# Treating Trauma Master Series

## How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal

the Main Session with
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Stephen Porges, PhD; and Ruth Lanius, MD, PhD

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Treating Trauma Master Series: Main Session #4

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# How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal

## Trauma Is Not a Life Sentence

**Dr. van der Kolk:** I don't think psychotherapy is done by having people tell stories. Psychotherapy is about people finding a way of getting along with their own internal systems, basically. So that's what the treatment is always about.

> "Psychotherapy is about people finding a way of getting along with their own internal systems."

**Dr. Buczynski:** Dr. Bessel van der Kolk is the world's leading expert in the treatment of trauma.

And to start us off, I want to zero in on something he just said:

Psychotherapy is about helping people find a way to tolerate what they're feeling, what they're experiencing in their body.

Now, I'm paraphrasing Bessel a bit there – but the point is . . .

This may never be more challenging than when we're working with people who have experienced trauma.

Because by its very nature, trauma can disrupt our clients' internal systems. And when THAT happens, it can become very easy for some clients to fall into near-constant cycles of reactivity, hypervigilance, or fear.

That's why it can be critical for practitioners to know how to employ the kind of interventions that can help clients short-circuit old patterns of reactivity, ground in the present, learn to tolerate their feelings and bodily sensations, and learn how to self-regulate.

Hi, I'm Dr. Ruth Buczynski, a licensed psychologist in the state of Connecticut, and the president of NICABM.

Now, I just want to start off with a message to the people watching who aren't practitioners.

This program is made for practitioners – people who have studied for years and have advanced degrees—and for the most part, licenses to practice.

But I know a small percentage of our audience is made up of lay people, people who don't practice in the

field.

First of all, I want to tell you, you are welcome here.

But the second point, and this is really important – the second point that I want you to hear is that trauma is not a life sentence.

I want you to hear that message clearly.

In my descriptions of the trauma experience, I have been careful throughout to say that certain things *can* happen. That doesn't mean they *will*.

And even if they do, that doesn't mean that you can't heal and grow from the experience.

So while it's certainly true that trauma can be devastating, it shouldn't be the way you define the rest of your life.

Now, let's continue on.

In this session, we'll be shining a spotlight on specific ways to help traumatized clients tolerate distress.

We'll look at hyperarousal, but we'll also look at hypoarousal. Now, we generally tend to talk a lot more about hyperarousal than hypoarousal. But today we'll really shine a light on hypoarousal, because it's important to know how to bring a client out of it.

Not only that, we'll also share one practice that can be particularly effective in helping clients bring their thinking brain back online after trauma.

Plus, we'll talk about the critical difference between a brain state where someone is *processing* trauma versus when they are *reliving* trauma.

And toward the end, we'll give you one key symptom that can help you know whether you're working with bipolar disorder versus trauma-related dysregulation.

Okay, so let's jump in.

To start, let's first look at how trauma affects self-regulation, particularly childhood trauma . . .

## How Childhood Trauma Affects People's Capacity to Self-Regulate

**Dr. Ogden:** Surgery might be one example of a childhood trauma. A child can have surgery but also have the integrated and consistent support of the parents who insist on staying with the child at the hospital, etc. So the parent is there, helping the child regulate the whole time.

That is very different from a child who had a trauma that is perpetrated by the attachment figures – where you don't have your attachment figure to help you regulate because they're also the threat. And the effects are much stronger if there's a long duration where the parent is the threat.

Like, if the parent loses it and hits the kid one or two times but otherwise really regulates, that's very different from the child who's hit on a regular basis over a long period of time. So there are different degrees of childhood trauma, and then of course, we're getting into attachment patterns. Is there an ambivalent attachment, an avoiding attachment, or a disorganized attachment? All those have their effects on self-regulation.

**Dr. Buczynski:** Now in Session 2, we went in-depth on the neurobiology of attachment.

But just for a moment, let's stay with attachment here to really consider how it affects our clients' ability to self-regulate.

In particular, let's look at how attachment can affect self-regulation for someone who *has* experienced trauma versus someone who *hasn't* experienced trauma . . .

> "A non-traumatized person with a secure attachment has the capacity to regulate independently of relationships."

**Dr. Ogden:** Well, a non-traumatized person with a secure attachment has the capacity to regulate independently of relationships. So if they're upset or if they're triggered or whatever, they still have a capacity to bring their arousal into that window of tolerance.

