# ACCEPTED MANUSCRIPT



Sitting on the edge of an abyss together – A methodology for working with hypo-arousal as part of trauma therapy

Abstract:

Hypo-arousal—or collapsed immobility—has been identified as a natural human survival reaction. In traumatic situations, hypo-arousal can be a functional solution to extreme impact; it can help us survive or prepare us to die. When we survive, the challenge becomes multifold: how do we exit the collapsed state; how does the autonomic nervous system up-regulate; and how do we integrate the experience of collapse in our perception of ourselves and of life?

In this article differentiation of degrees of immobility and parallels and differences between dissociation and hypo-arousal are discussed to clarify a methodology for clinical work with hypo-arousal.

Two examples (client and supervisee) demonstrate how low-dosed muscle activation and establishing a relationship to the experience of collapse, can build capacity in both client/supervisee and therapist to stay present on the edge of hypo-arousal, instead of being pulled into it and either over identify or struggle with it.

Key words:

Hypo-arousal, collapsed immobility, up-regulation, dissociation, survival reactions

## Introduction

What is hypo-arousal and what challenges are embedded in working with hypo-arousal in trauma therapy?

Hypo-arousal has been identified (Hodgetts, 2013; Ogden & Fisher, 2015; Porges, 2011; Siegel, 1999) as one end point of the natural extremes in human survival reactions. References include: Collapsed immobility (Baldwin, 2018; Kozlowska et al., 2015); hypo-freeze (Rothschild, 2017); dorsal vagal activation, immobilized, collapsed, shut down (Dana, 2018; Porges 2017); hypo-arousal (Ogden & Fisher, 2015; Porges, 2011). All describe a strong activation in the parasympathetic branch of the autonomic nervous system (ANS) including bradycardia (slow heart rhythm) (Baldwin, 2013; Kæreby, 2010; Rothschild, 2017) – a reaction that takes over when active sympathetic survival-reactions like fight and flight do not bring us out of stressful impact (Kozlowska et al., 2015). I use the word hypo-arousal because it names the phenomenon as a specific arousal-state connected to the ANS, which makes it easier to differentiate from other types of freeze/immobility and from dissociation.

In traumatic situations, hypo-arousal can be a functional solution to extreme impact (Baldwin, 2018; Kozlowska et al., 2015). Within the hypo-arousal reaction, our physiology slows impacting our heartbeat and breath; energy is redirected from outward reactions to basic survival needs. The opioid-system is activated—we anaesthesize ourselves with natural opioids (Kozlowska et al., 2015; Weeke, 2018). Hypo-arousal can thus help us to survive or prepare us to die.

When we survive, the challenges involve emerging from the collapsed state, supporting the ANS to return to its natural oscillation between sympathetic and parasympathetic activation in a normal arousal-level, and integrating the experience of collapse in our perception of ourselves and of life.

Thus, when approaching hypo-arousal we are challenged by emotional contagion and automatic reactivity in the ANS (Brantbjerg, 2018; Keysers, 2012; Schore, 2015). Based on my experiences as a trauma therapist, I hypothesize that hypo-arousal is a potent state that can challenge our capacity to stay bodily present and to mentalize the experience. We can easily be pulled into a collapsed state or defend against it both within ourselves and in relationship to somebody else. A typical challenge for clients and sometimes therapists is to not fall asleep or sink into exhaustion and be unable to mentally and/or emotionally process when facing hypo-arousal.

The methodology described in this article was developed in trauma therapy training-groups, with people who have resources to attend and learn. Furthermore, the methodological principles are used in supervision with therapists who are working with highly traumatized clients to both support the therapists and to find strategies for working with their clients. The process focuses on building bodily resilience and

developing empathic resonance including mentalising capacity in relation to hypo-arousal with the goal of supporting the inclusion of the collapsed state as a normal survival-reaction, online with flight and fight.

## Differentiations in the continuum of arousal states in relation to core concepts

### Hypo-arousal and immobility states

Hypo-arousal is one of a number of immobility-states awakened as reactions to threat. Immobility can show up in the early phase of reacting to stressful impact, noted as attentive immobility (Volchan et al., 2017) or freeze-alert (Baldwin, 2013). When detecting something that could potentially be threatening, we become attentive and orient to the threat; simultaneously we stay still to avoid detection (Kozlowska et al., 2015; Volchan et al., 2017).

