The importance of therapeutic presence for the pediatric chiropractor: "getting into right relationship"

By Anne Matthews DC, Dip Biomech, FRCC

Corresponding Author: Anne Matthews DC, Dip Biomech, FRCC.
Belfast Chiropractic Clinic, 228 Ormeau Road, Belfast BT7 2FZ UK
Email:annematthewsbcc@gmail.com

ABSTRACT

There are essential ethical elements required for a chiropractor to establish an authentic professional relationship in order to maintain the integrity of a healing relationship with their patients. Ethically, chiropractors also have an ongoing responsibility to do their own personal and professional development. Therapeutic presence is the capacity to hold a healing space for another person by developing trust and rapport and providing them with a safe energetic container influenced by one's calm and centered state of being. The Polyvagal Theory provides a neurobiological narrative that focuses on the importance of 'safety' and the adaptive consequences of detecting risk on our physiological state, social behavior, psychological experience and health to achieve presence. To fulfill our biological imperative of connectedness, our personal, professional and ethical agenda needs to be directed toward making patients feel safe in the moment and getting into right-relationship. Recognizing and interpreting the mother/baby dyad's adaptive behaviors provides an insight into their pre & perinatal imprints which reflect the child's Baby Body Language patterns.

Key words: ethics, right-relationship, chiropractor, therapeutic presence, Polyvagal Theory, safety, co-regulation, pediatric, birth trauma, pre & perinatal imprints.

Introduction

Professional relationships, especially in health care, work best when there are two essential ethical elements present.[1] The first is to have the willingness to be in a relationship in which authentic care is offered. The second element considers the motivation and willingness of the practitioner to shift whatever is needed, on both a personal and professional perspective, to bring themselves into "right-relationship" when necessary and to invite the patient (or in the case of the infant, the patient and parents) to be there with them.

Lambert found the therapeutic relationship to be at least 30% of what is healing for a client undergoing therapy.[2] Various studies have shown that in the therapeutic, medical, perinatal care, educational, mentoring or spiritual relationship, it is the relationship itself that is at the heart of healing.

The importance of any chiropractor or health care professional (HCP) establishing and maintaining the optimal standard of ethics and integrity is at the core of any healing relationship. The manner in which one enters into right-relationship in the therapeutic relationship involves how one can work with one's inner ethics, one's own self-discovery and course-correction so that one can consistently adapt to the constantly changing zone of connection with another person.

Ethically, health care professionals, including chiropractors, have an ongoing responsibility to their patients, colleagues and students to do their own personal and professional development work. Such self-reflective work is essential to prevent their own lack of self-awareness or have potentially unhealed blind spots interfere with the patient's healing trajectory. The role of the practitioner is to do whatever is appropriate to support and assist them. Basically, the chiropractor has a duty of care to show up as the best version of themselves as they apply the biopsychosocial model of care.

Such failure on the part of the HCP can be noticed by patients energetically and is often the issue around the misunderstanding, mishearing and lack of connection with the chiropractic patients (or parents of pediatric chiropractic patients) which may contribute to non-compliance of a treatment plan and less than optimal outcomes. Patients may leave the treatment room feeling dissatisfied and offended. They may perceive that there has been an injustice done to them while relating their experience or their pain and/or their child's lack of progress after that encounter. Such a situation paves the way for the disgruntled patient or parent whose perceived needs have not been met as they may not have been heard in an authentic and relatable way. Such miscommunications are cited as the second most common complaint against a chiropractor in 2020 to the General Chiropractic Council, the statutory regulatory body for chiropractors in the UK. Fortunately, the majority of those result in an admonishment being exercised against the chiropractor rather than a professional negligence case.[3]

Furthermore, as chiropractors are professional caregivers, professional compassion fatigue or burnout is often identified as being related to their own unresolved emotional and psychological issues. These factors, together with the amount of life stress indicators, tend to be the main issues rather than burnout being directly related to the number of patients they have on their caseload.[4] When a path into right-relationship is navigated from a strong ethical and authentic base, practitioners are more capable of achieving full personal mind/body presence which in turn creates the foundation for a strong therapeutic presence.

