Trauma and Holiday Stress

DMH Restraint and Seclusion Prevention Initiative

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1

What could possibly be stressful about the holidays?!!!

For staff:

- **On top of what we already do:** shopping for gifts, extra food shopping, holiday meals, parties and celebrations, family gatherings, clients who are stressed and triggered, pressure to please

For clients:

- **Impending absence** of gifting, celebrations, family closeness, and attunement
- **Triggering:** by contact with family or absence, aloneness, TV commercials, Xmas music, lights

2

The Autonomic Nervous System

Sympathetic Activation: action-taking system
Excitement, pleasure, lots of energy, able to get things done
Anxiety, irritability, anger, reactivity
Impulsivity, act before thinking, no ability to anticipate consequences

Sympathetic Hyperarousal

Window of Tolerance*
*feelings can be tolerated able to think **and** feel*

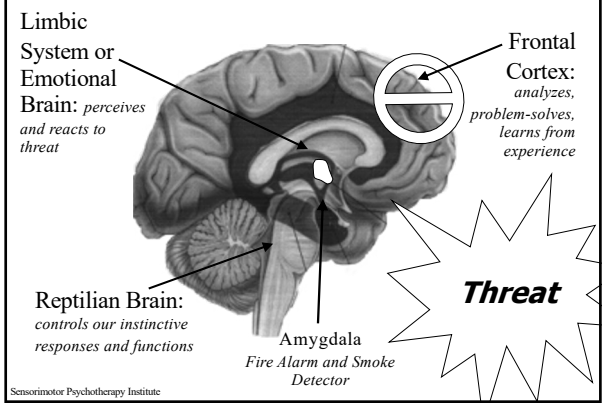
Parasympathetic Hypoarousal

Parasympathetic: action-inhibiting system
Restful, slow, able to pause, being instead of doing
Slowed thinking, loss of energy, unfocused
Feeling down, hopeless, discouraged
Wanting to give up

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

3

Threat and the Brain



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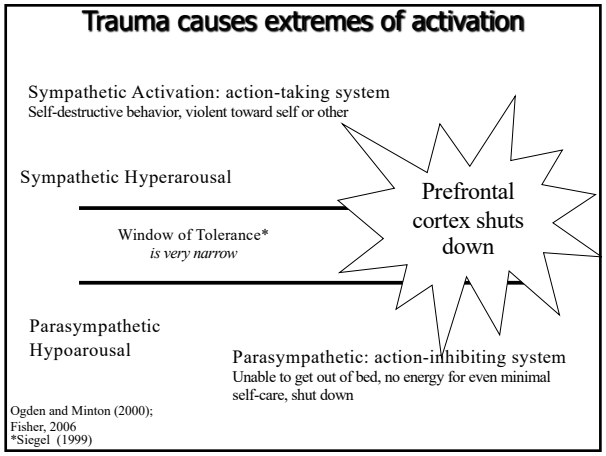
4

Trauma causes extremes of activation



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

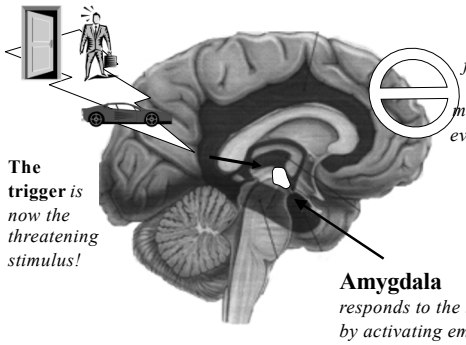
5

Without a prefrontal cortex. . .

- **Individuals lose access to information:** to their safety contracts, to their DBT or other skills, to what they've learned from past experience, to their values and intentions
- **Loss of activity in the prefrontal cortex also means that emotions can distort reality without interference from the client's logical mind.** Self-reflection and ability to observe what's happening in chronological sequence is lost
- No new learning can take place. Clients may not even remember that they have skills, much less remember how they had planned to use them! Their genuine wish to behave differently is also dependent on remembering it.

