Certified Clinical Trauma Professional:
Two-Day Trauma Competency Conference

J. Eric Gentry, PhD, LMHC, FAAETS
Board-Certified Expert in Traumatic Stress

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Two-Day Trauma Competency Conference

Developed, written, and presented by
J. Eric Gentry, PhD, LMHC

Table of Contents

WELCOME

10 Core Competencies of Trauma, PTSD, Grief & Loss

1. **Competency 1. Identify and Utilize the Evidence-Based "Active Ingredients" for Successful Trauma Treatment – Day 1.**
    - The participant will be able to articulate the three primary "active ingredients" of effective treatment for PTSD and complicated bereavement
    - The participant will have skilled understanding of how to implement and utilize these three ingredients within the treatment trajectory for treatment with clients who have diagnoses of PTSD and/or complicated bereavement.
2. **Competency 2. Ability to Develop and Enhance Therapeutic Relationship & Positive Expectancy – Day 1.**
    - The participant will understand the how and why the therapeutic relationship (including positive expectancy) is the MOST crucial element of treatment and why it must be achieved before treatment can be effective.
    - The participant will gain skilled utilization of empirical, evidence-based practice of developing and enhancing therapeutic relationship as the foundation of treatment and towards enhanced outcomes with their clients.
3. **Competency 3. Ability to Teach Clients the Role that Perceived Threat and the Autonomic Nervous System Plays in the Development and Continuation of PTSD Symptoms – Day 1.**
    - The participant will gain sufficient knowledge to educate their clients about the role that perceived threat and the autonomic nervous system plays in creating and exacerbating all anxiety symptoms.
    - The participant will be able to articulate how perceived threat and the dysregulation of the autonomous nervous system negatively affect the trauma survivor.
4. **Competency 4. Ability to Achieve, Maintain and Teach Relaxation & Self-Regulation Skills – Days 1 & 2.**
    - The participant will gain understanding and appreciation of the importance of ANS regulation (both for themselves and their clients) as a primary treatment intervention with trauma survivors.
    - The participant will acquire sufficient understanding of this process to teach their clients this important trauma resolutionskill.
5. **Competency 5. Understand Causes, Symptoms and Treatment of Posttraumatic Stress Sufficiently to Provide Comprehensive Psychoeducation to Clients – Day 1.**
    - The participant will acquire sufficient knowledge of causes, symptoms and course of PTSD to help clients understand their symptoms as a "normal" adaptive response to trauma and help them shed shame and stigma associated with the diagnosis of PTSD.
    - The participant will develop capacity to implement this CBT skill of trauma psychoeducation as a treatmentintervention.

6. **Competency 6. Ability to Assess PTSD Symptoms sufficient to Make a PTSD Diagnosis – Days 1 & 2.**
    - The participant will practice using the Clinician Administered PTSD Scale and other methods to learn the diagnostic criteria for PTSD.
    - The participant will become skilled at making PTSD diagnosis with their clients.
7. **Competency 7. Ability to Help Trauma Survivors Achieve "Good Enough" Safety and Stabilization (Phase I) – Day 2.**
    - The participant will learn the Tri-Phasic Model for Treatment of Traumatic Stress and be able to conduct treatment within its parameters.
    - The participant will learn the Six Empirical Markers for "Good Enough" Safety & Stabilization.
    - The participant will acquire skills for teaching client relaxation, self-regulation, containment, self-rescue and expression to help client develop stabilization necessary to transition to Phase II of trauma treatment.
8. **Competency 8. Ability to Utilize Cognitive-Behavioral Method(s) to Help Survivors Successfully Desensitize and Reprocess Trauma Memories (Phase II) – Day 2.**
    - The participant will learn various methods for applying the CBT principles of exposure and relaxation to help clients desensitize trauma memories.
    - The participant will develop skilled utilization of the IATP CBT 5-Narrative Model of Trauma Resolution
9. **Competency 9. Ability to Assist Clients with the Reconnection Phase of Treatment (Phase III) – Day 2.**
    - The participant will develop understanding of the tasks associated with the Reconnection Phase of Treatment.
10. **Competency 10. Ability to Assist Clients Successfully Resolve the Grief and Other Peripheral Issues Accompanying Treatment of PTSD – Days 1 & 2.**
    - The participant will be able to differentiate between common (non-pathological) grief and complicatedbereavement.
    - The participant will learn skills for supporting common grief and treatment principles for resolving complicatedbereavement.

OUTLINE OF THE TRAINING

Day I

Welcome

Intro: What causes Traumatic Stress/What has to happen for its resolution

Active Ingredients Approach – Science-based Practice

1. Therapeutic Relationship
2. Relaxation/Self-regulation
3. Exposure/Narrative
4. Cognitive Restructuring/Psychoeducation

Empowerment & Resilience Treatment Structure

1. Preparation & Relationship
2. Self-regulation & Skills-building
3. Integration & Desensitization
4. Posttraumatic Growth & Resilience

BREAK

Stage 1: Preparation & Relationship

- Informed Consent
- Positive Expectancy
- Therapeutic Excellence using FIT
- Assessment [later in day]

Stage 2: Psychoeducation & Skills-building

- Tools for Hope: What's Behind Trauma and Its Symptoms
  - Perceived Threat
  - Autonomic Nervous System

LUNCH

Stage 2: Psychoeducation & Skills-building (cont)

- *Skills: Self-regulation*
- *Exercise: Self-regulation*

BREAK

Trauma Assessment

- ACES
- *DSM-V*
- Diagnosing PTSD
  - *PCL-5*

HOMEWORK

Day II

Opening Discussion – sharing experiences of self-regulation

Polyvagal Theory

Trauma Assessment (cont)

- Trauma Recovery Scale (Part II and I)

Stage 2: Psychoeducation & Skills-building (cont)

- Graphic Life Line/Narrative

BREAK

- Tri-Phasic Model
  - Safety & Stabilization
- Six Empirical Criteria for Safety & Stabilization
  - Getting out of the war zone – Case Management
  - Am safe vs, feels safe
  - *Skills*
    - *Relaxation*
      - *Progressive Muscle Relaxation*
      - *Safe Place Anchoring*
    - *Grounding*
      - *3-2-1 Sensory Grounding*
    - *Anxiety Management*
      - *Thought Field Therapy Self-Help Anxiety Algorithm*
    - *Containment (End of Session)/Envelope Technique*

LUNCH

Stage 3: Integration & Desensitization (cont)

Grief & Loss

- Uncomplicated: Grief Counseling
- Complicated: Grief Therapy

BREAK

Stage 3: Mid-Tx Assessment

Professional Development

Eric's suggestions for Practitioner; Competence, Expertise and Mastery

Review of Trauma Treatments

- Prolonged Exposure
- Cognitive Processing Therapy
- Eye Movement Desensitization & Reprocessing

Stage 4: Posttraumatic Growth & Resilience

- PTG
- Forward-Facing Trauma Therapy

Course Closure

Healing Trauma: Simple not Easy

I have treated people who suffer the effects of trauma for over 30 years. In the beginning, I was terrified as I sat across from these survivors who put their hope and trust in me to help them navigate through the dark tunnel of traumatic stress. I was afraid that I would not be able to help them, or worse, that I would cause them harm. As a result of this fear, I became a very cautious therapist. With my anxious and overly cautious approach, I can see clearly now how I was actually causing harm and thwarting treatment—although I would have vehemently argued this 20 years ago. My anxiety had its upside though, as it compelled me to accrue more and more training. By the mid-90s, I had become trained in every known treatment, the whole "alphabet soup" of protocols, which had shown efficacy and/or effectiveness in treating traumatic stress. These include: Eye Movement Desensitization and Reprocessing (EMDR I & II); Traumatic Incident Reduction (TIR), Neuro-Linguistic Programming (NLP), TRI-Method, CBT protocols (DTE, CPT, SIT, etc), Dialectical Behavioral Therapy (DBT), Gestalt, Psychodynamic methods, Structural & Strategic Treatment for Dissociative Disorders, Thought Field Therapy(TFT), Somatic Experiencing (SE), Emotional Freedom Techniques (EFT), Hypnotherapy, and Critical Incident Stress Management.

In 1995-96, I completed a fellowship in psychotraumatology at WVU's School of Medicine, where I studied with Louis Tinnin, MD—a man Bessel van der Kolk has named the 20th Century's Pierre Janet. Lou is a genius in working with traumatic stress. He turned Pierre Janet's work of the 1880's into a comprehensive treatment model for effectively treating trauma and dissociation. I was able to assist in some of the research that demonstrated the effectiveness of this treatment. Lou taught me two very important ingredients in successfully treating trauma: the value of narrative and a fearless approach of the client's traumatic material.

After I completed this fellowship, I began my doctoral work at Florida State University where I studied under Charles Figley, PhD. Charles will probably become known by history as one of the most important people in the development of the field of Traumatology. His research in the late 1970s help lead to the diagnosis of PTSD being included in the DSM III. He was the first president of the International Society for Traumatic Stress Studies and was the first editor of the Journal of Traumatic Stress. It was an honor to have him as my major professor. In 1997, I assisted Charles in the development of the curricula for the Traumatology Institute at FSU and became one of the original faculty. In that first year, we won the UCEA award for the best continuing education program in the country. Since that time, as faculty and Associate Director of the Traumatology Institute at FSU, co-director the International Traumatology Institute at USF, and owner of Compassion Unlimited in Sarasota, I have trained nearly 100K professionals in some form of traumatic stress intervention.

In my doctoral coursework, I took the course that we all have to take—the one in which we learn to critically evaluate scientific writing. For my work in this particular course, I wanted to evaluate all the treatments for traumatic stress that had demonstrated effectiveness. In the process of doing this, I decided to ask the research question: "Are there any ingredients in

trauma treatment that are demonstrated to be important to all effective treatments?" After completing a qualitative analysis of the all Discussion sections of each of the articles I reviewed, I discovered that there was a resounding "yes" answer to this question. Integral to almost every effective treatment is the combination of some form of exposure to the traumatic material paired with relaxation.

After reviewing the work of Patricia Resick (1988, 1993), Charles Marmar (1989) and James Pennebaker (1989, 1997), and from my own experience of training with Lou, it became obvious to me that the type of exposure was very important. If we could help survivors construct *complete narratives* of their traumatic experiences while in a *relaxed state,* we could help them to accelerate healing of their traumatic stress symptoms. By facilitating this important narrative process, not only are we assisting them with confronting the traumatic material, we are also helping them to structure the intrusive sensory traumata into language. These previously mentioned researchers have been able to demonstrate that effective narrative construction has a powerful ameliorative effect upon the intrusive symptoms of trauma (i.e., flashbacks and nightmares). Virtually every treatment that demonstrated effectiveness with traumatic stress utilized some form of narrative (exposure) paired with some form of relaxation.

As I progressed in my understanding of central nervous system functioning and especially understanding the role of perceived threat and sympathetic dominance in the etiology of traumatic stress symptoms, I began to see ever more clearly the importance of relaxation. Integrating the work of Bob Scaer (2001; 2006) into my own research on relaxation, I began to see that as a person is able to develop and maintain parasympathetic dominance (i.e., relaxation), then symptoms abate. Through working with Emergency Medical Technicians, Neuro-Muscular Therapists, as well as several psychiatrists and neurologists, I stumbled onto the discovery of how 20-30 seconds of pelvic floor relaxation (e.g., psoas, sphincter, and pubio-coxyx , or Kegel, muscles) precipitates parasympathetic dominance. This simple relaxation strategy fortifies the individual with (a) comfort in their body; (b) total access to memory, language and neocortical functioning; and (c) the capacity for intentional living (more about this in the training). If and when a trauma survivor is able to keep their body relaxed, they no longer suffer symptoms.

For a while I thought and taught that these were the ***only two*** crucial ingredients to effective treatment of traumatic stress—narrative/exposure and relaxation (reciprocal inhibition). In 1999, Hubble, Duncan, and Miller released, in my opinion, the single most import text of the past decade—*The Heart & Soul of Change*. This book is chocked full of paradigm-shifting information. One of the most important truths to come from their huge meta-analytic study was what they learned about predictors of positive outcomes in psychotherapy. They found that the MOST important predictor of positive outcomes in our patient's psychotherapy has nothing to do with the therapy itself—it is occurrences that happen outside of therapy that account for over 40% of positive outcomes. Then, of the 60% that we, as helpers, can influence we find that 30% is contingent upon the development and maintenance of a good therapeutic relationship. The remaining 30% is split equally between positive expectancy (which has also been called either "hope" or "placebo") and techniques/models. There is a good argument that

