New Hope for Treatment Resistant Depression

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Janina Fisher, PhD

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New Hope for Treatment-Resistant Depression

Delphi Centre
26 and 27 October 2023

Janina Fisher, Ph.D.

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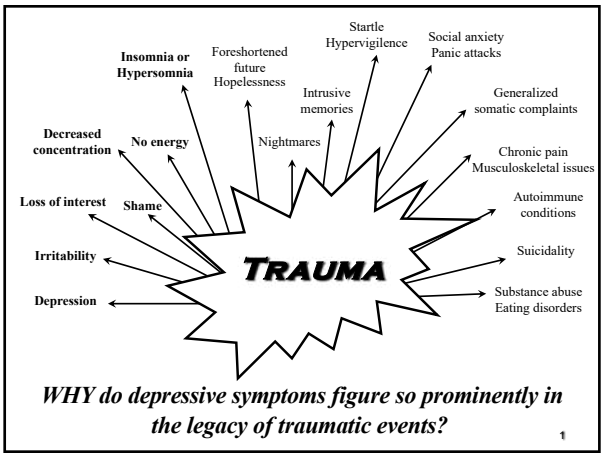

WHY do depressive symptoms figure so prominently in the legacy of traumatic events?

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Neuroception: How We Differentiate Friend from Foe

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 eye contact, vocalization, facial expression, vocalization to engage others

Danger: Sympathetic arousal initiates active defenses of fight, flight, or other self-protective action

Life Threat: Dorsal vagal activation facilitates defensive strategy of total submission

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

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Defensive responses can be unsafe or disabled during trauma

- **Flight responses would have been ineffective:** there was nowhere to run
- **Fight responses would have been overpowered** or punished
- There was not enough time to react
- **Resistance could have led to more danger**
- Conditioning from prior abuse led to **automatic submission and obedience or to freezing or dissociating**
- Victim experienced conflicted feelings about perpetrator

Ogden, 1999; Fisher, 2019

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Symptoms of Depression [DSM-IV]

- Depressed mood; feeling sad or empty, tearful
- Significant loss of interest or pleasure
- Significant weight loss **or** weight gain; decrease **or** increase in appetite
- Difficulty sleeping or sleeping too much
- Agitation **or** slowing down of thoughts and reduction of physical movements
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Poor concentration or having difficulty making decisions
- Thinking about death or suicide

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After the trauma is over, we 'remember' it with our bodies

- **Brain scan research demonstrates that traumatic memories are encoded** primarily as bodily and emotional states rather than as narratives
- **But, when trauma is "remembered" without words, it is not experienced as memory.** These implicit physical and emotional memory states do not "carry with them the internal sensation that something is being recalled. . . . **We act, feel, and imagine without recognition of the influence of past experience on our present reality."** (Siegel, 1999)

Fisher, 2009

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Implicit memories are triggered, not recalled

- The human body instinctively reacts to the **anticipation** of something bad happening. We usually call this response "triggering" or "getting triggered"
- **All danger signals it has known before become stimulators of implicit memories:** times of day or year, cerain people and places, colors, smells or sounds, weather, tones of voice, body language, disappointment, aloneness
- When implicit memories are triggered, we experience **overwhelming feelings, sensations, and impulses. This feeling of danger is misinterpreted as meaning "I AM in danger,"** not "I am remembering danger" Fisher, 2014

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Traumatic 'implicit' memories are experienced as:

- Ashamed, depressed or submissive states: numb, spacy, paralyzed, hopeless and helpless, self-loathing
- Feelings of desperation, despair, yearning to die
- Feelings of panic and terror, dread, apprehension
- Yearning for contact, painful loneliness, and a felt sense of abandonment
- Fight-flight responses: feelings of rage, impulses to run or "get out," violence turned against the body
- Body sensations: rapid heartbeat, constricted breathing, tightness, shakiness, physical collapse, nausea Fisher, 2008

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Compliance as a Survival "Resource"

*"In conflict situations, there are just two basic choices: to escalate or de-escalate. . . . The inhibitory functions of shame suggest that **shame [and depression] function as a defensive strategy** which can be triggered in the presence of interpersonal threat. . . ."*

Gilbert & Andrews, 1998, p. 101

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"Shame [and depression] signals (e.g., head down, gaze avoidance. . .) are generally registered as submissive and [appeasing], designed to de-escalate and/or escape from conflicts."

