Treating Trauma Master Series

How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal

a TalkBack Session with
Ruth Buczynski, PhD; Ruth Lanius, MD, PhD; and Ron Siegel, PsyD

National Institute for the Clinical Application of Behavioral Medicine

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Treating Trauma Master Series: TalkBack #4

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How to Help Clients Tolerate Dysregulation and Come Back from Hypoarousal

Dr. Buczynski: This is the part where we're going to synthesize all the ideas from Session 4. I'm joined by Dr. Ruth Lanius and Dr. Ron Siegel. Ruth is a professor of psychiatry at Western University of Canada, and Ron is assistant professor of psychology part-time at Harvard Medical School.

How to Work with Acceptance – Helping Clients Understand the Difference Between *Accepting* Experience vs *Endorsing* Behavior

Dr. Buczynski: Let's jump in and start by talking about what stood out to you this week.

Dr. Siegel: There were many helpful themes this week. One – the role of disorganized attachment in the diminished ability for self-regulation. Particularly the point that that's often more important than trauma, per se.

> "If we have disorganized attachment in our development history, it doesn't take much for trauma to be quite dysregulating to us."

If we have disorganized attachment in our development history, it doesn't take much for trauma to be quite dysregulating to us.

There was a lot of discussion about understanding and finding ways to help people find optimal windows of tolerance, which is, as we've already discussed, really quite important and central to our work – both in terms of how to feel out the edges of that and how to help people be mindful of the experience within that realm; helping people through mild and extreme hypo- and hyperarousal; and the need for bottom-up and top-down approaches. Each one of these is important, and we'll get to all of them.

But there was one little idea that Ruth L. mentioned, which I think deserves underscoring and some more attention – because I actually run into this a lot clinically.

She pointed out that many traumatized folks resist this idea of *acceptance* – the idea that the goal of our enterprise here is to open to

> "Many traumatized folks resist this idea that the goal of our enterprise is to open to ***be with*** and ***accept*** the experience."

be with and *accept* the experience.

She mentioned that they might interpret it as though acceptance means to be *endorsing*, or *liking*, or somehow *approving* of the experience.

Most folks who've been through trauma have some pretty strong feelings about justice. They've lived through a lot of what feels like really bad injustice so they tend to be quite sensitive to the idea that "I don't want to take part in an enterprise that's going to somehow endorse or allow bad things to continue to happen." And, of course, they're frightened by and want to stop perpetrators.

Again, I'm thinking of the patient I mentioned who was *very* reactive to men who were at all aggressive, because she had a very aggressive father. If she sees these stories on the news of some guy doing some bad thing that guys do, she wants the immediate death penalty for *that* guy – otherwise, she's politically relatively liberal. But, it comes out of this fear and this reactivity and this feeling, *This stuff must be stopped.*

> "When we're talking about acceptance, it's very important to talk about the difference between ***accepting*** experience as it's arising in our own body and ***endorsing*** a certain kind of behavior."

So, when we're talking about acceptance, I think it's *very* important to talk about the difference between *accepting* experience as it's arising in our own body, mind, heart, imagery, and *endorsing* a certain kind of behavior – or even suggesting that we would allow that behavior, that we will not punish the behavior, or not, at least, intervene to stop the behavior. People often confuse these two.

If you're just teaching mindfulness practice to any kind of broad audience, a fair number of people say, "Yes, yes, but what about bad things? We shouldn't be accepting bad things – we should be stopping them."

And frankly, mindfulness practice and psychotherapy generally don't tell us what the often more social intervention should be for criminal behavior or even just for unfair behavior in the marketplace. That's a complicated legal, social, political question.

But what these practices *do* tell us is how we might work with the feelings when they're coming up in each moment.

I think being very explicit about this with our clients or patients is actually helpful because then it allows them to understand, "Yes, it's okay to want to do something about the behavior, and yes, we can work on allowing these thoughts and feelings to arise in our consciousness."

Dr. Buczynski: What about you, Ruth – what stood out to you in this session?

