

Behavioral Reenactments: A Therapeutic Journey to the Present

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The Autobiography of the Self, is inscribed by experience on the brain, the body, and the central nervous system, and told and retold through its only language: behavior.

A "behavioral reenactment" is a replay of the past while grounded here, in the present. It involves using behaviors that were necessary and effective in the past when the circumstances in the present appear similar. Behavioral re-enactments provide us with an opportunity. The opportunity is to deny the past and find new ways of being, and behaving, in the present. We are able to

demonstrate for people that the present is different from the past. As caregivers, we can show that we are unwilling to replay the past. You might say behavioral re-enactments are the "with me or against me" moment. It is that moment during which we prove our willingness to support the person and in doing so pave the way to a new behavioral future.

Let's go back to an example we used earlier in the book. Remember Seth? When his teacher entered the classroom he gave a pretty strong non-verbal message to the class. To some students, it was an opportunity to put their eyes down, follow directions, and get on with their class. They knew they could get through it.

To Seth, the teacher's nonverbal communication signaled danger. It triggered defensive and survival behaviors and he unconsciously looked to the past for instructions on how to react effectively. Unfortunately, his experience led him astray. His arousal system kicked on, he froze, and then the reactions of the teacher drove his arousal system ever higher, until it proceeded through flight and fight. You'll remember that the event ended in physical restraint. This is not what anyone wanted, especially Seth.

While Seth was in the middle of the behavioral reenactment and no one, including Seth or the teacher, noticed. When Seth said "f!\$? you" to the teacher, it really didn't explain his position, or the state of his central nervous system, very well. What Seth should have said instead is, "I'm sorry but it's my subconscious, dissociated, procedural body memory that's driving my behavior. Please don't confirm the past and react the way I expect." Maybe then the teacher would have understood and reacted differently. The restraint probably would not have happened. If behavioral reenactments are to be handled therapeutically, then we have to understand them and make sure our reactions are therapeutic.

Behavioral reenactments are autobiographical accounts of the past, inscribed on the central nervous system by experience, and told (and retold) in the only language of the central nervous system: behavior. Simply put, they are behaviors that have been imprinted on the arousal system which dictate, below the level of consciousness, how to behave now, based on what was necessary in the past. They are not about the present. They shouldn't be treated as if they were.

So here comes an interesting example of the past playing out in the present as

if it were still happening— a real wolf in sheep's clothing, the past. A young lady came in this morning and when I asked her how she was doing.

"Fine." She said.

"Your body betrays you." I told her, and it really did. She quickly broke out of her frozen state.

"You're not going to force me to go with people I don't know and I'm not going to respite with anyone new!" She said, quite anxiously. I didn't react to her behavior.

"Sounds good to me." I said, as non-reactively as I was capable. Rather than pursue her thoughts, I pursued her body. I pointed out to her that her head was down, she wasn't making eye contact with me, and the tension was clear in her body. That worked.

"You can't f\$!*ing force me to do things!" She responded.

1. "True, true," I said. "Nor would we want to." I asked if she would like to do something about her body. I pointed out that we had a number of interventions which helped her, including power posing, singing, and tapping. She refused. I realized at that point that her social disengagement system had kicked on and she probably wouldn't comply with any of my requests to do something to settle her body down.

So with apprehension, I decided to pursue her thoughts. The apprehension was about not being sure that her frontal lobes were turned on, and she was able to process information. She was upset about having lost a respite provider. She knew well enough why the respite provider was no longer available, but despite the information, she still felt she was to blame. We talked about it some more, and she really understood it; however it still didn't help.

I pointed out once more that the information in her mind did not match the information in her body. Her frontal lobes understood it and her body did not. I repeated that I thought we should do some work on her body. Again, she refused. Fine. Her social disengagement system was still turned on. I decided to tackle the problem of the misunderstanding between her mind and body. We did some simple problem solving. Who did she know that she would like to do respite with? What are the characteristics of potential respite providers, and what activities would she like to engage in with them?

Under what conditions would she agree to meet new people who could potentially be respite providers for her?

She asked me to get a pad of paper so that we could write these things down. We soon called in her service coordinator to review the notes we had made and the list of people and characteristics for respite providers we had created. We talked with her about the process we had decided upon to select respite providers. We all agreed it was reasonable, and decided how we would inform the rest of the team. She looked and felt much better. I pointed out to her that with a little work, her body seemed to have made a pretty significant adjustment in its organization, and she was much more reasonable. She agreed.

At this point I decided to get into the role of the past in this present behavioral reenactment. How did I know this was a behavioral reenactment? The behavior certainly didn't fit the facts in the present. We had never dictated to her what she would do or pressured her to do things that she didn't want to do. We certainly encouraged her to do things that we felt might be in her best interest. The behavior she was reacting to was not in the present. It had to be in the past, and I told her so.

Then I asked her if anyone had ever forced her to go with people she didn't want to be with. She said that indeed they had. Prior to coming to us she had lived in a residential program in another state. When she "ran her mouth" to staff they would send her to "respite". Respite was at a local jail. No wonder she over-reacted, and reenacted, behavior that fit a different situation.

The main question when facing a behavioral re-enactment is whether to **treat or repeat**. Should we behave in ways that unlock the person from the past and help her to consider and appreciate the present, and the differences between them? Can we help her to see whatever they needed to do in the past, imprinted on her nervous system and unconsciously repeated, is no longer helpful, useful, or important? Can we help her anticipate something different, with different behavioral requirements, and conform to them, in order to be successful? Or will we behave in the present the same way people have in the past, and confirm that whatever she has done in the past should be repeated in the present. Treatment is about helping a person to see the present for what it is, and ending the cycle of repetitive,

traumatic, and experience-based behavior (behavior that was required to survive in the past and has been imprinted on the central nervous system, and unwittingly persists).

Behavioral reenactments occur in relationships, and are simply a repetition of what a person has experienced, and what has proven necessary and effective when interacting with others. If we are unaware of the cyclical nature of behavior, then we will most likely repeat whatever experience a person has had. We become the next dance partner. Don't be. We need to violate the "relational expectations", and create a novel experience in the relationship. Try the waltz a person doesn't expect instead of the cha cha she does. And play the music really loud, so she knows it's different.

