The Application of the Polyvagal Theory to High Conflict Co-Parenting Cases

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THE APPLICATION OF THE POLYVAGAL THEORY TO HIGH CONFLICT CO-PARENTING CASES

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Families, litigants, lawyers, advisors embroiled in cases of complex divorce with child contact issues, manage many stressors at once. Participants involved with these types of cases are often exhausted and burned-out from the long-term battles of prolonged litigation. The inability to problem-solve or even communicate effectively reflects the chaos and traumatic stress of the experience and can be seen as a hallmark of this population. When people are consistently stressed, there is a breakdown of communication skills that can create an immunity to receiving help from any direction. Often all parties involved appear to be both hyper-alert to potential threat, and hyper-reactive to one another: no one feels safe. Stephen Porges' Polyvagal Theory is premised on the idea that neuroception plays a key role in the nervous system's ability to assess danger in the environment. Neuroception is a neurophysiological response that does not involve cognitive processing. When cognitive processing is not involved, the result may lead to misinterpretation of, and an inability to accurately assess situations: executive functioning including rational thinking and communication skills are lost to physiological response. Rather than evaluating families and individuals involved in the aforementioned complex divorce cases through the lens of pathology, Polyvagal Theory explains their behavior as an adaptive stress reaction. Utilizing Polyvagal Theory offers a promising path to treatment with these families and diminishing the poor communication and the heightened emotion, assisting practitioners in understanding the impact of neurobiological response in managing stress and trauma. Applying Polyvagal Theory to court involved populations can help both litigants and practitioners recognize the role of the autonomic nervous system, providing the opportunity to understand, to self-regulate, and to improve communication and decision making.

Key Points for the Family Court Community:

- Separation and divorce.
- The impact of Parent/Child contact problems in high-conflict divorce and separation.
- The impact of high conflict co-parenting cases on family law and mental health professionals.
- Interventions: Current practice Polyvagal theory.
- Polyvagal informed therapy.
- Effects of polyvagal approach and self regulation.
- Managing physiological response from a cognitive perspective.
- Clinical setting and polyvagal theory.
- Family therapy and polyvagal theory.
- Experiential framework and polyvagal theory.
- *Equine assisted therapy, polyvagal perspectives and alternatives.
- Processing chaos and grief.
- Other opportunities for making connection.
- Implementation for professionals.

Keywords: *Autonomic Regulation; Dysregulation; Favored Parent; High Conflict Divorce; Neuroception; Parent Child Contact Problems; Parental Alienation; Polyvagal Theory; Rejected Parent.*

I. A FEELING OF SAFETY

When people are consistently stressed by abuse, neglect, fear, or deprivation, bodily systems break down (Black, 2002). Feelings of hopelessness and helplessness interfere with problem solving abilities (Gotlib & Asarnow, 1979). Trauma, Post-Traumatic Stress Disorder and chronic stress

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generate an alertness to threat and a feeling of lack of safety in which mental processing falls second to adaptive survival responses (Williamson, Porges, Lamb, & Porges, 2015).

An individual's history, the present moment environment, and the people in that same environment will each have an impact on both the embodied and cognitive understanding of safety and will affect physiological and psychological responses to perceived danger. Parents and children involved in litigation over divorce or separation often feel threatened by impending change and worry about limited resources as one household becomes two. Lengthy involvement with the legal system is likely to perpetuate the perception of danger, and uncertainty about the future threatens a sense of safety. In response, individuals engage in one of the reflex responses pre-programmed by evolution: fight, flight, freeze, collapse or connect.

A sense of not feeling safe naturally and indeed predictably leads adults and children into an adaptive survival response. Without the lens of Polyvagal Theory, these autonomically enacted responses may be viewed as voluntary acts and often are erroneously labeled as resistance, non-compliance, or disinterest. By understanding these behaviors as adaptive survival responses and exploring the factors triggering the sense of a lack of safety, clinicians and professionals can move away from assigning motivation and moral meaning towards in favor of increased awareness, understanding, and a greater capacity to intervene effectively. Without the layer of social judgment, clinicians and professionals can help all parties experience a sense of agency, feel included in the process and cope more effectively with inevitable changes.

When parents are in conflict, it may appear to the child that no one is caring for them. This experience activates a perception of danger and an autonomic response (that is involuntary or instinctual) and the child may move into a survival mode. Children who have become polarized as a way to cope with the adult conflict may commonly report a vague sense of "feeling uncomfortable" when in the presence of the least favored parent, and some will display a real sense of fear. The very use of the word "safety" may provoke a feeling of unease and discomfort. Children who have repeatedly been told they are safe and yet do not have a subjective feeling of security often cannot trust any adult reassurance and, in order to survive, instinctively learn to *not* listen to their own internal feelings. For parents, children, and the professionals working with these families, letting go of both judgment and the need to assign blame, and bringing curiosity and attention to the cues of danger triggering the survival response is a step toward creating a collaborative process.

This article will explore emotionally volatile, separating, divorcing or divorced couples where child contact problems exist, the professionals who are affected while working with these cases, and an approach to emotional regulation utilizing Polyvagal Theory (Porges, 2011). Significantly, research suggests that a strong relationship between parents and children is even more important to the well-being of the child than the level of conflict or type of co-parenting relationship between those parents (Nielsen, 2017) and thus, the focus of the process must be on promoting safe communication and social connection. This article encourages the utilization of a polyvagal-informed intervention as an approach to shifting the internal processing and patterns of connecting of the individuals, families, and professionals involved in cases of high conflict co-parenting after separation or divorce with parent–child contact problems. Integration of this approach may enable moving from a state of volatility and conflict to one of perceived social connection and safety, promoting better quality in relationships, clearer thinking, improved communication, increased problem-solving skills, and better outcomes for children and their parents, and for the professionals who work with them.

