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Tom Warnecke

ABSTRACT

Crisis intervention has become a widespread concern during the Covid-19 pandemic for psychotherapists seeking to support people acutely affected by this crisis. This article aims to introduce core principles of the crisis intervention conception as well as expanding these with relevant contemporary psychophysiological perspectives on somatic crisis phenomena and interventions. Conceptions and interventions are relevant and applicable in face to face, digital and telephone settings. The author draws on the contents of a virtual workshop, held multiple times from March to May 2020, which was created to assist psychotherapists who volunteered for online psychological initiatives and projects aiming to support frontline medical staff during the pandemic and assist with Covid-19 related acute psychological stress issues. The article clarifies distinctions between crisis and trauma and offers perspectives on recognising crisis states as well as ideas and conceptions that may guide psychotherapists seeking to support, contain and resource clients during a crisis.

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Introduction

The Covid-19 pandemic has made crisis interventions an acutely relevant topic. Unfortunately, there is a scarcity of psychotherapy publications on crisis states as a presenting issue in general and even more so, on the psychophysiology of crisis states. This article aims to introduce this salient but neglected aspect of psychotherapy and invite further discourse and research.

The unfolding pandemic in March and April 2020 prompted a number of psychotherapists to volunteer for online psychological initiatives that aimed to support frontline medical staff by offering a number of brief digital or telephone support sessions free of charge. When it emerged that crisis intervention skills are apparently rarely included in psychotherapy training curriculums, the author created a brief online workshop, held multiple times from March to May 2020, to support such initiatives with a crisis intervention skills training. This article evolved from these workshops and presents

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a contemporary understanding of crisis intervention, expanded with current psychophysiological perspectives. Both the conceptions and the interventions described are applicable to digital, face to face, and telephone settings.

The crisis intervention conception consists of two principle parts, firstly the recognition of crisis states as a distinct presenting issue and secondly, a clinical framework that facilitates constructive responses to such states. Of particular significance are hyper- and hypo-responses conceptions (Holm Brantbjerg, 2015, 2018) and clinical perspectives which utilise the stabilising potential of directive sensorimotor and respiration interventions. Not surprisingly, the field of bodied psychotherapies appears uniquely equipped to take a leading role in developing and disseminating psychotherapy skills suited to work with Covid-19 related acute psychological stress issues.

The crisis intervention conception

My first psychotherapy teacher, the clinical psychologist and Gestaltist Hanna Seele, introduced me to a simple but salient metaphor – in a crisis, the focus should be on ‘working up’ in contrast to ‘working down’ in ordinary therapeutic mode. This description already signals how crisis intervention is in some ways almost an opposite to ‘normal’ therapy. In therapy, we typically aim to deepen, open up, dissolve restrictive or maladaptive psychological defences or encourage emotional expression. With crisis as a presenting issue, the primary focus is on developing coping strategies, containing feelings and resourcing the person within their personal contexts and abilities. Whilst psychic, cognitive and somatic dimensions of experience always occur conjointly, psychophysiological perspectives appear a particularly crucial to understand crisis states and inform effective interventions.

The crisis intervention conception initially emerged during the 1960s, alongside Caplan’s (1961, 1964) pioneering research, and in recognition that clinicians should consider to prioritise crisis states (sometimes also described as an acute ongoing traumatic situation) whenever these appear as a presenting issue. In contemporary terms, this notion created an essential distinction between trauma and crisis. Whereas trauma usually refers to either a memory of a traumatic disturbance or to some re-activation or re-inflammation of a historic traumatic disturbance, a crisis occurs in the present and is characterised as impairing a person’s abilities to function, which may put them at risk of further deterioration if left unchecked. As such, a crisis does not afford the inherently available opportunities we may rely on with trauma re-activations, namely to return to a non-threatening ‘here and now’ refuge situated in the present moment. However, distinctions between crisis and trauma may become blurred on occasions, for example, when acute crisis experiences touch upon historic traumatic disturbances.

