Bonus 4

Advanced Master Program on the Treatment of Trauma

A Polyvagal-Based Perspective on Disscociation

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Using Polyvagal Theory to Help You Understand Dissociation

Dr. Buczynski: In Module 2, we talked a lot about how to work with dissociation at the level of the nervous system.

So to build on that, I want to go even a little more in-depth and give you a primer on working with dissociation from a polyvagal perspective.

Here's Dr. Stephen Porges . . .

Dr. Porges: Polyvagal theory was challenged by the psychological construct of dissociation. Because dissociation is not the same as collapse, or passing out, or death feigning. The body is maintaining its sufficient muscle tone, but the mind is, in a sense, going someplace else.

"Dissociation becomes an adaptive transition that is the product of our physiology on multiple levels – the physiology of below the neck and the physiology of our cortex."

So dissociation becomes an adaptive transition that is the product of our physiology on multiple levels – the physiology of below the neck and the physiology of our cortex. So we're in a sense able to create this very interested coordinated reaction that has adaptive functions on two different levels. One, it keeps our body from going into a state of being potentially injured by loss of oxygen, or damaged. And, it enables our mental understanding of situations to be reorganized by, in a sense, not feeling it, not being there.

How Chronic Abuse Can Lead to Frequent Dissociative Episodes

Dr. Buczynski: Now there's a particular traumatic circumstance that often leads to dissociation – and that's chronic abuse . . .

Dr. Porges: Dissociation is extraordinarily adaptive in situations of chronic abuse because what the person is doing is, they're basically taking their memories and their sense of self out of the equation. They're saying the body is being abused, but the mind isn't even there. So this act of dissociation, which is in a sense being disembodied, has this wonderful function of preserving the individual sense of self while not corrupting it by the acts that are being perpetrated on the body.

So you start seeing this heroic nature. But part of the heroic nature is not to be immersed in the actual events that are going on, but to be dissociated and almost a witness of it, if they're not amnesiac during it.

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The issue with dissociation is that this strategy, which is extraordinarily useful for chronic abuse, also results in a retuning of our neural circuits and we end up with chronic states of numbness. We don't feel our body, because that's part of the adaptive function of dissociation.

Dr. Buczynski: This is a key point – you see, habitual dissociation from chronic abuse can rewire the nervous system. And it can do that in two ways.

First, it can cause people to "numb out" and lower their capacity to feel. And second, it can lower their threshold for what triggers a dissociative episode . . .

Dr. Porges: People who have dissociative histories not only have a history of abuse, but they also have a history of frequent abuses within different relationships. So the threshold to use this type of mechanism becomes lower in people who have these experiences, to become disembodied or dissociative.

Why Patients Who Habitually Dissociate Might Find Themselves in Unhealthy Relationships

Dr. Buczynski: Now there's something else that often happens when a patient experiences chronic dissociation – they may find themselves in unhealthy or outright abusive relationships.

Polyvagal Theory can help us understand why this may be . . .

Dr. Porges: The fact that people who have dissociative experiences often find themselves in other relationships that are both dangerous and also trigger dissociation is in part due to the fact that people with these strong dissociative tendencies have also a depressed social

engagement system. So their ways of detecting true safety and creating reciprocal co-regulatory experiences are limited.

> "People with strong dissociative tendencies have also a depressed social engagement system."

The optimal nervous system uses the social engagement system to evaluate danger in the environment or danger in the relationship. The person who doesn't have accessibility to their social engagement system is using other things to dampen their body's intuitive defensiveness. Sometimes the person's using drugs, substances, anything that becomes an addictive behavior, which could also be exercise, or a sexual behavior, or self-harming. These are ways in which that person is attempting to regulate their physiological state. So they may be getting into these abusive relationships because they don't have a mechanism to regulate their physiological state in a more optimal way – being through safe co-regulatory relationships.

Strategies to Build Trust and Create Safety in a Nervous System Shaped by Chronic Dissociation

Dr. Buczynski: So what do we do to help these patients?

Dr. Porges: The strategy to improve a person's co-regulatory capacity when they're chronically disembodied, it's a difficult question. It's extraordinarily difficult, because you're dealing now with a nervous system that is really not trusting. And somehow you have to leverage trust in that nervous system with the therapist, and that therapist now has to expand those windows of opportunities of trust.

Dr. Buczynski: And building that stable therapeutic relationship is critical, because here's the thing . . .

Dr. Porges: It doesn't matter how adverse our situation is – if we have memories of being loved and feeling comfortable, if we have an image of an optimal relationship, it helps us get through difficult times.