II. SEPARATION AND DIVORCE

The process of separation is often complicated by disagreement between the separating partners. Conflict develops over finances, property, and other possessions and, for those with children, the

issue of custody (decision making) and access (parenting time) often becomes the focus of dispute. The ensuing discord and subsequent chaos contribute to an environment that appears out of control, creating further anger and disagreement. While disagreements may be managed easily when there is mutual accord, or with settlement through mediation, in approximately 8 to 10 percent of cases, couples are embroiled in high conflict divorce (Fidler, Bala, & Saini, 2013), with associated manifested behaviors such as verbal or physical abuse, parent–child contact resistance and refusal, even familial abduction. Attention to the dysregulation of all, most importantly the children, is often not addressed. When parents are unable to disengage from conflicted interaction, it falls to family court judges in the legal setting to make decisions about the children (Ayoub, Deutsch, & Maraganore, 2005). Though the effects of marital discord on children have been documented (Brock & Kochanska, 2016; Grych & Fincham, 1990), as have the negative effects of divorce on children (Amato, 2001; Grych, 2005), the literature regarding the general effects of *high conflict* divorce on children often relates to specific elements of continued dispute (e.g. custody arrangements, domestic violence, parental alienation, and parent–child contact resistance, and refusal issues [Sandler, Wheeler, & Braver, 2013; Holt, Buckley, & Whelan, 2008; Bernet, 2016; Fidler et al., 2013]). It is difficult to define, untangle or manage the chaos, confusion and anger emanating from these cases due to court involvement, myriad therapist recommendations, contradicting treatment plans from multiple practitioners, and a lack of communication between involved professionals.

A. THE IMPACT OF PARENT–CHILD CONTACT PROBLEMS IN HIGH CONFLICT DIVORCE & SEPARATION

Parent–child contact problems in high conflict divorce are complex and multi-faceted, and often leave children and their parents feeling helpless, attacked, devoid of hope, and powerless (Anderson, 2014). Children and parents, subject to numerous interviews from mental health practitioners and legal professionals often feel intensely scrutinized or judged. Children may feel torn between loyalties to parents and may feel forced to choose sides. Privacy may be compromised and, if parents are involved in mental health treatment, confidentiality may be violated as what is said in treatment is passed from one person to the next in order to produce a recommendation or come to a decision about custody or other court directed arrangements. All of this contributes to a child's diminished sense of safety and feeling unprotected, confused, and in a constant state of mobilization, shutdown or a combination of both. Parents, frustrated by an absence of clarity about their future security, often experience a similar sense of danger. Parents and children may adaptively retreat into a defensively reactive stance; the nervous system ever vigilant for cues of danger. As chronic distress becomes the norm, children and parents must be prepared for fight, flight or shut down at any moment. Behaviors, emotions and beliefs change in response to the inconsistency of approaches, court involvement, the family conflict itself, polarization of family members, the overwhelming feeling of no control, and finally, the activation of each individual's autonomic nervous system (ANS) adaptively responding to the sense of danger triggering a fight, flight or collapse response. These behaviors arise out of physiological dysregulation originating in an internal response to a lack of safety.

Neuroception as described by Dr. Stephen Porges, is detection without awareness (Porges, 2004). Not a cognitive process, neuroception is the way the ANS responds to cues of safety and danger felt inside the body, sensed in the environment, and signaled by other people. A neuroception of safety or danger leads to behaviors and beliefs that influence the way people think about the world and make their way through daily experiences.

B. IMPACT OF HIGH CONFLICT CO-PARENTING CASES ON FAMILY LAW AND MENTAL HEALTH PROFESSIONALS

In these difficult cases, judges, attorneys, officers of the court and mental health professionals are pulled into a similar dynamic as the population they serve. The chaos extends outward to

include clinicians, judges, attorneys, courts and associated practitioners, and is thus projected back toward families and children. These types of cases are challenging and solutions are needed as the demands on time consume the resources and emotions of professionals trying to help (Gaulier, Margerum, Price, & Windell, 2006). As the need for treatment increases with prolonged litigation and the chaotic experience of working with multiple professionals, clinicians may become apprehensive about their own involvement (Warshak, 2016). Professionals have experienced threats to self and family in response to the anger often directed at the professional's person and function as the conflict continues or intensifies (Warshak, 2016). Types of threats include violence and property damage, as well as intentional damage to reputations, and threats of loss of professional license through board complaints, lawsuits and other forms of harassment (Warshak, 2016). These complex and tumultuous cases may be handed from service provider to provider, creating a lack of predictability and additional turmoil due to inconsistent and often incongruent treatment approaches (Fidler & Bala, 2010).

When the parents are incapacitated by the conflict, it can be tricky for the court to identify whether mental health professionals involved are making the situation worse, or managing and leading the effort to support these families. Much of this difficulty is due to the varying perspectives of the multiple involved practitioners. In preparation for treatment and court intervention, a comprehensive forensic assessment and evaluation is often completed to determine causative factors and develop a direction for appropriate treatment tailored to the family's unique needs. Typically, during this phase, input from professionals who know the family through prior interactions is solicited to gather a more complete picture of the parents' attitudes, actions and behaviors. As part of the family law litigation, children or their parents may be given a mental health diagnosis during evaluation. Individuals may be assessed as having diagnosable problems such as unresolved adjustment disorders, personality disorders, anxiety disorders, depression or other mental illness, in addition to traumatic histories of their own (Kouros, Merrilees, & Cummings, 2008), or parents may simply lack parenting skills (Doolittle, 1999). A child's adjustment problems, and other child-centered conflicts may be cited in the disagreements (Emery, Sbarra, & Grover, 2005; Grych, 1999) and polarization of the child(ren) is also mentioned (Fidler & Bala, 2010). The needs of the children may alter the direction of treatment as specific intervention strategies may be focused toward them and not toward the conflict itself (Doolittle, 1999; Lebow & Newcomb Rekart, 2007). Opinions regarding causation and treatment differ as increasing numbers of professionals become involved.

