Polyvagal Theory for Perinatal Trauma

A Mother-Son Somatic Case Study

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ABSTRACT

This mother-child case study explores somatic assessment and intervention approaches used with a mandated client whose history of perinatal trauma had not previously been reported. The clinician shares how they incorporated Judith Herman's tri-phasic model of trauma resolution and Stephen Porges's Polyvagal Theory to assess triggers for shutdown and rage in the dyad. Daniel Siegel's interpersonal neurobiology framework and somatic interventions used to complete thwarted survival reactions and enhance a needed sense of safety and connection are explained. Self-of-the-therapist reflections are incorporated.

Keywords: interpersonal neurobiology, polyvagal theory, perinatal trauma, somatic interventions

Submitted: 01.12.2024 Accepted: 20.02.2025 International Body Psychotherapy Journal The Art and Science of Somatic Praxis Volume 23, Number 2, 2024-2025, pp. 165-174 ISSN 2169-4745 Printing, ISSN 2168-1279 Online © Author and USABP/EABP. Reprints and permissions: secretariat@eabp.org

Had this family's perinatal trauma been known or shared at the time of referral, I would not have needed as much time to join, build rapport, and begin treatment planning.



he following case study is based on weekly sessions over three years with a minor client and mother who have been de-identified to protect their

anonymity and confidentiality. It will follow the family's clinical presentation, our assessment and intervention process, termination, and aftercare. The case study explores how we applied Stephen Porges's polyvagal theory and Daniel Siegel's interpersonal neurobiology framework to their healing process in developmentally appropriate ways, using specific phrases and nonverbal somatic interventions guided by Judith Herman's tri-phasic model of trauma resolution. Themes related to in-utero experience, attachment, and ongoing developmental interruptions and betravals are addressed throughout. Given the subject matter, the reader is encouraged to pause, down-regulate activation, and provide self-soothing at regular intervals.

The identified client was an elementary-aged cis male of Native American and mestizo descent mandated to county mental health safety net services while going through the special education assessment process. His single mother was loving, supportive, exhausted, and out of ideas about how to help her son. They lived in Section 8 housing in a gang-involved neighborhood, and there were no protected outdoor places near the apartment to play. This beautiful boy was the descendant of a famous warrior, and the family had great reason to be proud of their ancestry. The savvy reader will also surmise that horrific unresolved historical trauma was a part of the family's epigenetic lineage, which is still being enacted in the United States today.

This clinician spent three months joining and building rapport with mother and son while gathering standard assessment information, as well as observing the family together and the child at school both in the classroom and on the playground. Observation and play therapy assessment revealed a deep sense of loneliness in the child. His sand tray and imaginary worlds generally did not include any people but often revealed a desire for a familiar pet or animals that would befriend him. He would often just stand on the playground and watch the other children play. In the classroom, he was rarely approached by peers, and when he was, it appeared to be in order to tease him. The teacher did not attend to these exchanges unless or until he exploded in response. He appeared lost in the shuffle, consistently betrayed by an absence of attending to his needs by the authority figure in charge of his well-being at school.

He was having difficulties falling asleep, eating at school, and connecting with any potential social support due to overwhelming anxiety that would combust into anger. His learning difficulties were becoming more evident even as their causes were becoming less clear; the district-issued tests were unable to identify a typical learning disorder, so we took him to a neuropsychologist for assessment. The neuropsychologist was able to identify very complex processing difficulties correlated with evident kindling of activation; it was as if not knowing what was happening would set off a panic attack that required life-protecting rage to stay alive. Social ostracism was compounding due to developmental delays, thus increasing the gap between his size (larger than peers) and his behavior (increasingly delayed compared to peers). As the child grew taller than his mother, he became more difficult to contain. We met with a child psychiatrist to assess if medication might be necessary or helpful to keep the boy in school since his ongoing suspensions were not helping anyone.

The assessment process began with county-issued forms, but over time, it became clear that the basic questions were inadequate to uncover the myriad specific causes of what might be driving his self-protective anger. The author was enrolled in a somatic psychology doctoral program with pre-and-perinatal psychology coursework at the time and thus began incorporating gentle inquiry with the mother about earliest developmental themes. The intention was to assess what may have contributed to setting the child's temperamental baseline in this increasingly reactive state, in addition to the evident limitations placed on them by the circumstances of their lives and the historical losses their lineage had been forced to endure.

