Making Virtual Psychotherapy a Relational Experience

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3 CPD Hours

Making Virtual Psychotherapy a Relational Experience: Creating the Sense of Connection from a Distance

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We all now live in a traumatic environment. . .

"Psychological trauma is **the unique individual experience of an event, a series of events, or a set of enduring conditions**, in which:

- The individual's ability to tolerate or integrate the emotional and physical experience is overwhelmed (eg, s/he dissociates), **and/or**
- **The individual experiences a sense of threat to life, bodily integrity, or sanity."**

Saakvitne et al, 2000

Sensorimotor Psychotherapy™ Institute 2012

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Trauma's Different Sources Ogden 2002

Attack	Medical/surgical	Religious Trauma
Child Abuse	Pandemic	Ritual Abuse
Neglect	Natural Disaster	Terrorism
Torture, Captivity	Racial Trauma	Pre/Perinatal
Trans-generational		Accidents
Inside Threat	Loss/Death	Persecution
Vicarious Trauma	War	

Sensorimotor Psychotherapy™ Institute 2012

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Neuroception: sensing that we are in danger

Porges, 2004

Autonomic Nervous System
Using "neuroception" (the neural circuits that sense or detect danger), we instinctively evaluate dangers and employ the most adaptive defensive responses

Safety: Ventral vagal system facilitates impulses to engage with others, using voice, eye contact, facial expression, signalling

Danger: Sympathetic arousal evokes fear and action: fight, flight, or other self-protective impulses

Life Threat: Dorsal vagal activation facilitates defensive strategy of total submission: numb, collapsed, dissociated

Social engagement system **Mobilizing defenses** **Immobilizing defenses**

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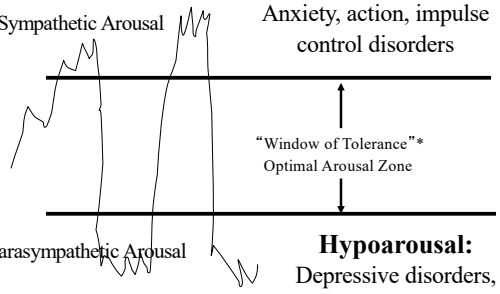
Our Nervous Systems Respond to Threat



Hyperarousal:
Anxiety, action, impulse control disorders

"Window of Tolerance"*
Optimal Arousal Zone

Hypoarousal:
Depressive disorders, hopelessness, shame

Ogden and Minton (2000)
*Siegel, D. (1999)

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When we 'neurocept' COVID-19. .

- **"Biased neuroception"** resulting from previous trauma may us feel in **more** or **less** danger than we really are
- **"When the going gets tough, the tough get going:"** sympathetic responses drive action-taking. We shop, sanitize, research the virus online, and sanitize again!
- **Collaboration and community:** social engagement responses can move some of us to connect **more** with others when we are anxious or to withdraw and isolate
- **When we isolate, it can feel like empowered action, OR** it can feel more like 'feigned death,' **OR** it can feel as we have been abandoned by the world

Fisher, 2020

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Implicit memories are triggered, not recalled, cont.

•The COVID-19 situation is especially difficult because **there is a real and present threat, AND that threat is also a trigger** for trauma-related feeling and body memories

•**The combination represents a 'double whammy' for traumatized individuals.** Experts are clear that isolation is an act of self-protection from the coronavirus, but isolation may be too triggering to **feel** self-protective for many

•**Another challenge for the therapist is if and how to name the role of triggering** in the client's state of distress without empathically failing the client during a time of stress

Fisher, 2020

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Challenges of Working Remotely

- **Technical issues:** finding the right platform for remote work, over-coming techno-phobia, problems with connectivity (freezing, loss of signal, fragmenting images)
- **Lack of privacy for therapist and/or client:** children, pets, and other adults are also working from home!
- **Two-dimensional space** is different from three-dimensional space: we can't 'read' clients as easily
- **The threat outside** is distracting, anxiety-provoking, and time-consuming for client and therapist
- **Beliefs** shared by client and/or therapist **about the need for physical proximity** to feel emotionally close