Gilbert and Andrews, 1998, p. 102

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*"Thus, insofar as **shame** [or depression are] related to submissiveness and appeasement behavior, [they are] **a damage limitation strategy**, adopted when continuing in a shameless, nonsubmissive way might provoke very serious attacks or rejections."*

Gilbert and Andrews, 1998, p. 102

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

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

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

Ogden, 2002

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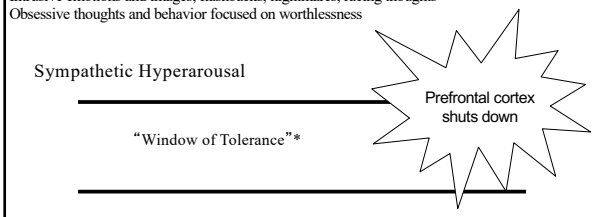
Nervous System Adapted to a Threatening World

Hyperarousal-Related Responses:
High activation resulting in impulsivity, risk-taking, poor judgment
Chronic hypervigilance, post-traumatic paranoia, chronic dread
Intrusive emotions and images, flashbacks, nightmares, racing thoughts
Obsessive thoughts and behavior focused on worthlessness



Hypoarousal-Related Symptoms:
Flat affect, numb, shut down
Cognitively dissociated, slowed thinking
Cognitive schemas focused on hopelessness
Disabled defensive responses, victim identity

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

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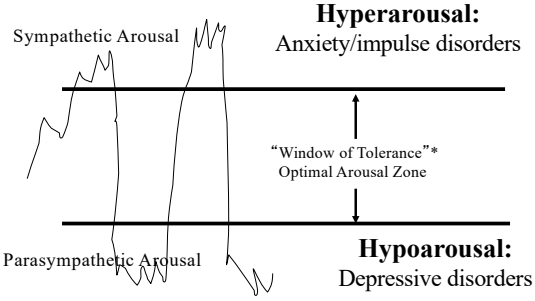
Autonomic Arousal & Depressive Disorders



Hyperarousal:
Anxiety/impulse disorders

Hypoarousal:
Depressive disorders

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

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A Polyvagal View

Sympathetic Arousal

Mobilizing defenses: fight/flight/duck/hide

Ventral Vagal or Social Engagement System:
vocal and facial signaling, eye contact

Parasympathetic Arousal

Dorsal vagal states: collapse, go numb, loss of energy, passive defenses

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

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Depression and Hypoarousal

•**Chronic autonomic hypoarousal is often diagnosed as chronic depression.** Hypoarousal can mimic or drive all of the following depressive symptoms:

- •Depressed mood
- •Loss of interest and pleasure (due to numbing)
- •Weight gain/overeating
- •Sleeping too much
- •Fatigue/loss of energy
- •Slowing of thoughts and physical activity
- •Difficulty concentrating
- •Difficulty with memory

Fisher, 2011 15

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"Depression" can also reflect implicit memory

- •**Autonomic memory:** numbing, emptiness, loss of energy and interest, physical collapse, passivity
- •**Emotional memory:** sadness, shame, feelings of inadequacy
- •**Cognitive schemas:** beliefs about worthlessness, defectiveness, damage, unlovability
- •**Procedural learning:** collapse, invisibility, self-deprecation, "flying below the radar"
- •**Phobias of positive affect:** it is unsafe to feel good

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Persistent patterns of response reflect another kind of learning

