

Revolutionizing Addiction Treatment with The Felt Sense Polyvagal Model™

Jan Winhall, Stephen W. Porges

ABSTRACT

This two-part paper begins with a discussion by Stephen Porges, whose pioneering work revolutionized our understanding of the autonomic nervous system. In part one, Porges applies his Polyvagal Theory to understanding addiction. In part two, Jan Winhall, a seasoned trauma therapist, lays out her Felt Sense Polyvagal Model™ of understanding and treating addiction that integrates Polyvagal Theory's safety-based neuroception with Eugene Gendlin's felt sense interoception. This paper provides a generic framework that complements and can vastly strengthen any therapeutic modality. This non-stigmatizing, embodied, strength-based model departs from the current top-down, disease-based understanding of addiction that dominates current clinical practice.

Keywords: Addiction, felt sense, polyvagal

Submitted: 07.03.2022

Accepted: 29.05.2022

International Body Psychotherapy Journal
The Art and Science of Somatic Praxis

Volume 21, Number 1,
Spring/Summer 2022, pp. 13–31

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

© Author and USABP/EABP. Reprints and
permissions: secretariat@eabp.org

PART I

Addiction

A Polyvagal Perspective

Stephen W. Porges

T

he development of Polyvagal Theory was not targeted towards explaining or treating addiction. Rather, the theory provided a more general explanation of how the mammalian autonomic nervous system adaptively adjusts in complex environments to support survival. This perspective emphasizes two important points relevant to addiction: 1) context functionally defines what is appropriately adaptive; and 2) behaviors are emergent properties of a neural platform mediated by autonomic states. Thus, the adaptive characteristics are dependent on the appropriateness of the behaviors within a specific context. Conceptualizing behavior (addiction) in these terms could change our understanding of behavioral pathologies. We might end up interpreting a behavioral pathology as a behavior that might have been adaptive in one setting, and is now being elicited in a setting where it is maladaptive. For example, trauma survivors, who may be dissociating or shutting down through the use of addictive substances and behaviors, might be expressing a reaction that would be adaptive during a past traumatic event, but maladaptive in a current social setting.

*Understanding addiction
within the context of
both an absence of and
a quest for safety is a
powerful framework.*

As the principles of the theory as a science of feeling safe and sociality are outlined ahead, consider the quality of feelings and sociality of those who are addicted. Does addiction disrupt feelings of safety and sociality? Note that within the theory, autonomic state functions as an intervening variable biasing reactions to context. Reflecting on this latter point, consider addictive behavior as a valiant and yet failed strategy in regulating autonomic state, and as a poor substitute for the potent co-regulatory influences on calming autonomic state attributed to social behavior. As you read the sections on calming mechanisms and sociality, consider the limitations of the self-regulatory and co-regulatory repertoire of those who are addicted.

Polyvagal Theory emerged from the identification of the phylogeny of the vertebrate autonomic nervous system. The phylogenetic transition from asocial reptiles to social mammals required a repurposing of the neural regulation function of the autonomic nervous system, which had efficiently supported asocial reptiles. The repurposed system provided mammals with new pathways to downregulate defensive states, and to signal cues of safety. The title of the initial presentation of the theory (Porges, 1995) succinctly summarized its essence: *Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A polyvagal theory*. The theory provided a neurophysiological understanding of how mammals were capable of sufficiently downregulating the autonomic pathways that support defense in order to promote proximity, establish social bonds, and serve supportive roles in caring for their offspring and select others. This process of downregulating defensive states provides insight into understanding the link between sociality and health, as well as the negative consequences of addictive behavior on relationships (i.e., co-regulation) and self-regulation. Consistent with this theme, Polyvagal Theory focuses on the evolved neural circuits that enabled mammals to downregulate the sympathetic activation that could support mobilization to fight or flee, to reduce psychological and physical distance with conspecifics, and to functionally co-regulate physiological and behavioral states.

The core of the theory emerged through the identification of a phylogenetic transition in the regulation of vertebrate autonomic nervous systems that provided the neural resources for mammals to become social and to cooperate. The theory provides an innovative scientific-based perspective that incorporates an understanding of phylogenetic shifts in vertebrate neuroanatomy and neurophysiology. This perspective identifies neural circuits that downregulate neural regulation of threat reactions, and functionally neutralize defensive strategies via neural circuits communicating cues of safety. The theory proposes that feelings of safety are operationally the product of cues of safety via neuroception (see below), downregulating autonomic states that support threat reactions, and upregulating autonomic states that support interpersonal accessibility and homeostatic functions. Basically, when a human feels safe, their nervous system supports the ho-

meostatic functions of health, growth, and restoration, while they simultaneously become accessible to others without feelings of threat and vulnerability. In the optimal social context of humans, social interactions serve as the prominent mechanism to calm the autonomic nervous system. However, in the world of addiction, we learn that social interactions are displaced by drugs and behaviors to regulate the autonomic nervous system, and these strategies result in poor outcomes, disrupting homeostatic functions and potentially compromising mental and physical health.

The theory focuses on the transition from reptiles to mammals, and emphasizes the neural adaptations that enable cues of safety to downregulate states of defense. Within Polyvagal Theory, the evolutionary trend has led to a conceptualization of an emergent and uniquely mammalian social engagement system, in which a modified branch of the vagus is integral. Neuroanatomically, this system is dependent on a brainstem area known as the ventral vagal complex. This area not only regulates the mammalian ventral cardio-inhibitory vagal pathway, but also regulates the special visceral efferent pathways controlling the striated muscles of the face and head. This does not preclude other structures being involved in mammalian social engagement behaviors, or homologous structures in other vertebrates who do not share our phylogenetic history having social engagement behaviors.

Polyvagal Theory proposes that the neural evaluation of risk and safety reflexively triggers shifts in autonomic state without requiring conscious awareness. Thus, the term *neuroception* was introduced to emphasize a neural process, distinct from perception, capable of distinguishing environmental and visceral features that are safe, dangerous, or life-threatening (Porges, 2003, 2004). A form of neuroception can be found in virtually all living organisms, regardless of the development of the nervous system. In fact, it could be argued that single-celled organisms and even plants have a primordial nervous system that responds to threat. As mammals, we are familiar with reactions to pain, a type of neuroception. We react to pain prior to our ability to identify the source of the stimulus, or even to be aware of the injury. Similarly, the detection of threat appears to be common across all vertebrate species. However, mammals have an expanded capacity for neuroception in which they not only react instantaneously to threat, but also respond instantaneously to cues of safety. It is this latter feature that enables mammals to downregulate defensive strategies to promote sociality by enabling psychological and physical proximity without anticipation of potential injury. It is this calming mechanism that adaptively adjusts the central regulation of autonomic function to dampen the metabolically costly fight/flight reactions dependent on sympathetic activation, and to protect the oxygen-dependent central nervous system, especially the cortex, from the metabolically conservative defensive reactions of the dorsal vagal complex (e.g., fainting, death feigning).

“Humans, as social mammals, are on an enduring lifelong quest to feel safe. This quest appears to be embedded in our DNA, and serves as a profound motivator throughout our life.”

Is it possible that those most vulnerable to addiction are in an autonomic state that promotes feelings of threat, and biases neuroception to detect cues of danger and adaptively be less sensitive to social cues of safety? Are those with addictions more likely to misinterpret positive social engagements via prosodic vocalizations, facial expressions, and gestures? If the addicted individual is chronically in an autonomic state that supports threat reactions and biases the detection of cues of threat, then these features would limit opportunities to co-regulate through the ventral vagal pathways and to successfully engage the social engagement system. The consequence of supporting an autonomic nervous system tuned for defense is to limit the functional neuromodulation benefit we derive from sociality, and become more reliant on the use of addictive substances and behaviors to modulate state. Ironically, this strategy of state modulation will not produce the physiological calmness that supports homeostatic processes, although it might numb bodily feelings of distress and physical pain.

Polyvagal Theory suggests a hierarchical conceptualization of feelings, as higher brain structures interpret the neural signals conveying information from visceral organs (e.g., heart, gut, etc.) to the brainstem. This psychophysiological perspective emphasizes the foundational function of autonomic state in the subjective experience of global feelings and emotions. Within this hierarchical conceptualization, feelings of safety are preeminent, and form the core of an enduring motivational system that shifts autonomic state, which in turn drives behavior, emotion, and thought. The resulting model suggests that feelings of safety reflect the foundational autonomic state supporting maturation, health, and sociality.