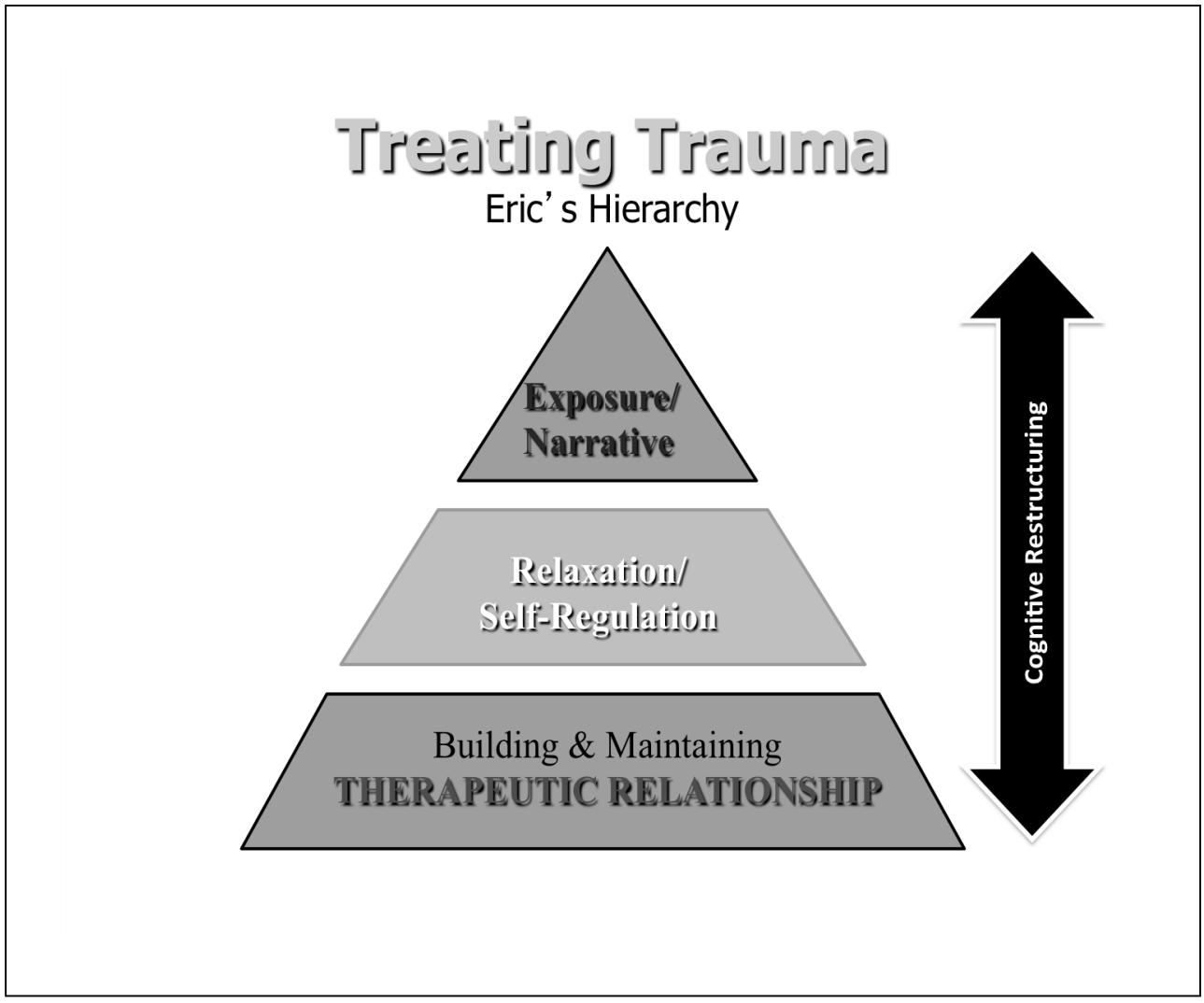
the process of developing expectancy/hope/ placebo is also a relational function. If this is so, then that means the degree to we can influence positive outcomes for our clients, 75% is contingent upon relational factors and 25% is contingent upon technical and/or philosophical factors. This data confirms what I, as a professional care provider for nearly three decades, have always intuited—people heal people! It is not EMDR, or CBT, or psychopharmacology that accounts for most of the magical transformation that happens in our office. It is the quality of the relationships that we build with our clients. All we have to do is confirm the gravity of this truth is to think back upon a time in our own lives when we navigated through emotional difficulty and we'll see that it was the support, care, and presence of another that we recall as the active ingredient in our own successful resolution of this problem.

After fully integrating the work of Hubble, Duncan & Miller, I started seeing that there were **three** "active ingredients" to successful resolution of traumatic stress symptoms— relationship, relaxation, and narratives. Without the relationship developed and maintained, I found that I was unable to successfully teach self-regulation or co- construct narratives with my trauma survivor clients. Since that time, I have treated thousands of people suffering the effects of traumatic stress. I have found that when we complete these three simple (not easy) therapeutic tasks, then my clients no longer meet diagnostic criteria for PTSD. And, unless they have some organic condition, when they complete these tasks they no longer meet diagnostic criteria for ***any*** Axis I or II condition.

Build and maintain a strong therapeutic relationship; teach survivors how to relax their bodies, especially in the context of a perceived threat; and help them construct complete chronological narratives of their traumatic experiences. The completion of these three tasks will heal traumatic stress. Three tasks = Trauma healed. Simple. Not easy but simple. Sometimes it takes years of work through countless sessions to complete these tasks. However, as a professional caregiver helping clients heal from traumatic stress, I am always working on one of these three tasks. I hope that I will be able to convince you, during today's session, of the value in this approach and why a clinician should avoid cognitive work with a trauma survivor. Either way, I suspect we're in for an exciting training.

Biographical J. Eric Gentry, PhD, LMHC is an internationally-recognized leader in the field of disaster and clinical traumatology. His doctorate is from Florida State University where he studied with Professor Charles Figley, one of the pioneers of traumatic stress. Dr. Gentry was one of the original faculty members of the Traumatology Institute and later became the co-director of the International Traumatology Institute at the University of South Florida. Dr. Gentry, along with Dr. Anna Baranowsky, is the co-author and co- owner of the Traumatology Institute Training Curriculum—17 courses in field and clinical traumatology leading to seven separate certifications. He has trained thousands of professionals and paraprofessionals worldwide in the treatment of traumatic stress. He has been a clinical member of several CISM teams and has provided assistance in many different disaster and critical incidents including Oklahoma City, New York City, and hurricanes in Florida. He was the developer of the Community Crisis Support Team, which began in Tampa, Florida and has become a model for

communities to integrate mental health services into their disaster response network. Dr. Gentry has published many research articles, book chapters, and periodicals in this maturing area of study. He is the co-author of *Trauma Practice: Tools for Stabilization and Recovery* published by Hogrefe and Huber in 2004 (2011; 2013) and *Forward-Facing Trauma Therapy* in 2016. He has a private clinical and consulting practice in Sarasota, FL and is adjunct faculty at many universities. Dr. Gentry draws equally from his scientific study and from his rich history of 35 years of professional care giving to balance this training with current, empirically-grounded information and experienced-based compassionate intervention skills. You will be challenged, inspired, and uplifted by Dr. Gentry and this unique day of training.



Certified Clinical Trauma Professional

J. Eric Gentry, PhD, LMHC, FAAETS

Counseling Services of Long Island

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Welcome

Day I

Certified Clinical Trauma Professional

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APA CEU Statement

Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professions standards

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Conflict of Interest

As required by several accrediting boards, speaker and activity planning committee conflicts of interest (including financial relationships with ineligible organizations) were disclosed prior to the start of this activity. To view disclosure information, please see activity advertising or the copyright and speaker biography pages in the front of your program materials.

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Eric's CEU Statement & Biases

- 400+ citations for this course
- Evidence-Based Treatments *DO not* resolve trauma – the *effective delivery* of these treatments by RELATIONALLY & TECHNICALLY proficient practitioners do.
- 37 years of clinical experience. Balance of science and literature-based interventions with practical relational-based delivery
- Anxiety/stress is a threat response. Much of this course is organized around teaching clinicians to interrupt their own threat responses and then teaching clients the same.

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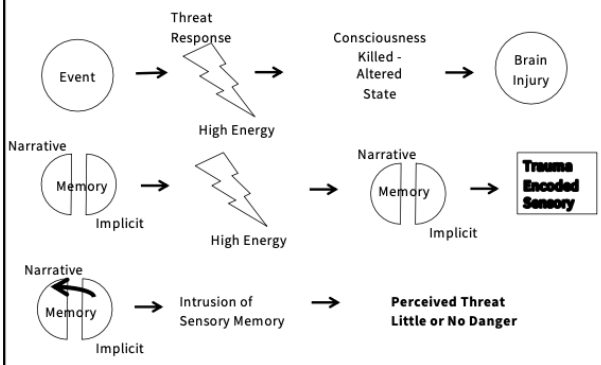
What Causes Trauma



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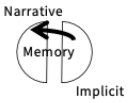
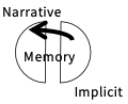
Healing Trauma



→ **Integration:**
Sensory memory into
Narrative (language)



→ **Desensitization:**
Reciprocal Inhibition
Exposure + Relaxation

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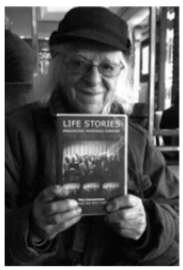
Reciprocal Inhibition



- Joseph Wolpe (1915-97)
- **CS (Anxiety) + Relaxation = Extinguished CR**
- Engine of ALL effective psychotherapeutic treatments for anxiety/trauma
- Most trauma survivors confront perceived threats with ANS arousal (i.e., "brute force"). Treatment proper is teaching them to confront these perceived threats with ANS regulation (left-hand side of Yerkes-Dodson)
- BOUDEWYNS promulgated this idea in 1990. He was, however, inconsistent with the use of relaxation with exposure.

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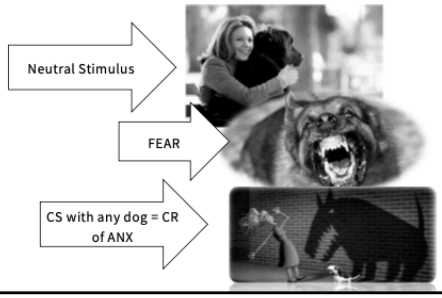
Associational Learning & Reciprocal Inhibition

Pairing Sensory Stimulus with Threat Response = Conditioned Stimulus

Essentially ALL trauma is associational learning



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Reciprocal Inhibition (Extinction)

CS + RELAXATION = Desensitization (extinction) of CR [ANX]

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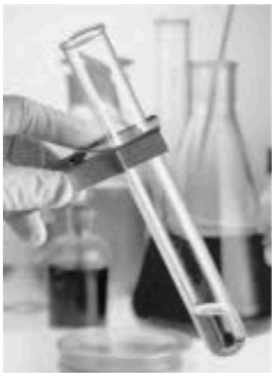

The Active Ingredients Approach

Trauma Treatment for the 21st Century

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What works?

therapists (5%–9%) is larger than the variability of

treatments (0%–1%), the

alliance (5%), and the

superiority of an empirically supported treatment to a placebo treatment (0%–4%)

Available evidence documents that the therapist is one of the most robust predictors of outcome among factors studied.

(CUIJPERS, P., REIJNDERS, M., & HUIBERS, M. J. (2019) DUNCAN ET AL., 2010; LUTZ ET AL., 2007; WAMPOLD, 2005).

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Trauma Tx: Active Ingredients

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Changing the Paradigm

The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder:

A meta-analysis of direct comparisons

Steven G. Benish, Zac E. Imel, Bruce E. Wampold

The primary analysis revealed that effect sizes were Homogenously distributed around zero for measures of PTSD symptomology, and for all measures of psychological functioning, indicating that there were no differences between psychotherapies.... The results suggest that despite strong evidence of psychotherapy efficaciousness vis-à-vis no treatment or common factor controls, bona fide psychotherapies produce equivalent benefits for patients with PTSD.

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Active Ingredients

VA/DoD (2010)

- Psycho-education
- Exposure
- Anxiety Management
- Cognitive Restructuring

Management of Post-Traumatic Stress Working Group (2010)

www.ptsd.va.gov

ISTSS (2009)

- emotion regulation strategies
- narration of trauma memory
- cognitive restructuring
- anxiety and stress management
- interpersonal skills.

Cloitre, et al. (2011)

Phoenix Project (Aus) (2013)

- Therapeutic alliance
- Psycho-education
- Emotional regulation and coping skills
- Some form of exposure to memories of traumatic experiences
- Cognitive processing, restructuring, and/or meaning making
- Tackling emotions
- altering memory processes.

http://phoenixaustralia.org/the-6-common-elements-of-evidence-based-therapies-for-ptsd/

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Active Ingredients

EU TSN (2015)

- Psychoeducation
- Emotional regulation and coping skills
- Imaginal exposure
- Cognitive processing & restructuring
- Meaning making
- Dealing with emotions
- Resolving memory processes

Schynider, et al., 2015

Common Elements of Trauma Approach (2015)
Johns Hopkins

- Relaxation
- Cognitive Coping
- Exposure-Trauma Memories
- DTE (*in vivo)* Exposure
- Cognitive Restructuring
- Behavioral Activation
- Problem Solving

Murray, et al., (2015)

Cuijpers, P., Reijnders, M., & Huibers, M. J. (2019).

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Trauma Competency:
An Active Ingredients Approach to
Treating Posttraumatic Stress Disorder

J. Eric Gentry, Anna B. Baranowsky, and Robert Rhoton

Meta-analytic studies have extracted 4 common elements among effective posttraumatic stress disorder treatments: cognitive restructuring and psychoeducation, a deliberate and continually improving therapeutic relationship, relaxation and self-regulation, and exposure via narrative of traumatic experiences. The authors present a clinical treatment structure catalyzing these active ingredients into discrete therapeutic tasks that counselors can focus on to maximize treatment effectiveness. The 4 tasks represent an attempt to identify critical competencies and baseline standards for the field of trauma counseling.