Judges, attorneys, judicial officers, and mental health professionals are faced with multiple stressors and pressures as they try to untangle the conflict and consider the appropriate response. Family law attorneys, tasked with advocating for their clients, are at the same time faced with the reality of the situation which may run counter to their clients' perspectives. Judicial officers often manage numerous cases with uncertain outcomes, and consequentially there may be limited time periods to make important decisions. Additionally, as public figures, judicial personnel may be subject to public scrutiny from a variety of polarized groups (American Board of Trial Advocates, 2019). Forensic mental health evaluators and clinicians are also subject to criticism and retaliation from litigants who are unhappy with the court's decisions. As the family law system is pulled into the chaos, forensic mental health practitioners and treating clinicians may begin to second guess treatment approaches and work against one another in the interest of advocating for one client over another and influencing court orders. These dynamics perpetuate a feeling of lack of safety for everyone in the milieu. Elements of heightened emotion, multiple treating professionals and practices, theoretical disagreement, poor communication, frustrated litigants, and polarized critics, are among the factors that add to multiple stressors and lead to consequent dysregulation for all parties. Evaluating behaviors based on dysregulation due to court involvement will create an irrelevant or ineffective long-term treatment plan or legal decision (Hess, Beale, & Miles, 2010)

It is important to note that in some cases individuals will struggle to respond to treatment and even addressing physiological states is not possible without other interventions. In these cases, (e.g. extreme resistance to parent contact, allegations of sexual abuse), the court may have no choice but to step in to change custody arrangements and place the child[ren] with an alienated parent, or

to mandate other changes to provide for emotional safety (Kelly & Johnston, 2005). In cases involving domestic violence or child abuse, a similar approach may be needed, with a suspension of contact with an abusive parent (Bowles, Christian, Drew, & Yetter, 2008). In these disturbing and dangerous situations, the focus on internal regulation may initially be of most benefit to the individual, judicial, and treatment professionals directly involved with making tough decisions and managing consequent behaviors.

III. INTERVENTIONS

A. CURRENT PRACTICE

There are a wide range of suggested approaches to resolving conflict between separated parents, including divorce mediation (Emery et al., 2005), exploration of grief (Somary & Emery, 1991), integrative family therapy (Lebow & Newcomb Rekart, 2007), parallel parenting (Stahl, 2010; Sullivan, 2008), improving parenting communication through better resources (Blair & Raver, 2012), parenting coordination (Orlow, 2007; Sullivan, 2008), Cognitive Behavioral Therapy (Garber, 2015), and enhancing parenting skills (Sandler, Miles, Cookston, & Braver, 2008). Programs exist that support specific approaches however, little empirical data is available to guide decisions (Drozd, Saini, & Olesen, 2016; Grych, 2005). Methodologies have been examined and advocated, papers and articles have been written, effective interventions have been suggested and disputed, yet clear consensus and direction remains elusive. A single effective intervention may not be appropriate, and none has emerged as the clear best practice. All may offer resolution and relief (Garber, 2015), but treatment choices continue to be made on a case by case basis.

The psychology and family law literature generally propose that early intervention can help alleviate existing parent–child contact problems and also prevent them from developing (Greenberg, Doi Fick, & Schnider, 2016). However, because these families are often involved in lengthy court proceedings and often more than one therapeutic intervention (or previously failed interventions), inconsistency and disparity in approaches is increased. Experts in the field have designed and utilized a range of programs and interventions to manage behavioral manifestations of conflict, including parent contact resistance, with varying degrees of success.

Benjamin D. Garber suggests that optimal intervention must be court ordered, child centered, and developmentally attuned:

It must account for the strengths and weaknesses of Parent A, Parent B and the child, the family's three subsidiary dyads, the system as a whole, and the system as it functions within larger (community, legal, therapeutic) systems. In the ideal, each participant should have an individual therapist and share a common, overarching family therapy. All of these therapists must be allowed to communicate with one another so as to minimize splitting and coordinate progress while respecting each participant's (and particularly the child's) confidences so as to build trust. (Garber, 2015, p. 103).

Although the approach is logical, a gap remains between aspiration, research, training and resources for implementation. The coordination of a team composed of multiple clinicians is often a difficult and expensive proposition, and the literature offering and outlining specifics about how to accomplish this is limited. The tension and confusion embedded in the process of litigation in these complex cases, the differences of opinion, and the lack of clear leadership provides ample fuel for dysregulation and conflict between professionals involved.

B. POLYVAGAL THEORY

Polyvagal Theory describes the primary role of the ANS in shaping thoughts, feelings, behaviors, and beliefs (Porges, 2007). The fundamental premise of Polyvagal Theory is that human beings need to not only feel safe, but to feel safe in connection with others for survival. At the same

time, human biology is fiercely devoted to preventing harm. Often, this sets up a conflict between the drive to survive and the need to connect. The body's rapid-response survival system is orchestrated by the ANS.

To briefly review, the autonomic nervous system operates two branches: the sympathetic and the parasympathetic. The sympathetic branch mobilizes a defense against danger through the fight-or-flight response while the parasympathetic branch has typically been viewed as a system that helps to lower defenses and regain a state of calm. Polyvagal Theory offers an updated understanding of the ANS showing that the parasympathetic branch in fact has two divisions of its own, one with the potential to create social engagement and connection, and the other that activates collapse and disconnection. These three pathways operate in a predictable hierarchy of response: ventral vagal – connection, sympathetic – fight and flight, dorsal vagal – disconnection. There is a default preference to be in ventral vagal safety and connection. When events in daily life bring too great a challenge for the capacity of the autonomic nervous system, the autonomic state shifts downward into sympathetic fight and flight and, if that does not resolve the challenge, the final move to the bottom of the hierarchy into dorsal vagal collapse and disconnection takes place.