Feeling safe functions as a subjective index of a neural platform that supports both sociality and the homeostatic processes optimizing health, growth, and restoration. Operationally, feeling safe is our subjective interpretation of internal bodily feelings that are being conveyed via bidirectional neural pathways between our bodily organs and our brain. Feelings of safety are not equivalent to objective measurements of safety, which could pragmatically be defined as the removal of threat. Feeling safe is more akin to the felt sense described by Eugene Gendlin (2018). Although Gendlin, as a philosopher and psychologist, was not physiologically oriented, he described a “felt sense/shift” as not just a mental experience, but also a physical one.

Polyvagal Theory provides the science to understand the profound role of feelings of safety in the expression of

sociality. The theory leads to a re-examination of the roles that feelings of safety and social behavior play in understanding addiction, and vulnerabilities to become addicted. Polyvagal Theory provides a perspective to understand addiction as a disruptor of the autonomic state that would support sociality and promote feelings of safety.

Humans, as social mammals, are on an enduring lifelong quest to feel safe. This quest appears to be embedded in our DNA, and serves as a profound motivator throughout our life. The need to feel safe is functionally our body speaking through our autonomic nervous system – influencing our mental and physical health, social relationships, cognitive processes, behavioral repertoire, and serving as a neurophysiological substrate upon which societal institutions dependent on cooperation and trust are based. While the optimal outcome occurs through fulfilling our biological imperative of connectedness, this is the product of individuals feeling safe through the co-regulatory properties of interactive social engagement systems. While the motivation to feel safe can be intense, the opportunity to feel safe may be difficult to achieve.

This may occur due to work schedule and location, in which proximity might limit availability of individuals who broadcast and are receptive to cues of safety. In addition, marginalized individuals experience barriers to the establishment of safe trusting relationships, even in their own community. Being marginalized through being identified by race, sex, ethnicity, religion, or disability frequently places an individual in a state of chronic threat, and greatly limits opportunities to co-regulate in work, school, and community settings in which those who are not marginalized can feel safe and co-regulated. However, in those experiencing limited access to positive cues of safety, the motivation to feel safe remains high, although the availability of appropriate individuals with whom to feel safe is low.

Although co-regulation and the use of sociality as a neuromodulator to regulate autonomic state is the neurobiological norm for our species to downregulate threat reactions, the norm is predicated on safe relationships. At times, opportunities to co-regulate with a trusted other are not available, and feelings of safety are not easily accessible. This may occur through either physical or social isolation. It also can involve an inability to feel safe with others. For example, individuals with severe adversity histories often experience feelings of threat in the proximity of others, and are unable to use sociality as a neuromodulator to calm autonomic state. Without

“Addiction, from a polyvagal perspective, reflects an unsuccessful strategy to reduce the impact of threat by numbing or mobilizing. Addiction can appear to successfully mask, distort, or numb feelings of threat.”

access to sociality as a calming neuromodulator, individuals may be vulnerable to addiction, in which the biobehavioral richness of sociality is replaced with substances or behaviors. Unfortunately, the substitution of co-regulation with addictive substances and behaviors will fail, and disrupt mental and physical health.

The literature confirms the strong link between trauma history and addiction. A survey conducted by SAMHSA confirmed that approximately 75 percent of women and men in substance abuse treatment report histories of abuse and trauma (see samhsa.gov). From a polyvagal perspective, this link reflects an attempt to regulate autonomic state by numbing feelings of threat. This supports the proposed consequence of trauma history, especially in abuse experienced during childhood, as retuning the autonomic nervous system to be locked in to states of defense that would lead to mental health vulnerabilities, and attempts to ameliorate feelings of threat via addictive behavior (e.g., Carliner, Keyes, McLaughlin, Meyers, Dunn & Martins, 2016; Enoch, 2011; Felitti, 2006). Unfortunately, these strategies mistakenly assume that numbing feelings of threat will lead to sociality.

The use of addictive substances and behaviors are effective in changing autonomic state, although the autonomic changes do not reliably support co-regulation, and frequently lead to poor outcomes. Two important factors contribute to these changes in state disrupting both feelings of safety and sociality. First, addictive substances and behaviors often downregulate the bi-directional feedback loops through which our nervous system communicates and regulates visceral organs. This numbing process may have short-term benefits, such as reduction of physical pain and mental distress, but it does not promote feelings of safety or spontaneous social engagement behaviors. Moreover, by damping the neural regulation of visceral organs, it might lead to end organ damage. Second, addictive substance and behaviors often recruit an autonomic state that supports defensive threat reactions, which may result in abusive and aggressive behaviors.

On the surface, addiction is related to difficulties in feeling safe and maintaining trusting relationships. Addiction, from a polyvagal perspective, reflects an unsuccessful strategy to reduce the impact of threat by numbing or mobilizing. Addiction can appear to suc-

cessfully mask, distort, or numb feelings of threat. Interestingly, the strategy of numbing and masking seems to follow implicit strategies frequently employed to foster a dissociation between feelings and actions, and frequent valiant attempts to prevent bodily feelings from disrupting intentional behaviors. However, unlike the neurobiological potency of sociality in generating feelings of safety, these strategies fail, and over time exacerbate feelings of threat.

A polyvagal perspective of addiction focuses on the attempted use of addictive substances or behaviors to damp underlying feelings of threat. This perspective frames the client's behavior within a quest to feel safe. Unfortunately, feeling safe is dependent on an autonomic state that can only efficiently be reached through sociality, while recruiting ancient neurobiologically-based survival strategies that are insensitive to the intentions of higher brain circuits will fail.

If the therapist's intention is to enable clients to feel safe, then it is important not to use evaluative phrases suggesting that their behavior is wrong or bad. By moving outside the moral veneer of societal norms, we need to explain to the client how their body responded in specific contexts. This exercise helps the client interpret their behavior not as an intentional violation of an expectancy, but as an adaptive feature of a nervous system that evolved to survive, and to explore potential pathways towards safety.

The client needs to appreciate this adaptive feature, and to understand that this adaptive feature is flexible, and can change in different contexts. The first step is to replace an evaluative focus with a curiosity about the adaptive survival prioritized repertoire of the nervous system. This curiosity leads to an appreciation of the emergent behaviors, which are dependent on the flexibility of autonomic state regulation while adapting to the challenges of complex contexts. A product of this journey is the development of alternative perspectives and personal narratives that would lead to greater bodily awareness, and an understanding of the difference between primitive neural pathways that support survival, and higher brain structures detailing intentions. With this rich information, the client can develop a narrative that treats atypical behaviors not as bad, but as understandable in terms of adaptive functions that may often be heroic.



PART II

The Felt Sense Polyvagal Model™

Jan Winhall

The Felt Sense Polyvagal Model™ (FSPM) is a healing paradigm that integrates Porges' Polyvagal Theory, and Gendlin's felt sense. While the model can be applied to any aspect of wellbeing, this paper focuses on the field of trauma/addiction. The two embodied processes of neuroception and interoception form the foundation of the model. Resting on that foundation are five theories that build the conceptual framework: 1) feminist trauma-informed theory; 2) focusing-oriented therapy/the felt sense; 3) interpersonal neurobiology; 4) learning model of addiction; and 5) Polyvagal Theory.

1. The Roots of the FSPM – A Feminist/Trauma Theory Framework

Over forty years ago, I began practicing as a somatic trauma therapist. My first job was leading groups for young women who were survivors of incest. I started reading feminist therapists, such as Judith Herman's *Trauma and Recovery* (Herman, 1992) and Sandra Butler's *Conspiracy of Silence* (Butler, 1978). They helped me to validate what I knew intuitively, that the top-down pathologizing model I was surrounded by was harming my clients. Feminist therapists understood how trauma and addiction happen in the body, and that we must help our clients to reclaim their embodied knowing. It was common knowledge in the feminist community that addictions were very effective and adaptive ways to attempt to regulate numbing and flooding responses. While many of us didn't connect these responses to the autonomic nervous system (ANS), we honored the protective quality of addictions in attempting to regulate these polarizing states. Herman saw the connection.

"Abused children generally discover at some point in their development that they can produce major, though temporary, alterations in their affective state by voluntarily inducing autonomic crisis or extreme autonomic arousal. Purging and vomiting, compulsive sexual behavior, compulsive risk taking or exposure to danger, and the use of psychoactive drugs become the vehicles by which abused children attempt to regulate their internal emotional states. Through these devices, abused children attempt to obliterate

their chronic dysphoria and to simulate, however briefly, an internal state of well-being and comfort that cannot otherwise be achieved" (Herman 1992, p. 109).

