things will be even noticed.

**Repeated focus leads to enhanced or expanded threat awareness, threat (real, perceived or imagined) becomes the dominant focus of what is noticed.**

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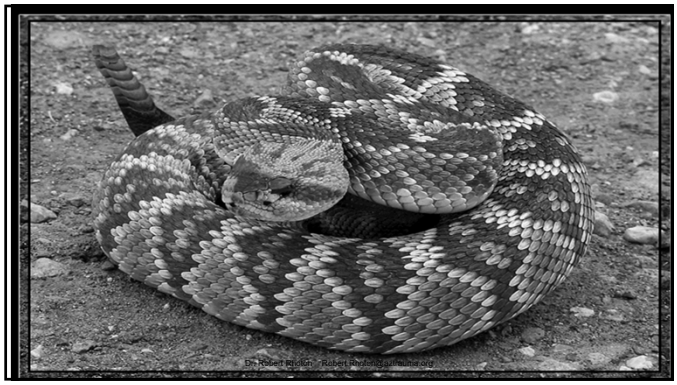

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What are the rattlesnake pictures that your clients have come to accept as reality and truth?



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## Repeated Activation of the *Relevancy System* (ACC)

**Increased potentiated reactivity --- faster too react, where other people might be able to pause before reacting.**

- The space between stimulus and response gets shorter
- This space between stimulus and response is maximized in an integrated brain (Bruce Banner Mode) and becomes increasingly diminished as the Sympathetic system becomes dominate (Hulk Mode is in charge)
- The more often and/or the longer the person is in HULK Mode, the shorter that space between stimulus and response will become.
- Making it almost impossible to exercise consistent self-control, think before one acts or to see and weigh consequences before acting.

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## A terribly inconvenient truth!

**Successful change can only occur with Bruce Banner Brain.**

**Change will not be effective with the Hulk Brain**

**How do you get people in the Bruce Banner Brain and out of the Hulk Brain is where helping and healing start. *NOT. . .behavior, thinking or emotions!!!!***

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## If the ACC has been activated too often or stayed on too long, these are what you should see!

A. **Rigid black and white thinking (sometimes thought of as irrational beliefs)**
B. **Strong beliefs systems that are not open to change**
C. **Many negative internal dialogues**
D. **Overly negative memories**
E. **Overly focused on finding pain, hurt and disappointment (negativity)**
F. **No tolerance for delayed gratification, everything is immediate**
G. **No ability to really orient to the future**
H. **Impulsive; Irrational/illogical**
I. **Little if any consistent self reflection or evaluation of the self**

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**What happens is we ask the wrong question because the culture of mental health, education and the justice system are all set up as (trauma reinforcing) binary systems.**

**Using problem oriented, control, punitive, labeling and shaming orientation when we need a collaborative relational approach to move people into Bruce Banner Mode**

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## Another way of explaining this

- Most models of treatment are neocortex-centric in conceptualization
- Most therapists practice from an Amygdala-centric (emotion-focused) process.
- Meaning that many therapist/counselor are rarely congruent which is very challenging for a trauma client that needs predictability and safety.



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## Sympathetic System Dominance

- *The nervous system learns from its environment through experience.*
- Remember that we all live in TWO (2) environments:
  - **External environment** ---- out there is the one we all start with. We have experiences and as we begin to make meaning of those interactions with the world around us, we develop and **Inner or internal environment**.



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**Unmet Basic Human Needs are the inside environmental activators of the threat/stress response system**

- Not feeling capable
- Not successful or achieving at something
- Not feel cared for
- Not belong to a group
- Not have power to and influence in environment/world
- Not control in one's life
- Not stimulated in mind and body
- Not have fun and pleasure
- Not understand reality
- Not appear competent to others
- Not be seen as being worthwhile or held in esteem by to others
- Not feel safe
- Not feel secure in our attachments to others
- Not have a sense of meaning or purpose in life

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## What we need to understand

- If children do not get regular opportunities to experience safety (physically, emotionally, and psychologically) because they have massively unmet **NEEDS**, then the ability to activate or inhibit the ANS appropriately **WILL** lead to difficulties engaging, disengaging and re-engaging relationally with others, increasing our difficulty to meet one's needs.
- Parents whose needs are not met, are going to struggle to meet the needs of their child, thus helping parents meet their needs and experience safety is vital to helping the child or the family!

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**Inside environment when it creates a LIMBIC shift creates Fears & worrisome fantasies, and critical negative thinking!**

- ✓being judged
- ✓Not measuring up
- ✓Not being liked
- ✓Not being loveable
- ✓What if I fail
- ✓What if I can never get better
- ✓Not being competent
- ✓What are they thinking about me
- ✓What if I can't do this
- ✓ Thought to be stupid
- ✓ Being criticized
- ✓ Not meeting other important folks expectations and demands
- ✓ Will they still like/love me
- ✓ Being asked questions
- ✓ If this doesn't work what am I going to do

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**Failing to activate & inhibit approrpiately**

- *When the Balance System (ANS) is dysregulated it responds with survival strategies at the expense of –**intentionality, deliberateness and living with integrity which are required to facilitate growth, learning, and rest**.*
- ***Trauma is the body's reaction to an overwhelming demand placed upon the physiology of the human system that occurred continuously or repeatedly creating changes in the CNS***



100

## Dysautonomia

- a disorder of the autonomic nervous system that causes disturbances in all or some autonomic (sympathetic and parasympathetic) functions
- may result from the course of a disease (such as diabetes) or from injury, poisoning or trauma and adversity.



101

1. What is PolyVagal
2. The function of the ACC or the Anterior Cingulate of the Cortex
3. How binary thinking is created
4. Memory distortions are based on relevance
5. An explanation of potentiated reactivity
6. Calm and balanced CNS (Bruce Banner) need to sustain any change
7. Unmet needs drive arousal and dysregulation like threat and danger do
8. Dysautonomia which is more accurately what we are dealing with

**Section #4**
Introduction to the Polyvagal function



102

1. Stress changes social behavior
2. Normal predictable reactions and how they change our thinking, emotion and behavior
3. Not good or bad, just completely human

**Section #5**

How Social behavior is impacted when stressor pushes us to be reactive



103

Insert Roderick's video here



104

## What is the Character of the sympathetic nervous system being dominate?

**Predictable attributes**

**neither good or bad, just existent**

**appropriate as long as SNS is in charge**



105

## Behaviors Associated




106

**Section #5**

How Social behavior is impacted when stressor pushes us to be reactive

1. Stress changes social behavior
2. Normal predictable reactions and how they change our thinking, emotion and behavior
3. Not good or bad, just completely human



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**Section # 6**

**hormonal and biochemical change in relationship**

1. Quick review of the Threat response system
2. Sub-diaphramatic systems and their impact on health
3. Ventral Vagal Complex or the social/relationship system
4. What happens to the executive functioning system



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## When the Hot System is activated…

- Shift away from real time environmental appraisal into the past. *(my present is contaminated by my history)*
- Perceptions shift to worrisome fantasies, memories, or repetitive negative thinking
- Internal conditioned dialogues are activated (inner critic)



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## When the Hot System is activated…

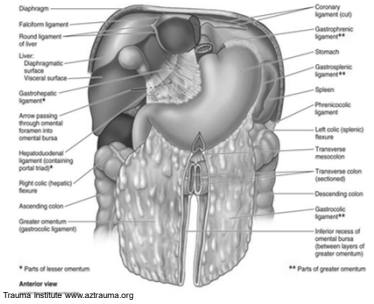
- Language ability reduces
- Logic and reason shift
- Moral reasoning lessens or disappears
- Reacting to perceptions
- Ruled by history or impulse rather than being intentional
- Poor impulse control
- Inadequate pleasure from activities that should be pleasurable
- Memory gaps and partial memory
- Problems with Sequential memory



110

## What are some of the suppressed systems?

- **Sub-diaphramatic systems**
  a. Gastro-intestinal functions
  b. Reduced nutrition from foods eaten
  c. Elimination difficulties
  d. Inflammation leading to a host of illnesses and pain
  e. Painful sexuality

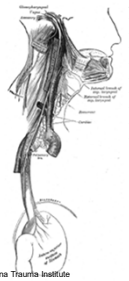





111

## What are some of the suppressed systems?

- **Relational/social engagement system (VVC)**
  a. Poor quality attachments
  b. Self-centered and narcissistic behaviors
  c. Poor understanding of social cues
  d. Unstable friendships and family relationships



***Effecting Ventral Vagal Activity***
- Touch
- Voice
- Eye contact
- Listening for attunement
- Facial expressions
- Body posture
- Pleasant level of warmth
- Relaxed muscles
- Rhythmic movement



112

## What about Executive Function


**Sympathetic system or the (HULK BRAIN) blocks access to executive functioning**

1. **Avoid (real or perceived) threat through flight**
2. **Shut down and freezes the body, paralyzing any action**
3. **Reduce (real or perceived) threat through aggression**
4. **Alter body tension and muscle readiness to act**
5. **tension and muscle readiness to act**



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## What about Executive Function

**Parasympathetic and Ventral Vagal systems give access to executive functioning**

1. **Bodily Regulation and coordination of physiological responses**
2. **Attuned Communications**
3. **Emotional balance and regulation**
4. **Flexibility in response (pause before reacting)**
5. **Fear modulation --- (RRR) response**
6. **Empathy**
7. **Insight/discernment/judgment**
8. **Moral awareness**
9. **Intuition/spiritual feelings**
10. **Identity**



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## Why do we loose access to executive functioning?


**Hormones**
**Bio-chemicals**
**Interfere with access to the executive functioning….**

**IT IS NOT A CHOICE**



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## Section # 6

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## Section #7

**Basics of Developmental trauma**

1. **ACEs study and the long-term impacts to health and well-being**
2. **Understand implicit memory and the need to be regulated to create sustainable change**
3. **Neuroception and understanding the need for intentionality**



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# The Adverse Childhood Experiences Study (ACE)

**Collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Center for Disease Control and Prevention (CDC)**



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**The Adverse Childhood Experiences (ACE) Study**

**Examines the health and social effects of ACEs throughout the lifespan among 17,421 members of the Kaiser Health Plan in San Diego County**

**What do we mean by Adverse Childhood Experiences?**

- **childhood abuse and neglect**
- **growing up with domestic violence, substance abuse or mental illness in the home, parental discord, crime**



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## Adverse Childhood Experiences Are Common

| | | |
|---|---|---|
| **Household dysfunction:** | **Substance abuse** | **27%** |
| | **Parental sep/divorce** | **23%** |
| | **Mental illness** | **17%** |
| | **Battered mother** | **13%** |
| | **Criminal behavior** | **6%** |
| **Abuse:** | **Psychological** | **11%** |
| | **Physical** | **28%** |
| | **Sexual** | **21%** |
| **Neglect:** | **Emotional** | **15%** |
| | **Physical** | **10%** |

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Out of 100 people…

| 33% Report No ACEs | 51% Report 1-3 ACEs | 16% Report 4-10 ACEs |
|---|---|---|
| With 0 ACEs | With 3 ACEs | With 7+ ACEs |
| 1 in 16 smokes | 1 in 9 smokes | 1 in 6 smokes |
| 1 in 69 are alcoholic | 1 in 9 are alcoholic | 1 in 6 are alcoholic |
| 1 in 480 use IV drugs | 1 in 43 use IV drugs | 1 in 30 use IV drugs |
| 1 in 14 has heart disease | 1 in 7 has heart disease | 1 in 6 has heart disease |
| 1 in 96 attempts suicide | 1 in 10 attempts suicide | 1 in 5 attempts suicide |

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Here what a pediatrician has to say about ACEs



122



123

## So why are these early life experiences so challenging to get past?



124

## Building the neuro-structure



125

## We are Neuroceptive to our environments

The concept of being ***Neuroceptive***

- ✓ Cellular awareness
- ✓ A child's nervous system is looking for stimulus to create procedural tendencies or templates. Those templates will be developed in:
  1. **Relational patterns** – meaning and view of self and others
  2. **Emotional patterns** – reduced array of emotional expression as habituated patterns emerge
  3. **Cognitive patterns** – not the content of thought, but the how one thinks and perceives
  4. **Physical patterns** – Tension, movement, posture, coordination, etc.

**Human beings look for conformation not disconfirmation regardless if the pattern built is it useful or helpful. Very little self-reflection or self-evaluation exists on habituated neuro-networks!**



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## Once a pattern is built

- It becomes non-conscious where it occurs without conscious decision making or awareness
- Even when new patterns are built – earlier or more primitive patterns are still available and will come forward when the body experiences stress
- It requires a great amount of attention and focus to build new patterns and becomes more difficult when we get distracted, dysregulated or fail to maintain focus and attention.
- Change is difficult because it requires (on-purpose) attentional focus and anything that interrupts that focus interrupts our intentionality



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The patterns built in Toxic Stress or High ACE score environments interfere with self-regulation and being able to use an integrated brain and nervous system

**Person & environment interaction builds implicit (procedural) memory which is tough to overcome**



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## What is procedural (implicit) memory?

- Sensory experience and expectations
- Emotions experienced
- Behavioral (how your body actually moved)
- Meaning making
- Body and muscle memory




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**So what is happening?**

- The physical and neurobiological systems are reacting to the relational environment.
- Patterns are developing around (perception, relationships, emotional regulation, physical and mental health) ***Adaptations and Mitigations are the primary function that is building implicit/procedural patterns of how to navigate the world.***

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## Section #7

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## Section #8

PRACTICAL APPLICATIONS



134

## Looking at situation #1

**Common Oppositional Defiant Disorder Symptoms**

- Failing to Accept Responsibility
- Verbal (or physical) hostility towards others
- Persistent refusal to comply with instructions or rules
- Easily annoyed, angered or agitated
- Deliberately trying to push the limits (in a bad way)
- Stubbornness to compromise with adults or peers
- Being deliberately aggravating towards others
- No respect for authority
- Lack of empathy, treating others with disdain
- Often co-exists with other disorders like ADHD or ADD



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139

## What we need to understand

- If children do not get regular opportunities to experience safety (physically, emotionally, and psychologically) because they have massively unmet **NEEDS**, then the ability to activate or inhibit the ANS appropriately **WILL** lead to difficulties engaging, disengaging and re-engaging relationally with others, increasing our difficulty to meet one's needs.
- Parents whose needs are not met, are going to struggle to meet the needs of their child, thus helping parents meet their needs and experience safety is vital to helping the child or the family!



140



141

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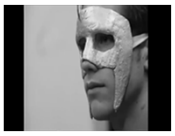
142





143

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## Does Evan meet the criteria?

**Common Oppositional Defiant Disorder Symptoms**

- Failing to Accept Responsibility
- Verbal (or physical) hostility towards others
- Persistent refusal to comply with instructions or rules
- Easily annoyed, angered or agitated
- Deliberately trying to push the limits (in a bad way)
- Stubbornness to compromise with adults or peers
- Being deliberately aggravating towards others
- No respect for authority
- Lack of empathy, treating others with disdain
- Often co-exists with other disorders like ADHD or ADD



145

**Would you be able to stay regulated if you lived in Evan's home?**

**Would you be able to focus, be intentional, feel safe on a consistent basis if you lived in Evan's home?**

146

## Adaptation and Mitigation example



147

## What we need to understand

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# Assumptions

- People are acting exactly as their history has wired them act, perceive, emote.
- Most poor or problematic behavior is the consequence of reactive adaptation and mitigation, founded in procedural memory.
- Growth and change require intentional, and sustained ability to stay in the cool system. ***Bruce Banner brain***
- **Self-regulation is always the starting point for intervention.** Behavior should never be the starting point of treatment ***(except for immediate danger of death or injury)***



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150

Section #8

PRACTICAL APPLICATIONS



151

**Section #9**

Parents and adults must manage themselves before they can manage children.

**1. No self-Regulation without Brain and Nervous System Integration!**
**2. The practice of introception is going to be vital to creating change**
**3. The adults must create the Optimal Living Environment**



152

## Neuroscientists have observed!

**The practice of various forms of relaxation, stress reduction, meditation, practicing calm focusing of attention, prayer, and being intentional increase the following:**

1. Manage and control destructive and negative emotions
2. Improve cognitive functioning (learning, reasoning, logic, and memory)
3. Increase social awareness
4. Expressions of empathy and kindness
5. Ability to use language to communicate more effectively
6. Mass and volume of neural circuits needed for thinking and planning
7. Moral decision making



153

**Change and growth can not happen if the environment is constantly, or repeatedly activating the HULK system.**

**Our first goal in working with any client is to increase the stability (Bruce Banner Brain) of their environment.**

**What are you going to have to change about you , your relationships, your work and home environments to keep you out of the hulk?**

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## *Interoception*

***You want to know what heals trauma? … Interoception heals trauma***

- Bessel van der Kolk

- Present "felt sense" on one's own physiological processes
- Becoming sensitive to "feedback" from one's body
- Lowering threshold of awareness of dysregulation
- Monitoring rising levels of energy (SNS activation) and recognizing when there is the need for conscious and intentional intervention (i.e., releasing constricted muscles)

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## Steps to Interoception

1. Recognize when experiencing a limbic shift
2. Detect what in the inner or outer environment is activating the Limbic system
3. Learn to calm, relax and reduce arousal in your limbic system quickly
4. Practice detecting and reducing limbic shifts at lower thresholds. Maybe you can recognize it at 8 of 10 at first, but we eventually want to recognize it at 1 of 10.

Robert Rhoton Psy.D.

156

## Optimal Living Environment (OLE)

- Optimistic thinking in general
- Purpose (action is relevant and purposive) not a series of tasks
- Self-aware and use that awareness to monitor our own behavior, emotion and thinking
- Goals that inspire personal and professional growth
- Action takers (choose right action)
- Pay attention to energy
- Look for wisdom (what is lesson that can be learned in each situation)
- Faith (the ability to act when the outcomes are uncertain)
- Love (attach and/or attune to) others
- Connect with the spiritual, or universal



157

- Insert Dr. Peca self regulation here



158

**Section #9**

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159

## Section #10

**As the helper what do we need to keep in mind?**

1. Our own personal growth has to continual
2. Our professional growth (particularly understanding the science)
3. Personal curiosity and a willingness to no rely on our assumptions
4. Always keep clear in our minds what is reasonable to expect and practice compassion
5. **Special Attributes of Trauma Clients**
   - ✓ Trauma happens primarily by derailing healthy biology, sensory, motor, emotive and social development.
   - ✓ Trauma often leads not just disconnected awareness of the body and its sensation, but actual associate body awareness as a perceived threat
   - ✓ Trauma is held in the body and impacts our core operations and systems, including being capable of regulating the body.
   - ✓ Trauma leads to a reduced range of tolerance



160

## Section #10

**Areas of impairment:**

- ✓ Regulation system
- ✓ Motor/body sensory system
- ✓ Nervous system and brain function
- ✓ Executive functioning
- ✓ Difficulty identifying and expressing emotional states
- ✓ Inability to tolerate all intense emotions regardless if positive or negative
- ✓ Relationship difficulties
- ✓ Explosive or unmodulated emotional expressions. Often having an inability to identify, experience, express or modulate emotion.
- ✓ Aroused system tends to over-react or over-inhibit actions
- ✓ Impulse control
- ✓ Learn better through experiencing or story than instruction
- ✓ Use of destructive behaviors to distract from distress and body arousal



161

## Now that you know, what can you do?

**Active in daily personal growth**

**We work on our own self-regulation, self-awareness, courage, compassion toward others, and personal integrity in our own daily lives.**

- *What have you done today "on purpose with a plan" to improve your character, talents, skills, relationships*
- *How do make sure you grow past your upsets, failures or disappointments*
- *What is your PLAN to grow tomorrow and then the next day, and so on*



162

## Do you really want to help?

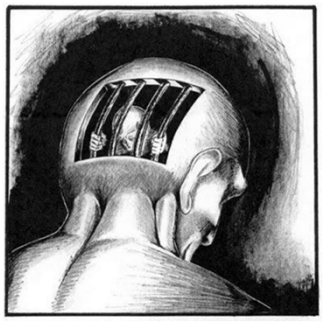
**Activate the inner resources in self and others**

**Focus on helping other find their inherent competency and capacity, emphasizing wholeness and possibility over pathology or weakness. Use our daily interactions with others to lift them up and empower.**

- What are you doing everyday to keep and enjoy relationships
- What things do you do to build your inner resources daily
  - Faith
  - Learning
  - Moving your body/exercising
  - Actively practicing compassion and kindness, even in the most annoying circumstances



163



**Free yourself from your addiction to yourself, your way of being with people, your habits of thinking.**

**Become Integrated in your own brain and nervous system and live each day that way as much as possible.**



164

Things to keep in mind



165

## Every interaction designed to create integration of the brain

1. **Avoid poking people in sensitive areas and activating defensive responses or driving difficulties in engaging, disengaging and re-engaging relationally with others, increasing their distress.**
   - ✓ Never rely on your assumptions, they are wrong
   - ✓ Never judge the behavior, thinking or emotions of other, you do not know their history of arousal
   - ✓ **Never** put additional demands on someone that is not integrated (in Bruce Banner or at the top of the ladder)
2. **To help those with large and painful Sore Spots and Sunburns to feel safe, accepted an respected by you.**
   - ✓ They feel liked by you
   - ✓ They feel like you care, not because you say so, but that you act so
   - ✓ Never explore their painful past or activate their memories in a body that isn't



166

## Every interaction designed to create integration of the brain

**To help those that are extremely sensitive to dysregulation remember that safety, self-regulation and integrated CNS are the first interventions. NOT A MODEL OF THERAPY!**

- ✓ They feel liked by you (NOT WHAT YOU SAY, BUT HOW YOU ARE WITH THEM)
- ✓ They feel like you care, not because you say so, but that you act so
- ✓ Never explore their painful past or activate their memories in a body that isn't relaxed and operating at the top of the ladder



167

## Every interaction designed to create integration of the brain

3. **To help those trying to avoid real or perceived (possibility of) pain find ways to adapt in more healthy ways.**
   - ✓ Do not confront emotions, thinking and behaviors that are designed to create space, doing so drives them to do more mitigating.
   - ✓ Never confront when you are not well regulated and in an integrated brain
4. **To help people heal from the pain, distress, and fear by having practice climbing to the top of the ladder, and then helping them find competence and value.**



168

## What do you need to be aware of in others that have a history of toxic stress, trauma, and adversity?



169

- Regulation system has not been used intentionally very often
- Motor/body sensory system are tied to past histories of creating safety or avoiding hurt
- Nervous system and brain function will be unique
- Executive functioning will BE UNAVAILABLE QUITE OFTEN
- Difficulty identifying and expressing emotional states
- Inability to tolerate all intense emotions regardless if positive or negative
- Relationship difficulties
- Aroused system tends to over-react or over-inhibit actions
- Impulse control IS NON-EXISTENT
- Learn better through experiencing or story than instruction
- **Cognitive functional impairment:**
  **Difficulty reasoning with logic, Make many emotional decisions that change when emotion does, Working memory is often poor, Self-reflection poor, Flexibility or adaptability poor, restricted ability to distinguish intention from the effect**



170

## Now that you know, what can you do?

- ***Get the brain and nervous system calm first links!!!!***
  - Think thru what to say before saying
  - Make sure you are in Bruce Banner mode (top of the ladder), before you open your mouth
  - Make sure you can stay in Bruce Banner mode (top of the ladder), no mater what others do or say
  - Realize no one can solve problems well in HULK mode, stop trying to intervene with the Hulk and invite others to live Bruce Banner lives.



171

## Now that you know, what can you do?

- **Be brief and clear, give many vivid descriptive examples of success, that show real effort!**
  - ✓ Think it through, and say it with as **few words** as possible
  - ✓ Give vivid examples of how people succeed, (what it looks like)
    - Include the efforts necessary
    - The challenges that are common
    - And how people triumphed
    - Talk about real stumbling blocks and how people deal with them



172

## Now that you know, what can you do?

- **Logic and reason systems will likely be off-line *unless* the brain and nervous system are calm.**
  - Stop trying to get logic, and reason out of the HULK brained folks
  - Always go for regulation and stability first, so that you can be effective
- **Focus on the environment and it's qualities more than behavior and emotion.**
  - Pay attention to the environment, is it one that invites Bruce Banner or the HULK, not for you but for the other that you are dealing with
  - Learn to calm environments and people



173

## Now that you know, what can you do?

- Think about the underlying assumptions of what is being said… **does it empower, strengthen or add competence?**
- **No lists…one item at a time**. As the person with a history of adversity develops the ability to self-regulate you may be able to give more at a time, but it may be a while.