Meanwhile, individual and family play therapy sessions focused on co-regulation via child-led preferences in the play therapy office, at home, in school, and in the community, to build internal resources, assess for triggers, and provide mother and son with various tools to down-regulate activation. What follows is a brief summary of how we collectively descended the rungs of the polyvagal ladder to systematically assess and support each of the three branches of the polyvagal system: the social, sympathetic, and parasympathetic branches, for both mother and son. The author hopes this fleshes out how a clinician may apply polyvagal theory to assessment and help integrate all three branches in developmentally appropriate ways, particularly to support secure attachment in family systems. Structuring a trauma-informed treatment plan along this polyvagal ladder can ensure the clinician does not move too fast or too far from what the client system can integrate toward wholeness.

Overview of Polyvagal Theory and Interpersonal Neurobiology

Stephen Porges's polyvagal theory is increasingly lending hard science grounding to the softer science of therapeutic intervention, specifically for trauma resolution across the lifespan (Conroy & Perryman, 2022; Porges & Dana, 2018; Ryland et al., 2021). Research exploring the three branches of the vagus nerve system and its evolutionary capacities clarifies that the human brain, and the vagus nerve that sends and receives signals from it, mimic the evolutionary heritage of vertebrates (Porges & Dana, 2018). In other words, the newer cortical architecture, or most recent social nervous system, that evolved in primates and belongs most fully to humans lies on top of the mammalian and reptilian sympathetic fight-or-flight layer, which ultimately wraps around the oldest history of our lower reptilian (indeed aquatic vertebrate) parasympathetic foundation at the deepest core of our brain and nervous system.

How the vagus nerve branches travel in and out of our body to our brain, and back out to their respective areas within the body, helps us assess our relative safety in the environment. When we perceive our setting and relationships as safe enough, all three branches of the autonomic nervous system work in balance and are optimally engaged to function biologically and emotionally. If we perceive the social or physical environment as too unsafe, we will do what we can with the social nervous system, our most recent evolutionary development, to navigate the situation in order to create safety. Some trauma literature calls this "please-and-appease," otherwise known as a "fawning" response (Aigner, 2022). We orient with our eyes, ears, facial muscles, and the tone of our voice to secure connection and help from the environment using processes that are largely subconscious, but can be manipulated intentionally with development and practice (Porges, 2003; Porges & Furman, 2011). Most talk therapy approaches focus on leveraging this newest branch of the autonomic nervous system. Babies are born hardwired to secure care from their assigned caregivers through the social nervous system, and healthy caregivers cannot help but respond positively to these bids for connection and support. When our bids for connection and support are received with appropriate attunement, we can stay engaged socially and function in emotional proximity (Porges & Dana, 2018).

If we cannot create emotional safety through the social engagement system, the next rung down the evolutionary ladder is sympathetic branch engagement; we will "fight or flee" to get back to safety (Bracha, 2004; Porges, 2009). Habitual fighting and fleeing tend to be assessed as anxiety and trauma disorders, impulse control disorders, and even certain personality disorders. However, sympathetic engagement within a healthy range is required to move us toward what we want and need, and away from what is dangerous, noxious, or unwanted. Exhibiting inappropriate sympathetic engagement when the situation does not warrant it by those with the power in the situation can often result in negative consequences (e.g., publicly losing one's temper at work, or with a police officer or teacher). On the other hand, insufficient sympathetic engagement can result in getting harmed in some situations where one could theoretically escape. One's developmental history will inform how this split-second decision-making is made; an armed special operations soldier will likely perceive the same situation differently than a small, neglected child and will engage accordingly. Babies are unable to fight or flee physically. Instead, this phase of evolutionary response will manifest as angry crying in protest. When they become too exhausted to maintain their elevated heart rate, they eventually collapse into despair (Goh, 2017; Porges & Furman, 2011).

If we assess that fight or flight is not available – and indeed, our socialization process tries to condition us away from knee-jerk or aggressive reactions as much as possible – we may descend another rung on the ladder to parasympathetic "freeze or flop" (Beaudoin & Maclennan, 2021; Swain & Brahimi, 2022). Getting stuck in this state is not uncommon in the case of PTSD and depressive disorders (Cummings, 2021).

When the parasympathetic branch of the ANS is balanced, we can restore our bodies and minds from recent stress through the "rest-and-digest" functions of the body that flush out inflammation from cortisol and catecholamines. We can sleep without hypervigilance, and our food intake and elimination become regular and healthy. Parasympathetic imbalance shows up as interruptions to biological processes, such as lack of appetite, sleep disturbances, low heart rate, flat affect, and limited facial expression. In the most catatonic state, neurophysiological shock can even lead to death in the imbalanced parasympathetic state (Porges, 2014; Porges & Dana, 2018).

