THE HEALING AND TREATING TRAUMA, ADDICTIONS AND RELATED MENTAL HEALTH DISORDERS CONFERENCE

John Arden, Ph.D.

Carissa Muth, Psy.D.

Caroline Buzanko, Ph.D.

Jeff Riggenbach, Ph.D.

Johann Blignaut, M.B.Ch.B., CCFP

Craig Extine, M.A., RCC

Varleisha Lyons, Ph.D., OTD, OTR/L

Daphne Fatter, Ph.D.

J.D. Vanderkooy, MD, BSc, FRCPC

Sara Klinkhamer, M.A.

WEDNESDAY APRIL 15 - THURSDAY, APRIL 16, 2026

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AGENDA	DAY 1 – Wednesday, April 15	DAY 2 – Thursday, April 16
8:30 AM – 10:00 AM	**Remodeling Mental Health: Combining Multi-Disciplinary Advances** - John Arden, Ph.D.	**Integrating Indigenous Healing Through Spiritual Traditions, Cultural Practices and Storytelling** - Varleisha Lyons, Ph.D., OTD, OTR/L
10:00 AM – 10:15 AM	BREAK	
10:15 AM – 11:45 AM	**Post-Traumatic Growth: Healing Emotional & Psychological Trauma** - Carissa Muth, Psy.D.	**Traumatic Memories: Evidence-Based Approaches to Trauma Processing** - Daphne Fatter, Ph.D.
11:45 AM – 12:30 PM	LUNCH BREAK	
12:30 PM – 1:30 PM	**Conquering Anxiety: Concrete Strategies for Helping Your Anxious Client** - Caroline Buzanko, Ph.D.	**Challenges in the Treatment of Eating Disorders** - J.D. Vanderkooy, MD, BSc, FRCPC
1:30 PM – 1:45 PM	BREAK	
1:45 PM – 2:45 PM	**Borderline Personality Skills Training** - Jeff Riggenbach, Ph.D.	**Comparing Biomedical Versus Psychedelic Ketamine Treatments for Depression: The Importance of Connectedness** - Sara Klinkhamer, M.A.
2:45 PM – 3:00 PM	BREAK	
3:00 PM – 4:00 PM	**Treating Young Adults with Co-Occurring Mental Health Conditions in an Inpatient Treatment Setting** - Dr. Johann Blignaut, M.B.Ch.B., CCFP & Craig Extine M.A., RCC	**Advanced CBT Skills Training** - Jeff Riggenbach, Ph.D.

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A MESSAGE FROM MELANIE ALSAGER

Dear Fellow Conference Attendees,

On behalf of the entire team at Georgia Strait Women's Clinic and Sunshine Coast Health Centre, we hope that you and your colleagues are able to join us for the Healing and Treating Trauma, Addictions and Related Mental Health Disorders Conference scheduled April 15 and 16, 2026. We are pleased to be co-sponsoring this live streaming event with our friends from Homewood Ravensview. Both of our organizations are committed to expanding inpatient care to include trauma, depression, and anxiety, and to establishing evidence-based treatment as a gold standard.

This conference is especially significant for our organization, as it will feature two of our star clinicians, Dr. Carissa Muth and Sara Klinkhamer. On Day One, Carissa is scheduled to present on post-traumatic growth (PTG). Since Carissa introduced PTG to our program, clients have reported finding deeper meaning, enhanced personal strength, improved relationships, and new life possibilities. On Day Two, Sara will present on ketamine-assisted therapy (KAP), which is getting lots of attention as a potentially transformative treatment for treatment-resistant depression. Sara is currently working on her Ph.D. dissertation on this topic and has lots of the latest research to share with attendees!

Thanks, as always, to Jack and his staff for providing this learning opportunity for all of us committed to this important work! While JHA training formats have evolved to include in-person, virtual, and hybrid formats, one thing that has stayed the same is their commitment to bringing cutting-edge topics presented by the best in the field. See you in April!

Melanie Jordan Alsager, MBA

Chief Executive Officer
Georgia Strait Women's Clinic
& Sunshine Coast Health Centre

Sunshine Coast Health Centre
A Non-12 Step Mental Health Program

Georgia Strait | WOMENS CLINIC

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December 16, 2025

Dear Conference Attendees,

On behalf of Homewood Health, we are pleased to welcome you to this important conference hosted by the Jack Hirose & Associates team. We are proud to be involved as a supporter of this event, which aligns closely with our shared commitment to advancing understanding, best practices, and collaboration in the areas of mental health, trauma, addiction, and concurrent disorders.

Homewood's involvement reflects our longstanding dedication to education, knowledge exchange, and strengthening the continuum of care across Canada. As part of this conference, members of our clinical team will be delivering two presentations, and we look forward to contributing practical insights, research-informed perspectives, and clinical learnings drawn from our work across diverse populations and care settings.

For more than a century, Homewood Health has provided evidence-informed treatment and support to individuals, families, workplaces, and communities, offering a full spectrum of services ranging from inpatient and outpatient treatment to workplace mental health solutions and research-informed clinical innovation.

We are genuinely excited to be part of this event and look forward to sharing insights, learnings, and meaningful dialogue with professionals who are deeply committed to this work. We hope the conference provides valuable perspectives, practical tools, and opportunities for connection that you can carry back into your practice and organizations.

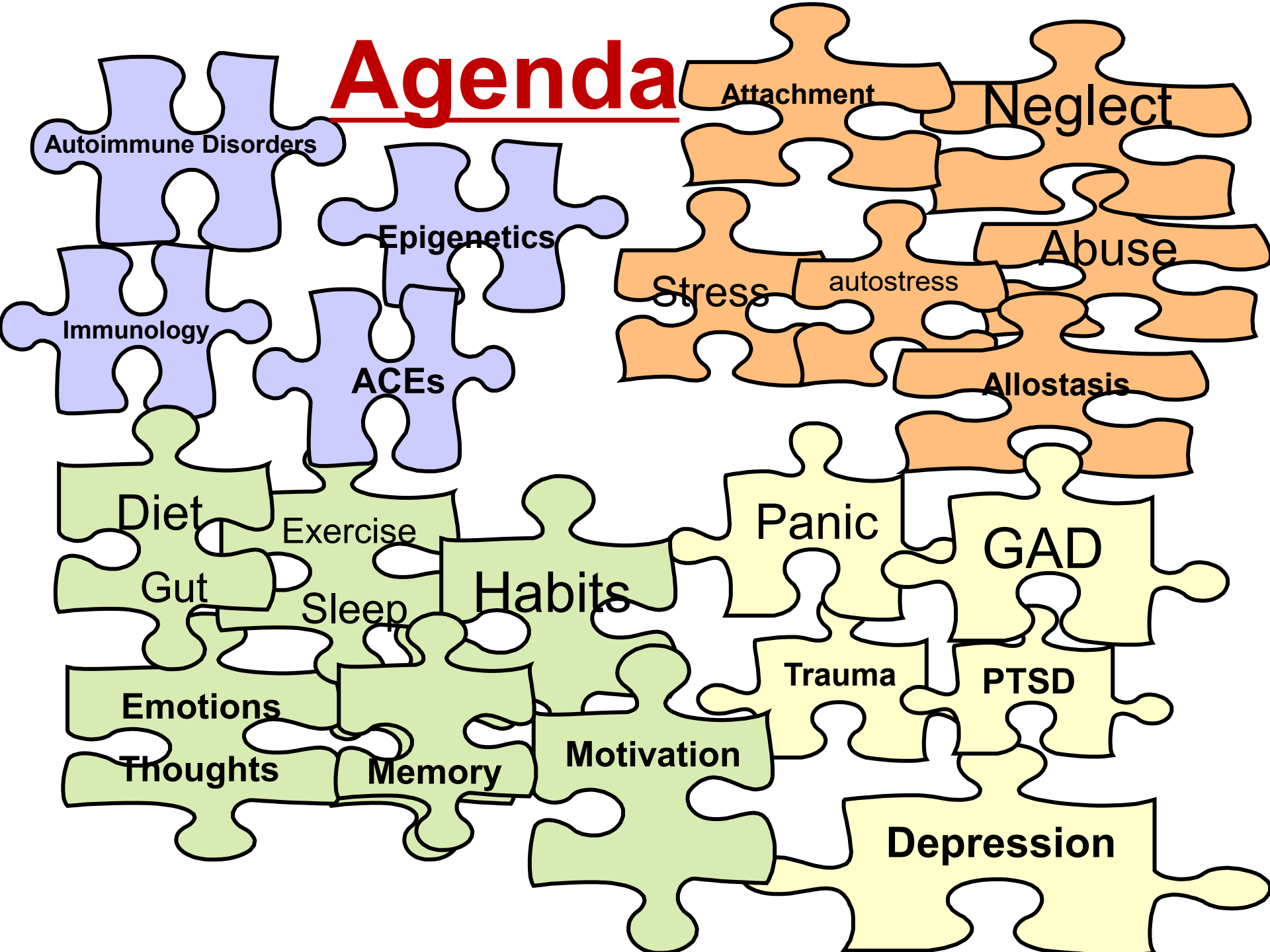
We look forward to seeing you in April 2026! In the meantime, we invite you to visit our facility websites to learn more about our programs and services, or to connect with us directly at treatment@homewoodhealth.com.

Warm regards,

Cassandra Sampson
AVP National Treatment Partnerships

Remodeling Mental Health

John B. Arden, PhD, ABPP

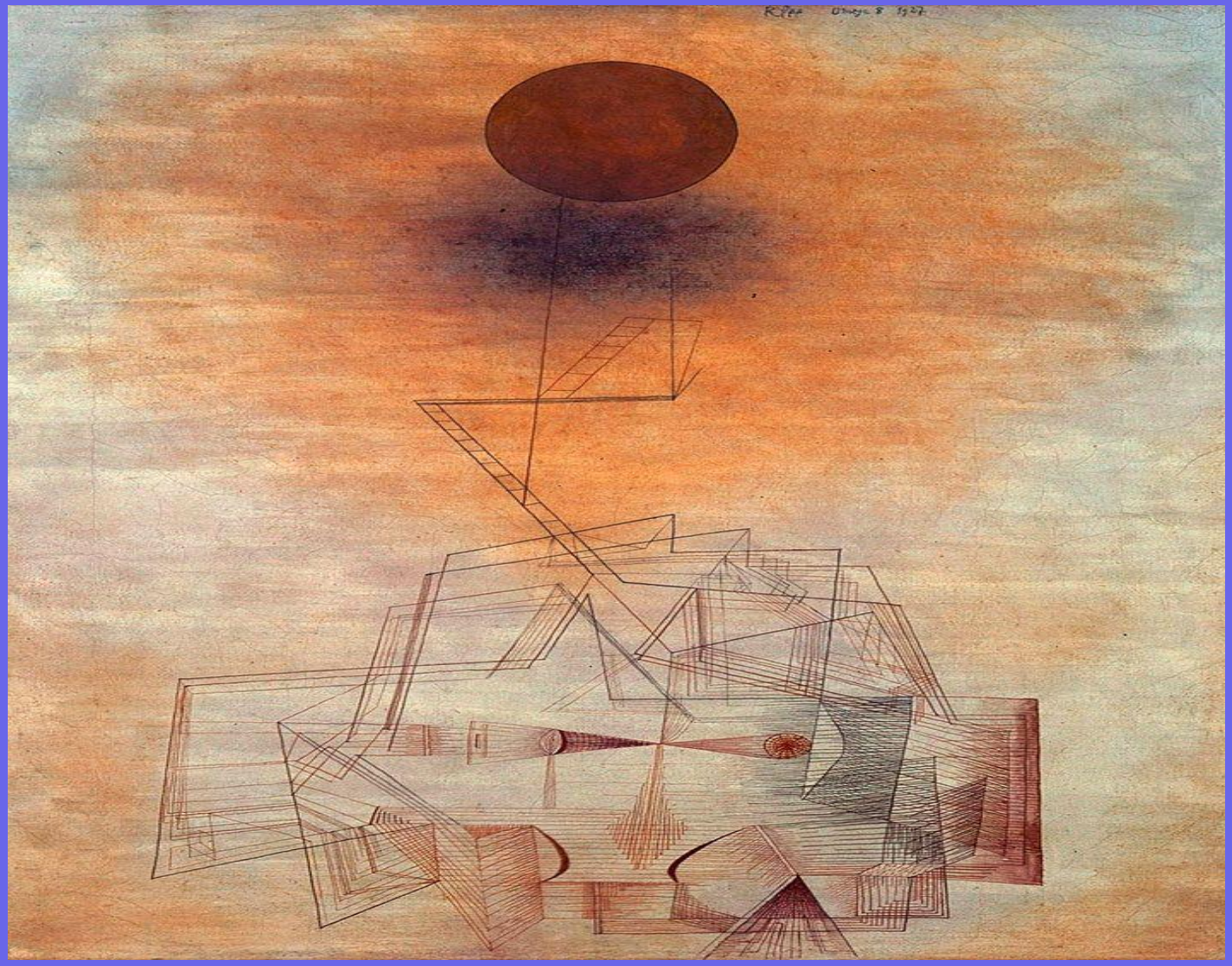

Agenda
Attachment
Neglect
Autoimmune Disorders
Epigenetics
Abuse
Stress
autostress
Immunology
ACEs
Allostasis
Diet
Exercise
Panic
GAD
Gut
Sleep
Habits
Trauma
PTSD
Emotions
Motivation
Thoughts
Memory
Depression

Refugee Crisis --122 Million Now In Ten years??

Re-traumatization caused by:

- relentless war in throughout the world with a growing level of violence, traumatic experiences extreme deprivation in daily life

Limits of Understanding (Klee)



Therapy might have been different

"We must recollect that all of our provisional ideas in psychology will presumably one day be based on an organic substructure."

--Sigmund Freud

"The act of will activates neural circuits"

--William James

But……

The Business Blizzard

Abreaction therapy
ACT
Adlerian therapy
Adventure therapy
Analytical psychology
Art therapy
Attack therapy
Attachment-based psychotherapy
Attachment-based therapy (children)
Attachment therapy
Autogenic training
Behavior modification
Behavior therapy
Biodynamic psychotherapy
Bioenergetic analysis
Biofeedback
Body psychotherapy
Brief psychotherapy
Classical Adlerian psychotherapy
Chess therapy
Child psychotherapy
Client-centered psychotherapy
Co-counselling
Cognitive analytic therapy
CBT
Coherence therapy
Collaborative therapy
CFT
Concentrative movement therapy
Contemplative psychotherapy
Conversational model
Conversion therapy
Core process psychotherapy
Dance therapy
Depth psychology
Daseinsanalysis
DNMS
DBT
Drama therapy
Dreamwork
DDP
Ecological counseling
EFT
EFT
EMDR
Existential therapy
Exposure and response prevention
Expressive therapy
Family Constellations
Family therapy
Feminist therapy
Focusing
Freudian psychotherapy
FAP
Future-oriented therapy
Gestalt therapy
Gestalt theoretical psychotherapy
Group analysis
Group therapy
Guided affective imagery
Hakomi
Holotropic Breathwork
Holding therapy
Humanistic psychology
Human Givens
Hypnotherapy
Inner Relationship Focusing
Integrative body psychotherapy
Integral psychotherapy
Integrative psychotherapy
Intensive short-term dynamic psychotherapy
Internal Family Systems Model
Interpersonal psychoanalysis
Interpersonal psychotherapy
Jungian psychotherapy
Logotherapy
Marriage counseling
Milieu therapy
Mindfulness-based cognitive therapy
Mindfulness-based stress reduction
Mentalization-based treatment
MOL
MDT
Morita therapy
Motivational interviewing
Multimodal therapy
Multitheoretical psychotherapy
Music therapy
Narrative therapy
Nonviolent Communication
Nude psychotherapy
Object relations psychotherapy
Ontological hermeneutics
Orthodox psychotherapy
Parent–child interaction therapy
Parent management training
Pastoral counseling
Person-centered therapy
Play therapy
Positive psychology
Positive psychotherapy
Postural Integration
Primal therapy
Primal Integration
Process oriented psychology
Process psychology
Prolonged exposure therapy
Provocative therapy
Psychedelic therapy
Psychoanalysis
Psychodrama
Psychodynamic psychotherapy
Psychosynthesis
Pulsing
RET
RLT
Reality therapy
Rebirthing-breathwork
Recovered-memory therapy
Re-evaluation Counseling
Reichian psychotherapy
Relationship counseling
Relational-cultural therapy
Remote therapy
Reprogramming
Rogerian psychotherapy
Sandplay Therapy
Schema Therapy
Self-relations Psychotherapy
Sensorimotor psychotherapy
Sexual Identity Therapy
Sex therapy
Social Therapy
Solution focused brief therapy
Somatic Experiencing
Somatic psychology
Status dynamic psychotherapy
Supportive psychotherapy
Systematic desensitization
Systemic Constellations
Systemic therapy
T-groups
Therapeutic community
Thought Field Therapy
Transactional analysis
Transference focused psychotherapy

The Demise of the Medical Model

NIMH spent $20 billion of dollars, researchers have not found genetic risk for psychological disorders.

NIMH rejects DSM-5. The developers of DSM-IV also reject DSM-5 which was heavily funded by big Pharm.

