Trauma and Addictive Disorders

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Delphi Centre
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The relationship between trauma and addiction is a complex one

•**Mental health and substance abuse treatment share the same solar system but have always existed as two different spheres,** usually administered by different agencies

•Substance abuse professionals find themselves confused by the trauma symptoms that complicate addictions recovery. **And therapists are alarmed by the challenges and risks posed by their clients' addictive behavior,** usually sending them to Alcoholics Anonymous or to recovery programs

• **But the research reveals a strong association between having a history of trauma and addictive behavior.**

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Trauma is hard to 'remember' but impossible to forget

*"**Under conditions of extreme stress, there is a failure of . . . memory processing**, which results in an inability to [form] a coherent . . . narrative, **leaving the sensory elements of the experience unintegrated and unattached**."*

Van der Kolk, Hopper & Osterman, 2001

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Sensory elements without words = 'implicit memory'

•Brain scan research demonstrates that trauma fails to be encoded as **autobiographical memories** ("I remember it happening") **Instead, victims are left with easily activated implicit memories:** disconnected emotional, physical, and somatosensory responses

•All experiences are remembered implicitly but not all are encoded explicitly. **The implicit or nonverbal memory system is a more powerful influence on our behavior than verbal memory** because implicit memories are not recognizable as 'memory:' **they are feelings and impulses, not narratives or pictures.**

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

•**When trauma is "remembered" without words, it is not experienced as memory.** These non-verbal 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)

•Worse yet, implicit memories are constantly stimulated in the course of daily life. Because trauma occurs in unsafe home environments, triggers are everywhere

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Triggering as an added complication

•Once traumatized, the human brain obeys the **"negativity bias." It is now primed to preferentially perceive negative cues and react to them as potential threats.** We call this response "triggering" or "getting triggered"

•**The body automatically responds to all danger signals it has ever known:** places, day or night, days of the week or times of year, facial expressions, smells and sounds, weather, disappointment, loss, incompetence, injustice, insensitivity

•Once triggered, we are suddenly **overwhelmed by feelings, sensations, and impulses—usually misinterpreted as meaning "I AM in danger,"** not "I was in danger then"

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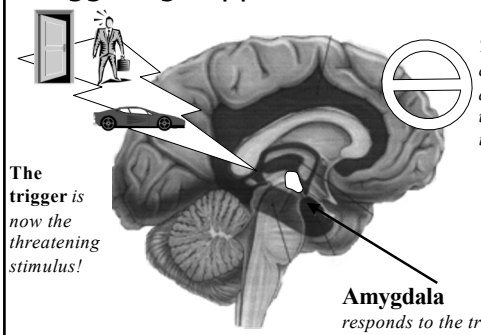
Triggering supports a sense of threat



The prefrontal cortex shuts down to allow us to respond instinctively

The trigger *is now the threatening stimulus!*

Amygdala
responds to the trigger by activating emergency stress response

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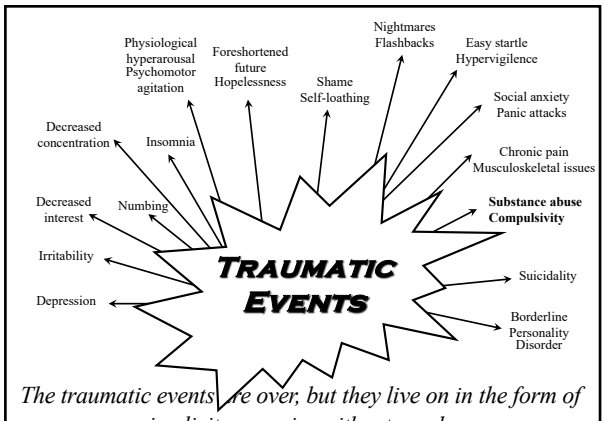

The traumatic events are over, but they live on in the form of implicit memories without words

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"When neither resistance nor escape is possible, the human system of self-defense becomes overwhelmed and disorganized. Each component of the ordinary response to danger, having lost its utility, tends to persist in an altered and exaggerated state long after the actual danger is over."