While the sympathetic nervous system is made up of spinal nerves in the thoracic and lumbar region, the parasympathetic nervous system is a cranial nerve system with the vagus nerve (Cranial Nerve X) as the primary component. Starting at the base of the skull and winding to the abdomen, the vagus connects to the pharynx, larynx, heart, lungs, digestive system and other organs. Normally referred to in the singular, the vagus is actually a complex circuit of nerves divided into two pathways – ventral and dorsal – each responsible for a distinct neurophysiological state. The ventral vagal pathway supports a sense of regulation and readiness for social engagement while the dorsal vagal pathway enacts a move out of connection into collapse. The ventral vagus also moves upward from the brainstem connecting with four other cranial nerves (CN V, VII, IX, XI) to form the Social Engagement System. Sometimes called the safety circuit, the Social Engagement System uses eye gaze, facial expression, tone of voice, head movements, and social gesture to create safe connections with others (Porges, 2004).

Through autonomic processes, this internal surveillance system works in the background reading subtle signals of safety or threat. This moment-to-moment search for cues for safety and danger operates beneath awareness without involving the thinking parts of the brain, in what Stephen Porges describes as neuroception (Porges, 2004). Through the ongoing neuroception process the ANS scans for cues of safety and danger, initiating actions in service of safety and survival. While we do not always recognize the cues of safety and danger, we feel the physiological response. And, because humans are meaning-making beings, what begins as the autonomic experience of neuroception travels to the brain and becomes the story that directs daily life. From a dorsal vagal or sympathetic state, danger rules and the story is one of survival. It is only from a ventral vagal state of safety and connection that the story can be one of hope and possibility.

C. POLYVAGAL-INFORMED THERAPY

The foundation for resilience and well-being comes from the ability to flexibly respond to challenges rather than reacting and remaining stuck in a survival state. From a polyvagal perspective, a primary goal of therapy is to help clients recognize their state, find ways to move out of a dysregulated numbed-out "dorsal vagal" or hyper-aroused "sympathetic" state and return to "ventral vagal," the biological seat of safety and connectedness. Through neuroception, clients pick up subtle cues from the therapist via tone of voice, eye contact, body postures, and facial expressions. Throughout the session, clients react to these signals with sympathetic activation, dorsal shutdown, or ventral openness and trust. With a polyvagal perspective, clients and clinicians become aware of the physiological processes that are shaping the session and begin to recognize that the therapist is responsible for being the regulated and regulating resource for the client. In fact, for both therapists

and clients, in therapy and in daily living, the ability to accurately identify autonomic state, and have skills to regulate back to ventral, is an essential skill.

Many people today come to therapy with a general understanding of the concept of mind/body and an awareness that their physical and emotional selves function together. However, few people understand how the ANS creates the platform for daily living experience. The ANS, responding to the demands of the moment, exercises a repertoire of mobilization, disconnection, and engagement behaviors. In each of these states, specific emergent properties – the thoughts, feelings, behaviors, and beliefs that are possible from that state – are activated. It is through these emergent properties that people are moved to behave in predictable ways and the stories about themselves and the world they inhabit are generated and perpetuated. With a map of the ANS, individuals can begin to understand the connection between their physiology and cognitions and begin to see the ways their autonomic state creates their psychological story (Dana, 2018).

A simple image to use in mapping the ANS is a ladder, with ventral vagal at the top, sympathetic in the middle, and dorsal vagal at the bottom (Dana, 2018). People begin to get to know their system by writing down their typical thoughts, feelings, behaviors, and body sensations for each state. For example, in dorsal vagal, people often identify feeling silent, out of focus, numb, hopeless, helpless, shut down, abandoned, and unwanted. When in a sympathetic state of fight or flight, clients often use words and phrases like out of control, angry, confrontational, fearful, and desperately seeking. Finally, as they recall times of being firmly planted at the top of the ladder—the ventral vagal zone – they often describe being openhearted, engaged, curious, and playful.

In one polyvagal exercise, people are asked to fill in two sentences for each state: "I am…" and "The world is…" These two sentence stems can elicit the core beliefs at work in each state and help people see how their narratives change as their states change. In a ventral state, people often characterize their story with statements like "I belong" and "The world is welcoming and filled with opportunity." In a sympathetic state, common descriptions are "I feel crazy, panicked. I'm trapped in a world that's unfriendly and scary." When in dorsal, the response is often, "I'm invisible, unlovable, lost, alone. The world is cold and empty." Through this mapping process, people have both a picture and a language for their "ladder" of autonomic activation and can begin to place themselves on their autonomic map at any given moment. The polyvagal perspective offers a shared language and a way for family members and professionals to understand each other through awareness of autonomic states and the accompanying behaviors and beliefs. Family members and professionals alike can be more effective in problem solving when they are able to reliably recognize and then subsequently regulate their internal states.

D. EFFECTS OF THE POLYVAGAL APPROACH AND SELF-REGULATION

Polyvagal Theory provides a way to understand how the nervous system responds and offers an approach to autonomic regulation as part of a mind/body consciousness. A polyvagal approach engages the ventral vagal system and skills to either activate or calm the nervous system through social engagement (Porges, 2009). This approach has been studied in various contexts with proven efficacy as a means of attaining self-regulation and positively affecting physiological and emotional outcomes in various settings. Self-regulation can promote better communication, clearer thinking, and improved problem-solving abilities (Park & Thayer, 2014). Much has been written about concepts related to the mind/body connection (e.g. mindfulness, the use of coping strategies, yoga, exercise and meditation among others) as a means to manage distress and anxiety (Regehr, Glancy, & Pitts, 2013). Skills implemented to decrease psychological stress and regulate the sympathetic nervous system will influence the musculoskeletal, cardiovascular and nervous system function and thereby enhance immune function and decrease inflammation (Kenney & Ganta, 2014; Muehsam et al., 2017). Many studies directed toward the mind/body connection are conceptually or specifically related to Polyvagal Theory and a polyvagal approach in managing worry, calming the nervous system and promoting better emotional and physical health. Managing stress through self-