"A system based on clusters of symptoms …not any objective, tested, reproducible, clinically actionable biomarkers for any psychiatric disorder."
(Insel, 2013)

Medications and the Medical Model

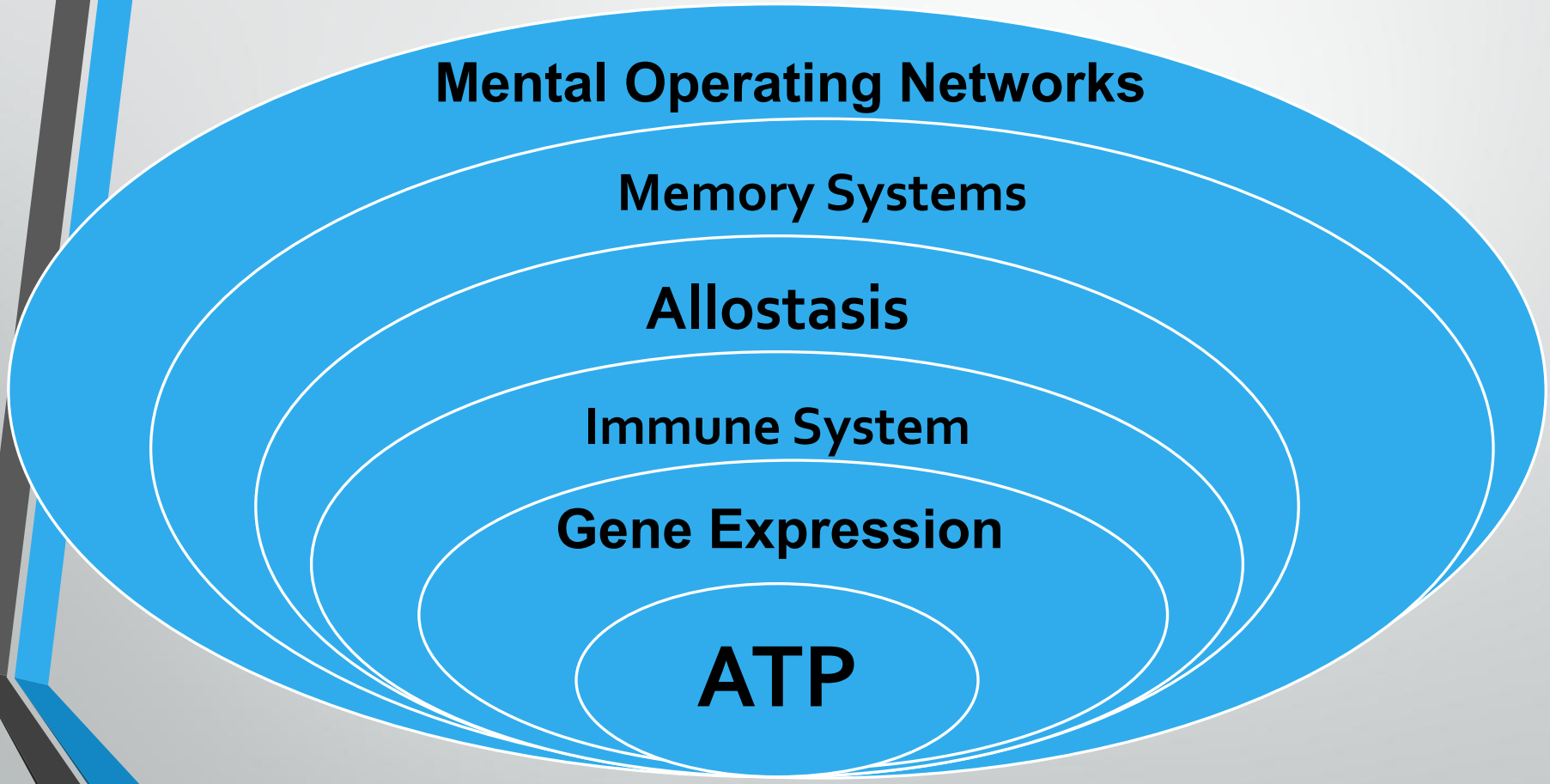
- Only 27% of the therapeutic response to drug effects.
- 50% of the responses to psychological factors surrounding the administration of the drug---10% to 70% placebo effect
- Down regulation of receptors

The Science has Changed

“Mental functions direct electrochemical traffic at the cellular level” Roger Sperry

“Psychotherapy works by producing changes in gene expression that alter the strength of synaptic connections…” Eric Kandel

“Self”-Organization



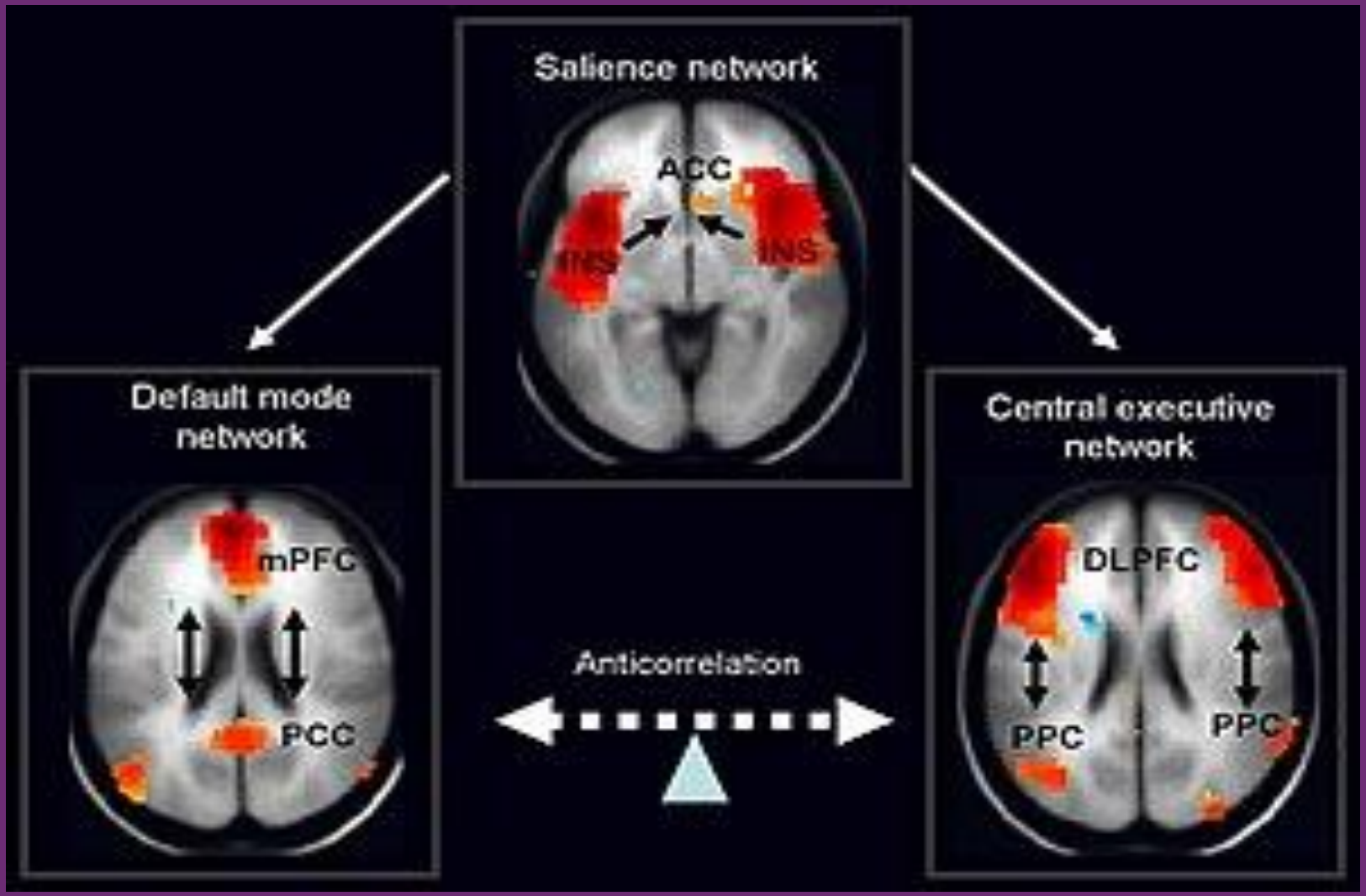
Body-Mind Basic Principles

- Maximize Energy Efficiency
  - Minimize Free Energy
- Reduce Uncertainty
  - Prediction Error
- Systems and Networks
  - Interdependence

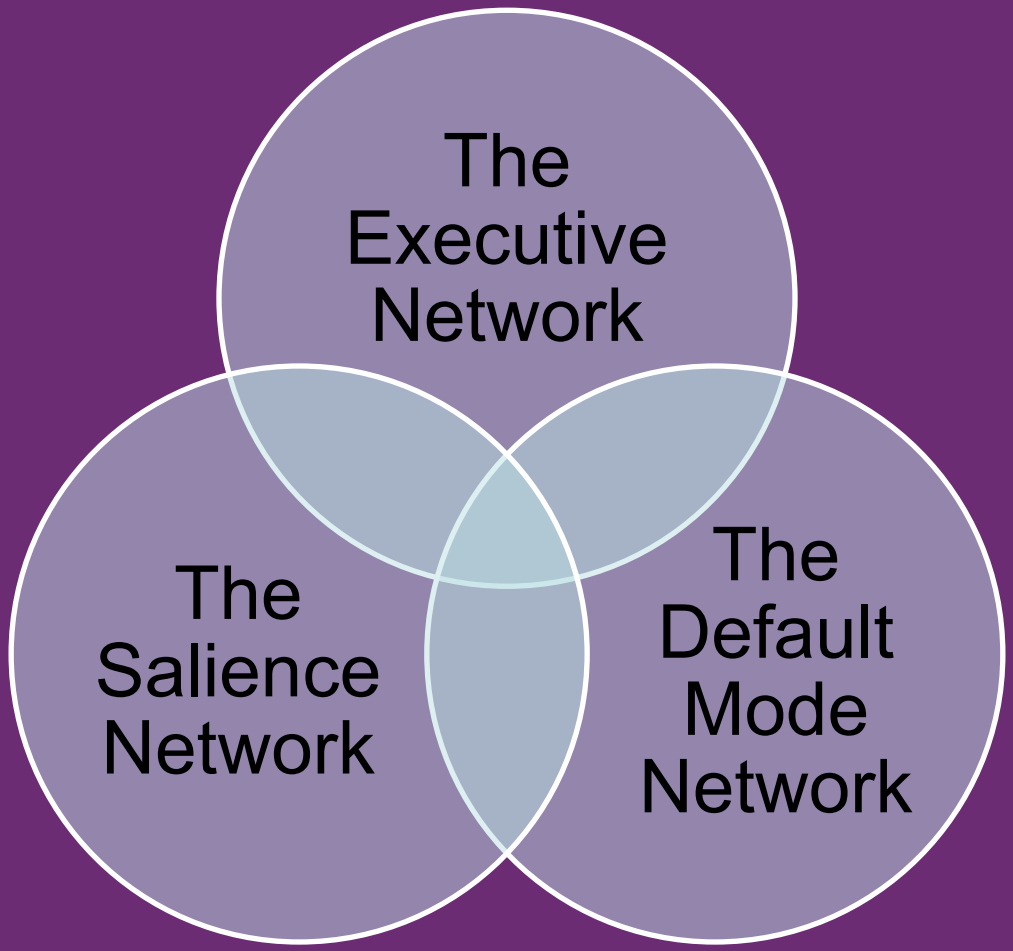
Symphony of Well Being

- Resilient systems and networks to minimize energy loss
- Network – neurovariability
  - Interdependence with others
- Positive Self-construal (narrative)
- States of mind support self

The Mental Networks



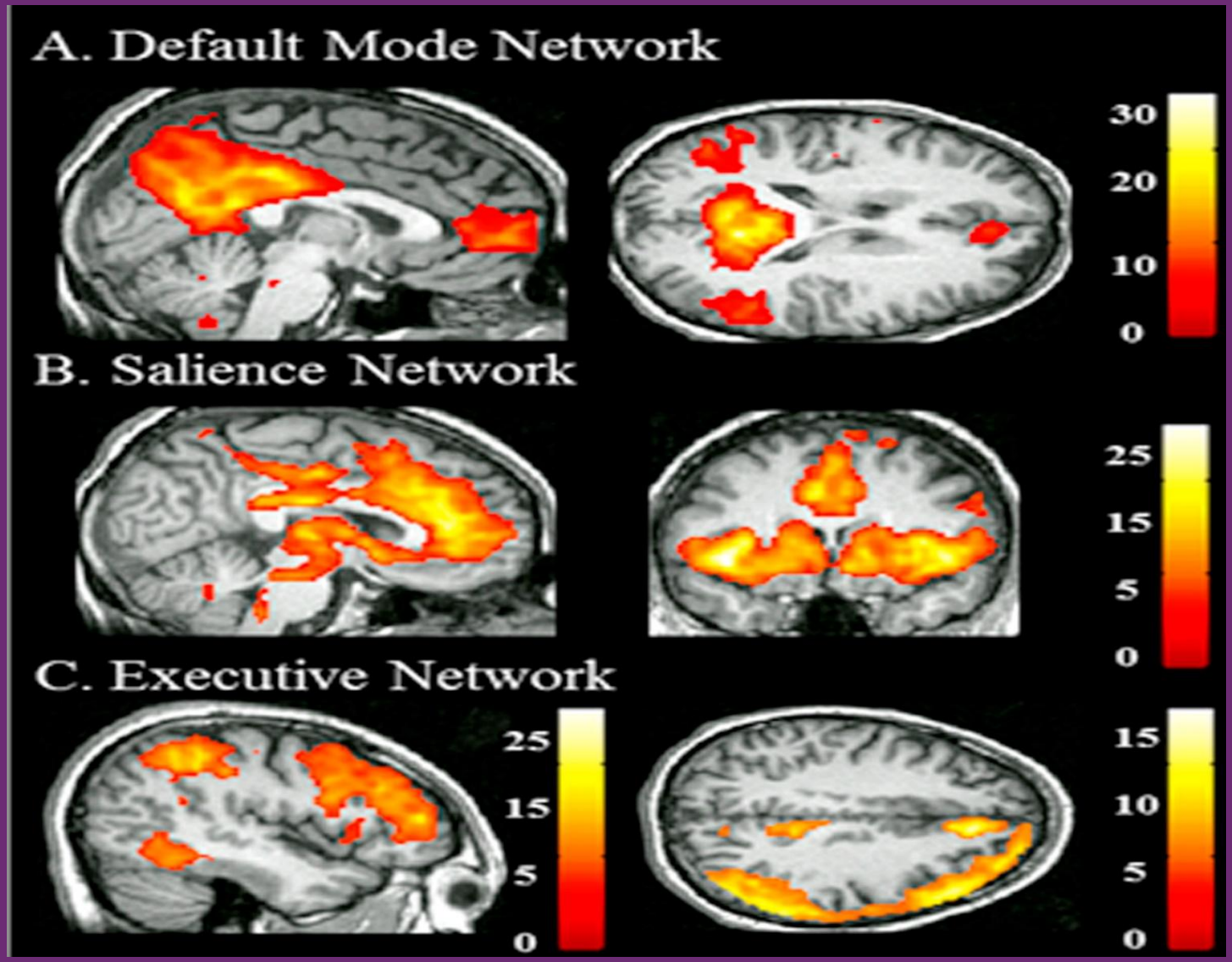
Balancing the Mental Networks

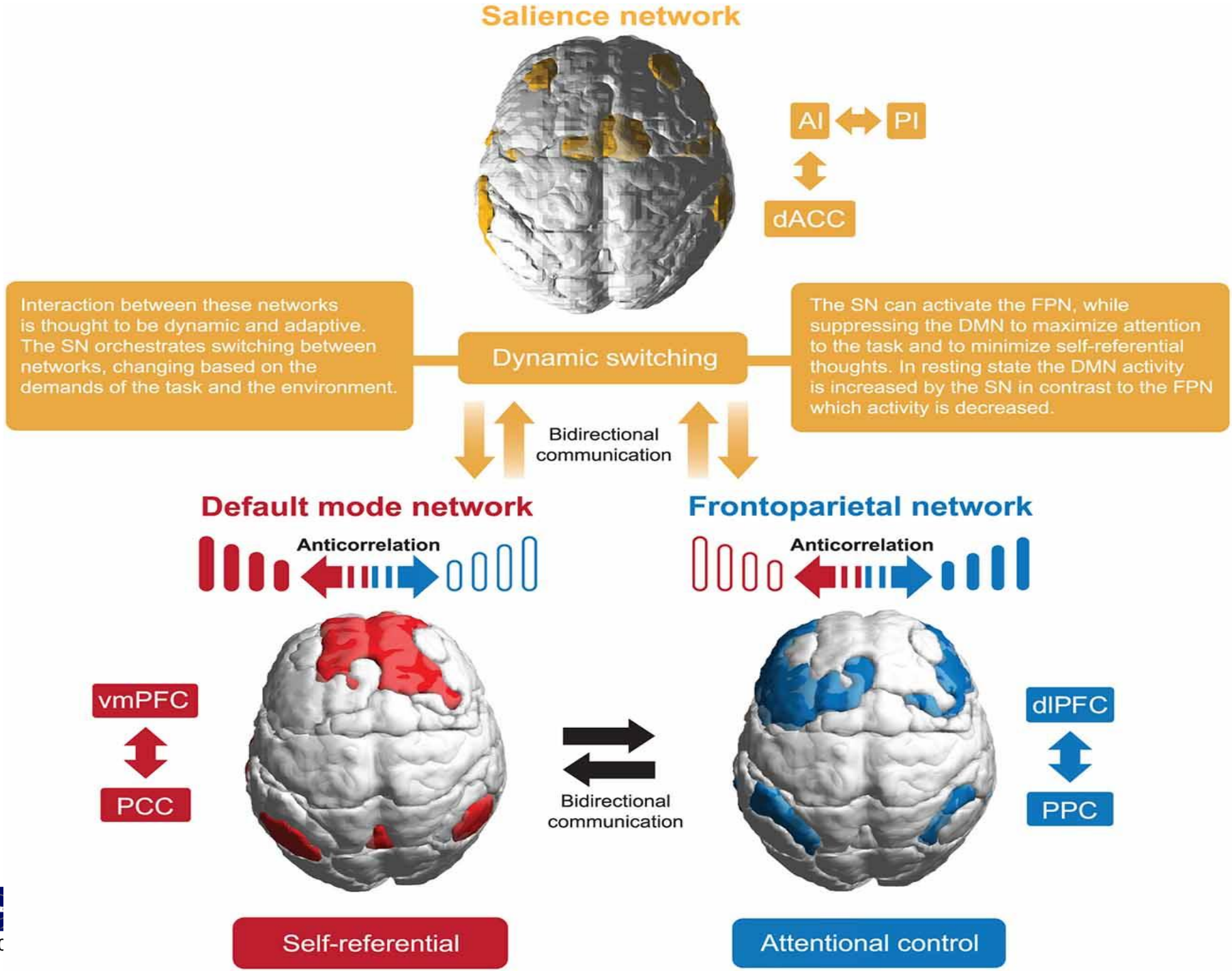


The Mind's Operating Networks:

- **Salience Network:**
- the material "me"
- emotional and reward saliency;
- **Default Mode Network:**
- mind-wandering; fantasying, ruminating
- mentalizing, projecting to the future or past;
- **Central Executive Network:**
- moment to moment monitoring of experience
- selection, planning, toward goals;

The Mental Networks




Salience network
AI
PI
dACC
Interaction between these networks is thought to be dynamic and adaptive. The SN orchestrates switching between networks, changing based on the demands of the task and the environment.
Dynamic switching
The SN can activate the FPN, while suppressing the DMN to maximize attention to the task and to minimize self-referential thoughts. In resting state the DMN activity is increased by the SN in contrast to the FPN which activity is decreased.
Bidirectional communication
Default mode network
Frontoparietal network
Anticorrelation
Anticorrelation
vmPFC
PCC
dlPFC
PPC
Bidirectional communication
Self-referential
Attentional control