Therapeutic Presence

Therapeutic presence is defined by Scurlock-Durana (2010) as the capacity to hold a healing space for another person by developing trust and rapport and providing them with a safe energetic container influenced by one's calm and centered state of being.[5] This presence amplifies the effectiveness of whichever skills the chiropractor has at his or her disposal and contributes to healthy treatment outcomes. As a chiropractor's own personal presence is the foundation for a strong, therapeutic presence there are basic skills needed to achieve this.

When a chiropractor is mindful, as in being conscientious and intentional in what they do, this allows them to be more open and creative with possibilities. Being mindful and practicing chiropractic with a conscious state of awareness enables the chiropractor to be more flexible, receptive and to be present. With such practice, they will tend to move toward an approach to a state of regulated neural firing and move toward, rather than away from difficult situations.[6] Cultivating presence and being mindful can provide the chiropractor with the resourcefulness that can help in one's life calling with more resilience and efficiency. Research by Goleman has shown that self-awareness is one of the starting points for both emotional and social intelligence.[7]

Establishing and respecting ethical and healthy relationship boundaries allows chiropractors and other health care professionals (HCPs) to nurture their resources and their own healthy lifestyle while filtering out what is physically, emotionally, energetically and spiritually draining.

Recognizing and tracking disrupted body presence in our patients is an ongoing and intuitive skill facilitating the experienced pediatric chiropractor to track and observe signs and expressions of their patients' internal landscape. One must listen to the patient and "hear" what is not being said. First, however, it is equally important that the chiropractor learn and master how to access and monitor their own inner world for the subtle cues and develop their body's innate intelligence. The impaired ability to sense or feel certain parts of their own body due to physical or emotional trauma; disease, physiological stress and exhaustion; sensory disorganization, or cultural or religious rules about body awareness can skew their perception and interfere with how the pediatric chiropractor can relate to children and their parents.

The ability of a chiropractor to recognize and interpret sensory information and subtle cues in their body and environment allows for developing energetic awareness. As a chiropractor, or any HCP, this is an integral part of tracking their internal physiological environment and navigational system while being aware of their physiological state in the moment. Developing their body's natural capacity to discern and track what is happening internally and externally allows the chiropractor to make more informed and intelligent decisions. This is a prerequisite to facilitating therapeutic presence in the treatment room.

Safety and social engagement

The Polyvagal Theory (PVT) provides the vehicle for explaining the importance of physiological state. The PVT describes how intervening variables influence behavior and our ability to interact with others. The theory explains how safety is not the removal of threat but that feeling safe is dependent on unique cues in the environment and in our relationships that have an active inhibition on neural defense circuits and promote health and feelings of love, trust and connection.

Porges, in 2017, highlights that current parenting and educational strategies are targeted toward expanding and enhancing cognitive processes while inhibiting bodily feelings and impulses to move. The result is a cortico-centric orientation in which there is a top-down bias emphasizing mental processes and minimizing the bottom-up feelings emanating from our body.[6]

Furthermore, Porges emphasizes that safety is associated with different environmental features defined by bodily responses versus cognitive evaluations. Our cognitive evaluations of risk in the environment, including identifying potentially dangerous relationships, play a secondary role to our visceral reactions to people and places. Porges further identifies that neuroception is the neural process that evaluates this risk in the environment which is without conscious awareness.[7]

The PVT provides a neurobiological narrative that focuses on the importance of 'safety' and the adaptive consequences of detecting risk on our physiological state, social behavior, psychological experience and health.[8] The ability to sense safe states is a prerequisite not only for social behavior but also for accessing the higher brain structures that enable humans to be creative and generative. PVT emphasizes the bidirectional communication between bodily organs and the brain through the vagus and other nerves involved

in the evolutionary adaptation to the regulation of the autonomic nervous system (ANS).

Presence depends upon a sense of safety as the brain continually monitors the external and internal environments for signs of danger. This neuroceptive evaluation involves prefrontal, limbic and brainstem processes and is shaped by ongoing appraisal of the significance of an event while referencing it to historical events of a similar type from the past. Knowing one's own neuroceptive tendencies is a necessary first step in creating presence as a chiropractor.

