WORKING WITH TRAUMATIZED TEENS

HOW TO GET UNHOOKED

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WEBINAR 2018

WEEK FIVE

PLAN FOR SESSION FIVE

10 TRUTHS ABOUT TRAUMA TREATMENT

DISSOCIATION AND DISORGANIZED ATTACHMENT

DISSOCIATION AND IDENTITY FRAGMENTATION

- DISSOCIATIVE SELF-HARM IN TRAUMATIZED TEENS
- COMPASSION AND EMPATHY
- INTERVENTIONS FOR UP-REGULATION WITH HYPOAROUSED, BLUNTED, DISSOCIATIVE TEENS

Ten Thoughts about Trauma

1. Trauma permanently changes us
   - There is no such thing as resolving it, "getting over it," becoming normal
   - Models of grief and loss may describe a pathway towards greater acceptance, but the work is also in accepting this imperfect life…
   - This is not just negative—the healing process also means finding new strength, sources of joy, connections, meanings, courage to go forward. **POST-TRAUMATIC GROWTH IS ALSO POSSIBLE**
   - Goal isn't to make things look "easier"—it's to acknowledge what's hard, what's hard-won, and what's meaningful and worth having.

Ten Thoughts about Trauma

2. Stay Close By

-Presence is always better than distance—in times of crisis and change people do NOT "need space."

-Trauma is lonely, and suffering alone makes it worse

-Fosha: Therapy as "Undoing aloneness"

-Very important for the client to be able to say, "Go away," "Back off" "Thanks, but no thanks…" NOT: "I was hurting and my therapist just did what everyone else did."

-Err on the side of saying, I'm here—and meaning it.

Ten Thoughts about Trauma

3. Healing Is a Wobbly Figure- Eight

-Clients do heal over time, but not the linear way we wish for. It's not a sign of failure to regress in this work—in stressful times, that's what happens

-It's common to get stuck, leap ahead, fall back at xmas (or springtime) or with a new school year once again.

-What we call «recovery » is actually life: Expect seasons, and help clients survive the downturns holding the knowledge that the figure eight can be real.

Healing Takes Time and Seasons…

"…feelings like disappointment, embarrassment, irritation, resentment, anger, jealousy, and fear, instead of being bad news, are actually very clear moments that teach us where it is that we're holding back. They teach us to perk up and lean in when we feel we'd rather collapse and back away. They're like messengers that show us, with terrifying clarity, exactly where we're stuck. This very moment is the perfect teacher, and, lucky for us, it's with us wherever we are." ~ Pema Chodron

Ten Thoughts about Trauma

4. Trauma clients need teams, not just therapists

- **The team needs both "firefighters" and "builders" on it.**
  - **Firefighters are allies who can drop everything and be there in an emergency—can be you, but needs to be someone the client identifies as their firefighter**
  - **Builders are more calm, steady, predictable allies who will be there over time to engage in a corrective relational experience.**
- **It is hard for therapists to fill both of these roles (and others, too), so spend time figuring out who is on the team, and keep building it: Isolation is the enemy, makes everything worse**

Ten Thoughts about Trauma

5. Grieving is Social, and so is Healing

-Attachment trauma is a social wound: the therapy relationship uses same parts of brain and heart

-The relationships can be with you, with other people, and animals, too. They can involve both giving and receiving support. Limbic resonance is essential in adolescence, too.

-Finding people to trust after all that is an act of Courage. If the client is in your office, she is doing something brave and necessary for her survival and healing

Ten Thoughts about Trauma

6. No Comparisons, No Platitudes

-Of course you want to offer comfort to someone who is suffering. But they GET to suffer.

-It is terrible, and if it could be fixed easily, they wouldn't be struggling here

-Most reassurances sound clueless, careless, and false.

-It might not get much better for them.

-It's their pain, not yours. "This is suffering"

Ten Thoughts about Trauma

7. Clients Get to Tell Their Stories or Not (even SOS)

-They need to find their own reasons for hope.

-They need to be able to tell the WHOLE story, or as much as they like, in the way they want to/or don't want to/remember/don't remember. It belongs to them.

-Open up silence, spaces for stories to come into. But they are not obliged to have one.

-The story can take a long time to construct for those with attachment trauma, and longer to feel. Patience.