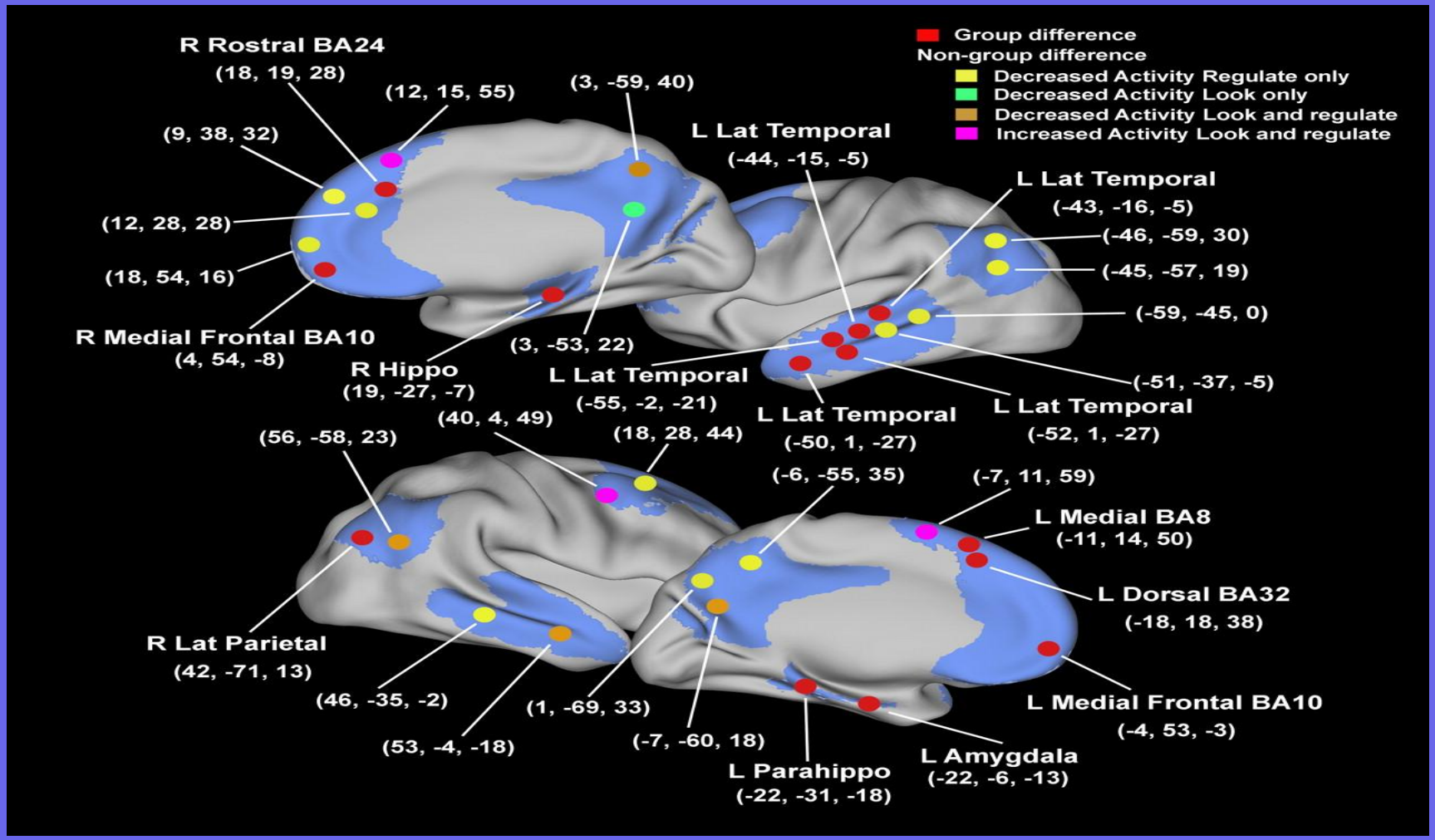
Salience Network:

- referred to as the ‘sentient self’ (the material “me”)
- detecting emotional and reward saliency;
- detecting and orienting toward external events in bottom-up fashion;
- bilateral anterior insula, dorsal anterior cingulate, amygdala

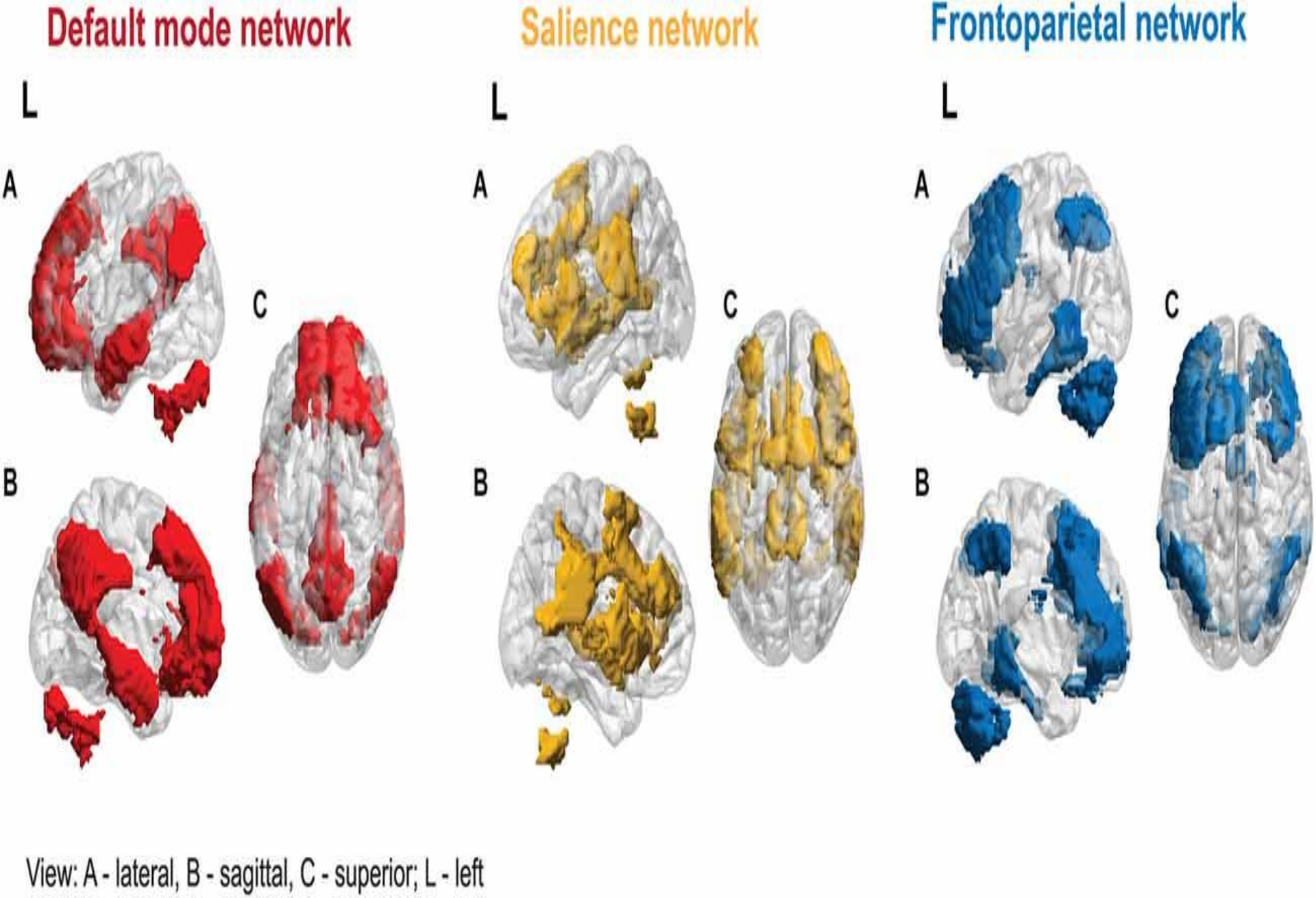
Default Mode Network:

- reflecting, spontaneous thoughts or mind-wandering;
- activated during tasks of mentalizing, projecting oneself into the future or past;
- activation when reflecting on social relationships;
- anterior and posterior midline and cingulate cortex

Activity in the default mode network



Sheline Y I et al. (2009)



The Journal of Neuroscience

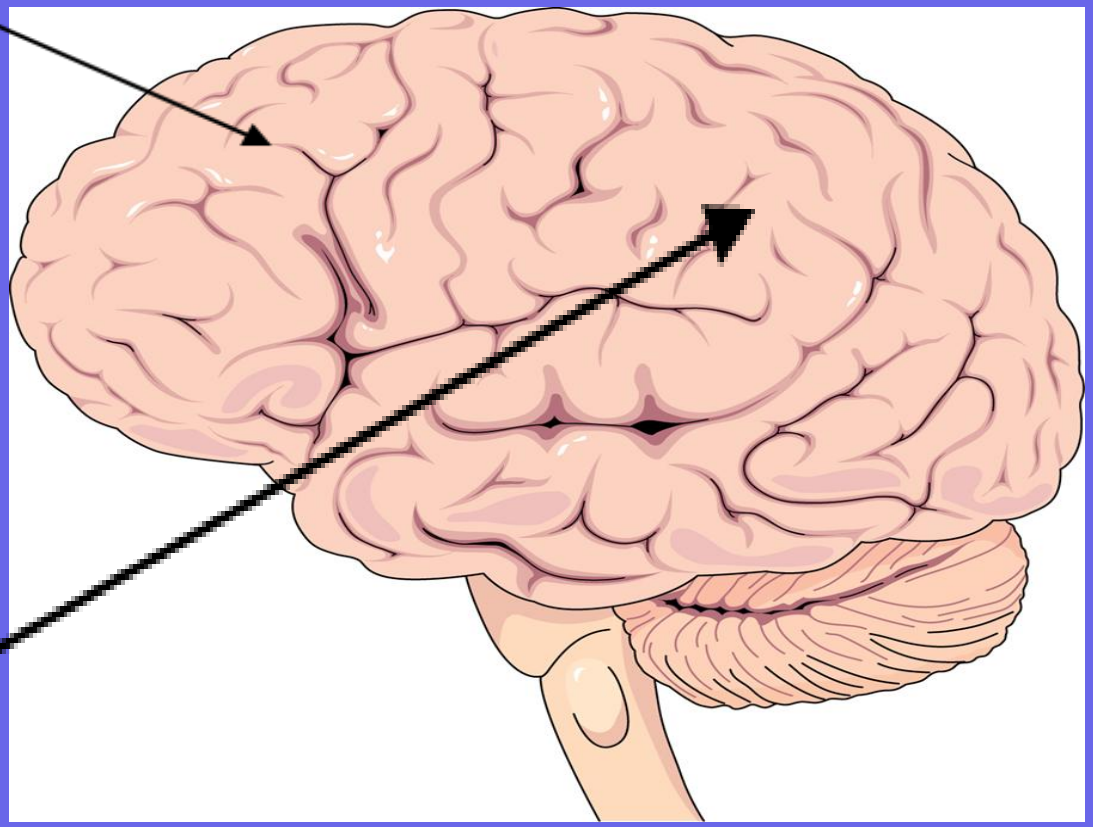
Central Executive Network:

- moment to moment monitoring of experience (meta-cognition)
- responsible for selection, planning, and decision-making toward goals;
- working memory that helps select, orient, and maintain an object in the mind;
- bilateral dorsolateral prefrontal cortex

Central Executive Network: CEN

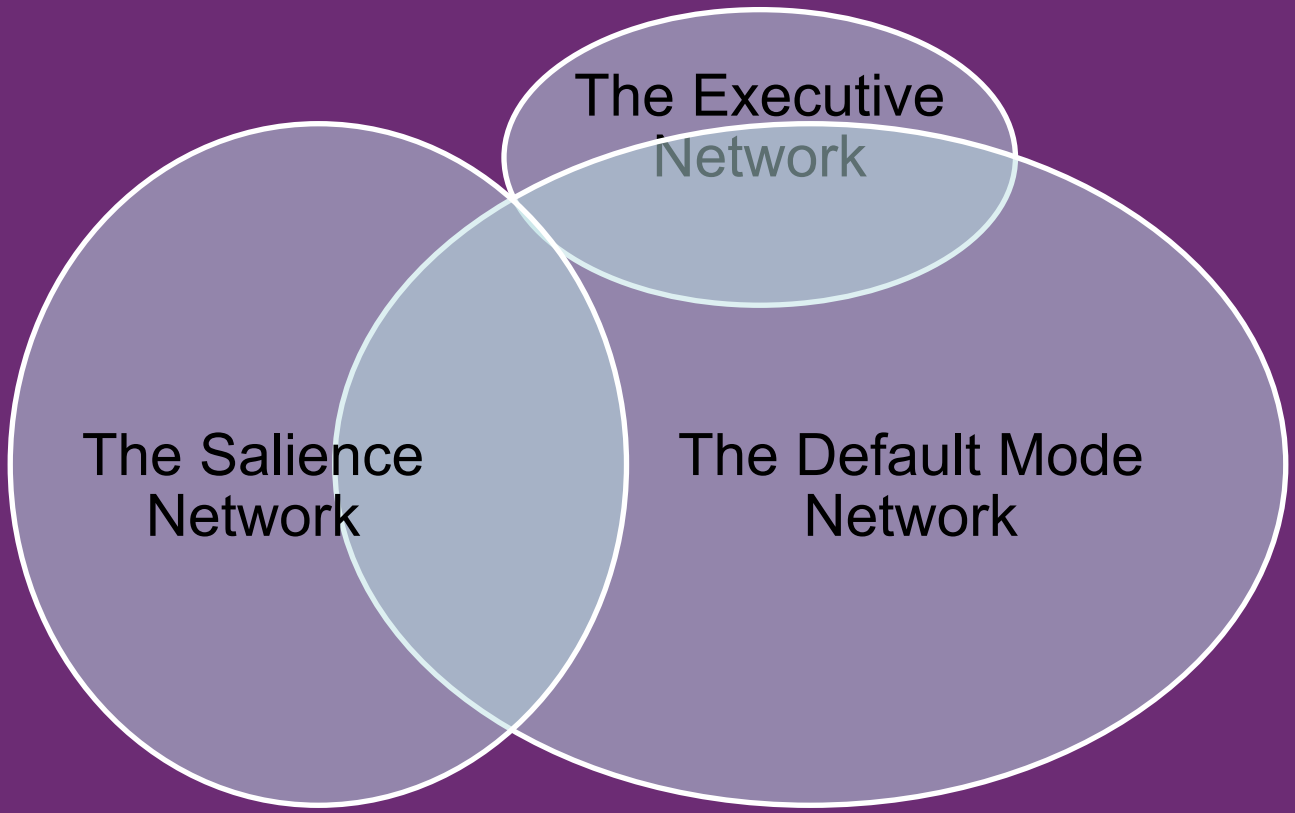
DLPFC and the OFC

Dorsolateral Prefrontal Cortex



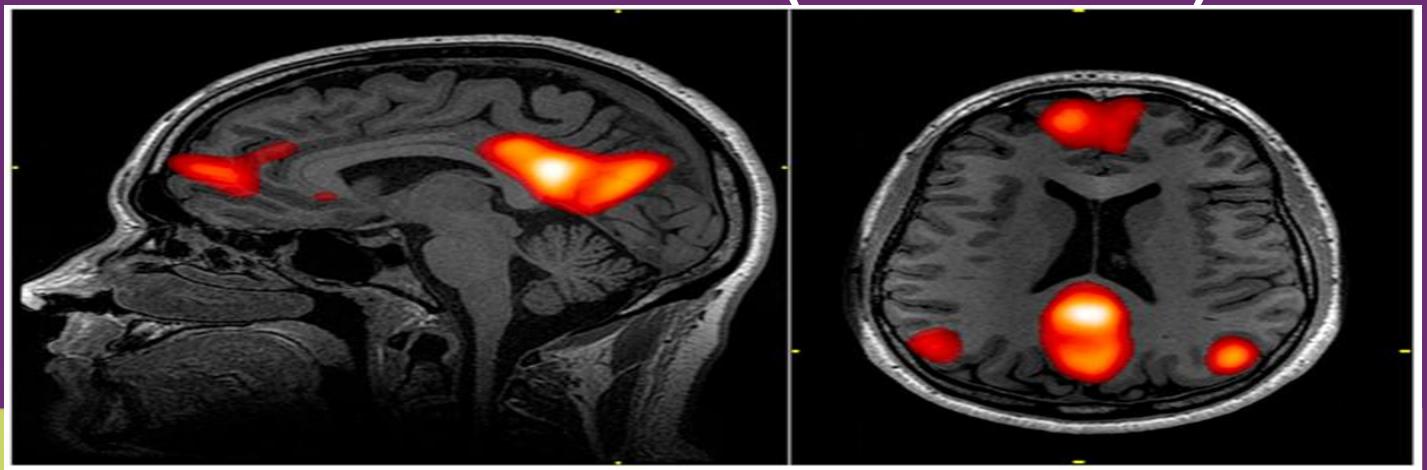
Posterior Parietal Cortex

Imbalanced Mental Networks



Life Satisfaction or Not

- Self-construal—narrative
  - mPFC involved in the representation of self-referential information and affect regulation
  - pCC is involved in the integration of self-referential info (narrative)