When a situation is perceived as threatening, the chiropractor, like any other human, will tend to move from the open state of receptive presence to the reactive physiological state of fight, flight, freeze or dissociation. Here the plateaus and peaks are on survival mode and drive the inner experience and neural firing patterns in engrained and limited ways. Siegel further highlights that the therapist, in this case the chiropractor, then disengages and shuts down the options with clients and limits presence.[9] As for patients becoming similarly physiologically reactive, this restricts their capacity to be open to the therapist's presence and their therapeutic interventions. Presence requires a tolerance for uncertainty and vulnerability as the therapist or chiropractor monitors their internal physical and mental world in order to create an integrated state of being. Siegel states that integration creates an openness for possibility and is at the heart of presence.

From a PVT perspective, the clinical interactions as a chiropractor in facilitating a meaningful therapeutic experience is by looking, listening and witnessing the patient in the present moment. This social engagement system experiences bodily feelings and is a portal for changing these feelings along a continuum extending from a calm, safe state that would promote trust and love to a vulnerable state that would promote defensive reactions. This shift involves the dynamic bidirectional communication between bodily state and emotional processes during a social interaction between both the chiropractor and patient, as in the therapeutic setting.

For this social interaction to be mutually supportive and enable a co-regulation of physiological state, the expressed cues from the dyad's social engagement systems need to communicate mutual safety and support. When this occurs, the active participants as for example, the pediatric chiropractor and child/mother dyad, will then have a sense of feeling safe with each other.

Furthermore, the bidirectional system linking physiological bodily states with facial expressions and vocalizations provides the portal for social communication that involves requests for neural co-regulation and mechanisms to calm and repair co-regulation following neural disruptions.

For example, how we look and see each other is a critical feature of this capacity to connect. Subtle cues of understanding, of shared feelings, and of intent are therefore conveyed. These cues which often covary with the intonations or prosody of vocalization, are also communicating the physiological state. A portal to change our physiology can be both through the breath and through listening as vocalizations, are important cues of safety which can create contexts to enable people to feel safer.[10] As such, a chiropractor can therefore facilitate a change in physiological state for their patient by using and reading these cues proficiently.

Understanding and applying the PVT is pivotal for connection and co-regulation with others which is one's basic biological imperative. To fulfill the chiropractor's biological imperative of connectedness, the personal, professional and ethical agenda needs to be directed toward making individuals, (the patients) feel safe. It is not really what you say – it is how you say it that makes the nervous system feel safe. This is the essence of creating a platform for therapeutic presence.

Birth trauma

The human ANS responds to danger and life threat with a common stress reaction that is associated with the sympathetic nervous system (NS) and the hypothalamus-pituitary-adrenal (HPA) axis. PVT emphasizes that danger and life threat elicit different defensive response profiles. According to the theory, danger reactions are associated with the accepted notions of a stress response expressed which increases in autonomic activation through the sympathetic NS and adrenals. However, PVT also identifies a second defense system related to life threat that is characterized by a massive down-regulation of autonomic function by an ancient pathway of the parasympathetic NS.[11]

The 'classic' stress response of mobilization is manifested in fight/flight reactions. The second defense system as proposed by PVT is one of immobilization, behavioral shutdown and dissociation. Although the fight/flight reaction is functionally adaptive in response to danger cues, the behaviors associated with immobilization are less adaptive when there is an inability to escape or physically defend. When the body immobilizes in defense, it goes into a unique physiological state that is potentially lethal which is not a conscious or voluntary response. It is an adaptive biological reaction to the inability to utilize fight/flight mechanisms to defend or to escape. This reflexive response is displayed, for example, when someone passes out in fear. The human NS is continuously evaluating risk in the environment, making judgements and setting priorities for behaviors that are adaptive. As the process occurs without

our awareness and without the conscious mental processes that we attribute to the prefrontal cortex, executive brain functions involved in decision-making.

Chiropractors who are working unknowingly with a patient who has a history of trauma, need to be familiar with the immobilization defense system. For example, the birthing experience can be viewed as a traumatic event for many women and could impede her anticipated response to treatment for her reported chief complaint. The root of her problem could be left unaddressed if the chiropractor only views the postpartum patient from a purely biomechanical perspective. Similarly, if a baby is evaluated as a separate entity from their biological mother and from the mother's birthing narrative then a vital neurophysiological and somato-emotional piece could potentially be missed. This could be perceived as a disservice to the baby or child as their birth history, a once in a lifetime event, would be skipped over.