Herman, 1992

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Nervous System Adapts to a Threatening World

Hyperarousal-Related Symptoms: Fight/Flight
Impulsivity, risk-taking, poor judgment
Chronic hypervigilance, anxiety, ruminations and compulsions
Intrusive emotions, flashbacks, nightmares, racing thoughts
Compulsive behavior: addiction, self-harm, suicidality

Sympathetic Arousal

Prefrontal cortex shuts down

"Window of Tolerance"*

Parasympathetic Arousal

Hypoarousal Symptoms: Submission
Flat affect, numb, feel dead or empty, "not there"
Cognitively dissociated, slowed thinking
Cognitive schemas focused on hopelessness
Disabled defensive responses, victim identity

*Siegel (1999)

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Human beings interpret their trauma-related activation as threat

"Feelings and sensations will rise and fall and run their course—unless we assign danger to them."

Recovery, Inc.

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"Assigning danger" to feelings

- Triggered **body sensations and feelings are interpreted as having negative meaning**
- Accelerated heartrate, tightness or hollow feelings in the chest, freezing, or muscle tension might be interpreted as: "I'm not safe" or "I'm trapped" or "I'm alone"
- **The activation or emotion might lead to fears** of a different kind of danger: "I won't be able to function if I let myself feel this," "I'll be killed if I show anger"
- Or **certain beliefs about the self may become connected to emotional reactions**, such as: "I'm stupid for reacting like this," "It's weak to cry," "No one will ever love me because I'm so defective," "It's shameful to feel these things"

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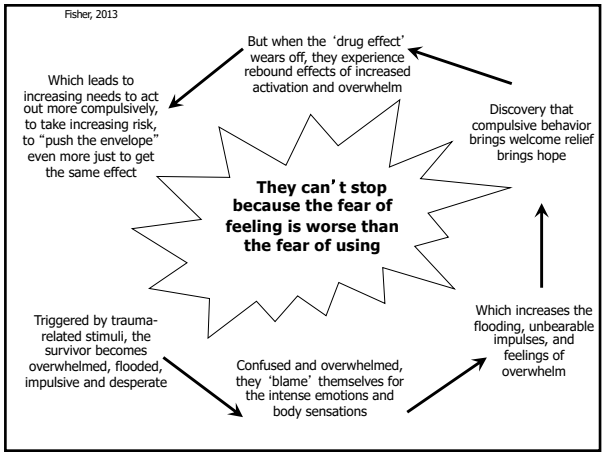

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How unsafe behavior 'helps'

- Jan, recalling abuse at age five: *"Every day, I would say to myself, 'I can die tomorrow.' I got through each day by promising myself I could die the next day."*
- Annie, recalling how cutting helped her to function: *"I would cut myself to get off the floor of the closet and go downstairs and make dinner for my family."*
- Anita, recalling a hospitalization at age 13: *"After I got out, I went to a party and had my first beer. I thought, 'If I have beer, maybe I won't have to go back there again."*
- Peter: *"I survived as a kid by locking myself in my room and eating and masturbating til I got numb."*

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Trauma and self-destructive behavior

Addictive behavior arises not as a pleasure-seeking strategy but as a **survival strategy:**

- *To self-soothe and self-regulate*
- *To numb the hyperarousal symptoms: intolerable affects, reactivity, impulsivity, obsessive thinking*
- *To combat helplessness by increasing hypervigilance and feelings of power and control*
- *To "treat" hypoarousal-related depression, numbness*
- *In the service of walling off intrusive memories*
- *As a way to function or to feel safer in the world*

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How addictive substances "medicate" complex PTSD

Hyperarousal symptoms:

- Alcohol and marijuana: induce relaxation and/or numbing effects, act as a "chemical barrier" to traumatic memory, facilitate social engagement by decreasing hypervigilence and anxiety, induce sleep, enhance mood
- Cocaine, speed, ecstasy, and crystal meth: increase alertness and confidence, provide a sense of power and control that combats helplessness
- Opiods: induce hypoarousal states coupled with euphoria

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How addictive substances "medicate" PTSD, cont.

Hypoarousal symptoms:

- Marijuana: induces numbing symptoms, bring hyperarousal and hypoarousal both under control
- Speed, cocaine, ecstasy, and crystal meth all counteract feelings of "deadness," hopelessness, or weakness
- Opiods: support numbing and hypoarousal while also changing mood from negative to positive

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Eating Disorders and Self-Harming Behaviors

- **Eating disorders:** under-eating or restricting induces numbing effects accompanied by increased energy. Binging lowers arousal, while purging results in a temporary increase in arousal followed by profound hypoarousal
- **Overeating:** induces numbing with relaxation, spaciness, and loss of energy and motivation, resulting in curtailed activity
- **Self-injury**: self-harm stimulates adrenaline and endorphin production in the body, increasing energy and feelings of power and clarity and also buffering the pain. It is instant relief.
- As in substance abuse, **prolonged use of these behaviors leads to tolerance: more and more is needed to achieve the same effect**