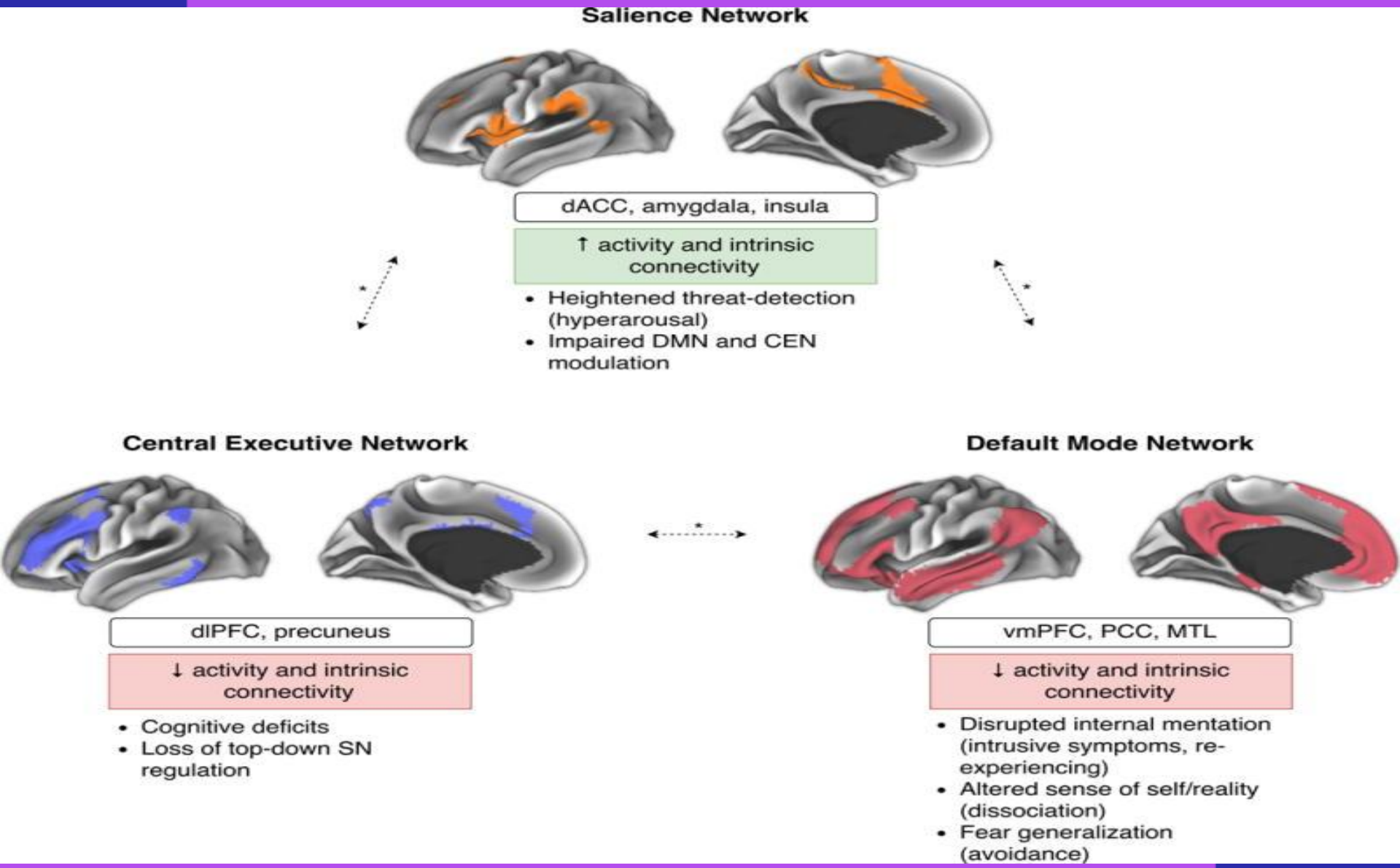
PTSD and Networks

- Decreased triple network connectivity
  - –Decreased connectivity of left middle frontal gyrus (CEN)
  - –Decreased connectivity right insula (SN)
  - –Decreased connectivity bilateral mPFC (DMN)
    - »Reduced functional connectivity in the DMN
-

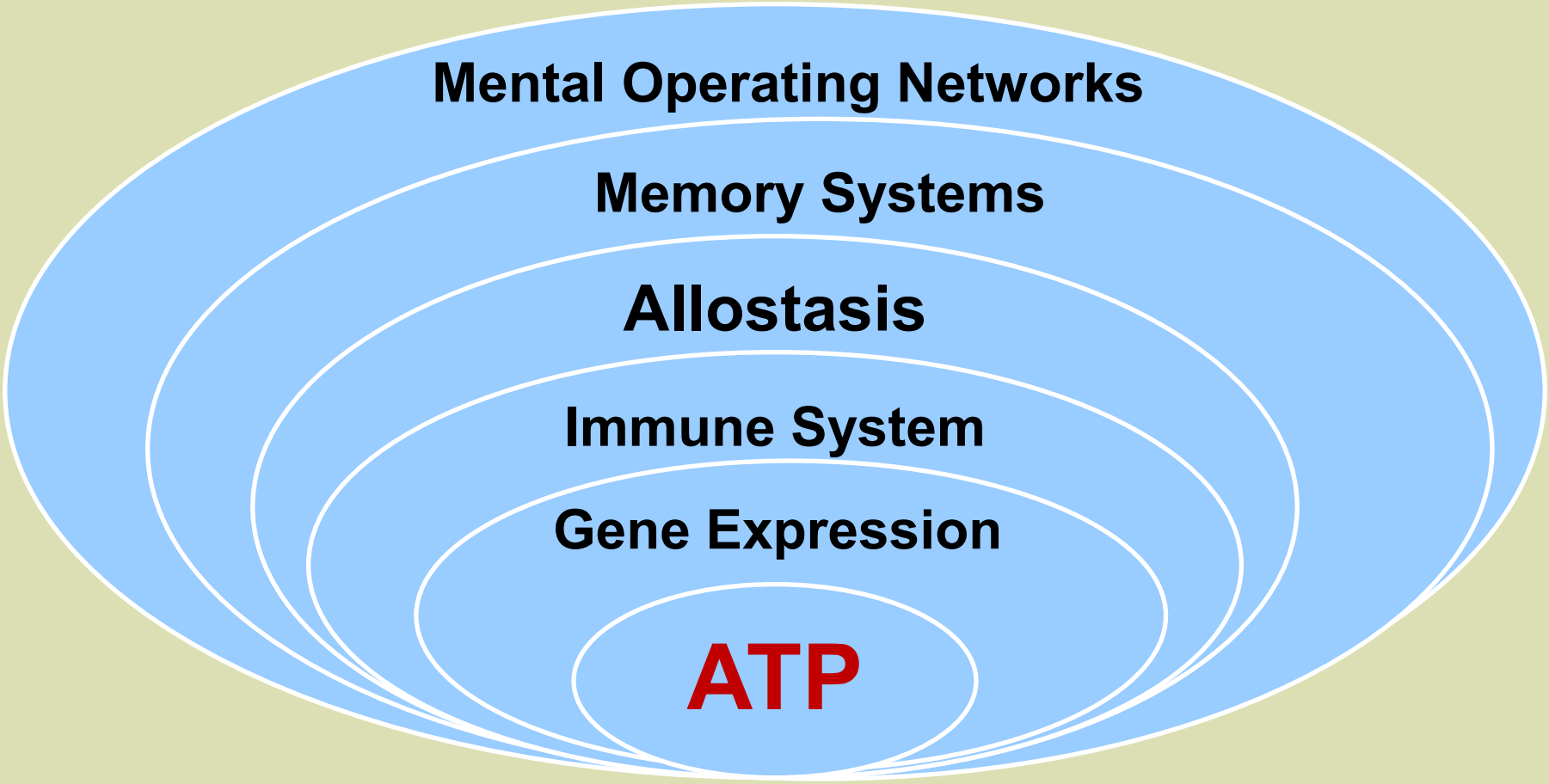
Body, Mind, & Social: Well-Being

- Together networks support:
  - self-organization
  - mental health
- Greater life-satisfaction associated with neural variability between the DMN, EN, and SN
  - They require physical health to function
  - Then they thrive with social health

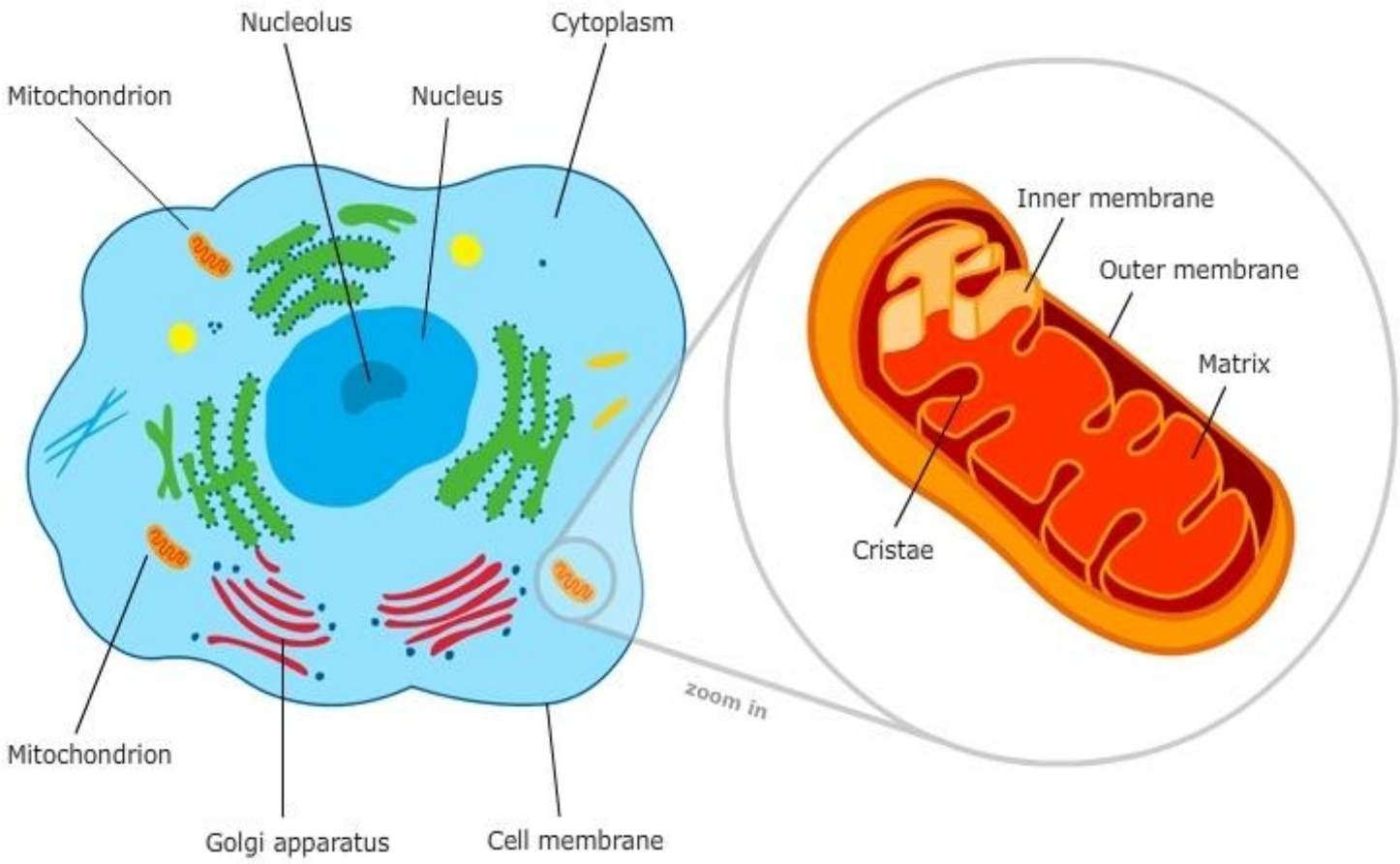
States of mind in conflict



“Self”-Organization



Cells and Their Energy Factories



Numbers of Mitochondria

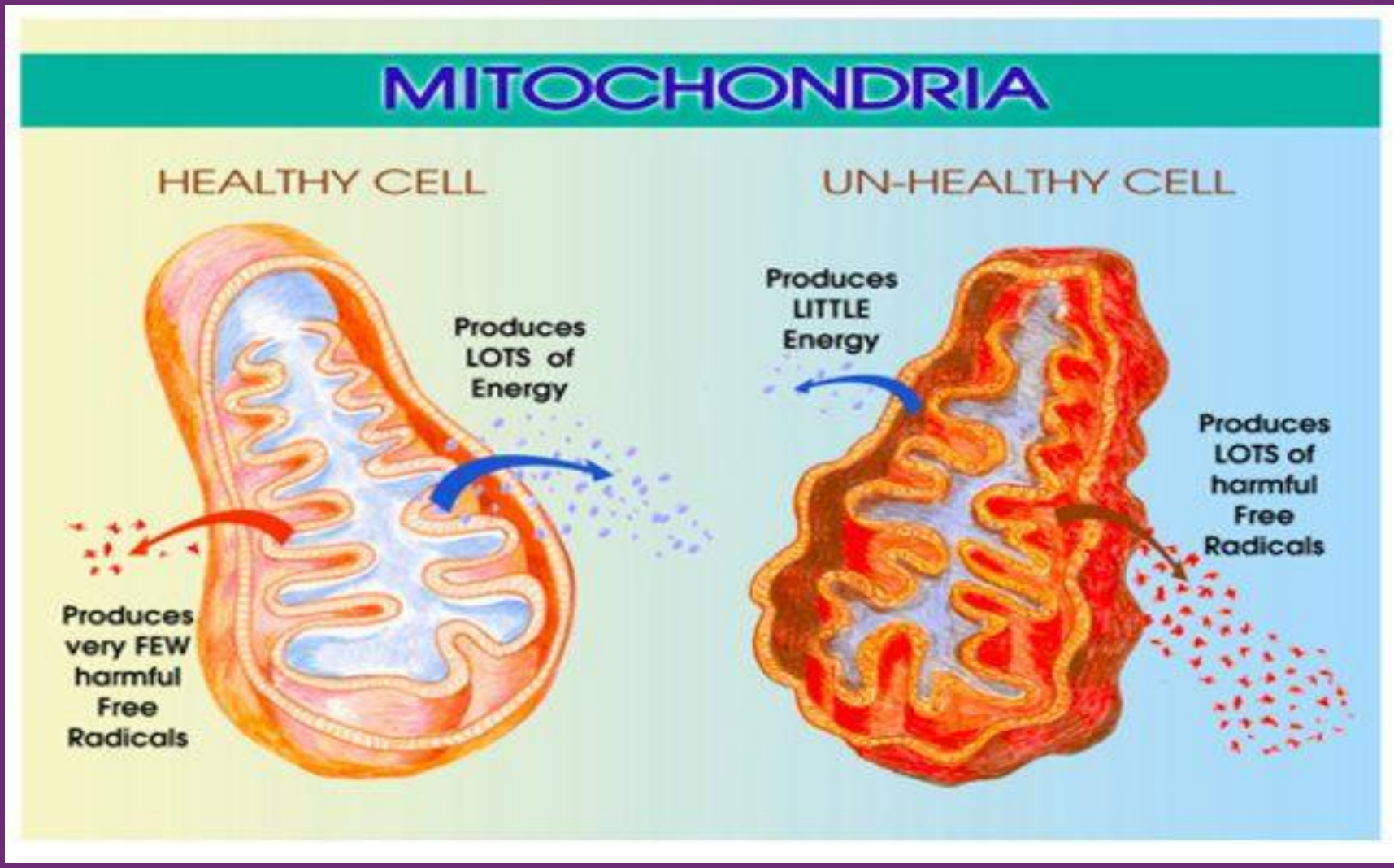
- On average each of our cells host 500 mitos.
  - Roughly 10 percent of our total body weight.
- Energy needs: our heart and brain cells contain the greatest number of number of mitos.
  - There are approximately 10 million billion mitos in an adult human brain.

The Energy Generating Metaphor

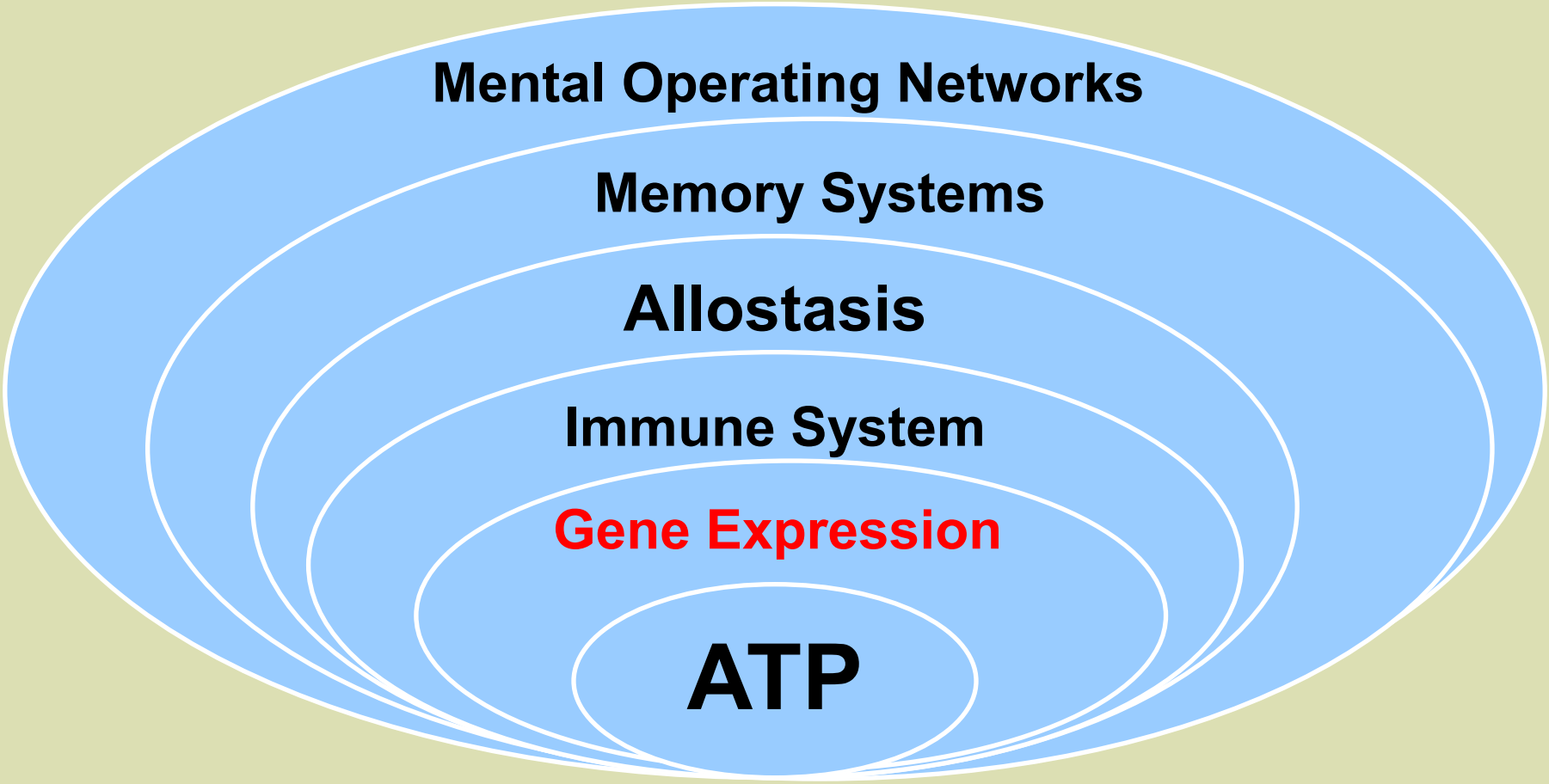
Mitochondria, just like a dam, uses pressure in each step so that energy is released from electrons within the pump.