Our clients will embody their movement up and down this ladder as they cope with stressors. Our treatment and intervention plans will be wellserved by knowing how to help bring balance to each rung, noticing where our clients get stuck, and creating interventions that help facilitate their movement up and down the ladder as necessary and appropriate.

This case study will reference the different branches of the autonomic nervous system (ANS) in descending order, and outline how assessment and intervention were performed at each rung.

Judith Herman's tri-phasic trauma resolution model (2016) nicely aligns conceptually with following these ladder rungs. The priority in each session is safety and stabilization; we only move toward a digestible amount of trauma memory processing after we have established safety and stabilization. After each dose of trauma discharge, we facilitate reconnection and reorientation to self, place, skills of daily living, and social support (Herman, 2016; Zaleski et al., 2016).

Social Nervous System Branch of ANS

Due to his developmental delays, the son was amenable to imaginal play typical of much younger children. Thus, most of our assessment and early intervention individual work was focused on integrating unmet needs through imaginal play, and then bringing what worked to role model and practice with his mom so that she could fulfill the needs and strengthen their attachment via theraplay-informed interventions (Money et al., 2021; Wettig et al., 2011). My goal was to identify the strategies this family needed to fulfill their attachment and regulation needs to enable them to achieve optimal functioning in all areas of their life. I gave mom respite by taking her child for field-based sessions for two to three hours per week, followed by family therapy to integrate what was learned in the individual play therapy.

To support Judith Herman's first phase of trauma resolution, safety, and stabilization, I would often step into the boy's wished-for animal friends, and give them voice through sand play or puppets, anticipating what the child wanted to hear from the animal in a loving and playful tone, modeled loosely on kind Sesame Street characters. Following Stephen Porges's recommendations for voice modulation to signal safety to the social nervous system (Porges & Carter, 2017), I was mindful of using a soft and soothing voice, saying little, always signaling praise and connection, and being invitational without conveying pressure to respond. Some of the phrases I softly and playfully used to stabilize the boy's nervous system in the perception of safety once we had transitioned into play included: "Oh, I finally get to see you today...I've been waiting all day for you!"; "I can't wait to hear

all about your day"; "I was thinking all day about what would be fun when we finally get to play together"; "Where do you want to go today?"; and, once we had gone somewhere for a while in the imaginal world, or out in the real world, "Let's have snacks together...what sounds yummy to you?" In family therapy, the mother initially had difficulty stepping out of her provider and caregiver role into a playmate role. However, once she saw how her child responded to the playful voice and settled into his skin, she became more willing to be disinhibited with him this way. This aided the family therapy so that the son would become engaged and stay interested in the emotional processing that later followed. Just as importantly, it also brought a joyful affect to mother and son as they both worked to rinse the residue of daily stress from their systems, and connected with a light-hearted tone.

I also identified an appropriate peer client at school to facilitate dyad play with the son so he had an ally on the playground. This peer did not need to be superior, and they were able to cultivate a friendship that they both truly enjoyed. Therefore, being pulled from unpreferred tasks for dyad play therapy was mutually enjoyable, and safety on the playground increased through allyship. To anchor the social support they had crafted together, I brought in preferred materials (Legos) for them to build together and show off their completed models, which they then used for show-and-tell. We did some somatic explorations while they played: "Wow, how does your belly feel as you put this complicated part together and see it working?!"; "Ooooh, I see how patient you are being by taking a pause and a big exhale on that hard part; way to go!"; "I love how you are each helping each other find the pieces you need to do your parts together; how does that feel in your heart knowing you are such helpful friends to each other?" I also made sure to give them time together uninterrupted on the playground equipment to release any stress that might have been brought up through emotional proximity before returning to class. This friendship developed into a playdate relationship after school over time.

Sympathetic Branch of ANS

As trust and safety grew over months, this clinician moved from grounding in safety and stabilization toward initial forays into Herman's second phase: trauma memory processing. While still emphasizing safety and stabilization, I gently probed themes of loss and challenge evident in the family history. Emphasizing pride in the son's continued effort in all areas of his life, I also began to inquire what he wished were easier. Using play to draw out wishes about his ideal friends, ideal teacher, and an ideal place to be free with his mom and brother, we invited the embodied experience of confidence, joy, and connection. We found ways for him to move toward those circumstances where possible. We then anchored these positive feelings with various activities to cross the midline rhythmically using Dennison's Brain Gym (Dennison & Dennison, 1986; Nussbaum, 2010) and EMDR principles (Beckley-Forest & Monaco, 2020): playing catch, walking while looking for interesting sticks and rocks, and engaging in balancing challenges on the playground.

