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A QuickStart Guide: Module 3—How to Work with Emerging Defense Responses To Trauma (Beyond the Fight/Flight/Freeze Model)

by Ruth Buczynski, PhD with Pat Ogden, PhD; Stephen Porges, PhD; Ruth Lanius, MD, PhD; Kathy Steele, MN, CS; Bessel van der Kolk, MD; Thema Bryant-Davis, PhD; Deb Dana, LCSW; and Janina Fisher, PhD

Behavior Patterns That Can Help You Recognize a Patient's Attach/ Cry-for-Help Response

According to Janina Fisher, PhD, there are five common behavioral patterns that can help you recognize the attach/cry-for-help response.

Dr. Fisher: I see the attach/cry-for-help response manifesting in multiple voicemails or texts. Clients may complain that it's too long between sessions. They may have a hard time leaving the office at the end of therapy. There's also a way in which the client becomes very sweet and helpless and childlike, that I associate with attach/cry-for-help. Finally, idealization of the therapist can be a sign.

How to Address a Patient's Attach/ Cry-for-Help Without Stimulating Their Need or Longing

When working with attach/cry-for-help, it's possible to push the patient further into the response and stimulate more need and longing. Here, Janina Fisher, PhD, offers advice on how to address the response without making this error.

Dr. Fisher: The therapist has to be warm, but

also has to be very careful not to answer too many texts, voicemails, or emails. You can hold the time boundary at the end of sessions by saying, "I'm so sorry that we're out of time today, it's such a shame. We could both keep talking longer but we have to stop now." That way, you're meeting that cry for help but not stimulating more frantic, desperate longing.

The therapist has to hold the boundaries without becoming rigid or confrontational. I do that by engaging my boundary muscles. We have a set of boundary muscles across the midriff and down our sides, so I bring warmth to my facial expression and tone of voice, but I keep my boundary muscles engaged. It's rightbrain-to-right-brain communication.

How to Keep Patients (and Yourself) Regulated When Working with Attach/Cry-for-Help

When working with the attach/cry-for-help response, it's important to keep both yourself and the patient regulated. To start, Deb Dana, LCSW, discusses what she does when she begins to feel overwhelmed by a patient's attach/ cry-for-help response.

Ms. Dana: I say, "Oh, I just noticed that I had this response, and I'm feeling like it was too big a demand for me to meet you in this way. Let me regulate and let's try that again."

Once she regulates herself, she then uses a Polyvagal approach to help regulate the patient. **Ms. Dana**: Interrupting the automaticity of the patient's sympathetic loop is important. I don't do that by saying, "Stop," or by distracting the patient. I do it by saying, "I see it, I feel it, and I'm meeting it with my ventral vagal energy. Can you feel or sense that? Can we stop for a moment and just be there?"

It's incumbent on the therapist to anchor in ventral and stay in that regulated state so that we can offer regulating energy to our clients, even the ones that are sympathetically demanding. The client's nervous system is saying, "This is what I need, and nobody's ever been able to give it to me." It can feel overwhelming, like a well that you'll never fill. But if you keep showing up, that well begins to get filled.

How to Help Clients Strengthen Their Internal Resources

A client who is caught in the attach/cry-forhelp response may rely too heavily on the therapist for help. Ruth Lanius, MD, PhD, shares how she helped one client develop internal resources to depend more on herself, and less on the therapist.

Dr. Lanius: When a client texts or calls a lot, it's important to bring that up with the client. I had a client who called me every day, and I said, "Just like we talk about dosing medications, let's talk about dosing phone calls. What do you think about the dose of the phone calls?" Then she took a pillow and threw it at me because she was angry. I sat with that anger, and she looked at me and said, "You're right. It's too much." And I said, "Yeah, we can't continue with that intensity because I'm going to burn out. What we really need to do is help you have some internal resources that are under your control, that you can bring up at any time without me present." That made a lot of sense to her, and so we worked with the adult part of her soothing the child part of her that always needed the therapist. Over time that was effective.

The other internal resource that we used was connecting with, and bringing out the positive imagery of, an animal. Especially connecting the child part of her with that animal. We practiced looking at the animal, the animal looking back at her, touching it, feeling the soft fur, and breathing together. We developed those internal resources, that internal locus of control, that she could call up at any time. Over time, that gave her a sense of mastery, and she could depend on herself.

Four Specific Ways That Collapse/ Submit Can Present in a Patient

It's important to know how to identify collapse/submit in a patient in order to avoid missing it or mistaking it for something else. Here, Deb Dana, LCSW, Pat Ogden, PhD, and Ruth Lanius, MD, PhD, offer four specific ways that collapse/submit can present.