Subsequently, the term crisis intervention also acquired confusing associations with ideas that survivors of major incidents required immediate therapeutic interventions. Such 'preventive' interventions often produce mixed results for complex reasons (Shalev, 2003) which are beyond the scope of this article. In contrast, psychotherapy crisis intervention responds to clients' initiatives and to their presenting issues which is a succinctly different scenario to preventive 'acute response' schemes which are typically initiated by the 'helpers'. However, confused or misleading understandings appear quite common in the public space, as for example, evident when the author's google search returned a topmost result that described 'expressing emotions' as 'a crisis intervention'. On the other hand, 'talking therapy' crisis intervention ideas and skills are widely and successfully used by professionals working with people struggling with severe and enduring mental health problems, or suffering panic attacks for example. Verbal crisis intervention skills commonly described in literature typically present variants of 'supportive' psychological-emotional interventions. It would exceed the scope of this article to review these here in detail or at depth.

Somatic crisis state presentations

Crisis states are most easily observed as hyper- and hypo-responses (Holm Brantbjerg, 2015, 2018) and associated affective arousal states. Hyper- and hypo-responses occur simultaneously and concurrently within the autonomic nervous system (ANS) and within the sensorimotor system (SMS). They manifest through ANS regulated phenomena, such as heartbeat and respiration patterns for example, and through SMS-driven motor activities as well as kinaesthetic or proprioceptive numbing. Both hyper- and hypo-responses appear in many guises, ranging from visually observable manifestations, or tone of voice, to somatic transference phenomena at the other end of the spectrum.

Overwhelming or flooding ANS hyper-arousal states are usually more readily observable, such as 'raging' hyper-responses for instance, as agonised helpless hyper-responses epitomised by Edvard Munch's iconic 'Scream' compositions, or as tearful flooding and overwhelm. Hypo-responses are typically more hidden but there are some common phenomena to observe, either visibly or by noting an absence or incongruence. For instance as a 'thousand-yard stare', a description commonly used for unfocused and vacant eye expressions in the context of combat stress reactions, which is pictured in Goya's portrait of Arthur Wellington at the height of the Napoleonic Wars in 1812. Goya's drawing provides a good illustration for a crisis hypo-response presentation. Hypo-responses may also be observable with attention to micro movements and their absences, or notable as incongruent bodied phenomena. For example, shoulders and upper arms may be

intensely and expansively engaged in a state of anger or rage while, simultaneously, the chest area may appear lifeless, deflated or contracted in fear states, or collapsed in helplessness, or some 'I don't exist' state. Such phenomena are discernable in both face to face and digital settings.

Both hyper- and hypo-responses commonly also present through a person's choice of words and verbal expression modes which allows therapists to listen to and 'hear' what a client's ANS and SMS are communicating about their bodied arousal states. Therapists can literally listen to a person's ANS arousal states by observing a client's manner of verbal expressions, ranging from reflective-emotional aspects in a client's narrative on the one end of the spectrum, to 'black and white' and 'either-or', life or death, aspects at the other end. Secondly, we may listen for words with somatic meaning, both symbolically and actually. Boadella (1994) described how somatic aspects may be present in dreams in the form of somatic qualities or references such as speed (e.g., slow or fast), weight (e.g., light or heavy), contractive or expansive dynamics, directions of movements (e.g., up or down, forward or backward), or spacial orientation and disorientation. Similar attention to a client's 'soma semantics' (Boadella, 2016) in crisis contexts allows therapists to notice what a client's SMS or ANS might be communicating in-between the lines of their verbal narratives.

Common characteristics of hyper- and hypo-responses

The list below gathers some commonly observed characteristics.

- Hyper-responses: accelerating/mobilising dynamics. Black and white perceptions (reflecting 'fight-flight' modes), speaking about the other person (e.g., in a conflict) instead of articulating the experience of a conflict situation, describing events or situations in extremes and superlatives, *'I'll show you'* perspectives or identifications. Qualities: expansive energies, fast, forceful or heated.
- Hypo-responses: decelerating/inhibitory dynamics. Low energy responses, 'in-between calm and collapsed states' (Holm Brantbjerg, 2020), hopelessness, predicament, lack of vitality, *'I'm not good enough'* perspectives or identifications, and 'bystander' countertransference (Holm Brantbjerg, 2018) experiences. Qualities: shrinking or contraction dynamics, shut down, collapse, or like 'blank areas on a map'.