They'll go for a run, they'll self-soothe, they'll curl up in bed with a good book, they'll have a nice cup of tea. They can auto-regulate by themselves independently of others.

But a securely attached person can also use interactive regulation. So they can reach out to another. They can call a friend and say, "I need to talk. Can I come over?" They can interact. And both of those are really

"Traumatized clients often have trouble regulating by themselves, but they also have trouble seeking others and taking in the support and regulation of others."

critical.

Traumatized clients often have trouble with both, especially if they've had an insecure attachment. They have trouble regulating by themselves, but they also have trouble seeking others and taking in the support and the regulation of others. So we want to address both of those. And we want to address the ability to use interactive regulation — to reach out, to call a friend — and we want to address how to auto relate, independent of relational contexts.

**Dr. Buczynski:** Now, I'm wondering whether you might recognize some of these patterns in a client you've worked with – especially if they've experienced trauma?

So before we move on, let's just look for one more moment at how early life trauma can affect self-regulation.

Because according to Bessel van der Kolk, there's an important distinction that we really want to pay attention to . . .

**Dr. van der Kolk:** Self-regulation is primarily affected by early-life neglect, abuse, and abandonment, actually. I'm really trying to push the field more into making a distinction between trauma and disorganized attachment.

## One Attachment Pattern That Can Harm People's Capacity to Self-Regulate

**Dr. van der Kolk:** Disorganized attachment is very bad for our capacity for self-regulation. Not being seen and not being known, and not knowing that somebody will come to our rescue when we get upset. To predict a life-long pattern of dysregulation or having to do a lot of hard work to make up for what you didn't get as a kid.

And so if you look at the work particularly of Karlen Lyons-Ruth, who's prospectively studied these kids with disorganized attachment over a 20-year period – she saw age 2 in terms of disorganized attachment, and predicted self-regulatory problems at the age of 18 to 20 or 22 in a major way.

So it's not trauma. It's the attachment system.

> "It's not trauma. It's the attachment system."

**Dr. Buczynski:** So just by way of quick review, disorganized attachment is what can happen when a child grows up with a parent or primary caregiver who is largely unpredictable.

So the child very often just doesn't know what to expect from one day to the next – or in some cases, perhaps even one *moment* to the next.

And what compounds the problem is that the child often cannot find a way to cope with this kind of unpredictability from an attachment figure.

**Dr. van der Kolk:** About a third of kids have mothers who were not very good to them, who are too traumatized, too upset, too depressed, too drug-addicted, too preoccupied to really pay attention to the kids in a proper way.

Most kids actually find a way of coping with that by shutting themselves down and going on mechanically – that's one way of coping with it.

The other way is by continuously asking for attention, becoming a little bit of a pain in the ass. But the worst thing is the environment is so unpredictable that they don't find a consistent way of dealing with their environment, and they just do anything at any time to just cope with whatever happens in a very disorganized way and that — about 10% of the population — goes on to have the most serious psychiatric problems.

**Dr. Buczynski:** So with regard to disorganized attachment, Bessel pointed out two specific coping skills that a child might adopt . . .

Number one – by shutting themselves down and going on about life sort of mechanically, or emotionlessly.

And number two – by becoming a virtually constant attention-seeker.

But it seems that the most dire prognosis for some people who have experienced disorganized attachment is not being able to find any consistent way to respond to or cope with their environment.

Now of course, all is not lost.

Because now that we've looked at the relationship between trauma, attachment, and self-regulation – now

we want to start looking at treatment.

So here's where Bessel begins every time when it comes to helping clients learn to self-regulate.

Maybe you do, too . . .

> "One of the first things I do when I see people is I look at whether they are actually able to live within their rib cages."

**Dr. van der Kolk:** When somebody walks in my office, I look at the way they walk in. I look at whether they're able to make eye contact. I look at their breathing. One of the first things I do when I see people is I look at whether they are actually able to live within their rib cages.

I may spend the first hour with a new patient helping them to just open up their rib cage and to breathe, because as long as that primitive part of someone's brain is all uptight, it's no use to do psychotherapy with them.

So you start off with the most elementary arousal systems of the body. Every session I do that – with everybody.

**Dr. Buczynski:** So it's from this starting point that we might best begin to assess how to resource our most traumatized clients with skills for self-regulating.

The next thing we want to consider?

Well, we want to keep in mind the window of tolerance . . .