- •**Procedural memory is the implicit learning and memory system for functional learning:** skills, habits, automatic behavior, conditioned responses.
- •Driving a car, playing an instrument, swimming or playing tennis, riding a bike, social behavior, and making eye contact are all examples of procedural learning.
- •Procedural learning allows us to respond instinctively, automatically, and non-consciously, increasing efficiency at the cost of a loss in reflective, purposeful action

Fisher, 2006

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Depression can result from Procedural Learning

- In traumatic environments, **children and adults alike depend on procedural memory to acquire** the adaptive physical and mental reactions, the cognitive schemas, or **behaviors that promote compliance**
- Because procedural learning takes place before we have language, **clients don't always recall why and how they developed hypoarousal and compliance-promoting depressive responses**. In some cases, automatic parasympathetic responses, collapse, numbing, and loss of interest may have started long before the client had a memory system capable of conceptualization

Fisher, 2010 18

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Depression and Procedural Learning

•Over time, **procedural learning of collapse and submission** to regulate hyperarousal states and induce compliance responses **becomes automatic and unconscious**

•**But the depression feels like "me."** It does not feel like an ingenious survival response

•Cognitive schemas develop to explain and reinforce the tendency to collapse, and these become procedurally learned

•Eventually, **the child learns to respond to most if not all affects and arousal states with depressive affect** and body responses accompanied by negative cognitions

Fisher, 2019 19

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"Flying Below the Radar"

•**In a dangerous environment, remaining invisible and unobtrusive is adaptive for children.** Depression serves the function of dampening energy and thus facilitating compliance and withdrawal

•It ensures that the child is less likely to engage in behavior that threatens adults and triggers retaliation

•It ensures that the child is less likely to try to impress adults or express needs or share moments of mastery, decreasing the risk of drawing attention to themselves

•Depression ensures that the child remains in a degraded state: **it is safer to "be down so low there is no place lower to go"**

Fisher, 2022 20

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"Flying Below the Radar," cont.

- **The neurovegetative symptoms of trauma** (loss of energy, psychomotor retardation, slowed processing) **also serve the purpose of "energy conservation:"** the less energy we expend, the more we can endure
- As a dorsal vagal "feigned death" response, **extreme chronic depressions result in a kind of "living death."** Clients go through the motions of living but have no life
- Often, **these chronic depressions result in a withdrawal from life:** isolation, constriction, less and less investment in even basic self-care (showering, brushing teeth). In a "long, slow flashback," the client relives the experience of a child trapped and without hope

Fisher, 2022

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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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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 "remembers" trauma and attachment failure and later to cognitive and emotional meaning-making**

Ogden, 2002; Fisher, 2006

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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."*** 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 procedurally learned to] organize experience and then changing how that experience is organized. . . ."***

Ogden, 2005

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Focus on Cultivating Curiosity

- **The therapist must listen with a mindful, curious ear:** we have to hear the client's 'depression' not as a diagnosis but as a pattern of thoughts, feelings and body responses that once served an adaptive function
- **Communicate curiosity in your voice and body language:** "Can you feel the depression right now? How is your body telling you that you're depressed?"
- **Help the client notice with excitement the patterns s/he calls "depression:"** "Isn't that amazing? Your nervous system won't allow you to have any energy, huh?" "The judgmental part of you just won't quit, will he?" "And how did this pattern help you survive?" Fisher, 2019

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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,** thereby regulating arousal and widening the window of tolerance
- **Mindful noticing reduces overwhelm**: the more mindful detachment from emotions we have, the less overwhelming the feelings are
- **Mindfulness discourages negative self-talk** and cognitive distortions that exacerbate symptoms
- **Mindful concentration** on new patterns of action or reaction **is associated with neuroplastic brain change** (Siegel)