Ten Thoughts about Trauma

8. Even Broken Hearts Can Love Again

-Only very few of us can't love at all, and it comes in all shapes and sizes—not just romantic love, not just people—help clients look for love and care in different places

-Allow the possibility for love to surprise

-Be ready for resonant, healing moments—the love with YOU that becomes a model for how to dance in relationships still to come

Ten Thoughts about Trauma

9. It Didn't Kill them, but It Could Have.

"Nietzsche famously said, 'Whatever doesn't kill you makes you stronger'…What he failed to stress is that it almost kills you." -Conan O'Brien

-The fight goes on—it doesn't just end—it has to be won over and over again.

-Clients may be stronger for what they've survived, but they also may not be.

-It's unfathomable how some people survive, just because they may appear to be "resilient" doesn't mean the wounds weren't mortally inflicted, or that they are not fighting the good fight every day

Ten Thoughts about Trauma

10. Trust The Process

-There is meaning everywhere

-Even when you have no idea what's happening, something is.

-Don't worry so much about facts—be open, curious, really show up-–okay to go small and deep.

-Tolerate ambiguity and uncertainty: when clients say "I don't know," it's an invitation to find out how come—the body may know, and say so.

DISSOCIATION…

WHO, WHAT, WHY, WHEN, HOW TO HELP

What is Dissociation

Breakdown in usually integrated states of conscious (BASK model):

- Behavior—behavior without awareness
- Affect—disconnected or 'whelmed over'
- Sensation—Numbing or exaggeration of bodily sensations
- Knowledge—Understanding of self and behavior, affect, or sensations

Dissociation in DSM-5

"A disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behavior."

"Dissociative symptoms can potentially disrupt every area of psychological functioning"

- DSM 5 p. 291

Common Dissociative Experiences in Everyday Life

Daydreaming
Missing parts of conversations
Vivid fantasizing
Forgetting part of drive home
Calling one number when intending to call another
Driving to one place when intending to drive elsewhere
Reading an entire page & not knowing what you read
Not sure whether you've done something or only thought about doing it
Seeing oneself as if looking at another person
Remembering the past so vividly you seem to be reliving it
Not sure if an event happened or was just a dream

Some Causes of Everyday Dissociation

Fatigue
Sleep deprivation
Stress
Binge drinking
Drug use
Confronting a new environment
Feeling preoccupied or conflicted
Engaging in certain religious or cultural rituals or events

DISTINGUISHING NORMAL FROM PATHOLOGICAL DISSOCIATION

FOUR DISTINGUISHING CHARACTERISTICS: IN PATHOLOGICAL DISSOCIATION
- LOSS OF EXECUTIVE CONTROL
- CHANGE IN SELF REPRESENTATION
- AMNESIC BARRIERS
- LOSS OF OWNERSHIP OVER BEHAVIOR- (Kluft, 1993)

DISORGANIZED ATTACHMENT: EARLY ABUSE AND NEGLECT EXPERIENCES LEAD TO UNINTEGRATED INTERNAL WORKING MODELS

LEADING TO DISSOCIATION

Attachment Trauma in History
Higher hypnotizability/dissociability
Disorganized Attachment Style
Multiple Abuse Types (and/or ACEs)
Long Periods of Time without Safety
Poor/Maladaptive Self Soothing
Inadequate External Integration Support*
High-demand Environment (for them)

STRAUS 2018

Disorganized Attachment and Dissociation

"TRAUMATIC EXPERIENCES, ATTACHMENT DYNAMICS, AND DISSOCIATIVE REACTIONS ARE…INEXTRICABLY INTERTWNED, LIKE THREE THREADS WOVEN INTO A SINGLE STRAND" (LIOTTI, 2004)

DISORGANIZED ATTACHMENT AND THE "DRAMA TRIANGLE"—DISORGANIZED INFANT/CHILD CONSTRUES BOTH SELF AND ATTACHMENT FIGURE QUICKLY AND SIMULTANEOUSLY AS PERSECUTOR, RESCUER, VICTIM

- CONTRADICTORY EMOTIONAL STATES (FELT EXPERIENCES)
- CANNOT BE SYNTHESIZED INTO UNITARY EXPLICIT MEMORY
- IWMS ARE INTRINSICALLY DISSOCIATIVE