Developing that scenario further, consider the woman whose NS was adapting to the long, intense pain of labor and as a result the physiological shift triggered the ANS towards the parasympathetic NS and to a dissociated adaptive state. The woman then receives an epidural for pain relief which would help her to regulate back to a social engagement state which then would allow her the emotional space to resource herself in preparation for delivery.

Now consider the baby's experience during this scenario given the raised cortisol levels in the maternal blood supply together with the awareness of her mother's NS dissociating and losing connection with the baby within. The intended pain relief from the epidural will assist the mother's NS in the short term. However, the baby will still be experiencing the compressional forces of labor within the birth canal but will experience them without the supportive connectedness of mother who now has disengaged from her "felt sense" and connection with her baby.

This is one of the many points during the gestational timeline when the neurological, physiological and emotional connection between the baby/mother dyad can be interrupted. As such, a mother's "felt sense" and in-the-moment presence is not in sync with her baby. In turn, the baby's NS will also adapt and may dissociate into parasympathetic survival mode. Such adaptive behaviors are displayed as in their pre & perinatal imprints described as their Baby Body Language patterns. These are important cues for the chiropractor who wants to be in right-relationship with both the mother and baby separately, while recognizing the autonomic state of the mother/baby dyad in order to be able to navigate a path towards achieving therapeutic presence within the treatment session.

For some people, traumatic events are just events, while for others these same events trigger life-threatening responses. Their bodies respond as if they are going to die. For example, the father observing the delivery of his baby or a mother delivering her own baby, can trigger their own individual early pre and perinatal imprints and past experience neural response patterns which may appear to have been life threatening. For some people, specific physical characteristics of an environmental challenge will trigger a fight/flight behavior, while others may totally shutdown in response to the same physical features. For example, the overhead bright lights in a delivery room could be a traumatizing trigger, for example under the lights in the dentist's chair. Understanding the response, not the association to a traumatic event, is more critical to the successful treatment of trauma.[12]

Neuroception and PTSD

Neuroception is a term coined by Porges which he uses to describe the process that evaluates environmental features of risk which trigger the neural circuits to shift autonomic states. This is different from perception which requires awareness and conscious intention while neuroception occurs reflexively.

Within the PVT, neuroception was postulated as a mechanism to shift the ANS into three broad states defined by the PVT (i.e. safety, danger, life threat) and to emphasize the potent role of the mammalian social engagement system, including the face, heart, and myelinated vagus, in down-regulating both the fight/flight and shutdown defense systems.

For example, the touching of a patient's head while rotating their neck, as in setting up for a gentle cervical adjustment can trigger a reflexive defensive pattern related to how that person may have had an assisted forceps delivery. These are the cues that the NS is detecting from a tissue memory of a past experience.

As per the PVT, when the social engagement system is engaged and working, it down-regulates defenses and people will feel calm, hug each other, and observers will look at them and feel good for them. However, when evaluated risk increases, the two defense systems take priority. For example, in response to danger, our sympathetic NS takes control and increases metabolic resources to support motor activity for fight/flight behavior. If, however, that doesn't help the individual to have a sense of feeling safe, they then will recruit the ancient unmyelinated vagal circuit of the parasympathetic NS and shut down or dissociate.

It would be clinically relevant for the chiropractor who seeks to be in right-relationship to develop protocols for neural regulation to assist patients in down-regulating defense

strategies in order to move optimally towards achieving therapeutic presence. When the social engagement system is triggered through the felt sense through neuroception, the social interaction calms the physiology which supports overall health, growth and restoration.