Immobility can show up during an attack; people may freeze—fight-flight reactions halt (Kozlowska et al., 2015; Volchan et al., 2017). This immobility-state is also named freeze-fright (Baldwin, 2013) and hyper-freeze (Rothschild, 2017). Sympathetic activation is still present under the immobility when we freeze, so if the threat diminishes, flight, fight, or other active survival-impulses can come to the foreground.

Tonic immobility and collapsed immobility are described by Kozlowska et al. (2015) as a last resort to un-escapable threat; they define the difference based on muscle-system reactions. Tonic immobility appears as a waxy hyper-tonicity, whereas collapsed immobility or hypo-arousal includes loss of muscle tone (Kozlowska et al., 2015). Others do not differentiate between tonic and collapsed immobility; rather, they name the last resort to un-escapable threat: hypo-freeze (Rothschild, 2017); dorsal vagal activation (Dana, 2018; Ogden & Fisher, 2015; Porges, 2011; Siegel,1999); or collapsed immobility (Baldwin, 2018).

The focus of this article describes methodology related to collapsed immobility/hypo-arousal. Further exploration would be necessary to discover possible differences in methodology with tonic versus collapsed immobility.

In hypo-arousal, the sympathetic activation is not on hold. The ANS drops into a state with just enough sympathetic activation to stay alive with a predominant activation of the dorsal vagal part of the parasympathetic nervous system (which regulates visceral organs below the diaphragm and connects to the heart and lungs) (Porges, 2017; Rothschild, 2017; Siegel, 1999). Hypo-arousal can show up in different degrees – going from withdrawal, sleepiness, apathy, passivity, and into the extreme of feigned death, fainting and serious bradycardia. Rothschild (2017) differentiates two degrees of hypo-arousal: Lethargic and hypo-freeze. The lethargic state is seen in slack muscles, shallow breathing, slow heart rate, withdrawal from contact. Hypo-freeze is seen in flaccid muscles, hypoventilation, very low bradycardia and blood-pressure, contact is not possible. If a client drops into hypo-freeze, Rothschild (2017) points to the relevance of seeking medical assistance. Lighter degrees of hypo-arousal are described as being

workable by bringing energy into the body. The degree of hypo-arousal met clinically may likely depend on the type of clients we work with. In this article, focus lies on the degree of hypo-arousal that can be negotiated through slow, careful, low-dosed interventions.

Hypo-arousal and dissociation

Another relevant differentiation is between hypo-arousal and dissociation. The concept of dissociation has transitioned through many phases of discussion beginning with Pierre Janet, Jean-Martin Charcot and Sigmund Freud (Loewenstein, 2018). The connection between dissociation and trauma has been intensively discussed; different professional viewpoints of dissociation remain (Ataria, 2015; Burton et al., 2019; Loewenstein, 2018). Dissociation can be conceptualized as a continuum from normal to pathological with states of absorption and spacing-out at one end and severe dissociative disorders at the other (Loewenstein, 2018).

In 2013, a dissociative subtype of post-traumatic stress disorder (PTSD) was included in the DSM 5 (Burton et al., 2019), which "reflects an initial and important step in formally recognizing the clinical, empirical and conceptual link between dissociation and PTSD" (Dorahy & Van der Hart, 2015, p.17). On the other hand, naming the second subtype "dissociative" is being questioned given that dissociation can be said to be characteristic of all PTSD.

This discussion matters in terms of differences between the concept of hypo-arousal and dissociation. If dissociation is present in all kinds of PTSD it clarifies that dissociation can be connected to both hyper- and hypo-arousal symptoms and that the arousal-states in themselves are not the same as dissociation. Dissociation is a more complex phenomenon than arousal-states. It can include experiences of depersonalization, derealisation, emotional numbing, flashbacks of traumatic events, absorption, amnesia, and more (Lanius, 2015). According to Dorahy and Van der Hart (2015), dissociation includes both positive and negative dissociative symptoms that manifest as psychoform and somatoform experiences. Lanius (2015) summarizes that all theoretical constructs and observed clinical presentations of dissociation seem to centre around trauma-related altered states of consciousness (TRASC), and that these states can be further classified along four dimensions of consciousness: Time, thought, body, and emotion.