Fisher, 2022

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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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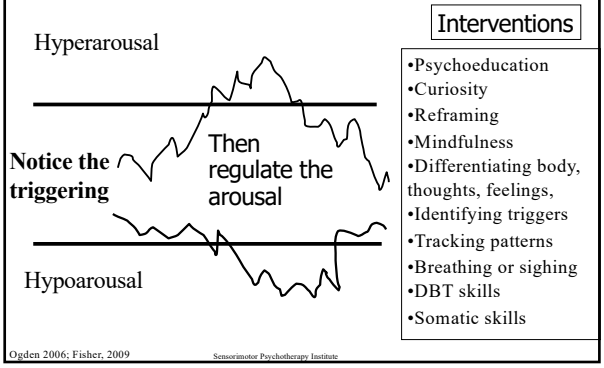
Teaching the Skills to Regulate Arousal Within the Window of Tolerance



Interventions

- Psychoeducation
- Curiosity
- Reframing
- Mindfulness
- Differentiating body, thoughts, feelings,
- Identifying triggers
- Tracking patterns
- Breathing or sighing
- DBT skills
- Somatic skills

Ogden 2006; Fisher, 2009

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Using the Body's "Library" of Resources

- When a client's frontal lobes go "off line," using somatic resources is often more effective because there is no requirement to "think," only to practice
- **The body is a rich source of resources:** movement, muscular tension and relaxation, breathing, balance, flexibility, alignment, musculoskeletal support
- **Many somatic resources support psychological capacities:** eg, musculoskeletal support enhances sense of emotional support, muscular relaxation supports relaxing anxiety, bodily flexibility supports psychological flexibility

Fisher, 2008

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Experimenting with Somatic Resources for Traumatic Reactions

Traumatic Reactions:	Resources:
Shaking, trembling	Slowing the pace
Numbing	Sighing, breathing
Muscular hypervigilance	Lengthening the spine
Accelerated heart rate	Hand over the heart
Collapse	Grounding with the feet
Impulses to hurt the body	Clenching/relaxing
Disconnection, spacing out	Movement, gesture

Sensorimotor Psychotherapy Institute Ogden,

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Sensorimotor Interventions [Ogden, 1999]

If the issue in chronic depression is loss of energy and inertia, then the remedy should be action and curiosity

- *"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 is numb, lengthening the spine counteracts numbing
- *"Then orient to the room by turning your head and neck and slowly looking all around. What happens?"* The actions of orienting and scanning increase perceptual contact with the environment and increase optimal levels of arousal

Fisher, 2007

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More Sensorimotor Interventions

• ""*Let's study what happens to the depression when you repeat those words, 'I'm a hopeless case.' Does it go up or go down?" "Notice what happens when you say the words, "I'm doing the best I can. . ."?* Experiments facilitate changes in emotions, body, and negative cognitions. Notice the experiments interrupt automatic responses of self-flagellation

•*Let's notice what happens if you assume that your depression belongs to just one part of you . . . Does that feel better or worse?"* Techniques in which the depression is studied as a part of the personality support mindful separation from the depression

Fisher, 2010

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Sensorimotor Approaches to Hypoarousal

•**Remember that hypoarousal** is a survival response: attempts to increase arousal will often backfire, causing either increased hypoarousal or an escalation into hyperarousal

•**Increase amount of information to be processed**, rather than trying to stimulate feelings: study the numbness; find out what words or emotions go with it; what images

•**Foster curiosity:** study how ingeniously hypoarousal "works." Study its details: how far the numbing goes, whether there is any other sensation, such as fuzziness or heaviness

•**Argue the case for keeping it instead of changing it!** Challenge the client by being an advocate for hypoarousal

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Modulation of Hypoarousal, cont.

•**"Drop the content:"** depression is often driven by negative beliefs, such as "I'm worthless," "There is something wrong with me," "I'm unlovable," "It was my fault." Clients can be taught to "drop" the thought when it arises and focus on the feeling of their feet on the ground or on a different thought as a way of treating the depression. Without the thoughts driving the depression and self-loathing, more energy becomes available

•**Encourage movement:** change posture, trade seats with the client, work standing up, use lots of gestures

•**Strengthen the client's resources before pushing for emotion:** hypoarousal means that the client is dysregulated and affect intolerant. Pushing for affect too soon will increase hypoarousal, rather than addressing it