One such pediatric management protocol recommended by the author, would be for the chiropractor to avoid physically separating a mother/baby dyad while carrying out any intervention and instead to work with the newborn or baby while remaining on the mother's lap. This would assist the chiropractor in tracking any physiological state change between the mother or baby and them, and between the dyad. The chiropractor could then track and readily facilitate an optimal state change towards social engagement for either the mum or baby. Separating a baby or young child from a parent can trigger both their own individual defense mechanisms and has the potential to escalate into an non optimal therapy situation. Interventions administered with positive intentions that may involve restraint may also trigger trauma responses unintentionally, including PTSD.[14]

As an example, chiropractic upper thoracic and cervical adjustments could potentially trigger cues of danger in both children and adults that were related to early imprints from the interventions in forcefully assisted delivery at birth.

Societal bias

In our society there is a bias against discussing the birth experience, a once in a lifetime experience for the baby, and which also can be an intense transformational experience for a mother. However, the manner in which this discussion is facilitated is of paramount importance as trauma resolution needs to be the negotiable factor between the patient and chiropractor.

Unresolved birth trauma for both a mother and a child can result in a lifelong narrative in which the recall of the event triggers an identification. For example, consider the example of a mother in a social setting talking about her 20 year old son's birth as an event that "made her never have another baby." A mother's narrative such as this has the potential for having an ongoing impact on her relationship with her son as a young adult because of her early issues with bonding and attachment as a result of her trauma. Equally, the son's emotional perspective from this narrative could be that he was the causative factor in his mother's trauma. Trauma resolution is about taking ownership and the chiropractor has a responsibility to lead by example and model behavior that is conducive to evolving a patient's somato-emotional intelligence. Taylor simply refers to the ethical dilemma, 'as do no harm and know thyself because what one does not know about oneself can unintentionally cause another harm.'[1]

Many of the defensive behaviors we observe in the chiropractic office are adaptive behaviors that are triggered by a patient's unconscious neuroception which can lead to misinterpreting the intentions of the chiropractor's cues. As a chiropractor, it is important to recognize and track the patient's apparent sense of feeling safe as portrayed by the PVT in order to moderate their ability to develop secure attachments. This in turn provides the patient with an understanding of the important role of one's physiological state in both prosocial behaviors and in response to trauma.

This understanding reduces the shame associated with assuming that the patient's behavior or reaction to a chiropractor's intervention is related to a voluntary decision, which is often a stigma that a patient can experience. For example, one chiropractor declared their patient "the worst patient I've ever had" as he roughly and insensitively pushed his finger into the patient's mouth to perform a pterygoid muscle trigger point release as the patient audibly gagged and struggled to move away and she felt ashamed and responsible for her perceived lack of cooperation.

According to Porges, as our NS likes predictability, then a vital treatment goal would be to provide the patient with the ability to access a physiological state that enables social engagement, rather than perpetuating a defensive state that has the potential to interfere with recovery. Explaining to a new mother that her unsettled baby is displaying a defensive pattern has the potential to educate, reassure and build her confidence and empower her to manage her newborn's physiological and emotional needs.

Guiding and assisting a distressed mother to change her physiological state from fear and shame, to feeling empowered so that she can understand and interpret her child's "Baby Body Language" is what can be achieved by the chiropractor being in right-relationship and in therapeutic presence. For example, in the treatment room when engaged with a child, the chiropractor could explain to the child that they want to show their parents how clever the child's nervous system has been at adapting to the situation that made them feel unsafe. This allows the practitioner to model a narrative of viewing the child's behaviors in the positive rather than in the conventional way of listing the negatives relating to the child's perceived dysfunctional behavior. The chiropractor can then assist both the parent and child to celebrate the child's adaptive behaviors as it was these responses that enabled them to survive.

This approach creates a bridge of understanding and promotes navigating a path for change rather than causing a mother to feel guilty or responsible for their child's past or cause a child to feel that their body has let them down in some misguided way. The author seeks to emphasize to

the parent the profound importance the adaptive response of the child's nervous system plays, even if the child experiences profound physiological and behavioral states that limit their ability to function in a social world. This approach allows for more realistic expectations for a child's development by having a sound and balanced starting point.