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A trauma model for treating addiction

- For traumatized clients, **any self-destructive behavior begins as a post-traumatic survival strategy aimed at regulating autonomic arousal**
- The problem results because **addictions require continual increases in "dosage"** to maintain their effectiveness. Over time, the addiction becomes more severe and less effective. Getting relief requires increasing the risk
- Treatment must the address the **relationship** between the two: the role of the addiction in "medicating" traumatic activation and **the reality that recovering from either requires recovering from both**

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To recover from either, the window of tolerance must expand

Hyperarousal: over-activation creates chronic hyperarousal and desperate craving for relief

Narrow Window of Tolerance

Hypoarousal: numbing, 'deadness' and passivity contribute to need for substance use to either shift or maintain this state

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First, we have to increase activity in the prefrontal cortex

*"In order for the amygdala to respond to fear reactions, the prefrontal region has to be shut down. . . . **[Treatment] of pathologic fear may require that the patient learn to increase activity in the prefrontal region** so that the amygdala is less free to express fear."*

LeDoux, 2003

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Simple ways of "waking up" the prefrontal cortex

- **Evoking curiosity: before we try to problem-solve with clients, we first need to help them be curious.** Curiosity stimulates the medial prefrontal cortex to allow observing
- **Providing accurate information** to counter clients' interpretations: "Let me explain why you might be feeling this way" or "why the cutting brings relief . . ."
- **Helping clients achieve more distance from the symptoms:** universalizing or reframing the symptoms, re-contextualizing them as "just triggering" or "just feeling memories" or "feeling flashbacks"

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Curiosity as a first step

- Rather than trying to help clients regulate addictive or unsafe behavior, **experiment with being endlessly curious. Being interested makes it safer for clients to also be curious** instead of evasive, defensive, or ashamed. Ask, *"How does it help?"*
- **Communicate curiosity in your tone to help the client open up:** "Wow! Something must have triggered you. . . . And then what happened next? You were so committed to staying sober, I know. Were you aware of what you were doing? Or did it just happen?"
- It is rare for clients to **intentionally** act self-destructively. These are moments of impulsivity

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Facilitating mindful awareness

- **Mindful observation in therapy depends upon the therapist becoming more mindful**: slowing the pace of thinking and talking, refraining from interpretation, helping clients simply notice the unfolding of their thoughts, feelings, and physical sensations
- **Mindful attention is present moment attention**. We use "retrospective mindfulness" to bring the client into present time: "As you're talking about what happened then, what do you notice happening inside you now?"
- **Curiosity is still an important ingredient because of its role as an entrée into mindfulness**: "Let's be curious about what triggered you. . ."

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The language of mindfulness

- "Notice what just happened right now . . ."
- "Let us be curious about that. . . "
- "What happens inside you when you remember that?"
- "Notice the sequence: you were home alone, then you started to get agitated and feel trapped, and then you just **had** to get out of the house. How could you tell you needed to leave?"
- "As you say those words, notice what part of you is speaking . . . The addict or the wise mind?"

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Curiosity 1st, Intervention 2nd

- **Approach crises mindfully rather than 'processing' or problem-solving:** *"wake up" the prefrontal cortex, increase awareness of patterns of triggering: what feeling got triggered first? What reaction was triggered next? Then what happened?*
- **Keep building curiosity:** *curiosity regulates arousal, lessens the need to act out, heightens focus, decreases shame*
- **Study the relationship between triggers and impulsive behavior:** *observe overwhelming feelings/impulses as "feeling memory," notice relationships between triggers, symptoms, and acting out behavior*

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Help clients observe the effects of substances on the nervous system

Hyperarousal: when you felt the impulse to use, was your activation higher or lower?

What happened in your nervous system after you used?	*And how long did the relief last?*

Hypoarousal: was your nervous system very numb or down when you felt the impulse?