Aside from his dyad play therapy partner, I began taking the son to a horsemanship therapy center where I volunteered. Bringing carrots and earning the privilege to enter the stalls because he followed the rules, I used equine-facilitated therapy to help regulate and soothe this sweet boy in proximity to large and imposing animals with whom he wished to have ongoing contact. While he never decided he wanted to ride, he did love getting to feed and pet the horses. To see his face light up when they clearly recognized him, whinnied to greet him, moved toward him, gently took the carrot from him, and let him hug them, was exquisite. Incorporating cross-midline movements, we would rhythmically groom and pet the horses and watch them run in circles in the arena. We also incorporated grounding sensory awareness explorations, such as deeply smelling the horses' skin, placing our ears on the barrel of their chest and belly to listen to their heartbeat and digestion, and sharing how it felt to brush their tail and mane compared to their body.

These mostly nonverbal sessions were a perfect reward for the boy moving toward what he wanted, taking risks in play to show and tell me what he hoped for, and then having a direct lived experience with it in his responsible assertion of will. He was naturally calm and alert around these large animals, as his survival instincts told him to pay attention. However, having a responsive guide who had built trust with him over time showed him how to approach and respect his boundaries around not wanting more contact than petting and feeding. It empowered his sympathetic nervous system to

approach the animals with increasing confidence, knowing his safety and comfort would be honored and prioritized. He began to feel very proud of himself over time, which showed in how he talked about helping the horses to his classmates, teacher at school, and his mother. She eventually assented to joining him with the horses a few times, and she began to shift from parasympathetic imbalance in that intervention. In family equine-facilitated therapy sessions, we began discussing how the family lineage had a great and storied relationship with horses as part of their survivance from white invaders and how the partnership between their ancestors and these animals continued to live in their bodies. Calling in the ancestors in this way was intentionally used to build more resourcing, support, pride, and connection. It also clearly moved his mother to feel more supported.

Parasympathetic Branch of ANS

Once significant rapport had been built, and the mother's parasympathetic shutdown began to unfreeze, she shared privately about the boy's father leaving them when he learned about the pregnancy. She did not believe there was anything traumatic about this, although she knew her child was sad about not having a dad. Because there seemed to be some dismissal, and perhaps numbing, about this loss, I took my time unpeeling the layers and expected that more would reveal itself over time as trust and safety grew. I expanded the empathic space for the mom to process each time she took the risk to share about an abandonment or betraval, naming the loss and normalizing the need for consistent and reliable support. She was initially understandably guarded about these vulnerable themes, and it was clear I would need to be very patient, touching on each wound to help the family system process each one in its own time.

Mom's parasympathetic coping showed up in a collapsed acceptance of the series of abandonments that led to her single motherhood of two children (one grown) by different fathers, having to live in Section 8 housing where drive-by shootings happened not infrequently, and losing a series of jobs due to her youngest child's ongoing suspensions from school. She was then on Social Security and losing hope that she would be able to hold a job due to her child's special needs, which made it difficult for her to show up for work reliably. She wanted to return to work badly for social support and financial independence but had no energy left to "fight" or maneuver for this eventuality. She was still functioning vegetatively, but her understandable fear for her child's future and her personal isolation appeared to be pulling her deeper down into depressive stillness, protection of her vital organs, avoidance of demands on her system by not taking her son out into the community, and not seeking financial support from the boy's father. She appeared resigned to her fate, with limited available affective and behavioral options.

Her flatness and detachment were understandable. They also impacted her ability to engage her child in the ways he consistently needed. It was unclear to me how early in his life this dynamic had begun, but something shifted in her once we began our family sessions with the horses. She began to negotiate with her landlord to see if they could adopt a cat as comfort for them both, and she hoped that having a pet who reliably soothed her son could help stabilize his moods and perhaps reduce the suspensions that made it impossible for her to keep a job.