I heard this story this morning. One of our caregivers was talking with another caregiver about where they should live. The first, a rather boisterous sort, was stating vehemently that a certain town was very undesirable. Unfortunately there was a consumer present whose mother lived in that particular town. He took offense to the remarks, and his rising arousal triggered an explosion. No violence, but lots of colorful language. All this was aimed at the boisterous caregiver who didn't see it coming and had no idea what it was related to.

The caregiver took the barrage, didn't respond, and didn't try to intervene on the behavior. He tolerated the behavior. The dysregulated young man decided to flee and took off into the front yard. He didn't try to leave the property, but that is probably because he was given the time and distance he needed to escape and re-regulate himself. His flight was not interrupted. (His expectations were violated, because in his previous placement his behavior would have been considered "oppositional and inappropriate" and he would have been punished for the outburst, and not allowed to get away.)

As soon as he seemed approachable the caregiver went down to talk with him. He politely asked the young man if he knew what had caused the explosion. The young man was able to say that he felt the caregiver was disrespecting his mother. (The caregiver resonated with understanding and empathy for the young man and the feelings he had when he felt his mother was being disrespected, not the anger he had expressed.) The caregiver was

surprised and quickly told him that he had no such intention and apologized for his behavior. (He validated his thoughts and feelings.). He told the young man that in the future, he could tell him if anything being said is offending him. The young man agreed that that was a better option. He also said he was sorry for what he had said. (They both came out on the other side regulated, and were able to make a plan for the future.)

The next day the young man went to talk with his therapist about what had happened. The therapist congratulated him! He told him that his feelings were warranted and that he appreciated that he finally felt safe enough with people to tell them what was going on. He also congratulated him for managing his arousal with an escape. The young man was dumbfounded, but impressed. In a similar experience in his previous placement he was told to go to his room or the police would be called after a similar verbal outburst. He went to his room, the police were called anyway, and he ended up in jail. That was the end of that placement. What do you suppose he anticipated after his verbal outburst this time? Follow the behavioral blueprint from the past, verbal outburst, failed placement, jail. With the expectation of total loss in place, the emotion to fuel the behavioral reenactment was in place as well.

The caregiver and the therapist had followed the steps we will soon outline. They didn't repeat the past by responding to the behavior and being punitive. They TOLERATED (1) the behavior, they VIOLATED (2) the young man's expectations of how they would respond, they RESONATED (3) with the feelings he had when he thought his mother was being disrespected, they VALIDATED (4) his thoughts and feelings, and helped him to REGULATE (5) himself by allowing him to escape. Nice work! But certainly not the way most people would respond. (These are the five steps to helping a person make a behavioral re-enactment a therapeutic journey to the present.)

Although the behaviors replayed in behavioral reenactments are adaptive and instrumental for survival at the time, they can be extremely detrimental in the long term. They limit the person's capacity to appreciate the present moment. The present moment may have very different adaptive behavioral requirements than the past. Behaving in rigid, stereotyped ways can limit the person's appreciation, and flexibility, to respond in appropriate ways in the present, and to reach his goals.

How do we tell the difference between a "behavioral re-enactment" and just good old-fashioned behavior? Good old-fashioned behavior that is problematic is stuff like cleaning your room. It is simple, explicit, and not emotionally charged. You don't really feel like doing it, and maybe you don't. Maybe someone attempts to pressure you to do it. Maybe you get a little mad, and so do they. Maybe an argument ensues. What doesn't happen, unless people are pushed too far, or the person is in the middle of a behavioral re-enactment, is a major meltdown, screaming, yelling, running away, and occasionally, even a punch in the nose.

Behavioral reenactments are quite different and characterized by a number of things. First of all, the level of arousal that is triggered, and the subsequent emotional outburst, appear way out of context. Second, the triggers that cause the reaction don't appear to be significant enough to justify the intensity of the reaction. Third, the person's responses are clearly limbic or emotional, and not mediated by either reason or the frontal lobes. Everybody, including the person, seems surprised by the behavior.

Behavioral reenactments are a much greater problem for people who have a history of trauma, and in particular relational trauma. Because of their experience in relationships, and their history of abuse, neglect, and danger, they are much more likely to replay past experiences in the present. Trauma modifies the central nervous system. Past experiences are firmly imprinted on their brain, autonomic nervous and neuroendocrine systems. That imprint is quick to signal danger, and quick to either turn on or off the sympathetic nervous system, resulting in hyper-arousal and powerful freeze, flight, and fight behaviors, or hypo-arousal and physiological shut down, submission, compartmentalization, and dissociation. This impaired ability to regulate the intensity of the responses of the body and central nervous system is the most enduring consequence of early relational trauma.

The psychobiological survival defenses described above, hyperarousal, or freeze, flight, and fight behavior, and hypoarousal, or submission, compartmentalization, and dissociation, become characteristic ways of responding for people who experience attachment trauma in early development. Trauma abruptly seizes perception, captures attention, limits the capacity to appreciate the present, and hurtles the person into the past, all subconsciously. However, instead of being obstacles to treatment,

behavioral reenactments can offer a way of reaching into deeply traumatized experiences. Before the behavioral reenactment, the trauma is inaccessible. It remains hidden in the subconscious, the central nervous system, and procedural or behavioral memory. During the behavioral reenactment there is a revival of the trauma and it is replayed. If caregivers are aware of the nature of the behavior they encounter, then they have the opportunity to deny the past, create a therapeutic experience, and rewire the body and the central nervous system to change its expectations and respond in different ways. If not, they will confirm expectations, react as others have in the past, repeat past experiences, and reinforce the behavior they are hoping to change.

Dissociation is a primary defense mechanism. It can be imprinted very early in life on the central nervous system. It is mediated by the dorsal vagal system and is represented as hypoarousal and physiological slowdown. Essentially, experiences that are too dangerous to experience, impossible to escape from, or fight your way out of, are not integrated into consciousness. They remain in the subconscious, stored in behavioral or procedural memory. They are, as Allan Schore has said, "memories which can neither be remembered nor forgotten."