Keywords: traumatic stress, PTSD, active ingredients, treatment, trauma competency

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Healing Trauma: Active Ingredients

(Gentry, 1999; Gentry, Baranowsky & Rhoton, 2017)

- → **Therapeutic Relationship**
- → **Relaxation/Self-Regulation**
- → **Exposure**
- → **Cognitive Restructuring/ Psychoeducation**

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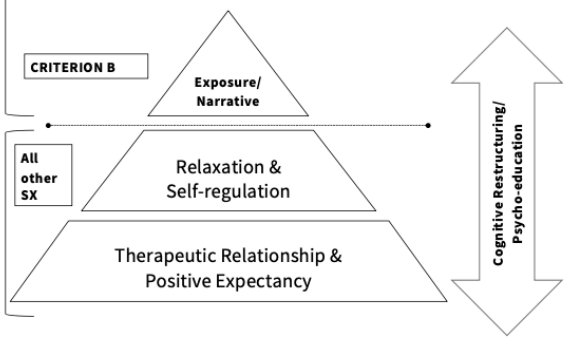
The Active Ingredients

Eric's Hierarchy



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The Salutogenic Treatment Structure: An Active Ingredients Approach

I. **Preparation & Relationship**
II. **Psycho-education & Skills-Building**
III. **Integration & Desensitization**
IV. **Post Traumatic Growth & Resilience**

Rhoton & Gentry, 2021

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Preparation & Relationship

STAGE I

Preparation
Assessment
Hope
Relationship

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Positive Expectancy/Placebo Hope

- Powerful predictor of positive outcomes in multiple metanalytic studies
- Necessary but insufficient for change
- Catalyzing expectancy improves efficacy of intervention
- Increases engagement
- Increased continuation
- **HOW DO YOU GET HOPE INTO THE HOPELESS?**
  - Technical – MI
  - Transpersonal – Felt-sense by client that helper believes in them and their path of healing. Surety.

Gallagher, Long & Phillips, (2020)

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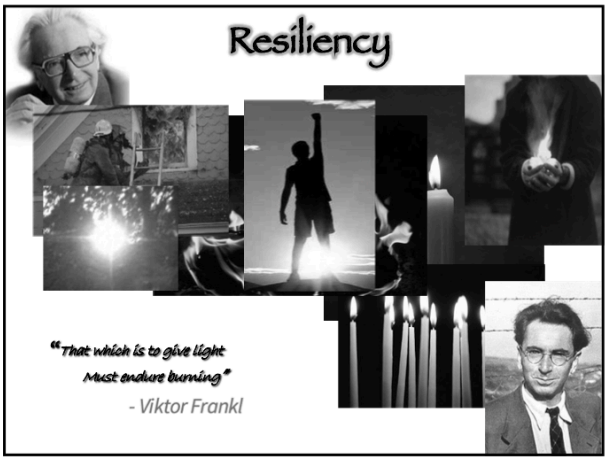

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Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.

- Viktor Frankl

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In 2013, Feedback Informed Treatment (FIT)–that is, formally using measures of progress and the therapeutic alliance to guide care–was deemed an evidence-based practice by SAMHSA, and listed on the official **NREPP website**. It's one of those good ideas. **Research to date** shows that FIT as much as doubles the effectiveness of behavioral health services, while decreasing costs, deterioration and dropout rates.

SCOTT D MILLER - FEEDBACK-INFORMED THERAPY

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Suggestions for Positive Outcomes

www.scottdmiller.com

1. **Collect empirical data evaluating the quality of the therapeutic process & relationship**
2. **Generate honest feedback from client on methods to improve therapy (i.e. relational)**
3. **Be willing to change toward what works best for client—demonstrate that change**

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Performance Metrics - Licenses for the ORS and SRS
$0.00
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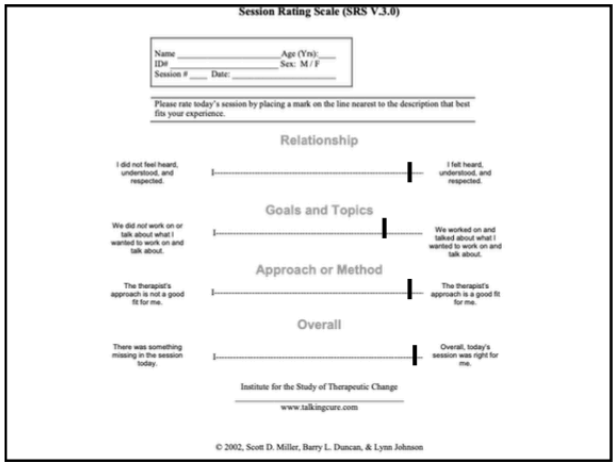
Session Rating Scale (SRS V.3.0)
Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____
Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.
Relationship
I did not feel heard, understood, and respected.
I felt heard, understood, and respected.
Goals and Topics
We did not work on or talk about what I wanted to work on and talk about.
We worked on and talked about what I wanted to work on and talk about.
Approach or Method
The therapist's approach is not a good fit for me.
The therapist's approach is a good fit for me.
Overall
There was something missing in the session today.
Overall, today's session was right for me.
Institute for the Study of Therapeutic Change
www.talkingcure.com
© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson

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STAGE II
Psychoeducation & Skills-building

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UNDERSTANDING TRAUMA

Making it Personal

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STRESS

CAUSE AND EFFECT

Causes | **Effects**

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Are You 100% Safe Right Now?

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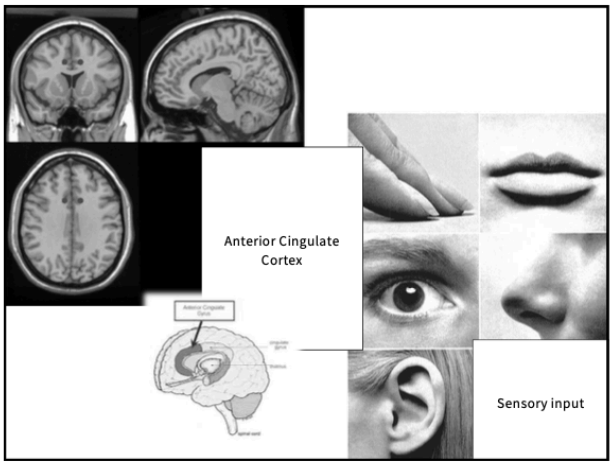

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NEUROCEPTION

DETECTING SAFETY IN THE ENVIRONMENT ESPECIALLY WHEN PERCEIVING THREAT

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Perceived Threat

Physiological	Brain Mechanics	Other Effects
▲Heart Rate	▲ Basal Ganglia & Thalamic Fx	▲Obsession + Compulsion
▲ Breathing Rate	▼ Neo-cortical Fx	▲ Symptom Generation
▼ Breathing Volume Centralized Circulation	▼Frontal Lobe activity ▼Executive Fx ▼Fine motor control ▼Emotional regulation	▼ Speed & Agility
▲ Muscle Tension	▼Temporal Lobe Activity ▼Language (Wernicke's) ▼Speech (Broca's)	▼ Strength
▲ Energy	▼ Anterior Cingulate Fx	Constricted thoughts & behaviors
▲ DIS-EASE	Energy transferred from FL to Midbrain	Fatigue

Fight OR Flight

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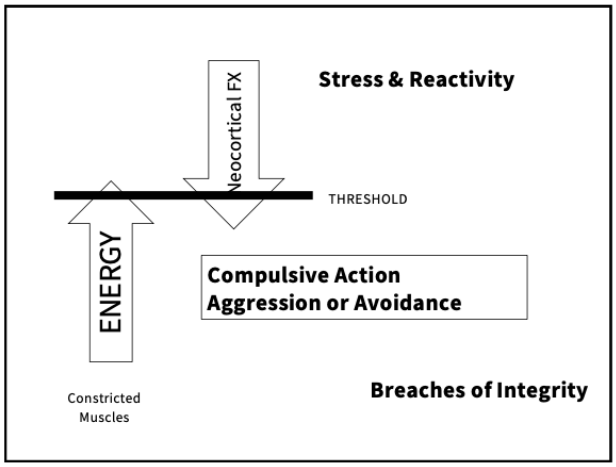
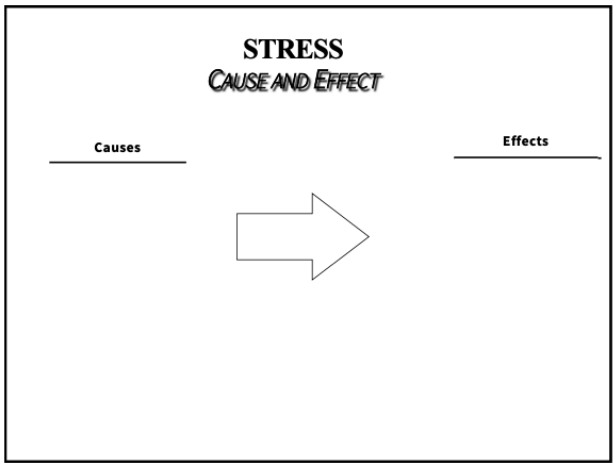
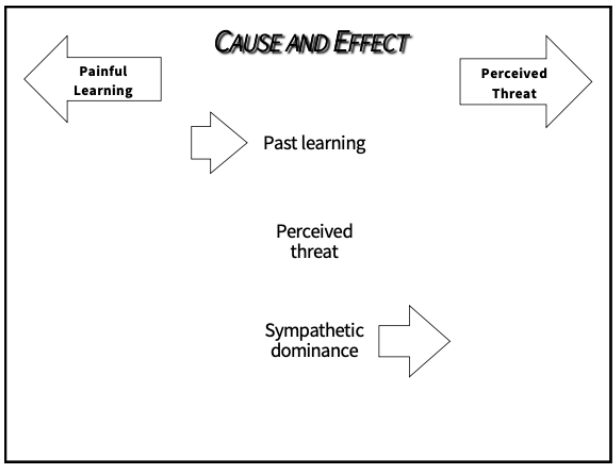

Stress & Reactivity
Neocortical FX
THRESHOLD
ENERGY
Compulsive Action
Aggression or Avoidance
Constricted
Muscles
Breaches of Integrity

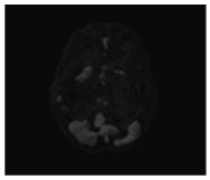
37


STRESS
CAUSE AND EFFECT
Causes
Effects

38


CAUSE AND EFFECT
Painful
Learning
Perceived
Threat
Past learning
Perceived
threat
Sympathetic
dominance

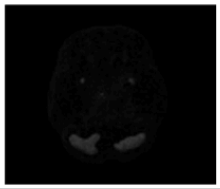
39



High Anxiety
Increased basal ganglia activity

Stress = Perception of Threat

Normal
Note the lessened activity of the basal ganglia



http://www.amenclinics.com/bp/atlas/ch2.php

40

SELF-REGULATION

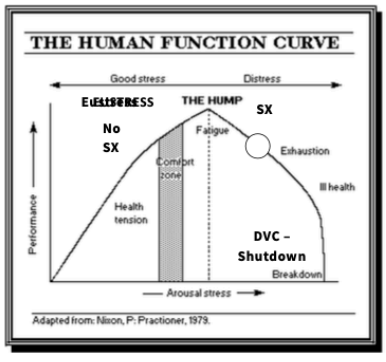
Neuroception - Interoception

&

Balancing the ANS

41

Optimal Performance



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Interoception

You want to know what heals trauma? … Interoception heals trauma

- Bessel van der Kolk

- → Present "felt sense" on one's own physiological processes
- → Becoming sensitive to "feedback" from one's body – making conscious our physical sensations
- → Lowering threshold of awareness of dysregulation
- → Monitoring rising levels of energy (SNS activation) and recognizing when there is the need for conscious and intentional intervention (i.e., releasing constricted muscles)

Interception + Acute Relaxation x 100/day = No Stress

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Interoception

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This article addresses the Core Competency of *Medical Knowledge* REVIEWS AND OVERVIEWS
Mechanisms of Psychiatric Illness

Using Neuroscience to Help Understand Fear and Anxiety: A Two-System Framework

Joseph E. LeDoux, Ph.D., Daniel S. Pine, M.D.

High-Road = FEAR Low-road = ANXIETY

Using Neuroscience to Help Understand Fear and Anxiety: A Two-System Framework (2016) Joseph E. LeDoux, Ph.D., Daniel S. Pine, M.D.

https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2016.16030353

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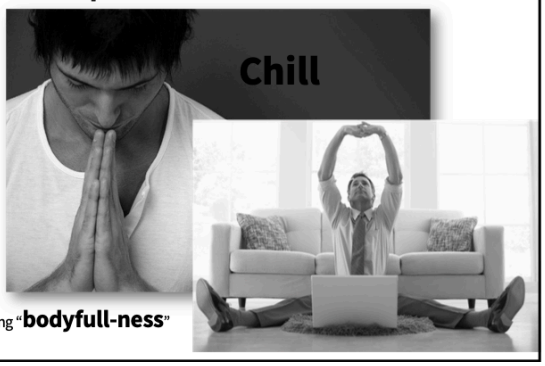
Neuroception/Interoception + Acute Relaxation + Exposure = Trauma Resolution



Developing "**bodyfull-ness**"

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SKILLS
Self-Regulation

- Body Scan/"Wet Noodle"
- Diaphragmatic Breathing
- Peripheral vision
- Pelvic floor relaxation

Note: These techniques have not been vetted with empirical research. Developed by author.

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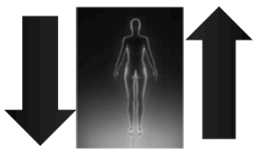
Non-technical Methods for Self-Regulation
Body Scan/"Wet Noodle"



Head-to-toe
Toe-to-head
RELAX TENSE MUSCLES

5 seconds
RELAX ALL MUSCLES

Secondary – Tighten tense muscles for 5 seconds then release

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Diaphragmatic Breathing

- **Abdominal muscles OUT on inhale**
- **RELEASE on exhale**

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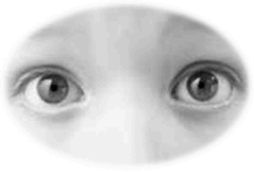
Self Regulation: Peripheral Vision

→ **Focus on a spot straight ahead**

→ **Keeping your focus, widen your field of view and notice what you see in your peripheral vision**



50

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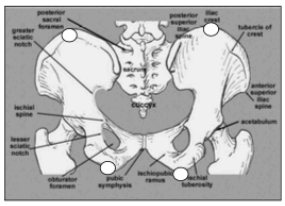
Self Regulation: *Pelvic floor relaxation*

→ **Focus on 4 points: Bilateral Anterior Superior Iliac Spine and Ischial Tuberosities**

→ **Imagine these 4 points pushing outward and muscles in-between softened**



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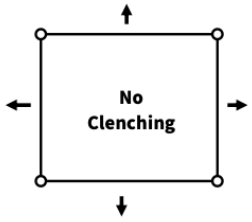
Self-Regulation



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Who is squeezing the muscles in your body?