174

## Now that you know, what can you do?

- **Genuinely like and care for the person/people you are with *(stop making their compliance or performance a criteria of liking).***
- **When giving information follow this format:**
  1. Overview/orient
  2. Show how this "activity/part" fit in the overviewed material
  3. Give examples of how people are successful achieving this activity/part
  4. Summarize by embedding them in their success story



175

## Now that you know, what can you do?

- Be organized and planful
- Develop and maintain faith in the people you work with
- Be predictable and routine
- Be reliable and transparent
- Collaborate on all documentation and disposition reports
- Build in breaks. . . "I have been writing for 5 minutes, and my hand is cramping, would you be ok with me just taking a break and shaking it out for a minute"
- Always follow-up on requests, questions, suggestions, and any feedback



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177

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178

## Now that you understand more about neurobiology and physiology how do you need to structure the delivery of therapy differently?



179

## Section #11

**Applying the knowledge of physiology and trauma to the design of the treatment process.**



180

- Many approaches or guidelines for treating trauma offer oversimplified representation of the evidence-based models that result in **service constraints** such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. **(Novotny & Thompson-Brenner, 2004. Coping with trauma-related dissociation)**
- Psychotherapy therefore is often protocolized. Which means that clients unable to make use of time limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance. **(Novotny & Thompson-Brenner, 2004. Coping with trauma-related dissociation)**



181

Calls for 'evidence-based' treatments can sound 'common-sense' as well as authoritative and scientific. But it is important to understand the many ways in which such treatments may not be optimal, and especially for complex trauma clients. **Corrigan, F. & Hull, A.M. 'Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions', *BJPsych Bull.* (39, 2, 2015), pp.79-86.**

Mental Health diagnosis viewed from the point of view of physiology and symptoms generated because that Physiology is out of balance (hyper-aroused or Hypo-aroused) help us understand that diagnosis is a faulty system. Without the ability to mobilize to action (hyper-aroused) or to inhibit activity (Hypo-aroused) is not a fair definition of mental illness.

(Dana, 2018)



182

## What about diagnosis specific treatment?

Results cast doubt on the power of the medical model of psychotherapy ***(pathogenic thinking),*** which posits specific treatment effects for patients with specific diagnoses. Furthermore, studies of other features—such, adherence to a manual, or theoretically relevant interaction effects—have shown little support. The preponderance of evidence points to the widespread operation of common factors that are not specific models of delivery.

**Messer, Stanley B. & Wampold, Bruce E. 2006. Let's Face Facts: Common Factors Are More Potent Than Specific Therapy Ingredients https://doi.org/10.1093/clipsy.9.1.21**



183

## Where is the science taking us?

- Rapidly expanding research and new insights into the brain, body and memory raise new issues which repeatedly challenge what we do in therapy
- There is a growing recognition that physiology and somatic processes and experiences are a major part of creating well-being. Understanding the relationship between mind and body, normal emotions, thinking and behavior that is a natural response to the functioning of the body is a game changer for therapist.



184

## Labels

Common Factors
Common Elements
Component Parts
Core Features
Active Ingredients



185

## What are the active ingredients?

- **Facilitate client safety at ALL times**
- **Understand how experience has shaped the brain and nervous system.**
- **Understand the impacts of trauma on the brain**
- **Acknowledge the extensive impacts of childhood trauma**
- **Know and adjust treatment to fit the client**
- **Expect a variety of client response based on how the body works, including shame and dissociation.**
- **Understand that dissociation underlies many diverse presentations**
- **Learn to recognize the client's window of tolerance and focus on staying within that window.**



186

## What are the active ingredients?

- Know what physical as well as psychological symptoms come from trauma
- Foster client resources from the first to last contact
- Regard symptoms as adaptive or mitigating responses, not pathology
- Utilize coping strategies as potential resources.
- Attend to attachment issues, starting with secure attachment of the therapeutic alliance
- Establish appropriate boundaries while being transparent and collaborative
- The approach promotes an integrated neurological functioning (focus on wellbeing)
- Realize most therapies designed for a single event are going to be marginally useful



187

## What are the active ingredients?

- Promote dual awareness (divided consciousness)
- Recognize that mindfulness and dissociation are rival brain functions
- Do nothing to move your client out of the window of tolerance
- Distinguish between acknowledging and focusing on traumatic material or narrative
- Assist client to befriend sensations of arousal
- Distinguish between real danger and past threat
- Know and understand the science of memory, and let go of the habituated mental health view of memory
- Know how implicit or procedural memory works and how much focus and intentionality it takes to move past.
- ***Treatment should be tailored, individualized and attuned to the client***



188

## What are the active ingredients?

- Understand that self-harm is a risk reduction and coping strategy
- Distinguish between "getting better" and feeling better
- Cultural competency and sensitivity to all dimensions of diversity (intense compassion and acceptance)
- End all sessions safely
- Engage in supervision and consultation as needed
- Tailor duration of session for client comfort



189

## Section #11

**Applying the knowledge of physiology and trauma to the design of the treatment process.**



190

## Section #12

**How to use the science to structure the therapeutic journey**



191

## Wampold & Imel (2015)

"Given the evidence that treatments are about equally effective, that treatments delivered in clinical settings are effective (and as effective as that provided in clinical trials), ***that the manner in which treatments are provided are much more important than which treatment is provided,*** *mandating particular treatments seems illogical*. In addition, given the expense involved in "rolling out" evidence-based treatments in private practices, agencies, and in systems of care, it seems unwise to mandate any particular treatment."



192

Cloitre M, Courtois CA, Charuvastra A, Carapezza R, Stolbach BC, Green BL. (2011). **Treatment of complex PTSD: results of the ISTSS expert clinician survey on best practices.** J Trauma Stress. 2011 Dec;24(6):615-27. doi: 10.1002/jts.20697. Epub 2011 Dec 6.

- emotion regulation strategies
- narration of trauma memory
- cognitive restructuring
- anxiety and stress management
- interpersonal skills.



193

**Psychotherapies for PTSD: what do they have in common?**
Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P. R., Resick, P. A., … Cloitre, M. (2015). European Journal of Psychotraumatology, 6, 10.3402/ejpt.v6.28186. http://doi.org/10.3402/ejpt.v6.28186

- Psychoeducation
- emotion regulation and coping skills
- imaginal exposure
- cognitive processing
- restructuring
- meaning making
- emotions
- memory processes



194

The Phoenix:Austrialia
http://phoenixaustralia.org/the-6-common-elements-of-evidence-based-therapies-for-ptsd/

- psychoeducation
- emotional regulation and coping skills
- some form of exposure to memories of traumatic experiences
- cognitive processing, restructuring, and/or meaning making
- tackling emotions
- altering memory processes.



195

Gentry, Baranowsky & Rhoton (July 2017). **Trauma Competency: An Active Ingredients Approach to Treating PTSD** Journal of Counseling and Development

- cognitive restructuring/psychoeducation
- a deliberate and continually improving therapeutic relationship
- relaxation and self-regulation
- exposure via narrative of traumatic experiences



196

## Putting it all together



197

## Active Ingredient #1

**Achieve these things first, then retain focus on them throughout**

- **Therapeutic Relationship**
  - Develop and maintain an attunement with the client
  - Establish an emotional bond based on liking the client, trustworthiness and transparency
  - Empower through focusing on building capacity and giving choices
  - Help the client find their own voice through curiosity and respect
  - Using the relationship to stabilize and recognition that healing occurs within a relationship



198

## Active Ingredient #2

**Achieve these things next, and retain focus on active ingredient #1 as you move through this process**

### Self-Regulation/Relaxation

- Intentional shifting from Sympathetic nervous system (SNS) activation to Parasympathetic (PNS).
- Relax physically to activate the Parasympathetic system
- Increase awareness of tension in the body, and learn to intentionally relax the tension in the body
- Psycho-education about the body and the stress and trauma responses to normalize symptoms
- Model self-regulation until client ready for instruction
- Provide physiology based self-regulation skills training



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## Active Ingredient #3

**Do not move into Active Ingredient #3 until active ingredient #1 & #2 have been achieved**

### Exposure/Narrative

Memory reconsolidation sequence **(Ecker, Ticic, & Hulley, 2012):**

1. ***Reactivate.*** The memory must be accessed and reactivated after self regulation is achieved.
2. ***Mismatch/Contradict***. While the memory is reactivated, create an experience that contradicts the problematic learning or mental model that the memory had created
3. ***Create New Learning***. Build capacity to aid a different viewing of the self in relationship to the habituated patterns and schemas build on the trauma history.



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## Active Ingredient #4

**Achieve these things next, and retain focus on active ingredient #1-3 as you move through this process**

### Cognitive Restructuring

- Normalizing symptoms by helping the client see themselves as human having a normal human experience
- Psychoeducation about symptoms and patterns
- Change the view and belief systems regarding self/family
- Correcting and clarifying perceptions
- Prepare for a future that is deliberate and intentional (choice directed rather than reactive)



201

**The Empowerment & Resilience Structure:**
**An Active Ingredients Approach**

I. **Preparation & Relationship**

II. **Psycho-education & Self-regulation**

III. **Integration & Desensitization**

IV. **Post Traumatic Growth & Resilience**

***Rhoton & Gentry, 2014***



202

# Preparation & Relationship



203

**stage #1**

- Orientation and acculturation around the therapy process ***(example in the next slide)***
- Discovering capacities and strengths while instilling faith and hope in the therapy process
- Formal and Informal assessments used to increase relationship and connection
- Assessing patterns and themes
- Developing global goals that will fine-tuned through the process



204

## stage #1

- **What is the healing process?**
  a. What does it look like as people are successful in moving through service
  b. Create as many success visuals as possible as you explain the healing process
  c. Review pacing differences: regular, slow and then fast

  ***We suggest that you write out an orientation so you are including important material only? Remember that the orientation is giving you safe ground to build a therapeutically secure attachment.***

- **What is it like to work with you?**
  a. What are the things anyone that works with you are likely to discover and be transparent
  b. Share some of your weaknesses and strengths

  ***We suggest that you write out which aspects of your personal character are going to be transparent about and how to share those things with clients in a way that encourages them? Continued building and stabilizing a therapeutically secure attachment.***



205

## stage #1

- **Format of sessions**
  a. Creating routine and predictability for the client sessions
  b. Discuss the fact that the sessions are formatted differently than most counseling
  **c. Feedback driven treatment**
  **d. Discuss the use of concurrent documentation**

  ***"Why" do this?***
  ***Remember that the orientation is giving you safe ground to build a therapeutically secure attachment, by ensuring that you achieve the following:***
  – ***Safety***
  – ***Seen as being Trustworthy***
  – ***Create and reinforce Choice***
  – ***Collaboration and inclusion***
  – ***Empowerment and competency focused***



206

## ***Feedback driven treatment***



207

## A narcissistic would for the counselor

**If you are successful at collecting feedback your evaluations will decline, worsen and be more critical.**

1. Criticism for most people creates fear and dysregulates us
2. We tend to avoid things that make us afraid or uncomfortable
3. As trust builds so does the client's honesty
4. As the client becomes more self-regulated they will become more accurate at self-reflection and self-evaluation
5. Self-reflecting and self evaluating people will want higher performance and accountability from others



208

## ***Discuss the use of concurrent documentation***



209

## The problem with post service documentation

- Doesn't work under fee for service and/or capitated actuarial based funding models
- Increases documentation to direct service ratio
- Greater risk of non compliance
- High documentation to direct service ratios creates need for No Show/Cancellations to "Catch Up"
- High documentation ratio reduces number of scheduled appointments in clinic and in community
- High documentation ratio creates "over whelmed" feeling by staff
- High documentation ratio negatively impacts service capacity



210

## Why are these two processes part of the Empowerment and Resilience treatment structure?

1. Constantly attends to the quality of the relationship
2. Focused on truly being genuine
3. Requires helper to keep them selves regulated and calm
4. Leads to less critical judging of clients
5. Attenuates mutual human differences
6. Encourages and empowers the client



211

## stage #1

- **Biases, Rules and healing philosophy**
  a. Biases are to connect you to the client, not create distance
  b. Rules are to connect people relationally, not create distance or add demand to the process
- **Limitations, if any, because of the setting and rules if there are any**
- **Give as many choices as possible**
  a. When ever a choice is made, explore for highlighting their competency and capacity
  b. Choice is more than just being respectful
- **Talk about how you approach transitions in treatment**
  a. Give visual descriptions of what people will see as they transition, including likely changes in how their lives outside of therapy can change
  b. Clarify that transitions are not rigid, and that when they move forward sometimes they may need to move back to the prior stage, and that is normal



212

## stage #1

- **Formal and informal assessments discussed and selected**
  ***Please sit down and write out detailed information about the use, construction, focus, purpose of the assessments so you are including important material only? Explain and let your client choose the one that makes sense to them***
- **Talk about the importance of being able to self-regulate before tackling the resolution work**
- **Setting the stage for modeling self-regulation by the helper**



213

## This training is organized to help you structure treatment for Trauma and histories of adversity

**Working in stage #1**

- What do you need to do to prepare the soil?
- How do you plant the seed?
- How do you nurture the seed?
- How do you plan to deal with weeds and vermin?
- How will you nurture the plants as they grow?
- When will you know it is time to harvest?

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214

## Psycho-education & Self-regulation stage

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215

## This training is organized to help you structure treatment for families dealing with Trauma

**Working in stage #2**

- **How does the threat response system work?**
  a. What that means is that the knowledge base needs to be possessed by the therapist/counselor.
  b. This isn't taught like a class, it is broken into small pieces and then ties client experience to the knowledge.
  c. Tie emotions, thinking and behavior to the threat response system.
- **Creating a common language by connecting the client experience to the physiology?**
  a. Help client come up with personalized names for the manifestations of physiology that they experience. (***how physiology = change in thought, emotion and behavior)***
  b. Tie resilience to management of the arousal system

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This training is organized to help you structure treatment for families dealing with Trauma

**Working in stage #2**

- **Explaining why the impact of environment is so important?**
  a. Vital that people understand that we as humans are designed to respond to the environment….we do not have a choice in that.
  b. Environment must be emotionally well regulated to foster secure attachment.
- **How are you going to convert discussions of anger, sadness, fear etc, to physiological dysregulation?**
  a. First, must recognize it in your own body
  b. Help them attach dysregulation of their physiology to their individual and family experiences.
  c. Less stigmatizing to address particularly strong thoughts, feelings and actions from the prospective of physiological arousal



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This training is organized to help you structure treatment for families dealing with Trauma

**Working in stage #2**

- **How will you explain and normalize internal negative messages and perceptions of self, significant relationships and the world?**
  a. Understand first that negative messages and critical beliefs are part of repeated arousal process.
  b. When they are in a relaxed body, can they prove the messages true?
- **What specific self-regulation skills must you possess and use daily in your own life before you try and teach them to others?**
  - Must possess 15-20 that you do every day, at work or not
  - You can not suppose you can help a client be more calm and regulated than you are




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## Integration & Desensitization




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## Integration & Desensitization stage #3

- **Orient the clients on the models of treatment available in detail. After explaining, ask them for a decision**.
  a. Remember to walk through the process they have used to decide, so you can confirm their competencies.
  b. You will have to know how to explain each model, and give multiple examples of what it "looks" like when it is working as intended.
- **Explain that in the beginning it is your job to keep the brakes on, so that things don't go too fast, and overwhelm the ability to stay regulated.**
  a. Describe the self-rescue or re-regulation process
  b. Let them know that is always Ok to go back to one of the prior steps



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## Integration & Desensitization stage #3

- **Creating narratives that can expand as needed and in the process lessen the reactivity to the event/events.**
- **Normalize difficulties, unwanted emotions, thoughts, behaviors and beliefs**
  a. Share images/stories how people have had strong emotions, thoughts and behaviors during this stage and how they have successfully moved forward.
  b. Help the client regulate as needed
- **Focus on discovering and highlighting strengths and capacity**
- **Mourning or working through grief**



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## Post Traumatic Growth & Resilience

**Your Road to the Future**




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## Post Traumatic Growth & Resilience stage #4

**Post traumatic growth**
- Consolidate change the Perception of Self
- Consolidate change the Interpersonal Relationships
- Consolidate changed Philosophy of Life

**Core features in resilience**
- Relating to Others, reconnecting or creating new connections
- Exploring new Possibilities
- Intentional applications of Personal Strengths
- Spiritual Change and maturity of integrity
- Appreciation of Life even when faced with stressors



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## Section #12

**How to use the science to structure the therapeutic journey**



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## Section #13

**The assessment process**



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# FAMILY ASSESSMENT OF NEEDS & STRENGTHS

Trauma Version

## FANS-Trauma

## An Information Integration Tool for Families Exposed to Traumatic Events

## Manual



Version 1 Date: April 2013

The **FANS-Trauma** is an open domain tool for use in service delivery systems that address the needs and strengths of families who have been exposed to traumatic events.

For more information on the **FANS- Trauma** assessment tool, please contact one of the primary contributors below:

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In developing the FANS-Trauma, we build off of several existing versions of the CANS, including the CANS-TEA (Kisiel, Lyons, Saxe, Blaustein & Ellis, 2002) and the Family Advocacy and Support Tool (FAST). Several of the trauma items were developed or adapted based collaborations with Cassandra Kisiel, Ph.D., Glenn Saxe, M.D., Margaret Blaustein, Ph.D., and Heidi Ellis, Ph.D., with the SAMHSA-funded National Child Traumatic Stress Network. Additionally, we want to acknowledge the work of all those individuals who made contributions to the development of the CANS family of instruments.

[1] The FITT Center is supported by funding form Substance Abuse Mental Health Services Administration (SAMHSA) as a member of the National Child Traumatic Stress Network.

## INTRODUCTION AND METHODOLOGY

As families seek assistance in addressing problems that arise following exposure to trauma, the first step involves identification and assessment. A good assessment provides information to support service planning and communicates to the larger system of care about the needs and strengths of families. We have decided to use a uniform methodological approach based on the Child & Adolescent Needs and Strengths **(CANS)** to develop the **Family Assessment of Needs and Strengths – Trauma (FANS-Trauma)**.

The background of the **CANS** comes from prior work in modeling decision-making for psychiatric services. In order to assess appropriate use of psychiatric hospital and residential treatment services, we developed the Childhood Severity of Psychiatric Illness (CSPI). This measure was developed to assess those dimensions crucial to good clinical decision-making for expensive mental health service interventions. We have demonstrated its utility in reforming decision making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). This measurement approach is face valid and easy-to-use, yet it provides comprehensive information regarding the clinical status of the child. This basic approach allows for a series of locally constructed decision support tools that we refer to as the Child & Adolescent Needs and Strengths **(CANS)**. Due to its modular design the tool can be adapted for local applications without jeopardizing its psychometric properties.

## DESCRIPTION OF THE FANS-Trauma

The Family Assessment of Needs and Strengths – Trauma (**FANS-Trauma**) is an assessment tool designed with three overall purposes: 1) to document the range of strengths and needs exhibited by families affected by trauma; 2) to describe the contextual factors and systems that can support a family's adaptation from trauma; and 3) to assist in the management and planning of services for families with exposure and adaptations to traumatic experiences.

The **FANS–Trauma** is designed to be used either as a *prospective* assessment tool for decision support during the process of treatment planning or as a *retrospective* assessment tool based on the review of existing information for use in the design of high quality, family centered, trauma informed systems of services.

As a *prospective* assessment tool, the **FANS-Trauma** provides a structured assessment of families who have been exposed to trauma along a set of dimensions relevant to adaptation to trauma and trauma-specific treatment planning. Used as a **profile** based assessment tool, it is reliable and gives the clinician, the family and the agency, valuable existing information for use in the development and/or review of the family plan of care and case service decisions.

As *a retrospective* assessment tool, the **FANS-Trauma** provides an assessment of families currently in care and the functioning of the current system in relation to meeting the needs and strengths of these families. It clearly points out "service gaps" in the current services system. This information can then be used to design and develop the community-based, family-focused, trauma informed system of services appropriate for the target population and the community. In addition, the **FANS-Trauma** assessment tool can be used by providers and supervisors as a quality assurance/monitoring device. A review of the case record in light of the **FANS-Trauma** assessment tool will provide information as to the appropriateness of the family plan of care and whether individual goals and outcomes are achieved.

Although the question format is consistent methodologically with the CANS, the FANS-Trauma is structured somewhat differently than other CANS instruments. It is designed to measure needs and strengths of a family system that has been exposed to trauma as illustrated in Figure 1:

- The first section includes items intended to describe a family's exposure to trauma and other stressors.
- The second section includes items intended to describe the family as a unit.
- Each additional section includes items addressing the subsystems of the family starting with individual family members.

**ADMINISTRATION OVERVIEW**

When the **FANS-TRAUMA** is administered, each of the dimensions is rated on its own 4-point scale after the initial intake interview, routine service contact, or following the review of a case file. Even though each dimension has a numerical ranking, the **FANS-Trauma** assessment tool is designed to give a **profile** of the needs and strengths of the family exposed to trauma. *It is **not** designed to "add up" all of the "scores" of the dimensions for an overall score rating*.

There are three types of items in the FANS-Trauma, items measuring exposure to trauma and stressors, items measuring needs and items measuring strengths. All of the items have four levels with anchored definitions; these definitions are designed to translate into action levels (separate for needs and strengths).

The basic design for items measuring **exposure to trauma and stressors** is:

- **'0' indicates** there is ***no evidence of any trauma/stress of this type***
- **'1' indicates** there is evidence of a ***single incident of trauma or suspicion exists of trauma experiences***; or ***mild stressors***
- **'2' indicates** there is evidence of ***multiple traumas experienced***; or ***moderate stressors***
- **'3' indicates** there is evidence of ***repeated and severe incidents of trauma*** with medical and/or physical consequences; or ***major stressors***

The basic design of the ratings for **needs** is:

- **'0' indicates** that ***no action is necessary***; no need identified
- **'1' indicates *watchful waiting to see whether action is necessary*** (i.e. flag it for later review to see if any circumstances change) or prevention planning; a mild degree of need
- **'2' indicates** that ***action is necessary***; a moderate degree of need
- **'3' indicates** that intensive/immediate action is necessary; a severe degree of need

The basic design of the ratings for **strengths** is:

- **'0' indicates** a ***centerpiece strength***
- **'1' indicates** a ***strength that you can use in planning***
- **'2' indicates** a ***strength has been identified – must be built***
- **'3' indicates** *that* ***no strength has been identified***

To administer the **FANS-Trauma** assessment tool found at the end of this manual, the clinician or other service provider should read the anchor descriptions for each dimension and then record the appropriate rating on the **FANS-Trauma** assessment form. The FANS-Trauma is designed to be completed by a trained clinician following a conversation with the family. Information used to

complete the FANS-Trauma is typically gathered by the clinician over the course of 1-3 sessions with the family. The clinician completes the FANS-Trauma using the information gathered and checks back with the family if additional information is needed or if the clinician needs clarification prior to rating certain items. If there is disagreement between the clinician and the family about a certain need or strength, the clinician should work to understand the family's point of view. If agreement cannot be reached, the clinician should use the rating reflecting the family's point of view and make note of the disagreement.

**Section 1 uses multiple time frames. Traumatic exposure items [1-11] are based on the family's history, Immediate Risk [12] is based on 30 days, Family Stressor items [13-17] are based on the last 12 months, while Military Transitions [18] is based on the family's history.**

**For the remaining sections, unless otherwise specified, *each rating is based on the last 30 days*. For baseline ratings, focus on the 30 days prior to beginning the assessment.**

The **FANS-Trauma** is a tool for decision-support and as such, when items are rated, they are not meant to be an average or composite score across different family members within a dyad but to indicate areas of strength, concern or need. Thus if family subsystems function differently (i.e., extended family or parent-child relations), the rating is designed to indicate the subsystem with the greatest need and to identify that specific subsystem.