regulation has been shown to reduce symptoms of chronic pain, depression and PTSD, and to positively affect emotional well-being, resilience after illness or trauma, and management of chronic pain (Goyal et al., 2014; Taylor, Goehler, Galper, Innes, & Bourguignon, 2010; Schmalzl, Powers, & Henje Blom, 2015; Muehsam et al., 2017). Polyvagal Theory has provided a framework for understanding parasympathetic regulation of cardiac activity and its effect on children's adaptive functioning (Hastings et al., 2008). Vagal control has been shown to activate areas in the brain responsible for regulating responses to danger, and identification of physiological processes related to emotions, self-regulation, and resilience, while poor vagal control has connections to poor self-regulation, depression, anxiety disorder, and other medical and mental health related illnesses (Maniscalco & Rinaman, 2018; Muehsam et al., 2017; Park & Thayer, 2014; Streeter, Gerbarg, Saper, Ciraulo, & Brown, 2012; Sullivan et al., 2018). A polyvagal framework adds a layer of understanding to the research that shows how the mind/body connection has proven to be beneficial in adaptation to adversity, emotional and physiological resilience (Tugade, Fredrickson, & Feldman Barrett, 2004; Whitson et al., 2016).

E. MANAGING PHYSIOLOGICAL RESPONSE FROM A COGNITIVE PERSPECTIVE

Clarification of real versus perceived threat can help parents and children distinguish appropriate worry from unnecessary vigilance; however cognitive understanding does not easily override neuroception. For example, even though parents struggling with conflict in separation or divorce are routinely warned to avoid any discussion of legal issues with children, many children hear bits of information that trigger chronic worry and lead to interpreting a relationship with one parent as dangerous. In addition, children have their own worries, separate from their parents' concerns. In an environment of safety, a conversation addressing questions and concerns can help reassure family members and bring clarity to the process.

Family psychoeducation about emotional dysregulation and its physiological manifestation is often helpful. A felt sense of safety is necessary to provide the framework to shift from dysregulation to stability. If one family member is experiencing an activated survival response, the family system reacts. Individual family members, sensing the dysregulation, often respond with a survival response and state change of their own. Utilizing cognitive skills from dialectical or cognitive behavioral therapy, can lead to awareness of triggers and identification of the cues of danger that drive dysregulation (Picardi & Gaetano, 2014; Fassbinder, Schweiger, Martius, Brand-de Wilde, & Arntz, 2016). Providing specific skills that each family member can use to manage their own physiological response to threat offers a pathway to emotional regulation and a sense of safety. This self-awareness promotes enhanced communication leading to increased family problem-solving abilities. With an ability to self-regulate, individuals can offer co-regulation to others who in the moment may be unable to regulate on their own. When professionals recognize a child or family member has moved into an active dorsal vagal or sympathetic state, the subjective experience of the lack of safety and emotional turmoil can be understood and appreciated. When individual history, family history and autonomically triggered responses to stress or trauma are understood and appreciated, individuals can be met with an offer of regulation and balance. This empathic response is an effective tool to facilitate safe connection and engage the ventral vagal self (Porges, 2001).

IV. IMPLEMENTATION IN A CLINICAL SETTING

The following discussion explores applications of a polyvagal perspective in practice, through the framework of the Transitioning Families intensive workshop. Using a polyvagal perspective, participants learn to recognize the impact of internal physiological response on cognitive processing and problem solving and understand the ways external stimuli impact autonomic states. This approach has application across many settings with benefits for families, clinicians, judges, attorneys and staff.

A. BACKGROUND AND DEVELOPMENT OF TRANSITIONING FAMILIES AND THE POLYVAGAL APPROACH

Transitioning Families is a multi-faceted, case specific approach to working with families involved in high conflict divorce, and other types of cases. It was developed as a result of the directors' experiences working with familial and non-familial abduction (Judge et al., 2016). It utilizes varied evidence-based interventions, specific to the needs of each family. Transitioning Families incorporates a psychodynamic and experiential based approach that has evolved and expanded to include a polyvagal perspective as an additional tool to help decrease the conflict and tension that exists within these challenging families. (Lebow & Black, 2012; Sullivan, Ward, & Deutsch, 2010).

V. EMOTIONAL DYSREGULATION IS CONTAGIOUS

A. FAMILY THERAPY AND POLYVAGAL THEORY

Family therapy emerged in the early 1960s (Kaslow, 2007). "The one central principle agreed upon by family therapy practitioners, regardless of their particular approach, is that the client is connected by interactive systems. Attempts at change are best facilitated by working with and considering the family or set of relationships as a whole" (Corey, 2013, p. 397). In a family, "actions by any individual family member will influence all the others in the family, and their reactions will have a reciprocal effect on the individual" (Corey, 2013, p. 397). Traditional therapeutic models focus primarily on the individual, leaving the rest of the family out of the recovery, or change process. In 2009, Charles Figley suggested it was better to keep the entire family together in addressing and processing change (Figley & Regan Figley, 2009).

Although family work is an accepted treatment for parent–child contact resistance cases, Polyvagal Theory has not previously been applied as a working model for intervention in this context. Emotional dysregulation is contagious and affects not only each family member, but also the larger family system and all other involved professionals. Interventions that help to explain the interplay of the autonomic messages and responses between all participants, and techniques to modulate and manage them, provide the opportunity for awareness, safety in connection, and repair.

