Therapeutic Container

1

Therapeutic Container

- The space you create for your patient during a treatment session that evokes the feeling of safety. The therapeutic container allows your patient to experience and express anything during the treatment session, while being supported and comforted without judgement, shame or abandonment.
- A relationship that encourages the exploration of the unknown
- The experience that whatever happens will be accepted, respected and protected.
- A place where the patient can let down their guard and be honest.

2

Therapeutic Alliance

- The quality of the relationship between client and therapist, to a large extent, is what determines the quality of safety, depth, and support that is found in the therapy. This relationship is the container that holds the therapy.
- "The therapist ability to form an alliance is possibly the most crucial determinant of his effectiveness."
  - Luborsky et al (1985)

"Therapeutic alliance: subtle, dynamic relationship between patient and therapist. Not an intervention or technique, rather vehicle within which therapeutic process is facilitated."

- Schore

3

Therapeutic Relationship

- Patient will not go where you fear to tread!
- Your security in your skill set and self exploration are keys in establishing a "container."
- The relationship is *confidential !!*
  - Barring duty to warn concerns.
    - The intent, the means, the motive.
- *DO NOT DOCUMENT ANYTHING OF A PSYCHOLOGICAL NATURE UNLESS IT IS READILY ACCESSIBLE THROUGH THE MEDICAL RECORD!*

4

Therapeutic Process

- Shame, blame, guilt internalized
- "I did something wrong."
- Rejection, abandonment
- Hypersensitized to your responses
  - Nonverbal!
- Expression and acceptance allows compensatory mechanism to dissipate
- Your relationship helps them experience being in the world as accepted and supported

5

The Neurobiology of Feeling Safe

- Words Vs Feelings
- Without safety there is no downregulation
- "So before analyzing, before classifying, before thinking, before trying to *do* anything,--we should *listen*."
  - Shay, *Achilles in Vietnam*
- "If we are not safe, we are in a chronic state of evaluation and defensiveness," (Porges, 2011b, pg 14).
  - Influences breathing and systemic myofascial tension

6

Modulation of Nurturance and Contact as Therapeutic Interventions

- Contact is the therapeutic intervention
- Eye contact modulates facial attunement
- Physical contact –nurturance

7

Attachment

- "Attachment relationships are formative because they facilitate the development of the brains self regulatory mechanism."
  - Fonagy & Target (2000)
- Dysregulation of the right brain: A fundamental mechanism of the psychopathogenesis of post traumatic stress disorders."
  - Schore (Australian & New Zealand Journal of Psychiatry, 2002)

8

Attachment as Regulation

- "Attachment, the intractive regulation of emotion, represents the regulation of biological synchronicity *between* and *within* organisms."
  - Schore

9

Therapeutic Presence

- Safety.
- Establish a non threatening presence.
- Be able to allow the client to downregulate.
- Be congruent.
- Meet all levels
- Create a sense of security, normalize their experience.

10

Therapeutic Presence

- Therapy is not the "talking cure" but the "communicating cure."
  - Communication takes place on many different levels
- Not what to *do* for the patient or what to *say* to the patient, but *how to be* with the patient.
  - Schore

11

The Dorsal Vagal Nucleus,

The Freeze Response,

and

Dissociation

12

Dissociation – 2001:

Disruption of the
usually integrated functions
of consciousness, memory, identity and
perception of the environment

13

Dissociation Psychobiology

- :…"vagal outflow from the dorsal vagal nucleus …is the psychobiological engine of …dissociation"
  SCHORE (2005)
- …"early trauma expressed as emotional neglect and abuse…predict…dissociation."
  i.e.: Impaired attachment and right O.F.C. development leads to autonomic dysregulation, and the emergence of dorsal vagal/freeze/dissociative states.
  Schore (2005)

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The Dissociation Capsule is Composed of:

- Somatosensory messages and motor actions
- Autonomic states
- Emotions
- Endorphinergic alteration of perception
- Emotion linked declarative memory