The dimension of emotion, and with that the concept of dysregulation of emotion after trauma, is relevant in connection to working with hypo-arousal. Lanius et al. (2010) differentiate hyper-aroused reactivity— connected to emotional under-modulation—from hypo-aroused over-modulation—emotional numbing, shut-down, immobility.

Based on my clinical experience, I hypothesize that hypo-arousal is the predominant arousal-state in the type of dissociation present in the dissociative subtype of PTSD and that emotional overregulation is involved in this. Further, fight, flight, and other active survival-reactions including freeze are the predominant arousal-states in the traditional hyper-aroused subtype of PTSD, which includes emotional under-regulation.

These two distinct different types of post- and peri-traumatic reactions point to the benefit of different methodology given that the regulation in ANS is either focused on down-regulation or up-regulation and that different types and degrees of dissociative symptoms can show up in these processes (Lanius, 2015).

Sitting on the edge of an abyss together: Suggestions for methodology to approach and explore hypo-arousal

The differentiation between attentive immobility and freeze as fight-flight-on-hold on one side and hypo-arousal/collapsed immobility on the other is essential in terms of trauma therapeutic methodology. When flight-fight and other active survival-impulses are on hold and thus available when threat lessens, a trauma-therapeutic method can focus on how to support the body to get out of the state of freeze and then explore, complete, and release the underlying active survival-reactions ( Jørgensen,1993; Levine, 2010).

The concept of completing and releasing impulses however does not match the state of hypo-arousal. When active impulses are not on hold under the predominant parasympathetic arousal there is nothing to complete or release.

Ataria (2015) points to “one’s knowing how structure collapses” when we go into immobility and that the stronger the freeze response, the bigger the loss of skills including both sensorimotor and action-perception skills (p.6). This suggests that an extensive loss of both cognitive and bodily skills is happening in hypo-arousal. Integration and regulation of hypo-arousal depends on accessing some of these skills before approaching the experience of hypo-arousal to reduce the risk of drowning in the experience, which does not bring integration.

With hypo-arousal, the challenge is how we invite the ANS into up-regulation from a very slow bodily rhythm, and how we, as both clients and therapists, relate to this slow rhythm.

Typical elements in approaching and exploring hypo-arousal

1.Acceptance and normalization of hypo-arousal supports approaching it without being pulled into the collapsed state or polarizing to it by trying to push for active outgoing impulses to become available or trying to avoid the collapse. This involves psychoeducation regarding expected reactions in the ANS following extreme impact.

2. Establishing a boundary between oneself in a conscious state (witnessing, being conscious of) and oneself in the hypo-arousal-experience supports approaching the collapsed state. This boundary can be supported both mentally and bodily:

a) Mentalizing the state: understanding the collapsed state as a normal reaction to extreme impact, knowing that it is an experience likely connected to a historical

traumatic event can start the process of establishing a relationship to the state instead of being it or fighting it (Fonagy et al., 2002).

b) Bodily: working with low-dosed activation of muscles and connective tissue can support the building of the boundary (Brantbjerg, 2012, 2020). If hypo-response (giving up) in muscles and connective tissue is modified, more energy becomes available in the body to support presence in the here and now, and with that it becomes possible to approach and start exploring the experience of collapse with curiosity (Brantbjerg 2020, 2012). The smaller an activation, the more likely that it happens in connective tissue rather than in muscle-tissue. Connective tissue activates when we mobilize to move before we actually move. Levine (2009) uses the concept "intentional movements" and sees them as a central component in trauma-patterns.

3. Relating to hypo-arousal together instead of trying to contain it. Modification of hypo-response and establishing a boundary to the arousal-state supports the capacity of staying in contact with oneself, and from there also with somebody else in the here and now, opening the possibility of two people facing and exploring the experience of hypo-arousal together, for example client and therapist. The focus is not to get the client out of the collapsed state nor contain it. Trying to contain a collapsed state risks taking us too close to it and with that into losing skills and capacity to integrate. The focus is to build-up enough resources to be close enough to and far enough away from the collapsed state to be able to explore it together with someone, get to know it and thus integrate it.