Fisher, 2005

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Cognitive Schemas Related to Hypoarousal = Depression

- **Hypoarousal symptoms of decreased energy, numbing, impaired concentration, and slowing of thought and action are just that: physical sensations.**
- When they are identified with by the client and interpreted as meaning "there is something wrong with me," the depressive symptoms **worsen.** When these physical symptoms are treated as "sensation," they can be inconvenient but not incapacitating
- **A negative feedback loop can develop:** the more insistent the client is on maintaining she is depressed or defective, the more entrenched the depression Fisher, 2007

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Interventions for Depressive Beliefs

- **Objectifying the depression:** "Depression is so sly and cunning—it is always trying to convince you to retreat, to blame YOU for the hypoarousal! What happens when the depresssion convinces you that it's all your fault? Do you feel better or worse? Depression is such a liar!"
- **"Going with the resistance:"** instead of trying to convince the client to fight the depression or to have some hope, disrupt the hypoarousal-related pattern by trying to find the value in the stuckness: "Change isn't all it's cracked up to be," "It's so much safer and more comfortable to say below the radar," "The depression is like a protective cocoon, isn't it?" Fisher, 2010

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Dis-identifying from Symptoms

Clients identify with the diagnosis of depression and accompanying cognitive schemas because the symptoms have been with them ***"forever."***

- **The therapist must differentiate 'self' and symptom:**
  - "I know it feels as if you are depressed—but the fact is that it's just your nervous system protecting you"
  - "A part of you feels so hopeless, so unworthy—have you ever thought how that part helped to keep you safe by never making waves, never being a bother?!"
  - "If you didn't feel so depressed, how would life be different? Could a part be trying to prevent that?"

Fisher, 2007

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"The concept of a single unitary 'self' is as misleading as the idea of a single unitary 'brain.' *The left and right hemispheres process information in their own unique fashion and represent a conscious left brain self system and an unconscious right brain self system."*

Schore, A. N. (2011). The right brain implicit self lies at the core of psychoanalysis. *Psychoanalytic dialogues*, 21:75-100. p. 76-77.

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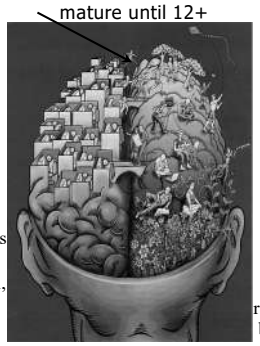
Traumatic adaptation and "splitting"

Left Brain

Increasingly dominant as language and cognition develop, the left brain is verbal and rational. It plans, organizes, learns from experience. It can evaluate danger cues but has positively biased neuroception, so it tends to minimize danger

Corpus Collosum does not mature until 12+



Right Brain

Dominant in first few years, the right brain lacks words but can read body language and scan for danger. It has 'street smarts,' not book smarts. It intuits threat but can't objectively measure the degree of threat. It can respond instinctively but not intentionally

Fisher, 2019

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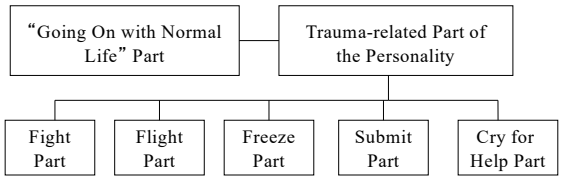
Structural dissociation model: surviving by fragmenting



The right brain-mediated Traumatized Part of the Personality becomes more compartmentalized: separate substates evolve, each reflecting the different survival strategies needed in a dangerous world

Van der Hart, Nijenhuis & Steele, 1999

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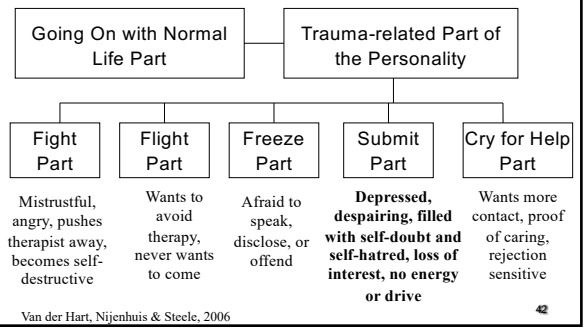
Depression can be a defensive response of a part