6

Triggering supports a sense of threat



With the pre-frontal cortex shut down, it may be hard to even know they are triggered

The trigger *is now the threatening stimulus!*

Amygdala
responds to the threat cue by activating emergency stress response

7

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

Judith Herman, 1992

8

Being trapped in "ordinary responses to danger"

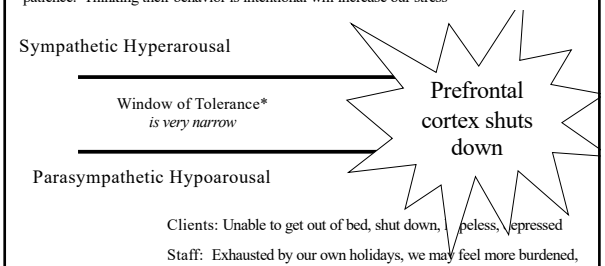
- **Chronic expectation of danger:** still feeling unsafe, the client remains hypervigilant, isolated and avoidant, phobic of many aspects of normal life
- **Chronic self-destructiveness:** decades after the trauma, the client is still fighting but now self-destructively
- **Chronic despair and self-loathing:** still trapped in a submissive, helpless state, clients still feel degraded, defeated, and powerless to help themselves
- **Chronically searching for rescue:** though the client desperately searches for help, the 'right' help is never there

9

Holiday stress affects both staff and client

Clients: Triggered by all the traumatic reminders connected to the holidays, they are hyper- or hypo-activated. They are more reactive, less safe, more 'resistant,' more easily triggered

Staff: with more stress and less Window of Tolerance of our own, we will have less patience. Thinking their behavior is intentional will increase our stress



Clients: Unable to get out of bed, shut down, helpless, depressed

Staff: Exhausted by our own holidays, we may feel more burdened, less hopeful, less patient. Thinking that they are choosing to have no motivation will increase our stress

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

10

Mindfulness = noticing experience instead of talking about it

- **Awareness** of thoughts, emotions, movements, impulses
- **Detachment:** noticing the thought or feeling without getting swept away by it
- **Labeling:** putting neutral language to what is noticed (e.g., "I' m having a thought—some emotion is coming up")
- **Mindfulness can be directed or directionless:** we can follow the flow of thoughts, feelings and impulses as they unfold or deliberately focus on an aspect of experience (e.g., the breath, the feet, a thought)

11

Facilitating Mindful Awareness

- **Mindfulness in therapy depends upon the therapist becoming more mindful**: slowing the pace of thinking and talking, refraining from interpretation or suggestion in favor of neutral observation, helping the client focus on the flow of thoughts, feelings, & impulses
- **Mindful attention is present moment attention**. We use "retrospective mindfulness" to bring the client into present time: "As you are talking about what happened then, what do you notice happening inside you now?"
- **Curiosity is cultivated because of its role as an entrée into mindfulness**: "Perhaps by cutting, you were trying to get calm before seeing your family. . ."

12

Distinguishing thoughts, feelings, and body sensations

In traditional talking treatments, we do not always clearly differentiate cognition, emotion, and body responses:

For example, when we say, "I feel unsafe,"

- It could reflect a **cognition**: "I am never safe," "The world is not a safe place"
- It could mean an **emotion**: "I'm feeling frightened"
- It could mean **bodily sensation**: "My chest is tight; my heart is racing; it's hard to take a breath"
- It could mean **an impulse**: "I want to hurt myself"

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13

Mindfulness Skills

- "Notice . . ."
- "Be curious, not judgmental. . . "
- "Let's just notice that reaction you're having inside as we talk about your boy friend"
- "Notice the sequence: you were home alone, bored and lonely, then you started to get agitated and feel trapped, and then you just **had** to get out of the house"
- "What might have been the trigger? Let's be curious—go back to the start of the day and retrace your steps"

14

Increasing Frontal Lobe Activity: Offer a Menu of Possibilities

- "When you feel the panic come up, what happens? Do you feel more tense? More overwhelmed? Or do you freeze?"
- "As you feel that anger, is it more like energy? Or muscle tension? Or does it want to **do** something?"
- "When you talk about feeling 'nothing,' what does 'nothing' feel like? Is it more like calm? Or numbing? Or is it fuzzy? " Ogden 2004

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15

Making Mindfulness Even Easier: Ask Contrasting Questions

- "When you vent your anger, do you feel better? Or worse? Is it more pleasurable or unpleasurable to vent?"
- "Does it feel like something is going to hurt you from the inside or the outside?"
- "When you say those words, 'I' m a loser,' does the shame get better or worse?"

Ogden 2004; Fisher, 2005

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16

Recognize triggering as it happens

- Traumatized clients can understand that they get triggered and can anticipate intellectually what will trigger them
- **The problem is that triggering is harder to recognize <u>when</u> it happens**—because the prefrontal cortex isn't functioning. The client recognizes they are upset, but they may not recognize that they are triggered.
- **They need staff to help them notice that they are triggered by changing our language from more behavioral to more mindful.** Before we call attention to the behavior, we can help them notice: "I notice that you're pretty triggered right now. How do you think I can tell?"