The biochemical reactions culminate with the final product, the synthesis of ***adenosine triphosphate*** *(ATP).*

Free Radical Damage

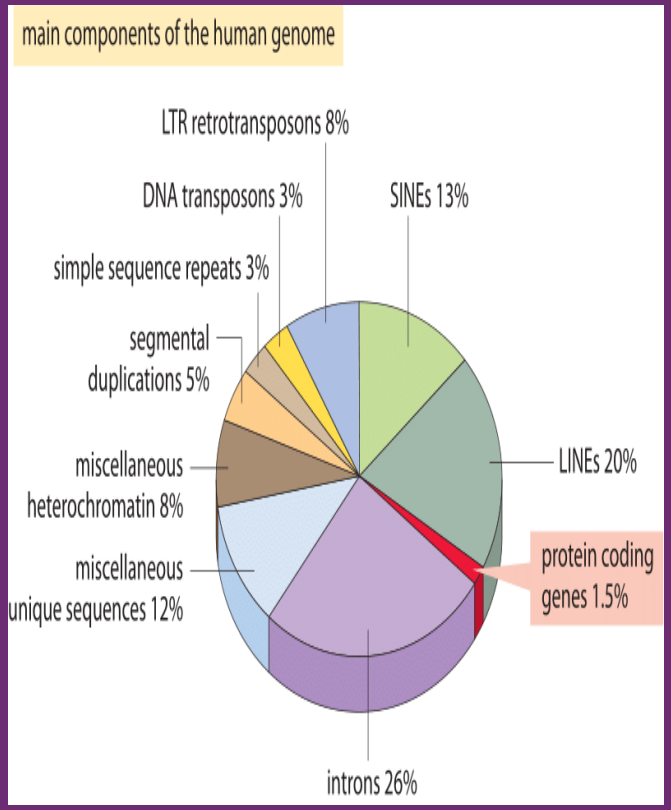


“Self”-Organization

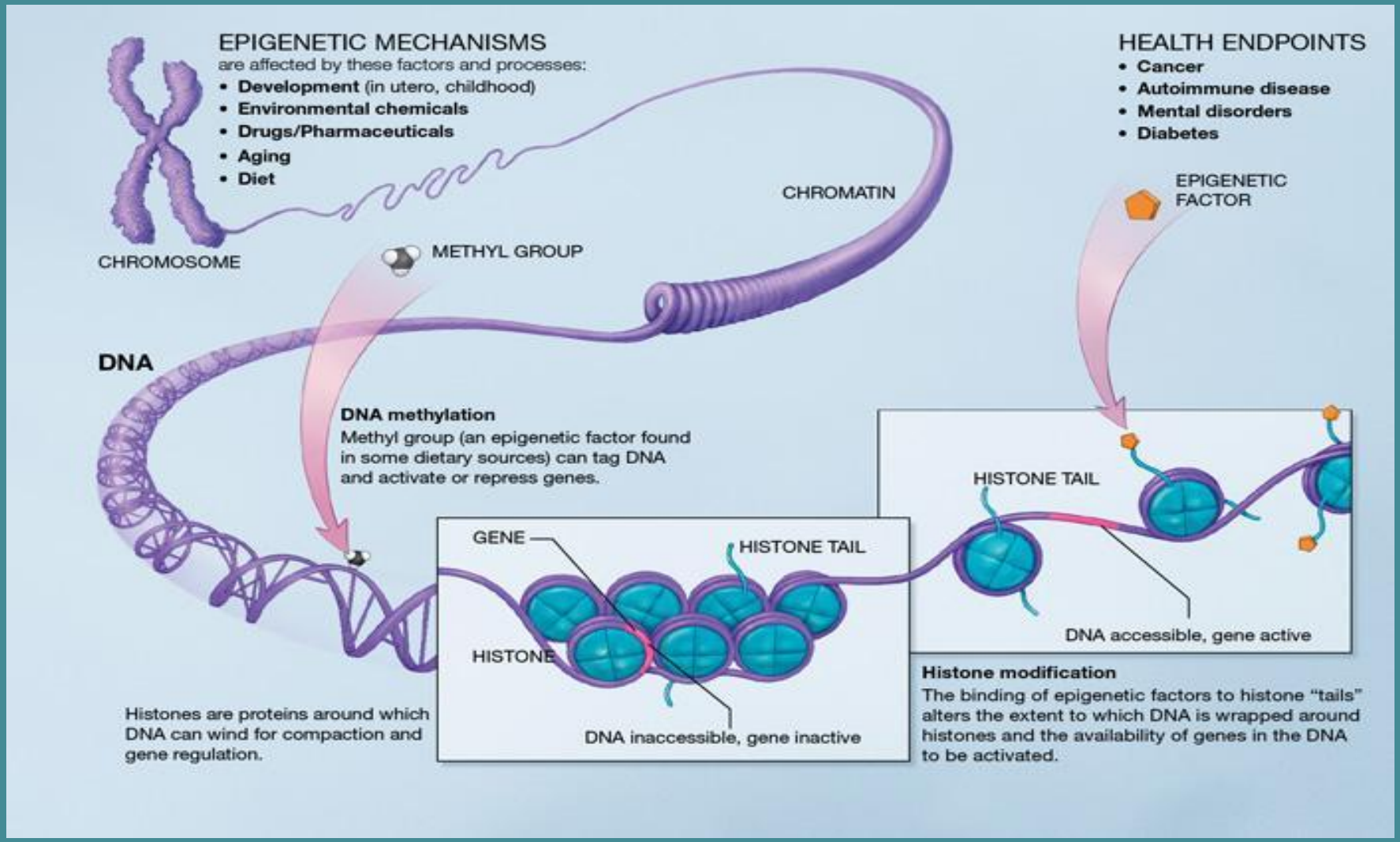


Epigenetics

- 24,00 genes (that code for protein)
  - Worm and human
- 2% (the rest—"junk DNA")
- As the complexity of the species increases so does the amount of non-coding DNA



Epigenetics



Epigentics and parenting

- Good parenting produces kids with less methylation of the cortisol receptor gene
- The kids have a better thermostat for cortisol and can turn of the stress response system more easily

Cortisol level

Factors that Impair DNA and Cells

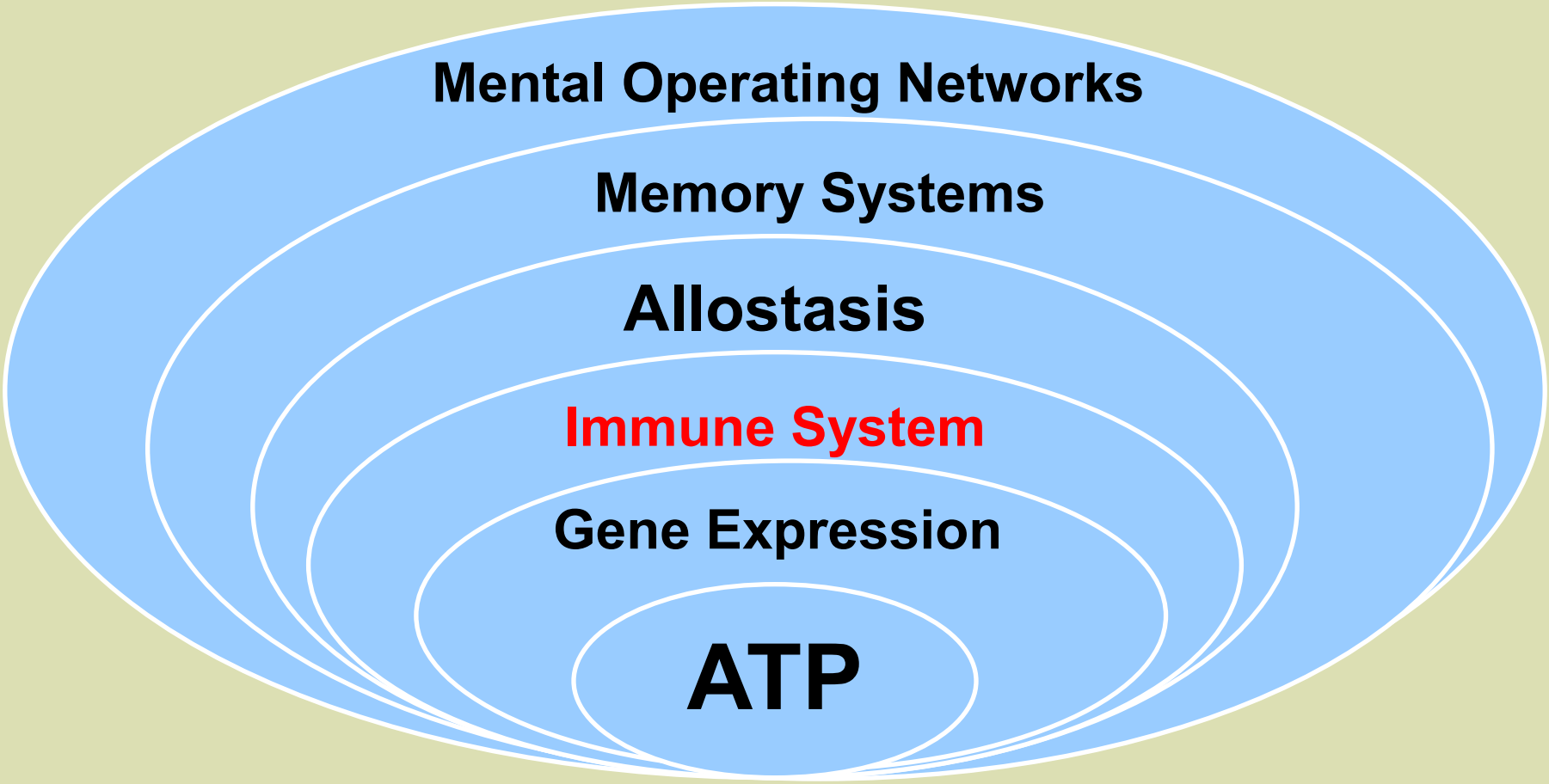
- When cells divide
- Telemeres shorten
- Gene expression changes
- Impairs cellular repair
- Recycling of cells slows
- Errors accumulate
- Cells fail
- Cells die

Factors that Shorten Telemeres

- Aging
- Cardiovascular disease
- Smoking
- Obesity (more than smoking!)
- Type 2 Diabetes
- Social isolation
- Poor diet
- No exercise
- Poor sleep
- Alcohol and other drugs
  - **All rendering DNA vulnerable to damage**

GAZA

“Self”-Organization



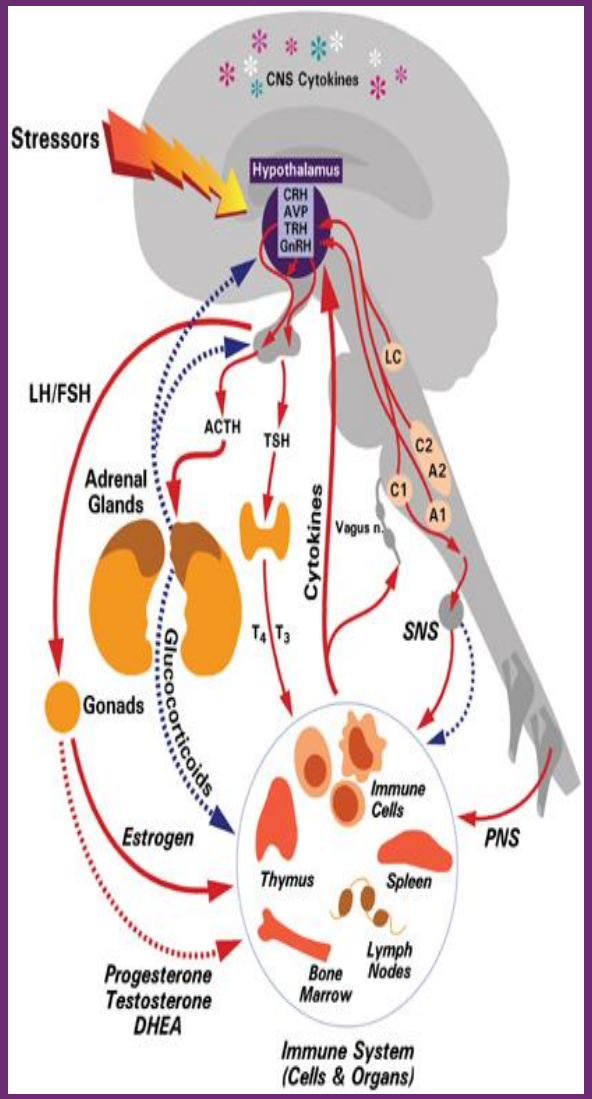
The Brain Controls the Stress Pathways

Distress, via the cortex and amygdala signal to the hypothalamus.

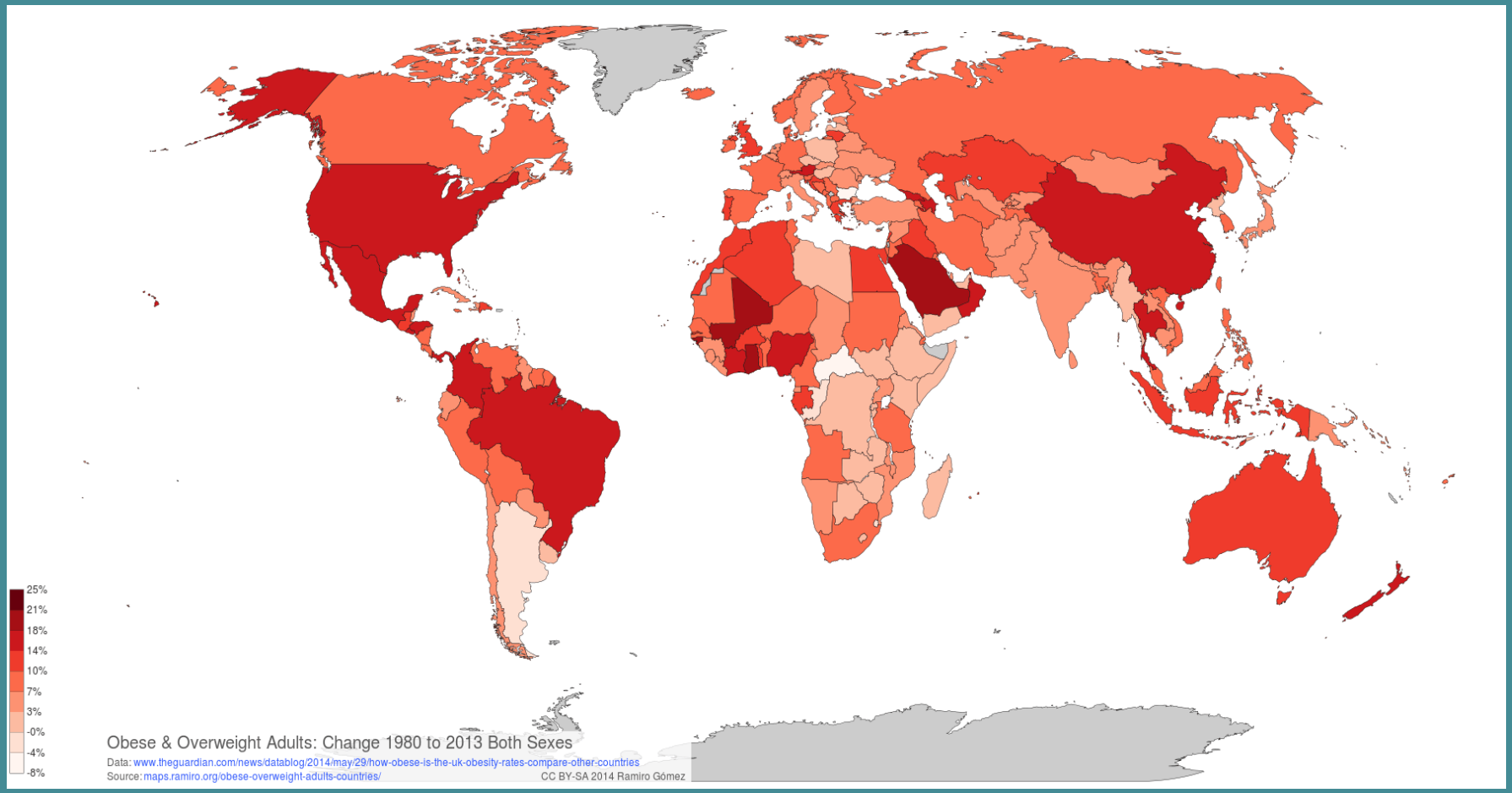
The hippocampus (memory) also has inputs to the hypothalamus.

The hypothalamus maintains homeostasis by regulating visceral activities: heart rate, blood pressure, body temperature, thirst, hunger, weight, sleep/wakefulness.