Van der Hart, Nijenhuis & Steele, 2006

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The parts are experienced as feelings and reactions, not as 'parts'

- Overwhelming emotions: desperation, despair, shame and self-loathing, hopelessness and helplessness, rage
- Chronic expectation of danger: hypervigilance, fear and terror, mistrust, "post-traumatic paranoia"
- Body sensations: numbing, dizziness, tightness in the chest and jaw, nausea, constriction, sinking, quaking
- Impulses: motor restlessness, 'hang-dog' posture, impulses to "get out," violence turned against the body
- Beliefs: "I hate myself," "No one cares," "I'm not safe here"

Fisher, 2012

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The parts are also experienced as:

- **Loss of ability to communicate:** client becomes mute, shut down, spacy, unwilling to speak, can't find words
- **Voices**: usually shaming, punitive, controlling
- **Constriction:** withdrawal, social isolation, agoraphobia
- **Regressive behavior:** loss of ability for well-learned skills, personal hygiene, ADLs, social engagement
- **Increasing preoccupation with helpers:** the only safe/unsafe place becomes the office/hospital/house
- **Alternating dependence and counterdependence**
- **Chronic self-harm,** suicidality and addictive behavior

Fisher, 2014

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The key to stabilization is the "Language of Parts"

•**The language of parts** as the language of therapy **increases the client's ability to be mindfully aware of parts** without acting on their impulses

•**That means the therapist must translate the narrative from "I" language to the language of parts:** *"A part of you feels ashamed," "a part of you feels it was her fault," "a part of you wants to hurt the body."*

•**Naming the symptoms as a part helps keep the frontal lobes 'online'** by increasing curiosity and concentration. **Naming distress as a part takes the edge off the intensity** of the emotion Fisher, 2021

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Learning parts language as a second language

•**Clients speak "I" fluently but not parts language, so we have to provide an intensive language class for them**

•**The therapist becomes a 'simultaneous translator.** Each time the client says, "I feel," the therapist translates the statement into parts language: *"A part of you feels hopeless," "the critical part thinks that's weakness," "a part of you wants to die."*

•**As in a language class, the more intensive the use of the second language, the more quickly the student learns!** The habit of prefacing each feeling with "I" is automatic for most people but dangerous for suicidal clients Fisher, 2020

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A depressed child, not a depressed adult

- **Relate to the depression as a child's natural response to abuse and neglect**, rather than as the client's 'illness.' That spontaneously changes mood
- It gives the therapist a different way to relate to the depression, too. **We can re-frame the depression as the child's brilliant adaptive strategy,** powerful and active rather than passive
- **And we can cultivate client admiration and empathy for the child who had to give up hope to survive,** changing the client's relationship to the depression

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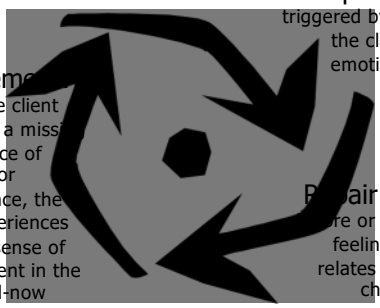
'Rupture' and repair of internal attachment

Rupture: a part is triggered by something; the client feels the emotional reaction



Attunement: when the client provides a missing experience of comfort or acceptance, the part experiences the felt sense of attunement in the here-and-now

Repair: rather than ignore or suppress the feelings, the client relates to them as a child's feelings

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Rupture and repair of internal attachment

- When clients feel a sense of compassion in response to the question, "How do you feel toward that part now?" **they are ready to "repair" the part's body memory of early rupture being felt as shame, fear, or sadness**
- **First, ask the client to notice a part or a pattern associated with distress:** "Can you feel the frightened part here with you now? How can you tell she's there?"
- **Try to elicit a felt sense of the part,** not an intellectual interpretation: "Notice how she speaks to you through emotions and body sensations——let her know you want to get to know her. . . "