Herman explains the power of autonomic state-shifting that sometimes brings comfort and protection. This self-soothing behavior becomes addictive as it shifts the body into a numb and dissociated state of relief, and/ or a sympathetic surge of activation. We see this clearly in the binging and purging cycles that occur with dysregulated eating. Herman understood the function of addictions in the context of trauma as state regulation strategies. She described a continuum from intrusion, the sympathetic response, to constriction, the freeze response. She included the calm, dissociated state as part of constriction in the body. Back then, our understanding of dissociation was limited by the traditional model of the ANS. We now understand this "calm" state as descriptive of the collapsed, shutdown dorsal state that Porges integrated into the new understanding of the ANS. Porges' contribution matched our clinical observations, and provided us with the missing piece. The state of collapse that appears to follow constriction explains the calm relief that our clients feel with profound dissociation and sleep. This is the place of relief that the body seeks when other forms of safety and comfort are unavailable.

Van der Kolk was curious about self-harming behavior (Van der Kolk, 2014). He asked, "Why are so many people attracted to dangerous or painful situations?" He conducted research with eight war veterans, who agreed to watch violent scenes from the movie *Platoon* (1986) while they took a standard pain test. They measured the length of time the veterans could keep their hands submerged in a bucket of ice water. They were then exposed to calm and peaceful scenes. They found that seven of the eight veterans kept their hands submerged in cold water thirty percent longer during the violent scenes. Van der Kolk states, "We then calculated that the amount of analgesia produced by watching fifteen minutes of a combat movie was equivalent to that produced by being injected with eight milligrams of morphine, about the same dose a person would receive in an emergency room for crushing chest pain". (Van der Kolk, 2014, p. 33)

This research was profound in helping us make sense of our clients' often-misinterpreted self-harming and

***“Instead of assuming masochistic or attention-seeking explanations,
we appreciate the role of the autonomic nervous system
in shifting states to survive.”***

addictive behaviors. Instead of assuming masochistic or attention-seeking explanations, we appreciate the role of the autonomic nervous system in shifting states to survive. We see how our clients re-enact their trauma stories by unconsciously returning to threatening situations that activate the release of endogenous opioids, creating a shift into a dorsal state of shutdown, and the calm relief that Herman spoke about.

Herman and Van der Kolk's work in unravelling the mysteries of self-harm and addiction are wonderful examples of the integration of top-down and bottom-up approaches.

They listened to survivors with curiosity and compassion. By conducting qualitative and quantitative research, they contributed to unravelling the mysteries of the body and mind as they seek to survive unrelenting pain.

Feminist therapists also understood that establishing moment by moment safety was the most important part of the healing journey. I learned that creating a “safe nest” for our clients is essential for healing to begin. Safety is our North Star; it invites us, igniting a path and keeping us company as it points the way to connection. Without it, we are lost. Herman provided a three-stage model that created a safe container for the healing journey: establishing safety, remembering and mourning, and reconnection (Herman, 1992). Her work guided feminist therapists to create more structure and containment at the beginning of treatment, particularly in group therapy with survivors of sexual abuse.

Herman's anti-oppressive lens provided a framework in which to understand the systemic nature of abuse on a personal and political level. This broad view of societal trauma provided a deeper, more sophisticated understanding of the challenges in creating safety for our clients, and in society.

2. Gendlin's Focusing and Felt Sense

In developing the FSPM™, I searched for a therapy that would help my clients reclaim their connection to body wisdom. In the mid-1980s, I found Gendlin's book *Focusing* (1978). His contribution to the FSPM™ is found in the breadth and depth of his teachings. His philosophy of the implicit (Gendlin, 1997) offers a fresh way of integrating science and first-person experiencing. It teaches us that the body's implicit knowing is beyond our conscious awareness. Gendlin discovered that clients who did well in therapy were connected to their body and its implicit knowing through what he called the felt

sense. This knowing is at first vague. Turning attention inwards and noticing feelings and body sensations allows a felt sense, a whole sense of a situation, to form in the body. The felt shift arises as the body makes meaning from the felt sense. Embodied knowing is implied in the next step towards growth. Gendlin called this deep listening process Focusing. While it is a natural process, many people find it hard to do at first, perhaps because we live in such a disembodied culture. He made six steps to teach it to people.

Gendlin created the Experiencing Scale, (EXP;1986) that provides clinicians with a validated seven-point scale to assess the level of emotional and cognitive awareness of one's ongoing experience. This interoceptive tool aids clinicians in tracking clients' ongoing progress in deepening their capacity to integrate traumatic experience and strengthen their ventral presence. It is an essential part of the FSPM.™

Gendlin encouraged the creation of Focusing partnerships. He believed that people were more often able to go deeper in their practice if they were accompanied by another person. Focusing is very much about listening to your partner in a way that honors their deep process. In this way, he created a powerful partnership practice based on the polyvagal concept of co-regulation. We help each other to connect and settle in our ANS as we deepen our Focusing practice.

Thoughts, feelings, physical sensations, and memories are avenues into the felt sense. In asking questions about these avenues, we help clients deepen their embodied knowing of an issue. As the felt sense forms, we pause and stay with the fullness of experiencing. Sometimes a felt shift, a physical release, happens as the client integrates new knowing. This relieving shift is the body's way of pointing us in the direction of safety and healing. These shifts are what Gendlin called “the motor of change” (Gendlin, 1964) that carries us forward in life.

As I learned about felt shifts, it helped me to understand what I was observing in my clients' bodies. As we worked through the trauma, I could see the physical shifts as their bodies opened and they became more present and socially engaged. With this presence comes a sense of meaning and purpose in life. This is vitally important, because trauma and addiction diminish and often shatter one's sense of meaning and purpose.

When I began to read about Polyvagal Theory, I could see the interconnection between the subjective experience of a felt shift and the neurophysiological shift in autonomic states. My FSPM™ incorporated this theory, and posits that these felt shifts are, in fact, shifts in



our autonomic nervous system that Gendlin would say “carry us forward.” This forward direction can be characterized as Porges’ ventral state of health, growth, and restoration.

3. Interpersonal Neurobiology

Dan Siegel’s work in helping us to understand the nature of mind-body interaction forms another layer of the FSPM™. Siegel takes us into the world of interpersonal neurobiology (IPNB), an integration of subjective experiencing and traditional science. He deconstructs the pathologizing paradigm, creating a new way of understanding mental health. His model emphasizes the regulation of emotional states on a continuum from hyper-aroused to hypo-aroused. This work compliments Polyvagal Theory. Siegel understands wellbeing as a state of integration where clients learn how to regulate through mindfulness practices.

4. Lewis Learning Model of Addiction

In developing the FSPM™ I incorporated Marc Lewis’ (Lewis, 2015) learning model of addiction. The disease

model argues that addiction changes brain chemistry. Lewis points out that brain changes, a process called neuroplasticity, that occur in addiction are the same as those that happen when we are in love, or absorbed in a sport. Thus, addiction is not a chronic disease, but a learned response – one that becomes habituated over time. This habituated response can also change as new neural exercises are learned, offering the addicted person hope in achieving a stable and healthy life. This de-pathologizing model of addiction provides a vital part of the FSPM™.

5. Polyvagal Theory

When I discovered Polyvagal Theory, I knew I had found the missing piece for my evolving model. I was now able to clearly see the functional role of addiction as activating a blended state of both the sympathetic and dorsal branches of the ANS. The theory resonated with me in three powerful ways: 1) Porges’ emphasis on safety as the precursor for healing; 2) his identification of both the dorsal branch of the ANS and the social engagement system; 3) the concept of autonomic state as the intervening variable in the traditional stimulus-response model.

*“...brain changes, a process called neuroplasticity,
that occur in addiction are the same as those that happen
when we are in love, or absorbed in a sport.
Thus, addiction is not a chronic disease, but a learned response...”*

Safety as the Precursor of Healing

Understanding addiction within the context of both an absence of and a quest for safety is a powerful framework. It challenges us to examine our understanding of what constitutes safety, and how lack of experiences of safety relate to trauma and the prevalence of addictive behaviors. Indeed, the research that links trauma and addiction is impressive, as emphasized by Porges, above (e.g. Carliner, Keyes, McLaughlin, Meyers, Dunn & Martins, 2016; Enoch, 2011; Felitti, 2006).