Even in their milder manifestations, both hyper- and hypo-responses will already disrupt and emaciate emotional-psychological reflective capacities. With further escalation, basic psychological or mental functions such as 'common sense' may become increasingly affected and impair abilities to make sound, context appropriate decisions. Catastrophic arousal states might

find expression in statements like 'I cannot think straight', 'brain fog' or 'my mind is going blank'. Such expressions signal severe hyper- and hypo-response overload which can render the common range of ordinary therapeutic interventions ineffective. Catastrophic arousal states can be regulated 'down' with directive breathing or sensorimotor interventions (as discussed further on) to restore functional capacities. Interventions to address such fractured or disintegrated states may require directive structure, similarly to catastrophic arousal triggered by trauma re-activations (Rothschild, 2000), with the extent and range of directive instructions proportionately increasing to match a client's loss of functional capacities. But first, a brief review of the 'dissociative' psychophysiology relevant for coping with stress dynamics.

Janet (1889) not only pioneered understanding how mental and physiological manifestations activate conjointly but was also first to describe the physiological dynamics of dissociations, which aim to manage overwhelming or unbearable experiences. Janet recognised dissociations as adaptively narrowed states of mind (or consciousness) arising from excessive (i. e. hyper) physical responses but also with 'deficiency of psychological energy' (i. e. hypo) that could impair a person's abilities to bind together all their mental functions into an organised unity (Janet, 1889; Schore, 2009). We have since evolved a more comprehensive understanding of ANS hyper- and hypo-responses and Vagus nerve dynamics (Porges, 2007). In parallel to ANS activities, SMS-driven psychophysiological defences manifest with kinaesthetic and proprioceptive numbing phenomena, namely a gradual loss of kinaesthetic sense and proprioceptive experience arising with both hyper- and hypo-responses (Boadella, 1994; Holm Brantbjerg, 2015, 2020; Warnecke, 2003). This could be partial (e.g., feet or legs only) or affect the entire body, but is typically made up by a concurrent patchwork of localised hyper- and hypo-responses.

Engaging with client's autonomic nervous and sensorimotor systems

In situations when it appears that clients may experience overwhelm or flooding, therapists might try to share their observations with a question like: '*Listening to you, you sound a little overwhelmed to me. Is that something you experience?*' When a client confirms, the therapist might invite and encourage a client to name and list feelings with an emphasis to name only rather than express any feeling (which may intensify such states). Recognition, identifying and naming can offer containment, make affect or emotional states less overwhelming, or may also reduce a need to suppress or defend against feelings, which can help conserve scarce resources during a crisis. Words naming feelings, or brief descriptions, have a beginning and an end with the potential to manifest a container

for experiences that might seem overwhelmingly all encompassing (Boadella, 1994). Also, at times of intense or heightened experience, our psychobiology will commonly metabolise several affective or emotional states concurrently (though one may appear dominantly in foreground) and queries like *'are there any other feelings?'* encourage clients to identify all feelings present. Affective imagery, for example, likening feelings to waves in ocean which rise and fall naturally, may also provide a containing effect.

With hyper-responses as a presenting issue, for instance, when clients speak about a third person in polarised black and white terms, the therapist might try to improve regulation with a suggestion to lengthen exhalation (e.g., 'two in – four out'): *'Could I just pause you for moment and ask you to try out some breathing with me for a few minutes? And then we will go back to what you are telling me.'*

Extending the exhalation phase of a breathing pattern will usually signal to our neurological 'alarm centres' (i.e. amygdala, cingulate or right orbital prefrontal cortex) that a threat is no longer immediate. Within a short space of time, we can typically observe an increase of reflective capacity with more awareness of internal feeling states (both self and others), as well as increased capacities for cooperation with others. It is always recommended that therapists, when possible, engage in the same regulation focused activity they initiate together with the client. Such synchronicity may also help to clarify anything unexpected that might come about.