In treating families experiencing parent–child contact problems, the goal is to address and repair the relationship between child[ren] and both parent(s), and to recover family function. Within the literature, there are suggestions that the treatment team should be specialized and have competence in family therapy and high conflict systems (Polak & Moran, 2017). Although there may be disagreement as to what the specific goal of a reunification session might be, in utilizing a polyvagal approach it is understood that the immediate goal is for each participant to experience a neuroception of safety in the company of others. A neuroception of safety activates the ventral vagal pathways that support regulation and connection and helps the individual create a narrative based on the accurate interpretation of incoming messages. From a polyvagal perspective, focusing on regulation of the nervous system may create an opportunity for reparative experiences by enhancing communication, social connection, clearer thinking and better problem solving. The responsibility for regulation is shared by all participating family members and professionals. Identifying skills to recognize and regulate shifting internal states provides the opportunity for connection and repair. Repair is only possible if the individuals experience a non-threatening environment in which the adaptive survival responses of the nervous system are not activated. For that reason, family-based treatment should be conducted in an environment that allows participants to calm their defense systems and move into the ventral state of safety that supports connection. Then the goal for each individual is to be able to self-regulate, for mutual regulation to take place between individuals, and for the family system to become a self-regulating unit.

B. PSYCHOEDUCATION

Psychoeducation has been shown to help families resolve a range of difficulties (Lebow & Gurman, 1995; Warshak, 2016), including reducing children's reactions to traumatic stress, understanding the negative effects of conflict and traumatic stress on child development, and teaching parents how to understand behaviors and adaptations related to the children's distress during major life changes (Leon, 2003).

Parents and children can learn how to intentionally stimulate the ventral vagus to regulate the physiological response to the visceral perception of a lack of safety (neuroception). A few slow deep breaths from the belly, engaging the diaphragm (the stomach rises, not the chest), an extended exhalation, even just breathing a sigh are ways to exercise the ventral vagus, slowing heart rate, lowering blood pressure, and bringing the body back into balance (George et al., 2000). Holding the breath for a moment and bearing down or putting cold or cool water on the face have also been shown to bring the body back into regulation (Shapiro & Schwartz, 2000). All of these actions increase the influence of the ventral vagus leading to clearer thinking and improved problem solving. Other simple practices to stimulate the ventral vagus and bring the nervous system back to regulation include a brief, purposeful break from the work environment, sipping (not gulping) a warm or cold beverage and bringing awareness to how it travels down to the stomach, a short walk with awareness of how the feet feel as they touch the ground, warming the hands and placing them on the chest noticing the warmth that is generated, and humming (Vago & Silbersweig, 2012).

It is important that psychoeducation with families experiencing high conflict with parent–child contact issues is offered with attention to individual differences including age (chronological and developmental), cultural background, level of education, learning and communication style, and other factors relevant to the particular family. Since the ANS is shaped by experience (Spennrath, Clarke, & Kutcher, 2011), understanding the variations in family histories can be helpful to both family members and to the court involved professionals such as judges, court personnel and attorneys. By providing psychoeducation regarding the moment to moment response of the ANS and the role that neuroception plays, we provide an opportunity for improved self-awareness which in turn supports the goal of social connection.

C. EXPERIENTIAL FRAMEWORK, PLAY THERAPY AND THE POLYVAGAL THEORY

In Experiential Therapy, direct experience is considered the primary agent of change (Mahrer, 1996). A wide range of experiential modalities including equine and other animal-assisted therapy, art and music therapy, cooking, and recreational activities may be embraced. Experiential techniques may be helpful with groups difficult to engage and integrated into traditional therapy to help an individual who struggles to find a neuroception of safety to access previously unrecognized or unprocessed internal feelings. Playing together in a safe and regulated environment can provide an opportunity for the development of empathic relationships within the family and between the family and therapists. During safe play, family members shift from an internal state of vigilance to a state of enjoyment as ventral vagal responses are stimulated. The experience of family play offers the opportunity for co-regulation.

Play may increase engagement (Forsythe, Sudo, Dinand, Taylore, & Bienenstock, 2009) and motivation among both parents and children (Thompson, Bender, Cardoso, & Flynn, 2010). Gil and Sobol (2005) suggest that play may help with families that are not verbally facile, may encourage family members to be less analytical and intellectual, and inspire new relational patterns. Again, in this setting, the ventral vagal state is activated and an opportunity to practice social engagement is created. In these high conflict cases, family members have often become so distanced from each other that being in proximity stimulates an uncomfortable and unsafe feeling in the child and a refusal to engage. When there are no objectively valid reasons for rejection, such as severe alienation, realistic estrangement, domestic violence, or child sexual abuse, Polyvagal Theory provides a viable explanation for the contact refusal and may present a doorway to reparation. A neuroception

of danger and the associated move out of safety into fight, flight, or shut down can be explored. When survival states are recognized, and self- or co-regulation brings a return to the ventral vagal state of safety, reflecting on, or more accurately framing the cues of danger that prompted the adaptive survival response can help family members better understand themselves and their relationships. Winnicott suggests that a playful environment provides a milieu in which a problem can be explored and a solution found (Winnicott, 2007). Research has also shown how powerful play is for helping children work through challenging experiences (Malchiodi & Crenshaw, 2015), but the importance of play in social connection and regulating and co-regulating physiological states cannot be overlooked.

Animal studies have demonstrated that interacting with a pet can calm an individual who is agitated. Having a dog or cat in the room during individual therapy can be soothing (Friesen, 2010). The therapeutic effect of the animal can be viewed as a demonstration of the individual's ability to manage fluctuations in internal physiological states. Another example is when a therapeutic animal's response to agitated voices can be utilized to encourage participants to pay more attention to their vocal tone and its impact on others in the room. The animal's action is translated into a barometer of stress. Responding to the animal's stress reaction is often easier for family members to understand by demonstration rather than explanation.