Behavioral reenactments may be the only means of encountering these dissociated experiences, since the memory is stored in the body, and not in the conscious, verbal mind. The memory systems that have captured the dissociated experiences are the procedural and behavioral memory systems, not long-term verbal explicit memory. Behavioral re-enactments represent opportunities that allow the revelation of parts of experience that have remained hidden, and can now be replayed and reexamined in real time, and corrected with positive interpersonal experiences. Behavioral re-enactments can be a major path to change, and possibly the most expedient way to recall and process dissociated memories and behavior.

Why do I welcome a meltdown or a "behavioral reenactment"? There are two reasons. The first is that behavioral reenactments offer us an opportunity, like no other, to right the wrongs of the past. The second is that I have come to think of them as windows to the past. They allow us to see in real time in the present what life was like back then. It is fundamental part of developmental psychology that the past dictates the future, yet rarely do we have such a clear view of what the past was like. Those past

experiences serve as the blueprint for current behavior. There is a special place in my heart for behavioral reenactment because that is when you have the opportunity to teach a person that his experience and behavior is no longer valid in this time, place, and relationship. If you're willing.

This reminds me of a time when we got a new young lady in our program. Within a few days of being the program she had assaulted one of the staff. She came to see me and immediately let me know what she had done. In my best psychotherapeutic tone I told her to "go tell someone who gives a "sh**". Then, without missing a beat, I asked her how she was getting along in her new school.

I believe I made a couple of points to her. I clearly violated her expectations. No doubt she had learned that the best way to get the time and attention of someone like myself was to report her "bad" behavior. I tried to make the point that this was no longer true. I also quickly moved on to something that I knew she was enjoying, her new school program. Among other things, I was attempting to show her that the "tough kid" identity she had developed was no longer going to serve her. I also wanted to make a point about our program. It's not about what you do wrong. It's about what you do right, and who you can become. That's how you get my attention.

Behavioral reenactments are the most challenging and stressful moments of treatment. They challenge the client, because of their major, inexplicable emotional response to minor triggers. They challenge the caregiver for the same reasons. In addition, they can trigger a reenactment on the caregiver's part. In other words, it is very possible for two reenactments to collide, effectively doubling the emotional power of the situation. This is a prime example of why caregivers must be aware of not only their clients' triggers, but their own.

As has been stated, behavioral re-enactment is nothing more than using the past to anticipate the present, and acting upon it. Let me give you an example of how the past can materialize in the present, and drive how we behave. I want to describe some experiences I had the opportunity to observe in a local mall and how I expect those experiences to play out in the future.

I was in the mall with my grandchildren. We were loaded in a shopping cart and headed toward Walmart. As we approached the store a three-year-old came running out holding a big firetruck. Clearly unpaid for. His father was in hot pursuit. I got a good laugh, until the father gets closer and I saw the look of rage on his face.

When the father caught up with him, he grabbed the young boy by the arm and spun him around. When he was facing his dad the father yelled at him and pulled the toy out of his hands. The father said, " You need to learn how to behave. You better not do this to me again." The father then turned and walked back up the mall and left the young boy unattended. The boy began to follow, but kept a distance of about 15 feet behind and off to the right.

I saw this is a simple case of undeveloped impulse control, and the opportunity to teach the young boy some critical lessons. The father clearly did not.

Behavioral re-enactments may be the best opportunity we have to facilitate change in treatment. If a behavioral re-enactment is handled therapeutically it can "violate expectations", and instead of repeating the past, it can provide both a novel relational experience, and a different way to respond to stress and emotional dysregulation in the future. It can help them think that their current blueprint for how we will respond to their dysregulation or difficulties, is no longer accurate. So the behavior they will re-act with, based on what they anticipate we will do, will no longer be necessary.

Behavioral reenactments may also be the best opportunity for caregivers to pay more than just lip service to their commitment to treatment and the consumer. My guess is that most treatment programs would describe themselves as patient, kind, and client centered, no matter what their theoretical approach. And most of the time I am sure they are. However the true nature of the program, and the people, is not revealed in the good times. It is revealed in the bad times, during crises and behavioral reenactments. If the caregivers are willing to violate expectations and create novel experiences they can treat. If not, they will just repeat. Read on.

Joe was released to us from a detention center. He was in the detention center because he failed in previous placements due to violent behavior. He was placed in a community setting with a very experienced caregiver. When he came to us we tried to explain our program. He nodded knowingly, and listened patiently, and seemed to accept what we had to say. I was left with the distinct impression that he did not believe us. However I knew the time would come when we would have the opportunity to show him who we are and what we stand for. We didn't have long to wait.

As luck would have it Joe was placed with a caregiver whose name was also Joe. We came to refer to them as big Joe, and little Joe. Big Joe, the caregiver, had a great deal of experience. A great deal of experience is helpful, but it doesn't make you perfect, and it certainly doesn't mean that you won't be influenced by your past, especially during very stressful moments.

So the inevitable crisis call came in. Big Joe and little Joe were in the middle of a meltdown, or perhaps a behavioral reenactment. I don't recall what started the incident, but that's less important. When the crisis worker arrived it was clear that not only was little Joe having a meltdown, but so was big Joe. It looked to the crisis worker that things might get physical soon, so he asked big Joe, the caregiver, to leave.

That helped little Joe to settle down. It also confused him. His expectation when the crisis worker arrived was that he would be blamed for the episode and would have some consequences for his behavior. He never guessed that the worker would see that both big Joe and Little Joe were having difficulties regulating themselves. He assumed the crisis worker would side with big Joe, and he would be in trouble.

Leaving helped big Joe to get his arousal back under control as well. The crisis worker stayed with Little Joe until he felt the Big Joe was ready to return. When he returned big Joe took responsibility for his part in the meltdown. He also helped little Joe take responsibility for his part. They both apologized and made a plan for what they would do in the future should similar circumstances again arise.

Little Joe would tell us after, that this was the moment when he realized our program was different. His expectation when things started to fall

apart was that he would be blamed. He went on to say that what we had originally told him about our program, is what he had been told many times before. Nevertheless, he expected that when there were difficulties, he would take the fall.

Handling the challenge reasonably, and sharing responsibilities when things went wrong, laid out a new blueprint for the future. His behavioral re-enactment, based on his past experience of what would happen in this kind of situation, was not validated. Because of the meltdown we had the opportunity to "violate his expectations", help him become more flexible in his responses, and see that his former ways of behaving might no longer be necessary or helpful. By the way, don't expect to go through this just once.