All Specific to
the Traumatic Experience

15

Features of the Dissociative Capsule

Capsules consist of procedural memories for the past trauma, but are perceived as being present, and are therefore dissociative

16

Examples of Capsule Procedural Memories

- Pain, numbness, dizziness
- Tremor, tics, paralysis
- Nausea, cramps, palpitations
- Anxiety, terror, shame, rage
- Flashbacks, nightmares or intrusive thoughts

17

The Dissociative Capsule is brought into conscious awareness (the present moment) by exposure to external cues or internal kindled memories associated with a traumatic event

18

The size, specificity and strength of a Dissociative Capsule depend upon the intensity or repetitive experience of the trauma that caused it

19

The more one is exposed to trauma, the greater the number of Dissociative Capsules, the less time one is able to spend in consciousness (the present moment)

20

Somatic Dissociation

Splitting off of a Region of the Body from Normal Conscious Perception That Results in a *Physiological Change* in That Body Region

21

Reflex Sympathetic Dystrophy/CRPS

- Regional Autonomic vasomotor dysregulation with burning pain ("Causalgia")
- Tropic and dystropic manifestations
- Avoidance, dystonia, hyperpathia, hyperalgesia
- Relationship to trauma

22

Neuroimaging in Conversion Disorder

- fMRI studies in hysterical motor paralysis and anesthesia reveal *reduced brain sensory message transmission*

i.e.: *CONVERSION "HYSTERIA" IS PHYSIOLOGICAL, NOT "PSYCHOLOGICAL"*

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Functions of Dissociation

- A Defensive and Protective Neurophysiological Mechanism to Modulate and Inhibit Intolerable Arousal
- A Means of Isolating Distracting Internal Arousal Cues to Allow Defense or Escape
- The Perceptual Component of the Freeze Response

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Dissociation

- Helps Us Modulate Conflict And Anxiety
- Characterized By Sensation Of Being Outside
  - One's Process
  - One's Body Or Body Parts
- Accompanied By "Separation Anxiety"

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Somatic Dissociation

- Compensatory mechanism with myofascial, biomechanical, behavioral components.
- The common denominator in the difficult patient in healthcare.
- The practitioner who is unable to identify Somatic Dissociation is likely to be reinforcing it!
- Dissociation provides pain reduction.

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Results of Dissociation

- Repression of Normal Physiological Responses
- Soft Tissue and Biomechanical Changes
- Loss of Proprioception and Coordination
- Weakness
- Impaired Motor Planning
- Emotional Repression

27

Neurophysiology of Trauma

- Previous traumas organize how the individual responds to future traumas
- Traumatic responses are locked into procedural memory and are therefore reflexive, conditioned, automatic, non-logical, and not under conscious control

28

Somatic Tracking

29

Somatic Tracking

- "Somatic"
  - Thomas Hanna of Hanna Somatics
  - "Soma" Greek for "living body"
- Skillful application of awareness to our internal physiological processes
- Mindfulness

30

Mindfulness

- Shifting your focus inward
- Calm awareness of one's body functions, feelings, content of consciousness, or consciousness itself
- Detached awareness
- Decrease reflexive reactivity, impulsiveness.

31

Mindfulness

- The first component involves the self-regulation of attention so that it is maintained on immediate experience, thereby allowing for increased recognition of mental events in the present moment. The second component involves adopting a particular orientation toward one's experiences in the present moment, an orientation that is characterized by curiosity, openness, and acceptance. *Bishop et al* (2004:232)

32

Therapeutic Awareness

- The awareness of the effects of the client's presence, story, emotions and process on the practitioners physiology.
- Physical countertransference/imprint
- Interplay
- Awareness of the scope of the therapeutic process.

33

The Antidote to Somatic Dissociation

- Somatic Tracking/Mindfulness techniques
- Allowing thwarted fight/flight /freeze response to go to completion.
- Increase in proprioceptive awareness in the somatic region.