Psychophysiological interventions and resources

Both movement and respiration organise seamlessly across the voluntary – involuntary divide and between them, offer the greatest potential for regulation and crisis resourcing. There are several key aspects relevant to crisis intervention and resourcing.

Amplification and sense of agency

Slow and medium speed movements such as walking or dancing for example, and particularly in conjunction with sensory attention, will amplify proprioception and kinaesthetic experience which in turn can restore some sense of agency and mastery in the world in moments when the individual may feel helpless or powerless. There is a parallel with Post Traumatic Stress Disorder which is typically associated with incidents in which the person was unable (e.g., powerless, helpless or incapacitated) to escape from, or act within, a traumatic event. Schalev's (Shalev, 2003) case vignettes describing extreme events illustrate how aspects of motor agency or movement are present in traumatic events responses and recovery.

Vertical and horizontal postural dynamics

Upright, standing positions are the most dynamic postures and therefore offer the greatest sense of agency and autonomy (Boadella, 1994). Horizontal postures in contrast typically improve access to vulnerability, feelings, or indeed to regressed states (as utilised by the psychoanalytic couch). As such, postural dynamics might be a salient psychophysiological aspect in a therapist's awareness or may offer potential crisis interventions.

'All clear, stand down' signals

While human anatomy does not provide any 'wiring' for direct communication that would allow us to communicate in some cognitive fashion from left brain language centres to the neurological alarm centres (Alan Schore, personal communication on 10. 9. 2005), we may nonetheless communicate indirectly. Extending the exhalation phase of a breathing pattern for a period appears to quite effectively communicate 'all-clear, stand down' signals to the neurological alarm centres. While we have yet to comprehensively understand such easily observable phenomena, neuroception (Porges, 2004) and reciprocity of top-down and bottom-up processes might provide at least partial explanations.

Stacking phenomena

Combining two or more dimensions of experience are likely to increase their effectiveness beyond the sum of their parts. These phenomena are widely recognised in dance movement and body psychotherapies and commonly utilised to deepen experiences for example, but are equally useful for crisis interventions and resourcing. For instance, when a client identifies that a walk from bus stop to work place forms a positive resource, the therapist might encourage the client to experiment with adding one or more dimensions of experience. For example, this could be a sensory awareness of feet on the ground or sensing the sun, or the breeze, on the skin. Awareness of breathing patterns (and lengthening the exhalation part when appropriate) could add a third dimension. An affective imagery or words might add further realms of experience and thus help building a powerful personal resource.

Contact channels

Boadella (1994, 2016) conceptualises four primary contact channels that facilitate our contact, interaction, and information exchange with others and our environment:

- (1) eyes/visual,
- (2) voice/hearing,
- (3) hands/arms,
- (4) feet/legs.

In Boadella's conception, a temporary functional decline of all four contact channels may equate to a semi-psychotic state with associated reflective or cognitive functional impairments. In a crisis state, therapists may consider which channels are available for a client to facilitate awareness of, contact or interaction with the therapist, or the environment, and shape their interventions accordingly as the following vignette may illustrate:

In an experiential training workshop setting, participants worked in small groups of four. The facilitator noticed something unusual happening in one of the groups and went to over to investigate. A male participant was lying on his back and appeared in an escalating hyperventilation state. The facilitator quickly checked with the student which contact channels remained available. The student struggled to communicate verbally and his hands and fingers were already curling up (a common hyperventilation symptom). Responding to the facilitator's enquiry, he indicated that he could still sense his feet and he was assisted into a standing position. The facilitator took his hands to support his balance and then utilised the hand contact to invite some small movements. These rapidly and quite spontaneously expanded into hopping around the room together whilst keeping the hand connection. The necessary motor effort required for the hopping motions quite naturally restored the student's respiration into a balanced pattern without any further interventions. On reflection, it appeared that this abreaction had been triggered when his group peers unwittingly touched upon some unprocessed historic traumatic disturbance.

