Trauma-Informed Stabilization Treatment

(TIST): Treating Unsafe and Addictive Behavior in Clients with Histories of Trauma

MODULE THREE

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Every System Needs a 'Leader'

- **Without a prefrontal cortex,** the brain operates on the basis of emotions and instincts. **We perceive the world and others through the narrow field of a survival mentality:** all that matters is surviving the moment. We have no access to principles, goals, commitments
- **Without top-down leadership, any organization is vulnerable to anarchy or even mutiny.** There is no way to stabilize our clients without helping them create some system of leadership or top-down management
- **That means differentiating and strengthening the Normal Life part** to assume that leadership position

Fisher, 2014

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Differentiating the Going On with Normal Life Self

- **Access to the prefrontal cortex:** capable of thought, insight, information retrieval, learning from experience
- **Qualities of wise mind:** curiosity, compassion, clarity, calm, creativity, courage, and connection
- **Functional abilities:** job skills, practical abilities, parenting skills, ability to care for others, responsible, good with animals and children, a hard worker
- **Aspirations:** although they can be affected by difficulty imagining a future, most clients want to have a future different from the past, want independence, stability, a home, relationships---not chaos and crisis

Fisher, 2020

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Normal Life Self, cont.

- **It is the therapist's job to notice and acknowledge these ego strengths and capacities** and differentiate them from the parts' responses
- Each time we help clients to connect to the Normal Life self we see, the client's experience of who they are or want to be becomes more palpable. **It is important that we just point out what we see mindfully** so that we are not giving compliments: we are naming observable facts
- **Help the client develop ways of accessing/recognizing the Normal Life part:** "Each time you can think straight, each time someone comes to you for help, each time you have a wise mind, that's your Normal Life part." Fisher, 2014

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

Bessel van der Kolk, 2009

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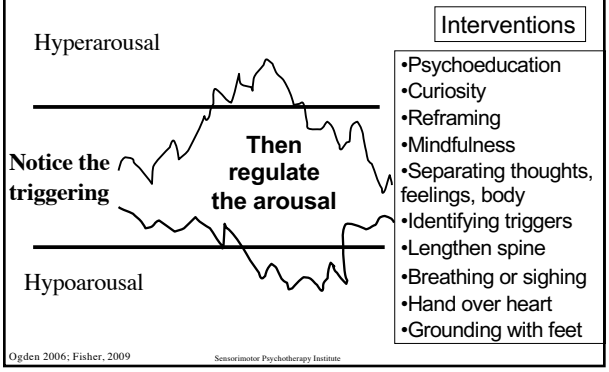
Teaching the Skills to Regulate Arousal Within the Window of Tolerance



Ogden 2006; Fisher, 2009 Sensorimotor Psychotherapy Institute

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Experimenting with Somatic Resources for Traumatic Reactions

Traumatic Reactions:	Resources:
Shaking, trembling	Slowing the pace
Numbing	Sighing
Muscular hypervigilance	Lengthening the spine
Accelerated heart rate	Hand over the heart
Collapse	Grounding with the feet
Impulses to hurt the body	Clenching/relaxing
Numbing, disconnection	Standing or moving

Sensorimotor Psychotherapy Institute® Ogden, 2000

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Cultivating "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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Asking Parts to "Sit Back"
[Schwartz, 2002]

- Unblending and mindful awareness are also enhanced by teaching the Adult to ask parts **to "step back" in order to "make more room" for the Adult** (Schwartz, 2002)
- The therapist asks, ***"Would you ask this part if it would be willing to sit back a little to make more room for you?"*** Often, there is an immediate softening or settling of feelings and sensations, creating dual awareness.
- Sometimes, the part resists, and the client is instructed to ask, *"Would you ask that part what she's worried about if she sits back? What does she need from you to be able to sit back?"* ***"Oh, so she needs to know that you won't ignore her if she sits back—could you reassure her of that?"*** Fisher, 2009

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Teaching Parts to "Sit Back," cont.