Dr. Lanius: We're at the core of the effects of trauma, and that's that *incredible* emotional rollercoaster our patients experience – right? They're going up and down; their emotions are changing minute by minute – sometimes second by second, sometimes hour by hour – but they have no control over their emotions. That's an incredibly frightening feeling.

I think it brings back several of the earlier sessions. Again, it brings us back to attachment, as Ron also talked about – attachment being the critical piece that allows emotional brain development, which allows these emotions to be regulated in a good way. Our patients haven't had that.

"Attachment is the critical piece that allows emotional brain development, which allows these emotions to be regulated in a good way."

It also brings back to what we've talked about so often: the window of tolerance.

If we don't have a secure attachment, if we have a disorganized attachment, people don't have a wide window of tolerance. Their window is very narrow and very quickly they become dysregulated – either hyperaroused or hypoaroused.

It has big implications for assessing traumatic-stress clients. When we think about the importance of emotion -regulation symptoms, these are symptoms that bring people into the emergency department; these are symptoms that people get hospitalized for. How can we understand them better?

Often, we're taught to take a trauma history, but I don't think that's enough. I think we really need to understand the traumatic experience in the context in which it occurred.

I always give this example. Teenager A was raped and then comes home and the mother says to the teenager, "God, you're a *slut*! What did *you* do to get raped?" versus Teenager B who comes home after a rape and the parents embrace the teenager and say, "Oh, my God – what an awful thing to happen to you."

"We can't just take a history of trauma; we have to understand the traumatic experience in the context in which it occurs."

We can't just take a history of trauma; we *really* have to understand the traumatic experience in the context in which it occurs.

It brings back all these things we've talked about and really centers us on these incredibly difficult symptoms

for our client – this difficulty with emotion regulation and self-regulation.

How Mindfulness Can Be Used to Construct a Sense of Self

Dr. Buczynski: Ron, expanding the window of tolerance often requires activating the interoceptive parts of the brain, and that's something that mindfulness can be really useful for. Can you share how you've used mindfulness with a client to help them with self-regulation after a trauma?

Dr. Siegel: Pretty much everybody in this session talked about mindfulness as a resource and talked about it as a way for combining top-down and bottom-up integration.

We use mindfulness practice to notice the experience here and now in the body, to be able to feel what's happening. We also use it in therapy to ask people to report *out* on their experience and to begin to put some words to that, which starts to introduce something more of a top-down approach to it.

> "If whenever pain arises in the body we try to stop it, we're not going to be able to really ***feel*** all of the dissociated feelings that are associated with the past trauma."

To develop the distress tolerance, it's necessary to work with painful feelings. If we have an instinctive reaction that whenever pain arises in the body, we distract or turn it off or try to stop it, we're not going to be able to really *feel* all of the dissociated feelings that are associated with the past trauma.

So mindfulness is very, very useful in this way. But what *didn't* get discussed explicitly in this session was that mindfulness practices do two things simultaneously.

On the one hand, they attune us to interoceptive processes; they help us to feel what's going on; and the increase our tolerance *to* feel what's going on, to be able to actually *be with* the discomfort.

But the other thing that they do is soften the repression barrier. They actually make more material that might otherwise not be accessible to consciousness come into consciousness.

This can be problematic for us because sometimes the material that comes in is even more overwhelming than the material that had been in awareness before the person had come into the therapy session or had sat down to do their mindfulness practice.

Ruth L. spoke eloquently about how avoidance makes matter worse – so that if we are flooded with something and then we're going to start avoiding it, we're going to be in even more difficulty.

So the trick in integrating mindfulness practices – or *a* trick – is to be aware of these two functions and look for some way to balance them.

Willoughby Britton, who's a friend and a colleague at Brown University, is about six years into a study of the adverse effects of mindfulness practices, and about 50 percent of people who have had these adverse effects are people with rather clearly identifiable trauma histories. In the case of those folks it's almost always the derepression that's the problem – that the mindfulness practice opened them into realms of experience that they weren't quite ready to have.