So, what is safety? The answer to this question differs greatly depending on what framework you employ. Our culture's current top-down approach typically understands safety as the absence of physical threat (Porges, 2017). We concentrate on making environments safe by building walls, fences, security systems, and jails. Our actions are driven by fear. We often fail to address our very real need to actively create cues of safety. When our needs for "enough safety" are not met, we are often traumatized by a culture that blames individuals instead of examining societal systems of oppression. Many of our clients live in chronic states of dysregulation, having learned to deal with traumatizing conditions by using substances and behaviors to alleviate overwhelming feelings of isolation. In terms of addiction, we create a "war on drugs," and then criminalize those suffering from addiction. In our current dissociated state, we fail to see the systemic causes of trauma and addiction.

From a bottom-up perspective, we view safety quite differently. While physical safety is important, it remains one dimension of our experience. Porges notes that feeling safe is akin to a felt sense. When we tap into our felt sense of safety, we become aware of thoughts, feelings, physical sensations, and memories. We have an embodied sense of connection with our emotional and physical needs. When we are connected to embodied knowing, we realize the importance of creating safe spaces that address all our needs: physical, emotional, sensory. When we nourish these parts of ourselves, we become interconnected as a species. We appreciate the inequalities that exist in our world, and how those inequalities create trauma and addiction. And, we understand the importance of repair instead of punishment.

From a polyvagal perspective, we must consider not only our clients' need for safety, but also our own. We understand that we co-regulate each other's ANS, and therefore need to create the conditions upon which we will both feel safe enough to grow together.

Unfortunately, our professional boundaries reflect the top-down methodologies that are currently dominating our therapeutic work. Forty years ago, the field of trauma was very underdeveloped. As we began to address issues of abuse and neglect, we were told that we should stop asking clients if they were abused, for fear of implanting "false memories" (Loftus, 1996). We were

instructed not to touch our clients, as that could trigger them. We were told that they couldn't distinguish between safe touch and sexually abusive touch. Many of us were afraid of being sued or sanctioned by our colleges, and an appalling sense of fear silenced us. I would argue that this fear is still shaping our professional standards. As therapists, we must feel safe enough to foster a warm, deeply intimate space in which to hold our clients. We must have the courage to move beyond fear, and share our own authentic self. When we share our own vulnerability in a carefully bounded way, we model what it is to be human in all its rich and various forms. As humans, wired to connect, we need to feel free to acknowledge our enjoyment of each other, and to relax into being ourselves. After all, we are engaging with our clients in an arduous and lengthy journey. Our commitment is fed by our enjoyment of the relationship.

Our job as therapists is like no other. We need to be able to create moment by moment experiences of enough safety so that healing can begin. From a polyvagal perspective, this requires much from us. We are our own instruments in the work. We cultivate, as much as possible, a grounded awareness and embodied connection with our clients. We do not have to be fully grounded, but we do need to be grounded. We gently and steadfastly coax the person we are accompanying into "eyes wide open" presence. This is facilitated by much patience, and often love, for our clients. It requires us to be firm in holding them accountable when facing the truth about their lives. As we build the safe nest, they will lean into us. We have to stand tall, like the oak tree. It bends in the wind, but it must stay standing.

Identification of the Dorsal Vagus and Social Engagement System

Porges' identification of the unique functions of the dorsal branch of the vagus nerve as part of the ANS facilitated a huge shift in the trauma world. It provided a clear understanding of the powerful numbing and shutting down experiences that we see in our clients' responses. We now appreciate the immobilizing effect of the dorsal state when the body is under great threat. Polyvagal Theory provides a top-down and bottom-up theory that explains the full range of options in the ANS, from sympathetic to dorsal responses. The shutdown, numbing function of the ANS can now clearly be identified as separate from the commonly called freeze state.

The freeze state is now understood as a blending of sympathetic mobilization and dorsal immobilization, resulting in a stuck process in the ANS. The body constricts with the sympathetic surge, but it is simultaneously immobilized with dorsal activation, creating a stopped process. This identification of the freeze state leads us to a deeper understanding of the role of addictions as state regulation strategies in the ANS. This stuck process is a powerful feature of addiction. From

a polyvagal perspective, it makes sense that addictions act as propellers that shift the body along this continuum in a quest for safety. Sadly, as Porges points out, even if these behaviors bring temporary relief, they create an endless feedback loop that results in unsuccessful attempts to regulate.

Norman Doidge describes this state as the “plastic paradox” (Doidge, 2017). The process of neuroplasticity – the way in which our brains are always changing – paves the way for healing from trauma and addiction. However herein lies the paradox: if behavior is repeated too often, as in addiction, the neural pathways become rigid and unchanging. Then, the addicted person is literally in a rut – spinning their wheels and going nowhere.

The social engagement system is a term coined by Porges that describes the cluster of neural pathways that interact in the ventral vagal complex to support sociality, while simultaneously supporting health, growth, and restoration (Porges, 1998). The ventral vagal complex is a brainstem area that regulates the ventral vagal pathways and the striated muscles of the head and face. The ventral vagus communicates with organs above the diaphragm, and facilitates bidirectional neural communication between the face and the heart. This demonstrates how we are wired to connect through our facial expressions and prosody of voice.

The social engagement system is activated when we feel safe enough to be grounded and present. We have the capacity to connect with others, and think through how we want to respond to situations, especially those that require empathy and good judgment. When we lose this connection due to activation of defensive states, our capacity to think clearly and respond with empathy is debilitated. In the state of addiction, the ventral vagal complex is compromised. We lose our clear-headed and compassionate selves. This is how good people can find themselves doing bad things. People who are addicted are compelled by a neurophysiological drive to acquire whatever it takes to self-soothe. The body is wired to survive, and in a desperate state the social engagement system is severely compromised.

This understanding is key to revolutionizing addiction treatment. Rather than invoking addictive metaphors of devils or greedy monsters that must be defeated, we describe the process in our autonomic nervous system that shifts the body into states of defense to survive. In chronic defensive states – the addictive loop – we lose our capacity to think clearly. Illegal and immoral acts then become options in our repertoire of behaviors. Appreciating the body’s attempt to keep us alive enables us to befriend the body, rather than treating it as a war zone. In my experience, explaining this to clients is

life-changing. It creates what I call “moments of liberation” from endless shame and despair. It sheds light on the profound confusion that clients have in understanding how they could have behaved in ways that they often abhor. *These moments are the treatment!* This understanding brings powerful felt shifts into ventral states of repair as clients learn to hold their addicted parts with love and kindness.

Knowing that our clients will want to avoid social engagement helps us to understand why the treatment of choice, group therapy, will be a scary proposition for most. I start with individual sessions, building co-regulation over time. As we establish some safety and connection, most clients will take a risk with group, especially knowing that I will be there to lead.

Autonomic State as Intervening Variable

Polyvagal Theory suggests that our autonomic state determines how we will experience the world. Our ANS is the intervening variable in the traditional stimulus-response model. Simply put, when we are stimulated by an experience, our present autonomic state will determine our response. I will give an example.

As I write this today, large numbers of people are demonstrating against vaccine mandates and other Covid measures in a movement for “freedom.” They are gathering in mounting numbers by foot, and driving large trucks into the center of the city. As they approach, a few miles from my home, they are chanting and honking horns incessantly. I listen to the news, and hear about police presence, and the concern that these trucks will attempt to block access to hospitals. I sense the momentum building, and feel a surge of sympathetic energy flow through my body. I am moving into a state of defense.

As I respond from this sympathetic state, I feel scared and angry. My body is mobilizing, and I want to hide or fight back. I feel judgment and despair about this behavior. If I invite my body to settle and engage in ventral energy, a felt sense of enough safety forms in my body. The story that follows from this ventral state is different. I understand that these folks are upset, and perhaps feel helpless and frightened by the very prolonged Covid measures that they are enduring. They too are surging into sympathetic flight/fight responses without much ventral capacity.

I understand that in order to move into social engagement and co-regulation, our officials will have to facilitate a way forward by listening to each other. As I breathe and stabilize, I feel much less judgment and much more capacity to empathize.



Focusing Practice

I invite you to take time to pause, to breathe into your response.

Notice how your ANS is carried in your body, and how the state impacts your felt experience.

Anti-Oppressive Theory

The FSPM™ is held by and accountable to anti-oppressive theory. From this lens, we understand the root causes of addiction and their role in the autonomic nervous system. Our culturally condoned systems of oppression lead to trauma, and trauma is the underbelly of addiction. Consequently, marginalized groups are much more vulnerable. Staci Haines, author of *The Politics of Trauma* (2019), puts it so well when she says that trauma robs us of safety, belonging, and dignity. Without these basic needs being met, we seek out twisted ways of soothing to help us survive.

Introduction of the Graphic Model Clinician and Client Versions

The graphic models help clients become familiar with the ANS using imagery. By visualizing images, we engage a bottom-up process that helps clients embody the concepts and pathways to healing through activating the right hemisphere. The use of these models early on in treatment accelerates the ability to befriend the body by harnessing the ANS and the felt sense as powerful vehicles for change.