4. Naming and picturing the experience of collapse. What does the experience of hypo-arousal look like or feel like? Typical words that clients use include: "a bottomless well", "falling into an abyss", "hibernating like an animal", "losing the grip of everything known", "lost in wilderness", "being in a desert" etc. Accompanying emotional experiences are often hopelessness, powerlessness, in a void, exhausted, gone, dissolved etc. Naming experiences and seeing them as part of the overall hypo-arousal-state can support separation from being identified with or drowned in the emotional states and rather becoming capable of relating to them.

The boundary between hypo-arousal and the conscious self is supported when picturing and naming the experience instead of going into the experience. It becomes externalized in an image and in descriptive words. The title of this article: Sitting on the edge of an abyss together, is an example of this kind of imagery. This aspect of the methodology is in line with the tradition of creative visualization (Holmes, 2010).

When working with these elements, signs of dissociation often show up. Loss of orientation in time, loss of words and/or sensation, sudden outbursts of emotion, body-sensations including pain can emerge, sudden access to memories, flashbacks etc.

With signs of dissociation, the speed of working benefits by slowing way down. Staying on the edge where these phenomena emerge, not going for solutions, including the information that becomes available bodily or in the mind, are the functional principles. Speeding up or trying to solve the phenomena risk worsening the dissociative symptoms.

The same goes for establishing a boundary to hypo-arousal. Some clients do not have enough skills to do this directly, but the therapist, being aware of a boundary to hypo-arousal can make a difference and can over time support the building of a boundary in the client.

The alternative to *releasing and completing active survival-reactions* thus becomes *establishing a relationship to hypo-arousal* and *sitting on the edge of the collapse together.*

The following client and supervisee examples will exemplify how the elements described can be used practically in a psychotherapy session and thus create a foundation for further intervention.

**Client and supervisee examples: Richard and Brenda**

The following anonymised examples are shared with written permission. The supervisee (Richard) and the client (Brenda) have many resources and function in life; they also have, to different degrees, areas of their lives challenged by unregulated arousal-states and post-traumatic stress. Notes taken directly following their sessions augment my presentation. I have discussed these sessions with my co-trainer, with whom I developed the methodology. I follow the EABP's code of ethics.

**Richard**
At the time of this session, Richard had been in supervision in my clinic in Copenhagen for six months. We had monthly sessions focusing on his trauma-therapeutic work at an institution offering psychotherapy to clients dealing with addiction and PTSD. Richard had taken over clients from a psychotherapist who had stopped six months earlier when Richard got the job. The case he brought into supervision was one of these clients.

Richard presented a female client as having symptoms of high degree of numbness, passivity, collapsing inwards. Her symptoms worsened during the transition. Richard was challenged; he felt desperate. Lacking a way to connect with his client he became polarized to her by trying to exit her passivity. Richard used movements in his arms and hands several times indicating a downward collapse in the client's body, where "the bottom goes out".

I named my hypothesis that the client was in a state of hypo-arousal, and that she had a strong degree of hypo-response in her centre area and pelvic floor, based on the

movements Richard showed. I normalized that hypo-arousal has a strong impact on everybody present, including me, the supervisor. Richard started relaxing more. The conceptualization of hypo-arousal helped him to start separating from the client. He came into contact with me, feeling met when I named that I also experienced the emotional contagion of hypoarousal. In relation to what to do, he still felt desperate.

I suggested we explored bodily presence; Richard accepted. The exploration focused on which areas in his body had gone flaccid (hypo-responsive) while talking about his client. Richard discovered that he had lost contact to his own pelvic floor and to the front side of the trunk. By using low dosed activations in these muscle-groups, (Brantbjerg, 2017) energy was brought back into the bodily container. I made the muscle-activations together with Richard to support my boundary to the hypo-arousal energy.

Richard came out of desperation activating his pelvic floor just a little. He felt centred in himself again, separate from his client. With more skills available – both bodily and cognitively – we focused on his client. More empathy was available to Richard and more realism in relation to what was possible with this type of client. We could sit together at the edge of the client's collapse, look at it without feeling threatened by it, and think about possible therapeutic strategies. The polarization and with that the push for getting out of passivity was gone.