The hypothalamus also controls HPA stress response system

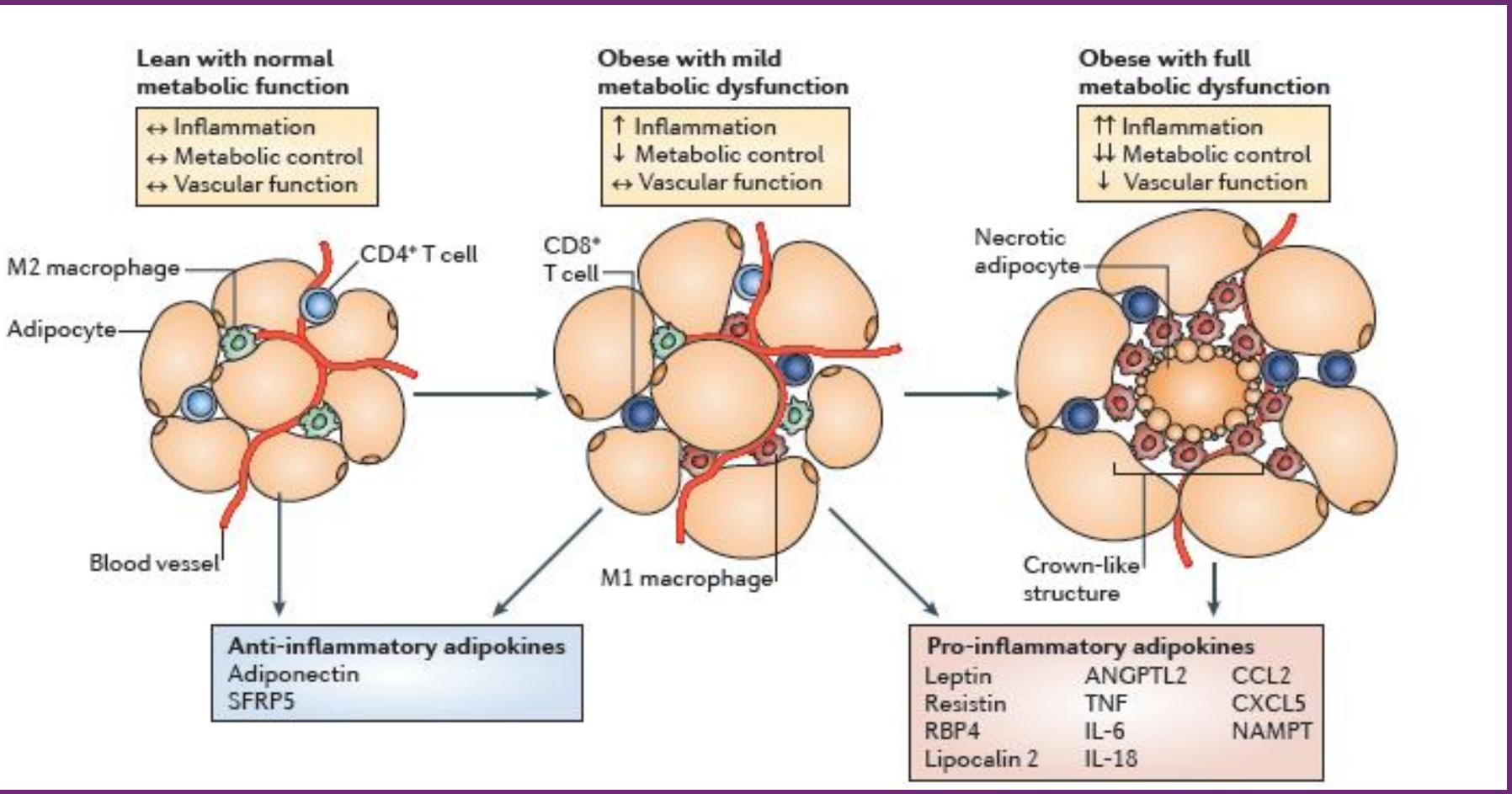


The Pandemic



Obese people over 40 will die 6-7 years earlier

Obesity-Associated Adipose Tissue Inflammation

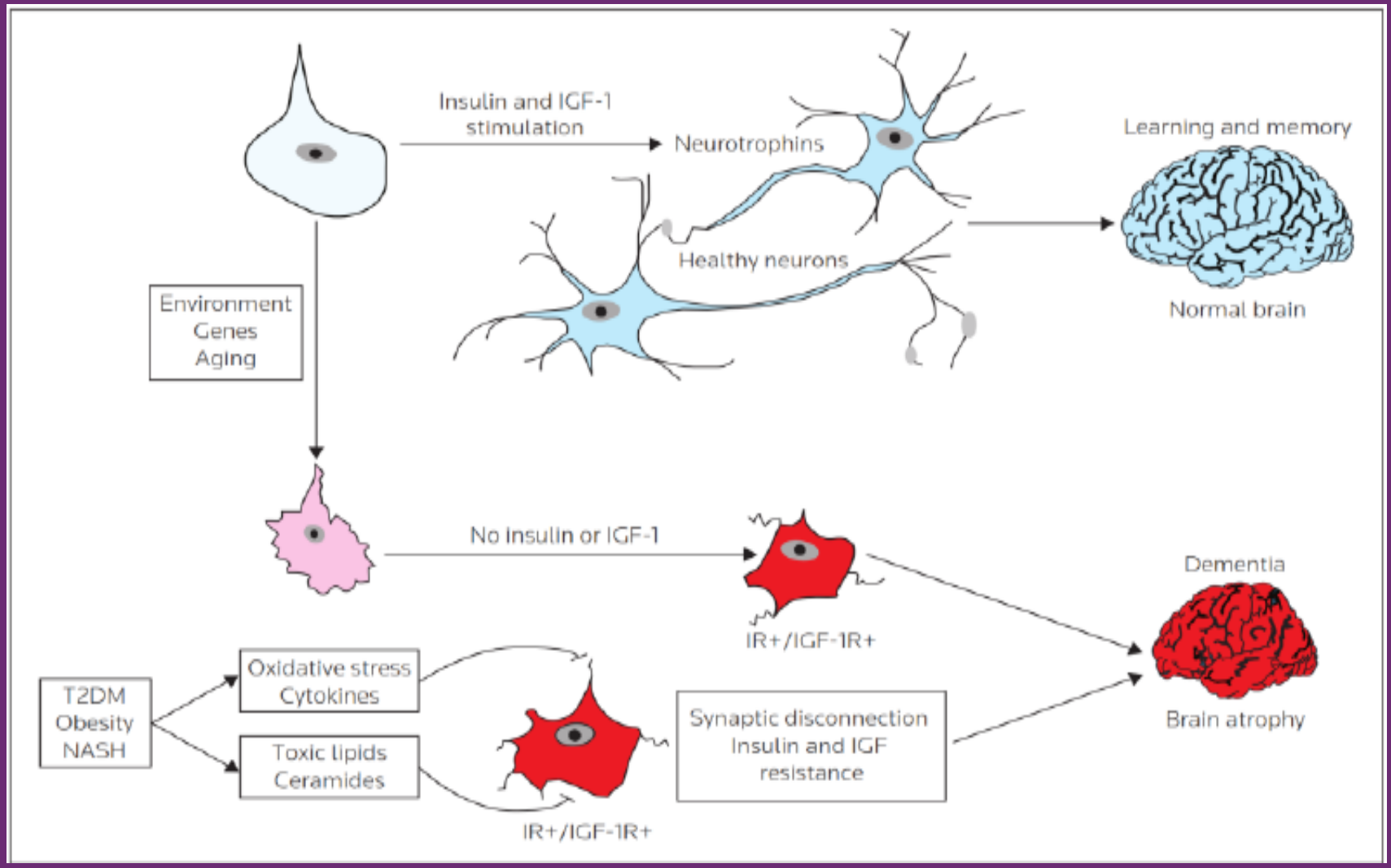


INFLAMMATION

Diabetes and Neuropathology

- Grey matter volume reduction in multiple brain regions (i.e. frontal temporal)
- Microstructral changes in white matter
  - ↓ connectivity and lesions
- Microvascular complications
- Metabolic impairment
  - ↓ insulin receptors

Diabetes and Brain Shrinkage

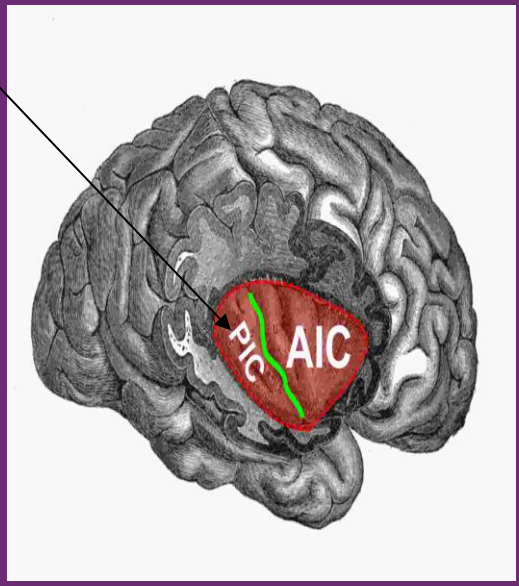


➢PICs cause a depression-like Sickness Behavior

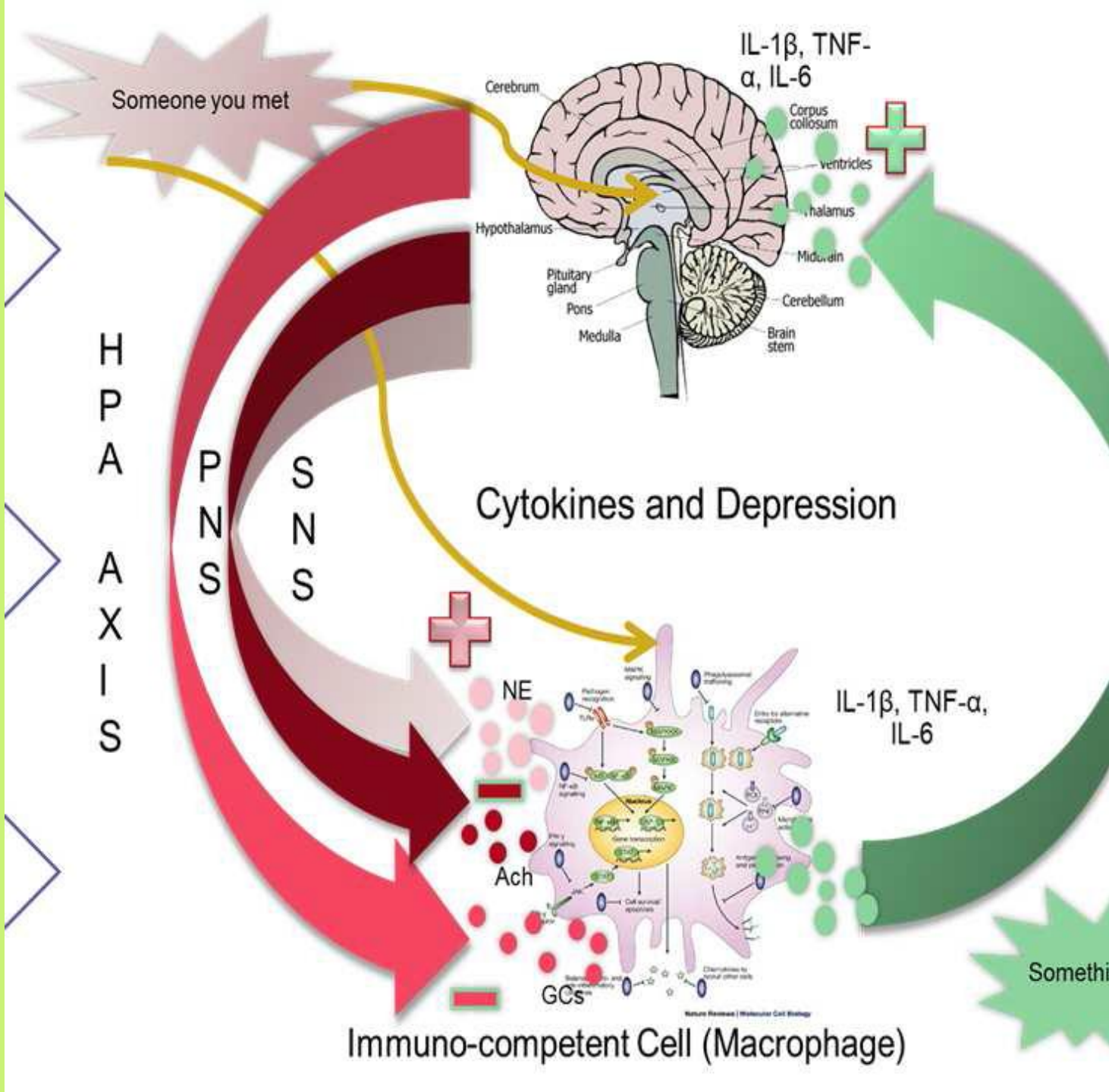
- Stress can increase PICs levels
- High PICs can lower the concentration of serotonin and DA
  - –Cognitive dysfunction, anxiety, fearfulness, depression, thoughts about suicide
- "Sickness behavior"---fatigue, social withdrawal, and immobility--depression (Hickie and Lloyd 1995).

Language of Gut

- Visceral sensations include:
  nausea, bloating
- All arrive at Insular Cortex in brain
  - Part of the Salience Network
- Plays role in emotions & body homeostasis
- Regulates the immune system
- Conscious desires – food, drugs

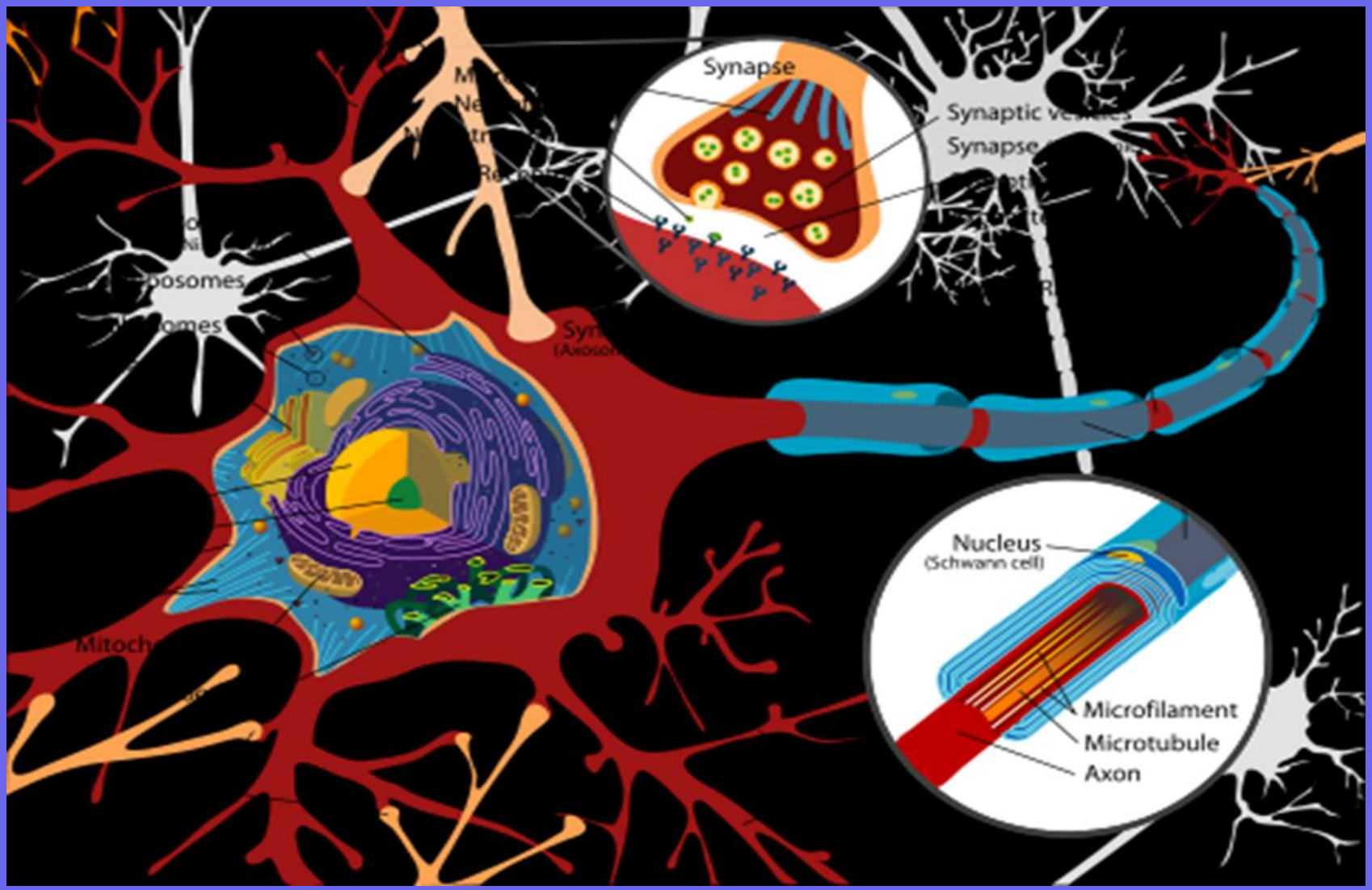


- Bad Diet
  - Simple carbs
  - Transfatty acids
  - Saturated fats
  - Food allergies
  - Bad oils
  - High dairy
  - High gluten
- No exercise
- Chronic illnesses
- Autoimmune disorders
- Chronic pain
- Chronic stress
- Being overweight
  - Apple shape
- Leaky gut