Disorganized Attachment and Dissociation

Many similar environmental stressors for both

Disorganized Attachment—unpredictable and unsafe environments

Periods of disconnection or scorn or blaming--misattunement

Repeating over time: Caregiver is both danger and comfort

No real possible source of safety and soothing

Caregivers are carrying their own legacy of unresolved trauma, loss

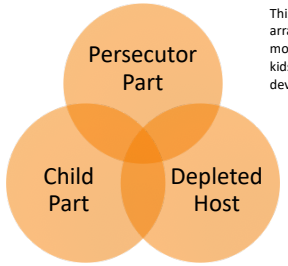
Note the comparability of Disorganized baby freeze state and the Dissociative absence

FEAR WITHOUT SOLUTION (Mary Main)

Not Safe Deposit Boxes

More Fluid, Sometimes Communicating

A Simple, Common System



This type of arrangement is much more characteristic of kids in process of DID development

Trance Logic

Hypnagogic Imagery (wake to sleep)

Self-hypnosis

The Patchy Ground Fog Metaphor

Shakespeare's Stage—with a fog machine

Once the teen is dissociating, you are less of a resource—like the adults off stage in the Peanuts cartoons

We all dissociate some—lose track of time, forget where we are—it's a continuum

For those of you in school settings—think of the teen who seems to be grinning when being punished—they may not even be hearing the adult any longer. It's all fog.

Consensus Treatment

Three Stage Model

- Stage I: Safety, Stabilization
  Therapeutic Alliance
- Stage II: Trauma Metabolism & Resolution
- Stage III: Self and Relational Development--Judith Herman
- ISSTD Has Published Guidelines available at the website www.isst-d.org

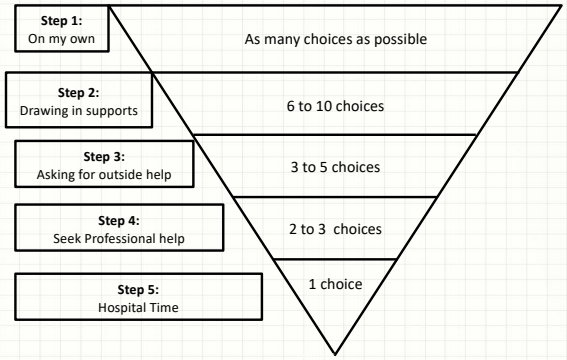
IFS Model: Paradigm Shift—Get permission from protector/fearful parts right away or "system" gets more destabilized waiting

Recursion, Not Lock-Step

Stage 1--Stabilization

Safety planning
- Multi-Step Safety Plan
- 5 step triangle
- Widest Base is things they can do themselves.
- Narrowest Peak is go directly to hospital ER.

Triangle of Choices for Safety



Stabilization on Own (cont.)

- Grounding Techniques
- Containment Techniques
- Meditation
- Exercise
- Music
- Yoga

Grounding Skills

One of the essential skills needed to do trauma processing and treatment

Skills taught to the client using the client's cognitive and sensory awareness of the present, in order to decrease flashbacks, intrusive memories, nightmares, dissociative symptoms,

Improve overall safety and function

Cognitive Grounding Skills

The day, date, year

Location

Age of patient

Resources available now

YOU

Sensory Grounding Skills

Using the 5 senses to reconnect with the here and now--Mindfulness

Decreases dissociative symptoms, sometimes almost immediately

Helps client better reality test if the reaction to a current stressor is out of proportion to the situation or not

Helps client feel safer, and more in control

Safe Place Imagery

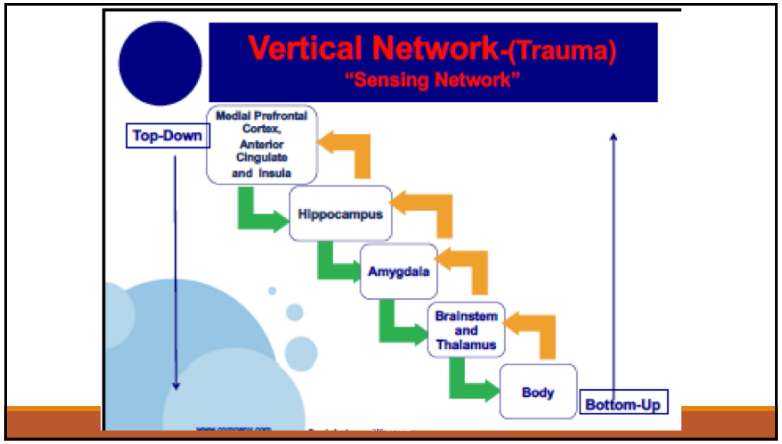
- **"Healing Place" may be a better choice of terminology**
- **Can be real or imagined**
- **Used to help create a place of comfort for all self-states**
- **Ego-strengthening, self-nurturing, calming**
- **Persecutory self-states may try to sabotage**