It can also open people into deconstruction-of-the-self experiences, because these practices are really designed to help us reconsider who we are and not just believe in our normal narratives about "I'm this kind of person/that kind of person."

In the process, if you're already feeling shaky because the different parts of you are not very well integrated, this deconstruction of self can be very, very threatening. In fact, it just happened to me last night with a patient who's having trouble with sleep.

"If you're already feeling shaky because the different parts of you are not very well integrated, this deconstruction of self can be very, very threatening."

I suggested, "See about just staying with the breath, not trying to fall asleep or anything – just coming back to the here and now with the breath."

She said she woke up that morning with profound derealization – and she's somebody with a bad trauma history – and she said, "I don't know how to describe this exactly, but I always used to feel like I had a self; I don't feel like I have one now, and this is not in a good way – this is like a problem and feels very, very hard to me."

Dr. Buczynski: Ron, do we have any sense of what percent of people have an adverse experience in mindfulness?

Dr. Siegel: We don't.

Dr. Buczynski: What would you guess?

Dr. Siegel: We know it's larger than we thought. And a lot of it unfortunately probably takes the form of

dropping out.

Dr. Buczynski: Would you guess it's like 10 percent, or . . . ?

Dr. Siegel: I would put it higher. I would guess that maybe, if we're talking about sending somebody to an MBSR course or going on a retreat or taking some other class, I'm going to guess that maybe a quarter of the people.

Something happens which is painful or difficult. I'm not saying it's severely damaging – people self-regulate; they just decide, "This isn't for me," you know?

Dr. Buczynski: Sure. But what about people where we just do something a little less intense than an MBSR course? MBSR stands for Mindfulness-Based Stress Reduction.

And when Ron is talking about retreats, usually those are silent, typically for nine days and so forth – and those probably, for sure, would be too intense. But what about something more simple?

Dr. Siegel: Well, I'll tell you what my experience is. I often lead groups in these practices. You certainly have unpleasant effects happening for a lot of people, and some people will say, "My mind's so restless."

I was leading a group of relatively young people at a restaurant the other night and somebody said, "I didn't like my arugula salad, eating it mindfully. But I like arugula salad when I eat them mindlessly."

So sometimes it's just being uncomfortable with something.

But I've had many times when people encounter tears or something where it *could be* therapeutic and useful but they feel *in the moment* overwhelmed. How many times do we have a *lasting* effect, like this derealization experience of my patient?

We just don't have the numbers on that, but Willoughby's research suggests it's not infrequent and therefore we need to be attentive to it as clinicians.

Dr. Buczynski: Sure. I'm thinking that if the person says, "I don't like my arugula salad," that's not an adverse experience. Therapy can be painful, for instance.

It doesn't mean it's not appropriate for this particular individual; it just means there are some tough parts of life and it can be painful to face them rather than to continue to repress or avoid them. I want us to be careful about what we would define as *adverse.*

Dr. Siegel: I think that's a good point. I was simply saying that's the kind of thing that is – even though not very serious and is a potentially growthful experience, it might lead somebody to drop out.

Out of the people who drop out, we don't know how many have had these more profound adverse experiences like derealization, or getting flooded by trauma that they didn't know was there, and how many just found something uncomfortable. But I think it's largely dose-related.

When it's provided in the context of social support – so if it's done in a therapy session or a meditation class but where there's a lot of time to talk about the experience and there's social support involved – I think there's going to be far fewer incidents of genuinely adverse effects where you get stuck. People are going to modify; they're going to see, *Oh, that person's really getting overwhelmed by this – let's move toward the grounding activities* that we've spoken about before.

How You Can Help Clients Shift the Brain to Connect with Others

Dr. Buczynski: Ruth, clients who have experienced trauma can have trouble connecting with others, and reaching out for help can be one way to – but reaching out for help can be a way to self-regulate.