D. EQUINE ASSISTED THERAPY, POLYVAGAL PERSPECTIVES AND ALTERNATIVES

Equine-assisted psychotherapies integrate equine activities within a treatment program's broader framework (Klontz, Bivens, Leinart, & Klontz, 2007). This practice differs from therapeutic riding programs in that it primarily incorporates working with horses on the ground, rather than riding them. As prey animals (i.e. they are preyed upon by others), horses have a well-developed ability to adapt to their surroundings and react accordingly. Observing horses for a short time reveals how sensitive they are; quick to move out of harm's way and just as quick to return to calm grazing when the perceived danger is past. Attuned to their environment and with a highly developed ability to respond to ambient changes, horses are excellent resources for using Polyvagal Theory to help treat parents and children. By reacting to human energy, horses become an example writ large of what they sense. When an individual recognizes a horse's reaction and adjusts to it, they can learn to attune and regulate their response. Horses can be helpful in addressing trauma and family issues through "the subtle art of communication, awareness about interpersonal boundaries, the effects of one's posture, demeanor and effect on others, and principles of emotional contagion" (Judge & Deutsch, 2017, p. 99). Horses can draw out a range of emotions and responses in families, which can then be used as therapeutic prompts for insight and directness, leading to change. Because of this innate ability, horses are included as extensions of the intensive reunification team and, as such, are agents of a therapeutic change.

Not every therapeutic environment has access to horses. However, every therapy environment inevitably has access to video images of horses and similar animal behaviors. A conceptual understanding of what equine behavior represents can be important to teaching families and involved professionals about the process of reaction and a return to regulation. Videos of horses grazing, startling at perceived danger in their environment and resuming grazing when the danger has passed is often sufficient to facilitate understanding. Utilizing other animals or exploring the behavior of family or friends' pets is another way to engender understanding. Seeing, and then practicing, the activation and return to calm is the goal. While horses certainly make it easier, there are many ways to demonstrate this concept (Nurenberg et al., 2015).

Parents and children who have experienced major stressful events tend to be hyper-alert; ready in an instant to move into fight or flight mode to respond to perceived threats (Johnston, Roseby, & Kuehnle, 2009). Observing and understanding equine behavior can teach families to discern the difference between a real, perceived threat and an irritation, or another interaction that is not an actual threat but a form of communication, thus supporting the skills of attunement and regulation. For

example, an observation of horses might be that they are big and should be feared, but understanding how horses model ANS neuroception, activation and calming builds a rapport that obviates the fear (Nurenberg et al., 2015). This observation reinforces the idea that the perception of threat does not always translate to reality. Learning new ways to evaluate perceived threat helps family members return to calm and reinterpret and reframe their environment.

E. PROCESSING CHAOS AND GRIEF

Understanding chaos and grief and the related effects on family dynamics can provide information relevant to healing. With this cognitive understanding, autonomic activation often decreases, leading to an increased ventral vagal response. A broad discussion utilizing a grief "wheel" and Kubler Ross' five stages of grief and grieving (i.e., denial, anger, bargaining, depression and acceptance) (Kubler-Ross & Kessler, 2005), can serve as a tool to encourage identification and verbalization of participants' feelings. The grief wheel can be easily adapted to the experience of separation and divorce.

To illustrate: in a high conflict divorce the disorganization phase can begin with sympathetically charged feelings of chaos, confusion, and dorsal feelings of helplessness, all of which are exacerbated by the involvement of law enforcement, the press, the legal system, social systems, numerous outside therapists and other would be "do-gooders," as the private system of the family is invaded by exterior forces. The family system, and each individual family member, feels the threat first through their autonomic responses and then through the stories that emerge from those activated states. Understanding the process through the grief wheel raises awareness, encourages tolerance of the anxieties and fears related to chaos and confusion, and provides a guide for communication that helps the treatment team to offer support and psychoeducation at the appropriate time. Tracking autonomic activation through the stages of the process and learning about each individual's personal experience of the stages, can enhance communication and provides a structure for speaking, listening, acknowledging, and engaging in a safe, ventral vagal mediated non-reactive environment.

F. OTHER OPPORTUNITIES FOR MAKING CONNECTION: COOKING, MEAL PREPARATION AND SHARING MEALS

In addition to animal-assisted techniques, activities such as meal preparation and cooking, art therapy, hiking, learning to walk on a low tightrope and other similar experiential/relational activities can foster safe connections among family members and create insight into entrenched family dynamics. Because these activities are physical, they help to reduce the autonomic arousal associated with anxiety and therefore create openness to new learning (Green & Myrick, 2014; Judge & Bailey, 2017).

Participating in activities of daily living is an essential part of a child's exposure to the rejected parent (Garber, 2015). Cooking and eating a meal together may start the process of reconnection in a natural way that does not require direct conversation about the relationship or the separation, or processing of events surrounding the family situation. Because auto-biographical memories evoked by odors are more emotional than memories evoked by verbal or visual cues (Herz & Schooler, 2002), cooking that includes culturally appropriate foods, and food that was historically eaten by the family prior to separation, can stimulate a ventral vagal state, promoting self-regulation and social engagement.

VI. IMPLEMENTATION FOR PROFESSIONALS

The term "parallel process" has been used by various family justice professionals (Ekstein & Wallerstein, 1972; Kelly & Johnston, 2005). In the context of working with court-involved families,

a parallel process occurs when professionals mirror or reenact the dynamics occurring in the families they are involved with, and professionals who normally work well together begin to find themselves in conflict. When justice system professionals and mental health teams are aware of this commonly occurring process, they are better able to avoid perpetuating the pattern. Understanding the mechanisms of Polyvagal Theory can help professionals increase awareness of how their own nervous system states impact the process, understand the need to self-regulate and maintain a ventral vagal state, and the importance of bringing regulation into their interactions with other professionals to reduce reactivity and support collaboration.

Research indicates that professionals who work with high conflict families are vulnerable to a range of problems (Warshak, 2010). The polyvagal approach serves as a buffer against the expected professional demands and challenges of working with families experiencing high conflict and parent–child contact problems. Understanding physiological responses and promoting self-awareness can help professionals manage experiences that may lead to burn-out or compassion fatigue.

By using a polyvagal approach and attending to neuroception, the importance of identifying environmental cues of danger and creating an environment in the office and in the courtroom that is child and family friendly is recognized – an environment that offers autonomic cues of safety. In addition to the environmental cues, a polyvagal approach requires professionals to recognize the power of prosody to send cues of safety and danger. The voice, through tone, pitch, and pace is one of the elements neuroception uses to assess safety and danger. We listen to intonation before taking in information, and modulation of voice either increases distress or encourages a feeling of safety and the ability to engage.