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Addressing these challenges virtually

- As if the coronavirus crisis were not enough stress, **therapists have to manage their own anxiety AND try to 'be there' for their clients**—in a new complicated way without the benefit of 'being with' the individuals
- Many therapists have been stressed by the challenges of learning how to manage the technical details of telehealth platforms, **AND** managing aspects of practice like billing issues and client crises from a distance
- **For many of us, ethical questions arise:** can we offer "good enough" therapy from a distance? What do I do if the client is suicidal or abusing substances?

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Addressing these challenges virtually, cont.

- For most therapists, **the biggest challenge is the lack of proximity:** the transition from three-dimensional space to two-dimensional, from 'felt' contact to visual
- Clients, too, are often triggered by the loss of close proximity, especially those who are already isolated or who have few safe, supportive people in their lives. Also, **clients who have struggled with proximity issues prior to the crisis**, who are rejection-sensitive or easily feel abandoned, **may react strongly to the virtual space**
- For some clients, **the crisis may be less frightening than their triggered 'feeling memories' of aloneness.**

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Longing for Proximity

- As another complication, **the longing for proximity and physical presence can be a feeling memory.** Feeling abandoned, unwanted, painfully alone, and at risk may have been a daily state for many clients
- It is the implicit memories of longing for connection that used to make it difficult for certain clients to tolerate the days and hours between sessions **before** the crisis
- These feeling and somatic memories will naturally be re-triggered by telehealth because, **in a virtual session, the therapist is 'there' but not there.** AND, if the therapist is also triggered, it will be even harder for the client!

Fisher, 2020 10

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Longing for Proximity, cont.

- **The belief that emotional closeness is only possible with physical proximity** is a natural one for clients who have never experienced safe connection, but it can be dangerous when shared by the therapist
- **Fact = secure attachment is built on the experience of learning to internalize the presence of a safe parent.** This crisis may be an opportunity to expand clients' capacity to feel close and connected at a greater distance. **The belief that we are no longer close when in a virtual space is an example of a failure of object constancy**
- "Object constancy" develops in childhood by age 5-6, allowing children to separate and go to school Fisher, 2020 11

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Longing for Proximity, p. 3

- **'Object permanence'** (the ability to perceive objects or people as still existing even if they cannot be seen) is acquired generally by age 3. '**Object constancy'** (the ability to perceive others as consistent and connected) develops next. When clients insist that they cannot feel our warmth and caring, that is a failure of object constancy
- **For telehealth to be successful, it is important that we offer something different and important rather than something that is less than "real" therapy**
- We can do that by using this opportunity **to challenge clients to feel our presence more AND increase our ability to communicate that we are present**

Fisher, 2020 12

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Cultivating Object Constancy

- **"Challenging"** the belief that we are **not** connected is important to avoid clients' misperceiving real contact
  - **Challenge #1:** "When you see me smile, what happens? When we laugh together, what happens?"
  - **Challenge #2:** "When you see my face and my expression, what thought comes up right away?"
- It is quite likely that traumatized clients have missed the smile or the laugh because **beliefs operate like a set of blinders**, preventing them from seeing the signs that we **are** connected. Asking the client to notice responses and be curious about them will widen their perceptual field

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Cultivating Object Constancy, cont.

- **Challenge #3:** "Pause for a moment, and notice that, right here, right now, I **am** here with you. And you are here with me. . . Just notice that. . ."
- **Challenge #4:** [Always said with warmth and lightness, not as a judgment] "Wait a minute—**I'm here, and you can't feel me?? I can feel you, but you can't feel me?"**
- **Challenge #5:** "I know you are probably VERY triggered by all that's going on, and it is very hard to believe that anyone is here for you, but **right here, right now, I am here--and I'm here for you.** Just notice that. . . I am here, and I am here for you. . . Can you take that in?"