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Talk about safety and sobriety from the client's point of view

- **Articulate the conflict between safety and unsafety:** the loss of control, of familiarity; the prospect of intrusive feelings; the fear of becoming overwhelmed or feeling "weak"
- **Acknowledge what the client is sacrificing in choosing safety**: loss of immediate relief, loss of control, loss of the "friend who is always there," loss of a social network
- **Foster a "de-coding" approach to acting out or unsafe behavior:** finding the trigger, creating a chain analysis focused on noticing patterns *("When you saw your father, what happened next?")*
- **"Bore the patient into health"** (Kluft) by a relentless focus on deconstructing each and every crisis

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'Boring the patient into health'

HOW do we bore the client into health?

- By avoiding the struggle in which our agenda is sobriety and the client fights for the addiction
- By endlessly connecting dysregulation, trauma triggers, and addictive behaviors
- By helping clients mindfully track the sequence of events and the consequences
- By repeating ourselves patiently and endlessly
- By foreseeing the future without trying for an outcome: *"You can bottom out now, or you can bottom out later," "You can take control of your life or let the eating disorder control it. . . It's up to you"*

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Most common mistakes made by therapists in working with addictive behavior

- Failing to validate the **relief** provided by the addiction
- Failing to see that the client's life and body are not a priority. When the body has only mattered as a vehicle for others to discharge tension, its care becomes meaningless
- Failing to understand trauma-related shame and secrecy: lies feel "safe and normal" and disclosure "unsafe"
- Failing to understand the fear of relying on others rather than relying on a substance or behavior under your own control
- Becoming engaged in a struggle in which we become the spokespeople in favor of sobriety and the client the spokesperson in favor of drug use, neglecting **the task of helping clients to face their own internal conflicts**

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Let the consequences lead the client to sobriety and safety

- As addictions or eating disorders progress and get more severe, there are increasingly negative consequences: blackouts, job loss, auto accidents, hospitalizations, assaults, health effects, deteriorating relationships
- The therapist must capitalize on those by naming the problem: *"Of course you can't just stop using [restricting, cutting], but it sucks that your life is becoming increasingly unmanageable. . . I'm so sorry…"*
- *"This is the problem with addiction: it's good while it's good, then it takes over. . ."*

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Let the consequences lead the client to sobriety and safety, cont.

- At this stage, the client usually suffers from the addictive pattern of blaming other people, places and things for these consequences
- Which means that the therapist has to walk a very fine line. We want to avoid colluding with the client and avoid a struggle: *"That's one way of thinking about it, but it would work better if you weren't using!"*
- *"Oh dear, your life is getting more and more unmanageable, isn't it? Let me know if you're bottoming out. . . You can bottom out any time you're ready"*

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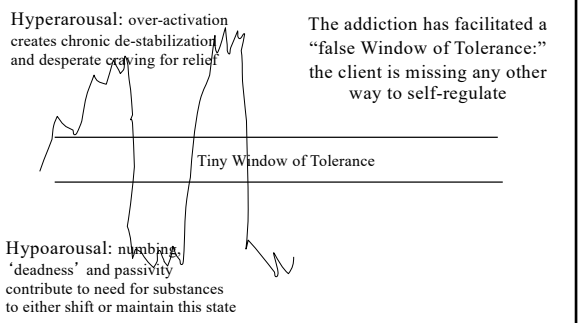
Unfortunately, sobriety brings more challenges, not fewer



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Building the Window of Tolerance bit by bit

Hyperarousal: therapist has to keep asking the client to notice how activated the nervous system is

Notice what's happening in your nervous system. . .	*Don't react to it—just notice it as triggering. . .*

Hypoarousal: or notice how de-activated it is . . .

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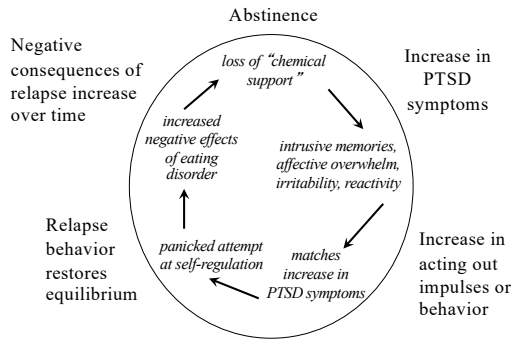
Abstinence/Relapse Cycle



Fisher, 2011

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Re-framing Addictive Symptoms