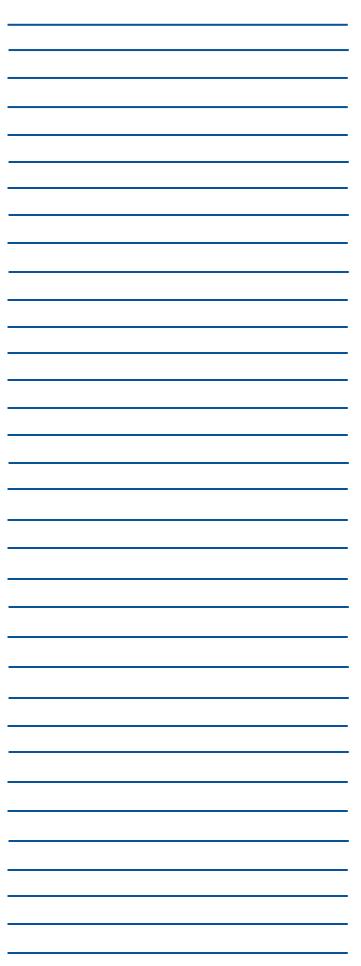
Ms. Dana: [1. Compliance/Obedience] It may seem like a client is just going along. We used to use the word compliance and I often wonder, were they really compliant or were they simply in a dorsal state, "I'm not really here, it doesn't matter." We want to be on the lookout for these moments of dorsal disappearing.

Dr. Ogden: With Holocaust survivors, there was this robotic movement. They just robotically obeyed the perpetrators because nothing else was a viable option. Children will also do that in severe abusive environments. There will be this automatic, mechanical obedience.

Dr. Lanius: [2. Learned Helplessness] The client has learned that the stress is inescapable, which has gotten them into a state of learned helplessness. This is often associated with chronic symptoms of depression. Often, these individuals would be diagnosed with treatment -resistant depression, which we have to be careful of. If we recognize it as a state of learned helplessness and collapse/submit, then we can help the individual get out of this state.

[3. Relationship Patterns] When clients are in collapse/submit chronically, they have tremendous difficulties in interpersonal relationships. I can think of clients that had difficulties dealing with their teenage kids. When their kids got out of control, the client's state of collapse/submit prevented them from engaging and setting appropriate boundaries. And because it got so out of control, they felt even more collapsed and helpless because they weren't able to deal with the situation. Patients can also present with difficulties at work because they can't stand up for themselves, and very often they get taken advantage of.

[4. Desire to Isolate] We also need to think about activities of daily living. When somebody is in a severe collapse/submit state, it's difficult to engage in anything; personal hygiene, cleaning your house, clearing snow, mowing your lawn, and engaging socially. It can lead to a



huge amount of social isolation.

One Question That Can Help Distinguish Between Collapse and Treatment-Resistant Depression

A client's collapse/submit response can often be misdiagnosed as treatment-resistant depression. When a client has a history of failed interventions, Kelly Wilson, PhD, takes the following approach.

Dr. Wilson: There are moments when the therapist sees something that looks so refractory and immovable, their response is to figure out a way to lean back. But if everything in me says, "Lean back," I lean in and I think, "What am I not seeing? What am I not hearing?" If I notice myself wanting to give up in the sense of the diagnosis, then I might ask the client, "I wonder if you've reached out to people and it looked like they might be able to help you, but then they just gave up?"

My expression is one of deepening curiosity, and clients are not used to having that happen when their outward appearance is utterly collapsed. When they encounter that deepening, persistent curiosity, it destabilizes that collapse because it's not having its usual results, which are either rescue or abandonment.

How to Work with Collapse/Submit at the Level of the Nervous System

When Deb Dana, LCSW talks about working with the nervous system, she often refers to three distinct states. There's the dorsal vagal, or collapsed, state; the sympathetic state that's charged with energy; and the ventral vagal state, which is the state of health, balance and social engagement. Ultimately, you want to help the client reach, and then feel comfortable being in, the ventral vagal state. Here's how Deb helps her clients practice being in ventral.

Ms. Dana: I help clients understand how their nervous system says "No" from each of these states. A sympathetic "No" is charged with energy, a dorsal vagal "No" says, "I don't care," and a ventral vagal "No," which many clients haven't yet discovered, says, "No, I'm setting a healthy boundary."

If my client's more common, habitual response is to go to sympathetic, I ask them to say, "No," from sympathetic, and I'll let them know how my nervous system just responded. Then I'm going to say, "Let me say no to you from my sympathetic and see how you respond."