Fisher, 2020 14

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Challenge and Caring

- **We can be challenging and still caring with clients. Both are equally important ingredients in secure attachment.** The parent both regulates and contains, encourages spontaneity and creates structure
- **But challenging clients also requires lightness, warmth, humor, a tone of encouragement, and authenticity.** That is what distinguishes us from neglectful, abusive or shaming parent figures.
- **Transparency is also useful:** when the therapist says, "I feel close to you—but you can't feel it?" we are being transparent as well as modeling object constancy Fisher, 2020

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Increasing Curiosity

- Most therapists have been taught to first and foremost **express empathy as a way to help clients feel "felt"** and to increase their self-connection
- However, **curiosity is often an easier and more effective path** to increasing the client's sense of a positive connection to us and to themselves.
- "Let's be curious: when you see me on the screen, do I look like me?" "And what's it like to see my familiar face?" **Before** the client is triggered and lost in the feeling memory of aloneness, asking the client to notice that **we are 'here'** will help keep the client 'here' with us

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Increasing Curiosity, cont.

- **Being curious is a non-shaming way** of interesting the client in triggered responses versus situational responses. E.g., being alone can feel protective but isolating, or just isolating and lonely, **or** as an 'act of triumph'
- When the client says, "It's just like my whole life—I never had anyone," we can be curious: "Yes, there was never anyone there when you were little. But right here, right now, someone is here with you. Can you feel that?"
- It is helpful to clients when we point out that a situation is triggering as well as stressful. **When we name their struggle with both, clients never complain of empathic failure**

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Increasing Curiosity, p. 3

- **The key to re-framing** a feeling as triggered or as a feeling memory **is the communication of empathy**: "It's so hard to be in the midst of a real crisis AND to be triggered, too. . . It makes it all doubly hard."
- **We can also empathize with the feelings of awkwardness or unfamiliarity:** "As if we didn't have enough to deal with, we have this weird new way of meeting, too!"
- Bruce Ecker's 'memory reconsolidation' approach emphasizes the provision of an experience that **directly contradicts** the client's internalized models and beliefs, the ones biasing the client to feel abandoned or far away

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"[E]motional learning usually consists of much more than stored memory of the 'raw data' of . . . what emotions one was experiencing during an original experience. ***Also [stored in implicit memory] is a constructed mental model of how the world functions, a template or schema that is the individual's sense-making generalization*** *of the raw data of perception and emotion.* ***This model is created and stored with no memory of doing so.*** *It does not exist in words. . . Emotional memory converts the past into an expectation of the future, without our awareness. . ."*

Ecker et al, 2012, p. 6

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Increasing Curiosity, p. 4

- **When the therapist challenges the client's perception** that we are not 'there' or the belief that she or he is alone, **and asks the client to notice the felt state of connection that is there in the moment, we are providing an alternative experience.**
- **It is not an alternative experience in words—**it is a palpably felt experience to which the words can be put after the old models have been contradicted
- How to help clients to feel or sense themselves or others, especially in a moment of crisis, is one of the contributions of Sensorimotor Psychotherapy

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Sensorimotor Psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from the work of Alan Schore, Bessel van der Kolk, Daniel Siegel, and Steve Porges.

Sensorimotor work combines psychodynamic techniques with body-centered interventions that can address the implicit learning of trauma. By using "just enough" narrative to evoke the implicit experience, **we attend first to how the body holds and keeps alive old trauma and attachment failure and later to cognitive and emotional meaning-making**

Sensorimotor Psychotherapy Institute

Ogden, 2002; Fisher, 2006

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"Long-lasting responses to trauma result *not simply from the experience of fear and helplessness but* ***from how our bodies interpret those experiences."***

Yehuda, 2004

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Noticing rather than narrating, playing rather than 'working'