NOTES:
Since families are all unique and develop as a unit that consists of individual family members at different ages and stages:

- Family developmental issues should be considered when rating items. For example, in scoring "Relationships Between Caregiver/Child" the interactions between a seven-year-old and caregiver will be different than that of the caregiver and an adolescent. The later could have developmentally appropriate conflicts and issues of differentiation.
- Child needs and skills change developmentally so all items should be rated within the context of developmentally appropriate needs and skills. For example, in scoring "Child Interpersonal Skills" the social network of an adolescent varies significantly form that of a three-year-old. In scoring this item consider what would be expected of the youth depending on the developmental age.

**OVERVIEW OF THE ITEMS**

I. FAMILY TRAUMATIC CONTEXT

Exposure

1. Sexual Abuse
2. Physical Abuse
3. Emotional Abuse
4. Neglect
5. Medical Events
6. Family Violence
7. Traumatic Loss/Separation
8. Community Violence
9. Natural or Manmade Disasters
10. Political Violence
11. Cultural Violence

Risk

12. Immediate Risk

Stressors

13. Family Life Cycle Stressors
14. Neighborhood Safety
15. Community Resources
16. Financial Resources
17. Residential Stability
18. Military Transitions

II. FAMILY UNIT

Strengths

19. Family Communication
20. Closeness
21. Organization
22. Coping Skills
23. Family Efficacy
24. Savoring and Optimism
25. Spiritual/Religious
26. Family Rituals
27. Community Connections

Needs

28. Family Role/Boundary Appropriateness
29. Family Sense of Safety
30. Family Affect Management
31. Family Conflict
32. View of the World

III. ADULT

Strengths

33. Adult Interpersonal Skills
34. Adult Vocational Functioning

Needs

35. Adult Physical Health
36. Adult Mental Health
37. Adult Alcohol/Drug Use
38. Adult Criminal Behavior
39. History of Maltreatment of Children
40. Adult Adjustment to Trauma
41. Adult Affect Regulation
42. Adult Anger Management
43. Adult Sleep Problems

IV. CHILD

Strengths

44. Self-Regulation Skills
45. Day Care/School Functioning
46. Child Interpersonal Skills

Needs

47. Child Physical Health
48. Child Mental Health
49. Child Alcohol/Drug Use (10 or over)
50. Child Conduct Disordered Behavior
51. Cognitive Skills
52. Child Adjustment to Trauma
53. Child Affect Regulation
54. Child Attachment Difficulties
55. Child Anger Management
56. Child Sleep Problems

V. INTERGENERATIONAL

Strengths

57. Support and Assistance
58. Intergenerational Communication
59. Patterns of Protection

Needs
60. Family History of Mental Illness

VI. ADULT PARTNERSHIP

Strengths
61. Adult Partner Relationships

Needs
62. Partnership Relationship Stability
63. Partnership Affect Management
64. Anger Management within Partnership

VII. CAREGIVING

CAREGIVERS

Strengths
65. Caregiver's Responsiveness
66. Satisfaction/Meaning of Caregiving
67. Caregiving Efficacy

Needs
68. Caregiver's Boundaries
69. Caregiver's Supervision
70. Caregiver's Discipline
71. Caregiver Anger Management
72. Caregiver Burden/Stress

CAREGIVING SUBSYSTEM STRENGTHS
73. Collaboration
74. Consistency

VIII. CAREGIVER-CHILD RELATIONS

Strengths
75. Relationships Between Caregiver/Child

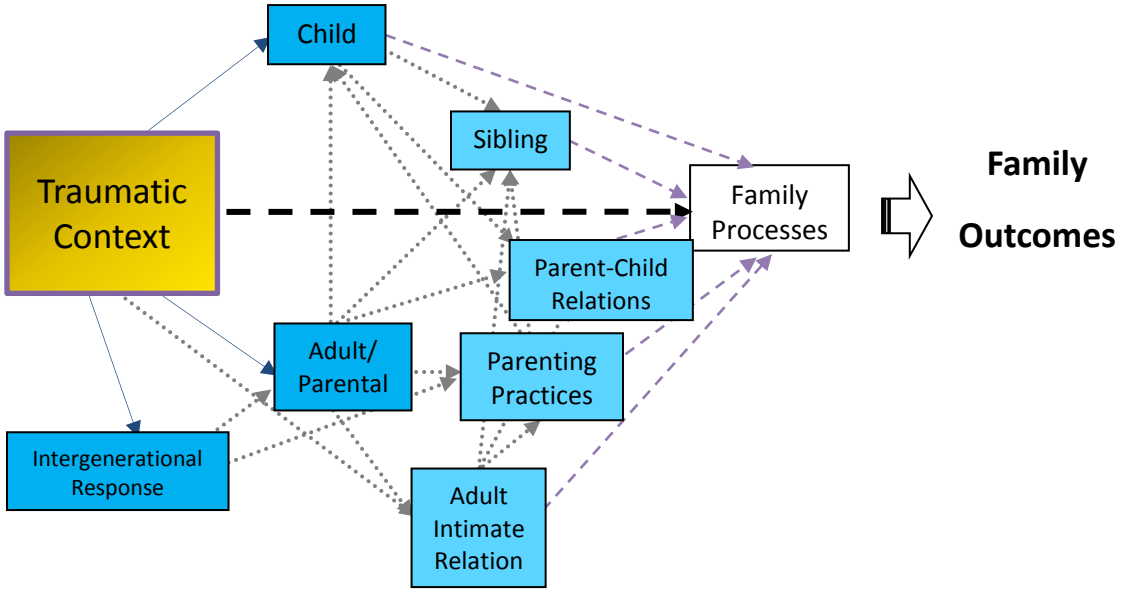
Needs
76. Caregiver/Child Relationship Stability

IX. SIBLING RELATIONS

Strengths
77. Relationships among Siblings

Needs
78. Sibling Relationship Stability
79. Sibling Conflict

**Figure 1: Systemic Response to Trauma**



# I. THE FAMILY TRAUMATIC CONTEXT

**In this section, the rater is interested in the experiences that the family has had regarding trauma and stressors. These traumas and stressors could have occurred to any one member of the family, multiple family members, or to the whole family together.**

**1. SEXUAL ABUSE –** *This rating describes the family's experience of sexual abuse. Sexual abuse is defined as sexual behavior that occurs between a child and a person who is older or who is in a position of authority over the child.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced sexual abuse. |
| **1** | There is a suspicion that a family member has experienced sexual abuse. This could include evidence of sexually reactive behavior in any family member as well as exposure to a sexualized environment or Internet predation. A family member who has experienced secondary sexual abuse (e.g., witnessing sexual abuse, having an extended family member sexually abused) also would be rated here. |
| **2** | Family member has experienced one or more incidents of sexual abuse but this abuse was not chronic or severe. This might include a child who has experienced molestation without penetration on a single occasion. |
| **3** | Family member has experienced severe or chronic sexual abuse with multiple episodes or lasting over an extended period of time. This abuse may have involved penetration or multiple perpetrators. |
| List family members exposed: | |

**2. PHYSICAL ABUSE –** *This rating describes the family's experience of physical abuse. Physical abuse is defined as behavior that causes physical harm to a family member. Physical abuse occurs between a child or other vulnerable family member and a person who is in a position of authority.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced physical abuse. |
| **1** | There is a suspicion that a family member has experienced physical abuse. Spanking without physical harm or threat of harm also would be rated here. |
| **2** | Family member has experienced moderate physical abuse and/or repeated forms of physical punishment (e.g., hitting, punching). |
| **3** | Family member has experienced severe and repeated physical abuse with intent to do harm and/or that caused sufficient physical harm to necessitate hospital treatment. |
| List family members exposed: | |

**3. EMOTIONAL ABUSE –** *This rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms. Emotional abuse refers to frequent situations when a vulnerable family member is insulted, sworn at, put down, or threatened with physical harm.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced emotional abuse. |
| **1** | Family member has experienced mild emotional abuse. For instance, a child may experience some insults or is occasionally referred to in a derogatory |

| | |
|---|---|
| | manner by caregivers. |
| **2** | Family member has experienced moderate emotional abuse. For instance, a child may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others. |
| **3** | Family member has experienced severe emotional abuse over an extended period of time (at least one year). For instance, an intimate partner may be threatened/terrorized. |
| List family members exposed: | |

**4. NEGLECT –** *This rating describes the severity of neglect. Neglect refers to the failure to provide for the basic needs (physical, educational, medical, and emotional) of family members.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced neglect. The caregiver provides for the physical, educational, medical, and emotional needs of the child. |
| **1** | Family member has experienced mild or occasional neglect. Children may have been left at home alone with no adult supervision. There may be occasional intended or unintended failure to provide adequate supervision of children, educational access, and/or needed medical care, Children's emotional needs may be ignored. |
| **2** | Family member has experienced moderate neglect. This includes repeated episodes of intended or unintended failure to provide adequate food, shelter, clothing, educational access, or medical care, with corrective action needed. |
| **3** | Family member has experienced severe neglect including frequent and prolonged absences by adults without minimal supervision, and failure to meet basic physical, educational, medical, and emotional needs on a regular basis. |
| List family members exposed: | |

**5. MEDICAL EVENTS –** *This rating describes the severity of medical events that the family has faced.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced any serious medical events. Family member may have experienced mild medical procedures including minor surgery (e.g., stitches, bone setting). Resolution of the medical event was immediate. |
| **1** | Family member has experienced medical events including major surgery or injuries requiring hospitalization. Families dealing with illnesses requiring crisis management over an extended period of time (i.e., emergency room visits needed to stabilize condition), such as asthma, would be rated here. |
| **2** | Family member has experienced life threatening medical events which have resolved without related death of a family member, prolonged separations, or significant change in functioning or capacity. |
| **3** | Family member has experienced life threatening medical events, including the related death of a family member, prolonged separations, or significant change in functioning or capacity. |

| |
|---|
| List family members exposed: |

**6. FAMILY VIOLENCE –** *This rating describes the severity of exposure to family violence, including domestic violence. Family violence refers to physical fighting in which family members might get hurt. Physical abuse is not considered here.*

| | |
|---|---|
| **0** | There is no evidence of family violence. |
| **1** | Family member has experienced mild violence between family members. This might include slapping or pushing. |
| **2** | Family member has experienced moderate violence between family members. This might include repeated episodes of family violence but no significant injuries requiring emergency medical attention have occurred. |
| **3** | Family member has experienced repeated and severe episodes of violence between family members. This might include when significant injuries or death have occurred;. weapons have been used;. a restraining order is currently in place; or a family member is incarcerated due to family violence. |
| List family members exposed: | |

**7. TRAUMATIC LOSS/SEPARATION –** *This rating describes the level of traumatic loss experienced by the family. Traumatic loss refers to the untimely or sudden death/separation of a family member or close family friend. The circumstances surrounding this death/separation often include violence. Details of the event are gruesome, terrifying, or horrific.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has experienced traumatic loss of family members or significant others. |
| **1** | Family member has experienced the traumatic loss of one family member, close family friend, or significant other. This event occurred sometime in the past, perhaps in the previous generation. |
| **2** | Family member has experienced the recent traumatic loss of one family member, close family friend, or significant other (2 years or less). |
| **3** | Family member has experienced multiple traumatic losses of family members, close family friend, or significant others. These may include both recent and past losses. |
| List family members exposed: | |

**8. COMMUNITY VIOLENCE –** *This rating describes the severity of exposure to community violence [including school and workplace violence].*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has witnessed or experienced violence in the community. |
| **1** | Family member has witnessed or experienced mild community violence. Family member has not been directly impacted by the community violence (i.e. violence not directed at family or friends) and exposure has been limited to occasional fighting or other minor forms of violence or criminal activity in the community. |
| **2** | Family member has witnessed or experienced moderate community violence. This might include witnessing the significant injury of others in |

| | |
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| | her/his community; having friends/neighbors injured as a result of violence or criminal activity in the community; being the direct victim of violence/criminal activity that was not life threatening; or witnessing/experiencing chronic or ongoing community violence. |
| **3** | Family member has witnessed or experienced severe community violence. This might include the death of friends/neighbors/family members in her/his community as a result of violence; being the direct victim of violence/criminal activity in the community that was life threatening; or experiencing chronic/ongoing impact as a result of community violence (e.g., family member injured and no longer able to work). |
| List family members exposed: | |

**9. NATURAL OR MANMADE DISASTERS –** *This rating describes the severity of exposure to either natural or man-made disasters.*

| | |
|---|---|
| **0** | There is no evidence that the family has been exposed to natural or man-made disasters. |
| **1** | Family member has been exposed to disasters second-hand (i.e. on television, hearing others discuss disasters). This would include second-hand exposure to natural disasters, such as a fire or earthquake, or man-made disaster, including car accident, plane crashes, or bombings. |
| **2** | Family member has been directly exposed to a disaster or witnessed the impact of a disaster on a family member or friend. This would include a family member who has been injured in a car accident or fire. |
| **3** | Family member has been directly exposed to a disaster that caused significant harm or death to a loved one or there is an ongoing impact or life disruption due to the disaster (e.g., house burns down, caregiver loses job, move to another community, separation from support system). |
| List family members exposed: | |

**10. POLITICAL VIOLENCE –** *This rating describes the severity of exposure to war, terrorism, or torture. Terrorism is the use of violence or the threat of violence to instill fear, intended to coerce or to intimidate governments or societies in the pursuit of political, religious, or ideological goals. Terrorism may include attacks by individuals acting in isolation (e.g., sniper attacks).*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has been exposed to political violence, war, terrorism, or torture. |
| **1** | Family's community has experienced an act of terrorism, but the family was not directly impacted by the violence. Family does not live in war-affected region or refugee camp. Friends or extended family may have been exposed to political violence, war, terrorism, or torture. |
| **2** | Family has been affected by political violence, war, terrorism, or torture. Family members may have witnessed others being injured in war or terrorist attacks; may have suffered minor injuries in war; or may have lived in an area where bombings, fighting, or terrorist attacks took place. Family may see daily signs of the attack in their neighborhood (e.g., destroyed |

| | |
|---|---|
| | building). Family may have spent an extended amount of time in refugee camp. Family may have been forcibly displaced due to war. |
| **3** | Family has experienced major effects of political violence, war, terrorism, or torture. Family members may have feared for their lives during war due to bombings or shelling very near to them. A family member may have been directly injured, tortured, or kidnapped. A family member may have served as a soldier, guerrilla, or other combatant in her/his home country. The family may have lost one or both parents during war or one or both parents may be so physically or psychologically disabled from war that they are not able to provide adequate caretaking of their family. |
| List family members exposed: | |

**11. CULTURAL VIOLENCE –** *Cultural violence refers to exposure to conflict or violence related to friction between a family's own cultural identity and the predominant culture in which the family lives.*

| | |
|---|---|
| **0** | There is no evidence that any member of the family has been exposed to conflict or violence related to their cultural identity. |
| **1** | Family has some mild or occasional exposure to cultural violence. This may include stressful circumstances resulting from friction between the family's cultural identity and their current living situation. |
| **2** | Family has been affected by conflict or violence related to their cultural identity. Family member(s) may have witnessed others being harassed or injured due to their identity or may have suffered minor injuries in incidences related to their cultural identity. Family may see daily signs of hatred and violence in their neighborhood. |
| **3** | Family has experienced major effects of cultural violence. Family members may have feared for their lives during incidences related to cultural violence. A family member may have been directly injured, tortured, or disappeared. |
| List family members exposed: | |

**12. IMMEDIATE RISK** – *This item refers to the family's **current** (30 days) risk of exposure to any of the previously rated traumas.*

| | |
|---|---|
| **0** | Family has no current risk of exposure to any trauma. |
| **1** | Family is at mild or limited risk of exposure to trauma. |
| **2** | Family is at moderate risk of experiencing trauma. |
| **3** | Family is at severe or high risk of experiencing trauma or is currently experiencing trauma. |
| Family at risk of exposure to: (circle all that apply): sexual abuse, physical abuse, emotional abuse, neglect, medical events, traumatic loss, family violence, community violence, natural or manmade disaster, political violence, or cultural violence. | |
| List family members at immediate risk: | |

**13. FAMILY LIFE CYCLE STRESSORS –** *This item describes the family's current (last 12 months) experience of life cycle stressors such as births, entry into school, marriages, separations or divorces, or the death of an elder family member.*

| | |
|---|---|
| **0** | The family is not currently experiencing disruptive family life cycle transitions. |
| **1** | The family is experiencing a mildly disruptive family life cycle transition. |
| **2** | The family is experiencing a single family life cycle transition that is moderately challenging or disruptive. |
| **3** | The family is experiencing either multiple family life cycle transitions simultaneously or a single family life cycle transition that is severely disrupting normal family functioning and taxing its available resources. |

**14. NEIGHBORHOOD SAFETY –** *This item describes the current characteristics (last 12 months) of the neighborhood where the family lives (within several blocks) pertaining to violent events (e.g., gang violence, robberies, muggings, rapes, assaults, physical fights, episodes of arson, vandalism) or significant tensions (e.g., gang activity, drug activity, verbal fights, disagreements between others in the neighborhood, extreme bullying).*

| | |
|---|---|
| **0** | Neighborhood is safe, no recent history of violent events or significant tensions. Residents of neighborhood are not generally concerned with their physical or emotional safety or the safety of their property. Caregivers feel comfortable sending their children out to play in neighborhood. |
| **1** | Neighborhood has history of one incident of violence or significant tensions. Residents of neighborhood feel safe most of the time, although they express some need to be aware of environmental events in order to assure safety. Caregivers still feel comfortable sending their children out to play in neighborhood, but are aware of need to monitor children frequently. |
| **2** | Neighborhood has history of more than one violent event or significant tensions. Residents express concerns about their physical or emotional safety as well as the safety of their property. Caregivers frequently do not feel safe to send children out to play and may restrict their activity to the home or some secure, structured agency (such as clubs, child centers, etc). |
| **3** | Neighborhood has ongoing, chronic history of multiple violent events or significant tensions. Residents do not feel that neighborhood is safe and feel frequent direct threats to their physical and emotional safety. Residents do not feel that their homes are secure or that their property is safe. Caregivers never feel comfortable sending children out to play in neighborhood and restrict their activity to the home. Caregivers do not feel comfortable sending children to structured agencies in neighborhood because of the level of threat. |

**15. COMMUNITY RESOURCES –** *This item describes the community resources available to the family.*

| | |
|---|---|
| **0** | The community has sufficient resources so that there are few limitations on what can be provided for family members. |
| **1** | The community has the necessary resources to help address the major and basic needs of family members but these resources might be stretched. |
| **2** | The community has limited resources that are often not sufficient to meet the needs |

| | |
|---|---|
| | of family members. |
| **3** | The community has severely limited resources available and is not able to assist the family in meeting the needs of its members. |

**16. FINANCIAL RESOURCES** – *This item refers to the income and other resources available to family members (particularly caregivers) that can be used to address family needs.*

| | |
|---|---|
| **0** | No difficulties. Family has financial resources necessary to meet needs. |
| **1** | Mild difficulties. Family has financial resources necessary to meet most needs; however, some limitations exist. |
| **2** | Moderate difficulties. Family has financial difficulties that limit their ability to meet basic family needs. |
| **3** | Severe difficulties. Family experiencing financial hardship, poverty. |

**17. RESIDENTIAL STABILITY** – *This item refers to the stability of the family's housing over the past 12 months. This does not refer to the risk of placement outside of the family home for any member of the family.*

| | |
|---|---|
| **0** | Family has stable housing for the foreseeable future. |
| **1** | Family has some mild difficulties maintaining housing. This may be due to difficulty paying rent or utilities or conflict with a landlord, that has not resulted in the family having to move. |
| **2** | Family has moderate difficulties maintaining housing. Family has had to move due to difficulty paying rent or utilities or conflict with a landlord. |
| **3** | Family has severe difficulties maintaining housing. Family has had to move multiple times or experienced homelessness. |

**18. MILITARY TRANSITIONS** – *This item refers to the family's military service commitments of one or more family members. This item is based on the family's history.*

| | |
|---|---|
| **0** | Family not experiencing any transitions related to military service. Families with no members involved in military services would be rated here. |
| **1** | Family anticipating a transition related to military service in the near future or family experienced a transition in the past which was challenging. |
| **2** | Family currently experiencing a challenging transition related to military service. |
| **3** | Family has experienced multiple challenging transitions related to military service and is currently experiencing another challenging transition. |

# II. THE FAMILY UNIT

**Instruct the family that for the purposes of this part of the interview, the family unit should include individuals working together to make sure that daily concrete and emotional needs of children and adults are being addressed. This does not have to be limited to one household but should be limited to those individuals involved in keeping daily family life running. Have the family identify who is included in this family unit and note that on scoring sheet.**

**19. FAMILY COMMUNICATION –** *This item refers to the extent and quality of communication within the family. It should only be about communication within the family unit not within subsystems in the family (e.g., adult partnership, siblings).*

| | |
|---|---|
| **0** | Family demonstrates significant strengths in communication. Communication is characterized by dynamic, reciprocal exchanges within the family. Communication is predominately open and direct. Family members are able to engage in sustained dialogue to problem-solve and manage conflict. |
| **1** | Family demonstrates adequate communication strengths. Family members generally communicate well with some exceptions. Communication is generally open, but the family may have difficulty sharing about difficult issues. Family members are often, but not always, able to engage in sustained dialogue to problem-solve and manage conflict. |
| **2** | Family demonstrates limited communication strengths. Family members sometimes communicate well. However, their communication is typically not reciprocal or direct. Problems with communication limit the frequency with which communication occurs. On occasion, family members are able to engage in sustained dialogue to problem-solve and manage conflict. |
| **3** | Family demonstrates no communication strengths. Communication among family members is seldom reciprocal and is generally indirect, if it occurs at all. Family is not able to engage in sustained dialogue to problem-solve and manage conflict. |

**20. CLOSENESS** – *This item refers to the amount of time the family spends in shared activity, their enjoyment of family activity, and the emotional bonding that family members have amongst each other.*

| | |
|---|---|
| **0** | Family members are involved in each other's lives. Family members like to spend free time with each other. Although family members have individual interests they still enjoy each other's company. Family members get along very well with each other. Family members feel very close to each other. |
| **1** | Family members are moderately involved in each other's lives. Family members like to spend some free time with each other. Family members have individual interests and although family members enjoy each other's company, these interests are at times chosen over family time. Family members get along reasonably well with each other. Family members feel moderately close to each other. |
| **2** | Family members are minimally involved in each other's lives. Family members come together when needed, but they typically spend little free time with each other. They normally do not enjoy each other's company and prefer to spend time away from family. Family members often do not get along very well. Family members feel |

| | |
|---|---|
| | minimally close to each other. |
| **3** | Family members are seldom involved in each other's lives. Family members do not like to spend free time with each other. Family members never get along well. Family members do not feel close to each other. |

**21. ORGANIZATION –** *This rating should be based on the ability of family members to participate in or direct the organization of the household, services, and related activities.*

| | |
|---|---|
| **0** | Family demonstrates significant organizational strengths. Family is well organized and efficient in working together to coordinate household, services, and activities. Family successfully accomplishes the routines and tasks of daily family life. |
| **1** | Family demonstrates adequate organizational strengths. Family is mostly organized and able to coordinate and support household, services, and activities. They may have occasional difficulties in accomplishing the routines and tasks of daily family life, for example, may be forgetful about appointments or fail to get to school or work on time. |
| **2** | Family demonstrates limited organizational strengths. Family has the ability to carry out some critically important tasks but has difficulty organizing or coordinating household, services, and activities. Family frequently fails to carry out the routines and tasks of daily family life. |
| **3** | Family demonstrates no organizational strengths. Family is unable to organize and coordinate their household, services, and activities. Daily family life is chaotic. |

**22. COPING SKILLS –** *This rating indicates the family's coping and problem solving skills related to successfully negotiating stressors.*

| | |
|---|---|
| **0** | Family demonstrates strong coping and problem solving skills. Coping skills are well developed and the family is able to flexibly and successfully problem solve to manage stressors. |
| **1** | Family demonstrates adequate coping and problem solving strengths. The family is generally able to use their skills for managing distress and can effectively engage in problem solving strategies. Coping and problem-solving skills may become less flexible when stressors are high. |
| **2** | Family demonstrates limited coping and problem solving strengths. For example, the family uses a narrow set of coping strategies that are rigidly applied to most situations. However, these are frequently inadequate for coping with distress and the family can easily become overwhelmed. |
| **3** | Family demonstrates no known or identifiable coping or problem solving strengths. The family is quickly overwhelmed and cannot develop any strategies to manage stressors. |