Fisher, 2022

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Repair of internal attachment, p. 2

- To maximize a felt sense of attunement, **the therapist tries to evoke the client's spontaneous compassion for children**: "Imagine that little girl is standing there in front of you right this minute. . . See her little face. . . What's your impulse?" "To reach out to her? Take her hand? Or pick her up and hold her?"
- **"Feel what that's like to have this little boy in your arms? To feel his hand in yours? Is it a good feeling?**
- **"Take in the warmth of his body and the feeling of holding him safely. . .** Ask him if he would like it if you did this every time he got afraid?

Fisher, 2022

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Repair of internal attachment, p. 3

•**Each response by the part becomes another opportunity for repair** facilitated by the therapist's guidance: *"She's telling you that she wants to believe that you understand, but she's afraid to trust you. . . Do you 'get' that?* ***Let her know with your feelings and your body*** *that you understand why it's hard for her to trust anyone. . ."*

- "Yes, you can feel him relaxing just a little bit when you acknowledge the truth. . . Not many grownups ever did that, huh?"
- "What's it like for her to have you take responsibility? To let her know that you realize you have been pushing her away?"

Fisher, 2022

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Repair of internal attachment, p. 4

- **Use what <u>doesn't</u> work as an attachment-building moment**: repairs are even more powerful when they follow from what goes wrong relationally.
- *"He's retreating, huh? He's so afraid of being hurt that he's backing away from what he most wants. Let him know that it's OK—you understand, right?"*
- *"What's it like for him to know that he can take as much time as he wants? That you won't go away just because he's still afraid to trust you. . .* ***Let him know with your feelings and your body*** *that you'll be waiting right here for him….."*

Fisher, 2022

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Building compassion, step by step

•**A direct approach tends to be too triggering for clients.** Keep in mind that compassion and kindness were once very dangerous in their experience

• Start with the basic ingredients of self-compassion:

•**Interest and curiosity:** once clients can use the language of parts, at least with you, ask them to be 'interested' in the part.

•**Listening:** could you listen to the part who's speaking?

•Interest, curiosity and listening rarely provoke resistance.

•**Next, we need to evoke more empathy for the part. . .**

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Building compassion, p. 2

•**There are two ways to evoke empathy for the parts in distress:**

- Facilitate imagining them: "Imagine that little child was right here in front of you. . . You can see the fear in her eyes. . . You can see the tear marks on her cheeks. . . Notice your impulse as you see her here with you."
- "How did this part help you survive?:" "Did it help that she was so quiet and afraid?" "Did it help he was ashamed?"

•**Next, empathy builds with inner dialogue:** "Ask the protector part what it's worried about if it doesn't harm the body?" "Ask the hopeless part what it's worried about if you have hope?"

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Building compassion, p. 3

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- Facilitate imagining them: "Imagine that little child was right here in front of you. . . You can see the fear in her eyes. . . You can see the tear marks on her cheeks. . . Notice your impulse as you see her here with you…"
- "How did this part help you survive?:" "Did it help that she was so quiet and afraid?" "Did it help he was ashamed?"

•**Next, empathy builds with inner dialogue:** "Ask the hopeless part what it's worried about if you have hope?" "What's the suicidal part worried about if you live?"

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Learning to "ask inside"

•**"Asking inside"** is an ego state technique, **a way of gaining access to less conscious internal states,** of finding out more about ourselves from "inside sources"

• ***"Ask that part what s/he's worried about****? What is that part afraid will happen if you are curious about the sad part? What is the harm if you comfort the sad one?"*

• ***"Ask the ashamed part:*** *is he judging himself? Or is some other part judging him?"*

•When we "ask inside," **answers may come in the form of thoughts, feelings or body sensations:** *"When you ask the scared part what he's worried about, you can feel your body tense. . ."* Fisher, 2012

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The Four 'Befriending' Questions

- "Could you ask that part what she is worried about *if she goes to the party*? What she's afraid will happen?"
- Could you ask her what she is worried about if *people look at her*?"
- "And *if people don't like her*, what is she afraid would happen next?"
- "What does she need from you—right here, right now—to feel less afraid of being abandoned?"