Awareness of hyper- and hypo-responses

Clients commonly benefit from developing such awareness (or 'mindfulness') and from finding ways to recognise and manage such responses. This can also lead to further reflective insights relevant to resourcing. One client for example, who in a digital meeting tracked her somatic symptoms during an exploration of her lower back region, noticed how a habitual posture was 'not supporting myself'. Building on her somatosensory insights, she was subsequently able to resource herself more effectively.

Psychophysiological resourcing

Psychophysiological phenomena and conceptions described above will be present and accessible in a wide range of contexts and activities. We need to consider, however, that resources already known and familiar to clients are most likely to become utilised which makes it paramount to establish all of

a client's 'helpful' activities. These will typically form the starting point to develop expansions of, or additions to, known resources together with the client. The earlier mentioned walk from bus stop to workplace is a good example. We can explore possibilities with the client to extend the walk, for instance by getting off one stop earlier. We can also introduce the 'stacking' principle and invite the client to consider any dimensions of experience they might think useful and doable. Furthermore, it is not uncommon for people to stop helpful activities during a crisis, which may come to light when we explore a client's familiar resources.

Any new psychophysiological crisis skills a client explores during a session will usually benefit from 'being practised'. This will commonly help clients to recall such skills in appropriate moments. As part of a community-based statutory mental health service project, the author facilitated weekly groups for people suffering panic attacks. Participants practised two simple 'exercises', one for indoor and the other for public spaces, which utilised a combination of motor activity and respiration. Both interventions proved highly effective as self-help skills to regulate panic attacks and restore calm states for all participants of these groups, as long as the person recognised the onset of a panic attack in its early stages. For most of their weekly group meetings, participants worked on developing their abilities to notice and track their early initial ANS symptoms which invariably precede any full blown panic attack. While the range of ANS hyper-arousal symptoms is universal, they are nonetheless personal variations with some symptoms more evident than other for each individual.

- Increased sweating;
 - Skin feels cold and possibly clam;
 - Faster respiration, heart rate and pulse;
 - Blood pressure increasing;
 - Skin colour pales, pupils dilate;
 - Digestion decreasing (e.g., food seems to sit on top of the stomach).
- (1) Intervention for public spaces: Standing and leaning lightly with one hand and sideways extended arm on any solid object (e.g., wall, lamp post). Pushing against the object while inhaling, relaxing during exhalation phase. This exercise acquires additional potency when the person is able to 'dose' (Holm Brantbjerg, 2015), i.e. sensing and adjusting the motor-effort to match the momentary felt preferences, which will maximise the effects.
 - (2) Intervention for home or other indoor spaces. This version involves sitting with the upper back resting against a wall (or a door), knees pointing up, and pushing with the upper back against the wall during inhaling and relaxing during the exhalation phase. As with the first, dosing will add further potency. This intervention can also

be used on chairs with straight and fairly solid backs. Reportedly it also works well on public transport such as bus seats for example. Such interventions are also highly effective via telephone as the following vignette illustrates:

Jennifer initiated a crisis telephone call to her psychotherapist. She reported that she was in the midst of a panic attack. The therapist quickly established Jennifer's surroundings to assess her situation. Jennifer was alone in her office and had sought refuge underneath her desk. He then directed her to sit with her back to a wall and talked her through the intervention described above. His own situational circumstances allowed him to assume a similar position and thus mirror the intervention (this aspect is not necessary but can increase the effectiveness of this intervention). Within a few minutes, Jennifer was able to adequately restore her functioning capacity.

Common aspects of crisis intervention perspectives and interventions shared with cognitive or 'talking therapies'

While this article is primarily dedicated to psychophysiological dynamics, it is relevant to mention some common reference points which are widely established and commonly guide cognitive crisis interventions. These references or 'attention to' points are universal and should equally frame psychophysiological interventions, be that in face to face, online, or telephone meetings.