**23. FAMILY EFFICACY –** *This rating should be based on the family's belief that it is effective in achieving its goals and able to successfully manage daily family life and handle stressors.*

| | |
|---|---|
| **0** | Family believes in itself and has confidence in its ability to successfully deal with family life. The family takes on problems and stressors with the attitude that they will be able to handle whatever happens. |
| **1** | Family believes that they are able to handle most situations adequately. Family |

| | |
|---|---|
| | members can be tentative about their ability to manage stressors at times. |
| **2** | Family has limited expectations about its ability to handle situations successfully. Family members are often surprised when they are successful at dealing with problems. |
| **3** | Family feels that it fails or is unable to handle most situations. Family members act based on the premise that "we are not able to cope with the things that happen to us". |

**24. SAVORING AND OPTIMISM –** *This rating should be based on the family's view of its future and their ability to remain hopeful when faced with life's challenges. This is intended to rate the family's positive future orientation including the ability to express joy and share positive life experiences.*

| | |
|---|---|
| **0** | Family has a strong and stable optimistic outlook on life. Family is future oriented. Family acknowledges and celebrates good things that happen and looks forward to continued good times. |
| **1** | Family is generally optimistic. Family is likely to be future oriented, but has difficulty expressing a positive future vision when under stress. Family adequately acknowledges and celebrates good things that happen. |
| **2** | Family may believe that some aspects of their life are positive, but has difficulty maintaining an overall positive view of itself and the family's future. Family is limited in its acknowledgement and celebration of positive life experiences. |
| **3** | Family has difficulty seeing any positives about itself or its life. Family does not acknowledge any positives in their family life. Family may be overly pessimistic and believes that negative outcomes to important events are inevitable and there is nothing that can be done to prevent the negative outcomes. Family outlook for the future is bleak. Alternatively, the family is not able to articulate a vision of its future. |

**25. SPIRITUAL/RELIGIOUS –** *This rating should be based on the family's involvement in spiritual or religious beliefs and activities.*

| | |
|---|---|
| **0** | Family possesses strong moral and spiritual strengths. Family members may be very involved in a religious community or may have strongly held spiritual or religious beliefs that sustain the family on a daily basis. |
| **1** | Family possesses moral and spiritual strengths that support the family in times of need. Family members may be involved in a religious community. |
| **2** | Family possesses limited spiritual or religious strengths. Family members may have little contact with religious institutions or are highly conflicted about spiritual or religious beliefs or practices. |
| **3** | Family possesses no identified spiritual or religious beliefs or involvement in a spiritual or religious community. |

**26. FAMILY RITUALS –** *Family rituals are activities and traditions that are part of the family's heritage, including the way the family celebrates holidays, spends leisure time together, or shares meals. Family rituals may include daily activities and traditions that are culturally specific (e.g., praying toward Mecca at specific times, eating a specific diet, being able to speak one's primary language with others).*

| | |
|---|---|
| **0** | Family consistently and deliberately practices rituals in accord with its family heritage and cultural identity. |
| **1** | Family is generally able to practice rituals consistent with its family heritage and cultural identity. Family sometimes experiences obstacles to the performance of these rituals. |
| **2** | Family can identify and tries to practice rituals but experiences significant barriers. Family is often prevented from practicing rituals consistent with its family heritage and cultural identity. |
| **3** | Family is unable to practice rituals consistent with its family heritage and cultural identity. |

**27. COMMUNITY CONNECTIONS –** *This rating should be based on the family's level of involvement in their community, including accessing natural supports. Natural supports refer to help that you do not have to pay for. This could include friends and families or a church or other organization that helps the family in times of need.*

| | |
|---|---|
| **0** | Family maintains significant and extensive long-term ties with the community. This includes substantial natural supports to assist in addressing most family, caregiver, and child needs. For example, family members may belong to community groups (e.g., community center, neighborhood watch) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc. |
| **1** | Family maintains adequate community ties although they may be relatively short term (e.g., past year). Family has natural supports but some limitations exist whereby these supports are insufficient to address some family and child needs. |
| **2** | Family maintains limited ties and/or natural supports from the community. |
| **3** | Family maintains no known ties or natural supports from the community. |

**28. FAMILY ROLE/BOUNDARY APPROPRIATENESS –** *Family roles and boundaries refer to the ability of family members to perform their roles within the family (e. g., parent, older sibling, grandparent, etc.) while separating themselves as individuals and consistently communicating their respect for each family member's role as well as the hierarchy of authority established in the family.*

| | |
|---|---|
| **0** | Adaptive roles and boundaries. Family has strong, appropriate roles and boundaries among members. Clear hierarchies are maintained. |
| **1** | Mostly adaptive roles and boundaries. Family has generally appropriate boundaries and hierarchies. May experience some minor blurring of roles during times of high stress. |
| **2** | Limited adaptive roles and boundaries. Family has difficulty maintaining appropriate boundaries and/or hierarchies. Some significant role problems exist. |
| **3** | Significant difficulties with roles and boundaries. Family has significant problems with establishing and maintaining reasonable roles, boundaries, and hierarchies. Significant role confusion or reversals may exist. |

**29. FAMILY SENSE OF SAFETY –** *This item refers to the degree to which family members feel safe in the home.*

| | |
|---|---|
| **0** | All family members feel that they live in a safe home environment. |
| **1** | Family members feel that they live in a home environment that presents some mild risks. This may include alcohol/drug abuse or gang membership of family members, but no immediate risk is present. They feel safe most of the time while at home. |
| **2** | Family members feel that they live in a home environment that presents moderate risk. This may include fears about abuse or family violence. The unpredictability of threats to safety cause family members to frequently worry about their own safety or the safety of another family member. |
| **3** | Family members feel that they live in a home environment that presents severe risk. Individuals in the family feel scared most of the time and believe that they face immediate risk of significant physical harm. |

**30. FAMILY AFFECT REGULATION** – *This item refers to the family unit's process of initiating, maintaining, or modulating the occurrence, intensity, or duration of emotion-related discourse across a whole range of emotions.*

| | |
|---|---|
| **0** | Family unit displays no difficulties co-regulating emotional responses. Family members recognize and respond appropriately to the affect expressed. Family is able to express strong emotions, both positive and negative, when appropriate, and maintain control. Emotional responses are appropriate to the situation. |
| **1** | Family unit displays some minor difficulties with affect regulation. Family members generally recognize and respond appropriately to the affect expressed, but there are some miscues and miscommunications. Family could have some difficulty tolerating and expressing intense emotions and become uncomfortable in response to emotionally charged stimuli. Family members may be more watchful or hypervigilant in general. |
| **2** | Family unit displays moderate problems with affect regulation. Family may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). Family may deal effectively with positive emotions but may be unable to tolerate or express negative affect. At times, family members' affect may be inconsistent with the situation. |
| **3** | Family unit displays severely dysregulated affect. Affective communication among family members is often misunderstood. Family members demonstrate severe problems as evidenced by unpredictable mood and inability to modulate emotional responses (feeling out of control of their emotions or emotionally "shut down"). Family may exhibit tightly contained emotions with intense outbursts under stress. Affect expressed is generally not consistent with the situation. |

**31. FAMILY CONFLICT** – *This item refers to how the family deals with disagreements.*

| | |
|---|---|
| **0** | Family seldom argues and negotiates disagreements appropriately. |
| **1** | Family seldom argues, but when conflicts arise resolution is difficult. |
| **2** | Family is generally argumentative and conflict is a fairly constant theme in family |

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|---|---|
| | interactions. |
| **3** | Family is constantly arguing and disagreements characterize family interaction. The family is unable to maintain civil communication during disagreements; yelling, name calling, and cursing are common. |

**32. VIEW OF THE WORLD** – *This item refers to the family's understanding of how the world operates and what place, power, or purpose the family holds in the world.*

| | |
|---|---|
| **0** | Family's actions, stories, and beliefs express trust in others, a sense that rules are fair, and a predictable notion of right versus wrong. |
| **1** | Family's actions, stories, and beliefs portray some people as trustworthy and that many rules are fair, but the family at times lacks clarity on right versus wrong. |
| **2** | Family's actions, stories, and beliefs express discouragement with others and with society. They express doubt about whether to trust others and often choose to disregard rules. |
| **3** | Family's actions, stories, and beliefs see the world as unpredictable and unfair and people as dangerous. The family may express distorted rules or they do not see society's rules as applying to them. |

# III. ADULT FAMILY MEMBER STATUS

**In some families there are many adults. They have various responsibilities and roles in the family that may or may not include caregiving for children. Please identify ALL of the adults (21 years and older) in the family who assume responsibilities for family management and describe each adult separately on the scoring sheet provided using the items described below.**

**33. ADULT INTERPERSONAL SKILLS –** *This item is used to refer to the interpersonal skills of the individual as they relate to others. This refers to relationships outside the family.*

| | |
|---|---|
| **0** | Significant interpersonal skills and strengths. Adult is seen as well liked by others and has significant ability to form and maintain positive relationships. Adult has multiple close friends and is friendly with others. Social connections are a focus of adult's life or well-being. |
| **1** | Adequate interpersonal skills and strengths. Adult has formed positive interpersonal relationships with peers. Adult may currently not have many friends, but has a history of making and maintaining friendships with others. |
| **2** | Limited interpersonal skills and strengths. Adult has some social skills that facilitate positive relationships with peers but struggles to maintain current healthy relationships. Has an erratic history of making and maintaining healthy friendships with others. |
| **3** | No known interpersonal skills or strengths. Adult currently does not have any friends, nor has he/she had any friends in the past. |

**34. ADULT VOCATIONAL FUNCTIONING –** *This item refers to the adult's work effectiveness including, but not limited to, attendance, productivity, and relationships with co-workers.*

| | |
|---|---|
| **0** | Adult demonstrates significant strengths in vocational functioning. Adult is fully employed with no problems at work. Alternatively, adult may not be seeking employment or chooses to be a full-time homemaker. |
| **1** | Adult demonstrates adequate strengths in vocational functioning. Adult is having or has had occasional problems related to attendance, productivity, or ability to get along with co-workers. Adult may be partially employed, employed significantly below her/his level of education/experience/training due to these problems, but still has a history of being consistently employed. |
| **2** | Adult demonstrates limited strengths in vocational functioning. Adult is working but is having or has had moderate problems related to attendance, productivity, or ability to get along with co-workers. Adult maybe temporarily unemployed because of such difficulties or has an erratic employment history. |
| **3** | Adult demonstrates no strengths related to vocational functioning. Adult is chronically unemployed and lacks basic education/experience/training, and regularly has work related problems. |

**35. ADULT PHYSICAL HEALTH –** *Physical health includes medical and physical challenges faced by the adult that impacts her/his functioning in the family.*

| | |
|---|---|
| **0** | Good health. No physical health limitations that require assistance or impact on her/his ability to carry out family responsibilities. Adult may have a physical health |

| | |
|---|---|
| | diagnosis but it is well controlled and does not interfere with functioning. |
| **1** | Adequate health. Some mild physical health limitations that do not require assistance and only minimally impacts functioning within the family. |
| **2** | Fair health. Moderate physical health limitations that make it difficult or prevent her/him from functioning in the family without assistance. |
| **3** | Poor health. Severe health limitations that make the adult physically unable to carry out family responsibilities. |

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**36. ADULT MENTAL HEALTH –** *This item refers to mental health needs that impact on the adult's functioning in the family (not substance abuse or dependence).*

| | |
|---|---|
| **0** | No mental health challenges. Adult has no signs of any notable mental health problems. |
| **1** | Mild mental health challenges. Adult may have mild problems with adjustment, may be somewhat depressed, withdrawn, irritable, anxious, or agitated. She/he does not require assistance and these symptoms do not interfere with her/his ability to function in the family. |
| **2** | Moderate mental health challenges. Adult has a diagnosable mental health problem(s) that makes it difficult or prevents her/him from being able to function in the family without assistance. |
| **3** | Severe mental health challenges. Adult has a serious psychiatric disorder and is unable to carry out family responsibilities. |

**37. ADULT ALCOHOL/DRUG USE –** *This item includes problems with alcohol, tobacco, illegal drugs, and/or prescription drugs that impact on the adult's ability to function as part of the family.*

| | |
|---|---|
| **0** | No problems with alcohol or drug use. The adult has no signs of any notable substance abuse problems. |
| **1** | Mild problems associated with alcohol or drug use. The adult may have mild problems with work that result from occasional use of alcohol or drugs but they do not require assistance or interfere with her/his ability to function in the family at this time. |
| **2** | Moderate problems associated with alcohol or drug use. The adult has a diagnosable substance-related disorder. Substance use makes it difficult or often prevents her/him from being able to function in the family without assistance. |
| **3** | Severe difficulties with alcohol or drug dependence. The adult is currently addicted to either alcohol, drugs, or both and is unable to function in the family. |

**38. ADULT CRIMINAL BEHAVIOR –** *This item rates the criminal behavior of adult household members.*

| | |
|---|---|
| **0** | No evidence that the adult has ever engaged in criminal behavior. |
| **1** | Adult has a history of criminal behavior but has not been incarcerated. |
| **2** | Adult has a history of criminal behavior resulting in a conviction or incarceration. |
| **3** | Adult has a significant history of criminal behavior resulting in multiple incarcerations. |

**39. HISTORY OF MALTREATMENT OF CHILDREN –** *This item describes whether the adult has any prior history of maltreating a child in her/his care.*

| | |
|---|---|
| **0** | No evidence of any history of maltreatment |
| **1** | Adult's maltreatment of children is limited. She/he has one incident of protective services' involvement. |
| **2** | The adult has two indicated incidents of protective services' involvement. |
| **3** | The adult has three or more indicated incidents of protective services' involvement and/or has been involved in an incident that ended in the termination of parental rights. |

**40. ADULT ADJUSTMENT TO TRAUMA –** *This rating describes posttraumatic reactions faced by adult family members, including emotional numbing and avoidance, nightmares, and flashbacks that are related to their own traumatic experiences or to the traumatic experiences of their children.*

| | |
|---|---|
| **0** | Adult has not experienced any significant trauma or has adjusted well to traumatic experiences. |
| **1** | Adult has some mild problems with adjustment due to trauma. She/he may have an adjustment disorder or other reaction that might ease with the passage of time. Or, she/he may be recovering from a more extreme reaction to a traumatic experience. |
| **2** | Adult has moderate symptoms associated with traumatic experiences. Adult may have nightmares or other notable symptoms of Post Traumatic Stress Disorder (PTSD) or complex trauma. |
| **3** | Adult has severe traumatic distress as a result of traumatic experiences. Symptoms are frequent and intense and may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of PTSD or complex trauma. |

**41. ADULT AFFECT REGULATION –** *This rating describes the adult's ability to identify, communicate, and modulate affect across a wide range of emotions.*

| | |
|---|---|
| **0** | Adult displays no difficulties with affect regulation. Adult is able to identify and communicate both positive and negative emotions. Emotions are communicated directly and emotional responses are appropriate to the situation. |
| **1** | Adult displays some mild difficulties with affect regulation. Felt emotions are sometimes not communicated clearly. She/he could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general. |
| **2** | Adult displays moderate problems with affect regulation. She/he may be comfortable with positive sharing positive emotions, but unable to communicate or regulate negative ones. She/he may be unable to modulate emotional responses. Adult may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). |
| **3** | Adult displays severe problems with affect regulation. She/he may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions). Adult's affect dysregulation places them at risk for self-harm. Adult may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, she/he may be characterized as emotionally "shut down". |

**42. ADULT ANGER MANAGEMENT** – *This item captures the adult's ability to identify and manage her/his anger when frustrated.*

| | |
|---|---|
| **0** | No evidence of anger management problems. Adult recognizes and manages her/his anger in a manner of mutual respect towards herself/himself and others. |
| **1** | Adult exhibits mild problems managing her/his anger in a respectful manner. She/he may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts. This adult may have a history of physical aggression towards property arising from inability to control anger, but none within the last 3 months. |
| **2** | Adult exhibits moderate problems managing her/his anger in a respectful manner. Her/his temper has gotten her/him in significant trouble with peers, family, and/or work. This level may be associated with some physical violence towards property in the past 3 months or increasing verbal outbursts. Others are likely quite aware of adult's anger potential. |
| **3** | Adult exhibits severe problems managing her/his anger in a respectful manner. Her/his temper is associated with physical aggression towards others and towards property. Others likely fear her/him. |

**43. ADULT SLEEP PROBLEMS –** *This item describes problems with sleep that cause sleep deficits including insomnia, frequent awakening, and nightmares. These sleep problems are frequent concerns after trauma exposure and impair functioning.*

| | |
|---|---|
| **0** | Adult experiences no sleep disturbance. |
| **1** | Adult experiences mild sleep disturbance. Adult may have occasional nightmares or difficulty falling asleep. This includes mild insomnia of up to 1 hour. |
| **2** | Adult experiences moderate sleep disturbance. Adult may have frequent (1 to 3 times a week) resistance to going to bed, difficulty falling asleep, frequent awakening, or nightmares. This includes insomnia for up to 2-3 hours. |
| **3** | Adult experiences severe sleep disturbance. Adult may have daily sleep problems, including insomnia, sleep onset problems, awakening in the night, or nightmares. This includes severe insomnia resulting in less than 4 hours of sleep per night or the occurrence of day/night reversal. |

# IV. CHILD'S STATUS

**In the family there may be at least one person under the age of 21. The following section is used to describe EACH of these family members individually. Again use the scoring sheet provided to describe each CHILD separately.**

**44. SELF-REGULATION SKILLS –** *This item refers to the child's ability to regulate bodily functions (eating, sleeping, toileting) and maintain self-care skills with increasing independence, as the child gets older.*

| | |
|---|---|
| **0** | Child demonstrates mature self-regulation skills. Child needs less guidance or supervision in this area than other children of a similar age. |
| **1** | Child demonstrates adequate self-regulation skills. Child is generally able to self regulate in an age-appropriate way. |
| **2** | Child demonstrates limited self-regulation skills. Child needs more guidance or supervision in this area than other children of a similar age. |
| **3** | Child demonstrates significant difficulties with self-regulation. Child is unable to manage her/himself in a developmentally appropriate way. Child has difficulty with self-regulation even in highly structured situations or with close supervision. |

**45. DAY CARE/SCHOOL FUNCTIONING –** *This item refers to the child's functioning at school or day care. It includes attendance, behavior, and achievement. Academic/learning issues are not included. If the child has completed her/his schooling then rate as '0'. If child has dropped out without completing then rate as '3'. If the child is too young for school and not in day care, please rate as 'NA'.*

| | |
|---|---|
| **NA** | Child is too young for school and not in day care. |
| **0** | Child demonstrates significant strengths in school functioning. Child is performing well in school/day care. |
| **1** | Child demonstrates adequate strengths in school functioning. Child is having or has had occasional problems related to attendance, productivity, or ability to get along with teachers or peers. |
| **2** | Child demonstrates limited strengths in school functioning. Child is attending school and is able to function in some areas, but is having or has had moderate problems related to attendance, productivity, or ability to get along with teachers or peers. |
| **3** | Child demonstrates no strengths related to school functioning. Child is experiencing severe problems with attendance, behavior, and/or achievement. |

**46. CHILD INTERPERSONAL SKILLS –** *This refers to the child's ability to make and maintain friendships and other relationships with peers and adults. Family relations are scored elsewhere.*

| | |
|---|---|
| **0** | Significant interpersonal skills and strengths. Child is seen as well liked by others and has significant ability to form and maintain positive relationships. Child has multiple close friends and is friendly with others. Social connections are a focus of child's life or well-being. |
| **1** | Adequate interpersonal strengths. Child has formed positive interpersonal relationships with others. Child may currently not have many friends, but has a history of making and maintaining relationships with others. |

| | |
|---|---|
| **2** | Limited interpersonal strengths. Child has some social skills that facilitate positive relationships with peers or with adults but finds it hard to make friends or struggles to maintain current healthy relationships. Has an erratic history of making and maintaining healthy friendships with others. |
| **3** | No known interpersonal skills or strengths. Child currently does not have any friends or satisfying relationships, nor has she/he had any in the past. |

**47. CHILD PHYSICAL HEALTH –** *This item is used to describe the child's current physical health.*

| | |
|---|---|
| **0** | Good health. Child is in generally good physical health. Child may have physical health diagnosis but it is well controlled and does not interfere with functioning. |
| **1** | Adequate health. Child gets sick more often than peers, but the health problems only minimally interfere with her/his general functioning (e.g., child may miss some school but is able to keep up with assignments). |
| **2** | Fair health. Child has some health problems that occasionally interfere with her/his functioning. |
| **3** | Poor health. Child has significant health problems that may be chronic or life threatening and that significantly interfere with her/his functioning. |

**48. CHILD MENTAL HEALTH –** *This item is used to describe the child's current mental health.*

| | |
|---|---|
| **0** | No mental health challenges. Child has no signs of any notable mental health problems. |
| **1** | Mild mental health challenges. Child may have mild problems with adjustment, may be somewhat depressed, withdrawn, irritable, anxious, agitated or inattentive. She/he does not require assistance and these symptoms do not interfere with her/his functioning. |
| **2** | Moderate mental health challenges. Child has a diagnosable mental health problem that occasionally interferes with her/his functioning. |
| **3** | Severe mental health challenges. Child has a serious psychiatric disorder that significantly interferes with her/his functioning. |

**49. CHILD ALCOHOL/DRUG USE –** *This item includes problems with alcohol, tobacco, illegal drugs, and/or prescription drugs that impact the child/adolescent's ability to meet academic or vocational expectations, as well as their ability to function as part of the family.* **PLEASE RATE CHILDREN AGES 10 THROUGH 21.**

| | |
|---|---|
| **0** | No problems with alcohol or drug use. Child has no signs of any notable substance abuse problems. |
| **1** | Mild problems associated with alcohol or drug use. Child has episodes of under-aged drinking and/or illicit drug use. Mild problems with school/vocational training or family life result and prevention intervention and education is indicated. |
| **2** | Moderate problems associated with alcohol or drug use. Child has a diagnosable substance-related disorder. Substance use makes it difficult or often prevents her/him from being able to function in school, vocation, or in the family without assistance. |
| **3** | Severe difficulties with alcohol or drug dependence. Child is currently addicted to alcohol, drugs, or both and is suffering significant consequences in multiple areas of |

| | |
|---|---|
| | functioning. Intensive intervention is warranted. |

**50. CHILD CONDUCT DISORDERED BEHAVIOR –** *This item rates conduct disordered behavior such as stealing, selling drugs, or major rule violations. This item refers to non–assaultive behavior.*

| | |
|---|---|
| **0** | No evidence that the child has ever engaged in conduct disordered behavior. |
| **1** | Mild problems associated with conduct disordered behavior. Child has a been involved in a few episodes of conduct disordered behavior but has not been adjudicated in the juvenile justice system. |
| **2** | Moderate problems associated with conduct disordered behavior. Child has a history of conduct disordered behavior with some resulting in adjudication. |
| **3** | Severe difficulties with conduct disordered behavior. Child has a significant history of conduct disordered behavior resulting in multiple adjudications and/or incarcerations. |

**51. COGNITIVE SKILLS** – *Cognitive skills refers to the child's intellectual capacity. Problems include mental retardation and learning difficulties that are a result of learning disabilities.*

| | |
|---|---|
| **0** | Good cognitive skills and functioning. Child meets or exceeds all cognitive developmental milestones. |
| **1** | Adequate cognitive skills and functioning. Child is close to meeting all cognitive developmental milestones. |
| **2** | Limited cognitive skills and functioning. Child has some problems with immaturity or delay in meeting cognitive developmental milestones. These problems occasionally interfere with her/his ability to function. |
| **3** | Severe difficulties or unevenness with cognitive development. Cognitive delays significantly impair her/his functioning. |

**52. CHILD ADJUSTMENT TO TRAUMA –** *This rating describes posttraumatic reactions faced by child family members, including emotional numbing and avoidance, nightmares, and triggered memories that are related to their own traumatic experiences. This dimension covers the range of traumatic responses seen in children including adjustment disorders, posttraumatic stress disorder, and complex trauma.*

| | |
|---|---|
| **0** | Child has not experienced any significant trauma or has adjusted well to traumatic experiences. |
| **1** | Child has some mild problems with adjustment due to trauma. Child may have an adjustment disorder or other reaction that might ease with the passage of time. Or, child may be recovering from a more extreme reaction to a traumatic experience. |
| **2** | Child has moderate symptoms associated with traumatic experiences. Child may have nightmares or other notable symptoms of Post Traumatic Stress Disorder (PTSD) or complex trauma. |
| **3** | Child has severe traumatic distress as a result of traumatic experiences. Symptoms are frequent and intense and may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of PTSD or complex trauma. |