In collaboration, therapist and client "study what is going on [for the client], not as disease or something to be rid of, but in an effort to help the client become conscious of how experience is managed and how the capacity for experience can be expanded. ***The whole endeavor is more fun and play rather than work and is motivated by curiosity, rather than fear."***

Sensorimotor Psychotherapy Institute

Kurtz, 1990, p. 11

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A mindfulness-based model rather than a narrative model

"Change happens through ***discovering how a client [has learned to] organize experience and then changing how that experience is organized. . . ."***

Ogden, 2005

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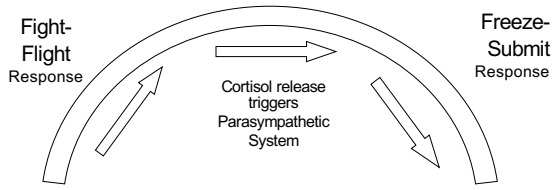
In an unsafe world, the human body has two choices for defending itself



Sympathetic Nervous System: adrenaline release, increased heart rate and respiration, agitation or restlessness, difficulty sleeping, irritability, tension, and reactivity

Parasympathetic Nervous System: decreased autonomic activation, exhaustion, no energy, shutting down or numbing, hopelessness and helplessness, feeling weighted down

Fisher, 2004

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Traumatized people tend to exhibit either hyperactive or passive defensive responses **or** an alternation between the two.

Hyperactive defensive responses: defensiveness, anger, irritability, aggression against self or others, hyper-alertness, hyper-vigilance, excessive motor activity, overly rigid boundaries, uncontrollable bouts of rage.

Habitual passive defensive responses: chronic patterns of helplessness and hopelessness, inability to set boundaries, feelings of inadequacy, and repetition of the victim role. The person may appear lifeless, non-expressive, and may fail to defend against or orient toward danger

Ogden, 2002

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Defensive responses can be unsafe or disabled during trauma

- **Flight responses are ineffective right now:** if we are self-quarantining, there is nowhere to run
- **Fight responses are even more ineffective:** if we rebel against restrictions, we endanger ourselves and others
- **Freezing and isolating** turn social distancing into hiding out and waiting for the war to be over
- **The challenge for some clients is that their bodies have learned to shut down or dissociate under stress, leading them to feel depressed,** despite the reality that passive defenses (willingness to stay inside) are more protective right now

Fisher, 2020

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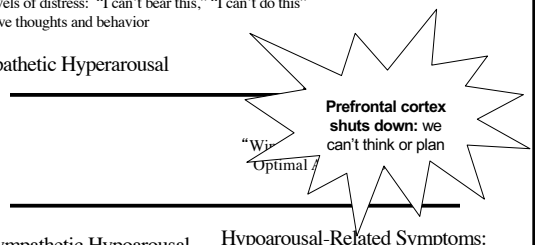
A Nervous System Adapted to a Threat

Hyperarousal-Related Responses:
Anxiety, paranoia, dread, anger and irritability
Chronic hypervigilance
High levels of distress: "I can't bear this," "I can't do this"
Obsessive thoughts and behavior

Sympathetic Hyperarousal



Parasympathetic Hypoarousal

Hypoarousal-Related Symptoms:
Flat affect, numb, shut down
Cognitively dissociated, slowed thinking
Helpless, hopeless, "I've given up"

Ogden and Minton (2000);
Fisher, 2006
*Siegel (1999)

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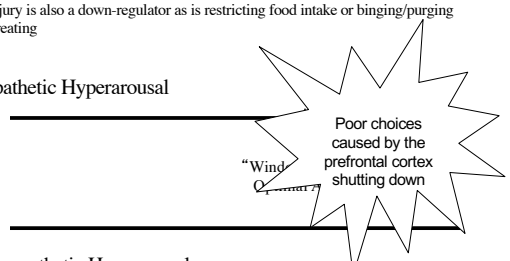
What we are likely to see. . .