34

Somatic Tracking

- Identify the environment before you change it.
- Facilitated “by in” when the patient can identify changes made
- Gives you an understanding of the level of somatic awareness of the patient.

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Somatic Tracking

- Client associates physiological response with a meaning/belief
- Tracking helps to disengage the meaning
- Shift in focus with shift the patterning and referent
- Make a change in the pattern, changes the Somatic Environment
- Allows the release of the compensatory mechanism

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Somatic Tracking

- Notice what you notice,
  - Where do you go, what do you key into
- Expand the Observation
  - Broaden physical awareness
  - Allow for shift in locus of control
- Stay with physiological response
- Normalize the process
  - Reflective Empowerment Language
- Allow the process to go to completion

37

Assessment

- Assess how the rest of the body responds to physiological changes made.

38

Looping

- Make general assessment of somatic awareness.
- Instill curiosity, limit desire to make conscious changes to what is perceived.
- Invite a "witnessing" observational outlook.
- Follow what the body does with the energy of observation.
- Increase in awareness may lead to increase in sensation, myoclonic discharge, then it may dissipate to a still point.

39

Flooding

- Flooding happens!
- Flooding
- Regression
- Flashback

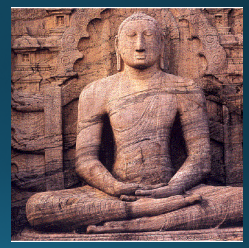
40

Conscious Breathing

41

Breathwork

- Breathwork has been a central focus in eastern philosophy meditation practices for thousands of years!
- Breathing and emotions: Reciprocal relationship
- Emotional states affect pattern of breathing
  - Short shallow: anxious, tight, restricted, control, reactive
  - Long deep: relaxed, resilient, loose, fluid, resilient
- Pattern of breathing affect emotional state
- Joy/Sadness/Fear/Anxiety/Anger/Passion



42

Breathe

- Shifting normalized rates: 12-14, 12-18, 12-20
- *Physiology of Respiration*: Hyperventilation 25-40
- Overbreathing affects body PH, increase in systemic myofascial tension, increase in anxiety, increases BP.
- It is the simplest intervention to create a systemic change
- It is the least likely intervention to be taken seriously!

43

Hyperventilation

- Studies designed to determine the effects produced by hyperventilation on nerve and muscle have been consistent in the findings on increased irritability
  - Brown, EB
- Hyperventilation leads to asynchronous firing of cortical neurons"
  - Huttunen, et al

44

Self Regulation

- Disorders of ANS can be influenced by breathwork
  - Hypertension Arrhythmias Migraines Asthma BS sleep apnea
- Breathing techniques do not act as fast as modern pharmaceuticals
- Results are long lasting provide self mastery and are free of toxicity
  - Telles, S, et. al, .
  - KaramM, Kaur BP, Baptist AP.
  - Sharma P, PoojaryG, VélezDM, DwivediSN, Deepak KK..

45

Mission Impossible: Rogue Nation

46

Conscious Breathing: Mind-Body-Medicine

- Breath can be conscious or unconscious
- Can form a bridge between these two mental functions
- Breathwork is a connection between mind and the body

47

Breathwork

- Notice your breath but do not change it.
  - Rate
  - Depth
  - Pattern; inspiration vs expiration
  - Location
  - Mind state

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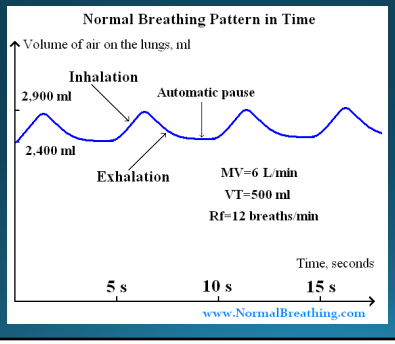
Features of the Normal Breathing Pattern