To support the FSPM™, I created two graphic models¹ – one for clinicians and one for clients. My clients helped me create a simple version where each state starts with the letter F to make it easy to remember. They keep track of their state by putting a picture of the model on their phone and/or their refrigerator. We call it orienting to the Six F's when we discuss the model. Together, we track states, tracing the pathways, as a way of describing the healing journey. The graphic images help clients see very clearly how addictions function as propellers between flight/fight and fold. The top half of the model shows the trauma pathways where the ventral social engagement system is compromised. The bottom half follows the ventral pathways, the states that support a fulfilling life.

Looking at the graphic depiction of the FSPM™ clinician version, we can see the three circuits of the ANS, connected via a solid-lined, inverted triangle.

- A. The ventral vagus is in yellow at the bottom of the page,
- B. The sympathetic in red is on the right, and
- C. The dorsal vagus is in grey on the left.

Next are blended states, connected by the dotted-line triangle. Blended states in the system utilize two pathways. The ANS has the capacity to blend states, creating a greater range of experiences. The blended states are represented in the model in mixed colors:

- A. Play is on the bottom right in yellow/red.
- B. Stillness is on the bottom left in yellow/grey.
- C. The FSPM™ also proposes a third blended state of addiction, which is at the top of the model in red/grey. Addiction is a blending of sympathetic and dorsal states. Substances and behaviors then serve as state regulation strategies.

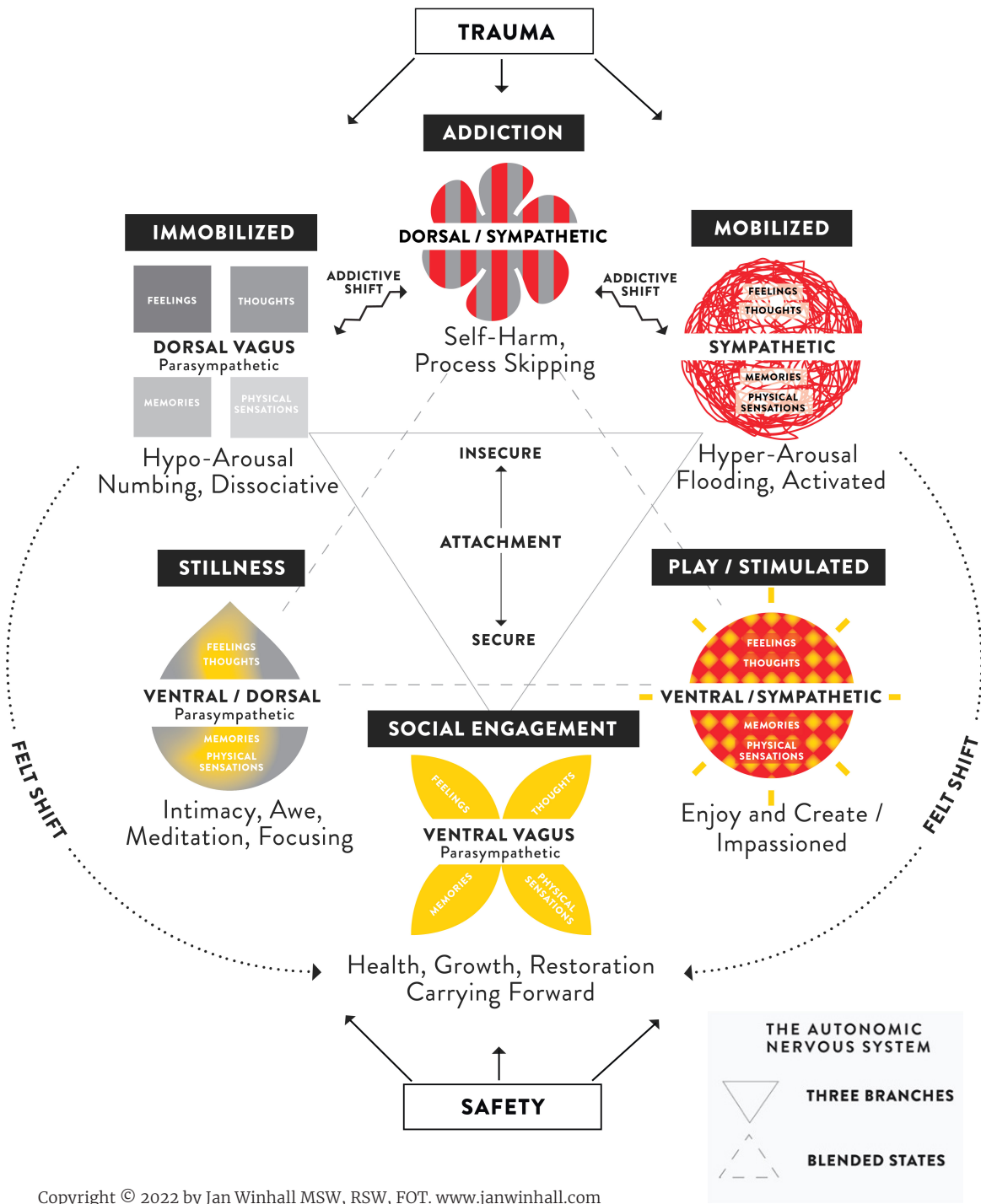
The client version uses what I call the Six F's to define the states of the autonomic nervous system: Fight/Flight, Fixate/Freeze, Fold, Flow, Flock, Fun/Fired Up. As we work with the model, we discover other blended states.

1. Fight/Flight – *sympathetic response*. Flight is a state of fear and anxiety. In this state, the body mobilizes to run and escape. Fight is a mobilizing state of anger.
2. Fold – *dorsal response*. Fold is a collapse of the ANS into a dissociative state when the sympathetic response is ineffective.
3. Fixate (Fight/Flight and Fold) – *blended state*. It is the blended state of addiction that acts as a propeller between Flight/Fight and Fold.
4. Flow – *ventral and dorsal response*. Flow is a blended state between ventral and dorsal. It is a state of safety with stillness.
5. Fun/Fired Up – *ventral and sympathetic response*. Fun is the blended state between ventral and sympathetic, a state of playfulness. Fired Up, an impassioned, activated state, is another blending of ventral and sympathetic.
6. Flock – *ventral state of grounding and safety*. This state promotes health, growth, and restoration.

1. For color images and downloads of the models, go to janwinhall.com

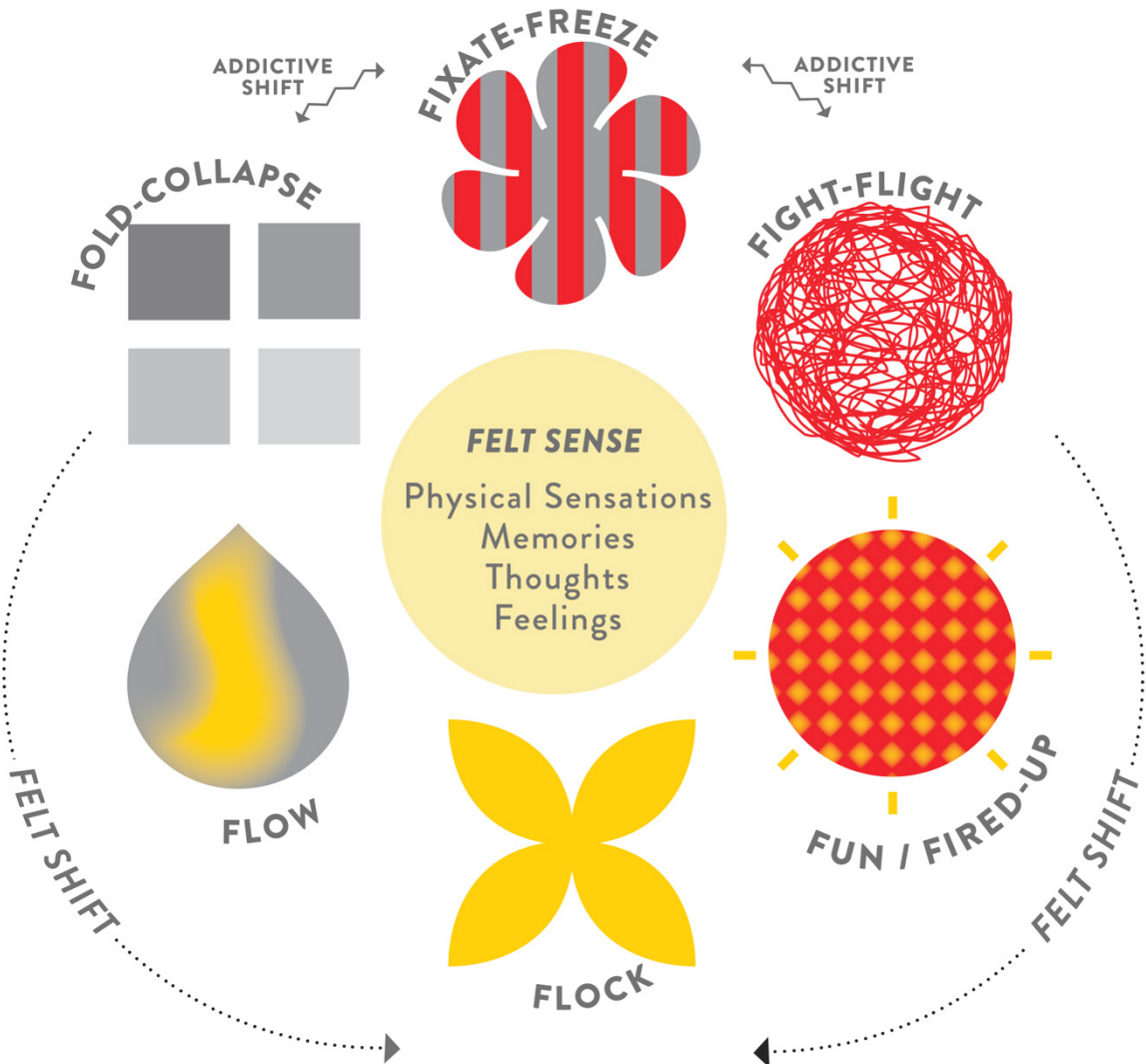
THE FELT SENSE / POLYVAGAL MODEL™ OF TRAUMA AND ADDICTION