In order for this to have been a learning experience for little Joe, everyone had to get through it. We had to tolerate some behavior we would rather not see. If we focused on the behavior rather than the experience, and restrained or punished him, than it would not have been a learning experience, it would have been a confirming experience. It would confirm to him what his experience had taught him. The re-peated lesson: if things went wrong, no matter who was at fault, he would get the blame.

So how about big Joe? What coping strategies, and life lessons, had he learned and brought to this encounter? He also had an intact nervous system. What defensive reactions had been turned on in him that helped him to understand, in a subconscious way, what to do in response to little Joe's behavior. Remember that human interactions are not one-sided. They are the interactions of two nervous systems that have both had experience in the world, and both which have learned, and internalized in procedural and body memory, how to react when certain things happen.

Big Joe's nervous system received some of its' training from none other than the US Marine corp. I don't think I am going out on a limb when I say that the Marines are trained to respond to aggression forcefully. (They are also trained to be respectful and disciplined.) I believe that the Joe's clash, and their mutual escalation, was fueled by the information loaded in big Joe's nervous system by his experience, as much as by little Joe's expectation of what might come. The greatest challenge facing caregivers like big Joe is the skillful management of these behavioral re-enactments that evoke caregiver anger and defensiveness and interfere with successful

treatment.

Reenactments are expressions in real time of early relational experiences and the emotional, psychological, and biological resources necessary to survive them. They are locked in procedural memory, unavailable to the conscious self. They are action plans, based on situations from the past, on how best to deal in the present, when the same situations are anticipated. As long as the same outcomes are anticipated, AND OCCUR, the behavior will not change.

So if they expect restraint, because they have been restrained in the past, then their escalating arousal will signal their autonomic nervous system to provide a sympathetic surge, and freeze, flight, and fight behavior, BEFORE anyone has put a hand on them. The BEFORE part is critical. They will re-act to us before we even have a chance to act! They will be re-acting to our "anticipated" action. The only way to change what they anticipate, is to change how we respond. We must "tolerate the behavior", "violate their expectations", and create new experiences that are based on very different re-actions by us.

Behavioral reenactments are representations of how the world "used to be". "Used to be" means how the world was, and isn't anymore. "Isn't anymore" means we are prepared to change it. Often these behaviors are very resistant to change. Especially when what they anticipate happens again, and again, and again. At times the best way to understand and intervene on a behavior, is to look at the persons past experience and try to evaluate why the current behavior may have been necessary in the past to survive. At the very least it will provide an empathetic boost to your treatment.

We had a young lady, named Christine, a few years ago who was quite explosive. She would explode throughout the day many, many times. What we were able to eventually understand was that many of her explosions were due to reflux disease. We worked with a physician and adjusted her diet and eventually most of those daytime explosions no longer occurred.

However, there was one particular time of day that remained a horrific and unexplainable problem. Each day, right around the same time, 5-6 pm, she would experience an extended meltdown. Most days this meltdown would

require crisis support and would last for at least an hour. It appeared that "out of nowhere" she would start to become dysregulated, and her behavior would spiral out-of-control. It didn't seem to matter who was with her, what they did, or which crisis worker responded. There was generally screaming, yelling, and cursing. Often things escalated into throwing objects, and sometimes into violence and aggression. In the middle of the episode, she would most often head for bed and at times choke herself and scream in what appeared to be someone else's voice.

Here's the "interesting" part. After about an hour of abject insanity, the behaviors just stopped. They stopped cold, and didn't seem to be in the slightest bit affected by any of our interventions. No matter what we did, the episode would last about an hour. Then she would react as if nothing happened, and become completely compliant with any requests we would make. She would jump in the shower, take her meds, and relate to those around her in a normal way. There seemed to be no emotional residue from her episode that would follow her into the next phase of the evening.

(Sidebar on dissociation. Often when people talk about dissociation they mean complete dissociation or a what appears to be a total break from reality. That is certainly the most extreme form of dissociation. However dissociation can also be thought of as the "inability to integrate" experience or information. Initially this is developed in an attempt to defend oneself from information too dangerous or difficult to tolerate. It can then become a part of how a person experiences and stores reality. A person who dissociates, experiences events as discontinuous. That is, events that occur are not perceived as a continuous narrative but more like a book of short stories told across time. Each event or story is unrelated or influenced by what happens before or after it.

So, recently a caregiver approached me about the confusion they were feeling about one of their clients. He said that she goes from being very upset and wanting to move to a new home, to being perfectly content and sitting on a couch with the family watching tv. When he told me about it he was incredulous about her "ability" to go from a state of near hysteria, to perfect calm, without any emotional residue or memory of the previous state, behavior, or goals. This is dissociation, the lack of integration of one experience with the next. It creates a lack of continuous experience of life, that can make life both bearable and disastrous.

In Christine's case the ability to go from completely out-of-control, to completely compliant behavior, was confusing for everyone. Some of the caregivers thought it was a good indication that she had control over her behavior the entire time. They thought she was somehow using the out-of-control behavior to get something she wanted. The problem was we couldn't identify anything she was getting from the behavior that was positive or something that she wanted. One of the crisis staff recounted for us her terror when he witnessed one of her re-enactments in which she choked herself. Terror doesn't look much like an instrumental attempt to get something you want. The answer to this complicated problem was clearly not in the present. It had to be in the past.

We decided to look at some of her experiences and see how these seemingly incomprehensible behaviors in the present, could've been adaptive in the past. One of the things that we knew was that she had been sexually abused in the past. What I've come to believe is that her sympathetic surge (freeze, flight, fight behaviors), early on in the potential abuse, may have protected her. That would explain her out-of-control behavior during the first hour. However at some point fighting back was probably no longer useful. We conjectured that when the potential abuser realized that his desire would not be consummated, he would get angry. Fighting back would no longer keep her safe. At that point it would make much more sense for her to become compliant and follow any direction she was given. That would explain her change of state and compliance.

We can see how experience imprinted itself upon her central nervous system. The autonomic nervous system, perhaps based on as simple a cue as the time of day, would provide the body with a sympathetic surge, lots of adrenaline and cortisol, and freeze, flight, and fight behaviors, for the first part of the program. Then based on an internal algorithm of time gone by, about an hour, it switched off the sympathetic system, and turned on the dorsal vagal complex in order to shut down the flight, and fight behaviors, and focus on compliance and submission. All in the service of survival. All from the past.