## How Trauma Impacts Our Clients' Window of Tolerance

**Dr. Lanius:** When I think about self-regulation, I really think about that optimum window of tolerance. In a non-traumatized client with good self-regulation skills, the window of tolerance is really quite wide.

> "When I think about self-regulation, I really think about that optimum window of tolerance."

And of course, you have to be in that window of tolerance to be able to think clearly, to have good relationships, to plan for the future. If you're outside that optimum window of tolerance, all those abilities are very much affected.

So, when we think about our traumatized clients who have great difficulties with self-regulation, I always

think of that optimum window of tolerance shrinking.

It's very narrow, and usually they're either too hyper-aroused or too hypo-aroused which prevents them from thinking clearly, or from being involved in stable relationships. It prevents them from being really able to function at work because they're constantly juggling either hyper-aroused or hypo-aroused states.

> "It's all about widening that optimum window through emotional awareness."

So, I think self-regulation is all about being in that optimum window of tolerance and widening that optimum window through emotional awareness, through learning how to regulate your emotions, and through really coming into your body and feeling safe in your body.

**Dr. Buczynski:** That was Dr. Ruth Lanius. Ruth is Professor of Psychiatry and director of the post-traumatic stress disorder research unit at the University of Western Ontario.

She's just given us an excellent sort of snapshot of Dr. Dan Siegel's concept of the "window of tolerance".

**Dr. Ogden:** I use that phrase to describe the space or the zone of optimal arousal within which information can be effectively processed and integrated. And that means integration of external information (like what's happening in your world), as well as internal information.

And when trauma happens, arousal bursts through that window of tolerance and goes way up, or it can also drop way down under that window of tolerance. In those two arousal states, you can't really process things effectively.

**Dr. Buczynski:** That was Dr. Pat Ogden. She's an expert in somatic psychotherapy and the founder of the Sensorimotor Psychotherapy Institute.

Now in many ways, the treatment of trauma is very much about working to expand our clients' window of tolerance.

Real quick - when we're talking about this "window of tolerance," we're basically talking about this sort of "equilibrium" between our different systems that helps us regulate during times of stress.

As Pat said, when arousal gets revved up, it can move the client way above their window of tolerance.

So we have to help them come back down.

Now as we also heard, arousal can plummet, which can drop your client below the window of tolerance.

But we also have to remember that different circumstances can affect the "size" of our window. Our windows can shrink when we lack the skills or the healthy attachment models that can keep the window open.

So let's look at how we can help our clients expand their window of tolerance . . .

## How to Help Traumatized Clients Expand Their Window of Tolerance

**Dr. van der Kolk:** If we know how to do it for ourselves, we know how to do it for other people. Because most of us are patients. Let's face it. So how do you expand the window of tolerance? By learning to be calm and to stay focused and by activating that mindful brain.

What's very clear is that we have these midline structures. The midline structures of the brain are the interoceptive parts of the brain, and we can only really become masters of our own ship by activating these interoceptive structures of the brain.

That means that in order to be in charge of ourselves, we need to shut up, be still, and notice what goes on inside, and to notice the flow of our internal states.

> "You need to just really pay attention to what goes on inside of yourself and notice what comes up. It can be very scary."

You need to just really pay attention to what goes on inside of yourself and notice what comes up. And it can be very scary. And that's why we have therapists who can help us, to guide us, to keep paying attention to our internal world, to our internal flow. I think it gives us the courage to notice what we notice inside.

**Dr. Buczynski:** So one way to help clients widen their window of tolerance is by activating the parts of the brain that are involved with interoception.

Now as you know, interoception is basically that sense that helps us understand and process what's going on in our body. And so it follows that people who struggle with interoception also often struggle with self-regulation.

So by working with mindfulness and with presence, we can help people activate the interoceptive parts of

the brain – and thereby boost their capacity to self-regulate.

Now if you remember Session One of this series, you might remember hearing that presence can also be a major catalyst for boosting integration and even for reducing inflammation.

Presence is being conscious of ourselves, of our movements, our thoughts, and our feelings . . . and now we see how presence can also play a role in expanding people's window of tolerance as well.

But broadening a narrow window of tolerance can also involve accessing a client's dysregulation . . .

**Dr. Ogden:** When a client has a narrow window of tolerance, they don't have much room in there to experience life. They have so many triggers that cause their arousal to shoot up or to drop down.