- **"Sitting back" is a particularly useful skill for clients who are overwhelmed or internally stimulated.** When parts sit back, their feelings are not so overwhelming and can be "heard" more easily.
- Critical thoughts can be asked to "sit back;" distracting or hopeless parts can be asked to "step back;" calm in the body can be enhanced by asking agitated parts to "sit back." In DID clients, parts must learn to "take turns"
- **Because "sitting back" is a skill, clients are asked to practice it themselves**. When the therapist has confidence that this instruction will work and that it is key to successful trauma treatment, clients (and their parts) respond accordingly

Fisher, 2009

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"If, Then" Scenarios

- Typically, the "Going on with Normal Life" self tends to avoid directly connecting to the parts because s/he fears being flooded with their feelings or memories. **The only motivation for the Adult is to improve the quality of life in the here-and-now**
- The therapist must consistently reiterate, **"If you want your life to be different**—if you want to be able to have relationships—if you want to be more visible, experience more pleasure in life, **then you will have to work with the parts who are afraid to have a more normal life."**
- We can't afford to wait until the Adult Self overcomes the phobia of the parts

Fisher, 2012

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Traumatic environments leave few options for attachment or survival

"If an individual is born into a malevolent and stress-filled world, it is crucial for his survival. . . to maintain a state of vigilance and suspiciousness that enables him to readily detect danger.

Teicher et al, 2002

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*"[S/he] will need to have the potential **to mobilize an intense flight-fight response and to react aggressively to challenge** without hesitation. . " [These survival responses will] markedly augment the individual's capacity **to rapidly and dramatically shift into an intense aggressive state when threatened by danger or loss."***

Teicher et al. 2002

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Maternal Unresolved Attachment = Disorganized Attachment in the Child

- Mothers with their own histories of trauma, loss, attachment failure, or separation face a special challenge: because caring for a child evokes the attachment system, they can be triggered by their babies' cries and needs.
- **"[Rather than] arousing impulses to calm and comfort, . . . the activation of the attachment system arouses in these parents strong emotions of fear and/or anger.** Thus, while infants are crying, 'unresolved' parents may interrupt their attempts to soothe them . . . with unwitting, abrupt manifestations of alarm and/or anger." (Liotti, 2004, p. 477)

Fisher, 2007

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"Frightened and Frightening" Caregiving

Frightened Behavior	Frightening Behavior
Backing away	Looming, attack postures
Frightened voice	Sudden movements
Dazed expression	Mocking, teasing
Exaggerated startle	Intrusive
Withdrawn	Emotionally reactive
Non-responsive	Loud, startling noises

Lyons-Ruth, 2000; Fisher, 2003

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Disorganized Attachment Status

- "Disorganized attachment" has been consistently correlated with **"frightened" or "frightening" caretaking** (Liotti, 1999).
- It is characterized by approach-avoidance conflicts: "because an infant inevitably seeks the parent when alarmed, **any parental behavior that alarms the infant places it in an irresolvable paradox** in which it can neither approach, shift its attention, or flee." (Main & Solomon, 1986)
- **Disorganized attachment is also a statistically significant predictor of** dissociative symptoms by age 19 and **diagnoses of Borderline Personality Disorder and Dissociative Identity Disorder** in adulthood (Lyons-Ruth, 2001)

Fisher, 2014

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"[Frightened/frightening] caregiving behavior causes "fright without solution" in the infant, because 'the caregiver becomes at the same time the source and the solution of the infant's alarm' (Main & Hesse, 1990, p. 163).

Fear comes to paradoxically coexist, in the infant's experience, with the soothing provided by proximity to the caregiver."