Thinking about behavioral difficulties as re-enactments in the present, based on expectations from similar experiences in the past, leads to very different types of interventions. Rather than simply giving the person

consequences for the behavior, or overreacting in some other way, which would confirm past experience, it is critical to make the present look as different from the past as possible.

Here's the treatment plan for intervening on behavioral re-enactments. Follow it so you don't contribute to the survival of the survival defenses, of freeze, flight, and fight, submission, compartmentalization, and dissociation. Let's do something different, so they can.

1. Tolerate: Don't interrupt it, get through it.
2. Violate: Don't do what the person's expecting
3. Resonate: Help them "feel felt", through body language.
4. Validate: Help them "feel heard", through verbal language.
5. Regulate: Help them get it back together.

And all in that order.

There are couple of things to remember before getting started. First, in order to provide treatment we must realize that we are entering a behavioral re-enactment. The cues that we are entering a behavioral reenactment include a minor trigger, major emotional reaction, unconscious, pre-programmed behavior, and yup, an intense emotional response by us. Our physiological, psychological, and behavioral response is often characterized by "I didn't do anything to deserve this!" This is generally followed by our own behavioral re-enactment. If you find your arousal going through the roof, you are probably in the middle of someone else's behavioral re-enactment. If you recognize it is in progress, than you can avoid a re-repeat of their past and provide treatment instead.

Successfully guiding someone through a behavioral re-enactment requires keeping our own nervous system from replaying it's history, as well as theirs. If we can realize that we are in the middle of a behavioral re-enactment, control our automatic, and autonomic responses, and follow the plan outlined here, we will find ourself, and our charge, on the significant journey to discovering the present.

Step 1. Tolerate. Here is a simple way to think about the foundation of this approach. "You have to get THROUGH to get TO it!" We have to be able to tolerate the behavior in order to get through the behavioral re-enactment, because the behavioral re-enactment has to FAIL. It has to

fail to be re-enacted or repeated with the same results. The person's behavioral re-enactment cannot get the response it expects. The person also has to notice that it has failed to get the response it anticipated. The problem is squarely located in the past, if we let it be, and resist allowing it into the present. Don't help them re-enact the past by playing the part of one of the former participants, in the present.

The critical point is that they have to act out the behavior so that they can see it isn't functional. It isn't sufficient to talk about it. **IT MUST BE EXPERIENCED.** What does this tell us about the crisis response? How does it inform us how to react in a crisis? Call the police? Restrain? Set limits? Force them to talk about it? Don't let them walk away when you are talking to them? (Or allow the behavioral re-enactment to unfold, comment on it, and refuse to participate in replaying what they expect.)

Most people don't use behavioral re-enactment as a framework within which to decide how to respond to behavior. It is a powerful frame that can lead to dramatic changes in people, sometimes very quickly. Let's consider the issue of whether or not to call the police, when things start to get out of control. There are number of ways to think about this. The simplest, of course, is to think about it as a consequence for bad behavior, or a natural consequence. This is a fine way to think about it. The reason we would do it and the predicted outcome would be less of this kind of behavior. However, for many people, especially those of been traumatized, it leads to more of the kind of behavior we don't want to see. So just using a consequence can sometimes make things worse.

Another way we can think about whether or not call the police is based on its effect on the central nervous system. When peoples arousal starts to escalate, and they demonstrate some of the behaviors that we would typically call the police for, more often than not their behavior is driven by fear. Arousal and fear typically escalate with police involvement, although sometimes, people shift to hypo-arousal and immobilization when the police arrive. Also not healthy. Although it looks like a positive response, in that the behavior we were concerned about ceases, it leads to dissociation, and unwanted future behavioral re-enactment. In other words, it can increase fear and arousal in the long-term, and cause more of the behavior we are trying to avoid.

One of the long-term consequences of responding to challenging behavior with police involvement, is that when the arousal system escalates in the future, the person will subconsciously anticipate the police being called. So subsequent rises in internal arousal will signal to the person that the situation is dangerous and bad things will happen. In other words, the person comes to anticipate bad things will happen when their arousal escalates. What we want them to anticipate is regulation, with the help of others. So help them get through it, and get to it, so they can anticipate regulation rather than further escalation.

Let's be clear this may not always be possible. Some behaviors cannot be tolerated. If safety becomes an issue then the behavior must be dealt with. However, only if the behavior becomes unsafe should we miss the opportunity to work through it.

So here is a pretty recent example. To me this is the ultimate story about tolerating behavior, and going through it, to get to it. Certainly I've seen much worse and more violent behavior than in this example. But rarely have I seen anyone so persistent in their behavior, and so dedicated to a behavioral re-enactment.

When we met Meg she was in a psychiatric hospital where she had been for the past six months. She didn't do particularly well there, but neither did she do particularly poorly. By the time she left the hospital and was placed in the community we had had the time to build a substantial relationship with her. One of us had visited her every week since the first time we met her. Despite that we didn't have any idea what we would have to tolerate to "get through it".

Our first therapy session together after she left the hospital was an eye-opener, at least for me. I was waiting for her to come in and wrote on a whiteboard the topic of our first session. It said, "what does your future hold", in order to begin a discussion about what she hoped to get from treatment. I soon found out how effective that strategy was. She came into my office and greeted me. Her body was already vibrating, and I quickly realized that just meeting me in my office was enough to set her off. I showed her what I had written on the board and asked her what she hoped to get from our time together.

It was if it was as if I had lit a Roman candle. She began to scream at me. Each time I tried to interject something the Roman candle burst into larger flames. I soon realized the best response was no response at all. This behavior was completely driven by her limbic system and her frontal lobes were not available for our conversation. The flames continued to burst for the next hour and a half. I barely said much, and just allowed my body to give her feedback that I understood how difficult this was for her. We were finally able to move on.

Over the next few months there were lots of crisis calls, lots of crisis calls. Every day. I believe the longest crisis call was 8 1/2 hours. In all of these situations she demanded the police be called and she be sent back to the hospital. Of course we knew this was the last thing that she really wanted. It was just her central nervous system feeding back to us what her expectations were of what we would do. And for good historical reasons. The police were never called, and she was never sent back to the hospital.