Internal Meetings

- **Modified version of the "Dissociative Table Technique"**
- **Create an internal meeting "space" (both internal and external)**
- **Encourage self-states to participate, may have "roles"**
- **To create safety, encourage self-states to problem solve ways to work together to manage safety**

Stage 2—Working the Trauma

- Here it is helpful to know a rapid trauma processing model such as EMDR
- Start with a mid-range trauma…
  - Expect and predict generalization…
- Need metaphor for passage of time…
- Need revised self-statements…
- Need letting go imagery…
- If stuck on anger move to grief
- If stuck on grief, move to anger
- Physical objects that change the narrative—family album…
- SP or other Mind-Body Techniques



What to Do with Hypo-arousal

- Move from *Dorsal* to *Ventral* branch
- First Assess where your client is at;
  - Can you look at me, Can you talk, Can you take a breathe? Can you move your finger?
- Don't talk about it. Bring feelings & body sensations back online.
- Foster nurturance and connection
- "Sense" where they are at.
  - *(Empathy not Compassion)*

www.company.com

Frank Anderson MD

WHAT TO DO WITH BLUNTING

BOTTOM UP STRATEGIES

- DEALING WITH UNDERWHELM—SLOW IT WAAAAY DOWN
- THE MORE YOU PUSH, THE HARDER THEY RUN
- "YOU'RE THE BOSS, TAKE AS MUCH TIME AS YOU NEED"
  - BLUNTING TAKES TIME TO RECOVER FROM
  - HAND OVER CONTROL AND TRUST
- HOW FAR AWAY IS THE PART THAT MOVED OUT OF CONNECTION; CAN IT MOVE CLOSER WHEN IT'S READY?
- BUILD CONNECTION FROM THE BOTTOM UP
  - **BODY FIRST, THEN EMOTIONS, THEN THOUGHTS!**
- AT HOME: ENCOURAGE EXERCISE, MUSIC, MOVIES—COMFORTABLE ENGAGED ACTIVITIES

Stage 3--Reconnection

- Often an existential crisis—in adolescence a shift in identity
- New sense of self and self in relationships
  - Meaning-making (may involve a survivor mission)
- Current life stage issues, family development
- School Participation/Career/Vocational choices… New opportunities
- Continued development of relationships
  - Intimacy and sexuality
  - Family
  - Friendships

The Relational Context
Part 1: Relationship to YOU

Relationship Management *is* Risk Management

- Therapeutic Alliance/Relational Stance
- We are in the business of ***Attachment Repair.***
  - Changing the client's entire schema about the nature of self and world…
  - **Replacing the repetitive chaos with safety.**
  - Becoming introjected by our clients.
  - A developmental anchor.

How to Act Ethically Relationally

- **Don't make promises you can't keep.**
- **Always ask how any comment or intervention may affect the goal of earned security.**
- **Process relational pushes and therapeutic mistakes.**
- **Document & review these with clients.**
- **Boundaries.**
- **Teachable Moments.**

Common Interpersonal "Contractual" Challenges

Ineffective Dependency (excessive, draining)

Counter-dependence—I don't need YOU or anyone!

Trust and testing—The therapeutic relationship is constantly tested to obtain object constancy.

Blame and Behavior—Will you be a blamer when they are "bad?"

Shame and symptoms—Shame turns off everything else.

Ethical Relational Responses

Humility
- Our patients/clients teach us how to help them—within the standard of care.

Demeanor
- The flat-bottomed boat.
- Your panic helps no-one.

Awareness of the level of mutuality.

Professionalism—A safe context.

Consultation and Supervision

Relational Context

Provide a relational context that encourages the safety of the attachment between client and therapist.

Relational attunement increases client self-regulation and self-development.

Use of therapeutic mistakes as teachable moments.

- I am the adult but and am not perfect, it is OK that you are not also.

All disappointments are not abuse.