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The Adverse Childhood Experiences Study (ACE)

Collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Center for Disease Control and Prevention (CDC)

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Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____
4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____
5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____
7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____
10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

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ACES

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Lifetime Repercussions of ACEs: Increased Likelihood of Physical & Emotional Illness

People with 4 ACEs have the following increased risk for:

- → Suicide: 1550 %
- → Heart Disease: 250%
- → Heart Attack: 275%
- → Cancer: 150%
- → COPD: 400%
- → Arthritis: 250%
- → Diabetes: 200%
- → Kidney Disease: 275%
- → Strokes: 250%
- → Loss of vision: 400%

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ACE Study Findings

ACE Scores of (4 and above) Linked to Physical & Mental Health Problems

- → Twice as likely to smoke
- → Seven times as likely to be alcoholics
- → Six times as likely to have had sex before age 15
- → Twice as likely to have cancer or heart disease
- → Twelve times more likely to have attempted suicide
- → Men with six or more ACEs were **46** times more likely to have injected drugs than men with no history of adverse childhood experiences
- → Much more likely to have chronic health issues
- → Exceedingly high predictability of needing mental health treatment

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Aversive Childhood Experiences Scale

Should ACES be used in clinical practice?

Why or Why Not?

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HOMEWORK

1. **Notice the frequency in which you encounter perceived threats over the next 16 hours**
2. **Get and keep the muscles in your body relaxed all they way through your encounter with at least one perceived threat**
3. **Be prepared to discuss in the morning the difference between the time(s) you were able to self-regulate vs. the times you did not**

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DSM-V

Posttraumatic Stress Disorder (309.81)

A. Exposure to actual of threatened death, serious injury, or sexual violence in one (or more) of the followingways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual death, the events must have been accidental or violent.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to the details of childabuse).

   Note: A4 does not apply to exposure through media unless it is work$related

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s) **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumaticevent.

   Note: In children there may be frightening dreams without recognizable content.
   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

   Note: In children, trauma$specific reenactment may occur in play
   4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
   5. Marked physiological reaction to external or internal cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing, memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the event(s) occurred, as evidenced by two or more of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that leads the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Marked diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others
7. Persistent inability to experience positive emotions (e.g., happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self$destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g. problems falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to physiological effects of a substance (e.g., medication or alcohol) or other medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for PTSD, and in addition, in response to the stressor, the individual experiences persistent or recurring symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from , and as if one was an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted).

Note: To use this subtype, the dissociate symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during intoxication) or other medical condition.

Specify if:

With delayed expression: If the full diagnostic criteria are not met at least 6 months after the event (although the onset and expression of some symptoms may be immediate)

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. I---------- I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I---------- We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. I---------- The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. I---------- Overall, today's session was right for me.

Institute for the Study of Therapeutic Change
www.talkingcure.com

Score: _____ **TRS** Name _____

T R A U M A R E C O V E R Y S C A L E

PART I

Directions: Please read the following list and check all that apply.

	Type Of Traumatic Event	Number of Times	Dates/Age(s)		
1.	Childhood Sexual Abuse	_____	_____	_____	_____
2.	Rape	_____	_____	_____	_____
3.	Other Adult Sexual Assault/Abuse	_____	_____	_____	_____
4.	Natural Disaster	_____	_____	_____	_____
5.	Industrial Disaster	_____	_____	_____	_____
6.	Motor Vehicle Accident	_____	_____	_____	_____
7	Combat Trauma	_____	_____	_____	_____
8.	Physical Injury/Medical	_____	_____	_____	_____
9.	Childhood Physical Abuse	_____	_____	_____	_____
10.	Adult Physical Abuse	_____	_____	_____	_____
11.	Victim Of Violent Crime	_____	_____	_____	_____
12.	Captivity	_____	_____	_____	_____
13.	Torture	_____	_____	_____	_____
14.	Domestic Violence	_____	_____	_____	_____
15.	Sexual Harassment	_____	_____	_____	_____
16.	Threat of physical violence	_____	_____	_____	_____
17.	Accidental physical injury	_____	_____	_____	_____
18.	Humiliation	_____	_____	_____	_____
19.	Property Loss	_____	_____	_____	_____
20.	Death Of Loved One	_____	_____	_____	_____
21.	Neglect	_____	_____	_____	_____
23.	Witnessed Event (see below)	_____	_____	_____	_____
24.	Other:_____	_____	_____	_____	_____
25.	Other:_____	_____	_____	_____	_____

If you witnessed trauma and it has caused significant distress or problems in your life please identify the even(s) and people involved.

Witnessed Event: _____
Witnessed Event: _____
Witnessed Event:
_____
Witnessed Event: _____
Witnessed Event:
_____
Witnessed Event: _____
Witnessed Event: _____

Comments: _____

TRS TRAUMA RECOVERY SCALE

PART II

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollections of past events.

0% 100% of the time

2. I sleep free from nightmares.

0% 100% of the time

3. I am able to stay in control when I think of difficult memories.

0% 100% of the time

4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).

0% 100% of the time

5. I am safe.

0% 100% of the time

I feel safe.

0% 100% of the time

6. I have supportive relationships in my life.

0% 100% of the time

7. I find that I can now safely feel a full range of emotions.

0% 100% of the time

8. I can allow things to happen in my surroundings without needing to control them.

0% 100% of the time

9. I am able to concentrate on thoughts of my choice.

0% 100% of the time

10. I have a sense of hope about the future.

0% 100% of the time

AS – FS

Scoring Instructions: record the score for where the hash mark falls on the line (0-100) in the box beside the item (average 5a with 5b to get score for 5). Sum scores and divide by 10.

Interpretation: 100 – 95 (full recovery/subclinical); 86 - 94 (significant recovery/mild symptoms); 75 – 85 (some recovery/ moderate symptoms); 74 (minimal recovery/severe); below 35 (probable traumatic regression)

Mean Score

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often**…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers:_____This is your ACE Score.

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ ***(please estimate if you are not sure)***

Did it involve actual or threatened death, serious injury, or sexual violence?

_____Yes

_____No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____Accident or violence

_____Natural causes

_____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

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Two-Day Trauma Competency Conference

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Day 2

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Board-Certified Expert in Traumatic Stress

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Welcome

Day II

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Certified Clinical Trauma Professional

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EVERGREEN CERTIFICATIONS

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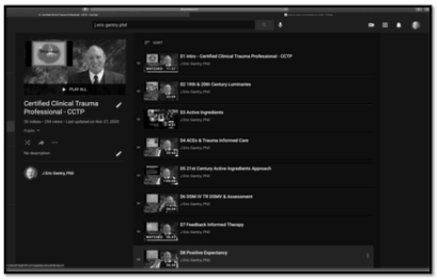
Resources

Certified Clinical Trauma Professional

https://youtube.com/playlist?list=PLZk8x28TSp9FWPrv2r1uQgQbBLoQ3Jy6C



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Tools for Hope

Jenny Brackman

Tools for Hope - Jenny Brackman

https://youtu.be/LEOEJXMt8Fg

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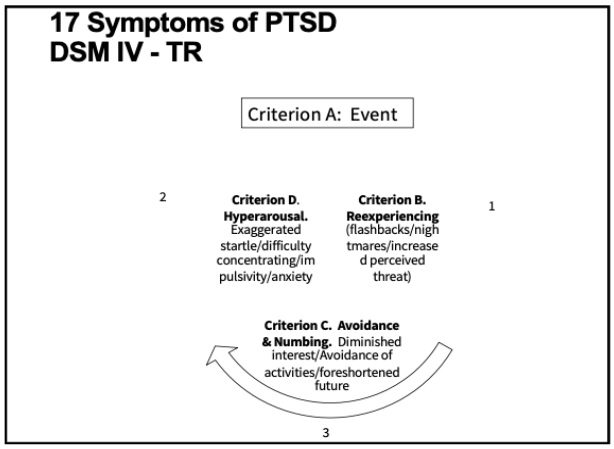
DSM V

309.81

PostTraumatic Stress Disorder

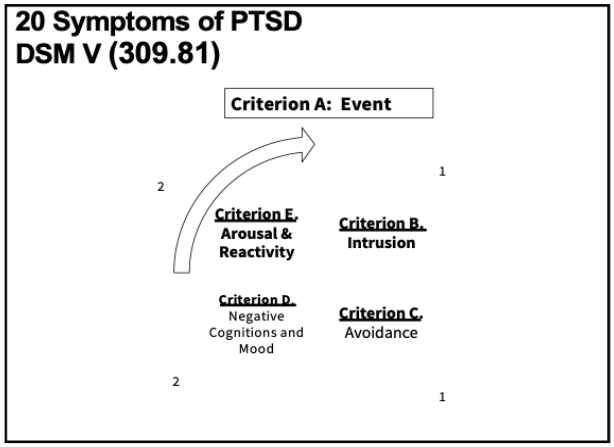
66

17 Symptoms of PTSD
DSM IV - TR



67

20 Symptoms of PTSD
DSM V (309.81)



68

Adjustment Disorder

DSM-5 Criteria for Adjustment Disorder

The *DSM-5* defines adjustment disorder as "the presence of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)"

In addition to exposure to one or more stressors, one or both of these criteria exist:

- Distress that is out of proportion with expected reactions to the stressor
- Symptoms must be clinically significant—they cause marked distress and impairment in functioning

Further, these criteria must be present:

- Distress and impairment are related to the stressor and are not an escalation of existing mental health disorders
- The reaction isn't part of normal bereavement
- Once the stressor is removed or the person has begun to adjust and cope, the symptoms must subside within six months.

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Other Specified Trauma/ Stressor-Related Disorder (309.89)

Other Specified Trauma/ Stressor-Related Disorder (309.89)

- Adjustment Disorder *with duration more than 6 months* without prolonged duration of stressor
  - subthreshold PTSD
  - persistent complex bereavement disorder
  - ataques nervios and other cultural symptoms

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DSM-5: PTSD Criterion A

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:

1. Direct exposure
2. Witnessing, in person
3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). **This does not include indirect non-professional exposure through electronic media, television, movies or pictures.**

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DSM-5: PTSD Criterion B

Intrusion (1/5 symptoms needed)

1. Recurrent, involuntary and intrusive recollections. (children may express this symptom in repetitive play)
2. Traumatic nightmares. (children may have disturbing dreams without content related to trauma)
3. Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. (children may re-enact the event in play)
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiological reactivity after exposure to trauma-related stimuli

72

DSM-5: PTSD Criterion C

Persistent effortful avoidance of distressing trauma-related stimuli after the event (1/2 symptoms needed):

1. Trauma-related thoughts or feelings
2. Trauma-related external reminders (e.g. people, places, conversations, activities, objects or situations)

73

DSM-5: PTSD Criterion D

Negative alterations in cognitions and mood that began or worsened after the traumatic event (2/7 symptoms needed)

1.Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs) (C3 in *DSM-IV)*

2.Persistent (& often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "the world is completely dangerous") (C7 in *DSM-IV)*

3.Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences (new)

4.Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame) (new)

74

DSM-5: PTSD Criterion D

5. Markedly diminished interest in (pre-traumatic) significant activities (C4 in *DSM-IV)*
6. Feeling alienated from others (e.g. detachment or estrangement) (C5 in *DSM-IV)*
7. Constricted affect: persistent inability to experience positive emotions (C6 in *DSM-IV)*

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DSM-5: PTSD Criterion E

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (2/6 symptoms needed)

1. Irritable or aggressive behavior (revised D2 in *DSM-IV)*
2. Self-destructive or reckless behavior (new)
3. Hypervigilance (D4 in *DSM-IV)*
4. Exaggerated startle response (D5 in *DSM-IV)*
5. Problems in concentration (D3 in *DSM-IV)*
6. Sleep disturbance (D1 in *DSM-IV)*

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DSM-5: PTSD Criterion F-H

F. **Persistence of symptoms (in Criteria B, C, D and E) for more than one month**

G. **Significant symptom-related distress or functional impairment**

H. **Not due to medication, substance or illness**

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Assessment Instruments

→ **ACES: Aversive Childhood Experiences Scale (Felitti, 1997)**

→ **TRS: Trauma Recovery Scale (Gentry, 1996; 2013)**

→ **PCL: Posttraumatic Checklist (NCPTSD, 2014)**

- CAPS-5: Clinician Administered PTSD Scale (NCPTSD, 2014)
  - **Only for Forensic**

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PCL
Posttraumatic Check List

- National Center for PTSD (www.ptsd.va.gov)
- Simple, easy to administer
- Self-report or clinician administered
- 20 item – all 20 symptoms
- CRITERION B: Items 1-5
- CRITERION C: Items 6-7
- CRITERION D: Items 8 – 14
- CRITERION E: Items 15 – 20
- Score of ≥ 2 = endorsement of that symptom
- Total > 33 = PTS(D)

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PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

G ≥ 33

	In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
B - 1	1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
	2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
	3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
	4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
	5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
C - 1	6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
	7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
D - 2	8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
	9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
	10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
	11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
	12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
	13. Feeling distant or cut off from other people?	0	1	2	3	4
	14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
E - 2	15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
	16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
	17. Being "superalert" or watchful or on guard?	0	1	2	3	4
	18. Feeling jumpy or easily startled?	0	1	2	3	4
	19. Having difficulty concentrating?	0	1	2	3	4
	20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr – National Center for PTSD