Then we go to dorsal, where I say, "Show me how dorsal would say no, and I'm going to receive it and give you a response. Then I'm going to show you mine."

Then we're going to come to ventral, and I'll say, "Ventral might be a bit weird for you, so let me show you some of the ways that my ventral system can say no." I'll have them ask me a question and I'll say, "No, I don't think that feels like what I want to do right now," and I have them notice how they respond. Then I have them ask another question, and I respond, "No, that won't work for me right now." I have them ask another question, and I answer it in another way until they begin to get the flavor of it. I may also have them ask me a question, and I may answer it in my three different states and get them to feel the difference in the moment.

We're also going to get them to understand how to say "Yes" from a ventral place, which I think is equally as important. If they've been in a survival response and haven't learned to say "No" from ventral, it may be that they don't know how to say yes from ventral either.

How to Stay Grounded and Clinically Effective When Working with Collapse/Submit

A client's collapse/submit response may be unnerving for a practitioner. Here, Deb Dana, LCSW, discusses how practitioners can learn to regulate their own response when a patient goes into collapse/submit.

Ms. Dana: Have a colleague take on the characteristics of a dorsal vagal collapse. Then, play around with staying anchored in your system while also bringing energy to the colleague who is playing the role.

You'll find it's an interesting roleplay to do with a trusted colleague, because many people find that their sympathetic system lights up really fast and says, "Let me get them out of there." Also, your colleague can give you feedback about what that feels like to their nervous system. This is an invaluable exercise to do, whether you're familiar with dorsal or not. Dorsal is really best done when you're getting some feedback from the person who's taking on that role, and who is able to be present enough to help you understand and give you some guidance.

A Somatic Approach to Working with Collapse/Submit

Here, Pat Ogden, PhD, shares how she took a somatic approach with a patient who was trapped in the collapse/submit response.

Dr. Ogden: The primary idea is to find a physical impulse because our instincts are not cognitive, they're subcortical. We can't develop flexibility in them just by thinking about it, but when we find impulses in the body, we can start to reinstate another response.

Sometimes though, you have to prime the pump. One client who came to me, she was waking up in the night, gagging and choking. She had an inkling of being orally abused when she was an infant, but no real memory of it. At one point she said, "I'm so sick of this," and her whole body just collapsed.

So I wanted to work with aligning her body. If you think of an active defense, like pushing away or running away, aligning the body is kind of like priming the pump. Fighting back is much easier from an aligned spine, so we primed the pump by helping her align the body.

Then we practiced boundary motions like pushing against a pillow. She didn't like broccoli, so I said, "This pillow represents broccoli. I'm going to move it into your circle, and you push it away." It's good to start in these nonthreatening ways. Then I always want to bring the symptom into the therapy room when I can. I asked if she could remember that choking motion that happened at night, and if she could go back and feel it. She did, and she started gagging. Then her hands just came up at one point, and I said, "Push out, push against this pillow, push out right now, push out." I had to coach her a little bit because it still wasn't familiar within the context of that symptom. But she did it, and that helped with her symptom. Her symptoms started going away as she got this other action in her body. So she went from collapse, to alignment, to being able to push and keep things out.

Techniques for Stimulating Active Defense Responses for Clients in Collapse/Submit

When a client is in collapse/submit, it's important to activate their nervous system so that they can shift from a passive defensive response to an active one. Here, Ruth Lanius, MD, PhD, shares techniques she uses with her patients who have collapsed.

Dr. Lanius: One thing I always try when a client goes into collapse/submit, is ask, "What would it be like for you to get up right now and push against the wall or the door?" Those actions resemble an active defensive response. If my client says "No, that doesn't feel right to me at all," then of course, I wouldn't go ahead with that.

If somebody is really shut down and doesn't want to do that, I encourage them to start jogging in one spot just to activate their sympathetic nervous system. But before they start jogging, I have them become aware of how they feel in their body, and then what shifts afterwards. When they're in this shutdown response their voice often becomes quite hoarse, and when they activate the sympathetic nervous system, the voice changes, their breath changes, their posture changes. Then, even after they're done jogging, getting them to engage in an active defensive response can be helpful.

Those are acute things we can do in the therapy sessions, but we also need to think about longer term interventions outside of therapy. I think martial arts can be very helpful for individuals who have these chronic states to really help them develop active defensive responses.

When people first learn how to express anger or active defensive responses, sometimes they can overshoot the mark. I always give the analogy, when you first learned how to drive, it's not smooth right away. Similarly, when you first learn how to be angry or engage in an active defense response, it's not going to be smooth. It's going to take a while until you learn how to regulate and normalize it.