**53. CHILD AFFECT REGULATION –** *This rating describes the child's ability to identify, communicate, and modulate affect across a wide range of emotions. Affect regulation skills*

*change developmentally so this item should be rated within the context of developmentally appropriate skills.*

| | |
|---|---|
| **0** | Child displays no difficulties with affect regulation. Child is able to identify and communicate both positive and negative emotions. Emotions are communicated directly and emotional responses are appropriate to the situation. |
| **1** | Child displays some mild difficulties with affect regulation. Felt emotions are sometimes not communicated clearly. She/he could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general. |
| **2** | Child displays moderate problems with affect regulation. She/he may be comfortable with sharing positive emotions, but unable to communicate or regulate negative ones. She/he may be unable to modulate emotional responses. Child may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). |
| **3** | Child displays severe problems with affect regulation. She/he may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions). Child's affect dysregulation places them at risk for self-harm. Child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, she/he may be characterized as emotionally "shut down". |

**54. CHILD ATTACHMENT DIFFICULTIES –** *This item should be rated within the context of the child's significant parental or caregiver relationships.*

| | |
|---|---|
| **0** | No evidence of attachment problems. Child appears able to respond to and seek out age-appropriate contact with caregiver and accept their nurturance, support and protection. Child experiences a sense of security and trust within her/his attachment relationships. |
| **1** | Mild problems with attachment. Child is at times unable to read caregiver's efforts to provide attention and nurturance. Child may be needy or demanding and does not recover easily after being angry, frightened, or sad, even with support from caregiver. Child may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may send mixed signals about wanting support from caregiver. |
| **2** | Moderate problems with attachment. Child may consistently misinterpret cues, act in an overly needy way, or not seek comfort even when distressed. Child may have ongoing difficulties with separation, may consistently avoid contact, or may reject support from caregivers. Child may have inappropriate physical or emotional boundaries and expectations of others. |
| **3** | Severe problems with attachment. Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in caregiving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate friendliness with others. Child is considered at ongoing risk due to the nature of his/her attachment behaviors. A child who meets the diagnostic criteria for Reactive Attachment Disorder would be rated here. |

**55. CHILD ANGER MANAGEMENT –** *This item captures the child's ability to identify and manage his/her anger when frustrated.*

| | |
|---|---|
| **0** | No evidence of anger management problems. Child recognizes and manages her/his anger in a manner of mutual respect towards her/himself and others. |
| **1** | Child exhibits mild problems managing her/his anger in a respectful manner. She/he may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts. Child may have a history of physical aggression towards property arising from inability to control anger, but none within the last 3 months. |
| **2** | Child exhibits moderate problems managing her/his anger in a respectful manner. Her/his temper has gotten her/him in significant trouble with peers, family, and/or school. This level may be associated with some physical violence towards property in the last 3 months or increasing verbal outbursts. Others are likely quite aware of child's anger potential. |
| **3** | Child exhibits severe problems managing her/his anger in a respectful manner. His/her temper is associated with physical aggression towards others and towards property. Others likely fear her/him. |

**56. CHILD SLEEP PROBLEMS** – *This item describes problems with sleep that cause sleep deficits including insomnia, frequent awakening, nightmares and nocturnal enuresis. These sleep problems are frequent concerns after trauma exposure and impair functioning.*

| | |
|---|---|
| **0** | Child experiences no sleep disturbance. |
| **1** | Child experiences mild sleep disturbance. Child may have occasional nightmares or difficulty falling asleep. This includes mild insomnia of up to 1 hour. |
| **2** | Child experiences moderate sleep disturbance. Child may have frequent (1 to 3 times a week) resistance to going to bed, difficulty falling asleep, frequent awakening, nocturnal enuresis, or nightmares. This includes moderate insomnia up to 2-3 hours. |
| **3** | Child experiences severe sleep disturbance. Child may have daily sleep problems, including insomnia, sleep onset problems, awakening in the night, nightmares or enuresis. This includes severe insomnia resulting in less than 4 hours of sleep per night or the occurrence of day/night reversal. |

# V. INTERGENERATIONAL ISSUES

**This section is intended to address how intergenerational relationships support family functioning. The rater considers interactions among family members from different generations (i.e. caregivers and their parents, children and their grandparents, children and their aunts and uncles, etc.). It excludes the caregiver-child relationship which is addressed in other sections.**

**57. SUPPORT AND ASSISSTANCE** – *This item refers to concrete support and assistance provided by extended family across generations. Examples of support and assistance include, but are not limited to: financial help, presence of a multigenerational household, family members offer childcare, or family members encourage shared leisure activity by vacationing together.*

| | |
|---|---|
| **0** | Support and assistance from extended family across generations are significant strengths for the family. Family members across generations offer support and assistance to one another in a consistent, appropriate manner that reinforces healthy family functioning. |
| **1** | Support and assistance from extended family across generations are moderate strengths for the family. Extended family members usually play a supportive role in family functioning if asked or if available. Support is typically constructive. |
| **2** | Support and assistance from extended family across generations are limited strengths for the family. Extended family members are marginally involved in supporting the family or their support sometimes compromises healthy family functioning. |
| **3** | Support and assistance from extended family across generations are not current strengths for the family. Extended family members offer no support or their support frequently compromises healthy family functioning. |

**58. INTERGENERATIONAL COMMUNICATION** – *This item refers to the extent and quality of communication among family members from different generations.*

| | |
|---|---|
| **0** | Intergenerational communication is a significant strength for the family. Communication is characterized by dynamic, reciprocal exchanges between members of different generations in the family. Communication is predominately open and direct. Extended family members are able to engage in sustained dialogue to problem-solve and manage conflict. |
| **1** | Intergenerational communication is a moderate strength for the family. Family members generally communicate well between generations with some exceptions. Communication is generally open, but the family may have difficulty sharing about difficult issues. Extended family members are often, but not always, able to engage in sustained dialogue to problem-solve and manage conflict. |
| **2** | Intergenerational communication is a limited strength for the family. Extended family members sometimes communicate well. However, their communication is typically not reciprocal or direct. Problems with communication limit the frequency with which intergenerational communication occurs. On occasion, extended family members are able to engage in sustained dialogue to problem-solve and manage conflict. |
| **3** | Intergenerational communication is not a current strength for the family. Communication among family members from different generations is seldom |

| | |
|---|---|
| | reciprocal and is generally indirect, if it occurs at all. Family is not able to engage in sustained dialogue to problem-solve and manage conflict. |

**59. PATTERNS OF PROTECTION** – *This item refers to patterns of interaction (e.g., monitoring practices, consistent nurturance, respect, and acceptance) among family members from different generations that promote a sense of safety and trust.*

| | |
|---|---|
| **0** | Protection across generations is a significant strength. Consistent patterns of interaction among family members across generations demonstrate an ability to support development of a sense of safety and trust. |
| **1** | Protection across generations is a moderate strength. Family members across generations are sometimes available to protect family members, especially in times of more acute need. Family members have minor difficulty consistently interacting in a manner that supports development of a sense of safety and trust. |
| **2** | Protection across generations is a limited strength. Patterns of protective interactions among family members across generations are not consistent. This may lead to a lack of confidence that protection will be available and there is evidence of insecurity regarding safety and trust. |
| **3** | Protection across generations is not a current strength for the family. Family members have longstanding patterns across generations of not providing protection, and these patterns demonstrate an inability to support development of a sense of safety and trust. These longstanding patterns across generations have produced an expectation that protection will not be available. |

**60. FAMILY HISTORY OF MENTAL ILLNESS** – *This item is used to describe the mental health status of relatives, including previous generations. This item includes substance use disorders.*

| | |
|---|---|
| **0** | No family history of mental health challenges. |
| **1** | Family history includes relatives with mild mental health challenges. |
| **2** | Family history includes relatives with moderate mental health challenges that have interfered with life functioning of affected members. |
| **3** | Family history includes relatives with severe mental health challenges including members diagnosed with serious psychiatric disorders. |

# VI. ADULT PARTNERSHIPS

**In this section, the rater considers the current intimate partner relationships between adult family members. If currently married or in committed relationships, this refers, for example, to the husband and wife dyad or same sex partnership. If divorced or separated, this refers to the new relationships each adult has formed. Multiple adult partnerships relevant to the functioning of the family can be rated. If the adults in the family are not in adult partnerships, the section can be skipped.**

**61. ADULT PARTNER RELATIONSHIPS –** *This item is used to rate the partnership's experience of maintaining close and supportive relationships.*

| | |
|---|---|
| **0** | Adaptive partner relationship. Partners feel a close bond with each other. Relationships are characterized by consistently dynamic and reciprocal interactions. Communication is predominately open and direct, and conflicts are resolved quickly. Partners offer emotional support and assistance to one another as needed and both partners derive pleasure and mutual benefit from this relationship. |
| **1** | Mostly adaptive partner relationship. Adult partners generally feel a close bond with each other although some interactions may be strained. Communication is generally open, but they may have difficulty sharing about stressful issues. Conflicts may linger but eventually are resolved. They are generally supportive of each other. |
| **2** | Moderate difficulties with partner relationship. Partners can relate civilly under a limited set of circumstances but they have generally strained interactions, typically cannot communicate about important issues, and do not often support each other. Conflicts are frequent and usually not resolved. One partner may be overly dependent on another or one partner exerts undue power over the other. |
| **3** | Significant difficulties with partner relationship. Partners are estranged and do not communicate or interactions are mostly negative and unhealthy. Relationship is characterized by mistrust and animosity. Partners do not support each other. The relationship is destructive to the individual functioning of the adults and interferes with family functioning. |

**62. PARTNERSHIP RELATIONSHIP STABILITY –** *This item refers to the degree to which the adult partnership has been stable. This item is rated historically.*

| | |
|---|---|
| **0** | Adult partners have experienced their relationship as stable and long term. |
| **1** | Mostly stable adult partner relationship. Adult partners have had a stable intimate partner relationship, but there is some concern about instability in the near future (one year) due to transitions, illness, or age. |
| **2** | Limited stability in adult partner relationship. Adult partners have experienced instability in the relationship, such as separations, limited commitment, nonexclusivity, or the relationship is relatively short-term. |
| **3** | Significant instability in adult intimate partner relationship. Relationship is transient with no commitment. |

**63. PARTNERSHIP AFFECT MANAGEMENT** – *This item refers to the extent to which adult partners modulate or express emotions and manage their reactions in the context of their relationship.*

| | |
|---|---|
| **0** | Adult partners display no difficulties co-regulating emotional responses. Adult partners recognize and respond appropriately to the affect expressed. Adult partners are able to express strong emotions, both positive and negative, when appropriate, and maintain control. Emotional responses are appropriate to the situation. |
| **1** | Adult partners display some minor difficulties with affect regulation. Adult partners generally recognize and respond appropriately to the affect expressed, but there are some miscues and miscommunications. Adult partners could have some difficulty tolerating and expressing intense emotions and become uncomfortable in response to emotionally charged stimuli. Adult partners may be more watchful or hypervigilant in general. |
| **2** | Adult partners display moderate problems with affect regulation. They may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). Adult partners may deal effectively with positive emotions but be unable to tolerate or express negative affect. At times, adult partners' affect may be inconsistent with the situation. |
| **3** | Adult partners display severely dysregulated affect. Affective communication between partners is often misunderstood. Adult partners demonstrate severe problems as evidenced by unpredictable mood and inability to modulate emotional responses (feeling out of control of their emotions or emotionally "shut down"). Adult partners may exhibit tightly contained emotions with intense outbursts under stress. Affect expressed is generally not consistent with the situation. |

**64. ANGER MANAGEMENT WITHIN PARTNERSHIP** – *This item captures the adult partner's ability to identify and manage their anger and frustration related to their relationship.*

| | |
|---|---|
| **0** | No evidence of problems managing anger in a respectful manner within the partner relationship. Both partners identify and communicate their anger in a manner of mutual respect towards one another. |
| **1** | Partner relationship with mild problems managing anger in a respectful manner. One or both partners may sometimes become verbally aggressive when frustrated. Partners may have a history of physical aggression towards property arising from inability to control anger related to partnership conflicts, but none within the last 3 months. Peers and other family members are aware of and may attempt to avoid stimulating angry outbursts. Parent/caregivers are generally able to keep arguments to a minimum when children are present. |
| **2** | Partner relationship with moderate problems managing anger in a respectful manner. There is reciprocal verbal aggression towards one another. This level may be associated with some physical violence towards property or increasing verbal outbursts within the last 3 months. Others are likely quite aware of anger potential. Children often witness these arguments between adult partners or the use of verbal aggression by one partner. |
| **3** | Partner relationship with severe problems managing anger in a respectful manner. Profound level of adult partnership violence that often escalates to mutual attacks or the use of physical aggression by one partner to control the other. Others likely fear |

| | |
|---|---|
| | being around the partners when they are together. Adult partners are not able to keep physical altercations from occurring when children are present. |

# VII. CAREGIVING ISSUES

**In the family certain family members have <u>primary</u> responsibilities for raising children. In some families, parents are the primary caregivers, in other families a step-parent, a grandparent, or an aunt or uncle also have these responsibilities. Please identify ALL of the caregivers in the family and describe each of them using items 65-71. All items should be rated in accordance with the developmental needs of the children in care.**

**The final two items (73-74) in this section rate the entire caregiving system and are scored only once. They are scored only when there is more than one caregiver in the family.**

**<u>65.</u> CAREGIVER'S RESPONSIVENESS –** *This item refers to the caregiver's availability and ability to attend to, understand, and respond to the emotional and physical needs of the children in the family.*

| | |
|---|---|
| **0** | Adaptive responsiveness. Caregiver is attentive, empathic, and responds to the children's needs. |
| **1** | Mostly adaptive responsiveness. Caregiver is generally attentive, empathic, and responsive to children's needs. However, certain psychological issues, including depression, avoidance, withdrawal, and high stress, undermine the caregiver's responsiveness. |
| **2** | Limited responsiveness. Caregiver remains involved with the children but is frequently not attentive, empathic, or able to respond appropriately to children's needs. |
| **3** | Significant difficulties with responsiveness. Caregiver is not attentive or empathic, and rarely responds at all to the children's needs. |

**<u>66.</u> SATISFACTION/MEANING OF CAREGIVING –***This item refers to the importance placed on the role of caregiving and to the sense of accomplishment or pride that the caregiver feels related to carrying out her/his caregiving role and responsibilities.*

| | |
|---|---|
| **0** | Caregiver gives high priority to her/his caregiving role and responsibilities and gains significant satisfaction from carrying them out. |
| **1** | Caregiver places some importance on her/his caregiving role and responsibilities and gains some satisfaction from carrying them out. |
| **2** | Caregiver feels that her/his caregiving responsibilities must get done, but only occasionally feels a sense of pride in accomplishing them. |
| **3** | Caregiver does not value her/his caregiving role and feels little or no sense of satisfaction for accomplishing any of her/his caregiving responsibilities. |

**<u>67.</u> CAREGIVING EFFICACY –** *This item refers to the caregiver's feelings and perceptions of being effective at carrying out her/his caregiving role and responsibilities.*

| | |
|---|---|
| **0** | Caregiver believes that she/he is a highly effective caregiver and is able to successfully carry out all of the tasks necessary to meet the needs of the children under her/his care. |
| **1** | Caregiver believes that she/he is an adequate caregiver and is usually able to |

| | |
|---|---|
| | successfully carry out the tasks necessary to meet the needs of the children under her/his care. |
| **2** | Caregiver believes that she/he is an unsuccessful caregiver and is only occasionally able to carry out the tasks necessary to meet the needs of the children under her/his care. |
| **3** | Caregiver believes that she/he is a completely inadequate caregiver and consistently fails at carrying out all of the tasks necessary to meet the needs of the children under her/his care. |

**68. CAREGIVER'S BOUNDARIES –** *Boundaries refer to the caregiver's ability to separate from children and appropriately keep things from children that they should not know or be exposed to given their age and role in the family. Boundaries can include the parent's need to be over/under protective her/his children.*

| | |
|---|---|
| **0** | Adaptive boundaries. Caregiver has strong, appropriate boundaries between her/himself and her/his children. |
| **1** | Mostly adaptive boundaries. Caregiver has generally appropriate boundaries between her/himself and her/his children. Mild boundary violations may occur during times of high stress. Minor problems of rigidity of boundaries may occur. |
| **2** | Limited adaptive boundaries. Caregiver has difficulty maintaining appropriate boundaries between her/himself and her/his children. Mild boundary violations may be routine, or significant boundary violations may be occasional. Boundaries may be rigid. |
| **3** | Significant difficulties with boundaries. Caregiver has significant and consistent problems maintaining appropriate boundaries between her/himself and her/his children, or is excessively rigid in her/his boundaries. |

**69. CAREGIVER'S SUPERVISION –** *This item refers to the success with which the caregiver is able to monitor the children in his/her care. This item should be rated consistent with the developmental needs of the children in care.*

| | |
|---|---|
| **0** | Good supervision. Caregiver demonstrates consistent ability to supervise her/his children according to their developmental needs. |
| **1** | Adequate supervision. Caregiver demonstrates generally good ability to supervise children. Some supervision problems may occur occasionally. |
| **2** | Limited supervision. Caregiver has difficulty maintaining an appropriate level of supervision of her/his children. |
| **3** | Significant difficulties with supervision. Caregiver has significant problems maintaining any supervision of her/his children. |

**70. CAREGIVER'S DISCIPLINE –** *Discipline refers to the caregiver's ability to encourage positive behaviors by children in her/his care through the use of a variety of different techniques including but not limited to praise, redirection, and punishment.*

| | |
|---|---|
| **0** | Good discipline methods. Caregiver generally demonstrates an ability to discipline her/his children in a consistent and benevolent manner. She/he is able to set age appropriate limits and enforce them. |
| **1** | Adequate discipline methods. Caregiver is often able to set age appropriate limits |

| | |
|---|---|
| | and to enforce them. On occasion her/his interventions may be either too harsh or too lenient. At times, her/his expectations of her/his children may be too high or too low. |
| **2** | Limited discipline methods. Caregiver demonstrates limited ability to discipline her children in a consistent and benevolent manner. She/he rarely is able to set age appropriate limits and to enforce them. Her/his interventions may be erratic and overly harsh but not physically harmful. Her/his expectations of her/his children are frequently unrealistic. |
| **3** | Significant difficulties with discipline methods. Caregiver disciplines her/his children in an unpredictable fashion. There is either an absence of limit setting and disciplinary interventions or the limit setting and disciplinary interventions are rigid, extreme, and physically harmful. |

**71. CAREGIVER ANGER MANAGEMENT –** *This item captures the caregiver's ability to identify and manage their anger when providing care.*

| | |
|---|---|
| **0** | No evidence of anger management problems. Caregiver recognizes and communicates her/his anger towards children in a respectful manner. |
| **1** | Caregiver exhibits mild problems managing her/his anger towards the children in a respectful manner. She/he may sometimes become verbally aggressive towards the child when frustrated. Children are aware of and may attempt to avoid stimulating angry outbursts. The caregiver may have a history of physical aggression towards property arising from inability to control anger, but none within the last 3 months. |
| **2** | Caregiver exhibits moderate problems managing her/his anger towards the children in a respectful manner. This level may be associated with some physical violence towards property within the past 3 months or increasing verbal outbursts when communicating her/his anger with her/his children. Children are likely quite aware of the caregiver's anger potential. |
| **3** | Caregiver exhibits severe problems managing her/his anger towards the children in a respectful manner. Her/his temper is likely associated with frequent physical aggression directed towards the children and towards property. Children likely fear her/him. |

**72. CAREGIVING BURDEN/STRESS –***This item describes caregiver's ability to manage the stress or burden the children's current needs are generating in the family system.*

| | |
|---|---|
| **0** | Caregiver able to manage the stress of the children's needs. |
| **1** | Caregiver has some problems managing the stress of the children's needs. |
| **2** | Caregiver has notable problems managing the stress of the children's needs. This stress interferes with her/his capacity to give care. |
| **3** | Caregiver is unable to manage the stress associated with child/children's needs. This stress prevents caregiver from parenting. |

## CAREGIVING SYSTEM STRENGTHS

**Items (73-74) rate the entire caregiving system and are scored only once.**

**73. COLLABORATION –** *This item refers to the relationship between parents (or other primary caregivers) with regard to working together in child rearing activities.*

| | |
|---|---|
| **0** | Adaptive collaboration. Caregivers usually work together regarding issues of the development and well-being of the children. They are able to negotiate disagreements related to their children. |
| **1** | Mostly adaptive collaboration. Generally good caregiver collaboration with occasional difficulties negotiating miscommunications or misunderstandings regarding issues of the development and well-being of the children. |
| **2** | Limited adaptive collaboration. Caregivers attempt to work together but experience moderate problems of communication and collaboration between two or more caregivers with regard to issues of the development and well-being of the children. |
| **3** | Significant difficulties with collaboration. Caregivers do not attempt to collaborate and exhibit destructive or sabotaging communication with regard to issues related to the development and well-being of the children. |

**74. CONSISTENCY –***This item refers to the ability of the caregivers to provide uniform caregiving environments for the children in the family.*

| | |
|---|---|
| **0** | Adaptive consistency. Caregivers establish rules, limits, and discipline in similar ways. There is concordance about what is important and valued. Children generally expect to be treated in a similar fashion by their caregivers. |
| **1** | Mostly adaptive consistency. There is some inconsistency in rules, limits, discipline, and values between caregivers. Children are able to negotiate the differences without problems. |
| **2** | Limited adaptive consistency. Rules, limits, discipline, and values are very different depending on the caregiver. These differences create some conflict between the caregivers. Children have mild difficulty negotiating these differences. |
| **3** | Significant difficulties with consistency. Caregivers exhibit extreme differences in how they structure the caregiving environments for their children. The children have problems functioning due to the inconsistency. |

# VIII. CAREGIVER/CHILD RELATIONS

**In this section, the rater considers the relationship between the caregivers in the family and their children. This is a rating of all the caregiver/child relationships in the family system and not each individual dyad relationship.**

**75. RELATIONSHIPS BETWEEN CAREGIVER/CHILD –** *This item is used to rate the caregiver's and children's experience of maintaining close and supportive relationships. Caregiver/child relations should be rated a 2 or 3 if any dyad is functioning at this level regardless of how well some caregiver/child dyads in the family are relating.*

| | |
|---|---|
| **0** | Adaptive caregiver/child relationships. Caregivers and their children feel a close bond with each other. Caregiver/child relationships are characterized by consistently dynamic and reciprocal interactions. Communication is predominately open and direct, and conflicts are resolved quickly. Both the children and parent/primary caregiver(s) derive pleasure and mutual benefit from this relationship. Children feel nurtured and supported as they strive to achieve their developmental tasks. |
| **1** | Mostly adaptive caregiver/child relationships. Caregivers and their children generally feel a close bond with each other although some interactions may be strained. Communication is generally open, but they may have difficulty sharing about stressful issues. Conflicts may linger but eventually are resolved. Both the children and parent/primary caregiver(s) derive some pleasure and mutual benefit from this relationship. Strained interactions and conflicts may disturb the children's feelings of being nurtured and supported but are not interfering with their ability to achieve their developmental tasks. |
| **2** | Moderate difficulties with caregiver/child relationships. Caregivers and their children do not often support each other. They have limited positive interactions and typically cannot communicate about important issues. Conflicts are frequent and usually not resolved. Both the children and parent/primary caregiver(s) are frequently distressed by their interactions and do not derive pleasure from this relationship. Children do not feel nurtured and supported, and the caregiver/child relationships are interfering with the achievement of their developmental tasks. |
| **3** | Significant difficulties with caregiver/child relationships. Caregiver/child relationships are either estranged, disrupted, or characterized by severely disorganized and maladaptive interactions. Interactions are almost always conflicted. Caregiver/child relationships are destructive to the individual functioning of both the caregiver and the children and significantly interfere with the achievement of developmental tasks. |
| List dyads rated as 2 or 3: | |

**76. CAREGIVER/CHILD RELATIONSHIP STABILITY –** *This rating refers to the stability of significant caregiver/child relationships. This item is rated historically.*

| | |
|---|---|
| **0** | Family has very consistent and stable caregiver/child relationships. |
| **1** | Family has had stable caregiver/child relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A family that has had one caregiver leave the family system (i.e., separation or divorce) but other caregiver has remained constant would be rated here. |
| **2** | Family has experienced instability in caregiver relationships through factors such as |

| | |
|---|---|
| | removal from home, abandonment, and death. |
| **3** | Family has experienced multiple transitions in caregiver/child relationships with little consistency in who is included in caregiver roles. |

# IX. SIBLING RELATIONS

**In this section, the rater considers the way that children in the family interact with one another. This could include children related to one another biologically, step-children, or cousins or other child relatives who live together. If this is a family with only one child, this section should be skipped.**

**77. RELATIONSHIPS AMONG SIBLINGS –** *This item refers to how the children in the sibling subsystem get along with each other.*

| | |
|---|---|
| **0** | Adaptive sibling relationships. Siblings generally get along well and feel a close bond with each other. Relationships are characterized by consistently dynamic and reciprocal interactions. Communication is predominately open and direct. Siblings offer emotional support and assistance to one another as needed. |
| **1** | Mostly adaptive sibling relationships. Siblings generally get along and feel a close bond with each other, although some interactions may be strained. Communication is generally open, but they may have difficulty sharing about difficult issues. Siblings are generally supportive of each other. |
| **2** | Limited adaptive sibling relationships. Siblings can get along but often do not. They have generally strained interactions, typically cannot communicate about important issues, and do not often support each other. |
| **3** | Significant difficulties with sibling relationships. Siblings do not get along. They are estranged and do not communicate, or interactions are mostly negative and unhealthy. Relationships are characterized by mistrust and animosity. Relationships are destructive to individual functioning and interfere with family functioning. |

**78. SIBLING RELATIONSHIP STABILITY –** *This rating refers to the stability of sibling relationships in the family. This item is rated historically.*

| | |
|---|---|
| **0** | Stable and consistent sibling relationships. Sibling relationships have been constant and are likely to remain so in the foreseeable future. |
| **1** | Mostly stable sibling relationships. There is some concern about instability in the near future (one year) due to transitions, illness, or age. |
| **2** | Limited stability in sibling relationships. Siblings have experienced one change in sibling membership through factors such as divorce, blended family, removal from home, and death. |
| **3** | Significant instability in sibling relationships. Siblings have experienced multiple changes in sibling membership with little consistency in who is included in the subsystem. |

**79. SIBLING CONFLICT** – *This item refers to how siblings deal with disagreements.*

| | |
|---|---|
| **0** | Siblings seldom argue and negotiate disagreements appropriately. |
| **1** | Siblings seldom argue, but when conflicts arise resolution is difficult. |
| **2** | Siblings are generally argumentative; conflict characterizes many of their interactions. |
| **3** | Siblings are constantly arguing and disagreements characterize sibling interactions. Siblings are unable to maintain civil communication during disagreements; yelling, name calling and cursing are common. |

## What is family dysfunction?

Reciprocal adaption and/or mitigation behaviors that activate Sympathetic System Dominance (SSD), characterized by a change in state, relevancy and social dominance between family members.