So in our work, we want to start really working at the edges of the window. If you stay in the middle of the window — if the arousal is just in the middle — you don't access any dysregulation and thus you can't regulate. You can't help them regulate.

If you think of a baby who gets dysregulated and then the mother or the father comes and holds the baby and soothes the baby and calms it down, that baby's window of tolerance starts to widen, and they start to develop those connections between the cortex and the subcortical brains.

And if we think of that in therapy, it's really the same. We're working at the edges of that window where dysregulation happens. And then, we're staying at that edge, staying with hyperarousal. We're staying up there with that hyperarousal. And we're helping them process and re-regulate.

And in that relational, somatic, emotional, cognitive endeavor, their window of tolerance starts to expand, and expand more, and expand more and more and more.

**Dr. Buczynski:** So being comfortable around dysregulation – and knowing how to stay with a client's hyperarousal – can be an essential part of helping clients expand their window of tolerance.

But before we can begin to work with their dysregulation, we might need to help our clients learn to tolerate the dysregulation in the first place. So, how would we do that?

**Dr. Porges:** I would give them tools that they could potentially use to self-soothe, because the tools would be relatively simple. And I would demonstrate to them the effects of these simple tools.

So when people change how they breathe, and they start to exhale more slowly, it's calming to their body,

and they can just compare that to more of a hyperventilation, or where they do much more on the inhalation where people literally get themselves mobilized.

And when they get angry, their breathing changes which supports their anger. And you can actually walk them through these different stages.

**Dr. Buczynski:** That was Dr. Stephen Porges – he's the creator of Polyvagal Theory, and he's just given us a look at how breath work might help us.

When it comes to accessing a client's dysregulation, or helping someone work through hyperarousal, we want to get them to change their breathing.

Specifically, we want to get them to slow their exhalations in order to help them calm their body.

## What Happens in the Body During Hypoarousal

**Dr. Buczynski:** Now so far, we've talked a lot about *hyper*arousal, especially with regard to the window of tolerance.

That's because, when we think of dysregulation we often think more about hyperarousal.

And because, of course, this state of heightened anxiety is quite common for people with PTSD.

But we also very much need to keep in mind how to work with someone who is in a state of *hypo*arousal. That's when the body slows down and even begins to *shut* down.

As you know, people can fall into hypoarousal when they're not able to fight back, or to flee from danger.

So let's think for a moment about our clients who have experienced trauma in a situation where they couldn't fight back or get away. For them, hypo-arousal might have been a very common adaptive response.

So now, let's take a closer look at what's happening when someone is hypo-aroused . . .

**Dr. Ogden:** In hypo-arousal, people's dorsal vagal system has increased tone. Sometimes a client has a hard time moving. They start spacing out. They don't feel presence.

**Dr. Buczynski:** When someone is hypo-aroused, they can often slip into immobilization – and immobilization

can sometimes downgrade into a “feigned death” response.

The feigned death response is sort of our “last-resort” option in the face of trauma – we might default to it when no other escape route is available.

Now ideally, you’d want to try and prevent a person from entering into this response to begin with. But sometimes it can happen very quickly.

So there are two things to keep in mind when we’re working with someone who goes into hypoarousal.

Number one, you want to think about movement. And number two, you want to think about social engagement . . .

**Dr. Ogden:** As they're starting to slide down toward that immobility, you want to catch them before they really drop way down, because it's harder to get out of it once you're way into it.

So you want to track through the spacey-ness. You want to track through that stillness that starts to happen, and then you want to re-establish social engagement. "What's happening right now? Can you feel your legs?"

"No, I can't feel my legs."

"Okay. Let's just stand up, you and me. Let's stand up. Let's walk around the office a little bit. Feel your feet on the floor."

And so you do a little bit of movement, and you help them come back and help their arousal come back up into that window.

Sometimes people don't track with the signs. This has happened to me a few times. And then sometimes they can't move. And they often even become mute. They can't talk. So that those times, with highly dissociative cases this happens. This can happen frequently. And you have to find ways to help them come back.

**Dr. Buczynski:** So let’s look a little further into how we might help them come back.

## How to Bring a Client Back from a State of Hypoarousal

**Dr. Buczynski:** Well, as Pat said, the first way is through movement. Movement is a very important catalyst here.

The second way is by talking with the person about the parts of the self.