17

Recognizing the signs of being triggered: am I just triggered or am I really in danger?

- ❑ Shaking, quivering
- ❑ Overwhelming emotions
- ❑ Sudden intense physical or emotional reactions
- ❑ Difficulty breathing
- ❑ Body wants to collapse
- ❑ Feeling 'possessed'
- ❑ Want to give up or die
- ❑ Want to hurt myself
- ❑ Want to drink or drug
- ❑ Knees knocking
- ❑ Going numb all over
- ❑ Want to run away
- ❑ Teeth clenching
- ❑ Feels unbearable
- ❑ Terrified, panicky
- ❑ Clenching or churning or pit in stomach
- ❑ Hate myself
- ❑ Hate others
- ❑ Feel rage
- ❑ Feel overwhelming shame
- ❑ Emotions or actions don't fit the situation

When you recognize you are triggered, just keep reminding yourself that "it's just triggering—that's all that's happening."

18

Sensorimotor Psychotherapy

•Sensorimotor Psychotherapy is a body-oriented therapy developed by Pat Ogden, Ph.D. and enriched by contributions from Alan Schore, Bessel van der Kolk, Daniel Siegel, and Steve Porges' polyvagal theory

•**Sensorimotor work combines traditional talking therapy techniques with body-centered interventions that directly address the somatic legacy of trauma.**

•Using the narrative only to evoke the trauma-related bodily experience, **we attend first to discovering how the body has "remembered" the trauma and then to providing the somatic experiences needed for resolution**

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19

Therapy must deliberately challenge, rather than reinforce, conditioned patterns of response

To challenge the patterns without further dysregulating the client, the therapist uses two interventions:

•"The first is to …**observe, rather than interpret**, what takes place, **and repeatedly call attention to it**. This in itself tends to disrupt the automaticity with which procedural learning ordinarily is expressed."

•"The second therapeutic tactic is to engage in activities that **directly disrupt** what has been procedurally learned" and create the opportunity for new experiences

(Grigsby & Stevens, p. 325)

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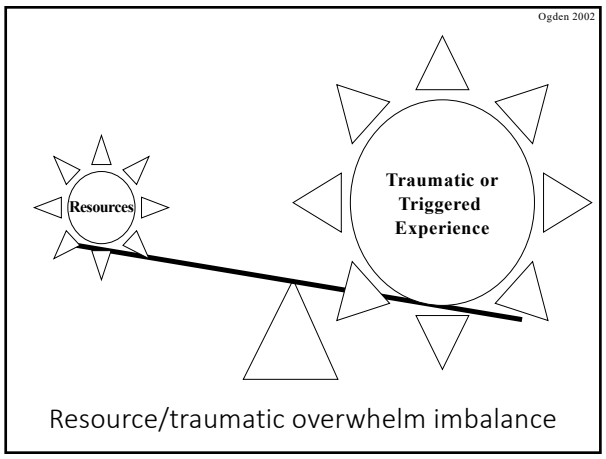
20

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

Bessel van der Kolk, 2009

21



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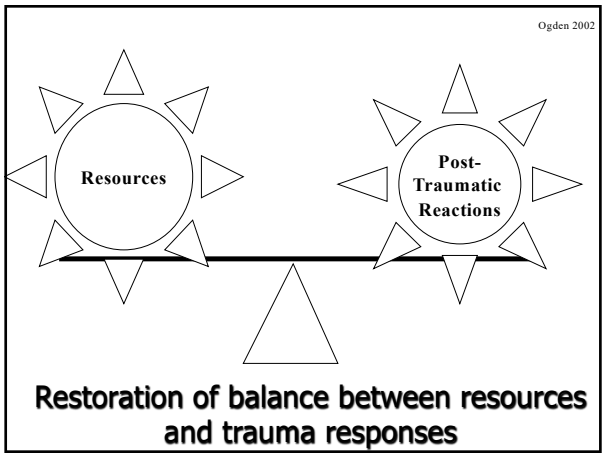