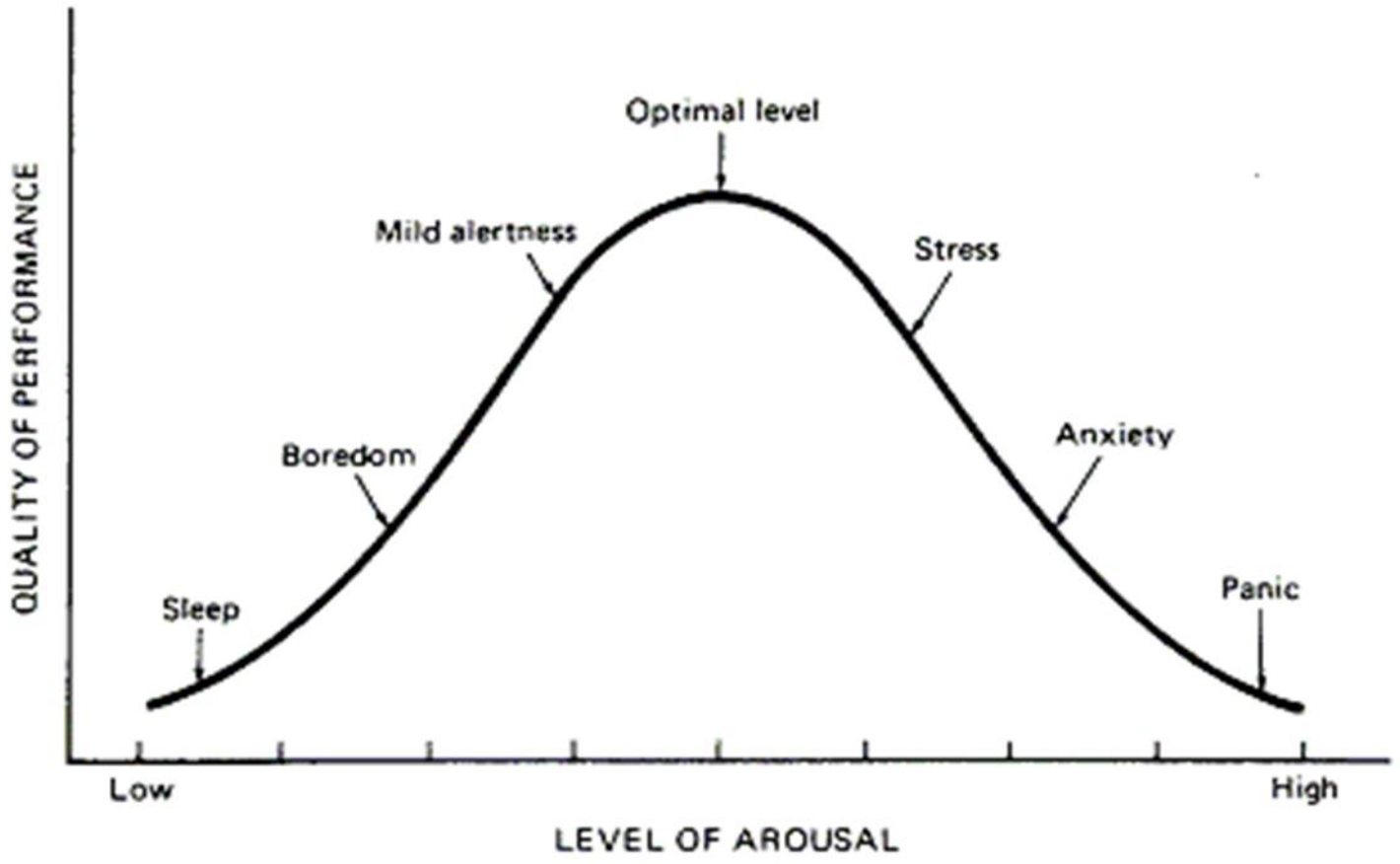


87 Billion Neurons

Each with 10,000 synaptic connections



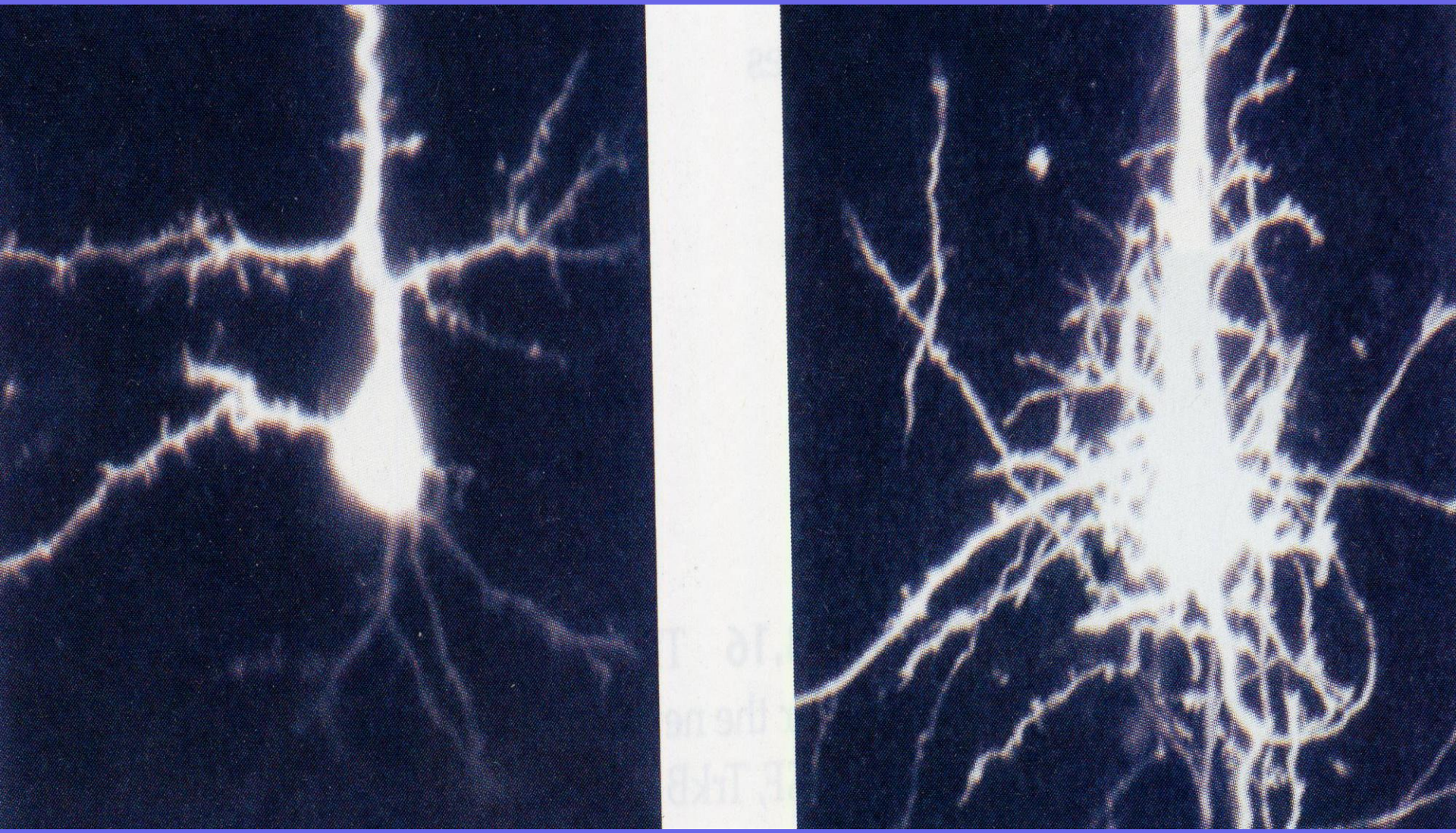
Yerkes Dodson arousal curve



Brain Derived Neurotropic Factor

- BDNF plays a crucial role in reinforcing neuroplasticity and neurogenesis. It helps:
  - Consolidate the connections between neurons.
  - Promotes the growth of myelin to make neurons fire more efficiently
  - Act on stem cells in the hippocampus and PFC to grow into new neurons

BDNF: Impact on Dendrite growth: 24 hours



Factors that Decrease Neurogenesis

- Aging
- Chronically high cortisol
  - Chronic stress
  - Recurrent depression
- Marijuana
- Obesity

Factors that Increase Neurogenesis

Exercise

- play induces BDNF gene expression

Fasting

Fewer calories consumed

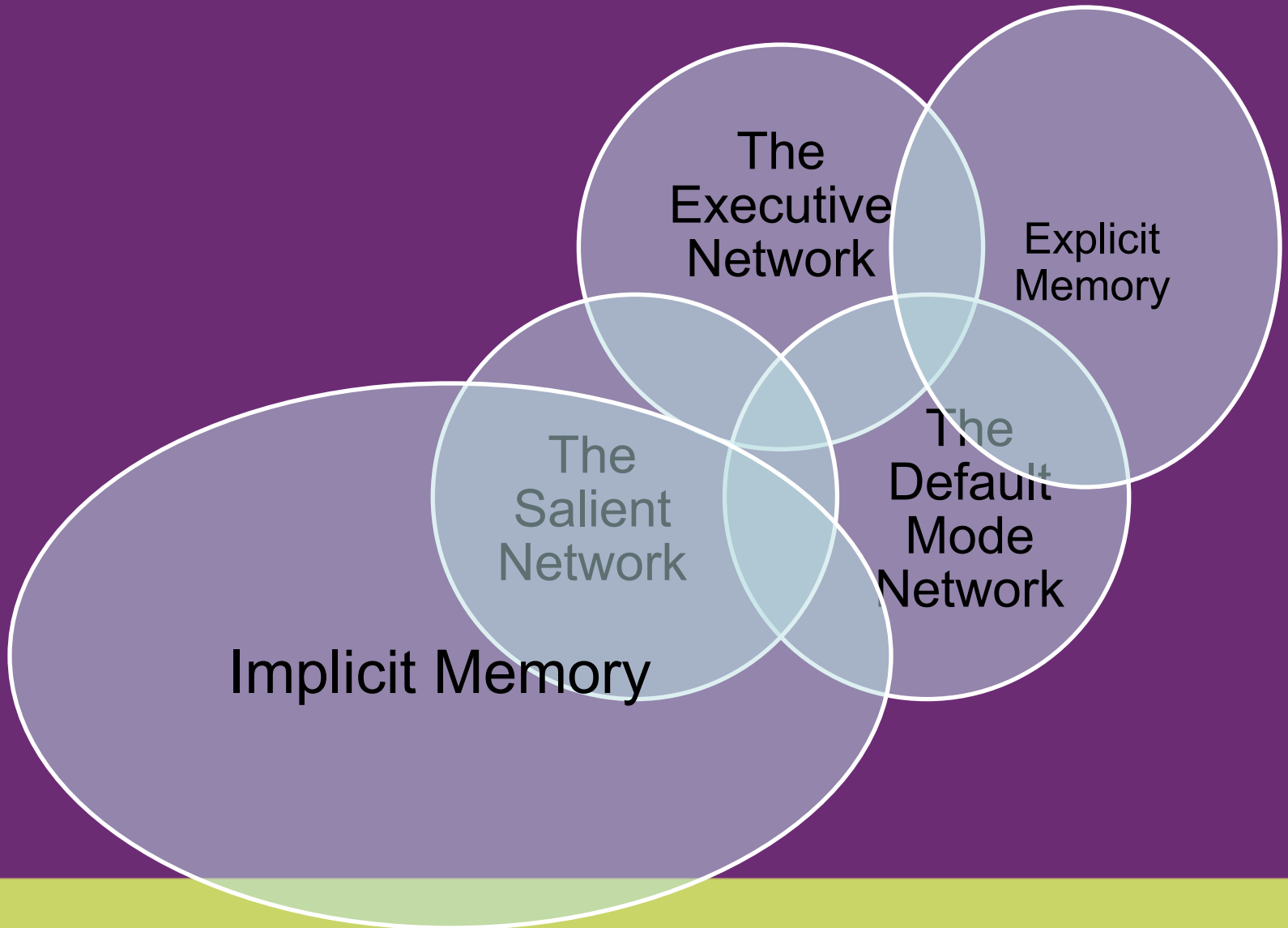
Food content --(Omega—3)

Profound new experience

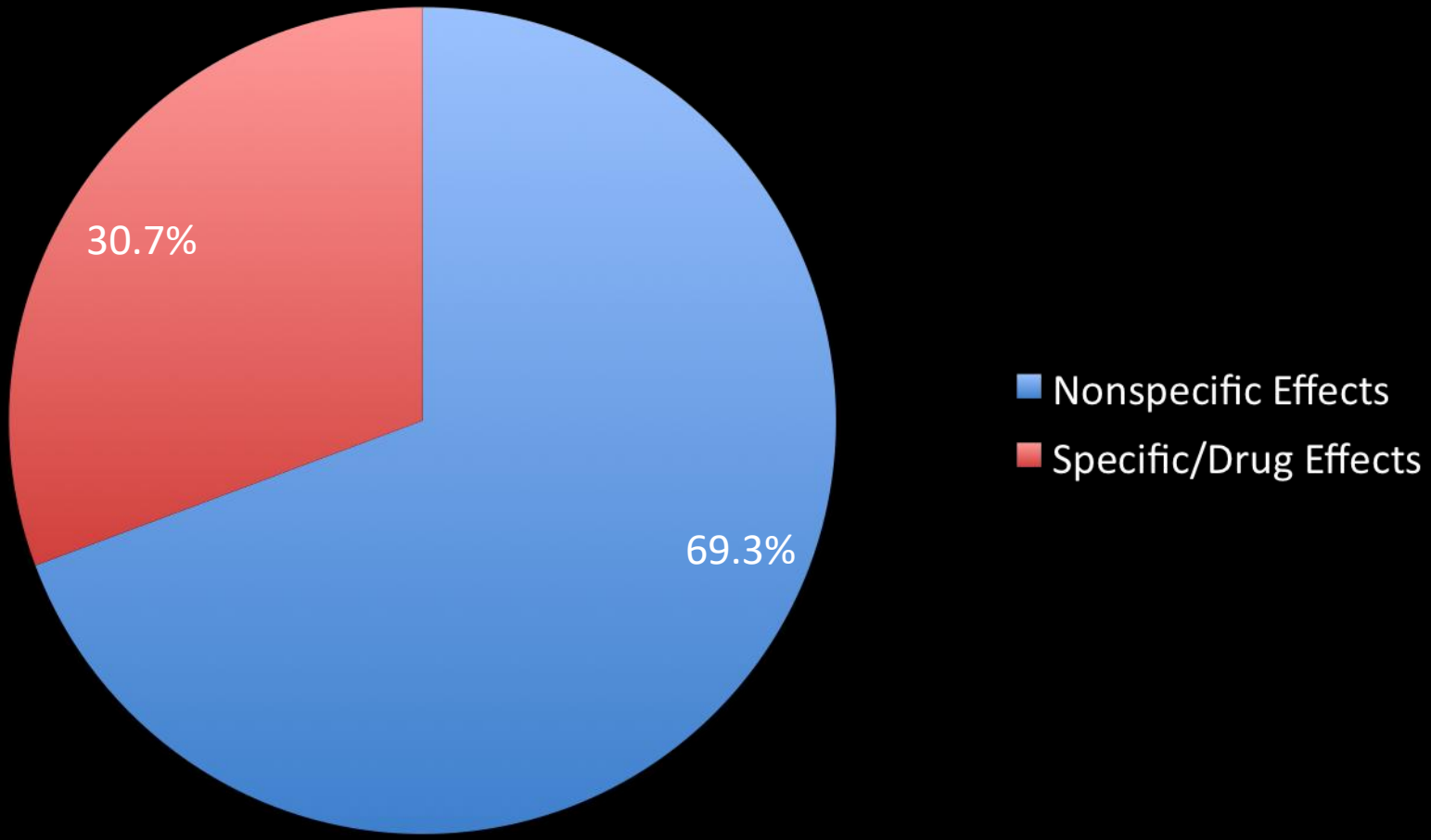
Symphony of Wellbeing

- mPFC involved in the representation and evaluation of self-referential information
- pCC involved in the integration of self-referential
- Together they support self-evaluation
- Increased connectivity within parts of the DMN

The Mental Neworks & the Long-Term Memory Systems



Placebo

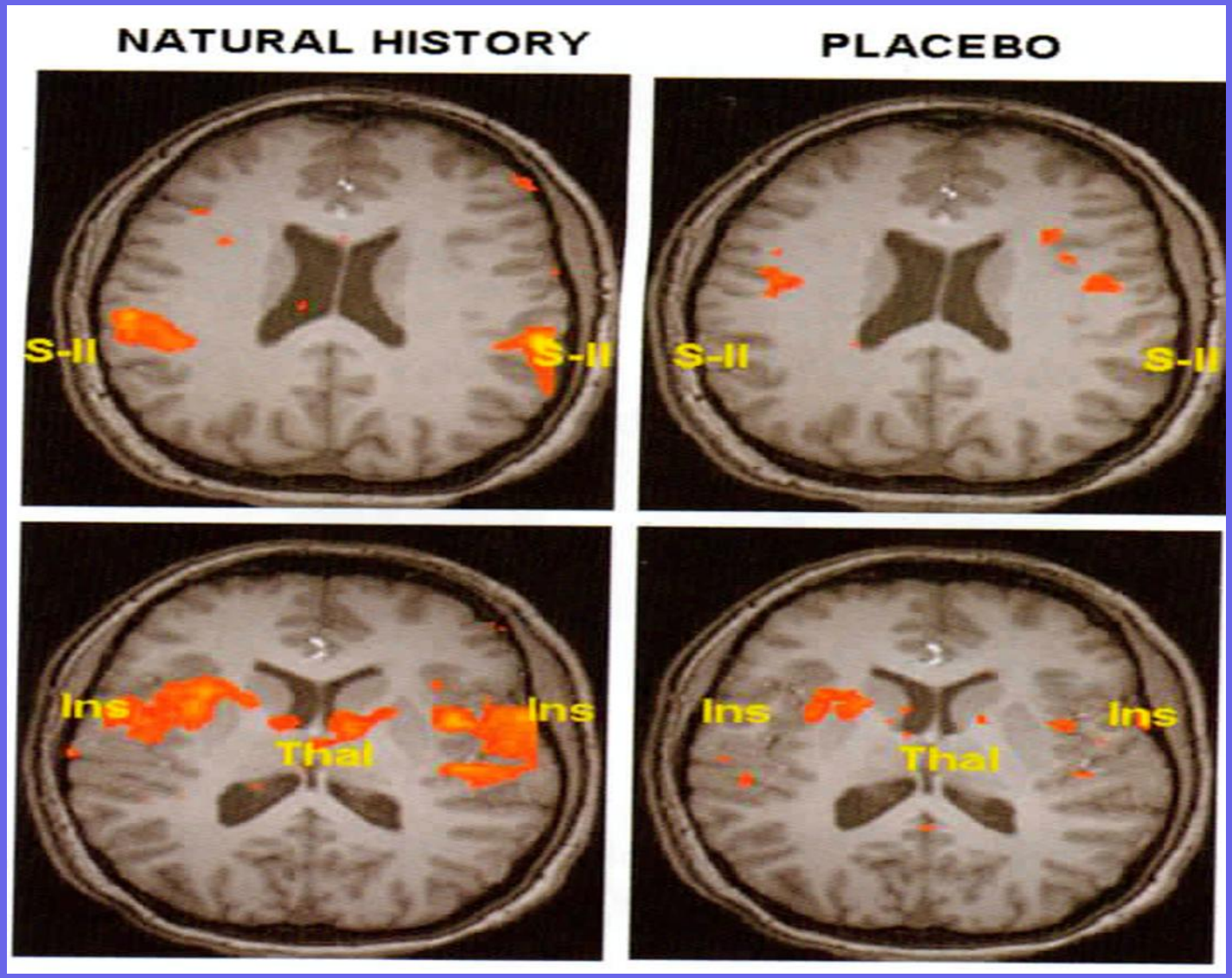


*Derived from pooled response rates for drug and placebo of 53.8% and 37.3%
Papakostas, *Eur Psychopharmacol*, 2009

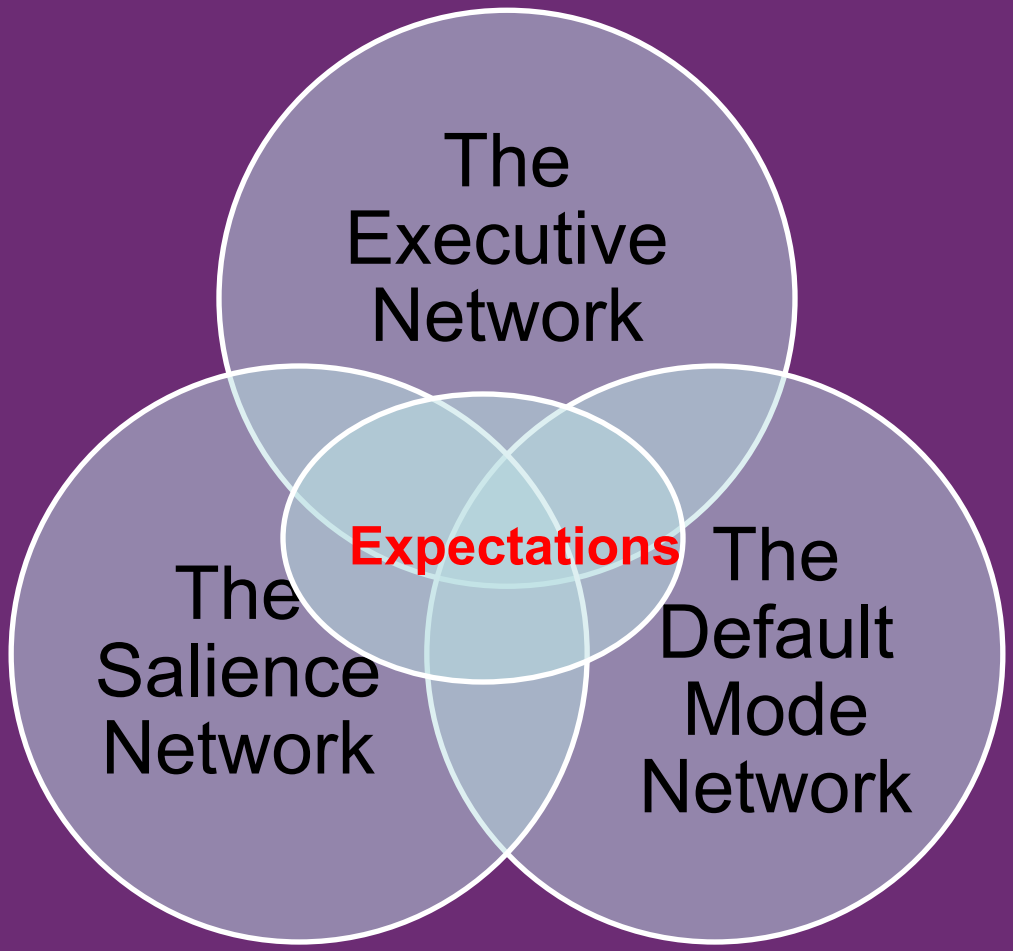
Incidence of Placebo Response

- 10% to 70%
- Average 35% across studies and diseases as well as psych disorders
- Works best for subjective outcomes like pain and psychological disorders
- Half as effective as morphine
- Quite effective with depression and anxiety

IBS and Pain vs. Placebo



Balancing the Mental Networks



Cultural Framing
Race -- Ethnicity

- An integrated constellation of practices, symbols, values, and ideals as well as humor
- Shared by a community
- Transmitted from one generation to the next
- Constantly renegotiated and subject to change
- Operating at the individual and societal level
    - Producing outcomes
        - Socialization
        - Identity
        - Healing

Self-Regulation Factors

- Social
- Exercise
- Education
- Diet
- Sleep

Telomerase

An enzyme that adds nucleotides to protects telomeres:

Insulin, IGF-1, VEGF, EGF upregulate telomerase activity.