80

Polyvagal Theory

Stephen Porges

81

[redacted]

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Polyvagal Theory

- **Ventral Vagal Complex - VVC**
  - Most recent
  - Fine-tuned response to the environment that helps create choice
  - Allows us to work with the nervous system to innervate or immobilize
  - **BLENDING nervous systems states**
  - Alert without threat response
- **SNS – Threat activation and mobilization**
- **Dorsal Vagal Complex - DVC**
  - primitive response
  - immobilization towards safety (no escape)
  - "fainting" as the last ditch effort (dissociation)
  - get away from the threat

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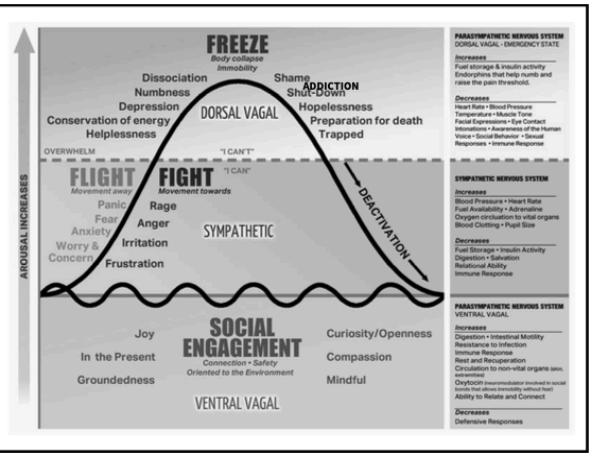

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TRS
Trauma Recovery Scale

- Gentry, 1996
- Developed as an outcome instrument
- Good psychometrics (Chronbach's a = .86 & convergent validity with IES = -.71)
- Solution-focused
- Mean score = % recovery from trauma
- Scores > 75 = minimal impairment
- Scores < 75 begin impairment spectrum and need stabilization
- 5a & 5b opportunity to discuss "am safe vs. feels safe"
- Part I is trauma inventory and administered only at intake
- Part II is repeated measure for outcomes
- Scores < 50 = treatment plan issue
- WARNINGS: May trigger survivor clients

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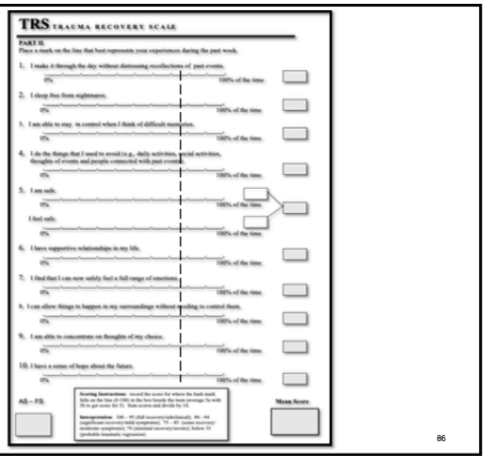

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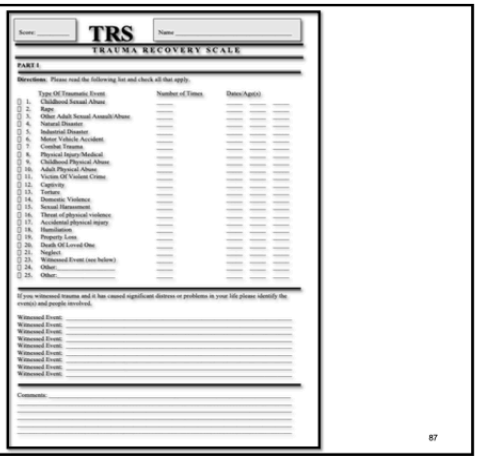

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Graphic TimeLine

- → Use Part 1 of TRS
- → 5 min – all the difficult/painful/traumatic experiences
- → 5 min – all the positive experiences
- → 30 min – verbal narrative
- → WARNING: Indicated only for client who are safe & stable. Intermediate Skills Training before this intervention with those not stable

Note: This technique has not been vetted with empirical research. Developed by author.

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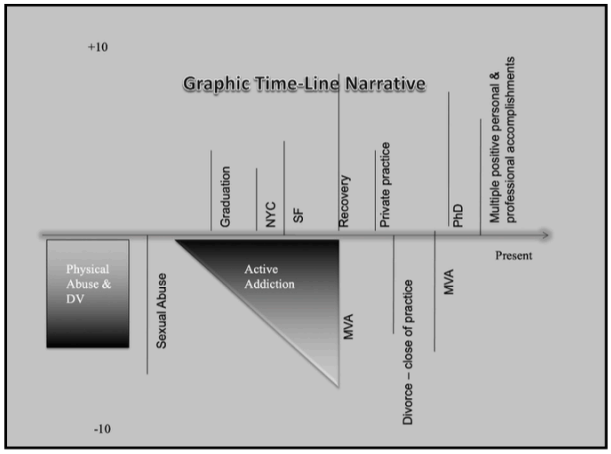
Graphic Time LifeLine

Birth → Present

89

89



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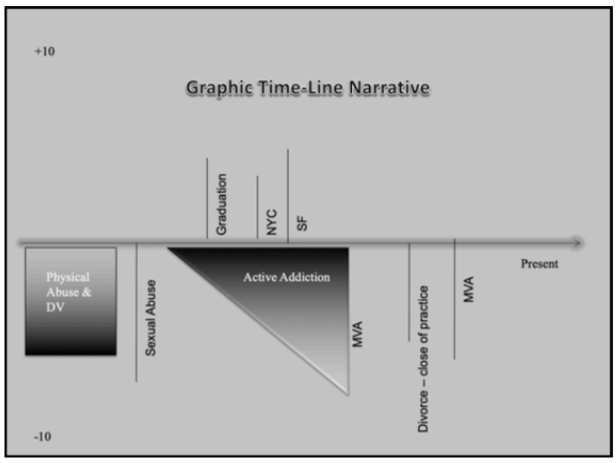

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Cognitive Restructuring

- What would any reasonable rational human being come to believe about ***themselves*** *(intellectually, emotionally, spiritually, psychologically, physically, socially, and academically)* from having these things occur in their life?
- What would any reasonable rational human being come to believe about ***important relationships*** *(intellectually, emotionally, spiritually, psychologically, physically and socially)* from having these things occur in their life?
- What would any reasonable rational human being come to believe about ***the world at large*** from having these things occur in their life?

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Early Sessions

- ACE – Trauma History
- TRS – Trauma History & Tx Planning
- PCL – Diagnosis
- Begin Feedback Informed Therapy (FIT)
- Tools for Hope (Perceived Threat/ANS/Self-regulation)
- Psychoeducation (Shame to Self-compassion)
- Graphic Time Line of life including ALL significant traumatic experiences
- Verbal Narrative using GTL as map

BEGIN IN VIVO EXPOSURE with SELF-REGULATION

93

Tri-Phasic Model

Herman, 1992

- → **Safety** (Stabilization & Skills Building)
- → **Remembrance & Mourning**
  - → Trauma Resolution
  - → Desensitization & reprocessing
  - → Metabolization of trauma
- → **Reconnection**
  - → Present & future

STANDARD of CARE

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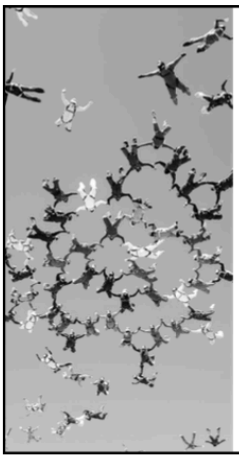

Tri-Phasic Model

Herman, 1992

- **Safety** (Stabilization & Skills Building)
- **Remembrance & Mourning**
  - Trauma Resolution
  - Desensitization & reprocessing
  - Metabolization of trauma

STANDARD of CARE

Safe, Stable, and Skilled BEFORE Addressing Trauma Memories

95

What is Necessary?

Gentry, 1998

Six Empirical Markers

ALL In Stage II

1. **Resolve (real) Danger**
2. **Distinguish between real vs. perceived threat**
3. **Develop battery of regulation/relaxation, grounding, and containment skill**
4. **Non-anxious presence + good prognosis**

Only for Stage III

5. Demonstrate ability to self-regulate & self-rescue while accessing trauma memory
6. Contract (verbal) to address traumatic material – transfer of initiative to CT

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Intermediate Skills

- Relaxation
  - PMR (sleep problems)
  - Tapping (TFT)
- Grounding
  - 3-2-1 Sensory
- Containment
  - Envelope method

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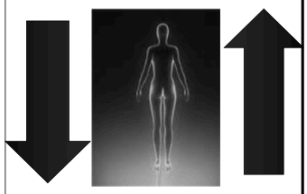
Progressive Relaxation



Liu, et al., 2020
Özlü, et al., 2021

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Thought Field Therapy (TFT)

R. Callahan

- **What is Thought Field Therapy® (TFT)?**
- Thought Field Therapy (TFT) is a little-known, but highly effective, drug-free and non-invasive way to reduce or eliminate even chronic pain without the risk of medications.
- TFT was discovered and developed by California clinical psychologist, Dr. Roger Callahan. **It works with nature's healing system combining the acupressure meridian system and modern psychology**.
- While there is increasing evidence as to its effectiveness for TFT (even more with EFT), especially with pain, we are using TFT here as a SELF-HELP METHOD for ANXIETY REDUCTION – not a treatment for traumatic stress!

99

Thought Field Therapy
Callahan

Connoly, S. (2004) Thought Field Therapy: Clinical Applications, Integrating TFT in Psychotherapy. George Tyrrell Press

Callahan, R. & Trubo (2004). Tapping the Healer Within: Using Thought-Field Therapy to Instantly Conquer Your Fears, Anxieties, and Emotional Distress. McGraw-Hill.

Note: Thought Field Therapy has been demonstrated to be an effective treatment with multiple psychiatric conditions in multiple RTCs. However, in this course it is only being taught as a self-help tool for clients with anxiety.

Connolly, S.M., Roe-Sepowitz, D., Sakai, C.E., & Edwards, J. (2013).

Connolly, S.M., & Sakai, C.E. (2011).

Dunnewold, A.L. (2014)

Edwards J. (2016).

Folkes, C. (2002).

Irgens, et al., (2017)

Irgens, A., Dammen, T., Nysaeter. T., & Hoffart, A. (2012).

Robson, R., Robson, P., Ludwig, R., Mitabu, C., Phillips, C. (2016)

Sakai, C., Connolly, S., & Oas, P. (2010)

100

Distressing Thought

	SUDs	SUDs
10		
9		
8		
7		
6		
5		
4		
3		
2		
1		
0		

101

Thought Field Therapy (TFT)
Callahan (1985; 2000; 2004; 2011)

1. **Trauma Memory**
2. **SUDS**
3. **Algorithm** (trauma)
   - → **Eye brow (8 -12 taps)**
   - → **Under eye (8 - 12 taps)**
   - → **Underarm (8 - 12 taps)**
   - → **Collarbone (8 - 12 taps)**
4. **9 Gamut**
   - → while continuously tapping 9-Gamut spot...
   - → Eyes open
   - → Eyes closed
   - → eyes open down right
   - → eyes open down left
   - → eyes clockwise
   - → eyes counterclockwise
   - → count to five (aloud)
   - → hum a tune
   - → count to five (aloud)
5. **Repeat # 3**

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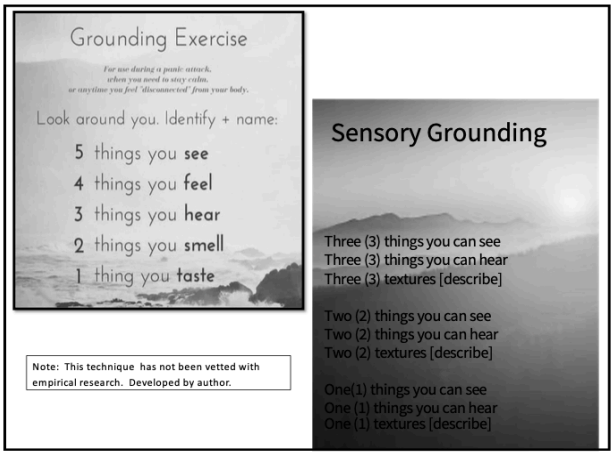

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End-of-Session/Containment

End of Session → Draw for 2 MINUTES an expression of what is happening inside of you

Containing Trauma → Draw for 1 MINUTE an abstract symbol of the memory

- Have client place drawing in envelope
- Staple envelope closed
- Brief statement
  - Therapy happens here/life out there
  - I will keep this safe here (the pain and fear associated with it)
- Ask client at beginning of next session if they wish to work on the envelope material

Note: This technique has not been vetted with empirical research. Developed by author.

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STAGE III

Desensitization & Integration

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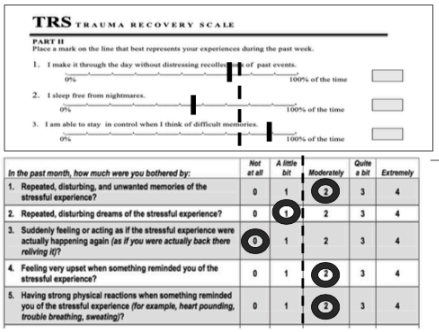
Mid-Tx Assessment

Criterion B: Intrusion

AFTER SESSION #8



TRS TRAUMA RECOVERY SCALE

PART II

Place a mark on the line that best represents your experiences during the past week.

1. I make it through the day without distressing recollection of past events.
   0% ——— 100% of the time
2. I sleep free from nightmares.
   0% ——— 100% of the time
3. I am able to stay in control when I think of difficult memories.
   0% ——— 100% of the time

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4

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21st Century Trauma Treatment

WHAT WOULD YOU LIKE TO DO ABOUT THAT?