Because according to Pat, when trauma causes a dissociative response, our clients can develop parts of the self that don't communicate with each other.

And so in those cases, we're trying to help clients work with their fragmented selves.

Here's an example . . .

**Dr. Ogden:** I had one client who said that in her previous therapy, she'd wanted her therapist to slap her because she couldn't get out of that state. And the first sessions she had with me, she couldn't remember it afterwards. She's highly dissociative.

So when she came back for the second session and I asked her about the first session, and she said, "I don't remember it," that was a real cue for me.

So we started talking about how there's this part of you that can go into that state, and when you get into that, it's like you become that part. So let's start finding the triggers for that state. Let's start finding the bodily sensations and movements that start to happen so we can catch it before you go all the way into it.

So for her, she would start to feel her eyes shift in some way. That was like the precursor to really going into that state. So that became a helpful bodily element that she could watch for and catch it before she went all the way into that hypoarousal.

**Dr. Buczynski:** Now, one important thing to note here . . .

Hypoarousal and dissociation are connected *some* of the time, but not *all* of the time. Someone *can* experience hypoarousal with*out* moving into dissociation . . .

> "Hypoarousal and dissociation are connected ***some*** of the time, but not ***all*** of the time."

**Dr. Ogden:** Yes, absolutely, because low arousal is really our dorsal vagal system, that one branch of the parasympathetic system that helps everything slow down.

So we can co-opt the dorsal vagal system, say, to go to sleep at night, to relax with a loved one during Savasana yoga – that definitely stimulates the dorsal vagal system.

One of the difficulties with traumatized patients is that immobilization is coupled with fear. So when they start to become immobilized, they become fearful, which prevents healthy sleeping patterns, prevents being able to rest.

**Dr. Buczynski:** So it might be worth noting here that the dorsal vagus is also what helps the body shift gently back and forth between arousal and relaxation.

> "The dorsal vagus is what helps the body shift gently back and forth between arousal and relaxation."

And when it shuts down, that's when our traumatized clients can start to experience the kind of difficulties that Pat is talking about.

So now that we've looked at the contrast between hyperarousal versus hypoarousal, and how each can affect the window of tolerance . . .

Now, let's look at how we can move a client back into their window of tolerance once they've slipped outside of it.

## How to Help Clients Shift Back Into Their Window of Tolerance

**Dr. Ogden:** Well, it depends how far out. And it depends on the client.

If somebody is just out of the window of tolerance, I'll often look for a bodily resource or a relational resource. Sometimes, it's enough to say, "Can you look at me? This is Pat. Right here, in the here and now – can you sense that? Can you sense this moment?"

Often when a person is really outside of the window of tolerance, they're in what Onno van der Hart calls *trauma time*, which is an expression I loved. They're not here in the here and now, realizing that they're *safe*, that there's somebody who could be trusted. They're back in trauma time.

> "Often when a person is really outside of the window of tolerance, they're not here in the here and now, realizing that they're ***safe***. They're back in trauma time."

So helping them somehow orient to the here and now through the relationship, through movement, through a resource like breathing or lengthening the spine, or feeling your feet on the floor, or containment – some kind of containment exercise can help a person come back into the here and now.

**Dr. Buczynski:** Pat's just given us some good guidelines for how to help a client shift back into their window of tolerance.

To do it effectively, we first need to consider whether they're just a step or two outside of it, or *way* outside of it.

When clients are just a bit outside of it, we might do it relationally – by bringing the person's attention to the present, for instance.

But when a person is in "trauma time," a bodily approach might be the more effective way to go – and we can do that through movement and breathing, just to name a couple ways.

Now let's go back to look at the brain for a moment – and look at *how* the brain deals with stimuli.

To do this, we need to introduce a new term – Evoked Response Potentials . . .

**Dr. van der Kolk:** Evoked response potentials are a way of measuring how the brain engages with novel stimuli and makes distinctions. And so in order for the brain to engage with something, it needs to have two capacities.

One is to ignore irrelevant stimuli. There's a certain wave that is being generated. As you talk to me, I have this little wave that says, "Don't pay attention to whether you're hungry right now or what you have to do next. So stay focused."

And the next thing is you need to fully engage with what's going on, pay attention, and to evaluate what's happening.

So what was discovered in PTSD is that people have a hell of a time filtering out irrelevant stimuli, and they also have a great difficulty getting fully focused on what's happening.