Moving Up and Down the Polyvagal Ladder in a Session

In retrospect, she probably should not have said anything to her son about negotiating to have a pet in the apartment. His hopes were pinned to an outcome beyond their control. Ultimately, she was told they would not be allowed to have any pets. Her fear of her son's reaction to this resulted in her asking that this news be delivered in the relative containment of the psychiatrist's office with me present. I believe she wanted multiple supporting witnesses to help contain her son's rage and have insight into her difficulties reconnecting him to the surrounding environment when he became enraged.

Though the adults had spoken ahead of time and prepared for this in-office delivery of bad news, we could not fully prepare for how the child reacted when he learned he would not be getting his deep dream fulfilled. He rose from his seat in the psychiatrist's office, leaned over his mother to scream at her, and stormed out down the hallway. He looked for an empty office, entered, slammed the door, and began throwing everything in it against the walls. Sandtray, computer monitor, and bookshelves were lifted and tossed. Mother and child went from socially engaged to the son in fightor-flight, while she was mostly frozen in terror. A show of force naturally arose in the office, and my supervisor whispered, "This is why we have insurance." We let the tantrum run its course and took our time to re-approach the child in a non-shaming way to soothe him for the deep grief that had overtaken him. Something clicked for me while I saw the pattern unfold.

Perinatal Assessment

After the crisis had passed, I reassured the mother that we would meet individually before I had more time with her son and with them as a family. I then reflected on the pattern and processed it with my supervisor to prepare for my meeting with her. In that next meeting, I asked permission to explore her pregnancy and birth further.

Through gentle inquiry, she was able to tell me that in addition to her partner leaving her when she shared news of her pregnancy, she and this son had a traumatic birth. In addition to being stressed and depressed throughout her pregnancy, she was alone in the hospital through a 36-hour labor before a cesarean section was ultimately performed. When the doctor went to pull the baby out, he could not because the umbilical cord was only four inches long. Therefore, mom and baby had labored for a full day and a half, with no hope of the baby giving birth naturally without mom likely dying or needing extensive surgery to repair the blood loss though this was not known until the emergency surgery was performed. The doctor shared that there had likely been oxygen loss to the son's brain due to this prolonged distress.

Learning this piece of the family's trauma history, I was able to intentionally create a treatment plan for the repair of the overwhelm between them and for the son as he navigated needs, desires, and completions of cycles in the world. We continued with the same forms of individual, family, and dyad play, equine-facilitated therapy, rhythmic midline movements, and sensory awareness. However, we began to focus on trauma memory processing by breaking down and taking in small bites the steps necessary to move toward a goal, staying deeply connected with the fear and frustration that would get activated, and pausing to reconnect over and over. We processed grief over goals that could not be achieved, and looked for alternate ways to meet the needs for repair.

In following Herman's tri-phasic model and setting up a container for traumatic material to arise with support, I learned that the mother and son's nervous systems were getting stuck in different branches of the ANS. The mother's abandonment by the boy's father could rightly be defined, and may have been read, as a betrayal trauma by both of them. This understandably led to depressed flattening and exhaustion, falling back into survival instincts that slow the heart rate and reduce blood flow to preserve life and limb.

Having the fight knocked out of mom is something her in-utero son could probably sense, even though he likely could not make rational meaning out of the feeling. The absence of meaningful, ongoing, logistical and emotional support throughout the pregnancy resulted in a host of negative feelings, all rooted in fear. Furthermore, this little fetus was not free to move about and reorient himself, explore, and avoid unwanted stimuli within the tight radius of a four-inch umbilical cord. He was unnaturally bound to a particular location, and as he grew bigger, he was forced to stay in a particular orientation while his world shrank around him. The sense of helplessness and vulnerability many fetuses feel was probably exaggerated for this little one.

Then, through this stressful and scary developmental period, though certainly tinged with hope, the birthing process was so different with this son than it had been with the mother's firstborn. Having no personal support, and no loved ones present, she had to depend on professionals to make all the decisions as her labor carried on, and her baby was stuck in distress. Depressed birthing mothers have a more challenging time asserting their needs and preferences in childbirth (Dalke et al., 2016; Patel & Wisner, 2011; Vigod et al., 2016), and this mother said she did not feel she had the right to ask for help. The absence of a reliable support system fostered a passive dependence on those assigned to assist her during this highly demanding process.

It is easy to imagine that the baby felt the impact of this abandonment. Between his ongoing inability to progress toward the cervix and the lack of support for his mother to feel safe in childbirth, development, and birth were more death-defying for this little one than for a baby with a full-length umbilical cord. While it cannot be known precisely how much frustration was built into the limitation of movement as the pregnancy progressed, nor how much oxygen loss he may have suffered during this overwhelming fight to be born, neuropsychological tests suggested sustained brain damage that created panic at the onset of confusion.