- **Heighten the client's curiosity about the role of addiction in his or her survival**: what was the timing of the initial attraction to drugs? How did the eating disorder help her to cope? How did later stressors impact addictive behavior?
- **Re-frame the history by assuming that the addiction had meaning and purpose:** "How did the addiction help you to be less afraid? Able to go to work? Or go to sleep? To handle being around people? To act like everything was normal?
- **Re-frame the relationship between PTSD and addictive behavior:** "The cocaine helped you to feel less numb, didn't it?" "So, you drank in order to sleep at night—that makes sense—you can't sleep, but you can pass out," "It makes sense that you needed the speed to be hypervigilant enough to go outside"

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Re-framing Relapses

- **Even relapse behavior is positively re-framed—it is a "golden opportunity"** or a "spiritual opportunity."
- **To challenge shame responses to relapses, clients are asked to notice 'the message' this relapse is sending:** *did they not have enough support? Perhaps she missed the early warning signs that she was starting to get overwhelmed. Perhaps she missed the fact that it was triggering to give her phone number to that guy*
- **The new learning is then celebrated** and the client asked to rehearse new options for dealing with these triggers or with what they evoke

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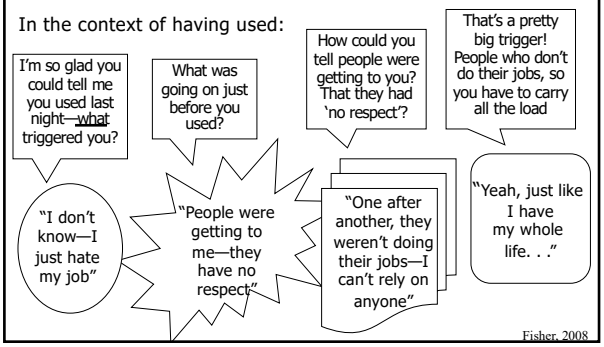
Making mindful connection Between symptoms and triggers



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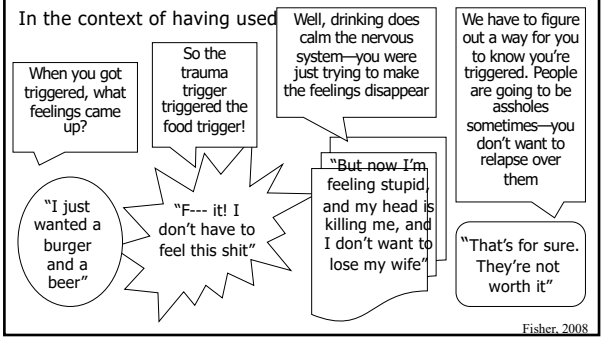
Connecting symptoms to triggers, cont.



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Confrontation versus Reframing

•**Trauma and neglect sensitize us to other human beings,** just as car accident trauma sensitizes us to car-related stimuli. Thereafter, **the body and nervous system will perceive humans as potentially dangerous.**

•**Hypervigilant attention** to tones of voice, body language, pace of speech, facial expressions, gestures, muscle tension **becomes habitual and automatic**

•In working with trauma, we accept that we cannot prevent triggering our patients, but **we can try to use the least triggering forms of communication** because that obtains the best clinical results. The prefrontal cortex **will shut down when triggered, interfering with new learning**

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Increasing the Client's Window of Tolerance

- **Expanding the Window of Tolerance is always an end goal of trauma treatment,** and increasing the capacity to tolerate how we feel is made more difficult by the challenges of early sobriety
- **How can clients expand the Window of Tolerance?**
- **First, we can help them learn to use their existing resources, if any.** Clients often forget there are things that do 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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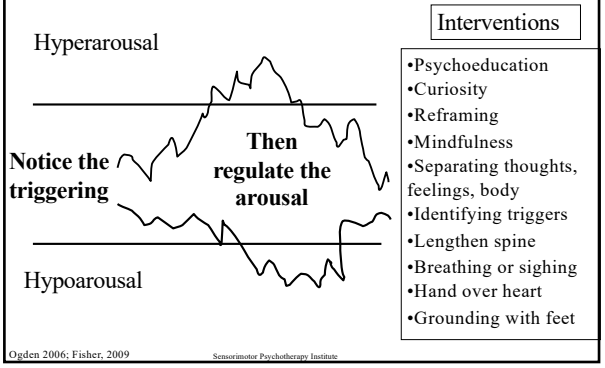
Teaching how to regulate arousal within the Window of Tolerance



Ogden 2006; Fisher, 2009

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Experimenting with somatic resources for traumatic reactions

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

Sensorimotor Psychotherapy Institute Ogden, 2000

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Cultivate "10% Solutions" to Overwhelming Feelings