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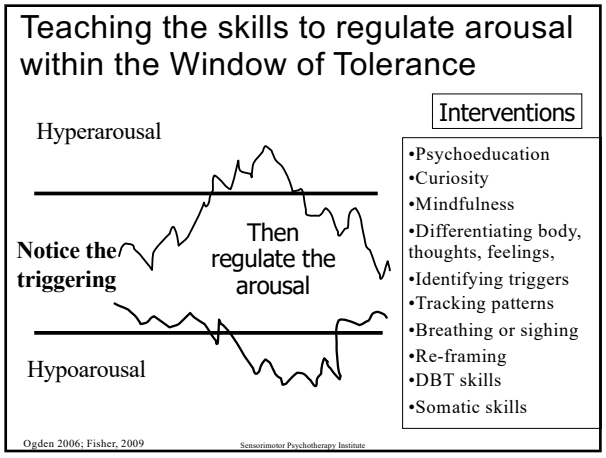

24

Using the Body's "Library" of Resources

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

Fisher, 2008

25

Experimenting with Somatic Resources for Traumatic Reactions

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

Sensorimotor Psychotherapy Institute Ogden,

26

Best for regulating hyperarousal and impulsivity

The client is asked to **do** something:

1. Breathe: sigh—breathe out
2. Ground: feel the floor under the feet, push down against the floor with the feet, feel the support of the chair
3. Orient: slowly look all the way around the room and notice selected objects, colors, familiar things
4. Lengthen the spine: gently lengthen the lower back
5. Stand up: stand up, walk around, feel legs and feet
6. Hand on the heart: focus on the pressure of the hand

27

Learning to "drop the content"

- When triggered, **clients are often bombarded with thoughts that stimulate unresolved trauma responses**, further dysregulating an already fragile nervous system
- A sensorimotor skill to address triggering thoughts, images, or memories is the ability to **"drop the content:"** to "let go" of any distressing thoughts, images, and feelings and to choose the direction of attention
- **Dropping the content changes the client's focus:** from the dysregulating thoughts to the feeling of the feet on the floor, or to sensations in the body, or to a new belief, such as "I' m doing the best I can" or "I' m triggered—that' s all it is—just triggering"

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28

Social engagement is a prerequisite for feeling safe

- **The social engagement system as described by Steve Porges is a neurobiological system** that 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)
- **The social engagement system is naturally engaged when human beings feel safe,** and it goes offline when we are not
- **Neglect and trauma interfere with social engagement**: blunted affect, frozen facial expressions, monotone speech alert us to its absence in our clients

29

Make use of "social engagement"

- **'Regulating' a client's nervous system requires using the social engagement system.** As the client describes events, feelings, or reactions, the therapist makes use of gaze, facial expression, body language, turning and tilting of the head, and the larynx for vocal tone
- "Tracking" the client's moment-to-moment responses and adjusting the quality of our social engagement accordingly brings us into 'synch' with the client. **Like a parent, our only goal must become 'dyadic dancing'** with the client, capitalizing on whatever avoids dysregulation
- **Using our presence to regulate the client elicits ventral vagal states in place of defensive states**

30

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

- Ideally, the psychobiologically attuned, affect-regulating primary caregiver **amplifies opportunities for positive affect** (Schore, 2001), e.g., in play states.
- Even though "good enough caregivers are inevitably somewhat inconsistent in their attunement with their children, **they promote recovery from breaches of attunement by providing interactive repair**. . . ."
- **"This transitioning between negative and positive affect helps the infant to develop resiliency** and, later, flexible adaptive capabilities." (Tronick, 1989)

31

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

Meares, 2005, p. 124

32

Experiment with the impact of different styles of communicating

- Vary your voice tone and pace of speech: soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- Experiment with facial expression: does the client respond differently to calm vs. warm, expressive, or playful expressions?
- Change energy level: very "there," energetic vs. quiet, calm
- Does the client respond better to empathy or to challenge? Better to playfulness or seriousness?
- Amount of information provided: does s/he do better with more explanation? Or does information cause overwhelm or spacing out?
- Experiment with proximity: is the client more comfortable with distance, closeness, or neither?

33

"The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

P = playfulness

A = acceptance

C = curiosity

E = empathy

Hughes, 2006

34

Playfulness affects both staff and client

Clients: Triggered by all the traumatic reminders connected to the holidays, they are hyper- or hypo-activated. Our playful, curious responses have a calming effect on the nervous system

Staff: Knowing they are triggered and relaxing our bodies, using the social engagement system to get through the crisis, we feel less stressed

Sympathetic Hyperarousal

Window of Tolerance*
is very narrow

Parasympathetic Hypoarousal

Prefrontal cortex shuts down

Clients: Unable to get out of bed, shut down, peless, epressed. Our playful response increases their activation or the better

Staff: Exhausted by our own holidays, playfulness alleviates stress and restores a little more energy to us

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

35

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36