**Brenda**

Brenda had attended several workshops with me; she found the focus on modifying hypo-response helpful and gained hope in relationship to a long-term struggle with exhaustion. Integrating the workshop material, Brenda worked on her own using low dosed muscle-activation to support her in daily life. When stress heightened in the early phase of the corona virus crisis, she dropped into hypo-arousal and exhaustion. She now wanted help in relationship to these reactions. Our therapeutic relationship was established in the workshops, which made it easy to start working individually.

This was our first session in my clinic. We started with clarifying our focus. Brenda presented her situation as a defeat – she had lost hope again when she dropped back into hypo-arousal. She blamed herself for not being able to "solve" or "release" her collapse. I offered a different thought: hypo-arousal is a state that cannot be solved or released. We can train ourselves to establish a relationship with it, and thus make peace with it as part of our survival-reactions.

This reframing was relieving for Brenda. She accepted it and with that it was easier to make a realistic plan for our session. I offered to teach her skills to help us start establishing a relationship to her hypo-arousal and from there get to know the state as it is. Brenda accepted this.

I started with gathering information about the history of Brenda's hypo-arousal symptoms. She had experienced a sense of serious burn-out at her job six years ago, and she was still in the process of recovering from it. Part of the burn-out symptoms

were stress-reactions in her digestion-system, symptoms that had been in her body on and off since her parents divorced, when she was 4 years old. This information told me that Brenda's hypo-arousal-symptoms were old, probably going all the way back to the overwhelm of her parent's divorce and that it had never been integrated or regulated, thus it could be reactivated when stress reached a certain level of intensity.

We then – on my invitation and her acceptance – explored which micro-activations would be supportive for her in the here and now. She discovered an impulse to stretch her body by pushing her feet into the ground primarily with the inside of the feet (Brantbjerg, 2020, 2017). More energy came into the front side of her body with the inside activation; she then discovered how the stretching movement can end in the neck elongating – a small movement that activates muscles on the front side of the throat. Her front side felt more gathered, more relaxed, and she felt a completion of energy rising through her body when the neck worked along. The activations were micro-small. I guided Brenda to do the movements without any feeling of push or hard work. The activations were barely physical, more just a thought or an intention of moving.

We now had a better platform from which it could be possible to approach the experience of hypo-arousal. Both bodily and cognitive skills had been built; we also spent time on establishing a sense of contact with each other in the here and now.

I then invited Brenda to look at the state of hypo-arousal. I asked her how the state looked. She first got a picture of herself as a 4-year-old lying immobile on the floor. I asked her to not go into this memory but focus on the experience of the hypo-arousal state itself. I asked her how the state looked. This brought her to a black and white picture of a desert, totally still, no movements. Brenda was surprised and satisfied with the picture. Looking at it supported her in separating from the experience of collapse and still acknowledging it. I asked her if she wanted to hear some of my versions of images of hypo-arousal. She said yes, and I shared an image of endlessly falling into an abyss or a bottomless well, experiential qualities I know from my own integration processes of hypo-arousal. We slowed way down, feeling the impact from the images. We were in contact on the edge of the experiences, sharing the knowledge that they exist and that we could relate to them together. This was touching for Brenda, and for me as well.

The sequence just described happened in a slow speed, with many silent moments, waiting for information or words to emerge, negotiating between an old pattern in Brenda of being totally alone with the experience and a here and now experience of being close to it together with another human being.

I asked Brenda if she was ready for one more step. She took time to sense into it and said no thank you. Her body had had enough and wanted to rest and integrate. She wanted time to stay with the experience of relating in an entirely new way to her hypo-arousal and let the experience of doing it in relationship sink in. I see this as an

important element in the session – a step out of a pattern of pushing to get somewhere and into listening for the speed that supports healing and integration.

## Discussion

These clinical examples show how the suggested elements of working with hypo-arousal can be used therapeutically. I highlight the following elements in terms of uses, outcomes experienced, and possible next steps.