- Breathing, sighing, releasing tension or taking in calm
- Taking walks, being physically active, yoga, tai chi, jogging
- Watching calming TV shows: eg, the Nature channel
- 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 visualization tapes
- 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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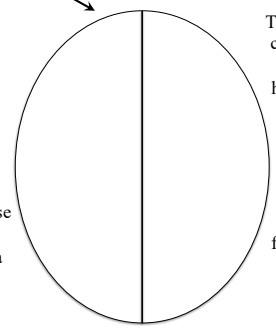
Compartmentalization = Survival

Left Brain

Slow growing in childhood, the left brain or "Chief Executive Brain" gradually learns to reason, organize, plan, learn from experience, and make meaning. It allows us to exercise good judgment and holds the sense of a "conscious, linguistic self" (Cozolino, 2002),

Corpus Collosum does not mature until 12+



Right Brain

The right brain is the child's brain and the survival brain. It holds the sense of a "corporeal and emotional self" (Cozolino, 2002). The right brain lacks words but reads body language and facial expression. It is intuitive, not rational.

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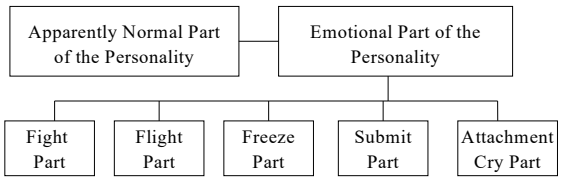
Structural Dissociation: trauma leads to both avoidance and preoccupation



The Emotional Part of the Personality becomes more compartmentalized: separate subparts evolve reflecting the different survival strategies needed in a dangerous world

Van der Hart, Nijenhuis & Steele, 1999

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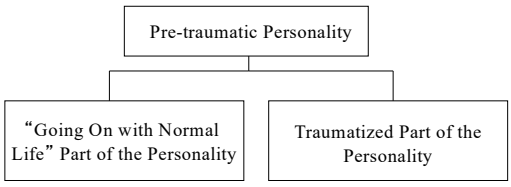
Client-Friendly Language



This Left Brain part of the self "carries on" with normal life and adaptation during and after the trauma

This Right Brain part of self holds both the traumatic memories and the survival responses employed

Van der Hart, Nijenhuis & Steele, 1999

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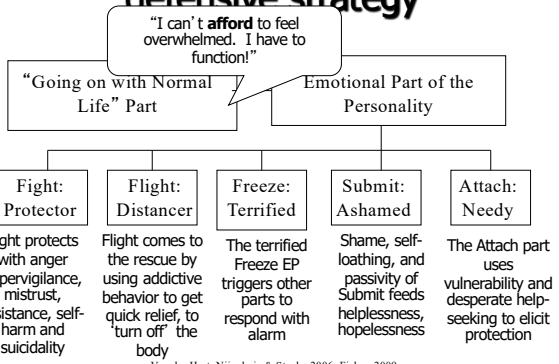
Each part contributes a conflicting defensive strategy



Van der Hart, Nijenhuis & Steele, 2006; Fisher, 2009

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Noticing 'who I am' moment to moment

- **We assume that 'we are what we feel:'** but the repercussions of trauma complicate that assumption. What "I feel" could be a spontaneous response to the present moment, the implicit memory of a part, or a survival response. Further, what we feel gives rise to meaning-making which affects what we feel about what we feel
- **Self-study**: what is happening right here, right now, in this particular moment? **Ask the client to avoid interpretation in favor of just noticing with curiosity. What part wants to drink? Which part is resentful? Whose words is the client voicing?**

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"De-coding:" identifying "parts"

- **Signs of internal conflict:** inability to make decisions, stuckness, trying to stay safe alternating with acting out, alternating sobriety and relapse
- **Emotions:** intrusive, overwhelming and out of proportion
- **Noticeable shifts in mood or behavior:** e.g., from neutral or fearful states to anger and acting out; asking for extra appointments, then not showing up; trust alternating with mistrust
- **Autonomic arousal patterns:** collapsed, numb, passive states versus angry or desperate or suicidal states
- **Cognitions:** "I am worthless and hopeless," "I know you are going to leave me," "I can't trust you," "I trust you completely"

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Establishing Mindfulness of Parts

- **Helping the client to notice the addictive behavior as that of a part,** not the whole of the client
- **Cultivating curiosity:** "Which part smokes marijuana? Which part takes opiates?" "How is that part trying to help?" "What is the addict part trying to prevent or trying to accomplish?
- **Noticing addictive behavior as a part trying to help other parts:** "I see . . . So when the little part of you is crying and crying, the addict part sedates her so she stops crying. . ."
- **Noticing inner chaos and overwhelm as parts:** "Notice the struggle that's going on inside you. . ." "I'm noticing that a part of you wants to go forward, and another part just wants to keep using to get that instant relief."