So, if they're having trouble connecting with others, it makes one of the avenues less available to them. What are some specific ways that we can help them start to learn to connect, to learn to *be with* others after trauma?

Dr. Lanius: Which is *such* a critical piece of therapy – right? It makes sense why our traumatized clients are often so afraid to – because they were hurt, often by their closest caregivers. So, *connecting* – even the *thought* of connecting with another person – and asking that person for help is absolutely *terrifying*.

In addition to that, their neurobiology underlying social connection is very much affected, so all those brain areas that are involved in social connection often don't turn on appropriately. It's a very multifaceted problem. So how do we think about it?

Frank Corrigan and Lisa Schwarz are two people who have really helped me think more about it.

When our patients connect, and when they've connected to abusive caregivers or people who have hurt them or people who haven't been able to see them or mentalize them, you get very negative brain chemicals

forming in the brain.

You have to shift that brain chemistry and you have to do it through attachment resources that feel *safe*, where the client doesn't shift into that negativity. You're really shifting that brain chemistry into a chemistry that's more supported by oxytocin, for example – that's termed to be the "love hormone"; it's a chemical that really facilitates connection.

"You have to shift that brain chemistry and you have to do it through attachment resources that feel ***safe***."

There are studies coming out that these chemicals are altered in people with a history of trauma. So, how do we shift that chemical environment?

Again, this brings us back to these attachment resources – but they *have* to be safe. If they're not safe, we're back into that brain chemistry that really facilitates negative emotion, dysphoria, horror and fear.

If we get somebody to imagine connecting with somebody in their life that may have felt safe, or an animal that they feel safe with – and really *facilitating* that attachment behavior.

Looking into that person's or animal's eyes in an imaginary way, feeling that sense of connection, feeling touch between the two, maybe feeling the person putting their hand on the person's heart – again, being careful; some people can't tolerate that – then them putting their hand on the other person's heart. Really facilitating, in an imaginary way, that sense of connection in an attempt to shift that brain chemistry into secreting, for example, more oxytocin.

Once we have created that different chemical environment in the brain, then we can take the next step, which would be both facilitating verbal and somatic ways of connecting – as Pat Ogden often talks about.

"Once we have created that different chemical environment in the brain, then we can take the next step."

Speaking to another person, actually role-playing and getting that person to say, "I'm in a lot of pain. May I ask for your help?"

Or reaching out, which is *incredibly* difficult for our patients to do – right? So, practicing that motion of reaching out to another person, reaching for another person's hand. Those are all things that are absolutely critical.

And also – eye contact. We know that traumatized people, when they make eye contact, they revert back to a very primitive level of consciousness that's involved in defensive reactions and that prevents eye contact.

So how can we get people to make eye contact once we've shifted that brain chemistry? How can we do that in a way – and, again, a stage-oriented approach where people can feel safe with that I think is really critical.

How to Balance Top-Down and Bottom-Up Approaches to Give Your Clients Their Best Chance for Healing

Dr. Buczynski: Ron, let's talk about something that Ruth Lanius talked about in the program. She was talking about working with people, both top-down and bottom-up approaches, and she suggested that both are needed.

Have you worked with clients in both ways? And what have you learned about responses to each approach? Or when do you think in terms of using top-down, and when do you think in terms of using bottom-up?

Dr. Siegel: First, it's very important to think about both ways and have a sense that these are both meaningful ways to work with folks who have been traumatized, and that actually we need to always be choosing whether to shift a little bit more toward a top-down or a bottom-up approach.

Just because the language can be a little off-putting coming from neurobiology, the bottom-up approaches are basically all of the therapeutic interventions that are about *being with* experience in a nonverbal way, in a visceral way – including painful experience, in the hopes that that will facilitate integrating it.

Mindfulness practices tend to work that way because we're repeatedly stepping out of the thought stream and just coming back into what's happening here and now on a sensory level.