Precautions to Take When Working with Please and Appease

When a client is stuck in please and appease, their behavior patterns can appear in the therapeutic relationship. If the therapist is not careful, these behavior patterns can lead therapy astray. Here, Thema Bryant-Davis, PhD, and Deb Dana, LCSW, discuss several precautions therapists should take when working with the please and appease response.

Dr. Bryant-Davis: We need to be intentional about giving clients permission to disagree with us. We also need to ask open questions, such as, "What was that like for you?" We can sometimes be leading in our questions, and that will let people know this is what they want to hear, even though no real shift, or change, or internalization has happened.

Ms. Dana: When a client is going along with you, you want to be curious about where they are in their nervous system state. Having these explicit conversations is incredibly important. Then, help the client map their nervous system and introduce this experience of please and appease so that they understand it's a sophisticated autonomic nervous system survival state. It is not a ventral vagal state of safety and connection, nor is it a full-on sympathetic fight/flight. It's an interesting and very sophisticated blend.

When you are working with a client and it feels like they're on the road with you, but your nervous system is saying, "I'm not so sure," stop there and check it out. I would say to my client, "My nervous system just sent me a message that it's not quite sure we're actually on this road together. Can we stop and have a discussion about this?" Your nervous system is giving you lots of good cues. Learning to tune into those is the first step. Otherwise, we may be asking our clients to do something that their nervous system is saying is dangerous.

Key Questions That Can Help Patients Discover the Origin of Their Please and Appease Response

Thema Bryant-Davis, PhD, works in collaboration with her patients to help them discover the origins of their please and appease response. To start this process, she asks them three specific questions.

Dr. Bryant-Davis: Where did the peoplepleasing start? Where did you learn that it was dangerous to have thoughts, feelings, and needs of your own? How can we go about recovering or reconnecting you to yourself, and to know that you are worthy in terms of being, as opposed to doing?

Specific Language to Help You Uncover Why a Client Is Self-Censoring in Therapy

When working with please and appease, you may find that the client is only telling you what they think you want to hear. Usha Tummala-Narra, PhD experienced this with one of her clients, and used very specific language to help the client censor themselves less.

Dr. Tummala-Narra: Midway through treatment, the client and myself were doing what we thought was really excellent work in terms of her trying new things in her life and feeling more stable. One of the things I brought up with her at one point was, "I can't help but wonder if you're telling me everything that you'd really like to share with me." She immediately said to me, "Well, I don't want to let you down."

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This theme of worrying that I would be disappointed, or would not approve, kept coming up. I asked her at one point, "Do you think something is happening between us, or is there something I may be doing that leads you to feeling that way, that you can't share certain things with me?" One of the things that she talked about was the transference that she had towards me. She thought, "Well, you seem like the kind of person that wouldn't make those mistakes, that you wouldn't have the kinds of problems that I have." That led into a deeper conversation about the differences that she perceived between me and her, and that she needed to see me as more vulnerable in order for her to really share and censor less.

Three Strategies for Practitioners to Stay Grounded When Working with Emerging Defense Responses

Working with defensive adaptations to trauma can be complex, and can sometimes overwhelm practitioners. Ron Siegel, PsyD, offers three grounding approaches that he uses when working with clients who have experienced trauma.

Dr. Siegel: [1. Name It] One approach is you have to name it to tame it. If we can see what's happening, what we're getting caught in, and our reactivity, that's a great first step. We're going to be much more able to step back and think, "Okay, how might I respond to this?" rather than just unconsciously, automatically, or even compulsively acting on the fact that we're feeling threatened by our client's response.

[2. Mindfulness] Another approach is my own mindfulness practice, particularly working with distress tolerance. If we practice mindfulness regularly, we learn to experience distress states as somatic events: sadness is in the belly, anger is in the shoulders. Wherever we feel it, we can notice emotions as embodied. As we learn to gently turn our attention toward what is difficult, we actually develop more distress tolerance and we're able to be with it. We also start to see that all of these things are transient, including our responses to our clients. In the heat of the moment in a clinical session, you can feel like, "I've got to do something!" But sessions, or even parts of sessions, don't last forever. It's about having faith that it is going to change.

[3. View It as Impersonal] The third pathway is seeing how it's impersonal. In this context, it's about letting go of our need to be a competent therapist. Often, when we're having trouble with our client's adaptation to trauma, we're afraid that we're not doing a good job. Those self-evaluative thoughts get in the way of being present with our client, which is the first thing we need to do. If we no longer take it personally, we can feel okay with being a good, but also bad, therapist. Then, we tend not to panic and we can find our way through.