This was the most challenging "get through it" that I had ever seen. This brought tolerance to a whole new level. The worst thing that we could have done was to try to verbally walk her through these situations, or problem solve with her. That would just inflame her even more. So therapy and treatment, at least verbally based, was off the table. We took a page out of Muhammad Ali's playbook and re-invented the therapeutic rope a dope.

We would sit with her, give her physical feedback with our bodies that we understood what she was going through, and say nothing more than yep, sure, um-hum. This was very challenging as you can imagine for people who are used to talking their way through problems with other people. At one point I was engaged in one of these long drawn out crisis situations, and I attempted to give her some verbal feedback about how to improve things. Her home provider just looked over to me and put his finger across his lips to remind me of the rope a dope strategy. I shut up.

Anyway get through it we did. We tolerated her behavior for so long that she eventually got that she was neither going to the hospital nor were the police going to be called. Her expectations of what we would do, and what would happen to her had changed. Then we could "get to it." As challenging as the "get through it" part was, the "to it" was much more painful.

Tolerating the person's behavior is the only way for them to learn that it is no longer effective or necessary. Tolerance is the foundation of making a behavioral re-enactment therapeutic. Just remember, when it all seems to be going to hell, it may actually be the moment when things shift and people change. If we can tolerate the behavior it can help them come into, and appreciate, the present.

Step 2. Violate. Don't replay the past. Don't fulfill their expectations. Don't participate in what they believe is about to happen in the present. Look for the "BIG" experience to make it clear that the present is remarkably different from the past, and needs to be handled in a different way. If they expect you to react, don't. If they expect you to yell, be quiet. If they expect a confrontation, offer an olive branch. If they expect you to offer consequences, offer kindness. If they expect anger, offer humor. If they expect admonition, offer hope. Make sure that they can see that this experience with you is very different from their past experiences.

I was talking to a young lady one day, and she was actually screaming at me. I don't remember about what. At some point she held her hand up to me and said "talk to the hand". Without much thought I looked at her hand and said, "Good morning dahhling, how are you today." It broke the spell.

She started to laugh, and made some comment about how ridiculous I was. I knew I had her, I had violated her expectations, and we were on our way to a very different outcome. Without violating her expectations we would have been stuck in an interpersonal battle, and I would have just helped her re-play the past.

One of the keys to understanding a behavioral re-enactment, is that when people get emotionally dys-regulated their capacity to make an attribution will be compromised. Attribution is the ability to relate how you feel to what caused it. Many times people will see the problem as interpersonal, no matter what the cause. They will act as if it is a problem is between you and them. Their expectation for how you re-pond will be based on past experience not present circumstances. Don't allow them to make the problem interpersonal. Help them relate the problem to the true cause.

I was with a young man when he became completely dysregulated. He became dysregulated because he had lost something that was very important to him. He quickly "tried" to turn his experience of loss, frustration, and

anger, into an interpersonal problem between him and me, and soon others. (Tried doesn't mean consciously.) I would not have it.

Rather than responding to his statements, that indicated in his mind the exact nature of the problem between us and him, I simply kept reminding him of the cause of his dysregulation. So when he said, "I hate it here, and I'm going to run away." I said, "This isn't about here, it's about what you lost." Then he said, "I can't stand you, and I want to get away from you." I said, "This isn't about me, it's about what you lost." This went on for quite some time, and included lots of other misattributions to other people. Finally he de-escalated, and was able to make the attribution. He then asked for help finding what he had lost. Had I not ignored his behavior, or interrupted and ended it, he never would've made the correct attribution. Nor asked for help. Nor had a new blueprint for future behavior.

I had an interesting opportunity to unintentionally violate expectations recently, at Costco! As with all behavioral re-enactments this one was as much a surprise to me as to the clerk. I had a broken chain and I wasn't sure if it could be returned or not. So I went to the counter to ask.

Although I wasn't forceful I probably should've said I was just asking. (Just to make it clear I was about to violate her expectations.) I was told that the clerk would have to do some research and see when it was purchased. There was a real edge to her response to me.

I said fine and just waited for her to try to find out when it was purchased. She returned and told me that I hadn't bought it there at all! It wasn't in my record. And now she had even more of an edge. She said it obviously couldn't be returned if it wasn't purchased there. I responded that I was sure it had, in as friendly a tone as I could. I also apologized for not having the receipt, and said I was sorry that I was making her job difficult. There was a quick change in her body state and she said she'd be happy to look again if I was sure I had purchased it there. I said thanks.

Then she made a phone call and said she had "a very nice man" at the counter who was trying to return something she wasn't sure was bought there. I was surprised. I wasn't sure when I became a really nice man and things had changed between us, but they clearly had. The person on the other end of the phone gave her some advice, she searched another way, and soon found the item. I thanked her for putting the time in to help me, and

she gave me some advice about what I should do next. She also gave me some information "off the record" about how best to get my chain replaced.

She went from being defensive (which looked like anger to me) to being an advisor on how to get what I wanted. (Which by the way I didn't.) What I interpreted as defensiveness on her part, other people may have interpreted as anger. She thanked me for my patience, again, and gave me some paperwork that I might need and sent me on my way with a big smile.

Here's what I think happened. I am sure that many people she serves feel that if they push hard they will get what they want. I think she "expected" me to push hard to get what I wanted. So she pushed back on me BEFORE I pushed her to get what I wanted. When I accepted her push without pushing back, she softened and really went out of her way to help. I had violated her expectations and that changed the way she behaved.

Let me say one more time that my behavior wasn't driven by my frontal lobes. I think everything that was said was said in our first language, with our bodies. I never even realized what happened until it was over, and I had time to reflect on it. Find yourself a clerk, and give it a try. Remember first tolerate, and then violate.

Step 3. Resonate. Our first language is somatic. It is the language of the body. It is what we are introduced to at birth, before we have the capacity to talk. The first years of our life are not about words. They are about actions. The non-verbal, subconscious, stream of body experiences, that the infant experiences with its early caregivers, continues throughout life to be a model for how others will behave, and how the person should behave in return. The nonverbal signals of what others will do, and what we should do in re-sponse, are buried in our bodies.