Trauma Treatment

This confusion and growing panic would, understandably, arise in novel circumstances and in the face of academic demands and social rejection. We thus worked on expanding pattern recognition of developmental tasks to approach them in a regulated fashion over and over. Following the wisdom of Bruce Perry's Neurosequential Model of Therapeutics (NMT) (Barfield et al., 2012; Hambrick et al., 2018; Perry, 2019), I used repetition to calm and regulate the boy's brain and nervous system by arranging predictable session times, start and finish rituals, and choice points within the preferred range of activities for each interaction. I also worked with his school staff to break down new tasks following the principles of NMT and to prioritize scaffolding social support in the classroom so it could be carried out to the playground. I provided the school staff with psychoeducation about the social nervous system and how to minimize circumstances that could lead to self-protective rage activated by the sympathetic nervous system. I highlighted circumstances that might lead to parasympathetic "freezing" and ways to gently join and engage the child smoothly so that he could slowly re-engage toward balance in all three branches of his ANS. We co-developed a "sensory diet" of regulating embodied activities, which we added to a picture card that the boy could point to as needed throughout the school day. This helped empower him to reveal his needs and have them met promptly when he was away from his mom (Pingale et al., 2019).

In family therapy, we increasingly focused on the grief and loss that mother and son were learning to live with. After joining the few equine therapy sessions with her son, the mother moved out of her protective flatness of affect and predominantly parasympathetic presentation. She began to show more balance in her sympathetic nervous system, as evidenced by more access to her emotional pain and process. As she shared her hopes and wishes for her son, she was also able to say she was sorry for how hard things were for them, and to show her grief in an emotionally present way. Her son clearly felt very connected to her once they began talking this honestly about their feelings; he would lean into his mom, give his weight over to her, and let her hold him while she warmly stroked his arm and hair. This emotional sharing and physical co-regulation returned them to their social nervous system. We anchored these family sessions with adventure and experiential exercises to expand their relational repertoire of new challenges they could take on together.

Due to the themes of loss beyond the family's control, termination was carried out with great care and intention and included the entire interdisciplinary care team. We titrated sessions down slowly to assess the boy's response to the reduced frequency. We scaffolded more community support through sponsorship of the YMCA as a healthy outlet for the family. We also established an agreement with the horsemanship center that the family could continue coming to feed and groom the horses on their own schedule. Follow-up calls with mom after termination clarified that the dyad partner playdates were continuing, so social support had stabilized, and that she and her son were taking advantage of both the YMCA membership and horsemanship center visits. Finally, she was able to obtain and keep a part-time job, which increased her financial independence and social support. Her son stabilized at school and was able to keep progressing with special education support.

Conclusion

Had this family's perinatal trauma been known or shared at the time of referral, I would not have needed as much time to join, build rapport, and begin treatment planning. I share this case because it is human nature to block trauma. Clinicians often need time to prove our embodied safety for and with our clients, especially those sent to us somewhat against their will. We need to take our time to become reliable co-regulators of their ANS, to learn of the multiple stressors they must cope with, and to hold that context empathically so they can begin to explore it in their own time. We also need to appreciate their incredible resilience and history of strength, however they survived to be here today, and find culturally responsive ways to celebrate and connect to that resilience so that it becomes a conscious resource. As their embodied expression of stress and coping is revealed, we may witness new patterns in contrast to patterns that seem to emerge from the youngest, most fragile moments of their lives. As we prove our trustworthiness to bear witness and soothe their most current fears and self-protective actions, they may slowly allow us to descend the polyvagal ladder with them to the core wounds. Each individual and family needs us to follow their pace and find ways to build their regulatory capacity while unpacking what was overwhelming at any point in their development. Learning how to work with the body's survival responses and calm them requires reliable, culturally responsive, developmentally appropriate support, and working with the support system and community resources as available.



Karen Roller, PhD, MFT, has focused on fostering secure attachment for underserved families since 1998. During her Somatic Psychology program at Santa Barbara Graduate Institute, she was introduced to Pre-and-Perinatal Psychology, which demystified many trauma reactions impacting bonding, co-regulation, self-regulation, and overall mental health. She began exploring ways to gently open early, vulnerable activations in close proximity between parents and children to help cultivate

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