Note: This technique has not been vetted with empirical research. Developed by author.

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Trauma Treatments

BONA FIDE & EBT

- → (TF)CBT
- → Prolonged Exposure
- → Cognitive Processing Therapy
- → EMDR
- → SIT/NET/DTE & other CBT
- → Hypnosis/NLP – V/KD
- → Psychodymanic
- → EFT & TFT

Good/Some Evidence

- **SE/Sensiomotor/TRE**
- **Yoga**
- **ACT**
- **ART/Brainspotting/**BLS
- Traumatic Incident Reduction (TIR)
- TRI Method
- Bio/Neuro-feedback
- Art/non-verbal approaches
- Group Therapy
- MAT
- CAM

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Eric's Recommendation – Part 1

- → Practice and get good at self-regulation
- → Engage FIT with ALL clients
- → Do the GTL with the cognitive restructuring for shame
- → Teach clients about ANS/perceived threat (vs. "stress") and self-regulation
- → Coach them to engage IVE then processes successes and shortcoming each session
- → **THIS WILL BE SUFFICIENT TO RESOLVE PTS WITH A LARGE PORTION OF YOUR CASELOAD**

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Eric's Recommendation – Part 2

Fully Competent

Get trained in:

EMDR

One narrative-driven approach

- → CPT
- → PE
- → TFCBT
- → 5 NARRATIVE APPROACH

Expert — Somatic Experiencing and/or Sensio-motor

Master — IFS or Other Methods for Treating DDs (Hypnosis)

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Prolonged Exposure (PE)

PE Coach (iTunes & Android)

Category A

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Exposure Based

Prolonged Exposure

- Developer: Edna Foa
- Individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.
- **Four components:**
  1. **Psychoeducation**
  2. **Breathing**
  3. **Imaginal Exposure**
  4. **In vivo exposure**
- Manualized 8 – 15 sessions
- (Can be) Abreactive

www.ptsd.va.gov

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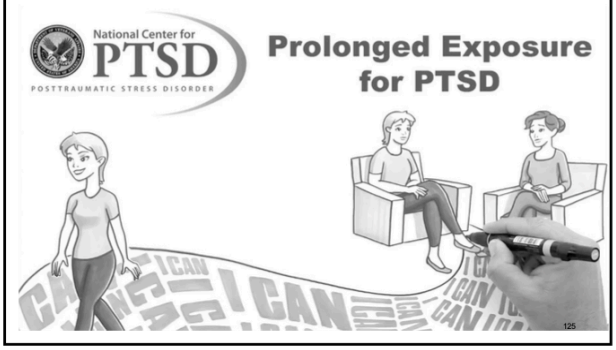
Prolonged Exposure



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Cognitive Processing Therapy

CPT Coach (iTunes & Android)

Category A

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Cognitive Based

Cognitive Processing Therapy

- Developer: Patricia Resick
- The four main parts of CPT
  - **Learning About Your PTSD Symptoms.**
  - **Becoming Aware of Thoughts and Feelings.**
  - **Learning Skills.**
  - **Understanding Changes in Beliefs.**
- 12-13 Sessions (depending upon bereavement)
- Manualized & Scripted Sessions
- Can be abreactive

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CPT Sessions

Session 1 - Introduction and Education

Session 2 - The Meaning of the Event*

Session 3 - Identification of Thoughts and Feelings

Session 4 - Remembering Traumatic Events

Session 5 - Identification of Stuck Points

Session 6: Challenging Questions

Session 7 - Patterns of Problematic Thinking

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- **Session 8 - Safety Issues**
- **Session 9 - Trust Issues**
- **Session 10 - Power/Control Issues**
- **Session 11 - Esteem Issues**
- **Session 12 - Intimacy Issues and Meaning of the Event:**

- Session 2 – Bereavement Processing (if loss)

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Cognitive Processing Therapy

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Eye Movement Desensitization & Reprocessing (EMDR)

Category A

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11-Steps

1. Situation
2. Target
3. Negative Cognition/Self-referencing Belief
4. Positive Cognition/Self-referencing Belief
5. Validity of Cognition (VOC)
6. Emotions
7. Subjective Units of Distress (SUDs)
8. Body Scan
9. Desensitization (Bilateral stimulation while processing target)
10. Installation
11. Body Scan/ Homework/Journal

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EMDR

Dr. Bessel van der Kolk
on Safety & EMDR

[Effective Trauma Treatment]

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STAGE IV

Posttraumatic Growth & Resilience

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POSTTRAUMATIC GROWTH

WHAT IS POSTTRAUMATIC GROWTH?

It is positive change experienced as a result of the struggle with a major life crisis or a traumatic event

- Tedeschi, R. G., & Calhoun, L. G. (1996). The Posttraumatic Growth Inventory Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455-471.
- Calhoun, L. G., & Tedeschi, R. G. (2013) *Posttraumatic growth in clinical practice*. New York: Brunner Routledge.

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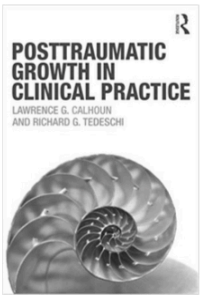

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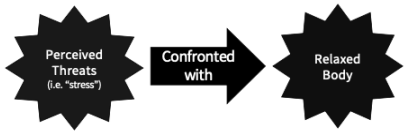
POSTTRAUMATIC GROWTH MADE SIMPLE



RESULTS IN…
- Comfortable Body > Minimal Distress
- Increased Motor & Cognitive Capacity/Performance
- Intentional vs. Reactive Behavior
- Facilitates & Accelerates Posttraumatic Growth

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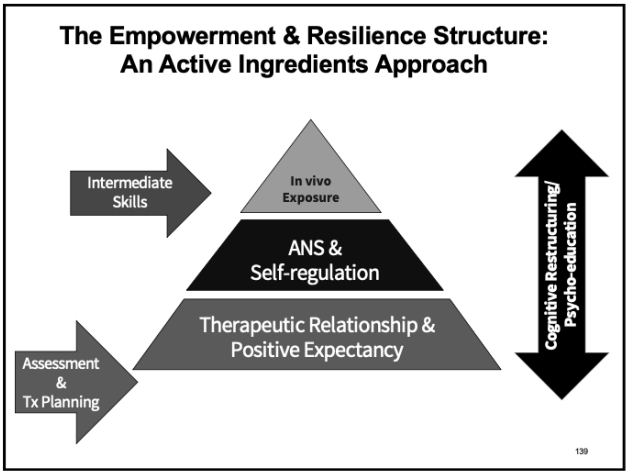

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FORWARD - FACING® INSTITUTE

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Phoenix, AZ 85001

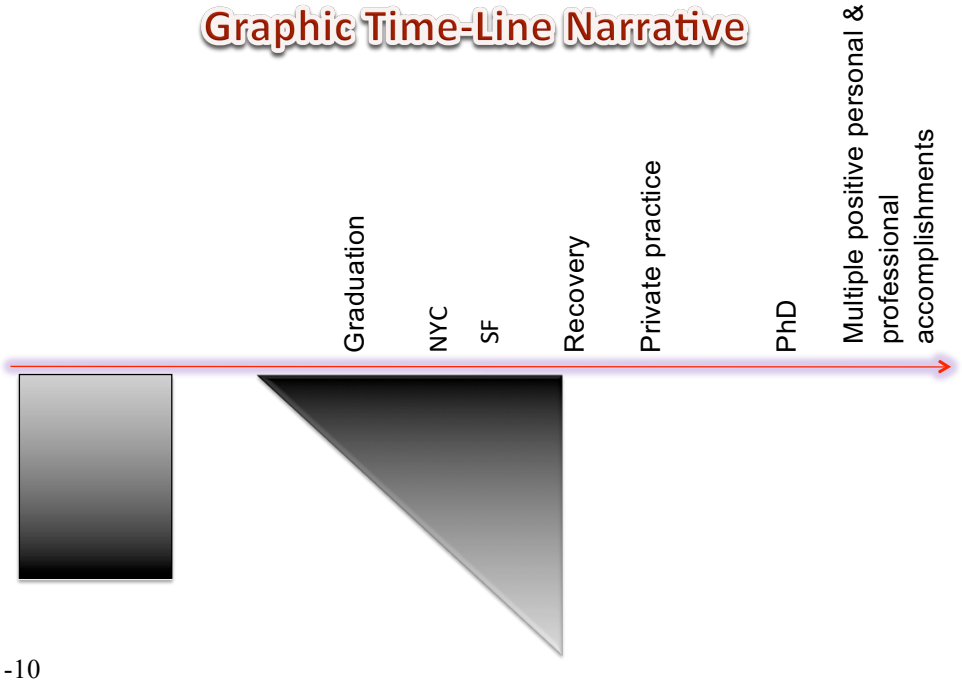
Notes:

+10 Positive

Present

Birth

10 Traumatic



Graphic Time Line – Life Narrative

- Use the TRS to get traumatic experiences
- 10 minutes to graph the traumatic experiences below the line (corresponding to SUDs level)
- 5 minutes to graph positive experiences
- < 30 minutes to provide a verbal narrative of life
- Keep copy of GTL in file

Postmodern Questions

- *What would any reasonable rational human being come to believe about themselves (intellectually, emotionally, spiritually, psychologically, physically, socially, and academically) from having these things occur in their life?*
- *What would any reasonable rational human being come to believe about important relationships (intellectually, emotionally, spiritually, psychologically, physically and socially) from having these things occur in their life?*
- *What would any reasonable rational human being come to believe about the world at large from having these things occur in their life?*

SAFETY & STABILIZATION

Six Empirical Markers

1. Resolve(real)Danger
2. Distinguish between real vs .perceived threat
3. Develop battery of regulation/relaxation, grounding, and containment skills
4. **Demonstrate ability to self-regulate & self-rescue**
5. Contract (verbal) to address traumatic material (survivor's initiative)
6. Non-anxious presence + positive expectancy

Skills

- Self-Regulation
  - Relax muscles of pelvic floor
  - Relax muscles of soft palate
  - Diaphragmatic breathing
  - Peripheral vision
  - "Stop squeezing"
- Progressive Muscle Relaxation (PMR)
- Diaphragmatic/Regulated Breathing
- Safe-Place Picture with Anchoring & Transitional Object
- Postural Grounding
- 3-2-1 Sensory Grounding
- Envelope Containment

SAFETY & STABILIZATION

SAFETY AND TRAUMA RESOLUTION

The lynchpin that connects treatment of both traumatic stress and addiction is the development and maintenance of safety and stability. Without the ability to self-rescue, one is at great risk for being overwhelmed by memories or resuming addictive behaviors. A good analogy to use for this phenomenon is the idea of firemen being trained to control fires. The first thing they learn is what to do when the fire begins to control them. Any fireman needs to know when it is time to step back from the fire in order to maintain safety and in the end, conquer vs. be conquered. The same is true with the trauma survivor. Without the ability to self-regulate their own anxiety and arousal, the trauma survivor is at risk of being overwhelmed by memories without the ability to induce a feeling of safety. At this point, the traumatic material renders the survivor once again with the feeling of entrapment, with no way to "survive" other than resuming the addictive behavior.

What is Safety?

Gentry (1996) attempts to define and operationalize the concept of "safety" into three levels, relative to the treatment of trauma survivors. These three levels of safety are as follows:

Level 1.
RESOLUTION OF IMPENDING ENVIRONMENTAL (AMBIENT, INTERPERSONAL AND INTRAPERSONAL) PHYSICAL DANGER;
Removal from "war zone" (e.g., domestic violence, combat, abuse)
Resolving active addiction
Behavioral interventions to provide maximum safety;
Address and resolve self-harm.

Level 2.
AMELIORATION OF SELF-DESTRUCTIVE THOUGHTS & BEHAVIORS
(i.e., suicidal/homicidal ideation/behavior, eating disorders, persecutory alters/ego-states, process addictions, trauma-bonding, risk-taking behaviors, isolation)

Level 3.
RESTRUCTURING VICTIM MYTHOLOGY INTO A PROACTIVE SURVIVOR IDENTITY by development and habituation of life-affirming self-care skills (i.e., daily routines, relaxation skills, grounding/containment skills, assertiveness, secure provision of basic needs, self-parenting)

Therapists are taught from the first days of clinical training to "above all do no harm (*primum non nocere)*," which makes it logical to assume that the more safety and stability that we, as clinicians, can impress in the lives of our clients, the better for their treatment – right? This may not always be the case and in many instances, the clinician's focus on safety is more about their own apprehension and may actually escalate the crisis of the client.

So, how safe do you have to be and how do you get there? Destabilization tends to be precipitated by client behaviors and thoughts in response to the bombardment of intrusive symptoms (nightmares, flashbacks, psychological and physiological reactivity). Therefore, being able to manage these symptoms safely is imperative. There are no hard and fast criteria for safety, but we will discuss various techniques to help establish safety and stabilization and discuss reference points that can be useful to help you decide. A clinician's best intervention to optimize safety is a non-anxious presence along with an unwavering optimism for the client's prognosis.

Firemen who only stay in the firehouse practicing what to do in the event of a fire never gain mastery over fighting fires. Clients should develop the minimum ("good enough") level of safety and stabilization and then address and resolve the intrusive symptoms by enabling a narrative of the traumatic experience. This is often counter-intuitive and usually anxiety producing for the clinician. However, the client will be much better equipped to change his/her self-destructive patterns (e.g., addictions, eating disorders, abusive relationships) with the intrusive symptoms resolved because s/he will have much more of their faculties available for intervention on their own behalf.