And what we saw clearly here, was how hard it is for many traumatized people to really learn and to grow from new experiences because there's some fundamental deficits that get in the way of absorbing new information.

"In PTSD, people have a hell of a time filtering out irrelevant stimuli and getting fully focused on what's happening."

**Dr. Buczynski:** So to review . . .

Trauma can impair a client's ability to stay focused, to ignore certain stimuli, and to engage with the present.

And because of that, it can be hard for people who've experienced trauma to learn from new experiences.

And THAT's because without focus we can't absorb new info.

So in treatment we need to focus on two things.

Number one, we want to retrain the brain so it can begin to ignore any irrelevant stimuli.

And number two, we want to help the brain to fully lock in on the present and evaluate what's going on.

But when a traumatic experience has derailed the brain's natural ability to do those things, how can we help?

## Three Strategies That Can Improve the Traumatized Brain's Capacity to Focus and Engage

**Dr. van der Kolk:** We train the brain with neurofeedback. Neurofeedback is my main research these days, and seeing how you can alter those things. It's the only thing that I know that can do that. I don't know anything else that can – although I suspect that boxing, martial arts, and playing music in a band can also do it.

> "We train the brain with neurofeedback."

It's all about getting in sync with people. It's all about, "I'll have to beat when the guitar plays that, I need to play it."

When you're boxing, somebody comes in here, you need to duck at the right time. It's all about rhythm and interaction.

That's living in the present.

**Dr. Buczynski:** So we want to strengthen someone's ability to engage and stay focused on novel stimuli.

Bessel noted three things in particular that can help – neurofeedback, getting in sync with people, and living in the present.

So in addition to retraining the brain for better focus and engagement, perhaps the larger goal here is to help clients learn to self-regulate and tolerate distress.

So how do we do that?

## How to Help Clients Tolerate Distress After Trauma

**Dr. van der Kolk:** You learn self-regulation by *noticing*, by noticing your distress and continuing to go on even though you notice it.

Meditation is a great way of doing it. So is sitting still and noticing when stuff comes up to you. *I wonder what happens if I take another breath? I wonder what happens if I sit here a little bit longer?* To enlarge the window to which you can learn to tolerate your distress.

> "You learn self-regulation by ***noticing***. Meditation is a great way of doing it."

But of course, a great way of doing it is to do the ancient practices that the Chinese and the Japanese and the Indians developed in terms of yoga, meditation, zen practices, taekwondo, qigong – all of those practices are mindfulness practices basically.

**Dr. Buczynski:** So – there's mindfulness again.

And what you've just heard is another way that mindfulness can play a role in healing – in this case by helping people increase their distress tolerance.

Now as you might know, there's a little more about mindfulness that we need to talk about, especially when it comes to asking some clients to "sit still."

Because for people with unresolved trauma, sitting still could actually be extremely difficult, even distressing. We'll be getting into why that is in the next session.

But while we're at it, there's another mindfulness-based practice that we may need to modify for people who have experienced trauma – and that's the body scan.

As a Gold Subscriber, you'll have a bonus on one way to do this. In this bonus, you'll hear about how to identify when a client's response to trauma is protecting them . . . and when it isn't.

Okay, so getting back to the topic at hand . . . yes, mindfulness practices can indeed be useful for helping clients learn to endure distress – as long as we're aware of the precautions we might need to take. And we'll

get more into that in the next session.

But there's still one other important ingredient for helping clients build up a tolerance for frustration.

And that's acceptance . . .

**Dr. Lanius:** The whole notion of acceptance is very important here, and it's a very difficult thing for traumatized clients because often they feel that acceptance means that you like something.

So, I think it's really important to teach people that acceptance is not about liking something but accepting the present, keeping in mind that we're learning in therapy something that can help them change and improve how they are.

> "Bringing this notion of acceptance into therapy early is really important."

So, I think bringing this notion of acceptance into therapy early is really important because so many of our traumatized clients spend so much time pushing away their distress, not accepting it.

Of course, that makes the distress worse, so the more you try to push it away, the more intense the distress becomes. But, over time, our clients learn to accept it more. Basically, accept the stance that *I'm in agony and it's horrible but I'm learning skills to change this.*

**Dr. Buczynski:** Now I want to key in on one thing in particular that Ruth just said.

And that is . . . it's very often avoidance that can make a difficult situation – almost ANY difficult situation – even worse.

That's why working with acceptance can be essential in the treatment of trauma.