VII. ADDITIONAL CONSIDERATIONS

It is not unusual for children and parents who have suffered the conflict of divorce and separation to have significant difficulty articulating and identifying their emotions around the event or events. In addition, many families in treatment may be tired of the emphasis on analysis, interpretation and talk. Rather than bringing increased understanding, a primary focus on verbal communication may instead increase resistance and decrease a visceral feeling of safety through the mind/body connection (Judge & Deutsch, 2017).

Experiences such as learning to co-regulate and self-regulate when emotionally flooded, understanding differing perceptions and options for approaching a task, and ways to engage in teamwork and collaboration, are some areas that can be strengthened when the ANS' patterns of protection and connection are understood. An environment that provides an atmosphere of safety promotes the development of connection and empathic relationships, and those attunement experiences can then initiate a practice of connecting with previously unprocessed or unrecognized emotions through the safety of social engagement.

VIII. DIRECTIONS FOR FUTURE RESEARCH

There has been little rigorous empirical research conducted to assess the effectiveness of mental health treatment programs that serve children and families involved in complex post-separation cases involving resist-refuse dynamics. There is continuing controversy among professionals involved in the family dispute resolution process about the efficacy and ethics of use of different interventions. The application of Polyvagal Theory to high conflict divorce populations is new. The theory itself is gaining recognition as a therapeutic tool for working with and supporting trauma survivors. It will be important to conduct rigorous, empirical research to assess the efficacy of mental health interventions that incorporate Polyvagal Theory concepts into their treatment protocols. Given the complexity and multidimensional nature of mental health treatment protocols, it would be useful to use logic models and change models to assess the various levels of efficacy so that multiple aspects of Polyvagal Theory-based approaches and interventions are understood. As the

research into Polyvagal Theory has grown, a variety of applications has been suggested. The identification and awareness of the impact of autonomic state in general, and the ventral vagus in particular, on individuals in high conflict populations to co-regulate could be measured pre- and post-intervention. Research could be conducted through, self-report measures including the Body Perception Questionnaire, Beck Anxiety Inventory, Quality of Life Scale, Self-Compassion Scale, personal progress scales designed to track increased flexibility of autonomic response, resilience scales, and purpose in life scales. These self-report measures could be given at incremental times before, during and after the interventions. A control group could include families who were given psychoeducation about Polyvagal Theory, created autonomic maps, and learned simple self-and co-regulating skills. A comparison group might be families who engaged in the psychoeducation phase but did not learn ways to apply the theory in their daily lives. Heart rate variability measures during interactions and informational interviewing regarding the perception of safety could add important additional information.

One research question might investigate whether the application of the polyvagal perspective provides an opportunity for more positive relationships between parent and child through better communication and enhanced social connection. Another important question addresses increasing our understanding of the role of the ventral vagus in supporting better communication in the court process between professionals and family members. Does awareness of autonomic response effect the experience of all participants in the court process? A simple comparison counting court involvement pre and post polyvagal education could be conducted to see if there is a change in the number of court appearances once participants understand the role of the autonomic nervous system and learn skills to self- and co-regulate. Judges, lawyers and other court officers and mental health professionals could be surveyed before and after learning about Polyvagal Theory, and before and after practicing specific components of self- and co-regulation such as prosodic tone, eye contact, breathing and awareness of individual responses to internal states. As individuals create increased capacity for autonomic regulation, the intensity of distress for both professionals and family members engaged in a high conflict divorce should reduce or even resolve.

IX. CONCLUSION

The use of Polyvagal Theory as applied to the court involved population in high conflict divorce and separation cases with parent–child contact problems would suggest that there needs to be a fundamental shift in the manner in which these cases are approached and managed. These cases often exhaust other approaches, including coming to agreement through mediation and collaborative attorneys. By definition these complex high conflict cases appear to generate additional conflict and chaos. As the literature has evolved, there have been numerous attempts to explain and create interventions and explanations that address and help to meet the needs of children and families in high conflict, particularly as they relate to child contact issues. The literature leaves the impression that the field may in some instances be as fractured as the population it serves. The definition of child contact resistance varies as does the definition of what constitutes a successful reunification. Defining success appears difficult to measure given the number of variables that exist within each case and within each family. The creation of an environment that encourages stability and safety in the context of court involvement is elusive. Acceptance of the numerous perceptions and opinions involved coupled with the limited and inconsistent evidence-based practices as applied to this conflicted population and field causes confusion and frustration in professionals and families.

Recognizing physiological response to perceived threat and learning how to regulate internally, cognitively, and interactively is an important first step in assisting families and professionals through complex cases with parent–child contact problems. When judges, attorneys, court personnel, family members and clinicians learn ways to focus on self-regulation, co-regulation, and the physiological calming of the nervous system, reactivity is expected to decrease, while effective problem solving will increase, and communication will improve. The current climate of conflicted

perspectives between clinicians has contributed to professional tension, confusion, and a lack of consensus in direction for the court. A focus on self- and co-regulation brings the possibility of creating coalitions and engenders cooperation between all parties supporting engagement in the much needed discussions about how to successfully work with these challenging families.

Attentiveness to the environment in which these families are served and treated may be an effective way to address dysregulation and create an atmosphere of safety. Courts have begun to implement trauma-informed guidelines to help with sensitive populations that can easily be applied to the high conflict populations with an emphasis on the polyvagal approach. The mental and physical well-being of all participants in this high conflict population is not easy to achieve. Applying Polyvagal Theory in treatment and court involvement provides a direction for creating a sense of safety that leads to subsequent improvement in social interaction, better communication and more efficacious problem solving. Decreasing stress in this difficult area involving clients, court and treatment professionals is essential to positive outcomes for all.

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