The Relational Context
Part 2: Relationship to SELF

INTERNAL ATTACHMENT DISORDERS

EARLY CAREGIVER ATTACHMENT SHAPES LATER ATTACHMENT TO **SELF**

- "IN CONTRAST TO A MORE DISCRETE TRAUMATIC EVENT, THE PARENT'S RESPONSES TO THE CHILD'S FOUNDATIONAL NEEDS FOR COMFORT AND SOOTHING ARE WORKED INTO THE FABRIC OF IDENTITY FROM A VERY EARLY AGE. THEY ARE ALSO WORKED INTO THE FABRIC OF THE CHILD'S BIOLOGICAL ORGANIZATION"

  -LYONS-RUTH ET AL. 2006, P. 15

"INTERNAL" ATTACHMENT STYLES (FISHER, 2013)

SECURE "INTERNAL" ATTACHMENT: WE FEEL WARMLY TOWARDS OURSELVES AND OUR PARTS, ACCEPTING EACH AS "DOING THE BEST IT CAN" WE FORGIVE OUR-SELVES FOR FLAWS AND MISTAKES

AVOIDANT: WHILE NOT HOSTILE TOWARD OUR PARTS, WE ARE DISCONNECTED FROM THE AND SINCE WE CAN'T FEEL THEM, WE DON'T ACKNOWLEDGE THEM; WE'RE OUT OF TOUCH

ANXIOUS: WE ARE SO BLENDED WITH THE INTENSE VULNERABILITY OF OUR YOUNG PARTS, WE CANNOT "BE THERE" FOR OURSELVES; WE WANT SOMEONE ELSE TO BE!

DISORGANIZED: WE CANNOT ACCEPT OURSELVES BECAUSE WE ARE LOCKED IN AN INTERNAL STRUGGLE BETWEEN YEARNING FOR ACCEPTANCE AND SELF-JUDGMENT/REJECTION

TRAUMA CAUSES ALIENATION FROM ONE'S SELF

WE NEED PSYCHOLOGICAL DISTANCE FROM OVERWHELMING EVENTS TO SURVIVE—THE SENSE OF SELF MUST ALSO BE KEPT SEPARATE FROM THE ONGOING TRAUMA

DISOWNING THE "BAD CHILD" OR "WOUNDED CHILD" IS A **SURVIVAL RESPONSE**—PRESERVES SELF ESTEEM, MOTIVATES US TO BE THE "GOOD CHILD WHO GOES TO SCHOOL AND BEHAVES

WE ALSO DISOWN THE TRAUMA BY DISOWNING THE TRAUMATIZED PARTS: THAT CARRY SHAME, ANGER, MOST WOUNDED PARTS, NEEDY PARTS, AND MOST OF ALL, THE MOST ANGRY, VENGEFUL PARTS

ALIENATION FROM SELF IS A SURVIVAL STRATEGY

IT CAN BE ADAPTIVE TO DISOWN NEEDINESS, GRIEF AND ANGER

- WHEN A CHILD DISOWNS NEEDS THAT CAN'T BE MET OR FEELINGS THAT ARE UNACCEPTABLE: **ADAPTATION TO THE ENVT IS ENHANCED AT THE COST OF FURTHER ALIENATION FROM SELF**
- FEELINGS AND NEEDS ARE "BAD" "NOT ME"
- **PARENTS AS MIRRORS**: FAILED PARENTAL ATTACHMENT PRECLUDES INTERNALIZING A COHERENT SENSE OF SELF—NOT JUST LOSS OF CARE AND CONNECTION
- **THE FRAGMENTATION PRESERVES FAMILY ATTACHMENT** AT THE EXPENSE OF SELF ACCEPTANCE AND FORGIVENESS (FISHER 2016)

MEMORY IS EMBODIED

THESE EARLY ADAPTATIONS ARE ENCODED IN THE BODY—VISCERAL RESPONSES, EMOTIONS OF FEAR, PLEASURE, HABITS, BELIEFS, EVEN AUTONOMIC AND MUSCLE MEMORY—ALL DIVORCED FROM THE EVENTS THAT SHAPED US

"REMEMBERING" WITH OUR BODIES AND OUR EMOTIONS IS ADAPTIVE IN INTENT: HELPS US AUTOMATICALLY AVOID BAD AND THREATENING EVENTS AND MOVE TOWARD WHAT FEELS GOOD, SAFE. ALL VERY INSTINCTIVE

-FISHER, 2010

MANIFESTATIONS OF SELF-ALIENATION

SELF LOATHING: self-judgment, internal attacks on self-esteem, inability to take in mitigating info