MINIMUM STANDARDS OF SAFETY

1. RESOLUTION OF IMPENDING ENVIRONMENTAL (AMBIENT, INTERPERSONAL AND INTRAPERSONAL) PHYSICAL DANGER.

Level One of Safety includes the resolution of environmental danger. When treating an addicted survivor, environmental danger may manifest itself in unsafe situations such as those of domestic violence, living with an active addict or self-destructive behaviors. **Traumatic memories will not resolve if the client is in active danger.**

Active addiction IS active danger. The addicted survivor must arrest active addiction before treatment for recovery to be effective. This needs be clearly communicated to the addicted survivor and may be articulated as: *"Safety is the requirement for resolving both your addiction and your traumatic stress. This safety will require that you bring your using behavior under control (i.e., abstinence) and that you develop ways of effectively regulating your own anxiety, without the use of chemicals or self-destructive behaviors."*

2. ABILITY TO DISTINGUISH BETWEEN "AM SAFE" VERSUS "FEEL SAFE."

Many trauma survivors feel as if danger is always lurking around every corner. In fact, the symptom cluster of "Arousal" is mostly about this phenomenon. It is important for the clinician to confront this distortion and help the client to distinguish, objectively, between "outside danger" and "inside danger." Outside danger, or a "real" environmental threat, must be met with behavioral interventions designed to help the survivor remove or protect her/himself from this danger. Inside danger, or the fear resultant from intrusive symptoms of past traumatic experiences, must be met with interventions designed to lower arousal and develop awareness and insight into the source (memory) of the fear.

Addicted survivors of trauma are used to resolving internal danger with mood altering substances. Not feeling safe is often a precursor to impulsive behavior. As noted above, Dayton (2001) discusses the phenomenon of emotional literacy. It is not necessary that a trauma survivor be fluid in their emotional literacy in order to resolve traumatic material yet they do need to be able to distinguish when they are not feeling safe. With addicts, it may be useful to develop a few words for the feelings of discontent that predispose the individual to turning to mood altering substances and behaviors. For instance, a client may not be able to articulate feelings of powerlessness or vulnerability but they may be able to distinguish an internal cue that tells them that things are "not right." An example of this may be a commitment to tell someone when feeling "irritable" or "uncomfortable."

3. **DEVELOPMENT OF A BATTERY OF SELF-SOOTHING, GROUNDING, CONTAINMENT AND EXPRESSION STRATEGIES AND THE ABILITY TO UTILIZE THEM FOR SELF-RESCUE FROM INTRUSIONS.**

Addicted survivors of trauma are accustomed to using mood altering substances and behaviors to self-soothe. The ability to use alternative methods of self-soothing is often a turning point for the survivor as they move from engulfment by the traumatic material to feeling a sense of empowerment over it.

When dealing with the traumatic material, the client must be able to identify to what extent they may explore the material before needing to retreat and return to the safety of the present. Just as with a fireman, before s/he can learn how to self-rescue, they need to be able to identify when it is warranted. One method of teaching the client how to determine this is by utilizing the Subjective Units of Distress Scale (SUDS). This is a scale from zero to ten that indicates what level of discomfort a client is experiencing. Traumatic material will inevitably produce discomfort, but the trauma survivor must practice leaning into the resistance without being overwhelmed. With a SUDS scale, the client can identify their own limits and when self-rescue is necessary. A SUDS rating of 10 would indicate the most discomfort a survivor could imagine feeling. This may be indicated during a flashback. A SUDS rating of 0 or 1 would indicate no discomfort. By using this scale, the client is then able to gain a sense of awareness as to what extent they may safely explore the traumatic material, without becoming overwhelmed.

It is useful to ask the client to begin to narrate the traumatic experience(s) and as their emotions intensify, the clinician may challenge the client to rescue themselves from these

overwhelming feelings by implementing the skills above. This successful experience can then be utilized later in treatment to empower the client to extricate him/herself from overwhelming traumatic memories. It is also a testament to the client now being empowered with ***choice*** to continue treatment and confront trauma memories.

4. Positive prognosis and contract with client to address traumatic material.

The final important ingredient of the Safety Phase of treatment is negotiating the contract with the client to move forward to Phase II (Trauma Resolution). Remember the importance of mutual goals in the creation and maintenance of the therapeutic alliance. It is important for the clinician to harness the power of the client's willful intention to resolve the trauma memories before moving forward. An acknowledgment of the client's successful completion of the Safety Phase of treatment coupled with an empowering statement of positive prognosis will most likely be helpful here (i.e., "*I have watched you develop some very good skills to keep yourself safe and stable in the face of these horrible memories. Judging from how well you have done this, I expect the same kind of success as we begin to work toward resolving these traumatic memories. What do you need before we begin to resolve these memories?").*

Skills for Developing, Maintaining & Enhancing Safety

In order to fully resolve traumatic material, feelings of empowerment must mitigate the victim role. These skills are meant to be suggestive and may not work for every survivor. It is important that the client be able to identify what works for them. Some clients experience a feeling of failure if they attempt to lower their SUDS scale and it does not work. It is important that we as clinicians normalize trial and error and instill hope in the trauma survivor.

Remember that the goal of these skills is to take the client out of the fight or flight option and back into intentionality where they control their internal and external world. It is helpful to use the term staying "intentional" vs. being rendered "reactive." When we are intentional, we have the ability to act out our intentions. When we are in a reactive state of mind, we react to situations without thought or insight. A reactive state is fear driven and impulsive.

In her excellent book, "The Body Remembers" Rothschild (2000) encourages clinicians to teach clients how to put the "brakes" on when beginning trauma therapy. She uses the analogy of teaching a new driver to be really comfortable with the braking system in a car before "accelerating". In the same manner, she finds methods for teaching client's how to "brake" before becoming deeply involved in trauma work. In this way, the client moderates the trauma work. A client can begin to work beyond the fear once they have learned that they need not be stuck in fear forever. Once an individual learns that they can touch just the surface of their experience and then return to a safe or neutral ground it is empowering and affords them the knowledge that they can master their own discomfort.

Progressive Relaxation

Ehrenreich (1999) provides a simple script for Progressive Relaxation that can be expanded or contracted with just a minimum of effort. Begin this exercise by instructing the individual to focus on lengthening and deepening the breath. Focus on the inhalation and exhalation making the breath smooth and deep.

Now tighten both fists, and tighten your forearms and biceps … Hold the tension for five or six seconds … Now relax the muscles. When you relax the tension, do it suddenly, as if you are turning off a light … Concentrate on the feelings of relaxation in your arms for 15 or 20 seconds … Now tense the muscles of your face and tense your jaw … Hold it for five or six seconds … now relax and concentrate on the relaxation for fifteen or twenty seconds … Now arch your back and press out your stomach as you take a deep breath … Hold it … and relax … Now tense your thighs and calves and buttocks … Hold … and now relax. Concentrate on the feelings of relaxation throughout your body, breathing slowly and deeply (Ehrenreich, 1999, Appendix B).)

Autogenics

A favorite script for Autogenic Relaxation comes from "Mastering Chronic Pain" (Jamison, 1996). Although written for a different audience, it is applicable to the addicted survivor. Autogenics is a process of using internal dialogue to self-soothe. It is NOT hypnosis. The client is in control the entire time. It begins by encouraging the client to find a relaxing place and position. Focusing on their breath allows it to soften, lengthen, and deepen. The internal dialogue can then begin.

> "Now slowly, in your mind, repeat to yourself each of the phrases I say to you. Focus on each phrase as you repeat it to yourself"
> I am beginning to feel calm and quiet
> I am beginning to feel quite relaxed.
> My right foot feels heavy and relaxed.
> My left foot feels heavy and relaxed.
> My ankles, knees, and hips feel heavy, relaxed, and comfortable.
> My stomach, chest, and back feel heavy and relaxed.
> My neck, jaw, and forehead feel completely relaxed.
> All of my muscles feel comfortable and smooth.
> My right arm feels heavy and relaxed.
> My left arm feels heavy and relaxed.
> My right hand feels heavy and relaxed
> My left hand feels heavy and relaxed
> Both my hands feel heavy and relaxed.
> My breathing is slow and regular.
> I feel very quiet.
> My whole body is relaxed and comfortable.
> My heartbeat is calm and regular.
> I can feel warmth going down into my right hand

Now encourage the client to bring their attention back into the room in which they are relaxing. Suggest that they can bring feelings of relaxation into their regular waking day simply by focusing in the same manner as they have during this exercise.

It can be very empowering for the client to develop their own script which they can then read when they are feeling overwhelmed or in need of self-rescue. This can also assist the client in becoming more creative and proactive in resolving their traumatic material.

Diaphramatic Breathing

If we watch an infant sleep, we will see the rhythmical movement of deep belly breathing. This is the ideal breathing for relaxation and the nourishing of the body with the breath. Again, it is important for the addicted survivor to recognize when they are in need of an exercise to self-soothe. For instance, many addicted survivors can relate feelings of anxiety to a "lump in their throat" or a "pain in their chest." These somatic experiences will act as a cue that feelings of safety may need to be addressed.

When we feel upset or anxious about something our breathing is often the first thing to change. It is likely to become shallow, rapid and jagged or raspy. If on the other hand, we were to practice an intentional diaphragmatic breathing, we would be more able to consciously regulate our breathing when we became upset.
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Find a comfortable, unrestricting position to sit or lie in. Place your hands on your belly as a guide to the breath. Begin to consciously slow and smooth out the breath. Just noticing the rhythm of the breath through the inhalation and exhalation. Is it smooth, deep and full or jagged, shallow and slight? Now focus on bringing a deeper breath into the belly. Let a full breath be released on the exhalation. Inhale fully, not holding the breath at any time. On the exhalation release completely and pause, counting to 3 after the exhalation is complete. Then inhale slow full and deep. Continue to focus in this manner on the breath.

Gentry (2002), suggests placing one's clasped hands behind the neck. This opens the chest through the lifting and spreading of the elbows. As this occurs, breath moves much more freely deep into the belly, thus allowing an excellent alternative (to hands on the belly) for those just learning deep breathing exercises.

At first, the individual is taught to deep breath in sets of 5. Then this is increased to 10 inhalations and exhalations. Finally, an instruction is given to practice 2 times each day for 5 minutes per day. In this way, the individual is learning to relax through deep breathing.

3-2-1 Sensory Grounding

This technique assists the trauma survivor in developing the capacity to "self-rescue" from the

obsessive, hypnotic and numinous power of the traumatic intrusions/flashbacks. It is based on the assumption that if the survivor is able to break his/her absorbed internal attention on the traumatic images, thoughts and feelings by instead focusing on and connecting with their current external surroundings through their senses (here-and-now), the accompanying fight/flight arousal will diminish. This technique will assist the survivor in understanding that they are perfectly safe in their present context and the value of using their sensory skills (sight, touch, smell, hearing, and even taste) to "ground" them to this safety in the present empirical reality.

1. Begin by asking the client to tell part of their trauma narrative and allow them to begin to experience some affect (reddening of eyes, psychomotor agitation, constricted posture).
2. When they have begun to experience some affect (~ 5 on a SUDS Scale), ask them "would you like some help out of those uncomfortable images, thoughts and feelings?
3. If they answer "yes," ask them to describe, out loud, three (3) objects that they can see in the room that are above eye level. (Make certain that these are physical, not imaginal, objects).
4. Ask them to identify, out loud, three (3) "real world" sounds that they can currently hear sitting in the room (the sound can be beyond the room, just make certain that they are empirical and not from the traumatic material).
5. Hand them any item (a pen, notebook, Kleenex), and ask them to really feel it and to describe, out loud, the texture of this object. Repeat this with two additional objects.
6. Return to objects that they can see and ask them to identify now two (2) objects that they can see, above eye level. Do the same with things that they can hear and feel (instead of handing items to the client, ask them to reach out, touch, and describe the texture of two objects). Repeat this now with one object each for sight, sound, and texture.

When completed, ask the client "What happened with the traumatic material?"

Note: This technique has not been vetted with empirical research. Developed by author.