Eugene Gendlin's focusing does this, exploring inside looking for the felt sense. Gestalt therapy techniques certainly do this, by talking about what is occurring in the here and now, and often quite visceral. And all of the wonderful descriptions that Pat Ogden and Peter Levine have been giving about their work, which is totally about staying with what's happening at the level of sensation or movement in the body at a given moment.

All of these experiential approaches are very much about the here and now and they're very much about the body. They're great – they develop all sorts of regulation. They help us with regulation in realms that are very, very basic, by things – like directing our attention to safe stimuli allows us to not stay within the window of tolerance, or stepping out of the thought stream.

Our thoughts about stuff are a big part of our distress. Some of it is just visceral, but some of it is thinking, *Oh, my God – this might happen. Oh, my God – that might happen. This person is dangerous. This situation is frightening.*

"If we step out of the thought stream, it can help us to feel safety."

If we step out of the thought stream, it can help us to feel safety. All of the grounding activities we've talked about – about *being with* the feet, trees, contact with animals, and others that Ruth has just been discussing – is about connecting safely to others.

These top-down approaches are really much more what was more dominant in the history of psychotherapy, which we might think of as *narrative therapies* – therapies that use words to describe experiences.

Ruth had mentioned CBT is one of the most obvious ones, in which people are beginning to develop metacognitive awareness and notice which thoughts are true, which thoughts are not so true, which ones are adaptive, which are not so adaptive.

We do the same thing in psychodynamic therapy also – that's also very much top-down. Yes, we may try to connect to affect, but it's really *how* are these feelings and reactions occurring in the transference, in other relationships, in our histories? Systemic or family therapies often do this as well – what is it about your culture, your upbringing that is determining that?

That's also extremely useful because it allows people to get some perspective and be able to talk to themselves about what's going on in a way that makes sense and meaning.

If we're just staying with the bottom-up stuff, we're not developing new stories for ourselves – and humans have been telling stories for a long time. We need to have a sense of meaning: *I'm this person. This happened to me. That's why I'm experiencing that.* That construction of meaning becomes extremely important as well.

This calls for all of us to notice how both are important and to try and decide when's one going to be more useful than the other. A quick rule of thumb for that is – well, when a certain one is not working, we might want to shift to the other one a little bit.

In other words, a person who is able to be with wave after wave of intense feeling but their story about what's going on is still, *I'm a horrible person,* they might benefit some from more of a top-down approach of "What made your parent act the way they acted when they did that? Where did that message come from?"

"Clinically I think we're needing to be cognizant of both approaches and experiment between one and the other."

A person who's intellectually telling us about the story of the trauma over and over, they might benefit from connecting to the gut experience.

So, clinically I think we're needing to be cognizant of both approaches and experiment between one and the other.

Why Breath Work Can Be Vital in the Treatment of Trauma

Dr. Buczynski: Ruth, we looked at two ways to work with hypoarousal: that was movement and social engagement. Can you share a story of how you've worked with a client who was in hypoarousal?

Dr. Lanius: Again, I think this is such an important topic and often neglected I think in our teaching programs as well, and it can cause so much guilt and shame, as we've talked about in this program already.

Something else that I think is really important that's often associated with hypoarousal and that we don't think of often enough maybe is that often when people freeze and they go into these hypoarousal responses, they're unable to move – of course what also freezes is their breath.

When people freeze, if you have them mindfully track how their breath freezes – this is something I've been doing with my clients recently and I've learned a lot from it – I've been shocked to see how many of my clients tell me, "My breath freezes dozens of times."

Dr. Buczynski: They're probably in shock too, as they become aware of that.

Dr. Lanius: Absolutely. My most extreme client said to me, "You know, this happens *hundreds* of times a day."

And so how can we think about dealing with this? Again, I think it takes us to the reptilian part of the brain that really initiates those freezing responses.

"Breathing directly affects the reptilian brain that mediates freezing."

What's really exciting that's happened recently is that we've actually been able to show – there's several groups throughout the world – that breathing directly affects the periaqueductal gray, that part of the reptilian brain that mediates freezing. This makes sense when we think about freezing also being so much

associated with cessation of the breath.