Hyperarousal-Related Responses:
Alcohol and marijuana down-regulate hyperarousal
Self-injury is also a down-regulator as is restricting food intake or binging/purging or overeating

Sympathetic Hyperarousal



Parasympathetic Hypoarousal

Hypoarousal-Related Symptoms:
Alcohol is a stimulant in small doses
Marijuana maintains hypoarousal, zoning out
Belief that one is depressed feels confirmed

Ogden and Minton (2000);
Fisher, 2006
*Siegel (1999)

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Focus on Cultivating Mindfulness

- **Instead of trying to continue with the work of therapy as it unfolded pre-COVID-19,** try to use this uninvited opportunity to help **build the client's resilience and creativity**—both essential ingredients in coping right now
- **Mindfulness changes our bodily state: "**When we say, 'I'm scared,' notice that the heart rate goes up—there is a more intense feeling of anxiety." When we ask, "How is your body telling you you're scared? What sensations do you notice?" there is a feeling of interest or curiosity.
- **The bodily state of being mindful is calmer, more open, less tense,** all of which are immune system-supporting responses. Fisher, 2020

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Focus on Mindfulness, cont.

- **In a pandemic, we need 'signal anxiety,'** enough anxiety to drive us to take the precautions recommended, but not so much anxiety that we become chronically stressed
- **Mindfulness does not judge--it just notices:** "Interesting—I have wiped down my entire kitchen and bathroom again today even though no one has come in. And what do I notice? Less anxiety or more?"
- **In Buddhism, mindfulness requires "interest" in whatever comes up "without attachment or aversion."** Meaning that we do not agree with any thought or feeling and we don't reject any thought, feeling or sensation. In a pandemic, it is easy to get 'attached' to fear Fisher, 2020

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Neurobiological Effects of Mindfulness

- **Mindful concentration has been correlated with** increased activity in the medial prefrontal cortex and **decreased activity in the amygdala,** the brain's fire alarm and smoke detector, which down-regulates fear
- **Mindful noticing inhibits impulsive behavior**: the more mindful detachment from emotions, the less overwhelming the feelings are and the less likely we are to act out
- **Mindfulness discourages negative self-talk** and cognitive distortions that exacerbate symptoms. Clients may be used to their critical, shaming thoughts, and the current crisis gives them "ammunition" to use against themselves

Fisher, 2013

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"Although mindfulness is often seen as a form of attentional skill that focuses your mind on the present, [we can also see] mindfulness as a form of healthy relationship with oneself. ***That is, mindful awareness is a form of intra-personal attunement. Being mindful is a way of becoming your own best friend."*** *Dan Siegel*

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"[The restoration of] competence is the single biggest issue in trauma treatment"

Bessel van der Kolk, 2009

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Sensorimotor Interventions [Ogden, 1999]

If the issue in the COVID-19 crisis is anxiety and isolation, the remedy should be action and self-support

- *"Notice what happens if you lengthen your spine just a little bit . . ."* The action of lengthening the spine increases energy and feelings of solidity. If the client feels hopeless, lengthening the spine helps support hope
- *"See what happens if you orient to the room by turning your head and neck and slowly looking all around. What do you notice?"* The actions of orienting and scanning increase perceptual contact with the environment and accurate assessment of threat

35 Fisher, 2020

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More Sensorimotor Interventions

- *"Let's notice what happens if you assume that your fear is trying to help you?"* Techniques in which the symptom is studied as survival response support curiosity and interest
- 'Experiments' facilitate changes in emotions, body, and negative cognitions. Notice that these experiments interrupt automatic responses of either anxiety or self-flagellation
- *Let's study what happens to the hopelessness when you repeat those words, 'There is no hope for the future.' Does it feel better or worse?" "*
- *Notice what happens when you say the words, "I'm doing the best I can. . ."?*

Fisher, 2010

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Increasing the Client's Window of Tolerance