CLINICIAN VERSION



THE FELT SENSE POLYVAGAL MODEL™ OF TRAUMA AND ADDICTION

CLIENT VERSION 6 F's (3/3)



Applying the Felt Sense Polyvagal Model™ Embodied Assessment and Treatment Tool (EATT)™

When I began working with the FSPM™ I realized that I would need to create an assessment tool that captured the experiential process of the work and the somatic history of the client. The traditional bio-psycho-social assessment is completed in the first or second session. It focuses on taking a detailed assessment of the client's history, with no reference to embodied processes. There are many problems with this approach. For example, clients are required to share detailed traumatic experiences and addictive behaviors all at once, and at the beginning of treatment, when a sense of safety is just beginning to be explored. At the very least, this is uncomfortable for clients, and at worst it is retraumatizing.

In sharp contrast, the Embodied Assessment and Treatment Tool (EATT)™² slowly integrates assessment and treatment over time. In keeping with the experiential nature of our work, and the attention to body process, the client's history unfolds as the body reveals its wounded places. By tracking neuroception (polyvagal theory) and interoception (focusing) as our framework, we develop a comprehensive assessment package that documents ongoing progress, and provides the client with therapeutic tools and practices they can use as resources in their healing journey.

The Importance of Asking

If your early assessment with a client indicates a lack of ventral presence for significant periods of time, it is important to consider that they may be using self-harming and potentially addictive substances and behaviors to manage neurophysiological state changes. It then becomes essential, from a polyvagal perspective, to explicitly ask about self-harm and addiction. We need to bring the body on board, to recruit the ANS as a collaborator in helping us unlock the addictive pathways, by shifting neuroception. When we work *with* the body, we invite all the parts of a person to embrace the idea of reducing harm. Otherwise, we engage in an unspoken power struggle: the mind wants to stop addiction, but the body is stuck in a ANS trauma loop.

With the FSPM™ as our guide, we begin to track the client's autonomic state and capacity for embodied experiencing. The tool has eight components that include the following:

1. The Felt Sense Polyvagal Model™
2. The Experiencing Scale (EXP,1986)
3. The Felt Sense Polyvagal Dialogue™
4. The Three Circles (Carnes, 2001)
5. The Trauma Egg (Murray, 2012)
6. The Nine Domains of Integration (Siegel, 2012b)
7. The Privilege Wheel, (https://www.oise.utoronto.ca/edactivism/Activist_Resources/The_Power_Flower.html)
8. Specific Concerns

In a top-down approach, we would use each of these in order. I start by tracking neuroception with the FSPM™ and interoception, using Gendlin's Experiencing Scale. Then I use the rest when, and if, they become helpful in our experiential journey. For the sake of brevity in this article, I will give a case example using the FSPM™ and the Three Circles practice by Patrick Carnes. For a detailed description of the Felt Sense Polyvagal Dialogue™ that I used in this case, see Chapters 13 and 14 in my book *Treating Trauma and Addiction with the Felt Sense Polyvagal Model* (Routledge, 2021).

A Case Example Lily and Lucas

Lily, a hip young woman in her mid 30s, came to see me five years ago. She and her partner Lucas met at a ballroom dancing course. They fell into a routine of going for drinks after class. Over time, they moved in together, and the drinking became a nightly routine. It was never enough to prevent either of them from performing well at work, but Lily was feeling more and more uneasy about it.

During our time together Lily and I explored the feelings that surrounded this behavior. She learned how to connect with her felt sense of the problem. It came quite naturally to her, since she was a trained dancer. She became adept at understanding her calmed and smoothed the jagged edges of her anxious state. Together we traced the addictive pathways from Fight/Flight (sympathetic) to Fold (dorsal) with alcohol and sugar planted firmly in Fixate(sympathetic/dorsal). She resonated with the understanding of addictions as propellers that shifted her from one extreme to the other. She appreciated how the addictive neural pathways were in the top half of the FSPM™, limiting her capacity for social engagement and a feeling of safety. We used Carnes' Three Circle Practice to help Lily make a harm reduction plan and be accountable

2. For a detailed example of the EATT, including the Process Recording Form, a copy of the Three Circle Practice, and the Body Cards, downloads are available on my website janwinhall.com and further elaborated in my book *Treating Trauma and Addiction with the Felt Sense Polyvagal Model* (Routledge, 2021).

to herself. This practice, called a neural exercise in polyvagal language, helped Lily create new ways of finding grounding energy that moved her into Flock, Flow, Fun (ventral).

Body Cards

In keeping with the enhancement of bottom-up processes in working with the FSPM™, we use Body Cards to invite the client to draw the felt sense of a neuro-physiological state. The imagery helps to explicate the implicit experience, and in the case of ventral states, the cards can be used as resources. Here is an example of a Fight/Flight sympathetic state Body Card.

The Three Circles

The Three Circle practice is a tool that was developed by Patrick Carnes (2001) in his work with sex addiction. The three concentric circles provide a map for clients to document their management of addictive behaviors. I integrated the ANS states into the three circles.

The Inner Circle: Fixate

The inner circle represents addictive behaviors that clients are ready to change. We work with the process by using the FSPM™ as our guide.

By explaining the model, we are recruiting the person's nervous system to collaborate in the healing

process. We invite the body to consider letting go of addictive behaviors. When clients are ready, we place the behaviors inside the circle. The behaviors must be quantifiable for clear accountability. Clients agree to check in with their therapist to build accountability on a daily or weekly basis, and/or they can check in with their focusing partner. If they want to change the boundaries around the behaviors, they agree to negotiate with their therapist first.

Lily's inner circle contains no alcohol, and two deserts per week.