### Bodily regulation through low-dosed muscle-activation

The low-dosed muscle-activation in a micro-version is used in both cases to support separation from the experience of collapse, staying in contact in the here and now, and establishing a relationship to the experience. When being close to or inside hypo-arousal, working with muscle-activation benefits from being very low-dosed (Brantbjerg 2012, 2020). Micro-activations – barely moving, sometimes only thinking a movement – is enough to start an activity in the sensory-motor system. Working with micro-activations makes it possible to bring in activation without polarizing to the collapse – bringing in just enough energy so it becomes possible to separate between you being collapsed or being close to the experience of collapse. The intention in the activation matters. The goal of the activation is not to get away from the collapse – the goal is to activate the body with the intention of staying present while including the collapsed state in the awareness.

### Verbal interventions

In both cases, the verbal contact and conceptualization around hypo-arousal mattered. Brenda's judgmental thinking around her hypo-arousal-symptoms represents a normal pattern. We often distance ourselves from parts of us that we cannot handle and that we risk becoming a victim to. We may judge these parts, avoid them, fight with them etc. Fighting with our own or other's hypo-arousal often includes thought patterns where the risk of dying and hypo-arousal are not separated out. We may think or assume that going close to hypo-arousal is the same as dying. Negotiating with these patterns is a first step in being able to approach and explore hypo-states in general (Brantbjerg, 2012, 2020) and hypo-arousal. Knowing how to negotiate hypo-response in the body can be an important step in taking us out of a victim-position to unregulated hypo-arousal. And with that it becomes easier to let go of fight and judgment and start approaching with curiosity, into discovering that I am alive in a very slow rhythm inside the experience of hypo-arousal.

Hypo-arousal easily induces feelings of helplessness and hopelessness both in client and therapist, which is what happened in Richard's case. Knowing how to bodily move from being identified with, trapped in, or fighting with the collapsed state into building up enough energy in the body to be able to relate to the experience of collapse including the emotional qualities embedded in it, can support moving out of feeling victimized. It can open an experience of hope and making peace with the collapsed parts of the self.

Focusing on the experience of hypo-arousal – not the story.
When Brenda's childhood memory arose, I asked her to let go of focusing on the memory and focus on the experience of the arousal-state itself. This intervention builds on experience showing that going for mutual regulation and integration of the arousal-state itself is more empowering than going into the trauma-history. The story still matters. It is a question of when and why to focus on it; a topic that lies outside of focus of this article.

My primary focus when working with trauma is to normalize, include, and support regulation of the entire spectrum of arousal-states including both hyper- and hypo-arousal, and with that bring the ANS back into functioning with a natural swing between sympathetic and parasympathetic activation. This process is supported by mutual regulation of all the arousal-states, which points to the role of the therapist.

Mutual regulation – the relational aspect of working with hypoarousal
In both cases I worked along with the clients. I openly named to Richard that I also get impacted by hypo-arousal. I participated in micro-activations in both cases. I offered my versions of experiential qualities of hypo-arousal to Brenda. I positioned myself "in the boat" together with the client where whatever arousal-state the client was presenting could be shared and mutually regulated. Taking this position as a therapist is a core element in relational psychotherapy (Benjamin, 2018; Rolef Ben-Shahar, 2014) where the emphasis lies on offering a here and now contact with attunement, limbic resonance, and willingness to co-regulate (Brantbjerg 2020, 2018).

When working with hypo-arousal, the therapist's job is to be willing to share and explore the experience of hypo-arousal with the client in a way that leads to co-regulation. The job is not to get the client or ourselves out of the collapse but to make peace with it and to be able to relate to it and include it. In Richard's case, his capacity to relate to the client grew significantly when he learned how to manage his own hypo-arousal symptoms that emerged in natural ANS reaction to the client's hypo-arousal.

Regulation of hypo-arousal
Regulation of any arousal-state leads to the ANS resuming a normal oscillation between sympathetic activity and parasympathetic being and resting (Dana, 2018; Stauffer, 2010). Regulation of hypo-arousal means to come from a very slow, predominantly parasympathetic rhythm, back into sympathetic impulses awakening. Experience shows that any kind of push in this process leads to polarization instead of regulation, which is a way of understanding why hypo-arousal often stays unregulated. We can jump out of or push ourselves or others out of a collapse and that can be necessary to do at times, but it does not lead to natural regulation of hypo-arousal and thus leaves us with the risk of dropping into the old collapse again. This is the pattern Brenda was facing when she asked for sessions.