- **Expanding the Window of Tolerance is always an end goal of body-informed trauma treatment,** and increasing the capacity to tolerate how we feel is crucial for processing the pandemic experience
- **How can clients expand the Window of Tolerance?**
- **First, we can help them learn to use their existing resources to regulate fear and loneliness.** Clients often forget there are things that help them feel better or they forget to use them when stressed or triggered
- **And** we can teach them **simple somatic resources**

Ogden, 2000; Fisher, 2005

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Increasing the Client's Window of Tolerance, p. 2

Trauma responses:	**Resources:**
Fear, tension	Deep breath or sigh
Frozen—can't move	Movement, standing up
Slowed thinking, no energy	Grounding
Collapsed, helpless	Lengthening the spine
Feeling overwhelmed	Rolling the shoulders back
Hopelessness and other trauma-related beliefs	Lifting the chin
	Hand on the heart

Ogden, 2000; Fisher, 2005

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Cultivating "10% Solutions" to Overwhelming Feelings

- Sighing, breathing in calm and breathing out fear, lengthening exhale
- Taking walks, stretching, yoga, tai chi, doing chores
- Watching calming TV shows, avoiding the news
- Engaging in any safe activity that calms the body (taking a bath, making cookies, ironing, knitting, drawing, playing with a pet)
- Engaging in activities that require concentration but not much thinking (tanagrams, jigsaw puzzles, computer games, solitaire)
- Working with the hands (gardening, cooking, needlework, painting)
- Prayer and meditation, listening to guided visualizations, podcasts
- Inspiration: finding one thing that makes you smile
- Using mantras or sayings: "This too shall pass," "One day at a time"

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The Challenge of Making Virtual Space Feel Relational

- **What complicates** implementing all of these ideas and interventions **is most often the distraction of client's experience of isolation and deprivation**
- Isolation is challenging for therapists, too, but **when isolation is also triggering, clients can feel overwhelmed** by feeling memories of loneliness
- In addition to challenging the beliefs and implicit memories, **therapists can also make virtual psychotherapy a more relational space.** It 'just' requires a change in how we 'are' in the therapeutic encounter

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Make Use of the Social Engagement System [Porges, 2005]

- **The 'social engagement system' regulates movements of the eyelids, facial muscles, middle ear muscles, larynx, and head tilting and turning movements**
- The development of an infant's social engagement system is dependent upon the caregiver's ability to stimulate and interactively regulate social interaction
- When clients have had abusive and neglectful parents, social engagement was usually absent, and they come to therapy with an inhibited or shutdown social engagement system and dorsal vagal dominance

Ogden, 2006; Fisher, 2007

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Increasing your level of social engagement in tele-therapy combats the perception of distance

- **Make use of your own social engagement muscles**, being sure to utilize facial and eye expression, your head movements, intonation, and synchrony so that you evoke the client's social engagement system.
- **The social engagement system is body-oriented**: it relies upon the "muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds." (Porges, 2004, p. 21)
- **Because social engagement is associated with safety, it decreases fear and overwhelm**

Ogden, 2004; Fisher, 2007

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Be "louder" relationally

- In the physical presence of the client, our energy and the sense of our listening and positive regard can be felt**. In virtual space, our ability to listen and resonate cannot be felt**—unless the client has secure attachment
- **To compensate, the therapist has to become a bigger presence**: more vivid, more socially engaged, more reactive, more "there"
- Think of an actor trying to communicate a character's presence to an audience of hundreds: **it takes the ability to exaggerate just enough to communicate that individual and not so much that it feels 'fake'**

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Be "louder" relationally, cont.