*Rhoton 2010*



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## To stabilize a child and see reductions in disturbing behaviors the adults in a child's life have to be stable and self-regulating

- Be kind and compassionate
- Practice keeping your own body relaxed regardless of what is happening.
- Provide support for the small and large stressors
- Help them have a voice, by giving them non-judgmental labels to connect their emotions to their feelings
- Practice emotional and physical relaxation and self-regulation right in front of them
- Create structure and predictability
- Remember relationship before rules
- Be patient and kind with yourself, it can be difficult to remain calm and supportive when children are exhibiting the signs of toxic stress and Sympathetic System Dominance.



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## Assessing family trauma

Key steps for conducting a comprehensive assessment of trauma:



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## Key Steps

1. Assess for a wide range of traumatic events, toxic stress and adversity.
2. Determine when they occurred so that they can be linked to developmental stages.
3. Assess for a wide range of symptoms, risk behaviors, functional impairments, and developmental derailments based on the family injunctions (compulsory/inhibitor) that are or have been in operation.
4. Gather information from a variety of perspectives
5. Try to make sense of the adaptations and mitigations that have become procedural memory and functioning.
6. Understand cultural and family history's impact
7. Working with the family unit to ensure the safety and well-being of all family members



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## Key Steps

8. Strengthening the capacity of families to function effectively by focusing on solutions.
9. Engaging, empowering, and partnering with families throughout the all processes
10. Developing a relationship between parents and service providers characterized by mutual trust, respect, honesty, and open communication
11. Providing individualized family, culturally responsive, flexible, and relevant services for each family
12. Linking families with collaborative, comprehensive, culturally relevant, community-based networks of supports and services



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## Goal of Assessment

- Build a therapeutic relationship
- Develop trust and transparency
- Give and explore choices
- Show respect and warmth without judgement/criticism or an organizational agenda
- Obtain necessary information about patterns, themes and function



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**Formal Measures**

- **YSQ-3S**
- **ACE**
- **FANS-Trauma**
- **CAPS- C**



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## Schema Theory

Jeffery Young

History of arousal leads to adaptive and mitigating behaviors that can develop relatively permanent mental structures that influence thinking and behavior



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## Characteristics of Environments that generate adaptations and mitigations

1. ABANDONMENT / INSTABILITY
2. MISTRUST / ABUSE
3. EMOTIONAL DEPRIVATION
4. DEFECTIVENESS / SHAME
5. SOCIAL ISOLATION / ALIENATION
6. DEPENDENCE / INCOMPETENCE
7. VULNERABILITY TO HARM OR ILLNESS
8. ENMESHMENT / UNDEVELOPED SELF
9. FAILURE TO ACHIEVE
10. ENTITLEMENT / GRANDIOSITY
11. INSUFFICIENT SELF-CONTROL / SELF-DISCIPLINE
12. SUBJUGATION
13. SELF-SACRIFICE
14. APPROVAL-SEEKING / RECOGNITION-SEEKING
15. NEGATIVITY / PESSIMISM
16. EMOTIONAL INHIBITION
17. UNRELENTING STANDARDS / HYPERCRITICALNESS
18. PUNITIVENESS



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# FANS

**Family Assessment of Needs and Strengths for Trauma**



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## Section #13

**The assessment process**



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Section #15

**Models of treatment**



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# ITCT-A: Integrative Treatment of Complex Trauma for Adolescents

GENERAL INFORMATION

| | |
|---|---|
| **Treatment Description** | **Acronym** *(abbreviation)* **for intervention:** ITCT-A<br><br>**Average length/number of sessions:** 16-36<br><br>**Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Specifically developed to be responsive and sensitive to cultural differences as well as the effects of poverty and social marginalization. Widely used by programs with diverse clients.<br><br>**Trauma type** *(primary)*: Complex trauma, physical abuse, sexual abuse, emotional abuse and neglect, community violence, domestic violence, medical trauma, traumatic loss<br><br>**Trauma type** *(secondary)*: Parental substance abuse |
| **Target Population** | **Age range:** 12 **to** 21<br><br>**Gender:** ❒ **Males** ❒ **Females** ☒ **Both**<br><br>**Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Hispanic-Americans, African-Americans, Caucasian Americans, Asian-Americans. Unaccompanied minors from Mexico and Central America<br><br>**Other cultural characteristics** *(e.g., SES, religion)***:** Applicable for all SES groups; particularly adapted for economically disadvantaged and culturally diverse clients<br><br>**Language***(s)***:** Interventions adapted for Spanish-speakers<br><br>**Region** *(e.g., rural, urban)***:** Urban and rural<br><br>**Other characteristics** *(not included above)***:** Homeless youth, those in juvenile justice system, residential treatment clients |
| **Essential Components** | **Theoretical basis:** Assessment-driven, multimodal, evidence-based treatment, with interview and/or standardized trauma specific measures administered at 2-3 month intervals to identify symptoms requiring special clinical attention. ITCT is based on developmentally appropriate, culturally adapted approaches that can be applied in multiple settings: outpatient clinic, school, hospital, inpatient, residential, and involves collaboration with multiple community agencies.<br><br>**Key components:**<br><br>• Treatment follows standardized protocols involving empirically based interventions for complex trauma and includes multiple treatment modalities: relational/attachment-oriented, cognitive therapy, exposure therapy, mindfulness skills development, affect regulation training, trigger management, psychoeducation in individual and group therapy. Specific collateral and family therapy approaches are also integrated into treatment. |

# ITCT-A: Integrative Treatment of Complex Trauma for Adolescents

| | |
|---|---|
| **Essential Components continued** | • Titrated therapeutic exposure and exploration of trauma is facilitated in a developmentally–appropriate and safe context, balanced with attention to increasing affect regulation capacities, self-esteem, and self-efficacy.<br>• Incorporates specific approaches for complex trauma treatment including aspects of the Self Trauma model, relational, cognitive-behavioral, and affect regulation approaches.<br>• The relationship with the therapist is deemed crucial to the success of therapy; safety and trust are necessary components.<br>• Multiple adaptations for youth presenting to clinic, those identified in the school system, and those receiving treatment in a residential context.<br>• Clients receive treatment based on needs identified through regular assessment protocols (using the Assessment-to-Treatment Flowchart, and, in some centers, standardized tests), attention to developmental and cultural issues, and ongoing focus on arising challenges and traumas in the youth's environment.<br>• Immediate trauma-related issues such as safety, anxiety, depression, and posttraumatic stress are addressed earlier in treatment (when possible), in order to increase the client's capacity to explore more chronic and complex trauma issues.<br>• Complex trauma issues are addressed as they arise, including attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, identity-related issues, and substance abuse. There is a specific integrated or stand-alone substance use/abuse treatment module. |
| **Clinical & Anecdotal Evidence** | **Are you aware of any suggestion/evidence that this treatment may be harmful?**<br>**❒ Yes ☒ No ❒ Uncertain**<br><br>**Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5<br><br>**This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.**<br>**❒ Yes ☒ No**<br><br>**Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No**<br><br>**If YES, please include citation:**<br>NCTSN quarterly and annual reports, 2012-2015<br><br>**Has this intervention been presented at scientific meetings? ☒ Yes ❒ No**<br><br>**If YES, please include citation***(s)* **from last five presentations:**<br>Many, including at NCTSN, ISTSS, APSAC, APA meetings, 2009-present |

# ITCT-A: Integrative Treatment of Complex Trauma for Adolescents

**Clinical & Anecdotal Evidence continued**

**Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No**

**If YES, please include citation:**

Briere, J. (2015). Mindfulness and trigger management interventions for traumatized, substance-using youth. *Counselor, 16*, 41- 47.

Briere, J., & Lanktree, C.B. (2013). *Integrative treatment of complex trauma for adolescents (ITCT-A): A guide for the treatment of multiply-traumatized youth, 2nd edition*. Los Angeles, CA: USC Adolescent Trauma Training Center, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration.

Briere, J. & Lanktree, C.B. (2012). *Treating complex trauma in adolescents and young adults*. Thousand Oaks, CA: Sage.

Briere, J., & Lanktree, C.B. (2014). *Treating substance use issues in traumatized adolescents and young adults: Key principles and components*. Los Angeles, CA: USC Adolescent Trauma Training Center, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration.

Lanktree, C.B., & Briere, J. (2013). Integrative Treatment of Complex Trauma (ITCT) for children and adolescents. In J.D. Ford and C.A. Courtois, *Treating complex traumatic stress disorders with children and adolescents: An evidence-based guide (pp. 143-161)*. NY: Guilford.

Lanktree, C.B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., Adams, B., Maida, C.A., & Freed, W. (2012). Treating multi-traumatized, socially-marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828.

**Has the intervention been replicated anywhere? ☒ Yes ❒ No**

**Other countries?** No

| Research Evidence | Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)* | Citation |
|---|---|---|
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* | **N=**151<br>**Gender**:<br>35% (**N=**53) male and<br>65% (**N=**98) female | Lanktree, C.B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., Adams, B., Maida, C.A., &<br>Freed, W. (2012). Treating multi-traumatized, socially-marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828. |

# ITCT-A: Integrative Treatment of Complex Trauma for Adolescents

| | | |
|---|---|---|
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* **continued** | **Ethnicity**:<br>48% (**N=**73) Hispanic<br>25% (**N=**38)<br>Black or African American<br>14% (**N=**21)<br>non-Hispanic White and<br>13% (**N=**19) Asian<br>or other | |
| **Outcomes** | **What assessments or measures are used as part of the intervention or for research purposes, if any?** Trauma Symptom Checklist for Children (TSCC and TSCC-A), Children's Depression Inventory, CBCL<br><br>**If research studies have been conducted, what were the outcomes?** Significantly reduced (average of > 40%) symptoms on all trauma-related areas as measured by the TSCC: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns. | |
| **Implementation Requirements & Readiness** | **Space, materials or equipment requirements?**<br>Materials downloadable at no cost from *attc.usc.edu* or *http://keck.usc.edu/Education/Academic_Department_and_Divisions/Department_of_Psychiatry/Research_and_Training_Centers/USC_ATTC.aspx*<br><br>**Supervision requirements** *(e.g., review of taped sessions)***?**<br>Dependent on needs of program<br><br>**To ensure successful implementation, support should be obtained from:**<br>USC-Adolescent Trauma Training Center *(attc.usc.edu)* | |
| **Training Materials & Requirements** | **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.**<br><br>Briere, J., & Lanktree, C.B. (2013). *Integrative treatment of complex trauma for adolescents (ITCT-A): A guide for the treatment of multiply-traumatized youth, 2nd edition*. Los Angeles, CA: USC Adolescent Trauma Training Center, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration.<br><br>Briere, J., & Lanktree, C.B. (2014). *Treating substance use issues in traumatized adolescents and young adults: Key principles and components*. Los Angeles, CA: USC Adolescent Trauma Training Center, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration.<br><br>Both manuals can be downloaded at no cost from *attc.usc.edu* | |

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# ITCT-A: Integrative Treatment of Complex Trauma for Adolescents

GENERAL INFORMATION

| | |
|---|---|
| **Training Materials & Requirements continued** | **How/where is training obtained?** By contacting training coordinator at attc.usc.edu<br><br>**What is the cost of training?** None<br><br>**Are intervention materials** *(handouts)* **available in other languages?**<br>☒ **Yes** ❒ **No**<br><br>**If YES, what languages?** Spanish<br><br>**Other training materials &/or requirements** *(not included above)*:<br>Training subject to accepted training application *(attc.usc.edu)* |
| **Pros & Cons/ Qualitative Impressions** | **What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)*?<br>Multimodal, highly appropriate for multiple cultural and socioeconomic groups, developmentally adapted for clients aged 12 years to 21 years, addresses challenges specifically associated with complex trauma, specific (separate) substance use/ abuse treatment manual, many interventions specifically deal with “acting out” or self-injurious/maladaptive behaviors, flexible time-frame.<br><br>**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)*?<br>Longer treatment sometimes required; less structured/manualized than some approaches<br><br>**Other qualitative impressions:**<br>Youth friendly, nonstigmatizing, flexible, culturally inclusive |
| **Contact Information** | **Name:** Cheryl Lanktree, Ph.D., John Briere, Ph.D., Karianne Chen, M.S., MFT<br><br>**Address:** USC Adolescent Trauma Training Center, 3625 Del Amo Boulevard Suite 170, Torrance, CA 90503-1643<br><br>**Phone number:** (310) 370-9208<br><br>**Email:** attc@usc.edu **Website:** attc.usc.edu |

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# ITCT-C: Integrative Treatment of Complex Trauma for Children

GENERAL INFORMATION

## Treatment Description

**Acronym** *(abbreviation)* **for intervention:** ITCT-C

**Average length/number of sessions:** 16-36

**Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Specifically developed to be responsive and sensitive to cultural differences as well as the effects of poverty and social marginalization. Widely used by programs with diverse clients.

**Trauma type** *(primary)*: Complex trauma, physical abuse, sexual abuse, emotional abuse and neglect, community violence, domestic violence, medical trauma, and traumatic loss

**Trauma type** *(secondary)*: Parental substance abuse

## Target Population

**Age range:** 5 **to** 12

**Gender:** ❒ **Males** ❒ **Females** ☒ **Both**

**Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** Hispanic-Americans, African-Americans, Caucasian Americans, Asian-Americans. Unaccompanied minors from Mexico and Central America

**Other cultural characteristics** *(e.g., SES, religion)***:** Applicable for all SES groups; particularly adapted for economically disadvantaged and culturally diverse clients

**Language***(s)***:** Interventions adapted for Spanish-speakers

**Region** *(e.g., rural, urban)***:** Urban and rural

**Other characteristics** *(not included above)***:** Children in foster system, school-based programs, those in juvenile justice system, residential treatment clients

## Essential Components

**Theoretical basis:** Assessment-driven, multimodal, evidence-based treatment, with interview and/or standardized trauma specific measures administered at 2-3 month intervals to identify particular symptoms and issues requiring focused clinical attention. ITCT is based on developmentally appropriate, culturally adapted approaches that can be applied in multiple settings: outpatient clinic, school, hospital, inpatient, forensic, and residential, and involves collaboration with multiple community agencies.

**Key components:**

- Treatment follows standardized protocols involving empirically based interventions for complex trauma and includes multiple treatment modalities: relational/attachment-oriented, cognitive therapy, exposure therapy, mindfulness skills development, affect regulation training, trigger management, psychoeducation in individual and group therapy. Specific collateral and family therapy approaches are also integrated into treatment.

# ITCT-C: Integrative Treatment of Complex Trauma for Children

| | |
|---|---|
| **Essential Components cont'd** | • Titrated therapeutic exposure and exploration of trauma is facilitated in a developmentally–appropriate and safe context, balanced with attention to increasing affect regulation capacities, self-esteem, and self-efficacy.<br>• ITCT is relationally based and incorporates specific approaches for complex trauma treatment including aspects of the Self Trauma model (e.g., Briere & Scott, 2014), attachment theory, and cognitive behavioral approaches.<br>• The relationship with the therapist is deemed crucial to the success of therapy; safety and trust are necessary components.<br>• Multiple adaptations for the child presenting to clinic, those identified in the school system, and those receiving treatment in a residential context.<br>• Clients receive treatment based on needs identified through regular assessment protocols (using the Assessment-to-Treatment Flowchart, and, in some centers, standardized tests), attention to developmental and cultural issues, and an ongoing focus on arising challenges and traumas in the child's environment.<br>• Immediate trauma-related issues such as safety, anxiety, depression, and posttraumatic stress are addressed earlier in treatment (when possible), in order to increase the client's capacity to explore more chronic and complex trauma issues.<br>• Complex trauma issues are addressed as they arise, including attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues. There is also a focus on interventions that address the impacts of insecure caretaker-child attachment relationships as they compound or intensify the psychological effects of traumatic experiences for the child. |
| **Clinical & Anecdotal Evidence** | **Are you aware of any suggestion/evidence that this treatment may be harmful?**<br>**❒ Yes ☒ No ❒ Uncertain**<br><br>**Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 5<br><br>**This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.**<br>**❒ Yes ☒ No**<br><br>**Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No**<br><br>**If YES, please include citation:** NCTSN quarterly and annual reports, 2001-2009<br><br>**Has this intervention been presented at scientific meetings? ☒ Yes ❒ No**<br><br>**If YES, please include citation***(s)* **from last five presentations:**<br>Many, including at NCTSN, ISTSS, APSAC, APA meetings, 2009-present |

# ITCT-C: Integrative Treatment of Complex Trauma for Children

| | | |
|---|---|---|
| **Clinical & Anecdotal Evidence cont'd** | **Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No**<br><br>**If YES, please include citation:**<br>Lanktree, C. B., & Briere, J.N. (2016). *Treating complex trauma in children and their families: An integrative approach*. Thousand Oaks, Ca.: Sage.<br><br>Lanktree, C.B., & Briere, J. (2013). Integrative Treatment of Complex Trauma (ITCT) for children and adolescents. In J.D. Ford and C.A. Courtois, *Treating complex traumatic stress disorders with children and adolescents: An evidence-based guide* (pp. 143-161). NY: Guilford.<br><br>Lanktree, C.B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., Adams, B., Maida, C.A., & Freed, W. (2012). Treating multi-traumatized, socially- marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828.<br><br>**Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No**<br><br>**Other countries?** *(please list)* Sweden and Australia | |
| **Research Evidence** | **Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)* | **Citation** |
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* | **N =** 151<br><br>**By gender:** 35% (n = 53) male and 65% (n = 98) female<br><br>**By ethnicity:** 48% (n = 73) Hispanic, 25% (n = 38) Black or African American, 14% (n = 21) non-Hispanic White, and 13% (n = 19) Asian or other | Lanktree, C.B., Briere, J., Godbout, N., Hodges, M., Chen, K., Trimm, L., Adams, B., Maida, C.A., & Freed, W. (2012). Treating multi-traumatized, socially- marginalized children: Results of a naturalistic treatment outcome study. *Journal of Aggression, Maltreatment & Trauma, 21*, 813–828. |
| **Outcomes** | **What assessments or measures are used as part of the intervention or for research purposes, if any?**<br>Trauma Symptom Checklist for Children (TSCC and TSCC-A), Children's Depression Inventory, CBCL<br><br>**If research studies have been conducted, what were the outcomes?**<br>Significantly reduced (average of > 40%) symptoms on all trauma-related areas as measured by the TSCC: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns. | |

# ITCT-C: Integrative Treatment of Complex Trauma for Children

| | |
|---|---|
| **Implementation Requirements & Readiness** | **Space, materials or equipment requirements?**<br>Usual AV equipment set-up including capacity to show videos, multiple microphones for group interactions and discussion.<br><br>**Supervision requirements** *(e.g., review of taped sessions)***?**<br>Dependent on needs of program<br><br>**To ensure successful implementation, support should be obtained from:**<br>Cheryl Lanktree, Ph.D. (email: lanktree@usc.edu or cblanktree@gmail.com) |
| **Training Materials & Requirements** | **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** (see above citations: Lanktree & Briere, 2016; Lanktree & Briere, 2013.<br><br>**How/where is training obtained?** By contacting Dr. Lanktree<br><br>**What is the cost of training?** One-day training: $4000, Two-day training: $8000 plus associated travel expenses. Follow-up consultations via Zoom, Skype, or in person, can also be contracted with the trainer for an additional fee.<br><br>**Are intervention materials** *(handouts)* **available in other languages?**<br>❒ **Yes** ☒ **No**<br><br>**Other training materials &/or requirements** *(not included above)***:**<br>See ITCT-A fact sheet for materials available for clients 12 to 21 years. |
| **Pros & Cons/ Qualitative Impressions** | **What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**<br>Multimodal, individualized interventions based on assessment; trauma-processing related to child's self capacities while increasing affect regulation skills (such as through mindfulness-oriented interventions); highly appropriate for multiple cultural and socioeconomic groups; and addressing developmental differences in clients aged 5 years to 12 years. ITCT-C incorporates structured, direct interventions that include developmentally appropriate expressive and play-oriented interventions. Flexible time frame based on the individual needs of child and family. ITCT-C addresses challenges specifically associated with complex trauma including an emphasis on relational/ attachment processing and systemic interventions with relevant caretakers.<br><br>**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?**<br>Longer treatment sometimes required; less structured/manualized than some approaches requiring decision-making and flexibility on the part of the clinician.<br><br>**Other qualitative impressions:**<br>Client-oriented, nonstigmatizing, flexible, culturally inclusive. |

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GENERAL INFORMATION

# ITCT-C: Integrative Treatment of Complex Trauma for Children

| | |
|---|---|
| **Contact Information** | **Name:** Cheryl Lanktree, Ph.D<br>**Address:** 1137 2nd St., Suite 213, Santa Monica, CA. 90403<br>**Phone number:** (213) 701-1149 (voicemail)<br>**Email:** lanktree@usc.edu<br>**Website:** www.cblanktree.com |

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GENERAL INFORMATION

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

## Treatment Description

**Acronym** *(abbreviation)* **for intervention:** SMART

**Average length/number of sessions:** Approximately 12 months comprised of 34 individual sessions, 40 family sessions, and 24 group sessions (number of individual/family sessions may vary based on the needs of the child and family).

**Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** The family power structure, and perceptions regarding sexuality, gender roles, identity, stigmatization of mental health, and spirituality are aspects of culture that are integrated into the treatment.

**Trauma type** *(primary)*: sexual abuse

**Trauma type** *(secondary)*: Physical abuse, neglect, and community violence

**Additional descriptors** *(not included above)***:** The S.M.A.R.T. model is a structured, phased- based approach to treatment for sexually abused children who are exhibiting sexual behavior problems. The model has been successfully implemented with a primarily African American population since 1998. It incorporates already established practices proven to be effective in trauma treatment, such as CBT, as well as psycho-education and skill building to directly address the behavioral and emotional concerns associated with the experience child sexual abuse and the resultant victimizing behavior. The primary objectives of the model are: 1) to eliminate the sexual behavior problem; 2) to establish stability and a sense of safety in the lives of children; 3) to improve insight, judgment, and empathy; 4) increase awareness of personal risk patterns and triggers; 5) to develop coping skills and strategies that improve emotional and behavioral regulation; 6) to provide parents with the skills to meet their children's physical/emotional needs; and 7) Increasing children's connectedness to positive others and building internal objects that support future growth.

## Target Population

**Age range:** 3 **to** 11

**Gender:** ❒ **Males** ❒ **Females** ☒ **Both**

**Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** To date the model has been effectively used with primarily African American children.

**Other cultural characteristics** *(e.g., SES, religion)***:** Majority of families are low income; more than 50% of the children reside in foster or kinship care; most of the children have experienced multiple traumas including physical abuse, exposure to violence, traumatic grief, and neglect.

**Language***(s)***:** English

**Region** *(e.g., rural, urban)***:** Urban

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

## Essential Components

**Theoretical basis:**

The theoretical underpinnings of the S.M.A.R.T. model include Trauma theory, Multi-Systematic Family Therapy, and Cognitive Behavioral Therapy. The model also integrates concepts

**Key components:**

The model consists of three clinically essential phases: Safety & Stabilization, Trauma Integration & Recovery, and Re-Socialization & Mastery. Each phase contains content modules that must be mastered in order to move to the next phase of treatment. Each module includes specific activities and interventions and provides indicators of mastery to inform and guide clinical practice. Care giver involvement is mandatory and a combination of individual, family, and group therapy services are provided and tailored to meet the individualized needs of the child and family. To date, the average length of stay for model completion is 12 months. The S.M.A.R.T. model includes a specialized treatment workbook that was specifically designed to address issues related to victimization, victimizing, and steps towards healthy touching and relationships. The workbook provides specific activities that address the components of each stage of treatment. It serves as a tool to assist children and their care givers to better understand the impact of the trauma, triggers, and emotional needs of the children while creating a useful dialogue for the formation of the parallel trauma narratives. Ultimately, the parallel narratives are integrated into one comprehensive narrative.

Key Components: Psycho-education, Safety Contracting and Monitoring, Sexuality, and Skill Building are core components of each phase. Concepts are introduced in Phase I and the scope and intensity increase and are reinforced throughout each stage. Additional Key Concepts included in each stage are:

**Safety & Stabilization**

- Trauma Assessment
- Risk Reduction Plan
- Family and Community Engagement

**Trauma Integration & Recovery**

- Impulse Regulation
- Affect Modulation
- Trauma Triggers

**Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)**

- Cognitive Processing
- Trauma Narratives

**Re-socialization & Mastery**

- Stress/Relaxation
- Healthy Intimacy
- Self-esteem
- Relapse Prevention

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

## Clinical & Anecdotal Evidence

**Are you aware of any suggestion/evidence that this treatment may be harmful?**
❒ Yes ☒ No ❒ Uncertain

**Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 3

**This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

**Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)*? ☒ Yes ❒ No

**If YES, please include citation:**
There are annual Program Evaluation Reports for the period December 1999-December 2003 submitted to the Jessie Ball duPont Foundation who provided foundation support for the development and piloting of the model.

**Has this intervention been presented at scientific meetings?** ☒ Yes ❒ No

**If YES, please include citation***(s)* **from last five presentations:**
The model was presented as a poster presentation at the annual APSAC conference in 2003 and as a 3 hour clinical intensive session at the 15th Annual Child Abuse and Neglect Conference in 2005.

**Are there any general writings which describe the components of the intervention or how to administer it?** ☒ Yes ❒ No

**If YES, please include citation:**
The preliminary findings and descriptive features of the pilot administration are currently being written for submission for publication. In addition, a treatment manual and specialized workbook will be completed by January 2007.

**Has the intervention been replicated anywhere?** ❒ Yes ☒ No

**Other clinical and/or anecdotal evidence** *(not included above)*: Preliminary findings from data collected during the pilot are favorable and indicate that the model improves emotional and behavioral regulation in the home, school, and in the community. Data collected specific to the sexualized behavior indicates a significant reduction and in many cases the elimination of sexualized behaviors. Details of the pilot and preliminary data analyses are in the process of being written up for submission for publication. Plans to implement clinical trials with control groups are being explored.

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

| Research Evidence | Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)* | Citation |
|---|---|---|
| **Published Case Studies** | Yes | Offermann B, Johnson E, Johnson-Brooks S, Belcher H ME. (2008) Get SMART: Effective Treatment for Sexually Abused Children with Problematic Sexual Behavior. Journal of Child and Adolescent Trauma 1:179-191. |
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* | **N=**62<br>**By gender:**<br>Male=34<br>Female=28<br>**By ethnicity:**<br>African-American=38<br>Multi-racial=8<br>Hispanic=2<br>Caucasian=16<br>**By other cultural factors:**<br>Foster Care=26<br>Kinship Care= 18<br>Natural Family=16 | In progress |

**Outcomes**

**What assessments or measures are used as part of the intervention or for research purposes, if any?** During the pilot phase of model development beginning in August of 1998, the following outcome measures were utilized to assist in the formulation of clear treatment goals, inform practice, and to measure the program's success: SMART Symptom Checklist (a 26 item checklist monitoring the frequency of behaviors) was administer at intake and every month thereafter, the CAFAS/PECAFAS was administered at intake and every three months thereafter, and the Child Sexual Behavior Checklist was administered at intake and every 6 months. Follow up administration of the measures was completed at 6, 12, and 18 months post discharge for each patient.

Effective October 1, 2004, a decision was made to change the assessment/ measures protocol. Measures are administered at intake, 6 months and at discharge. Current measures include:

UCLA PTSD Index
Trauma Symptom Checklist for Children
Child Behavioral Checklist
Child Behavior Checklist- Teachers Report Form
Child Sexual Behavior Inventory
Parent Stress Index

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

| | |
|---|---|
| **Implementation Requirements & Readiness** | **Space, materials or equipment requirements?**<br>Large enough space to accommodate group treatment for between 8-10 children<br>Private treatment rooms<br>Treatment manual and workbook.<br><br>**Supervision requirements** *(e.g., review of taped sessions)***?**<br>1-2 day intensive training in the model.<br>6-month on-going expert consultation from trainers.<br>On-going Weekly individual/bi-monthly group clinical case consultations at the completion of the expert consultation.<br><br>**To ensure successful implementation, support should be obtained from:**<br>Funding stream that allows for the provision of intensive services. |
| **Training Materials & Requirements** | **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.**<br>The treatment manual and intervention workbook are in progress and anticipated to be completed by January 2007.<br><br>**How/where is training obtained?**<br>Contact developer: Betsy Offermann at the Kennedy Krieger Family Center<br><br>**What is the cost of training?**<br>Determined by the training/on-going supervision needs of the site.<br><br>**Are intervention materials** *(handouts)* **available in other languages?**<br>❒ **Yes** ☒ **No**<br><br>**Other training materials &/or requirements** *(not included above)***:**<br>Workshops at national conferences |
| **Pros & Cons/ Qualitative Impressions** | **What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**<br>• The intentional incorporation of cultural beliefs and influences promote family strengths and the development of adaptive coping responses to problematic sexualized behavior.<br>• The model is not based on Juvenile or Adult offender models and reduces stigmatization.<br>• The parallel formation of victim and victimizer narratives reduces shame, instills hope, and provides a supportive, non-threatening framework to address painful affect and content.<br><br>**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?**<br>Lack of consistent caregiver participating in treatment. The inconsistency often triggers regressions in emotional and behavioral regulation and can lead to placement disruptions. |

# SMART: Safety, Mentoring, Advocacy, Recovery, and Treatment

## Contact Information

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## References

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NCTSN The National Child Traumatic Stress Network

# Sanctuary Model

GENERAL INFORMATION

| | |
|---|---|
| **Treatment Description** | **Acronym** *(abbreviation)* **for intervention:** N/A<br><br>**Average length/number of sessions:** N/A – the Sanctuary Model is a systemwide approach to creating a trauma-informed culture.<br><br>**Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Addresses marginalization of specific cultural groups through exposure to trauma.<br><br>**Trauma type** *(primary)*: Interpersonal<br><br>**Trauma type** *(secondary)*: All types<br><br>**Additional descriptors** *(not included above)***:** The Sanctuary Model® , is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma. |
| **Target Population** | **Age range:** 4 **to** no upper limit<br><br>**Gender:** ❒ **Males** ❒ **Females** ☒ **Both**<br><br>**Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All<br><br>**Other cultural characteristics** *(e.g., SES, religion)***:** All<br><br>**Language***(s)***:** English and Spanish, but accessible for translation<br><br>**Region** *(e.g., rural, urban)***:** All |
| **Essential Components** | **Theoretical basis:**<br>The aims of the Sanctuary Model are to guide an organization in the development of a trauma-informed culture with seven dominant characteristics all of which serve goals related to recovery from trauma spectrum disorders while creating a safe environment for clients, families, staff, and administrators with measurable goals:<br><br>• Culture of Nonviolence – building and modeling safety skills and a commitment to higher goals<br>• Culture of Emotional Intelligence – teaching and modeling affect management skills<br>• Culture of Inquiry & Social Learning – building and modeling cognitive skills<br>• Culture of Shared Governance – creating and modeling civic skills of self-control, self-discipline, and administration of healthy authority<br>• Culture of Open Communication – overcoming barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries |

NCTSN The National Child Traumatic Stress Network

# Sanctuary Model

GENERAL INFORMATION

| | |
|---|---|
| **Essential Components continued** | • Culture of Social Responsibility – rebuilding social connection skills, establish healthy attachment relationships<br>• Culture of Growth and Change – restoring hope, meaning, purpose<br>**Key components:**<br>• Shared language of Safety, Emotion Management, Loss and Future in the acronym SELF<br>• Development of a core team for implementation<br>• Concrete tools for intervention: community meetings, red flag reviews, psychoeducation in trauma, self-care planning, safety plans, team meetings and treatment planning conferences. |
| **Clinical & Anecdotal Evidence** | **Are you aware of any suggestion/evidence that this treatment may be harmful?** ❒ **Yes** ☒ **No** ❒ **Uncertain**<br>**Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)*. 4<br>**This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** ❒ **Yes** ☒ **No**<br>**Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**<br>**Has this intervention been presented at scientific meetings?** ☒ **Yes** ❒ **No**<br>**Are there any general writings which describe the components of the intervention or how to administer it?** ☒ **Yes** ❒ **No**<br>**Has the intervention been replicated anywhere?** ☒ **Yes** ❒ **No**<br>**Other countries?** *(please list)* Mexico, Ecuador, Australia (pending) |

| **Research Evidence** | **Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)* | **Citation** |
|---|---|---|
| **Published Case Studies** | | Rivard, Bloom, Abramovitz, Pasquale, Duncan, McCorkle, et al., 2003 |
| **Pilot Trials/Feasibility Trials** *(w/o control groups)* | **N=**18 | Study is currently in progress at the Andrus Children's Center which measures changes in environment along domains aligned with the seven Sanctuary Commitments while measuring achievement of implementation milestones. |

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# Sanctuary Model

GENERAL INFORMATION

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|---|---|
| **Outcomes** | **What assessments or measures are used as part of the intervention or for research purposes, if any?**<br>• Demographic Survey<br>• Implementation Survey<br>• Environmental Survey, developed by the Andrus Children's Center's Department of Policy, Planning and Research.<br>• COPES, developed by Moos.<br>**If research studies have been conducted, what were the outcomes?**<br>At this time, only baseline data has been collected. |
| **Implementation Requirements & Readiness** | **Space, materials or equipment requirements?** No.<br>**Supervision requirements** *(e.g., review of taped sessions)***?** Supervision of clinicians and other service providers should include assessment of perfomance along the seven Sanctuary commitments and the use of trauma-specific interventions.<br>**To ensure successful implementation, support should be obtained from:**<br>All levels of leadership in the organization. |
| **Training Materials & Requirements** | **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Staff Training Manual, Implementation Guide,and Data Collection Manual are available through the Andrus Center for Learning and Innovation as part of the Sanctuary Leadership Development Institute.<br>**How/where is training obtained?** Training can be obtained through the Sanctuary Leadership Development Institute at the Andrus Center for Learning and Innovation.<br>**What is the cost of training?** $65,000 for 2.5 years of training and consultation<br>**Are intervention materials** *(handouts)* **available in other languages?**<br>☒ **Yes** ❒ **No**<br>**If YES, what languages?** Spanish<br>**Other training materials &/or requirements** *(not included above)***:**<br>Application and commitment from CEO required |
| **Pros & Cons/ Qualitative Impressions** | **What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**<br>Pros of the intervention are that it is easily adaptable for many cultures. It addresses the stigma of mental illness, has demonstrated reduction in restraints and improved staff retention.<br>**What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Funding for training may be difficult to obtain due to cost. Full implementation of the model may take 2-5 years. |

NCTSN The National Child Traumatic Stress Network

# Sanctuary Model

GENERAL INFORMATION

| | |
|---|---|
| **Pros & Cons/ Qualitative Impressions continued** | **Other qualitative impressions:** The model provides a common language that is accessible to staff, clients and other stakeholders. It is not rigid, and therefore, can be adapted to many settings and populations. Practitioners are encouraged to be innovative in adapting it. |
| **Contact Information** | **Name:** Dr. Sandra Bloom<br>**Address:** Andrus Children's Center, 1156 North Broadway, Yonkers, NY 10701<br>**Phone number:** 914-965-3700<br>**Website:** www.sanctuaryweb.com |
| **References** | Rivard, J. C., Bloom, S. L., Abramovitz, R., Pasquale, L. E., Duncan, M., McCorkle, D., et al. (2003). Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. *Psychiatric Quarterly, 74*, 137-154. |

**The Internal Family Systems Model**

The Internal Family Systems Model is both an accurate map of the personality system and a form of psychotherapy developed by Richard Schwartz that is compassionate, inclusive, spiritual, powerfully healing and deeply respectfully of our inner life.

This paper is intended to help you get to know and work with your system.

**Basic Assumptions:**

- Multiplicity of the Mind: the mind consists of a number of sub-personalities or "parts". You'll notice this when, for example, a friend asks you to an event and you respond with, "Well a part of me wants to go but a part of me doesn't." We speak for our parts all the time – we just often don't notice it.
- As we develop, parts form a system of interactions among themselves – just like a family. Some parts like each other and some parts don't. But they all have your best interest at heart from their own perspective. If parts are in difficult positions that they don't like (feeling overworked or not feeling good about themselves) when we pay attention to them and help the system reorganize, they can change rapidly.
- Everybody has a "Self" – has the qualities that can and should lead the internal system.
- There are no 'bad' parts and the goal of working with the system is not to eliminate parts but instead to help them take on the roles they would like.
- When your internal system changes then the external system changes and vice versa. For example if an angry protector part always responds to somebody asking you to do something, and you pay attention to the protector and get permission to help out the part it is protecting, (which may be feeling controlled by the other person for example) then the next time they ask you to do something you will find yourself responding differently. The angry protector no longer needs to take the lead as the part feeling "controlled" is no longer feeling burdened.

**By paying attention to your system you can:**

- Feel more balanced and easy by recognising your parts; at the same time sharing your Self (Courage, creativity, clarity, compassion etc.) with them
- Guide parts to release burdens/difficult experiences and transform into their preferred roles in the system.
- Improve the quality of your relationships as you bring more Self to them.

**IFS Concepts: Self**

Connectedness Courage Calmness Curiousity Confidence Creativity Compassion Clarity

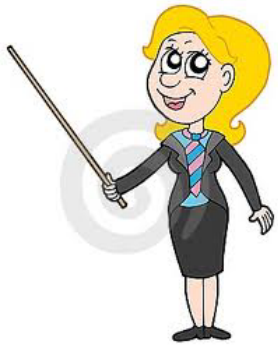
Self exists in everyone. It is present at birth – distinct from parts. It is the aspect of our being that is free of ego.

Self is the seat of consciousness, of who we are and has the qualities of a natural leader. It is the place from which we can watch, experience and be with the parts and with other people in an easy and relaxed way.
When we recognise and come from our Self we have the qualities of calmness, curiosity, connectedness, confidence, creativity, courage and clarity. When you consider people you admire and feel supported by they probably show a lot of Self energy in their relationship with you.

**Parts:** Sub-personalities/aspects of our personality

- Interact inside in ways that are similar to the ways that people interact externally. Some like each other and some don't and they all act in ways they consider good for you – unless they are exiled and in distress.
- They are experienced in a number of ways – thoughts, feelings, sensations, images, sounds, physical symptoms.
- All want something positive for you and will use different strategies to get your attention (showing up as depression, making you "space out", doing addictive things, bursts of feelings, telling you that you "should" be different from how you are etc.)
- They are organized to protect you (Self) and to do so may take on extreme roles by either dominating or hiding (protectors). Some, like the Exiles, hold the burdens of pain and vulnerability.
- Protective parts are referred to as either Managers or Firefighters depending on if they are proactive (trying to stop a vulnerable part from being activated) or reactive (trying to distract from a vulnerable part that has been triggered).
- Exiled parts are often young parts holding extreme feelings and/or beliefs that become isolated from the rest of the system (such as "I'm worthless").

**Managers:**



These are the parts that are **pro-active** and run your day-to-day life .

They seek to maintain balance within the system by keeping us in control of every relationship and situation in an effort to prevent the feelings of the exiles - pain, shame, fear of rejection etc. coming through and taking us over. They do this in a number of ways:

- Controlling their environment, the body and others.
- People pleasing or taking care of others
- Trying to be perfect
- Criticising/Evaluating/Judging self and others
- Avoiding risks/Worrying/Apathy
- Achieving/Striving/Pressuring
- Being passive and pessimistic
- Denial/Numbing/Shutting down

They are ***experienced*** or seen in the body as:

Holding, containing, rigidity of the body, breath constriction, tension, pain, restrained impulses, body armouring and muscle constriction.

They ***relate*** to the body by:

manipulating (including weight gain or loss), criticizing, neglecting, distorting perceptions, numbing and punishing.

Often a manager part will claim to be you (they like to run the show).

If you know someone who seems really tight and restricted in their way of being then chances are they are manager-led.

**Common Fears of Managers:**

- That the exiles will take over and flood the system. There will be no return from the dreaded 'black hole'. Often this is based on remembering a time when the exile was completely blended and the system was stuck in complete shame or fear. Manager parts say "Never again!" and work hard to prevent that from happening.
- That getting to know exiles and exploring deeper will 'trigger' dangerous firefighter backlash.
- That you will be overwhelmed by the exiles or be repulsed or contaminated by them.
- That 'secrets' the system cannot handle, will become exposed.
- They cannot see the benefit of going deeper as it invites more pain. They may think that they are too damaged to ever get better.
- Doing internal work will result in unwelcome and possibly dangerous changes in external relations.

**Firefighters:**

These are the **reactive** protectors – they are heroic, impulsive, and often seen as destructive and narcissistic by manager parts. The goal of the firefighter is keep exiles away from you – to distract from or get rid of their feelings.

They come into play when the exiles are activated – they distract or dissociate to prevent overwhelm or flooding of the inner system.

Managers want you to look good and be approved of, FFs only care about distracting from the pain of the exile so manager parts are often in opposition to FFS – disapproving and judging.You can often hear the two voices playing out in your head:

- "You were too wild at that party last night. "
- "But I was having fun, what's wrong with that?"
- "People will think you're an idiot…"

Etc, etc. When these two parts are battling it out in your head the exile remains lost – nobody is paying attention to it.

Firefighters may often experience their role as burdensome and may welcome the transformation to an easier role once they know it is possible.

They are often ***experienced*** in the body as:

=> anxiety
=> panic
=> hyper-vigilance
=> digestive problems
=> pains
=> illness
=> cravings and impulses.

They ***relate*** to the body by:

attempting to soothe and may use chemical substances, self-mutilation, numbing, eating and sleeping disorders, sexual acting out, and other strategies to ease the distress coming from the exiled part.

**Working with Firefighters:**

Do not try to 'manage' them – you may need to address your own fearful Managers when you're getting to know your firefighters. It helps to:

- Form a compassionate, appreciative relationship with the FF part to let it know you are genuinely grateful for how it has supported you until now and to negotiate access to the exile so that you can help both to transform less extreme roles.
- Look for those parts polarized with the ff parts – usually Manager parts that are critical of them
- Negotiate respectfully and remember the power of these parts in the system.

**Exiles:**

These are young parts that may have experienced trauma and/or neglect and other overwhelming experiences. They often become isolated from the rest of the system for their own protection and for the system's protection.

They hold the memories, sensations and emotions of difficult events and are stuck in the past. When activated Exiles present with extreme feelings and/or beliefs. They can become increasingly desperate in their effort to be cared for and to have their story told.

Once relieved of the burdens that they carry they are usually the most sensitive, vulnerable, playful, innocent, creative and intimacy-loving parts.

Exiles can be ***experienced*** or seen in the body as feelings of emptiness, lethargy, depression, shame, pain etc.

Exiles may ***relate*** to the body by numbing, freezing, immobilizing the body; depleting energy and/or overwhelming with emotion and sensation.

**Neo-exiles**: These are parts that are exiled by our relationships and may be seen as threatening to our partners.

**Burdens:**

These are the beliefs, memories, emotions and sensations that accumulate from past experiences. There is often a core belief or wound being held by a part and it is helpful to discover,

- "What does this part say about itself?" (e.g. "I'm worthless")
- "What was the message it got?" (e.g. A parent saying "I wish I hadn't had kids!")
- "What meaning did it make of that?" (e.g. "I shouldn't have been born")

Exiles attempt to tell their story through words, images, behaviours, sensations, movement, dreams, physical symptoms or illness. In the example above you might notice that each time you don't succeed (failing a job interview, breaking up a relationship) this burdened part will try and get your attention ("I guess I didn't deserve that job, him/her" etc). Once the story is witnessed and the full weight of the distress recognised, the burdens can be released.

**IFS Process**

**Accessing Parts** There are various ways to access your parts:

- Situational – re-experience an upsetting situation. You can focus on what happened to connect with the part(s) that got activated.
- Emotional – access feelings that are already present.
- Somatic – locate feeling in the body.
- Visual/Sensory – describe what feeling looks like – colour, shape, size, density, image?
- Verbal – access the feeling via message it carries.

**You may ask yourself:**

"Is there a part of me that I'd like to get to know better?"

"What part is here right now?"

"What do I notice in or around my body?" "How do I sense or experience it?"

"Does it feel alright to focus on it right now or are there concerns about doing that?"

**Checking for Self Leadership**

Once you have located a part check the following:

"How do I feel towards this part? Do I feel open to it?""

"How do I experience the quality of the connection with this part?"

"Is there a heart connection there or is something else going on?"

"How do I feel as I look at the part?"

**Being Present:**

How close are you to the part?

How close can you get to the part? Close enough to sense what it is feeling, but not so close that it overwhelms you?

Is it possible to stay very present with this part – no pushing – no rushing – no agenda?

**Unblending (if necessary):**

Blending happens when a part takes you over, often saying it feels like you. Remember: if the experience of yourself is not that you feel easy, open and relaxed then chances are a part is blending with you (anxious/depressed/annoyed/unhappy etc).

Unblending and getting access to Self is the heart of the work, and it is often difficult to do. Be patient and know that it will become easier.

One approach is to remember a time in your life when you felt calm, or a sense of inner peace; felt full of love or compassion for someone. You can begin to separate parts from Self by asking various questions.