So now, let's take things even a step further.

Because we also want to consider a few brain-based ways to help traumatized clients strengthen their ability to self-regulate.

## Brain-Based Approaches for Helping Clients Strengthen Their Ability to Self-Regulate

**Dr. Buczynski:** So first, let's go to the brain stem.

Because according to Stephen Porges, the brain stem is something we might think of as a "pivot point" . . .

**Dr. Porges:** It's a pivot point between higher cortical cognitive functioning, higher brain structures, and the body. And the brainstem is, in a sense, very primitive, very old through evolution, through our phylogenetic heritage.

**Dr. Buczynski:** Now, in addition to being a pivot point, the brain stem also has another role. And that role is being our innate alarm system.

When someone has experienced trauma, this alarm system is often kicked into overdrive. So when that's the case, how can we help clients "retrain" this alarm system?

In other words, how can we help them reconnect the brain stem response with higher brain functioning – the thinking brain?

## How to Help Traumatized Clients Reengage the Thinking Brain

**Dr. Lanius:** I think that's a great question, and I think that's exactly what's at the core of trauma – that these lower brain structures function independently of the cortex, and the upper part of the brain that can actually engage in top-down modulation.

So, we have all these circuits that are running crazy and we've lost that top-down control. So, how do we reestablish that? I think this is really what we do in treatment. I think there's two ways to go about that.

One way is called a bottom-up approach and the other way is called the top-down approach. Probably using a combination of bottom up and top down approaches is most effective.

So, a bottom-up approach would be working with defensive action, working directly with the midbrain, helping to complete those defensive actions such as the sensory-motor psychotherapy or Peter Levine's treatment. That would be a bottom-up approach.

"We have all these circuits that are running crazy and we've lost that top-down control. So, how do we reestablish that?"

Another therapy that's recently been published on is the comprehensive resource model and that therapy is

aimed to directly work with the emotional responses that are generated at the midbrain level.

So this is a treatment that really tries to resource people, and in a resource state, then encourages them to step into the emotion that they felt at the time of the trauma.

The hypothesis is that by dealing with the affect or the emotion at its root, that you reregulate the brain from a bottom-up kind of perspective and bring online these upper parts of the brain that can then regulate the brain top-down.

**Dr. Buczynski:** So to summarize, Ruth just highlighted two bottom-up approaches in particular . . .

Number one – helping clients to complete their defensive actions, which involves working directly with the midbrain and employing the sensorimotor approach of psychotherapy . . .

And number two – the comprehensive resource model therapy that focuses on working with emotional responses that are generated at the midbrain level.

But top-down approaches can be equally effective in the treatment of trauma.

One example of a top-down approach we might use? Well, cognitive behavioral therapy.

So ideally, you'd be teaching people how to think differently about the things that affect their emotions.

But often, there's one key factor that needs to be in place . . .

**Dr. Lanius:** I think what's important to be aware of is if this disconnect is very prominent where the lower parts of the brain are disconnected from the upper parts of the brain.

> "Working both bottom-up and top-down over time will really help the person then be aware of what they're feeling."

If that is extreme, how much working with the upper parts of the brain can affect the lower parts of the brain if you have a disconnection?

So considering how much do you have to reconnect before using upper parts of the brain to regulate lower parts of the brain, I think, is really important. I don't think we know this at present.

But I think working both bottom-up and top-down over time will really strengthen these connections, and help the person then be aware of what they're feeling, intervene early, being able to regulate their feelings, and being able to connect these intense feelings with what may have

happened in the past and make sense of them.

So, if they feel really overwhelmed in the present by something that may not be all that triggering, but if they feel an intense emotional response, slowly becoming aware of the fact that this must be triggered by something in the past and how can we overcome this?

**Dr. Buczynski:** Now Ruth has just given us a useful framework for using a combination of top-down and bottom-up approaches with clients who have experienced trauma.

So next, let's look at another way to help clients reconnect higher brain functioning with their brain stem response after trauma . . .

Or to put it a different way, how can we help someone who's been traumatized bring their thinking brain back online?

"Mindfulness is key here."

**Dr. Ogden:** I think mindfulness is key here because traumatized clients will not have that cortical connection when they're having that trauma response. If we take that window of tolerance and arousal as outside of the window, their thinking brain is not online – often not at all.