Sitting on the edge of the experience of hypo-arousal together is a methodology that can lead to organic regulation. The challenge is that you cannot make it happen. We

can sit there with awareness of the collapsed state, not fall into it, be curious about it together and be curious about what happens. At some point something often starts changing organically – a little shift in breathing rhythm, a bigger in-breath, a little movement-impulse can show up somewhere in the body. And if you start exploring them – without pushing – they often lead into more sympathetic energy, impulses to do something. To support integration of hypo-arousal it is critical to not be in a hurry when the sympathetic energy awakens again. You need to go slow enough yourself as therapist and to ask the client to go slow enough, so there is awareness and acceptance of both the slow rhythm and the faster one at the same time, like swinging between them instead of escaping one by getting into the other. In Brenda's case, I mentioned that I asked if she was ready for a step more, and she said no. My hypothesis is that she stayed in contact with the slow rhythm from having been close to hypo-arousal by not taking a new step right away and thus supported the regulation of hypo-arousal that had started.

Possible steps after regulation of hypo-arousal

Next steps can be relevant and available when regulation of the hypo-arousal state has started happening. Often the client will benefit from more than one experience of "sitting on the edge" of hypo-arousal together. The boundary between the experience of collapse and the capacity to mentalise it strengthens with repetition. The results typically show a decrease in fear or judgment connected to hypo-arousal and an approach toward making peace with it. Small signs of returning sympathetic impulses will typically emerge. At that point, the loss of skills happening in hypo-arousal is no longer there or is in the process of changing (Ataria, 2015), and with that, other trauma-therapeutic methods can be used.

The next step I had in mind with Brenda was to get curious about which emotions and arousal-states came before going into hypo-arousal. This could mean focusing on her situation as 4-year-old with divorcing parents, or on the onset of the corona-crisis, or the job-situation where she ended up in burn-out. It could mean going for discovering the precise triggers that impacted her before she went into hypo-arousal and then staying on the edge of the collapse, not go there, but be curious about what happened in her body and mind right before. This process can lead into uncovering split off emotions and impulses of panicky fear, anger, rage, despair, pain, disgust etc. – emotions that often feel unbearable and impossible to regulate alone. Access to mutual regulation in the here and now with the therapist can make it possible to invite these emotions into regulation and with that, the risk of falling into collapse again lowers. The energy that was channelled into hypo-arousal as a solution to something unbearable can now be channelled back into regulation in the sympathetic nervous-system through discovering, exploring, releasing, and completing impulses.

## Conclusion

Differentiation between methodology that focuses on hyper- and hypo-arousal has shown useful. As Ataria (2015) points out, a person's capacity to recover from freeze-reactions and especially the most serious of them, probably impacts whether the person gets PTSD or not. Releasing and completing active survival-reactions is relevant when focusing on hyper-arousal-states. However, the goal in working with hypo-arousal is different given that a collapsed state cannot be released or completed. Hypo-arousal easily triggers emotional contagion pointing to the importance of developing methodology that is supportive for psychotherapists. Their conceptual and practical relationship to hypo-arousal has a strong influence on the therapeutic process. They must come first when building a bodily and mental boundary between the conscious self and the experience of collapse.

This article discussed a goal to establish a relationship to hypo-arousal, not to solve or change it, but to sit on the edge of the collapsed state together and witness the potential emergence of natural arousal-regulation. Key elements included: Normalising and including it in the map of normal survival-reactions; developing bodily and mental capacity to stay present when close to hypo-arousal so it becomes possible to relate to and explore the state with curiosity. These elements are supported by trauma therapeutic work including: Micro-activations in the body to support a boundary between being pulled into the collapse or fighting with it thus becoming capable of staying present on the edge of the experience; psychoeducation to normalize and include hypo-arousal as a survival reaction online with flight and fight; mutual regulation and making peace.

Several aspects introduced in this article are relevant for future writing including a comprehensive case study denoting the process and the role of dissociative symptoms when working with hypo-arousal.

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