But if we visualize what a foster child is experiencing, the relationships that have evolved to be the relationships that are supposed to be our protective relationships – our parents – have been

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hurtful. And this becomes very difficult. And so I've asked this question to some of my friends who work with these populations, and of course they say this is a very difficult population to work with. And yes, they say, you can get moments of trust and safety and you have to build off of that.

But what really happens – or frequently happens – is, when a child feels safe for that moment, their body takes those cues of safety and says, "Been there, been abused there, getting away from that." And in fact, we can see this in relationships. We see this in all types of situations. If you carry your trauma history and your intention in life is to have a healthy relationship with another person, and suddenly a person gets close to you, and then suddenly you realize that you're uncomfortable being hugged, or you're uncomfortable with a person being in your proximity, it's because your body is saying to you, "Been there, and I've been hurt when I've been there." So, there's this learned template.

Dr. Buczynski: So how might you work with a patient to rewire their social engagement system and dissolve the link between proximity to others and threat?

Dr. Porges: Part of what therapy needs to do is to allow the client to understand their bodily reactions and not to create a narrative of why they're justified in being reactive. So what we tend to do is close the loop, that if we feel that we can't hug that person, there's something wrong with that person. Because we don't want to say there's something wrong with us.

There's nothing wrong with us, but our body is trying to protect us. And we need to know when we need to work on relaxing and getting the cues of safety. So this always circles back to, "How can we get the cues of safety to relax our bodies?"

Dr. Buczynski: Now you may be wondering, what do these cues of safety look like? Or, what do they sound like . . .

Dr. Porges: This actually has gone into some of the work that I've been doing with the acoustic intervention I've developed, which is called the Safe and Sound Protocol.

It's about taking the distilled vocalizations of safety and stealthily dumping them into a person's nervous system. So in this sense, it's a computer-altered acoustic activity, but it actually functions as an acoustic vagal nerve stimulator. So it tries to calm the body.

Now what we learned is that it works amazingly well with kids and autistic kids or kids who have sensitivities. But when you start using it with people with trauma histories, it starts working in a complex way. So initially they say, "Oh, this feels great. I haven't felt like this. I haven't slept like this in weeks, or months, or even years." And then after a couple of hours of this – we do one hour a day for five days – their bodies say, "I can't handle this." They get anxious and they start trying to protect themselves because the body is giving cues that it's giving up its defenses.

"When you have a trauma history, the cues of safety may work for others. But they don't work universally for those with a trauma history."

Now, the way that the astute trauma informed therapists are working with this is they're using it in shorter episodes – only a few minutes – and they're using the trigger as a point of discussion with their clients.

When you have a trauma history, the cues of safety may work for others. But they don't work universally for those with a trauma history. And that's part of what I think therapy is about, it's about understanding and respecting one's own body's reactions. And then as we respect it, we learn what our body has attempted to do for us, to protect us. As we respect it we realize, maybe it doesn't have to do it all the time.

Dr. Buczynski: So like Stephen just said, when exposing patients to cues of safety and pleasure, their nervous system may interpret them as signs of danger.

To help your patient acclimate to these cues and reinterpret them as signs of safety, the trick is to help them gradually expand their Window of Tolerance.

Dr. Porges: So we start expanding the window. And within polyvagal theory, Window of Tolerance translates into staying within the social engagement system and the ventral vagus. So it gives you a neurophysiological substrate of the Window of Tolerance.

So what therapy is doing is enabling people not only to spend more time in the social engagement state, but also to expand the contextual cues in which they will remain in social engagement, so that you can have transitory disruptions and they will not lose their state. They won't become reactive and defensive.

Dr. Buczynski: But how do we encourage a nervous system shaped by chronic dissociation to come into a regulated state so it can engage with others?

Dr. Porges: When we give our hugs to people who are rigid, how do we feel? They are transmitting that tension to us. And what we need in the therapeutic world is not to say, "Hey, just relax." We have to respect that that body is in a state of tension and we have to come up with a toolkit of getting that body out of a state of tension.

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We can teach people that if they learn how to breathe, if they learn how to exhale slowly, their vagal activity will actually increase. So if you exhale slowly through a longer exhalation, or we talk with longer phrases, or we sing with longer phrases, that vagal activity starts working and it down-regulates the defensive arms of the autonomic nervous system.

Dr. Buczynski: Now in Module 2, we talked about how we might use our prosody to help patients regulate when we see that they're leaving their Window of Tolerance. And Stephen just gave us a look at how effective measured exhalations can also be for helping patients regulate.

In the next bonus, we'll continue looking at trauma through the lens of polyvagal theory – we'll consider a polyvagal approach to working with the adaptive survival responses of collapse/submit, attach/cry-for-help, and please and appease.