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Advantages of using the language of "parts"

- **Parts language is a way to cultivate mindfulness,** which allows the client to have a wider Window of Tolerance and prevents highjacking
- **It helps clients to differentiate** scared or ashamed or unsafe parts from their competent, resourced selves
- Parts language **helps clients dis-identify from the symptoms** ("'I' am not depressed, but parts of me are") and re-frame them as parts holding survival strategies
- **It increases self-compassion and self-care**
- It allows the client to utilize the resources of their adult selves on behalf of their younger wounded selves Fisher, 2012

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We use parts language to bring the client's attention to the following question:

"Which one of the many people who I am, the many inner voices inside of me, will dominate [today]? Who, or how, will I be? Which part of me will decide?"

Hofstadter, 1986

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How the parts dominate: "blending"

[Schwartz, 2001]

- When clients become flooded with a part's feelings, thoughts, and impulses, **the parts' thoughts and emotions feel like their feelings.**
- Because they are **not aware that** they are blended and **these feelings belong to the parts**, clients act on them or try to suppress them, forcing parts to become more intense. **Blending with addict parts is thus very dangerous**
- If only to ensure safety, **it becomes the therapist's job to help clients identify that they are blended:** *"Notice that you're blended with the addict part. . ." "Notice that you're blending with the anorexic part right now. . ."*

Fisher, 2023

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Mindful "un-blending"

- **Unblending is a two-step process.**
- **First, we have to help clients notice that they are "blended:"** *"Notice how blended you are with the suicidal part. . ."*
- The client can't "unblend" from any part until they are able to notice they are blended with it
- **To unblend, clients are asked to 'just separate' from the part a little**: *"Just stay with that feeling and notice it as a part trying to tell you how it wants to cut. . . When you notice the impulse and you name it as* ***'the cutting part's,****' do you feel better or worse?"* Most clients report feeling better when they use the 3rd person instead of "I"

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Blending and unblending

- **This stage of the process can be long and repetitive but crucial.** As long as the addict part or suicidal part or eating disordered part is able to influence the client's choices, recovery is in jeopardy
- Focus on blending and unblending should include all distressing feelings on the **assumption that distressing feelings or behavior = parts**
- **Clients with addictive disorders often struggle with feelings that trigger their impulses:** anger, shame, hopelessness, body dysmorphia, sadness. Practice in unblending from parts holding these types of feelings will contribute to unblending skill and recovery

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Respect for protector parts

- Therapists often end up in an adversarial role with addict parts because we are concerned about client safety or because the client enlists us on the side of abstinence. **But if we take sides, we won't make much headway with the treatment**
- **Respect for the fact that addictive, eating disordered, and self-destructive parts are trying to protect means** letting go of our usual goals and **prioritizing collaboration with and compassion for the protectors.**
- The addiction or eating disorder cannot be our enemy. It has to remain the client's problem or internal struggle, no matter how hard they try to induct us into being responsible

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Acknowledging Protectors, p. 3

- **It's always better to acknowledge that a part is a protector** rather than to fail to do so.
- **It's always better to acknowledge the protector's good intentions** even if their behavior is dangerous
- **Assume that whatever the protector is guarding against was originally a very real threat**
- **Never try to talk a protector into change!** That puts you and the part at opposite sides of a conflict
- **Assume the protector's relationship is to the client, not to you!** The problem to sort out: what does the protector part need from the **client on behalf of the parts**?

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Building compassion, step by step

- **Keep in mind that compassion and kindness were once very dangerous** in the client's experience
- Rather than making the goal 'to take care' of the parts, start with the basic ingredients of self-compassion:
  - **Interest and curiosity:** once clients learn the language of parts, ask them to be 'interested' in the part.
  - **Once they can be interested, ask them to listen:** could you just listen to the part who's speaking?
- Interest, curiosity, and listening rarely provoke resistance.
- **The next ingredient is developing empathy for the part.** Explicitly naming it will provoke resistance, however

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Building compassion, p. 2

- **There are two ways to evoke empathy for the parts:**
  - Facilitate imagining them: *"Imagine that little girl was right here in front of you. . . You can see the fear in her eyes. . . the tear marks on her cheeks. . . As you see her here with you, notice your impulse. . ."*
  - "How did this part help you survive?:" *"Did it help that she was so quiet and afraid?" "Did it help he was ashamed?"*
- **Empathy also builds with inner dialogue:** "Ask the addict part what it's worried about if you don't get high tonight. . ."