These nonverbal, subconscious, body based experiences make an everlasting imprint on the organization and functioning of the brain, and subsequently, behavior. It is so second nature to us that we don't even notice how our bodies constantly feed information back to the brain, and central nervous system, and organize our behavior. When we communicate with others this non-verbal, subconscious, powerful body based system "does the talking". Make sure it says the right things.

Behavioral reenactments begin with a dialogue between two central nervous systems, two bodies that silently and unconsciously communicate with each other, long before any words are spoken. Beyond infancy interactions include not only two minds, but also two bodies. We communicate not only verbally, but nonverbally as well. Researchers say that somewhere around 90% of what we communicate to others is nonverbal.

Unfortunately we pay little attention to what our body has to say. If we begin to think of our bodies as a major communication device, we may be able to deliver the right messages.

Our central nervous system resonates our internal state through facial expression, vocal quality, prosody of speech, eye contact, muscle tension, and body position. In order to help the person through a behavioral reenactment we must resonate regulation, peace, safety, and dare I say, love and acceptance. Not control. This may be the most challenging thing to train a person to do.

The goal in treatment and interaction is to help the other "feel felt". The only way to do so is to resonate or vibrate at a frequency which reflects their internal, underlying feelings, and offers them a safe haven in their storm. Essentially we are trying to tell them two things with our bodies. First, that we understand how they feel. Second, that we are prepared to offer them a "safe haven", and a regulating experience.

Resonate means to reflect back to them the feelings that you want to validate, with your body. We need to resonate with the underlying emotion, not the presenting emotion (fear versus anger). Our bodies must reflect back to their body, that we get it emotionally, that we understand their pain, fear, and frustration. This is empathy in action. We must be careful not to reflect back to them the anger they present us with, although this may just be just what our central nervous system is inclined to do. While we are resonating with their underlying pain, we must also resonate with confidence. Confidence that we are a team, and that we can get through this together. Despite any words that are spoken, our bodies will make all of this clear.

A very helpful way to think about this is to reflect on the famous DW Winnicott quote. He said that the child will become what they see reflected in the eye of the mother. Profound. I would slightly expand upon this. The child will become not only what they see reflected in the parents eye, but in

their voice, tone, muscle tension, body position, and affect. Resonate back with your body all you believe they can be. And they will become it. If we can reflect back to them all we believe they can be, in the middle of a behavioral re-enactment, they will get through it. Once we get through it, the relationships will be stronger and a new blueprint for future behavior will be drawn.

So remember, we are all actually bilingual. Words can name emotions but they cannot convey the essence of emotional experience, only the body can. Talking is just not sufficient. Only when we resonate with our bodies can we let people know that we "feel how they feel", and are prepared to provide them a regulating experience, and an anchor in their storm. So after we tolerate, and violate, we must resonate.

I recently had a meeting with a caregiver who has a great deal of experience and is quite passionate about his work. I wasn't quite sure what the meeting was about until I entered the room. One look at him and I knew where the meeting would go. I could see that he was emotionally charged and upset but I was yet to learn about why. His body said everything that needed to be said.

Since I wasn't quite sure why we were getting together I asked. I got an earful, from both his mouth and his body. I actually agreed with most of what he had to say, and we were able to make a plan to address his concerns. After our discussion it didn't seem as insurmountable to him as it had before. We agreed on of course of action to fix some of the things that he felt needed attention.

The mood was much lighter at the end of the meeting. He leaned across the table and told me that if the meeting hadn't gone the way it did, he had been prepared to leave his position. "I knew it", I said, "your body said it all before you had a chance to!" I told him that before his lips said anything his body made his position very clear. Words convey meaning in many situations, but the body is much more straightforward. And it doesn't lie. It's always out front with its thoughts, if we just listen.

And a quick reminder for caregivers, before your lips move, in most cases, your body has said everything that needs to be said. And you might as well pay attention to it, because everyone else will, and you can't hide it. If they

know where you're coming from, you should know as well! Resonate.

Step 4. Validate. This is the first real opportunity for words to convey meaning other than emotional meaning. Prior to this all the information that we will be feeding back to them will be physical. It will be our tone of voice, our posture, tension, affect, and arousal level. Now we can reinforce with words what our body has already been telling them.

Validation is about honoring the thoughts and feeling of the other person. (Men beware.... we are inclined to jump in and problem solve, and give people solutions.) Validation is not about giving advice or direction. It is about letting them know that we understand how they feel, what they think, and why they are reacting the way they are. We must let them know it is how we might feel, think, and behave in the same situation.

Validation is not about agreeing or approving. It is about communicating our acceptance and understanding. Validation is the recognition and acceptance of another person's thoughts, feelings, and behavior, in words. It is about letting them know "I get it".

The goal in validation is to have them "feel" that they have been heard. In order for them to feel heard we must allow them to set the pace, and determine how long we stay with their experience, and in their pain. The most challenging part of validation is that it is a subjective experience. They have to "feel" that they have been heard. This may take quite some time.

Here are some of the kinds of things we can (and can't) say when attempting to validate someone:

Validating statements: things you can say.

"I'd feel the same way."

"I'd be pissed too."

"I know it sucks."

"That's terrible."

Invalidating statements: things you can't say.

"Come on, it's not a big deal."

"Get over it, you're an adult."

"I'm sure he didn't mean it."

"Don't worry about it."

So remember validating is a way of letting the person know you get it. You know how they feel, and you let them know it in words. So tolerate, violate, resonate, and then validate.

Step 5. Regulate. In the end the critical ingredient is having walked through the arousal experience and come out on the other side regulated. Then in the future bodies will anticipate regulation. They will not anticipate the hopelessness induced by losing it one more time, and being subject to the harsh judgement of themselves and others.

Arousal is in itself a powerful internal signal to the self. If we've had lots of bad experiences the signal will be received as threatening, and the person will get prepared for danger and a bad outcome. The internal signal will say danger is coming, get prepared, turn on either the mobilization, or demobilization defense systems. Get ready for freeze, flight, and fight, or go into complete shutdown. The primary defense system of affiliation, attachment, and social engagement, will be shut down. Remember all of this will be out of the awareness of the person, and the caregiver.

We need to help the person experience arousal without it signaling danger to the body. We need to help them re-experience arousal as a signal to "pay attention", that there might be a problem. Maybe the most efficient, and probably the only way to do this, is through behavioral re-enactment.