The Middle Circle:

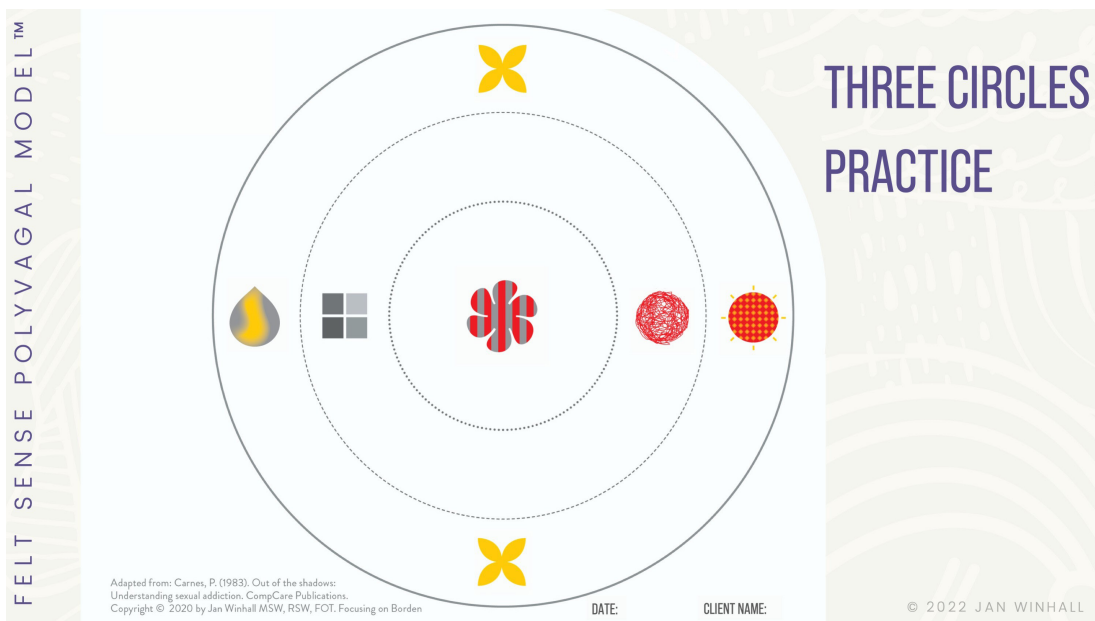
Fight/Flight, Fixate/Freeze, Fold

The middle circle represents the stressors, the experiences that lead to the activation of the addictive behaviors. These can be current-day stresses like job problems, conflicts in relationships, systems of oppression, poverty, and early abuse histories. We trace the ANS states on the FSPM™ to help clients begin to understand how these soothing behaviors ease anxiety and rage. They begin to appreciate how addictions act as state regulation strategies, propelling them often from flight/fight to fixate to fold. They appreciate the adaptive nature of their very bad habits when flock was not available.

Lily's middle circle contains stress at work, loneliness, anxiety, and feelings of shame that are profound and confusing.



Lily's Body Card: Fight/Flight



The Outer Circle: Flock, Fun/Fired Up, Flow

The outer circle is the sweet spot where bodies feel safe enough to engage in social interaction, to rest, to digest, to trust. It is the place of health, growth, and restoration in the body. The felt sense experience of life is engaged, and purpose and meaning carry us forward in a productive life. Addictions are not active in this state of social engagement.

Lily's outer circle contains:

- doing daily practices including checking Three Circles and FSPM™
- spending time with friends and family, and with Lucas
- teaching dance, yoga
- attending weekly therapy sessions
- Focusing weekly with her partner

Lucas Joins Us

Lily was making some progress with the use of the Three Circles and the FSPM™, but she was finding it difficult without Lucas' participation. When we invited him to join us, he was eager to begin his own journey. Lucas did his Three Circle Practice so they could work together on a plan. They both agreed to stop drinking alcohol, placing "no alcohol" in the inner circle. They cultivated their outer circle behaviors, and their relationship began to settle into a flock, flow, and fun rhythm. We said goodbye for now, and I didn't see them again until I got a call from Lily about a year later.

The Call

I opened my office door to tall, elegant Lily, dressed in gorgeous colors and delicate silver earrings. My body remembered beautiful, vulnerable Lily with a loving feeling of delight. But something was terribly wrong. Lily sat down and collapsed into our warm space. She had discovered that her handsome, safe, and loving Lucas, the man she trusted as kind and honest, was hooking up with men for sex.

As she shared this with me, Lily fell into a dorsal state of shock, her body folding into the couch, eyes sinking into oblivion. I felt alarmed, and leaned in. I whispered to the Lily that I know, coaxing her back to breath, back to me and to life. She began to surface, breathing more deeply as she returned to the room, but her eyes held mine with a despairing gaze. It was hard to greet her here, in such a painful, dark place. But that is our job, to be present and hold these places with love and care. This is the arduous work of co-regulation. I gently extended my hand, and she reached over, hungry for the anchoring warmth of touch. We paused and breathed, feeling our feet on the ground.

The Healing Journey

Lily, Lucas and I met over several years. Together, we explored their embodied stories through the relational felt sense, the body's way of co-regulating. We started by building a safe nest together. They revisited the Three Circle Practice and Lucas agreed to add "no use of pornography" and "sexual activity only with

Lily” to the inner circle. We checked in at the beginning of each weekly session to help them be accountable to each other as the therapy progressed. Over time more of their trauma stories were revealed as we moved deeper into the wounded places. This work is the heart of the journey, excavating the trauma that forms the underbelly of the addictive behaviors.

As Lucas connected with his felt sense, deepening his capacity for experiencing, he was able to share more of his struggle with obsessive use of pornography, and unsafe sexual encounters with men. He was confused and frightened by this behavior describing it as an ‘out of body, mechanical” feeling that came over him. It seemed clear that this behavior was addictive. He wanted to stop but was struggling to stay grounded.

As they established safe boundaries in their relationship, we worked through the trauma using the FSPM™ to help them understand their ANS pathways. They became familiar with their default autonomic states. Lucas was aware that he lived much of his life in a somewhat dorsal state – seeking aloneness and shutting down intense emotion. Lily recognized her general tendency towards sympathetic activation, often feeling the full range of fight/flight feelings. She acknowledged that she flew into raging at Lucas when she was angry, which activated his shutdown response. Lucas began to cry as he heard Lily’s acknowledgement of her anger. To hear her capacity to give to him now, after he had hurt her so deeply, was overwhelming for him. He was as confused by his acting out behavior as Lily was, but he knew his confusion was not an excuse. He was responsible for hurting her. I saw him slowly peek at Lily, as he tried to find his voice.

“It feels really good to hear you acknowledge your rage. When you yell, I die inside... In fact, right now my heart is racing.” Lily asks Lucas to check down into the center of his body and see what is happening now. “It feels shaky, like butterflies in my stomach. I can see that red ball, like the fight/flight place on the model, in my gut. It feels good though to talk openly with you, and for you to hear me.”

Lily mirrors back, and I see a moment of connection deepen between them for the first time since this all happened. Together, we pause and help Lucas explore more of his felt sense. He checks in with the butterflies in his stomach, the red ball in his gut. He shares that it feels calmer in there now, more relaxed, and expansive. I tell him that we call this the felt shift when the body changes neurophysiological states. “Like going from flight to flock,” he says.

“Yes!,” I say, and we all laugh (Winhall, p. 203).

From time to time they both slipped in their efforts to not drink alcohol. Lily did well with her two desserts a week. Lucas was able to stop hookups with men, but did occasionally slip into watching pornography

when Lily was traveling for work. This caused a lot of reexperiencing of the trauma. I decided to refer Lucas to a Focusing-oriented sex addiction group for men, and Lily to a women’s group.

During their separate therapy sessions, Lily and Lucas both awakened early memories of sexual abuse. While these memories were never completely dissociated, they lay dormant in the body. As the body healed, more of the story emerged. They eventually revealed to each other, with heart-wrenching tenderness, their shared histories of child sexual abuse. Lily shared a history of being abused as a little girl by her uncle and his friend. Her body takes her back to the felt experience of the abuse, and her soothing with food. This connection is powerful, and creates a felt shift for Lily. Fragments of feelings and behaviors start to fall into a cohesive narrative about her life. Lucas and I can see the physical release in her body as she settles into a ventral state of relaxation.

Through his work in the group, Lucas began to make deep connections with past and present behaviors. He was able to share memories of being sexually abused by an older male neighbor, and a teacher. By tracking his felt sense of these memories, he began to connect his hookups with the same feelings that originated in these early experiences – a deeply confusing mixture of sexual excitement and repulsion. While he still wasn’t clear about it all, he was beginning to understand that his body was taking him back to wounded places that he needed to make sense of. He realized how the acting out was followed by a deep dorsal state of numbing, bringing him relief from anxiety and depression. Now it became clear to both of them how the abuse activated the middle circle dysregulated trigger states, subsequently leading to their inner circle addictive behaviors. They both recognized how their addictive behaviors told a deeper story about their lived experiences.

The couple still struggled in their relationship. While Lucas no longer identified as being sexually addicted, he challenged the relationship in his need to explore his sexual orientation. While unclear, he was very committed to Lily, not wanting to lose the deep intimacy they had created. Lily grew to accept that Lucas was attracted to many kinds of sexual expression, but for now she needed him to be monogamous. For now, he agreed.