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The challenge of "giving up" depressive states

- If the depressive state once felt "safe," then **it may be triggering/frightening to be without it**
- **Chronic hypoarousal creates affect intolerance**: even a little bit of emotion can be experienced as overwhelming. If clients "give up" the depression, they feel more emotion
- If the depression has helped the client to be more invisible, to "fly below the radar," **lifting of the depression may cause increased anxiety about visibility**
- And if the depression represents a communication from a depressed Submit part, **efforts to "treat" the depression can backfire** if it appears to be a way to 'shut up' a part

Fisher, 2019 58

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The challenge of "giving up" depressive states, cont.

- Validate that it might be hard at first to live without the depression. Validate the depressed part's fear that it would not be wanted anymore
- **Validate the fear of the emotions or visibility that client and parts might feel**: validating helps reduce fear rather than reinforcing the avoidance of emotion
- Make sure to honor the depressed part's service as a heroic act and see if the depressed part is tired of being depressed.
- **The validation and honoring is a reparative experience for parts**

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

- **The 'social engagement system' is a neural system regulating the eyelids, facial muscles, middle ear muscles, larynx, and head-tilting and turning**
- The development of an infant's social engagement system is dependent upon the caregiver's ability to stimulate their own social engagement system
- When clients have abusive and neglectful parents, social engagement is usually absent, and they come to therapy with an inhibited social engagement system, in a dorsal vagal dominant state

Fisher, 2022

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Increasing capacity for social engagement in the therapy

- **The social engagement system is only available when the individual feels safe at a body level.** When clients come to therapy unable to use the social engagement system, they cannot feel safe
- To compensate, **therapists must make use of their social engagement muscles**, being sure to utilize facial expression, head movements, intonation, and type of gaze to evoke the client's social engagement system.
- **Social engagement not only communicates safety, but it also regulates the nervous system and lifts depressive states**

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

- Ideally, the psychobiologically attuned, affect-regulating primary caregiver **amplifies 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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"Not only is the therapist . . . unconsciously influenced by a series of slight and . . . subliminal signals, so also is the patient. ***Details of the therapist's posture, gaze, tone of voice, even respiration, are [unconsciously] recorded and processed.*** *A sophisticated therapist may use this processing in a beneficial way, potentiating a change in the patient's state without, or in addition to, the use of words."*

Meares, 2005, p. 124

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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
- **Does the client respond better to empathy or to challenge?** Better to playfulness or seriousness?
- **Amount of information provided:** does s/he do better with more explanation? Or does information cause overwhelm?
- **Experiment with proximity:** is the client more comfortable with distance, closeness, or neither?

Fisher, 2022

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Secrets of skilled 'co-regulation'

- **Rhythm:** begin by just echoing the client's words. "You feel the depression, huh?" "Yes, it makes you angry. . ."
- **Play with tone, pace and energy**: let your voice and body language resonate with the client's energy or tone. "Yeah, of course you're upset—that nurse was hurting you!"
- **Communicate curiosity:** this is the most fascinating, ingenious, creative adaptation you've ever seen! When a way of being 'works,' keep using that
- **As you fall into resonance with the clients' words and body language, they will feel heard and "met."** "Yes, I get that" or "Help me to get that—this feels important" are the themes to sound.

Fisher, 2013

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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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"Leavening" Distress States with Positive States

"Playful interactions, focused on positive affective experiences, are never forgotten . . . Shame is always met with empathy, followed by curiosity. . . . All communication is 'embodied' within the nonverbal. . . . **All resistance is met with [playfulness, acceptance, curiosity, and empathy], rather than being confronted."**

Hughes, 2006

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