The capacity to tolerate someone else's behavioral re-enactment and help them through it using the steps outlined above can lead to a whole new level of attachment. Behavioral reenactments can be extremely challenging both to the caregiver and to the person. If a caregiver can manage his own central nervous system and defensive reactions, and help the person manage his nervous system and defensive reactions, they both will come out regulated. This is no easy task, but fundamental to relieving people from replaying their past, over, and over, again. If we can help them **get through it, and get to it**, and come out regulated on the other side, it may be a completely new experience for them that violates all of their expectations. It can be a new blueprint for the person, as well as the caregiver who takes

the unexpected journey with them.

Here's a rather extreme example that contained significant amount of violence. Perhaps due to the emotional stamp imprinted on the experience because of its emotional intensity it caused a quick and significant change in our relationship. (Emotions function as the "pay attention system" of the mind, and helps us to focus on things that are important.)

I welcome new visitors to our crisis bed, (aka: do intake), in central Vermont in a program that we've run for just about 25 years. After 25 years you'd think we'd get the hang of it, and I think we mostly have. I have a couple of goals when I welcome someone new. The first is to gather information about the person so that we can make sure that the program is able to meet his or her needs. The second and equally important goal is to make the new client feel at home, and to assure their caretakers they will be well taken care of. We ask questions not only about medication and special medical procedures, but also about favorite activities and favorite foods. We attempt to customize the program for each person we serve. We sometimes refer to it as the crisis bed and breakfast. More often than not people appreciate and do well with this approach.

A while back we had a young man come in who really didn't want to be there. During our initial interview he stated repeatedly that he wasn't staying and he was headed back home. I anticipated trouble and asked for additional staff just in case. Just as I expected when the primary caregivers got ready to leave violence erupted. The young man took a healthy swing at one of the staff and they ended up on the ground. The staff person attempted to restrain but the young man twisted him right around, and was soon on top of him.

I don't really believe in restraint, but I do really believe in safety. It was our good fortune that I was close to the door and I could escort him right out into the backyard. He was angry and yelling but did not attack me. He did however begin to look around the backyard to find something that he could use as a weapon. I took a few things away from him, but fortunately I did not have to touch him again. After about fifteen minutes of this the violence ended.

Soon after, he approached me and asked for a hug. I gave him a hug and

he quickly burst into tears. He said he was sorry. I accepted his apology and reassured him that we knew the reason he acted up was because he was afraid. I attempted to reassure him that he had nothing to be afraid of. For a while he just wanted (and needed), to hold on to me.

I can't say I'm happy that any of this happened. However, there is no quicker way to prove yourself to be safe and supportive than to go through a behavioral re-enactment with someone. Helping him feel safe, and regulated, proved to be an attachment building experience. We provided a "safe haven" for him when he felt threatened and in fear. The hug was verification that I had become a safe haven. So finally, tolerate, violate, resonate, validate, and regulate.

I have to end this chapter with the story of a young lady I have known for some time. She has all the diagnosis one could hope for. She also has an incredible history of trauma, mistreatment, abuse, and neglect. As you might guess she has also been very challenging to support.

When she first came into the program many years ago she had a wonderful young lady who worked with her. Her name was Megan. Megan was very devoted to Ali and they did very well together. The "behavioral re-enactments" however, we're hell!

It was a beautiful afternoon and I was cruising home along a road that paralleled the Mad River. It was one of those warm sunny afternoons where the sun flickered off the river and the dry breeze was full of the smell of fresh mown hay. I realized that ahead of me on the road were Ali and Megan. My eyes began to get misty as I thought of the fact that Megan and Ali were probably off swimming in the river. How wonderful it seemed at that moment that she was no longer locked up in the hospital, and here in the Mad River Valley. The mist soon disappeared as their car swerved onto the shoulder of the road and abruptly came to a halt. Both doors flew open and Ali and Magen came tearing down the road on either side of the car.

I pulled over almost as quickly and jumped out of the car. Good fortune was with us and Ali ran straight into my arms. She wrapped her arms around me and burst into tears. Then she said, "Megan doesn't want to be with me anymore", and continued to sob. I looked over at Megan who was clearly perplexed. She had said nothing of the sort. But Ali was convinced that that

was the outcome of whatever had occurred in the car, most likely because this was the outcome of these kinds of experiences in the past.

Ali began to come around, and I decided to try to find out what it happened. At that point we had had enough time together that she anticipated support from me and not consequences. Megan quickly let me know that they had been driving down the road when, "out of nowhere", Ali took a juice box she had been drinking and threw it at Megan. She hit her squarely in the back of the head. Not good. I decided to do a little bit more investigation, to see if we can get a clearer picture of what had happened in Ali's head.

I noticed Ali had been sitting in the backseat, which was unusual. She usually sat in the front. So I asked about that. Megan said that she had to pick up another kid after she dropped off Ali, who had a wet bathing suit on from swimming in the river. At least I was right about that. She didn't want the front seat to be wet when she picked up the other kid. This little report caused a burst in Ali's arousal, which in very descriptive language highlighted her feelings about the other kid. Clearly she felt replaced by the other kid, and rejected by Megan.

When I suggested that to her, the tears again began to flow. It seemed pretty straightforward where to go from there. I asked Ali if she had told Megan about how she felt. She quickly responded that she had. Once again Megan's face took on that perplexed look. I asked Ali what she had said to Megan. Another burst of arousal, followed by her response. "I told her she was a bitch", said Ali. I pointed out that that statement may not have delivered the information to Megan that she needed in order to understand how Ali felt. We continued talking and soon resolved the situation.

When we had resolved things, and everybody was feeling more regulated, I asked Ali if she had anything to say to Megan. I assumed she knew that I was looking for an apology, and some relational repair, between her and Megan. She looked at Megan, and said, "I love you Megan." Megan responded with, "I love you to Ali". Big hugs, lots more tears, and a failed behavioral re-enactment. Megan had been able to tolerate the behavior, and had behaved in ways that violated Ali's expectations. We had all resonated with Ali's feelings of rejection, validated her thoughts and feelings, and come out regulated on the other side. The past was not re-played, and Ali had a new

behavioral blueprint for the future. It was clearly a therapeutic journey to the present. Take one of your own.