TERMINAL AMBIVALENCE: get stuck, can't decide, can't commit to a plan, "self sabotage"

NUMB, INTELLECTUALIZED: no emotion

OVERWHELMED: emotional outbursts, no ability to soothe

ACTING OUT: addiction, eating disorders, self harm

PARADOXICAL CONTRADICTORY BEHAVIOR: mood shifts

REGRESSIVE OR AGGRESSIVE BEHAVIOR: no ownership

DISSOCIATIVE DISORDERS

A FEW WORDS ON SELF-HARM

SELF HARM IS A COPING STRATEGY THAT, WHILE MALADAPTIVE TO US, WORKS QUITE WELL FOR MANY ADOLESCENTS

TRAUMATIZED SELF HARMING TEENS OFTEN SWITCH COPING STRATEGIES: CUTTING, SUBSTANCE ABUSE, BULEMIA AND/OR ENGAGING IN RISKY SEXUAL BEHAVIOR

IT'S A PROBLEM THAT'S A SOLUTION TO ANOTHER PROBLEM—PARADOXICALLY SELF PROTECTIVE

CAN BE TRAUMATIC RE-ENACTMENT, A WAY TO WAKE UP FROM A DISSOCIATIVE TRANCE, SELF-PUNISHMENT, AN ESCAPE, CONTROL, A WAY TO FEEL SOMETHING AND MANY OTHER THINGS FOR THEM.

BE CURIOUS, ASK ABOUT MEANINGS BEFORE TEACHING DISTRESS MANAGEMENT SKILLS OR

VALIDATE BELIEFS, HOLD THE POSSIBILITY THAT WHEN THE TEEN CAN RELY ON OTHERS—AND ON HER *SELF* TO REGULATE, SHE WON'T NEED TO RESORT TO DISSOCIATIVE SELF HARM AS MUCH.

Another Way to View Self-Harm/Fragmentation

A Few More Interventions for Hypoarousal

THE KEY IS THINKING "BOTTOM UP"

1. • **Remember that hypoarousal** is a survival response: attempts to increase arousal will often backfire, causing either increased hypoarousal or an escalation into hyperarousal
2. • **Increase amount of information to be processed**, rather than trying to stimulate feelings: study the numbness; find out what words or emotions go with it; what images
3. • **Foster curiosity:** study how ingeniously hypoarousal "works." Study its details: how far the numbing goes down or in, whether there is any other sensation, such as fuzziness, fogginess, heaviness
4. • **Admire the hypoarousal!**

REMEMBER, THEY ARE ALSO ALIENATED FROM THEMSELVES "INTERNAL ATTACHMENT DISORDER"

• **To survive, human beings need psychological distance from overwhelming events.** The sense of self must also be kept separate from the ongoing trauma

• **Disowning** "**the bad child**" **or** "**wounded child**" (the child who endured the abuse and humiliation) **is a survival response**: it preserves self-esteem, motivates us to be the "good child," helps us go to school and do our homework

• **We also disown the trauma by disowning the traumatized parts,** parts that carry the shame and the anger, the most wounded parts, the needy parts, and, most of all, the angry, vengeful parts

SELF-ALIENATION IS A SURVIVAL STRATEGY

• It can be adaptive to disown neediness, grief, and anger. When a child disowns needs that can't be met or feelings that are unacceptable, adaptation to the environment is enhanced–at the cost of further alienation from self. Those feelings and needs are 'bad' or 'not me'

• And because parents are a child's 'mirror,' failed parental attachment precludes internalizing a coherent sense of ourselves, not just a loss of care and connection

• Alienation and fragmentation helps maintain attachment to the family necessary then but interferes with self-acceptance and self-forgiveness we need later

HELPING HYPOAROUSED TEENS STAY PRESENT

- **Conduct small experiments** to increase arousal: use humor, raise your level of arousal, work multi-modally, use body language, do something unexpected or silly
- **Ask the client to evaluate the hypoarousal:** how "pleasurable or unpleasurable" it feels in the body: experiment with what increases the arousal to a more pleasurable level
- **Encourage movement:** change posture, trade seats with the client, or work standing up
- **Strengthen the client's resources before pushing for more arousal:** hypoarousal means that the client is dysregulated and affect intolerant. Pushing for affect too soon will increase hypoarousal, rather than addressing it