Liotti, 2011, p. 234

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Beginning around age 2, disorganized attachment develops two different 'flavors'

Controlling-Punitive	Controlling-Caregiving
When the attachment drive is aroused, the child responds with attempts to take control of the relationship via **hostile, coercive, or shaming behaviors toward mother**	The attachment drive leads the child to attempt to control parental responses by **entertaining, charming, directing ("helping"), or offering approval to the mother**
This strategy is more common among boys in response to maternal hostility	This strategy has been correlated with maternal role-reversal and guilt-inducing behavior

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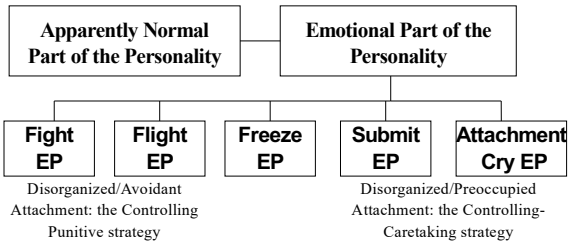
Different parts of the personality = different attachment 'solutions'



Attachment disorganization = internal struggles between attachment-seeking parts and hypervigilant, mistrustful parts

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Manifestations of Disorganized Attachment in the Transference

- Intense proximity-seeking behavior alternating with devaluing, distancing, or increased de-stabilization [Fight]
- Flights from treatment, forgetting appointments, lateness, coming in and out of therapy [Flight]
- Difficulty leaving the office at the end of sessions [Attach]
- Difficulty using therapy: coming but not being able to articulate issues/feelings; becoming mute or distracted in sessions, "good" sessions alternating with "bad"
- Need for repeated proof of therapist 'caring:' failure of object constancy and often object permanence [Attach]

Fisher, 2009

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Manifestations of Disorganized Attachment, cont.

- Hypervigilent attention to the therapist's manner and tone of voice, perhaps even policies or office environment [Fight]
- Strong, out of proportion reactions: unable to tolerate therapist imperfections/limitations [Attach and Fight]
- Repeated requests for changes in treatment frame [A & F]
- Disproportionate distress around therapist's absences [Attach]
- "Destructive entitlement" to special treatment [Fight]
- Crisis and self-harm become relational "negotiating currency" (Rivera, 1996) [Attach, Submit]
- Inability to share responsibility for the therapeutic alliance

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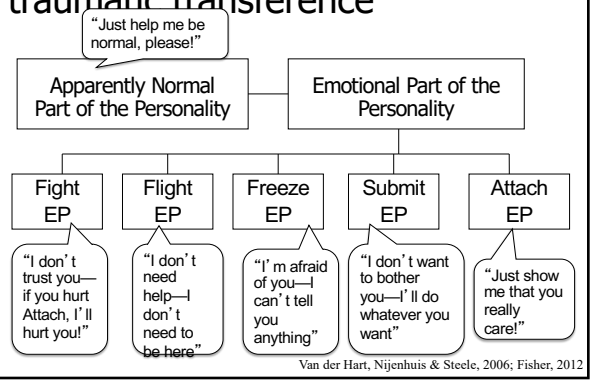
Each part has a different traumatic transference



Van der Hart, Nijenhuis & Steele, 2006; Fisher, 2012

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Addressing disorganized attachment in the therapy

- **Attune to the effects of disorganized attachment on the therapeutic relationship**: begin by accepting that the therapy relationship poses **as much threat as hope**, avoid induction into the system, recognize countertransference (especially anxiety, the pull to help, wish to connect)
- **Strive for equal validation of both defensive AND attachment drives:** allowing distance, validating mistrust, "going with" resistance rather than opposing it
- **Emphasize mastery instead of relationship:** avoid doing too much for the patient, try taking a "consultant role," increase your tolerance for crisis/stuckness, be curious

Fisher, 2011

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Right Brain Communication with Parts

- Just as we use 'right brain-to-right brain' communication differently with babies than school-age children than teenagers or adults, we must do the same with parts
- **The tone of voice and body language we use with an adult client** can trigger shame or abandonment fears if heard by a five-year-old part. Or provoke anger or resistance in a teenage Fight part.
- **We need to "speak" differently to each part** depending on its age and stage in order to regulate the whole system. **If we talk to all parts like adults, we can inadvertently dysregulate the system more!** Fisher, 2013

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Right-brain Communication, cont.