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Breathwork Guidelines

- When you focus your attention on your breath try and make it
- Deeper
- Quieter
- Regular
- Slower

- This affects the parasympathetic nervous system and also our mental state
  - Sengupta P. Health impacts of yoga and Pranayama: a state of the art review. *Int J Prev Med*. 2012 Jul; 3(7): 444–458

50

Breathwork

- Inhale deeply, notice where you are restricted
- Exhale deeply, notice where you are limited
- Diaphragmatic Breathing
  - Hand on abdomen, expand as you inhale.
  - Hand on ribs, note bucket handle movement
  - Notice side and back

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Hanna Somatics Diaphragm Release

- Place left hand on the lower left abdominal quadrant and the right hand on the right upper thoracic quadrant. On the inhalation draw in the lower abdomen, try to breathe into the right hand expanding the right thoracic quadrant.
- On the exhale expand into the lower left quadrant as you constrict the upper right. Perform ten cycles.
- At the end compare the right to left side of the abdominal and thoracic area.
- Repeat to the opposite pattern.

52

Normalizing Breathing

- Accentuate exhalation
- Crocodile breathing
- 4:7:8
  - Exhale completely through your mouth making a whoosh sound. Close your mouth and inhale quietly through your nose to a mental count of four. Hold your breath for a count of seven. Exhale completely through your mouth making a whoosh sound to a count of eight.
- This is one breath. Now inhale again and repeat the cycle three more times for a total of four breaths.

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Breathing Assessment

- Need to assess when patient not aware
  - Patient will always alter respiration when you state that you are assessing just like posture!
- Typically assess for 30 sec x 2 to allow for assessment of irregularity in pattern.
- Can measure at axilla, xyphoid and R10.
  - Note change between max inspiration expiration

54

Breathing Assessment

- Oxygenation of the organism can be determined by monitoring how long the patient can pause their breath with no stress
  - 20-60 Sec in health
  - 5 Sec in diseased states.
    - Buteyko KP. Public lecture. Moscow State University. 1969
- Breathing can be altered through training

55

Abnormal Breath Patterns

- Use upper accessory musculature
- >20 CPM
- Inhalation/exhalation even
- Lack of movement in rib cage
- No pause after exhalation
- May not even be able notice visually

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Traumatized Breath Pattern

- Short sha ow rap d breath ng ha mark of anx ous affect
  - Increases systemic muscular tension
  - Fac tates sy mpathet c dom nance somat c d ssoc at on
  - Affects O2 saturation in blood
  - Facilitated CNS irritability
- W not not ce any changes w th d aphragmat c breath ng act v t es
- Chang ng breath pattern ng may ncrease rr tab ty and pa n eve s
  - RIA

57

Inspiratory/Expiratory Respiratory Muscle Trainers

58

Personal Boundary

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Personal Boundary

- Energet c sense of se f that extends beyond the phys ca body
  - Helps to define a sense of privacy

60

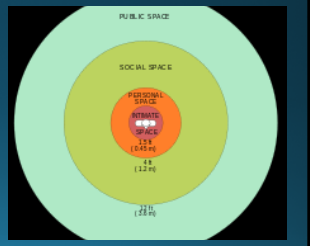
Proxemics

- Edward T. Hall, PhD
- Anthropologist and cross-cultural researcher
- **Proxemics** s the study of human use of space and the effects that popu at on dens ty has on behav or commun cat on and soc a interaction.