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Parts and reparative experiences

•In treating trauma, **we should not just be interested in what happened. We should also be interested in what should have happened but DID NOT.** Was the child offered comfort? Safety? A safe base for exploration? Freedom from fear of abandonment? Acceptance of anger and sadness? What were the "missing experiences"?

•**Each part has had a different missing experience:** Submit was not able to say "no" or set boundaries and still be safe and loved. Fight was not able to exercise control or defend the body against harm. Flight was trapped; Freeze couldn't move; Cry for Help was abandoned.

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From alienation to attachment

- **There is a way for all wounded human beings to experience the love and comfort they didn't get 'then:'** by visualizing secure attachment experiences and evoking the associated emotional and body responses
- **"Secure attachment" and "attunement" are somatic experiences:** we feel warm, our bodies relax, we feel an energetic connection and sense of safety. **When our wise minds begin to provide those felt sensory experiences for young child parts, the parts can begin to heal**
- As in all attachment relationships, this work requires consistent attention to the dysregulated feelings of the child parts, not just trying to manage their behavior

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Beginning the process of repair

•**Make sure that the part is present in the moment!** It will not help to work in retrospect or in the memory of trauma because the past cannot change.

•**Instead, ask the client to notice the part associated with any 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 feelings, thoughts, physical reactions——let her know you want to get to know her. . ." "Is she more anxious or more depressed?" "More angry or indignant?"

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Providing "missing experiences" for parts

- **First, encourage inner communication:** "Ask her if she can feel you here with her now? Let her know that we are listening, and we want to understand how scared she is."
- **Be curious about each part's the fear:** is it the fear of annihilation? Or is it fear of abandonment?
- **And encourage clients to sense:** "What does this part need from you right now in order to feel safer?? Reassurance? Protection? Presence? Validation?"
- **Clients are then asked to meet the need:** either verbally, somatically or emotionally

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Repair of internal attachment

- **Emphasize the togetherness of client and child:** "What's it like for her to feel you here with her? To feel your interest and concern?"
- **Cultivate trust:** "Let her know you understand: she wants to trust you but it's hard—she's been hurt so much. What's it like for her to sense that you 'get' it?"
- **Validate the part**: "Of course she thinks it's her fault—that's what she was always told. . ."
- **Encourage inner communication:** "Ask her if she likes it when she feels that you understand. . ."

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Repair of internal attachment, p. 2

- **Each response by the part becomes another opportunity for repair**: "She's saying that she wants to believe you understand, but she's afraid to trust. . . 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?"*

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Capacity for social engagement is a necessity for recovery

- **The social engagement system is a set of hard-wired instinctive response in our bodies** governed by the ventral vagel system in the brain.
- **This 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)
- **Social engagement system is designed to come "online" when we feel safe and go "offline" when we don't—**even if we are safe, it goes off if the body doesn't feel it

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Increasing capacity for social engagement in the therapy, cont.

- For clients to feel safe with us, **we must make use of our own social engagement muscles**, making sure to utilize facial expression, head movements, intonation, and gaze to evoke the client's social engagement system. **Talking about social engagement does not in itself engage the ventral vagal system**
- **We instinctively make use of our social engagement systems when we relate to small children and animals**, but we may not think to use it in the therapy hour with clients who are shut down, resistant, belligerent, anxious or feeling hopeless. Especially, we may fail to use it with clients who are relapsing, unsafe, or acting out

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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 or encouragement?
- **Amount of information provided:** does s/he do better with more explanation? Or does information cause overwhelm?
- **"Go with the resistance:"** admire the hopelessness, mistrust or impulsivity as survival resources!

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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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We can't do it all . . .

"You are not responsible for being down, but you <u>are</u> responsible for getting up."

Jesse Jackson

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What we can do . . .

"Your role as helper is to BE things, not to DO things."

Nar-Anon

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And when the client is crashing and burning, remember:

"In the midst of movement and chaos, keep stillness inside of you."

Deepak Chopra

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