•When attachment has been disorganized by frightened and frightening caregiving, **the therapist must concentrate on trying not to stimulate the sense of threat OR the intense attachment longing**.

•We can avoid stimulating longing or threat by finding a middle ground between too much distance **or** closeness, between warmth and intimacy, support and availability, strength and gentleness.

•We keep in mind that **"too much" closeness evokes too much longing and triggers fear, fight, or flight, while "too much" distance is experienced as abandonment**

Fisher, 2010

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Fostering mastery rather than closeness to the therapist

•**By using right brain-to-right brain attunement:** *finding words and tones that regulate fearful arousal and maximize pleasurable states, that increase curiosity instead of fear*

•**By tracking what parts are present** *so that the words and tone we choose are 'age-appropriate'*

•**By changing our responses to proximity/distance issues:** *allowing distance, balancing closeness/distance*

•**By emphasizing the client's attachment to the parts over attachment to the therapist:** *"Your parts cannot feel safe if you reject or distance from them—how might they interpret that?"*

Fisher, 2008

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Right-brain strategies for neurobiologically regulating clients

•Varying voice tone and pace: soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone

• Energy level: very "there" and energetic versus more passive

•Empathy vs. challenge: how does the patient respond to more/less empathy? to challenge? Does s/he need limits to regulate?

•Amount of information provided: noting the effect of psychoeducation or therapist self-disclosure

•Titrating vs. encouraging affective expression

•"Dancing" with the patient: adjusting pace, tone, affect, language to "repair" patient's dysregulated states

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Social Engagement System [Porges, 2005]

- **The social engagement system is an innate system connected to the vagus nerve, which regulates movements of the eyelids, facial muscles, middle ear muscles, laryngeal and pharyngeal muscles, and head tilting and turning muscles**
- As the caregiver interacts with the infant in a responsive manner, she or he elicits social engagement responses from the infant or capitalizes on those that occur spontaneously
- The development of an infant's social engagement system is dependent upon the caregiver's ability to stimulate and interactively regulate social interaction

Ogden, 2006; Fisher, 2007

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Increasing capacity for social engagement in the therapy is a precursor to repairing attachment patterns

- In the therapy hour, **the therapist must make use of his or her 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
- **The social engagement system is body-oriented**: it relies upon the "muscles that give expression to our faces, allow us to gesture with our heads, put intonation into our voices, direct our gaze, and permit us to distinguish human voices from background sounds." (Porges, 2004, p. 21)

Ogden, 2004; Fisher, 2007

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Trauma-informed communication

- Keep in mind the type of environment to which your client was forced to adapt—just to survive. **Over-reactions** to our words and body language are not indications of being "dramatic" or "attention-seeking."
- They **reflect the experience of knowing that a slight change in an adult's tone or body language could mean the difference between safety and danger.** They reflect the experience of being with adults who seemed to take pleasure in humiliating or intimidating children
- For our interventions to be effective, **our communications must be accompanied by body language and facial expressions that feel safe**, not threatening Fisher, 2011

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Trauma-informed communication, cont.