- Talking through any presenting crisis issues and lowering stress levels.
- Reality testing and reframing (e.g. recognising the limits of a person's powers or responsibilities).
- Identifying tasks, prioritising problems, setting achievable goals (within the person's limits of responsibility and power).
- Building on existing strengths and resources (supporting clients to recognise and value their strength and capabilities can be empowering).
- Inviting clients to identify already familiar 'helpful' activities or objects. What are they, how are they helpful? Such conversations often lead to better recognition of known resources, or expansions of these, or recognition of unutilised resources.

Such common cognitive aspects of crisis intervention are manifestly supported by psychophysiological perspectives or interventions and both realms will generally compliment one another effectively.

Survival intelligence

'Survival intelligence' (SI) is a term coined by Holm Brantbjerg (2012) for a psychophysiological response to persistent high stress situations, also

described as ‘low-road processing’ by Siegel and Hartzell (2004). SI appears as a relatively high-functioning variant within the dissociative spectrum since SI is associated with more effective decision-making in fast moving situations compared to common low-functioning dissociative psychophysiology dynamics. It appears that survival intelligence is more commonly observable in geographical locations where war or civil war created persistent high stress situations (e.g. the Balkans or the Middle East). But the Covid-19 virus may well create similarly persistent high stress situations for professionals at the frontline of the pandemic. While survival intelligence will be quite an unlikely presenting issue, it may well enter the consulting room in other ways. The key phenomena that can alert therapist is a conspicuous ‘matter of fact’ mode, or emotional disconnect, whenever one particular subject, ‘*the war*’ for example, becomes a conversation topic. This is typically in distinct contrast to how the same person may speak about other subject matters. While SI seems a learned and quite effective crisis response, it typically impairs the individual’s capacity for reflective emotional-psychological ‘high road processing’ (Siegel & Hartzell, 2004) of events and experiences. This puts client’s presenting with SI at risk of burn-out, and particularly so when abilities to rest, switch off, or sleep are impaired simultaneously (Holm Brantbjerg, 2012). As such, it may be appropriate to alert clients who present with SI to the risks and encourage them to take steps as soon as the present crisis situation comes to an end.

Conclusions

Whilst psychotherapy crisis intervention differs quite fundamentally from primary, depth-psychology-oriented, psychotherapy practice, it utilises common psychotherapeutic skills, and incorporates the same values and clinical ethos. Crucially, crisis intervention follows, and abides by, universally recognised psychotherapeutic principles such as the notions of therapeutic space and alliance, of a collaborative endeavour protected by a contracted ‘formal frame’, or commitments to enhance a clients personal autonomy and agency. Within the psychotherapeutic context, crisis intervention constitutes a vital response to external situations a client is temporarily faced with, with the aim to prevent further destabilisation and harm. Commonly, any periods of crisis intervention, which may be necessary within an ongoing therapeutic relationship, will strengthen the therapeutic alliance and thus also benefit any macro or long-term therapeutic goals pursued by a client.

Body and dance movement psychotherapists will be able to draw on a range of stabilising and resourcing interventions which are already well established by somatic trauma psychotherapy approaches. Whilst such bodied interventions, and associated psychophysiological perspectives, appear highly significant for crisis interventions, we need to address the paucity of research

and publications on applying our field's rich body of knowledge when acute ongoing crisis states are a presenting issue. Body and dance movement psychotherapies are well equipped to further develop the crisis intervention knowledge base, publicise these and provide such services. The impact of this devastating pandemic will hopefully stimulate our field to give more attention to this salient but neglected aspect of psychotherapy. Arguably, crisis conceptions and interventions are of wider relevance beyond the current pandemic.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes on contributor

Tom Warnecke (PgDip, ECP) is a relational psychotherapist, supervisor, consultant, artist and writer. His work is grounded in psychodynamic and psychophysiological perspectives and he teaches internationally for various psychotherapy and supervision diploma courses. His publications include book chapters and articles, the book *The Psyche in the Modern World - Psychotherapy and Society* (Karnac 2015), and a relational-somatic approach to Borderline trauma he developed. He is a co-editor for this journal, a European Association for Psychotherapy (EAP) Executive Committee and Governing Board member, and a former UKCP Vice Chair.

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