So for me, helping them reconnect has to do with accessing a little bit of that reptilian brain response, and then having them report what that feels like, to tell me, and just stay socially engaged with me.

"Traumatized clients will not have that cortical connection when they're having that trauma response."

So if a client says, "I see that mugger coming towards me, and I started to tighten up, and I can't move." They're going into a freeze response, which is a reptilian brain instinctive response.

I would say, "Okay, let's stop right there and just feel your body. Can you tell me where the tightening is?"

**Dr. Buczynski:** Now whichever way the client answers, you might then say to them "Okay, let's stay with that."

"And as you stay with the tightening, what are you experiencing?"

Ask them what else they can tell you about the sensation – whether it's sharp or dull, constant or intermittent. Details like that. Because when you do that, here's what you're essentially doing . . .

## The Critical Difference in the Brain Between Processing Trauma and Reliving Trauma

**Dr. Ogden:** You're listening to their frontal lobes to describe to you that instinctive reptilian brain response, and I think that really helps the integration because they have to experience that dysregulation of those instincts in the fight, flight, freeze, feigned death, and the attachment cry too.

They have to experience that to be able to integrate. But if they experience that without their frontal lobes being online, that's a re-enactment of the trauma. That's not going to do any good.

So I insist that a client report to me what's going on. And if they can't, I'll say, "Okay, let's stop and talk about this," because there's no point in proceeding if they can't tell me what's going on, and they can't stay engaged with me.

> "There's no point in proceeding if they can't tell me what's going on."

**Dr. Buczynski:** Now here's the piece we really want to get ahold of here . . .

We want our clients to be able to *experience* their dysregulation, yes. But not unless they can also *describe* that dysregulation.

Because *that* is what brings their brain's frontal lobe online.

And that's the key difference between someone who is processing trauma versus someone who is just reliving trauma.

Now as we move on, I'd like to talk a little more about the dysregulation that can happen during trauma.

Because earlier, we said we'd give you one key symptom that can help you know whether you're working with bipolar disorder versus trauma-related dysregulation.

This is important because it can help us when it comes to landing on the right diagnosis – and therefore, of course, choosing the right treatment . . .

## How to Know Whether a Client's Dysregulation Is a Symptom of Bipolar Disorder or Trauma

**Dr. Lanius:** I think there is one symptom that really helps me to distinguish bipolar disorder from emotion dysregulation.

I think one of the most important systems that helps to distinguish the two disorders is sleep.

So, in bipolar disorder, when you're in a manic state, the person actually needs less sleep. People will tell you, "I got really high and I had tons of energy. I thought I could control the world, and an hour of sleep was absolutely fine for me. I didn't need anymore."

When we hear that, that doesn't sound like our trauma patients, right? They're very different.

Our trauma patients often have very chronic and persistent sleep problems. So, they will tell us, "I couldn't sleep, I can never sleep, I never feel rested when I wake up."

So, they may even be in a state that appears hyper-energized, and often that's driven by anxiety. But it will never be accompanied by them saying, "I didn't need sleep. I was fine on an hour or two."

So, I think this decreased need for sleep is really helpful in distinguishing bipolar disorder from this trauma-related emotional rollercoaster.

**Dr. Buczynski:** So Ruth just laid out a way to distinguish the emotional dysregulation that can come from trauma – to distinguish *that* from the manic part of bipolar disorder. And that is through sleep.

What we're saying here is – patients who have experienced trauma can sometimes have a lot of trouble sleeping. They can get up in the morning feeling very tired.

That's very different from bipolar disorder, when someone is in a manic state. In that circumstance, the person usually feels like they only need an hour of sleep – and they have times where they get no sleep at all and still feel ready to go.

The other point Ruth made that I think is so important, is that we don't want to confuse the hyper-energized state that comes from trauma-related anxiety with the manic state that goes with bipolar disorder.

That manic state has a more grandiose sense to it – more of a sense of controlling the world.

# About NICABM . . .

**Ruth Buczynski, PhD** has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she's been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she's expanded into the 'cloud,' where she's developed intelligent and thoughtfully researched webinars that continue to grow exponentially.

**The National Institute for the Clinical Application of Behavioral Medicine** is a pioneer and leader in the field of mind-body-spirit medicine. As a provider of continuing education for health and mental health care professionals for over 20 years, NICABM is at the forefront of developing and delivering programs with "take home" ideas, immediately adaptable for practitioners to use with their patients.

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