- **Make your gestures bigger, your facial reactions more dramatic**—don't be afraid to be a 'drama queen' or king
- **Use the social engagement system to its capacity**: use facial expression to support the words you say, soften or put a sparkle in your eyes, tilt your head as you listen so the client can see you listening
- **Laugh and smile more!** Remember that laughing is associated with increased immune function as well as with regulating sympathetic arousal states. We can laugh WITH and FOR our clients so that the laughter feels like a shared experience

Fisher, 2020

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Be "louder" relationally, p. 3

- **The stress of navigating telehealth technology can take its toll on the therapist** as well as the client. We may be more stressed and more frozen, less relaxed
- **Try to relax your shoulders, lengthen your spine, and stay in contact with the floor.** The more grounded you are, the more likely the client can feel you there
- **Be more of neighbor than a therapist:** we are all literally in this together, and there is no usefulness to being a blank screen right now. We can have boundaries and be somewhat more transparent at the same time
- **Be practical:** this is survival time, not processing time!

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Be "louder" relationally, p. 4

- **Don't just rely on your facial expression: use your whole body.** You may need to sit back a little from the screen, but the result will be worth it
- **Remember the theory of 'mirror neurons:'** the client's ability to be present will increase the more you are present
- Use gesture, shrugging, tilting or turning the head, and **make sure to demonstrate skills like lengthening the spine so the client can imitate your movements**
- **Be more spontaneous, silly, 'real,' and unexpected.** The expected in virtual space may be disappointing or evoke feelings of deprivation. A slightly different you is novelty

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Experiment with the impact of different styles of communicating

- **Vary your voice tone and pace of speech:** soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- **Experiment with facial expression:** does the client respond differently to calm vs. warm, expressive, or playful expressions?
- **Change energy level:** very "there," energetic vs. quiet, calm
- **Notice: does the client respond better to empathy or to challenge?** Better to playfulness or to seriousness?
- **Amount of information provided:** does the client benefit from psychoeducation? Or does it evoke more feelings of distance?
- **Experiment with posture:** different postures communicate different messages about ourselves and the client

Fisher, 2015

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Maximizing positive states, not just repairing negative ones

- Attachment theory says that secure attachment is equally the result of caregivers **amplifying opportunities for positive affect** (Schore, 2001), e.g., in play states.
- Even though "good enough caregivers are inevitably somewhat inconsistent in their attunement with their children, **they promote recovery from breaches of attunement by providing interactive repair**. . . ."
- **"This transitioning between negative and positive affect helps the infant to develop resiliency** and, later, flexible adaptive capabilities." (Tronick, 1989)

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Maximizing positive states, not just repairing negative ones, cont.

- To the extent that therapists have been taught to resonate to and empathize with states of distress, we are failing to use the lessons of the attachment research
- **Clients may experience telehealth as a failure of empathy** rather than seeing it as a resource. It is our job to empathize with their feelings while also helping them to laugh, smile, and enjoy the encounter with us
- Keep in mind that **we are not minimizing their feelings—we are regulating them,** just as attuned parents do in promoting secure attachment

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"Co-regulation"

- **Co-regulation refers to the moment-by-moment 'contingent interaction' of emotional and somatic reactions between humans**: e.g., the baby wakes up in the middle of the night and the parent gets anxious. That anxiety is felt by the baby, and he or she becomes harder to soothe
- **The key is that co-regulation is mutual and contagious.** We are all neurobiologically impacted by each other moment-by-moment via body-based communications—not just in our early years but throughout our lives. Someone smiles, and we smile back. The other person looks angry, and our bodies tense. **We all "continuously" communicate through an exchange of nonverbal language**

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Co-regulation, cont.

•**Co-regulation in therapy can best be described as the moment-by-moment interaction between the nervous system of the therapist and that of the client**: e.g., the therapist's anxiety goes up as the client is silent and unresponsive. The client senses the anxiety and is further dysregulated. As the client expresses hopelessness, the therapist feels a combination of hopelessness and frustration. Neither is aware that they dysregulating the other, and each blames the other person!

•**BUT if the therapist intentionally regulates arousal, the 'co-regulation' effect can benefit the client** Fisher, 2019

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How do we learn to co-regulate?