HELPING HYPOAROUSED TEENS STAY PRESENT

ORIENTING STRATEGIES TO "COME BACK INTO THE ROOM"

- **•Ask the teen to turn the head and neck and slowly scan the entire space around them: to one side, then straight ahead, then to the other side of the room. If necessary, the client can be asked to focus on particular object**
- **• Have teen practice turning movements through the neck and spine, and notice what happens in the body**
- **Experiment with what happens when client lengthens the spine just a little bit, then a little more. What shifts? Does it feel better or worse?**

TOLERATING STATES OF CALM

For the hypoaroused client, calm states within the window of tolerance can result in increased connection to emotions and bodily experience that overwhelms rather than informs

• Often the therapist has to work toward achieving "calm but alert" states before "calm and relaxed" is possible

MORE GROUNDING STRATEGIES

• Grounding helps with both "staying here" and "staying present" in the body

– Sitting in a chair, ask the teen to gently push his feet against the floor and notice what happens in his body or "what it feels like." The therapist encourages experimenting to find the right amount of pressure until patient has a positive experience

– Standing, ask the teen to first study the sensation of her feet on the floor or carpet, noticing even her heels and toes, then to bring awareness to the legs, the hips and pelvis, then to the spinal column, shoulders and ribs, and finally to the head and neck. Ask her to notice what happens in her whole body when she is grounded in this way.

—Agree upon a phrase or idea that one of you can say to become more present "I am here with you sitting on the blue couch at three in the afternoon" "You are not alone and I am here."

—DROP THE CONTENT!: Say, "Let go of those thoughts and feelings and move your attention to your feet on the floor/sensations in the body/ a belief 'I'm doing the best I can'" "I'm being triggered and Ihat's all that's happening… {from Janina Fisher/Sensorymotot Psychotherapy)

THE THERAPEUTIC RELATIONSHIP

INCREASING CAPACITY FOR SOCIAL ENGAGEMENT IS A NECESSITY FOR REPAIRING TRAUMATIC ATTACHMENT

THE THERAPIST MUST STAY ENGAGED AND ANIMATED USING HER SOCIAL ENGAGEMENT "MUSCLES"—FACIAL EXPRESSIONS, HEAD MOVEMENTS, INTONATION AND GAZE TO EVOKE AND MAINTAIN THE TEEN'S SOCIAL ENGAGEMENT SYSTEM – REMEMBER IT'S A TWO PERSON SYSTEM

The Social Engagement System of the Therapist

- **Amplifying client capacity for self-compassion and loving feelings towards all parts 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 even 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, 2016

SUMMARY OF WORKING W HYPOAROUSAL

1. BOTTOM UP: WORK WITH BODY FIRST THEN THOUGHTS THEN FEELINGS
2. SENSE AND CONNECT USING YOUR SUPER POWER OF EMPATHY (FEEL FOR/WITH THEM)
3. SLOW IT DOWN, TRUST THEY KNOW WHAT THEY NEED, AND HAND OVER CONTROL
4. GET PERMISSON TO COMMUNICATE WITH RELUCTANT PARTS
5. MAKE SURE TO PUT ON THE BRAKES WITH GROUNDING, ORIENTING, AND RELATIONAL STRATEGIES

WRAPPING UP

- MOST TRAUMATIZED TEENS EMPLOY DISSOCIATIVE COPING SKILLS—SOMEWHERE ON THE CONTINUUM
- DISSOCIATION AND FEARFUL DISORGANIZED ATTACHMENT MAY SHARE EARLY HISTORY OF ABUSE AND NEGLECT
- TREATMENT HAS THREE STAGES THAT NEED TO BE REPEATED MANY TIMES—RECURSIVE AND SLOW
- INTERVENTIONS ARE "BOTTOM UP" BEGINNING WITH THE BODY/GROUNDING THEN THOUGHTS AND FEELINGS
- SELF HARM CAN BE BOTH A SYMPTOM AND A SOLUTION TO DISSOCIATION
- THESE TEENS ARE DISCONNECTED FROM YOU AND FROM THEIR SELVES—"INTERNAL ATTACHMENT DISORDERS"
- WE ENGAGE WITH AND WELCOME ALL THE PARTS, EMPATHIC CURIOUS, PATIENT AND STEADY AND AS FULLY PRESENT IN MIND AND BODY AS WE CAN BE