61

Personal Space

- -Concept widely accepted
- -Used in conflict resolution
- -Restaurant layout design
- -Architecture designs
- -City Planning/Park Planning
- -Interrogation



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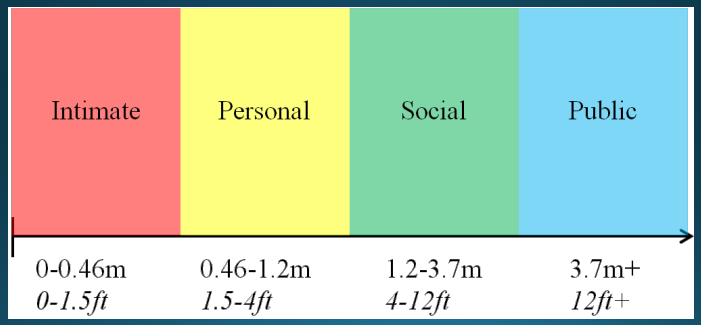
Personal Space



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Personal Boundary

- Energet c sense of se f that extends beyond the phys ca body
  - In health, extends 2'-4' outside body
    - Valerie Hunt, PT, PhD, at UCLA, *Infinite Mind*

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Personal Boundary Ruptures

- Violation of Energetic Container
- "Collapse in the Bio-Field"
- Usually hyperactive & hyper-aroused in affected region
- Stimulation produces emotional liability
  - Valerie Hunt, PT, PhD, at UCLA, *Infinite Mind*

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Personal Boundaries

- Assault or injury to a particular aspect of our "field" sensitizes us to all sensory input associated with the infraction.
  - Heat
  - Sound
  - Touch
  - Smell

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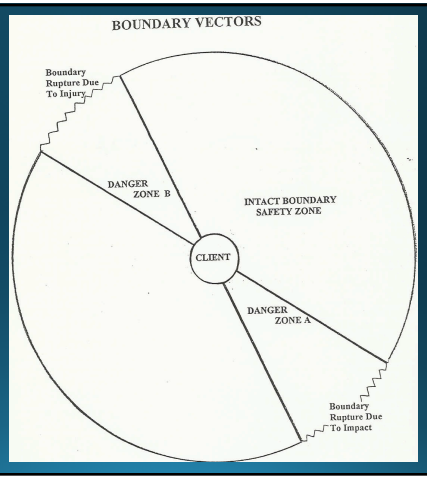
Boundary Assessment

Assess perimeters



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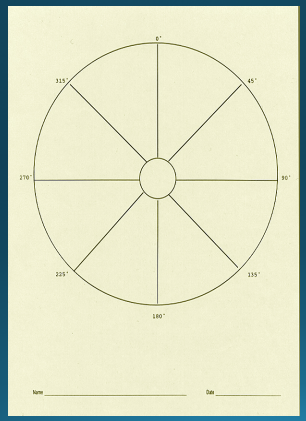

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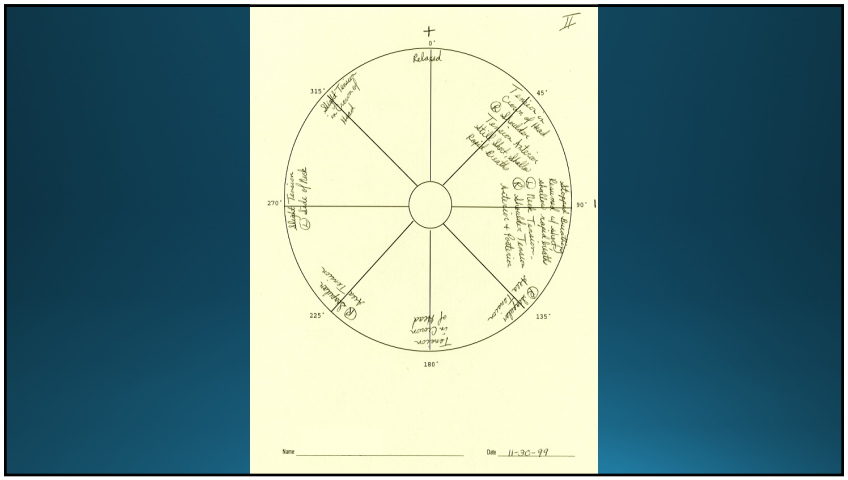