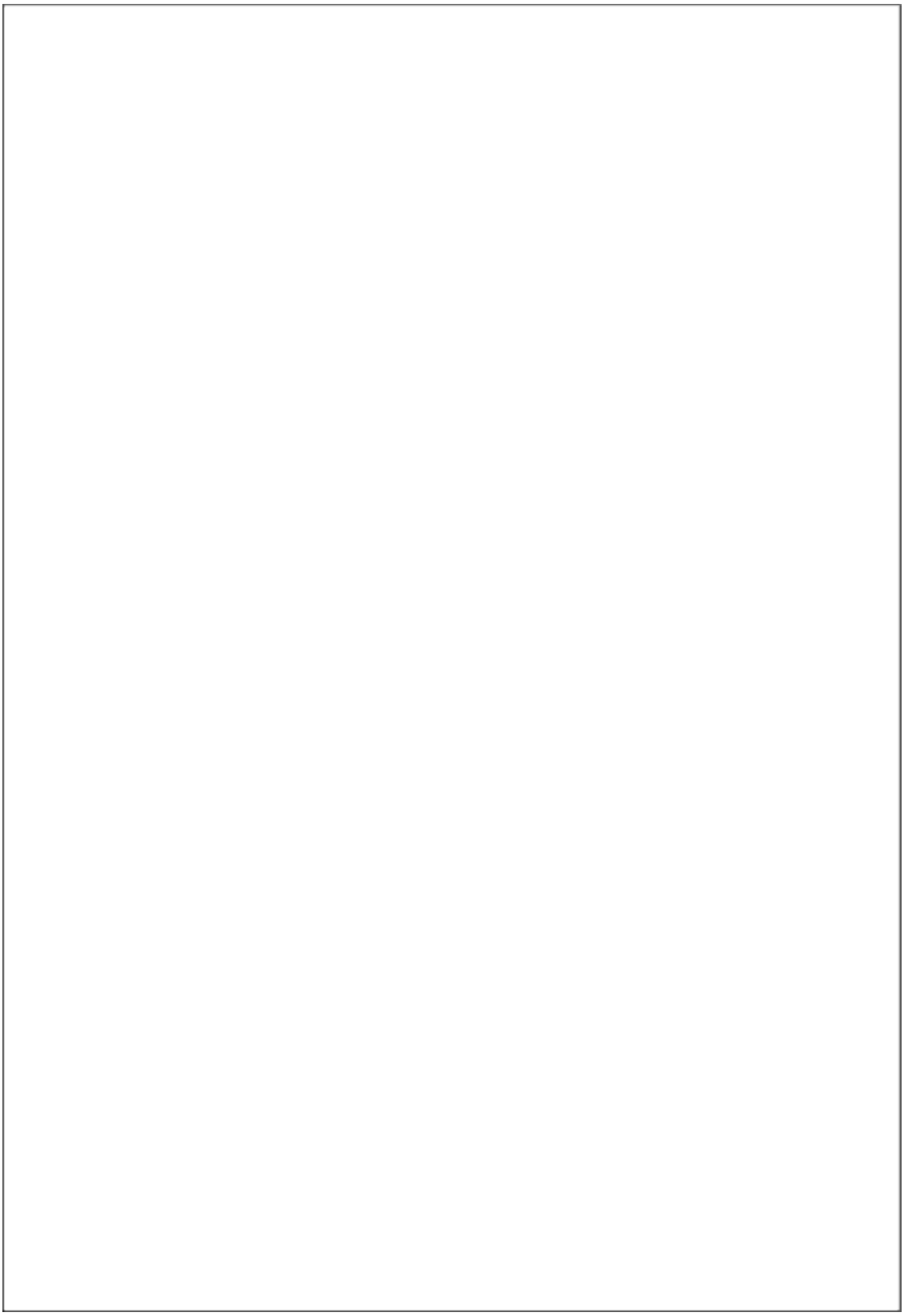
Safe-Place Picture with Anchoring & Transitional Object (alternative to Safe Place Visualization)

- Distribute paper and colored markers
- Tell client: *Draw a picture of a place that is safe and comfortable...it can be some place from your memory, that you been to before, or some place from your imagination, some place you've not yet been...just take the next five minutes to draw a picture that makes you feel safe and comfortable*
- Tell client "STOP" after 5 minutes
- Ask them: "May *I approach you?"*
- With permission, approach them and ask them to tell you about their drawing.
- Before they start hand them a polished stone and say to them: *"You know how you have memories and flashbacks of those BAD things that have happened to you? And how uncomfortable the feelings associated with those memories can be? Well some scientists found out several years ago that you can make flashbacks of GOOD memories also—so that you can call up to the present those positive feelings associated with this drawing in times when you are scared or overwhelmed. Would*

those positive feelings from that drawing into that stone while you are telling me the story of that picture. Ready to start?"

- Participate in the narrative...ask questions and provide support. When done ask how they are feeling.

Note: This technique has not been vetted with empirical research. Developed by author.



Postural Grounding

- While the client is exhibiting the constricted and fetal posture, ask her/him, "How vulnerable to do feel right now in that posture?" You will usually get an answer like "very."
- Ask them to exaggerate this posture of constriction and protection (becoming more fetal) and then to take a moment to really experience and memorize the feelings currently in the muscles of their body.
- Next, ask them to, "stand up, and turn around and then to sit back down with an ADULT POSTURE—ONE THAT FEELS' IN CONTROL." [It is helpful for the clinician to do this with the client as demonstration].
- Ask them to exaggerate this posture of being IN CONTROL and to now really notice and memorize the feeling in the muscles of their body.
- Ask them to articulate the difference between the two postures.
- Ask them to shift several times between the two postures and to notice the different feelings, thoughts, and images associated with the two opposite postures.
- Indicate to the client that they are now able to utilize this technique anytime that they feel overwhelmed by posttraumatic symptoms— especially in public places.
- Discuss with the client opportunities where they will be able to practice this technique and make plans with them for its utility.

- Note: This technique has not been vetted with empirical research. Developed by author.

Containment with Envelope (Trauma Containment or Session Closure)

When a client is either overwhelmed by a trauma memory or has accessed some difficult material in the last 1/3 of a session you can use this technique to contain the traumatic material or safely bring a session to a close.

- (FOR SESSION CLOSURE) Give client paper and colored markers...ask them to draw what it feels like inside right now. 2 minutes only.
- (FOR TRAUMATIC CONTAINMENT) Give client paper and colored markers...ask them to draw what it feels like inside right now. 2 minutes only.
- After two minutes say: *STOP. Put your marker down and look at me.*
- While client has been drawing, retrieve a 9 x 12" envelope. Ask client to place their drawing in the envelope. Next, hand client a stapler and tell them: *Put as many staples in the top of this envelope as you need to make certain that this drawing stays in here.* Allow client to staple as many times as they wish.
- Say to client something like: *OK. You and I both know that you still have some work to do on this material and we'll get to it. However, therapy happens here, in my office, and life happens out there. If it is OK with you, I would like to hold on to this drawing and all the fear and feelings associated with it. I will keep it safe, locked in my filing cabinet. When you are ready to work on it, we will take it out and address it. But until then, will it be OK if I hold on to it?*
- Remember to show to client upon their first return to your office following this session and ask them if they wish to address this material today or wait until another day.

Note: This technique has not been vetted with empirical research. Developed by author.

Self-Rescue from Abreaction/Sensory Grounding

- Signs of abreaction: shaking leg, wringing hands, fetalization of posture, downward fixation of eyes, tearfulness, flat or pressured speech, describing trauma with present- tense verbs.

- If you have a spontaneous abreaction, go to step "c". If your client does not spontaneously exhibit an abreaction during the first few sessions, it will be important for you to attempt to elicit or trigger one. You can do this by asking you client: Tell me the worst part of that trauma (look/listen for the above signs).

- After about 5-10 seconds of you client exhibiting progressive signs of an abreaction, get their attention by whistling or waving your hands followed by saying their name out loud. Ask them: Would you like some help out of that place and to learn how you never again have to get stuck there...so you can always pull yourself back out? Elicit "yes" response from client.

- Ask client to describe, out loud, three (3) objects that they can see in the room that are above eye level. (Make certain that these are physical, not imaginal, objects).

- Ask them to identify, out loud, three (3) "real world" sounds that they can currently hear sitting in the room (the sound can be beyond the room, just make certain that they are empirical and not from the traumatic material).

- Hand them any item (a pen, notebook, Kleenex), and ask them to really feel it and to describe, out loud, the texture of this object. Repeat this with two additional objects.

- Return to objects that they can see and ask them to identify now two (2) objects that they can see, above eye level. Do the same with things that they can hear and feel (instead of handing items to the client, ask them to reach out, touch, and describe the texture of two objects). Repeat this now with one object each for sight, sound, and texture.

- When completed, ask the client: What is different than it was 90 seconds ago? Most of the time your client will describe a significant lessening of negative feelings, thoughts and images associated with the traumatic material.

Note: This technique has not been vetted with empirical research. Developed by author.

THOUGHT FIELD THERAPY (Callahan, 1995)

Thought Field Therapy (TFT) is based upon ancient techniques of applied accupressure and energy meridians points. It is through the application of tapping upon specified "points" that energy is said to be freed and negative perceptions and bodily held emotions and fears are believed to be "released". Callahan calls these negatively held perceptions "Perturbations" of the "thought field". This rapid technique for reducing negative emotional discomfort has been shown to be useful for treating phobias and anxiety responses in preliminary case studies.

EXPERIENTIAL: The facilitator presents TFT for participant to experience firsthand. The participant is asked to select a troubling memory or concern that they are willing to process using TFT. Procedure follows below.

PROTOCOL - Algorithm for Simple Trauma (Phobia & Anxiety)

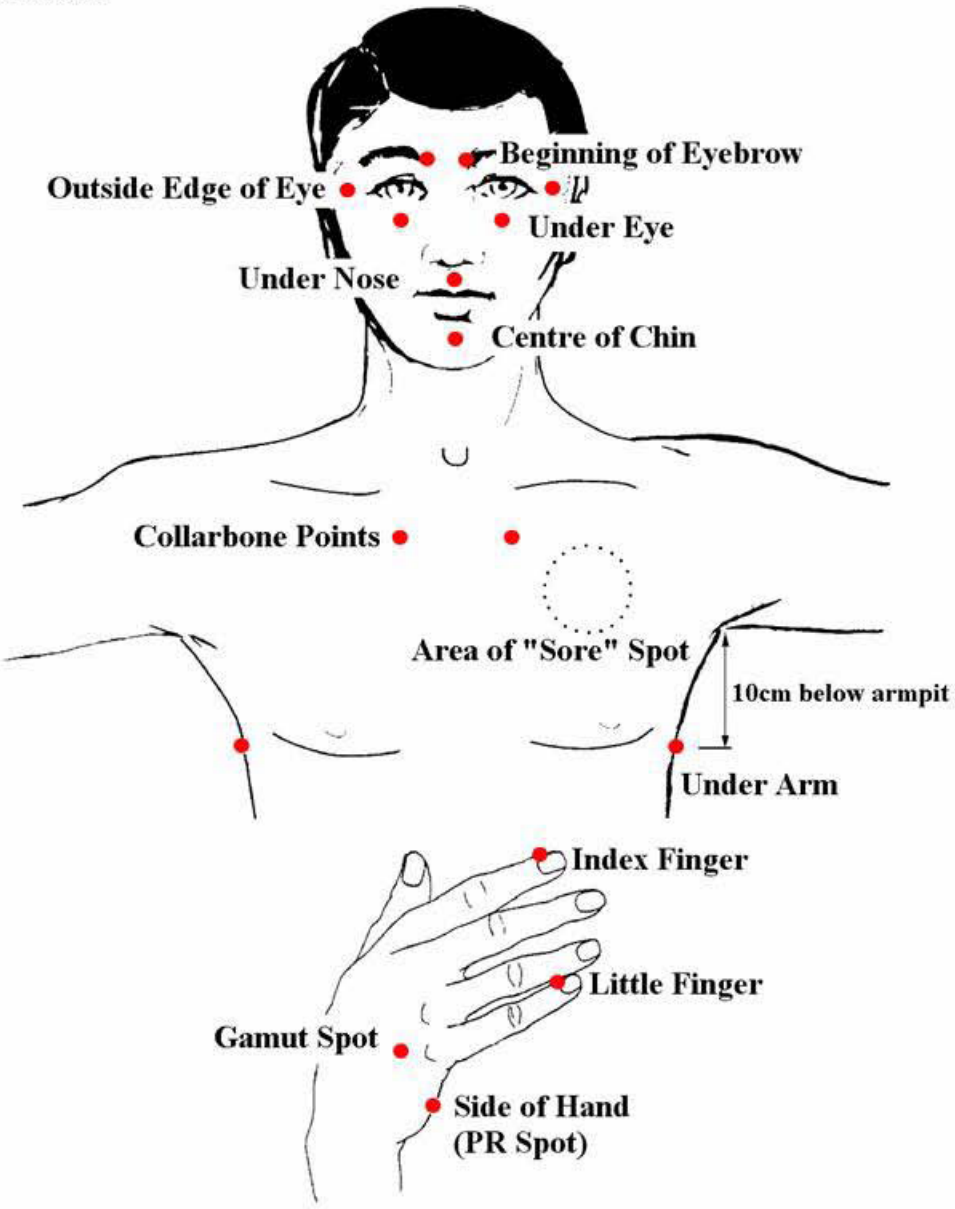
1. Identify Target Memory (Trauma, Phobia, Anxiety)_____
   _____
2. SUDS rating on the 1 to 10 disturbance scale _____
3. Tap eyebrow (5-8 times)
4. Tap under eye (5-8 times)
5. Tap underarm (5-8 times)
6. Tap collarbone (5-8 times)
7. Self-administer the 9 Gamut Series -- continuously tapping the Gamut point, located just above and between the little and ring finger knuckles. Follow the instructions below.
   - Eyes open -- look straight ahead
   - Eyes closed
   - Eyes open -- look down to the right
   - Eyes open -- look down to the left
   - Eyes open -- large clockwise circle
   - Eyes open -- large counterclockwise circle
   - Count out loud to five (1, 2, 3, 4, 5)
   - Hum any tune
   - Count out loud to five (1, 2, 3, 4, 5)
8. Repeat #'s 3-6 (above)
9. SUDS rating _____
10. Treatment Progress:
    - If decrease in SUDS $\geq$ 2 units; continue until < 2
    - If decrease in SUDS $\leq$ 2 units; then treat for "Psychological Reversal" and repeat from # 3

Psychological Reversal

1. Tap on heel of hand (pinky finger side of hand on the edge)
2. Say out loud while tapping "I accept myself even though I still _____" (x3)
   (Fill in blank as appropriate - i.e., feel fear, worry, concern, anger, phobia, etc.)

THE CALLAHAN TECHNIQUES®

Treatment Points



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Resource Page

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National Center for PTSD: **www.ptsd.va.gov/ptsd101**

The Phoenix Project (AU): http://phoenixaustralia.org/the-6-common- elements-of-evidence-based-therapies-for-ptsd/

Scott Miller/Feedback-Informed Treatment/International Center for Clinical Excellence (Instruments): www.scottdmiller.com

ACEs Video (Paper Tigers): https://youtu.be/ccKFkcfXx-c and www.acestudy.org

Course Videos:
https://www.youtube.com/playlist?list=PLZk8x28TSp9FWPrv2r1uQgQbBLoQ3Jy6C

TOOLS for HOPE Videos: https://www.youtube.com/playlist?list=PLZk8x28TSp9FFpaNUuaAEmF-yFKuSTd6C

Thought Field Therapy: www.tftrx.com