•**By changing our therapeutic habits. We must learn to prioritize non-verbal communication and co-regulation above problem-solving, insight, and crisis resolution.** That means that the therapist has to let go of the need to put the experience into words!

•**By training ourselves to shift attention from thoughts about "what we should do" or "what is going on"** to enter a more receptive and curious state. By relaxing the body and focusing only on tracking the moment-by moment changes in the patient's availability and state, we enter **"the co-regulation zone"** Fisher, 2014

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Elements of Co-Regulation

- **Attuning our facial expressions and rhythm** or pacing of speech to that of the client
- **"Affect synchrony:"** matching their emotional states just enough to communicate resonance but not too much
- **"Contingent responsivity:"** modifying our nonverbal responses to increase their regulation or comfort level.
- "The synchronizing caregiver facilitates information-processing by **adjusting the mode, amount, variability, and timing [of] stimulation** to the infant's actual integrative capacities." (Schore, 2001a) The therapist matches and then slightly modifies his/her response to help client shift into a more comfortable state

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Elements of Co-Regulation, cont.

•**Concentrate on co-regulating your own activation first and then the client's:** adjust your verbal and non-verbal language to evoke more optimal states in you and the client, capitalize on positive moments, avoid language and tones of voice that seem to dysregulate the client

•**Prioritize "right brain to right brain" communication over verbal left-brain communication:** pay less attention to words and more to how you "talk about" what is happening. Right brain communication speaks through continuously adjusting our actions, reactions, arousal, and body language to shift the nonverbal experience of the client—as well as our own

Fisher, 2019

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Co-regulation is contingent

•**The essence of co-regulation is moment-by-moment synchrony**. Does the client resist your offer to teach him/her resources? *Empathize with the difficulty learning anything new in a pandemic, or share, "I want you to have resources, but that's my anxiety—I want to help you."*

•Is the client uncomfortable when you empathize? *What happens if you universalize the empathy? Say,"anyone"*

•When the client argues in favor of hopelessness, *what happens if you re-frame it as perfectly understandable?*

•Is the client not processing our new information? *Simplify your next response.* Is the client responding irritably? *Try lightening your tone or increasing humor*

Fisher, 2013

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"Dyadic dancing" with clients

- **Rather than a therapeutic style of listening** to all that the client has to say before responding, **the therapist engages in a "duet" with the client.**
- The client says something, then the therapist responds by echoing the words or making a clarification in them; the client reacts to that, and the therapist echoes again or re-directs the client to be curious or . . .
- **When clients use "self-defeating" interpretations, the therapist interrupts:** *"Isn't it interesting ? The thought comes up that it's your fault. Wow. . . That's right where your mind went, huh?"*

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"Dancing" with clients, cont.

- But therapists have a 'phobia' of interrupting! **If we interrupt, we believe we fail them empathically.** But if we do **not** interrupt, the client will be dancing alone to a very old negative song—and encoding it more deeply.
- The key to ensuring that clients feel no loss of empathy when they are interrupted is the therapist's tone of voice. **When we are excited,** awed, fascinated, touched, or amused by their words, **clients will feel "met" by our interruptions, rather than cut off.**
- The success of a therapeutic "dancing style" rests on it feeling like we are "with" the patient, not just trying to evoke the emotional pain or move stuckness Fisher, 2019

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"Dancing" with clients, p. 3

- In good attachment, **each maternal response soothes or builds excitement.** The attuned caregiver makes sure to track the baby's signals to ensure that she or he is enjoying the exchange and not getting over-stimulated.
- Similarly, **the attuned therapist observes the client's body to track what elicits the patient's curiosity and interest,** what is irritating, reassuring, what helps them come more present, what is soothing and what is not
- **Like a 'good enough' mother, the therapist repeats what maintains the patient's positive state** and refrains from repeating words, tone, and body language that dysregulate the patient Fisher, 2019

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"The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

P = playfulness

A = acceptance

C = curiosity

E = empathy

Hughes, 2006

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