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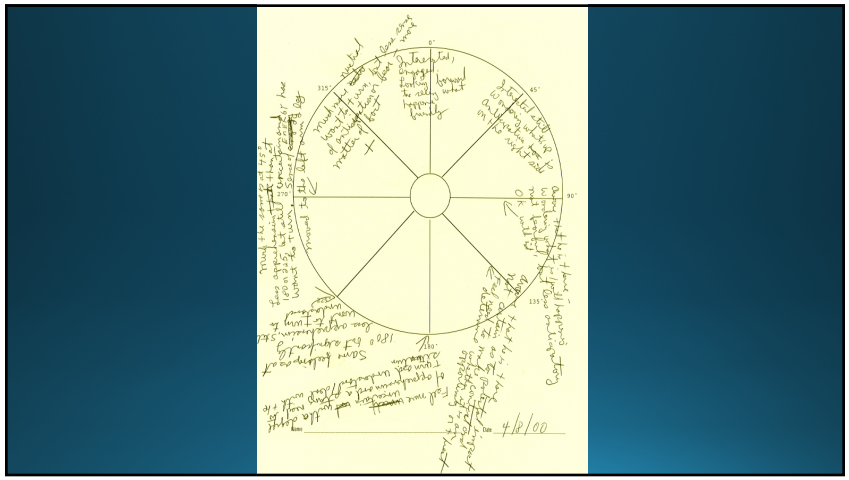

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- "By acknowledging the absence or presence of warmth from the body of another marks the line between intimate and non- intimate space."
  - Hall
- Your ability to acknowledge sensory information is how you define your zones.
- If you loose the ability to regulate the fields you feel lost, not able to communicate effectively, increase the sensation of helplessness.

71

- "People inhabit different sensory worlds and will respond to input differently."
  - Edward T. Hall, PhD
    - Proxemics

72

Increased Vulnerability

- With collapsed energetic fields and hyperreactive sensation, the traumatized patient may not be able to be alone, even if s/he is.
- Hyper reactivity to stimuli prevents downregulation

73

Boundary Assessment in the Clinic

- Rank levels of activation in sitting and supine
- Patient controls proximity by giving permission to approach
- Activation encourage patient to request retreat
- Repeat until extinguished and you can approach w o activation

74

Tactile Defensiveness

- Tactile defensiveness (TD)
- A pattern of observable behavioral and emotional responses which are aversive negative and out of proportion to certain types of tactile stimuli that most people would find to be non-painful (Royeen & Lane, 1991).
- It was first identified by Dr A J Ayres an Occupational Therapist around the 1960s.

75

Tactile Defensiveness in Trauma

- Combined with somatic dissociation
- Unaware of personal physiological responses to overwhelm
- Response out of proportion to stimuli therefore often ignored
  - May not notice
  - Increases dissociation
- Associated with withdrawal intellectualization increase in tension eye fluttering increase in G sounds alteration of breath patterning.
- Key to helping patient understand their own states of overwhelm

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Limit Setting

The Opportunity to Reclaim What was Lost

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Limit Setting

- Inviting the patient to explore their inner environment
- Teach patient to recognize physiological signs of threat and overwhelm
- Encourage patient to set boundaries based on observation of their physiological responses
- Then observe the resulting physiological response
- Give meaning to the response

78

Limit Setting

- Inviting the patient to explore their inner environment
- Teach patient to recognize physiological signs of threat and overwhelm
- Encourage patient to set boundaries based on observation of their physiological responses
- Then observe the resulting physiological response
- Give meaning to the response
- Normalize/model this practice in your office
- Encourage practice with other providers

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Limit Setting

- Assess physiological response to subtle contact.
- Ask permission to begin and ask patient to suggest a location to start.
- Contact, assess, ask patient to verbally or physically remove your contact
- Note change and repeat until activation is extinguished.
- Begin with less involved site and progressed to more activated site
- Never assume since this process has been performed, it is totally completed, always reassess.

80