- **Become a "neurobiological regulator:"** slow and soften your voice, relax your facial muscles, try to bring lightness or warmth to your tone. Imagine you are with an animal that's frightened of you and will either freeze or become aggressive if threatened
- **Avoid language that is interpretive:** traumatized clients associate feedback about themselves even from the therapist with abuse and humiliation
- **Avoid using the word "you:"** "That was very triggering" is better than "You got triggered"
- **Slow your own nervous system:** talk slower, move slower. Soften your tone of voice, smile more

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Trauma-informed interactions, p. 3

- **Use a reassuring tone:** "It's OK---I know you just want to feel better . . ." "Let's slow it down---I can't stop you from hurting yourself if that's what you really want, but maybe we can figure out a better solution" "It's just the triggering—it's just feeling memory."
- **Keep a very slight distance the way you would from a rescue animal:** traumatized clients are very sensitive to space and boundaries
- **Remember that it's just the client's survival defenses at work:** s/he is not intentional in a conscious way. **Clients in crisis are in their animal brains, not their wise minds!** Fisher, 2017

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Trauma-informed interactions, p. 4

- **Use your body rather than your words:** a crisis means the prefrontal cortex is 'offline.' Relax your extremities, breathe slowly, soften your expression, use your calm to induce calm in the client
- **Avoid too much language:** without a working prefrontal cortex, the client cannot process verbal information. Repetitive simple language: "A lot of triggering, huh? It's so hard when anyone gets triggered---it feels overwhelming—life or death"
- **Plan to process a crisis at a time when the client's nervous system is more regulated:** don't try to process ruptures when the client is triggered Fisher, 2019

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Attunement and Interactive Regulation

•Especially **with clients are in crisis, we therapists feel pressure to "do something."** That "something" might be a skills intervention (eg, distress tolerance), a somatic resource (grounding, centering, etc.), or an interpretation

•But when we are working with fragmented clients, no intervention will be successful in the absence of attunement to the parts. **Without attunement to ALL parts, we risk empathic failure or resistance from some parts**

•**To attune to fragmented clients** (ie, those with Complex PTSD, BPD, and DDNOS or DID), **we must attune to the entire 'inner community'** Fisher, 2014

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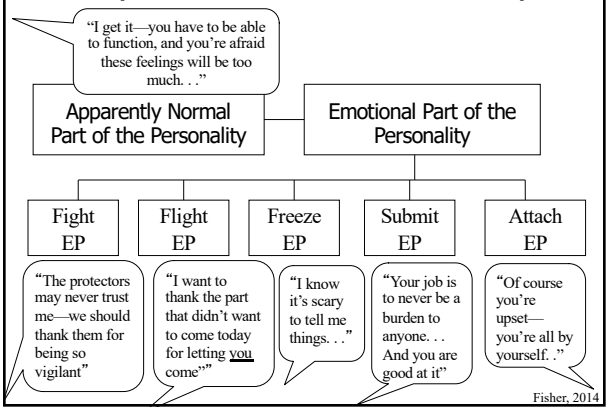
Therapist attunement to each part



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Expecting the best brings out the best in all of us . . .

"If I accept you as you are, I will make you worse; ***if I treat you as though you are what you are capable of becoming****, I help you become that."*

--Johann Wolfgang von Goethe

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The Social Engagement System of the Therapist

- **Amplifying the capacity for self-compassion** and loving feelings towards all parts of us **requires a therapist whose social engagement system responds to all parts**
- **As the therapist's voice exudes compassion for the ashamed part**, once humiliated by parent figures and now by the judgmental part, **the client's body will respond with increasing warmth or openness**
- When the therapist is not afraid of the suicidal part but responds with smiles and warmth to its determination not to lose control and dignity, the client's body will relax—and thereby suicidal intensity will lessen Fisher, 2012

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The Social Engagement System of the Therapist, cont.

- As our "shining eyes" communicate that all parts are welcome and valued, **the client begins to increase the capacity to turn "shining eyes" on younger selves**
- The Adult self of the client has "inside information" about the parts and their unmet needs, facilitating integration of the therapist's empathy with an intuitive understanding of the part: "No, she isn't afraid to be alone; she's afraid that she'll be rejected"
- **As our faces soften and our voices become warmer, the client begins to soften as well,** relaxing the body and creating a pervasive sense of warmth. **Our acceptance becomes internal acceptance.** Fisher, 2012

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