Moments of Liberation and Couple Felt Shifts

“So, we have little Lily and little Lucas, child parts that learned about sexuality in a scary way. A way that was confusing and robbed them both of the right to decide how and when to share that part of themselves. As I say this, we all start to cry. I try to honour my tears and at the same time, tuck them inside so I can be here for this wonderful moment of liberation

"It is easier to offer brain disease models than to address the source of the problem by dismantling systems of oppression that undermine safe spaces."

for Lily and Lucas. As we unravel the triggered places, I invite us all to notice the felt shifts as we sense into this exquisite moment" (Winhall, p. 210).

The Five R's for Addiction Treatment

I have adapted Deb Dana's four R's as they apply to the Felt Sense Polyvagal Model™ for addiction. They summarize Lily and Lucas' healing journey. They are as follows:

- Reframe addictions as state regulation strategies
- Recognize and explore the autonomic state/felt sense
- Respect the adaptive survival response
- Regulate or co-regulate into a ventral vagal state
- Re-story [Adapted from Deb Dana] (Dana, 2018, p. 7)

Lily and Lucas were able to *re-story* the rupture in their relationship by working through their early abuse histories. The Felt Sense Polyvagal Model™ helped them *reframe* their addictive behaviors and *respect* them as state regulation strategies that were adaptive survival responses. By *recognizing* and exploring their ANS and their relational felt sense, they were able to *co-regulate* into a ventral vagal state.

Conclusion

Polyvagal theory and the work of Stephen Porges makes a major contribution to our understanding of addictive behaviors. In the language of Polyvagal Theory, we understand that behaviors are emergent properties of a neural platform mediated by autonomic state. A behavior viewed as pathological in one setting can be adaptive in another setting. Addiction disrupts feelings of safety and sociality through changes in autonomic state that function as an intervening variable, biasing reactions to context. Although addiction strategies are an attempt to dampen underlying feelings of threat, the strategies frequently downregulate the bidirectional feedback loops, resulting in a numbing process that may have short-term benefits in relation to physical pain and mental distress, but in the long term, dampened neu-

ral regulation of visceral organs may lead to end organ damage.

In the optimal social context of humans, social interactions serve as the prominent mechanism to calm the autonomic nervous system. In contrast, in the world of addiction, social interactions are displaced by drugs and behavior to regulate the autonomic nervous system, thus disrupting homeostatic functions and potentially compromising mental and physical health.

The Felt Sense Polyvagal Model™ is grounded in Polyvagal Theory, and integrates the work of Eugene Gendlin's Focusing Oriented Psychotherapy, as well as Marc Lewis' learning model of addiction. It is a generic framework that provides an embodied, comprehensive, non-pathologizing model for understanding and treating trauma and addiction. The model brings addiction treatment into the world of somatics, and can provide the psychotherapist with a framework for any treatment modality that they are currently using.

This paper offers a new and deeply embodied way of understanding and treating addiction. Bringing attention to the body's autonomic nervous system, our safety monitor, reveals the protective qualities of addiction when faced with prolonged feelings of isolation and lack of enough safety. By recruiting our nervous system as a collaborator in the healing process, we tap into the key to successful treatment, establishing safe enough spaces for healing to begin. We know that addiction is created and prolonged by states of vulnerability. Embodied psychotherapists see the trauma of addiction every day. We see how the addicted person is stigmatized. "The drug addict is today's scapegoat," says Gabor Maté (2008, p. 58).

It is easier to offer brain disease models than to address the source of the problem by dismantling systems of oppression that undermine safe spaces. But there is a growing social movement that seeks embodied approaches – a movement that longs for connection, cooperation, and dignity for all. While we may appear to have lost our way, it is only in our heads. Our bodies know the answer.





Jan Winhall, M.S.W. F.O.T., is an author, teacher, and psychotherapist. She is an Adjunct lecturer in the Department of Social Work, University of Toronto. Jan is Director of Focusing on Borden, a psychotherapy and training center, and a Coordinator with the International Focusing Institute. She teaches internationally on trauma and addiction.



Stephen W. Porges, PhD, is a distinguished university scientist at Indiana University, where he is the founding director of the Traumatic Stress Research Consortium. He is professor of psychiatry at the University of North Carolina and professor emeritus at the University of Illinois at Chicago and the University of Maryland. He has published more than 400 peer-reviewed scientific papers. He is the creator of the Polyvagal Theory and a music-based intervention, the Safe and Sound Protocol™, currently used by more than 2000 therapists to reduce hearing sensitivities, improve language processing, and increase spontaneous social engagement. He is a co-founder of the Polyvagal Institute. He is the author of *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation*, *The Pocket Guide to the Polyvagal Theory: The Transformative Power of Feeling Safe*, and *Polyvagal Safety: Attachment, Communication, Self-Regulation*, and co-editor of *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies*.

REFERENCES

- Butler, S. (1978).** *The Conspiracy of Silence: The trauma of incest*. Volcano, CA: Volcano Press.
- Carliner, H., Keyes, K. M., McLaughlin, K. A., Meyers, J. L., Dunn, E. C., & Martins, S. S. (2016).** Childhood trauma and illicit drug use in adolescence: A population-based national comorbidity survey replication – adolescent supplement study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(8), 701–708.
- Carnes, (2001).** *Out of the shadows: Understanding sexual addiction* (3rd ed.). Center City, MN: Hazelden Publishing.
- Dana, D. (2018).** *The Polyvagal Theory in Therapy*. New York: W. W. Norton & Co.
- Doige, N. (2007).** *The brain that changes itself: Stories of personal triumph from the frontiers of brain science*. New York: Viking.
- Enoch, M. A. (2011).** The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology*, 214(1), 17–31.
- Felitti, V. J. (2006).** The origins of addiction. *Evidence from adverse childhood experiences*. [<https://nijc.org/pdfs/Subject%20Matter%20Articles/Drugs%20and%20Alc/ACE%20Study%20-%20OriginsofAddiction.pdf>]
- Gendlin, E. T. (1964).** Theory of personality change. In P. Worchel & D. Byrne (Eds), *Personality change*. New York: Wiley.
- Gendlin, E. T. (1978/1981).** *Focusing*. New York: Bantam Dell.
- Gendlin, E. T.** *Focusing oriented psychotherapy: A manual of the experiential method*. New York: Guilford Press.
- Gendlin, E. (2017).** *A process model*. Evanston, IL: Northwestern University Press.
- Gerge, A. (2020).** What neuroscience and neurofeedback can teach psychotherapists in the field of complex trauma: Interoception, neuroception and the embodiment of unspeakable events in treatment of complex PTSD, dissociative disorders and childhood traumatization. *European Journal of Trauma & Dissociation*, 4(3), 100164.
- Haines, S. (2019).** *The Politics of trauma*. Berkeley, CA: North Atlantic Books.

- Herman, J. (1992).** *Trauma and recovery*. New York: Basic Books.
- Klein, M., Mathieu-Coghlan, P. L., Gendlin, E. T., & Keisler, D. (1970).** *The experiencing scale: A research and training manual* (Vol. 1). Madison, WI: Wisconsin Psychiatric Institute.
- Lewis, M. (2015).** *The Biology of Desire: Why addiction is not a disease*. New York: Public Affairs.
- Loftus, Elizabeth (1996).** *The myth of repressed memory: false memories and allegations of sexual abuse*. New York: St. Martin's Press.
- Maté, G. (2008).** *In the realm of hungry ghosts: Close encounters with addiction*. Toronto, ON: Alfred A. Knopf Canada.
- Murray, Marilyn (2012).** *The Murray method: Creating a wholeness beyond trauma, abuse, neglect and addiction*. Vivo Publications. Nov 30th 2017, ISBN-10 0985509317.
- Porges, S. W. (1995).** Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A polyvagal theory. *Psychophysiology*, 32(4), 301–318.
- Porges, S. W. (1998).** Love and the evolution of the autonomic nervous system: The polyvagal theory of intimacy. *Psychoneuroendocrinology*, 23, 837–861.
- Porges, S. W. (2011).** *The polyvagal theory*. New York: W.W. Norton & Co.
- Porges, S. W (2017).** *The pocket guide to the polyvagal theory: The transformative power of feeling safe*. New York: W.W. Norton & Co.
- Porges, S. W. (2021).** Polyvagal Theory: A biobehavioral journey to sociality. *Comprehensive Psychoneuroendocrinology*, 100069.
- Siegel, D. J. (2021b).** *The developing mind, second edition: How relationships and the brain interact to shape who we are*. New York: Guilford Press.
- Van der Kolk (2014).** *The body keeps the score*. New York: Penguin Books.
- Winhall, J. (2021).** *Treating trauma and addiction with the felt sense polyvagal model bottom-up approach*. New York: Routledge.