- "Would you separate from me, so that I can look at you and get to know you?" (*If this is the part that you are trying to get to know*)
- "Would you consider stepping back or out of my body into a witnessing role?" (*If this is **not** the part you are trying to get to know)*
- "What are you concerned might happen if you did step back?"

Keep working with your parts and remember that the protectors are serving you. As you appreciate them for their work and reassure them about their concerns they will begin to trust you.

**Creating Trusting Relationships**

When you are in Self Leadership, you may experience compassion towards the parts that are hurting in some way. If there seems to be sufficient 'Self' energy (such as calmness and curiosity) let the part know:

- That you are aware of it
- Who you are (and how old you are) so it doesn't confuse you with another part
- That you would you like to send it your acceptance/appreciation/compassion/love

Check to see if there are parts in the way of having your heart be open to the part, and if so see what their concerns are about you opening to it. Creating trusting relationships in the internal system is important.
Sometimes a part may be mad at you for not having been around or feel like it doesn't and can't trust you. Often this will activate other parts that want to respond. If so just let them know you've got it covered. A part has every right to not trust or be mad at you. Can you be curious about that?

**Identifying the Role of the Part:**

Assess the role/function/purpose of the part you are getting to know by asking:

- "What is your job? What do you do for me?"
- "Tell me what you want me to know about you"
- "Do you like what you are doing and how you do it?"
- "Can you tell me about when you started doing this?"
- "What are you afraid would happen if you did not do this job?"
- "If you did not do this job, is there something else you would like to do?"

**Addressing Concerns/Fears:**

Identify and validate what the part is afraid of and offer reassurance that all concerns will be addressed before proceeding further.

"What is the part afraid would happen if ....?" (You kept getting to know an exiled part)

**Offering Realistic Hope:**

"What if we could do this without your worst fears happening?"

"How would it be for this part if you were able to .....?" (Get to know the other part without the concern being realised?)

**Getting Permission to Work with an Exile:**

Your manager and firefighter protectors have been around for a long time helping protect you and/or the exiled part. It is respectful to get permission from them to get to know the distressed part (if it is an exile) by asking:

- "Is it alright with you (*manager/firefighter part)* if I get to know this part?"
- "If I could ensure that I will not get stuck in their pain would you be interested in allowing access to the parts that are feeling (sad, scared, lost etc)"
- "Would it be okay for to witness while I work with this part?"
- "If it looks like it may be too much would you be willing to come in and shut down the communication?"
- "If I were to be able to help these parts to feel better would you still have to do what you do?" (Sometimes protectors are *driven* to do what they do (overwork/rage) by the presence of the exile. Once the exile is unburdened they can *choose* to do what they have always done; but need not be driven to do it. This is often very appealing to protectors.
- "What would you like to do instead if you could?"

**Unburdening of the Exiles:**

- Check that you feel yourSelf close to the part without blending/flooding. Sometimes exiled parts are so relieved that you are there that they may flood the system with what they are holding. You can ask them not to do that as it will only serve to activate your protectors which means you cannot stay with them. Let them know that you get how big the feelings are.

- As you pay attention to the Exile's story, memories, feelings and/or sensations and it shows you where it is stuck in the past you can identify and validate its beliefs. If a part wants to minimise, discount, soothe or argue with an exile's beliefs ask it not to do that. It is important to fully witness what the exile is holding without moving to change it.

- If it feels right you can enter the past scene and do what the part tells you it needs to be done. The Exile may need to be removed from an unsafe place and be retrieved into the present time.

- Unburdening ritual: Once the Exile has told you everything about what it is holding you can invite it to bundle all those worries, concerns, feelings, beliefs etc and to send them away permanently to light/air/fire/earth/water or anything else.

- Invite the part to breathe in whatever qualities will help it to move forward now.

- If the part is no longer stuck in the scene in the past ask it where it would like to settle now. Parts may want to be with other parts, live in your heart or mind, grow up, stay the age they are but in a better place like a park or playground… be open to what the part is seeking and give it your blessing.

- Check with other parts that may react to the unburdening by inviting any and all parts connected to the Exile to notice this shift. Invite comments or concerns and address the concerns (such as, "What do I do now that I'm not protecting this part anymore?")

- Thank all the parts that trusted, stepped aside, transformed.

In a sense the work here may be regarded as information transfer. The exiles hold distressing information in the form of feelings and beliefs that they have taken on. Once they have let you know everything that has been hard for them they can release it and return to their preferred place. It is not dissimilar to a child telling a trusted adult about something that worries them, and then once reassured dancing off to play with their friends.
Had there been a trusted adult around to reassure the young child at the time it was upset then it would not have become stuck in the past as an exiled part. Yet now it can be helped.

**Polarizations**

A polarization occurs when two parts or clusters of parts seemingly operate at cross-purposes develop an on-going, escalating power struggle while attempting to control a behaviour, outcome or decision.

This escalated inner conflict is typically between parts that are protecting the system with vastly different approaches. Since virtually all manager activities are considered socially acceptable and oftentimes even socially desirable behaviours, even the external environment of the family, work and the culture supports and encourages these behaviours, as in, “If I work hard, I will get ahead” or “If I am nice to people, they will like me.”

This is in contrast to many of the firefighter activities, which are often impulsive and risk-taking. These behaviours cause concerned managers to want to seek control as they judge the firefighter activity as wrong and often dangerous. As each side battles to determine which parts can best protect the person’s functioning and best maintain inner stability there is a near constant tension within the system.

This power struggle can escalate into a cycle of addiction that includes compulsive, repetitive firefighter behaviours with their characteristic chaotic or impulsive acting out and managers that are extremely judgmental, fuelling intense inner self-criticism or self-loathing. Generally in an addiction cycle, the same protective parts interact over and over again, often without ever acknowledging the existence of the sensitive, fragile emotions that are underlying and fuelling these warring parts; those parts are exiled.

**How to work with Polarized Parts:**

- Find the different parts in your body
- Focus on the parts one at a time, letting them know they will both be heard.
- Reassure the parts that you are not going to collude with one part over another.
- Explore the concerns of the parts.
- Have parts share their concerns with each other.
- Support a Self-led resolution.

The unburdening of the exiles protected by both factions may be necessary for genuine healing and permanent internal change.

**Techniques for getting to know your Parts**

There are various ways to get to know your parts.

**Concretise** If they are willing to unblend a little from you then you can choose an object to represent them. Say for example a young girl part would like your attention, you could select a doll, a rock, a piece of wood, whatever she would like and place it (her) in your home where you could acknowledge her each day

**Journal** Another technique is to journal from part to part or part to Self. Divide the page in 2 and start the dialogue on the left hand side, then continue from another part on the right: This is an example of a firefighter/manager dialogue. This conversation has probably occurred many times in the system and by putting it outside and perhaps revisiting it the next day it can become clear how there is an exiled part connected to these protectors (I would assume a young part scared of its father's anger).

| | |
|---|---|
| My Dad is driving me crazy! I'm going to have to tell him to back off. | Come on be reasonable, that's just how he is. |
| Well maybe I'm finally tired of you excusing him – what's so wrong about standing up to him? | If you do that he might get mad at us. |
| So What? I can stand up for myself, I'm an adult | |

**Email** You can set up an account for your parts. For example if someone is driving you crazy and you're mad at them (your firefighter is triggered) then you can fire off and angry email to your own designated account. Later when the firefighter energy has cooled you can open it, witness the firefighter and perhaps enquire about the exile to which it is connected.

**Video** If you have a webcam you can make short videos for yourself speaking from a blended part. You can then review them later and learn about what that part is holding.

**3-D Parts** This tool is called the Youniverse and is available from David Cantor at www.davidcantor.net/ You can move parts around the Self as you explore your system.
You may also use a sandtray or drawing/painting to become more clear about your system.

**Meditation** Some meditation techniques regard thoughts and feelings as distractions to be excluded from the focus of the meditation. Using meditation to connect with parts differs from these techniques. The point here is to bring the attention *to* the parts.
One method is to sit quietly and ask your parts to separate out a bit. If they have a concern about this then just bring your attention to what their concern may be. If they separate out you feel expansiveness in your system. When it feels right ask whatever parts would like some attention to let you know about themselves. Or simply sit and a part will present itself to you.
The CD - "Meditations for Self" by Richard C. Schwartz is available from the Centre for Self-Leadership (web address below)

**********

**A Last Word**

I hope this handout is helpful to you.
For more information about IFS please visit

- Me (Derek Scott) at www.yourtherapist.org
- The Centre for Self-Leadership at www.selfleadership.org

And to have a place to talk about your work with your own system check out the Facebook Page: IFS Me and My Parts at
http://www.facebook.com/pages/IFS-Me-and-My-Parts/181763701840869?v=wall

## Models of treatment for families



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## Family Empowerment

Charles Figley 1986

- Once the therapeutic relationship has been developed, Figley's Family Empowerment Model is used to assist families to resolve conflicts associated with the traumatic event and to develop a healing theory to enable family members to recognize the strengths that allowed them to survive and move on with their lives.
- Focus:
  - Acute Stress in Family
  - Acute Stress Disorders in Families
  - Posttraumatic Stress Disorder and it's impact on families



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## ARC: Attachment, Self-Regulation, and Competency

Blaustein & Kinniburgh

A Comprehensive Framework for Intervention with Complexly Traumatized Youth

- Age range 2-21
- This approach is grounded in four primary theoretical/empirical literatures:
  1. attachment theory
  2. child development
  3. traumatic stress impact
  4. factors promoting resilience



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## ITCT: Integrative Treatment of Complex Trauma

**John Brier & Cheryl Langtree**

Treatment of Complex Trauma for Adolescents (ITCT-A), is being adopted by a growing number of treatment centers for adolescent trauma survivors in the United States and beyond.

- Age range: 10 to 21
- Average number of sessions 16 to 36
- multiple treatment modalities:
- cognitive therapy,
- exposure therapy,
- play therapy,
- relational treatment
- family therapy also integrated into treatment.



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## PCIT: Parent-Child Interaction Therapy

PCIT is an evidenced-based treatment model with highly specified, step-by-step, live coached sessions with both the parent/caregiver and the child. Parents learn skills through PCIT didactic sessions.

**Age Range 2-12**



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## Strengthening Family Coping Resources: Multi-family Group for Families Impacted by Trauma

Uses family ritual and routine to increase the family's sense of safety, stability, and ability to cope with crises. Intended to help families regulate their emotions and behaviors and improve family communication about and understanding of the traumas they have experienced. Consists of a 15-week multifamily group process that includes work on storytelling and creation of a family trauma narrative.

a. Age range 0-adult
b. All members of the family are encouraged to attend. Developmentally relevant breakout groups address all ages from infants to grandparents
c. Skills based



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## Child-Parent Psychotherapy

- Average length/number of sessions: 50
- Integrates a focus on the way the trauma has affected the parent-child relationship
- and the family's connection to their culture and cultural beliefs, spirituality,
- intergenerational transmission of trauma, historical trauma, immigration experiences,
- parenting practices, and traditional cultural values.
- Dyadic attachment-based treatment for young children exposed to interpersonal violence.



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## Trauma Adapted Family Connections (TA-FC)

TA-FC builds on the Family Connections (FC) program, an evidence based neglect prevention intervention. Core components of the model include:

1. **trauma-focused family assessment and engagement**
2. **psycho-education to teach family members about trauma symptomatology**
3. **a focus on building safety capacity within the community and immediate environment**
4. **trauma informed parenting practices and intergenerational family strengthening and communication**
5. **trauma informed in-depth family and individual work including emergency response to help the family meet the basic needs of their children, advocacy and referral.**

A promising treatment; The outcome evaluation for TA-FC includes the use of any of the above listed measures for baseline and follow-up assessments across multiple domains of identified risk and protective factors.



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## Section #15



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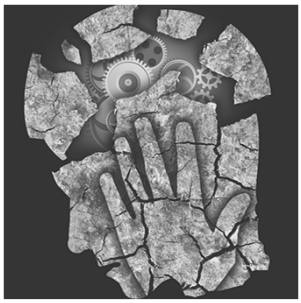
## Section # 16

**A trauma informed use of language and communication**

- Communicate in a trauma sensitive way with everyone
- What do you need to know to communicate with trauma clients?
- How do you make communication come together and be powerful?





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## Trauma-informed or sensitive communication

- To communicate with sensitivity requires that we, ourselves be in the Bruce Banner Brain (or) in a calm and balanced central nervous system (CNS)
- To communicate in a trauma-informed way requires deliberate intentionality and focus on our part.

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## What does Trauma-informed communication look like?

- Relaxed in body
- Stays in the present
- Cultivates comfort with inner silence
- Pause and reflect on deepest or primary values
- Increase our positive expectations
- Access pleasant
- Be observant
- Express appreciation
- Speak warmly
- Speak slowly
- Be brief (sentences no more than 7-10 words)
- Listen deeply with intent



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## The nature of human communication

**Once connected we move into reliance on subtext rather than content as our primary communication.**

**What does that really mean?**



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## We us subtext in intimate relationships

**Typical statements:**

- **The trash is full**

**Subtext???**

- Some action should be taken to change this status
- Someone should take the action to change the status
- Assumes one's knowledge of a process of moving from empty to full
- Assigns some value to fullness/emptiness



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## Benign subtext assumptions:

- They have acted in some way before
- They have acted on multiple occasions
- They can recognize distinction in their bodily experience
- They can recognize distinction in their emotional experience
- They can recognize distinction in their thinking experience
- They can recognize distinction in their sensory experience
- They can order their own experience
- They can articulate their own history
- They have competence in self-examination
- They have competence in self-reflective
- They can evaluate their own history
- The can articulate their experience



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## Ask a typical mental health question!

1. How many day per week do you use. . .
2. How many different street drugs have you used in the last three months . . .
3. What is your history of being abused emotionally, sexually, physically or by neglect?

***Questions taken from psychiatric intake document***



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## SUBTEXT example explorations

**When was the very first time… you remember waiting … before you used. . . . ?**

***Assumptions:***

- They have waited before acting
- They have waited before acting on multiple occasions
- They can order their own experience
- They can articulate their own history
- They have competence in self-examination
- They can be self-reflective
- They can evaluate their own history



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## SUBTEXT example explorations

**Where in your body…. do you first notice the sneaky rage monster creeping up on you?**

**When was the last time… that the Rage monster wasn't peaking around a corner hoping you would ask them in?**



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## Difference between strength based and capacity based questions

**Strength based ????**

- What is working well?
- Can you think of things you have done to help things go well?
- What have you tried? And what has been helpful?
- Tell me about what other people are contributing to things going well for you?

**Capacity based ????**

- What is the first thing you noticed working well?
- What is one of the essential things you have done to get things going forward?
- What is a key thing have you tried that has been helpful?
- How did you first learn to let other people contribute help and support to move you forward?



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## Difference between strength based and capacity based questions

Strength based ????

- How have you faced the challenges you have had?
- How have people around you helped you overcome challenges?

Capacity based ????

- How did you first decide to face the challenges you had?
- What was the most important thing you decided that has helped you accept help from other people?



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## Question examples and discussion

- What is the first thing you discovered about yourself that has helped you . . . . ?
- How did you begin to discover the first thing that helped you?
- What things did you have to look at before you found that thing that has helped?
- When you were evaluating the different things that you might be able to do, what seemed to be the most important?
- When you found that you could do . . . you gave yourself permission to act on it…what was the first thing you did to give yourself that permission



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## Question examples

- What was the first thing you decided to help you begin this process you went through?
- What were specific reasons that it was Ok to give yourself permission to act in your own best interest?
- Letting go of familiar ways of thought can really be uncomfortable, what was the first thing you discovered you could do to get yourself to tolerate moving through the discomfort.
- What was one of the most important things you thought of doing and decided not to act on?



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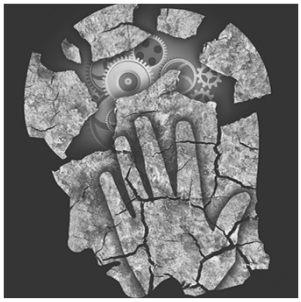
## Section # 16

**A trauma informed use of language and communication**

- Communicate in a trauma sensitive way with everyone
- What do you need to know to communicate with trauma clients?
- How do you make communication come together and be powerful?





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## Section #17

Beginning the narrative process




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## Creating a time line

- **Never the prejudicial words of:**
  - **Trauma**
  - **Issues**
  - **Problem behaviors**
  - **Rape**
  - **Assault**
  - **Domestic Violence**
  - **Diagnosis**
  - **Fear**
  - **Anxiety**

**Because of the way we use language in Mental Health; clients report:**

- 64 % anticipate discrimination and marginalization that stops them applying for work, training or education
- 55 % stop looking for a close relationship
- 80 % claim having a diagnosis made life more difficult.
- 88 % think the public associated diagnosis with violence and/or danger to the public

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## Beginning

- **Explain you are needing to have a better understanding of how things work for their family.**
- **Explain that a time line is a list of positives and negatives that have happened to each person in the family:**
  - Give examples of both positive and negative things and then how you would summarize them into small 3-4 word statements
  - Start with the oldest to the youngest
  - Remind them of the first rule
- **Begin with the safe items:**
  - Foster parents or adoptive parents also need to be able to create a timeline.
  - Then compare if their timeline is different or similar to the child and what might those similarities or differences lead to?

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## Next step

- Go back over the items one at a time
- Focus on the negative ones – ask on a scale of 0-10, 10 being the strongest let's rank these experiences.
  - Ground them as you ask…*(looking back, how disturbing was it when you first experienced it, and as you sit in your chair now looking at it how disturbing do you find it?)*
- When you have them ranked….go back and ask the following type of questions:
  - Pick things that have significantly changed 4-5 points, and ask "what did you actively do to move this down?" "What is the first thing you can recall that let you know things were move in a better direction with this?"

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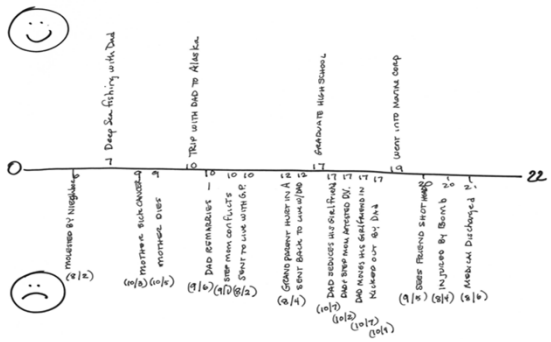


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## Section #17

Beginning the narrative process


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## Section #18

**Skill building to work through the narrative with a client**

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## COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

**Deconstruct an experience with a focus on uncovering <u>ACTION</u> oriented movement through adaption and mitigation.**

a. Every situation is full of data. The client has been focused on the pain, misery and hurt of their experiences based on what their system tells them is relevant.
b. Deconstruct the situations in "great" detail focusing on process rather than emotion.
c. Focus on actions over thinking and emoting
d. Since the natural focus is on the situation and the related distress, be careful to keep the client focused on their actions



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## COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

**Let the client then connect and make meaning out of the action pieces of their adaption and mitigation narrative.**

a. Do not tell or instruct the client, instead have them make the action oriented connections between the parts of their story.
b. Encourage the client make connections with multiple parts

**Summarize the connected ideas, themes, patterns into a short statement**

a. Create a brief summary statement captures all of the elements of the connected parts
b. Clarify the statement



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## COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

**Fine tune the statement until it is a clear statement, *then* ask them to give examples of it (what would someone see you doing that would suggest you are . . . .?)**

a. Generate 4-5 action statements that are descriptors of the summary statement in action.
b. Review the action statements and make certain that they reflect actions

**Now that we understand the competency, give it a name…the more personally meaningful to the client the more effect this will be.**

a. Humor or well known characters work well
b. Creative names are also easy for people to remember

*Like-a-tude-us* *Bump, bump and sway*
*Taz-tastic* *Pepe' Le Pew*
*Speedy Gonzales*



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**COMPETENCY AND CAPACITY DISCOVERY WORKSHEET**

If I said ….would you immediately think of….. (review the 4-5 action steps) if I were to use the label, would you be able to recall the action steps.

a. Walk them through 2-3 examples of how they could apply this process to a situation
b. If you could see yourself apply (". . . . . .") when ever you needed to, how would that change how you see yourself?



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## Section #1

**Skill building to work through the narrative with a client**



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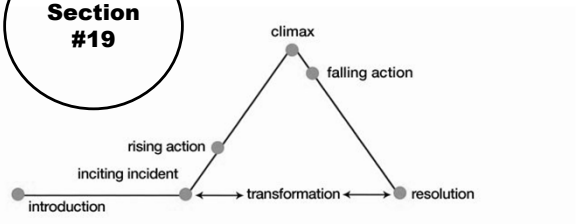
**Section #19**

## Moving through the narrative



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# COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

*Process of helping one to discover competency:*

1. Deconstruct an experience with a focus on uncovering **ACTION** oriented movement through adaption and mitigation.
    a. Every situation is full of data. The client has been focused on the pain, misery and hurt of their experiences based on what their system tells them is relevant.
    b. Deconstruct the situations in "great" detail focusing on process rather than emotion.
    c. Focus on actions over thinking and emoting
    d. Since the natural focus is on the situation and the related distress, be careful to keep the client focused on their actions
2. Let the client then connect and make meaning out of the action pieces of their adaption and mitigation.
    a. Do not tell or instruct the client, instead have them make the action oriented connections between the parts of their story.
    b. Encourage the client make connections with multiple parts
3. Summarize the connected ideas, themes, patterns into a short statement
    a. Create a brief summary statement captures all of the elements of the connected parts
    b. Clarify the statement
4. Fine tune the statement until it is a clear statement, ***then*** ask them to give examples of it (what would someone see you doing that would suggest you are . . . .?)
    a. Generate 4-5 action statements that are descriptors of the summary statement in action.
    b. Review the action statements and make certain that they reflect actions
5. Now that we understand the competency, give it a name…the more personally meaningful to the client the more effect this will be.
    a. Humor or well known characters work well
    b. Creative names are also easy for people to remember
        i. Like-a-tude-us
        ii. Bump, bump and sway
        iii. Taz-tastic
        iv. Pepe' Le Pew
        v. Speedy Gonzales
6. If I said ….would you immediately think of….. (review the 4-5 action steps) if I were to use the label, would you be able to recall the action steps.

## YOUR GOAL IS TO DEVELOP 15-20 CAPACITIES THAT WILL FORTIFY THE CLIENT

| Worksheet | | | |
|---|---|---|---|
| **Connection #1** | **Connection #2** | **Connection #3** | **Connection #4** |
| | | | |

**Summary statement**

**Action statements:**

1.

2.

3.

4.

**The client's creative name to label this set of actions**

# COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

*Process of helping one to discover competency:*

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## Traumatic Memory Processing

Trauma Memory Processing

Exercise

Graphic Narrative

- Use Large Paper
- Draw the events of the trauma in chronological order

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| | | |
|---|---|---|
| Before any idea that anything was going to happen | | |
| | Worst possible moment | |
| | | When the fear and upset were over or manageable |

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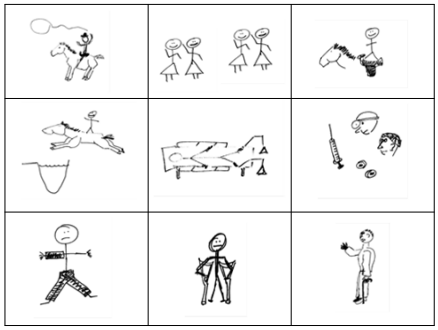

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## Story Board Reprocessing

1. **Establish a timeline**. Establishing when and where the story takes place, and deciding in which order the events of the story happen chronologically.
2. **Identify the key scenes in your story.** A storyboard is meant to give the gist of the story. The point isn't to try to recreate the entire experience, but to demonstrate important key parts.
3. **Draw out of what each cell will show.** Now that you know what main scenes you want to show, think about how to write about it.
4. **Write a description of what each cell shows.**

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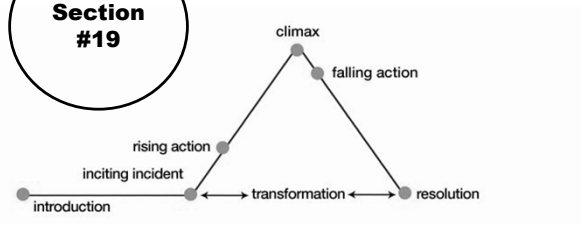
## Moving through the narrative

**Section #19**

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