It would be imperative from a PVT perspective to reiterate that there is no such thing as a bad response, just an adaptive response. This is the basic premise in which a child's NS is trying to do the right thing for them to survive. As a chiropractor we need to facilitate a parent's understanding and recognition of this fact. Equally, a parent's NS is also experiencing their own adaptive reaction to the situation which has triggered their NS responses.[13]

It is the authors' view that for a chiropractor to achieve and maintain therapeutic presence they need to track the changing cues of the child and/or the mother/baby dyad's changing physiological states to social engagement. The application of the ongoing evaluation of these states functionally contributes to the treatment and healing process and facilitates a sound basis for the ongoing connectedness of the mother/child dyad.[14]

Such an inclusion in the chiropractors' management style will facilitate an ongoing ethical permission-based practice for executing any therapeutic interventions. By the pediatric chiropractor focusing their intention and attention to tracking the child or the dyad in a session would translate into the chiropractor knowing 95% more about the dyad, than the dyad knows about them at the end of each session. (Caution should be exercised in sharing unnecessarily one's personal narratives in the session, in order to stay focused in remaining in therapeutic presence with the dyad.)

Conclusion

Practicing the principles of therapeutic presence requires patience, experience and ongoing commitment as it is an invaluable model or paradigm of conscious awareness for helping others. A chiropractor who chooses the path of self-development to help them be more present for others in each moment, in a space of caring and compassion, would enable them to receive as well as give. The ability to serve in presence for someone else's healing brings the professional into a deeper state of grace and resonance.

When both the chiropractor and mother/child dyad respect their own individual body's physiological responses, they move towards a more evaluative state in which they become more respectful of themselves and the treatment outcomes. The PVT provides the neuroscience in understanding the continuum between the physiological states of fight, flight, freeze and dissociation. The application of the ongoing evaluation of these states functionally contributes to the treatment and healing process and facilitates a sound basis for the ongoing connectedness of the mother/child dyad.

The way in which practitioners are grounded in themselves, open to others (while holding appropriate boundaries) and participate fully in the life of the mind and body, are important aspects of practicing therapeutic presence which is at the heart of relationships that help others to grow. This inside-out view helps chiropractors to see the ongoing personal development work they need to do as professionals to develop the essential receptive starting place of therapeutic presence for all clinical encounters.

References:

1. Taylor K. *The Ethics of Caring. Finding Right Relationship with Clients*. Third Edition. Santa Cruz, CA: Hanford Mead Publishers, Inc; 2017.

2. Lambert M.J. Psychotherapy outcome research: Implications for integrative and eclectic therapists. In C Norcoss & M. Goldfried. *Handbook of Psychotherapy Integration*. New York, NY: Basic Books; 1992.

3. General Chiropractic Council, UK: Fitness to Practice Annual Report 2020.

4. Taylor K. The Ethics of Caring. Ch 4 *The Ethics of Caring Model*. Third Edition. Santa Cruz,CA: Hanford Mead Publishers, Inc; 2017.

5. Scurlock-Durana S. *Full Body Presence. Learning to listen to your body's wisdom*. Novato, CA: Nataraj Publishing, New World Library. 2010.

6. Davidson R.J. The neurobiology of personality and personality disorders. In D.S. Charney & E. J. Nester, *Neurobiology of Mental Illness* (2nd ed., 1062-1075. Oxford:Oxford University Press.

7. Goleman D. The Emotionally Intelligent Leader. Harvard Business School Publishing. 2019.

8. Porges S. The Pocket Guide to The Polyvagal Theory. *The Transformative Power of Feeling Safe*. New York, NY. W. W. Norton & Company, Inc; 2017.

9. Siegel D. *The Mindful Therapist*. Ch 1 Presence. 12-23. New York, NY: W.W Norton & Co., Inc: 2010.

10. Porges S. Neuroception: A subconscious system for detecting threats and safety. *Zero to Three* 2004 May; 24(5),19-24.

11. Porges S. The Polyvagal Perspective. *Biological Psychology* 2007 Feb: 74 (20),116-143.

12. Porges S. *The Polyvagal Theory: Neurophysiological foundations of emotions, attachment, communication and self regulation*. New York, NY: W. W. Norton & Co, Inc; 2011.

13. Porges S. The polyvagal theory: New insights into adaptive reactions of the autonomic nervous system. *Cleve Clin J Med* 2009 Apr; 76(12): 86-90.

14. Ogden P et al. *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: W.W Norton & Co., Inc: 2006.