How can we bring in the appropriate form of breathing, to help people overcome those frozen-breath states?

I think continuous breathing here is really important because that's what people aren't able to do when their breath gets frozen. They hold their breath.

I really like this continuous breathing – getting people to breathe in on the count of five and then breathe out on the count of five, and again breathe in on the count of five and breathe out on the count of five.

I just want to give a brief client example with my client who became mindful of actually stopping breathing several hundred times a day, and I discussed that continuous breathing with her and she said, "You know, Ruth, I *really* don't like that. I much prefer forms of breathing where I breathe in and then I hold my breath, and then I breathe out."

And I said to her, "Of *course* you prefer that, because that's what you've been doing all along." And she goes, "Oh, my God – you're right!"

But as soon as she developed awareness around that, she goes, "You know what? I'm going to do that continuous breathing."

She's now been practicing continuous breathing, and these freezing/frozen-breath states have really decreased, and she's also noticed that her cognition – so her ability to think and plan – has really improved.

This also makes sense because when we scanned people years ago, we also measured their oxygen saturation in their blood, and we noticed that it significantly decreases when people go into these hypoarousal frozen states.

> "The breath is the foundation of everything."

It has big implications, and so when we talk about freezing, let's also remember freezing of the breath because, as we know, the breath is the foundation of everything.

Dr. Buczynski: Thank you. That's it for us.

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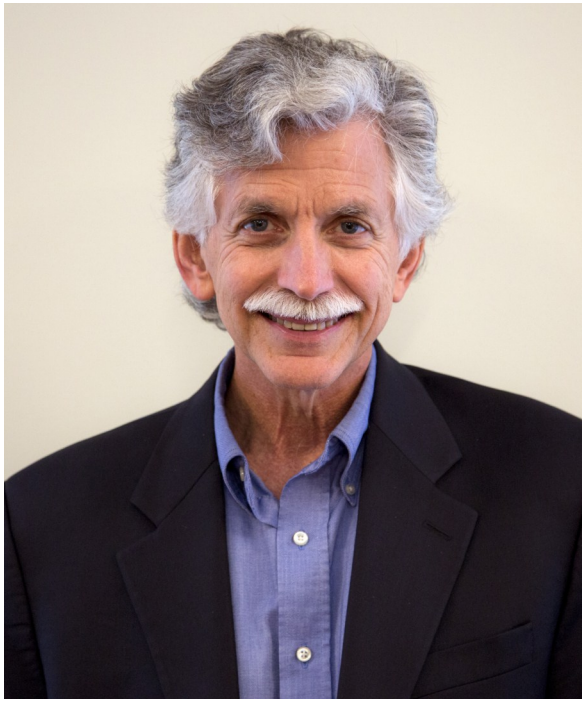
About the Speakers . . .

Ruth Lanius, MD, PhD is a professor of Psychiatry and the director of the PTSD Research Unit at the University of Western Ontario. She established the Traumatic Stress Service and the Traumatic Stress Service Workplace Program, both specializing in the treatment and research of PTSD and related comorbid disorders. She currently holds the Harris-Woodman Chair in Mind/Body Medicine at the Schulich School of Medicine and Dentistry at the University of Western Ontario.

She has authored more than 100 published papers and chapters in the field of traumatic stress, regularly lectures on the topic of PTSD nationally and internationally, and has published *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment*, together with Paul Frewen.

Ron Siegel, PsyD is an Assistant Clinical Professor of Psychology at Harvard Medical School, where he has taught for over 20 years. He is a long time student of mindfulness mediation and serves on the Board of Directors and faculty for the Institute for Medication and Therapy.



Dr. Siegel teaches nationally about mindfulness and psychotherapy and mind/body treatment, while maintaining a private practice in Lincoln, MA.

He is co-editor of *Mindfulness and Psychotherapy* and co-author of *Back Sense: A Revolutionary Approach to Halting the Cycle of Chronic Back Pain.*