All increased by aerobic exercise

It is an evolutionary imperative to nurture our SEEDS (Heather Lowndes)





Socialise

Calms nervous system
↑ Oxytocin (feel good)
↓ Cortisol (less stressed)
↑ Sense of connection
↑ Problem solving
↑ Attention
↑ Humour and fun
↑ Energy

Exercise

Calms nervous system
↑ Serotonin & Dopamine
↑ GABA (calm)
↑ Energy levels
↑ Growth new brain cells
↑ Sleep
↑ Alertness and thinking
↑ Attention
↑ Chance to socialise
↑ Cardiovascular strength
↑ Physical strength
↑ Flexibility & endurance

Education

↑ Brain power
↑ Serotonin & Dopamine
↑ Growth of new brain cells
↑ Thinking ability
↑ Working memory
↑ Challenge to learn
↑ Novelty – try new things
↑ Social connection
↑ Interest in life
↑ Ability to focus
↑ Sense of achievement

Diet

Calms nervous system
↑Brain chemistry
↑ Brain clarity
↑ Mood
↑ Sleep
↑ Energy
↑ Alertness
↑ Concentration
↑ Ability to focus

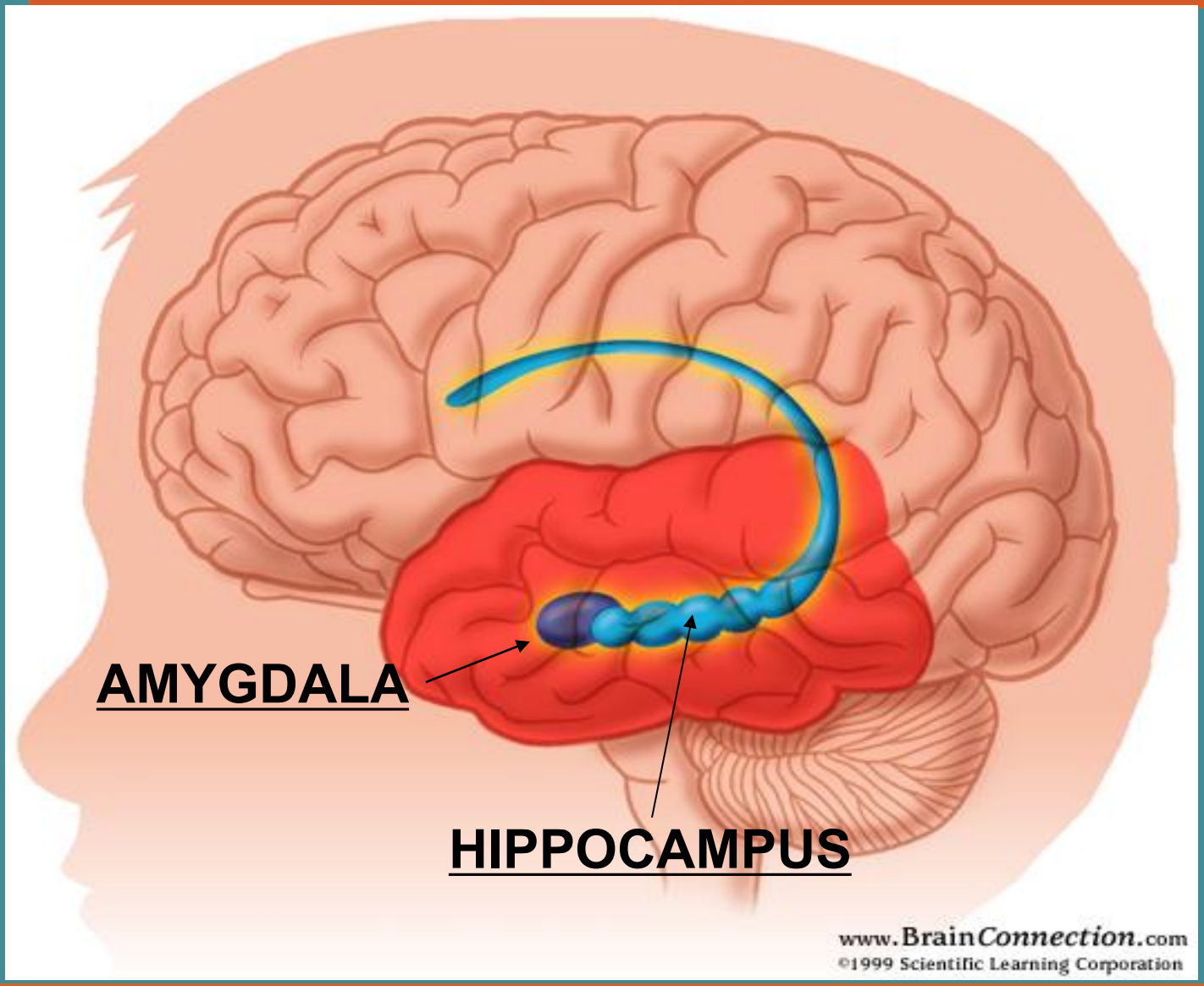
Sleep

↑ Hippocampus activity
↑ Memory
↑ Brain cell growth
↑ Serotonin
↑ Immune system
↑ Mood
↑ Energy
↑ Alertness
↑ Concentration

…AND MUCH MORE…

Exercise and the Brain

Mechanism	Impact
Gene Expression	Neuroplasticity (Cottman & Blanchard, 2002)
Brain Derived Neurotrophic Factor (BDNF)	Neurogenesis & Neuroplasticity (Adlard, et al, 2005)
Insulin-like Growth Factor (IGF-1)	Energy Utilization (Carro. et al 200)
Nerve Growth Factor	Enhanced Neuroplasticity (Neeper, et al, 1996)
Vascular Endothelial Growth factor (VEGF)	Capillary Health (Fabel, et al, 2003)


AMYGDALA
HIPPOCAMPUS
www.BrainConnection.com
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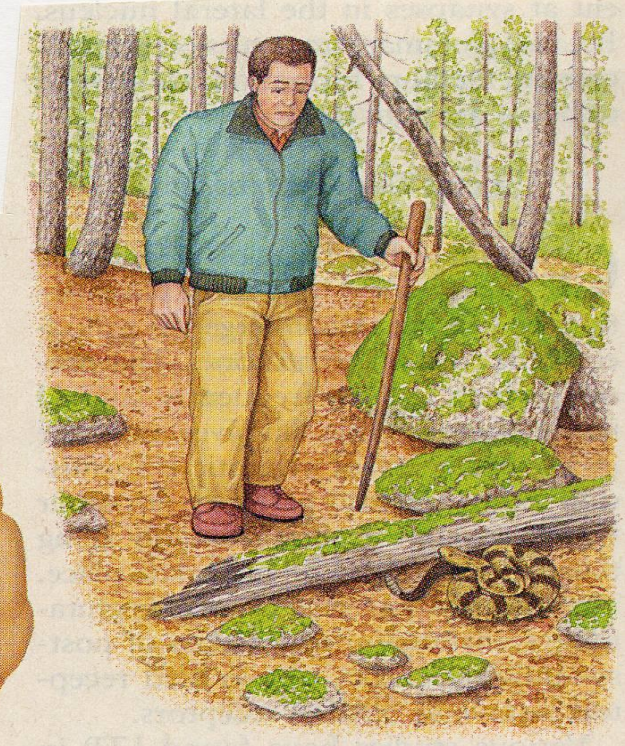
AMYGDALA
Implicit Memory System

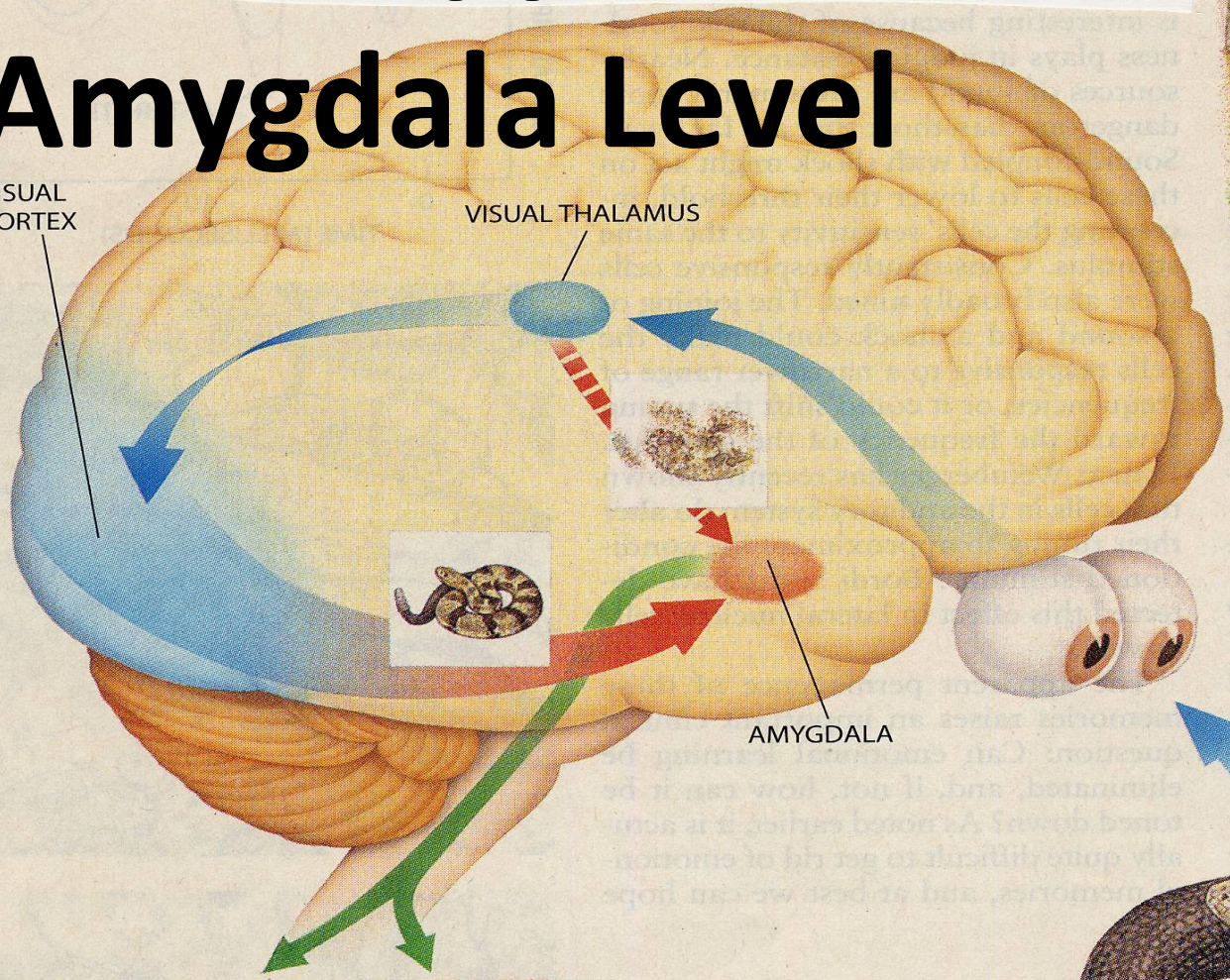
- Fear Conditioning
- Emotional Valance
- Generalized
- Cortisol Heightened
- Sensitivity
- (Hypervigilence)
- Matures Early
- "Little Albert"
- "LSMFT"

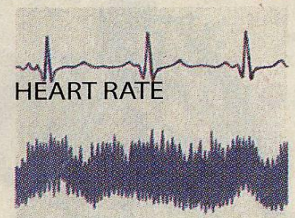
HIPPOCAMPUS
Explicit Memory System

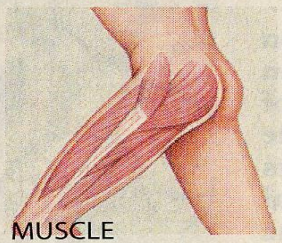
- Many Cortisol Receptors
- Context Specific
- Heightened Cortisol leads to atrophy
- Matures Later
  - Vs. Infantile Amnesia
- "H.M."

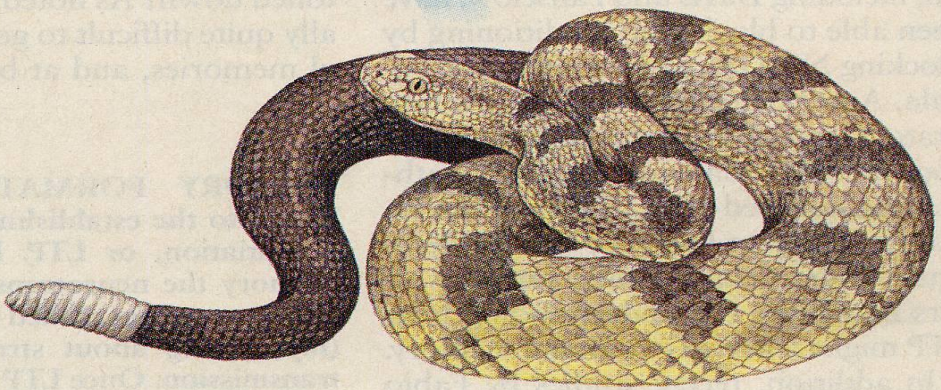
Threat Appraisal: Amygdala Level











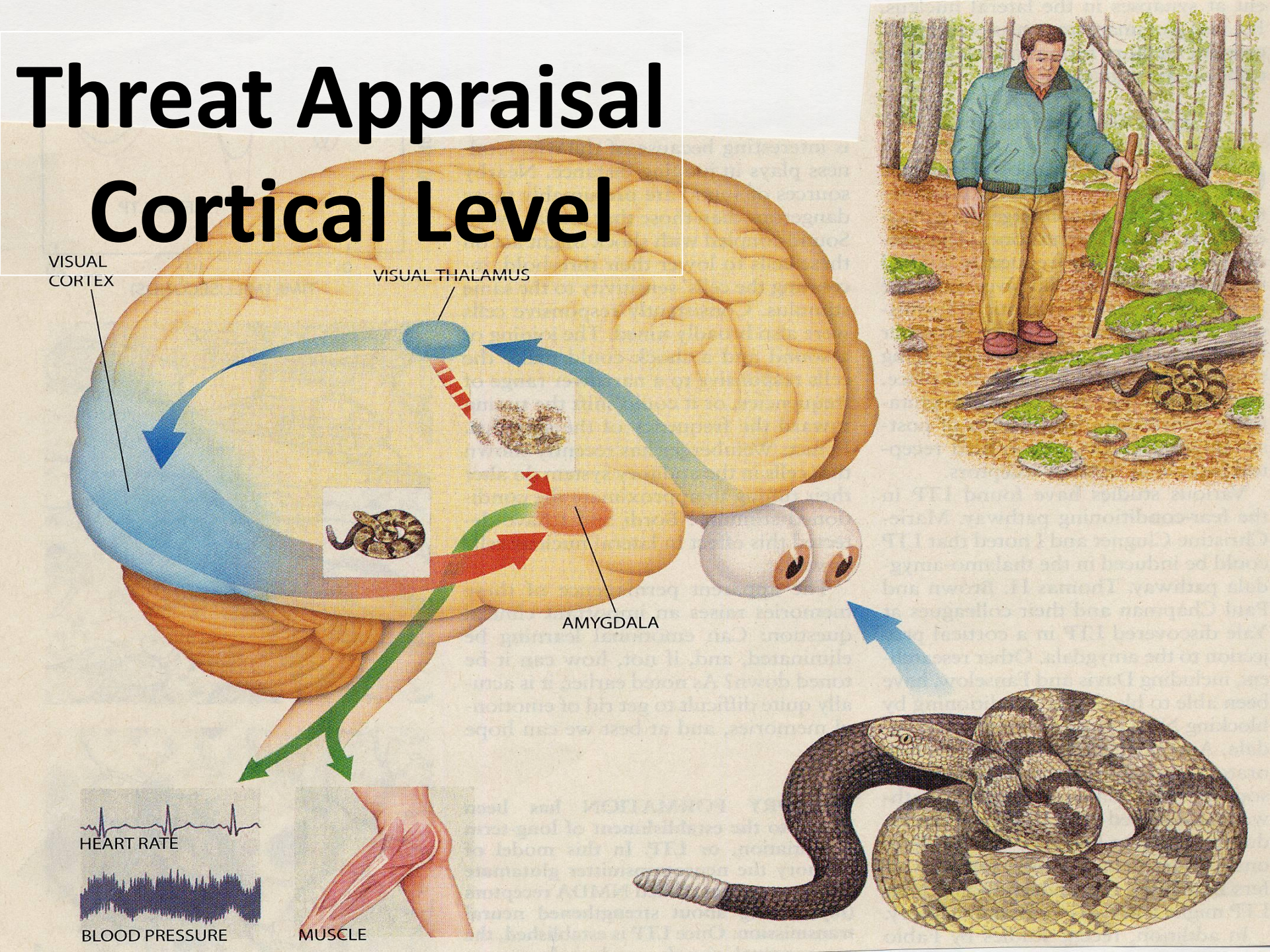
The Fast Circuit to the Amygdala

- Sensory info goes to the Thalamus then directly to the Amygdala:
- Fight or Flight: SNS and HPA activation
- Emotional Learning
- Fear Conditioning
- PTSD, panic, etc.
- Flashbacks
- “Bottom up”

The Fast Track to Survival

- Rapid, crude, adaptive, and immediate
- Cannot reality test
- Prone to false alarms

Threat Appraisal Cortical Level



The Slow Circuit to the Amygdala

Sensory info goes to the Thalamus through the Cortex and Hippocampus to the Amygdala

Complications:

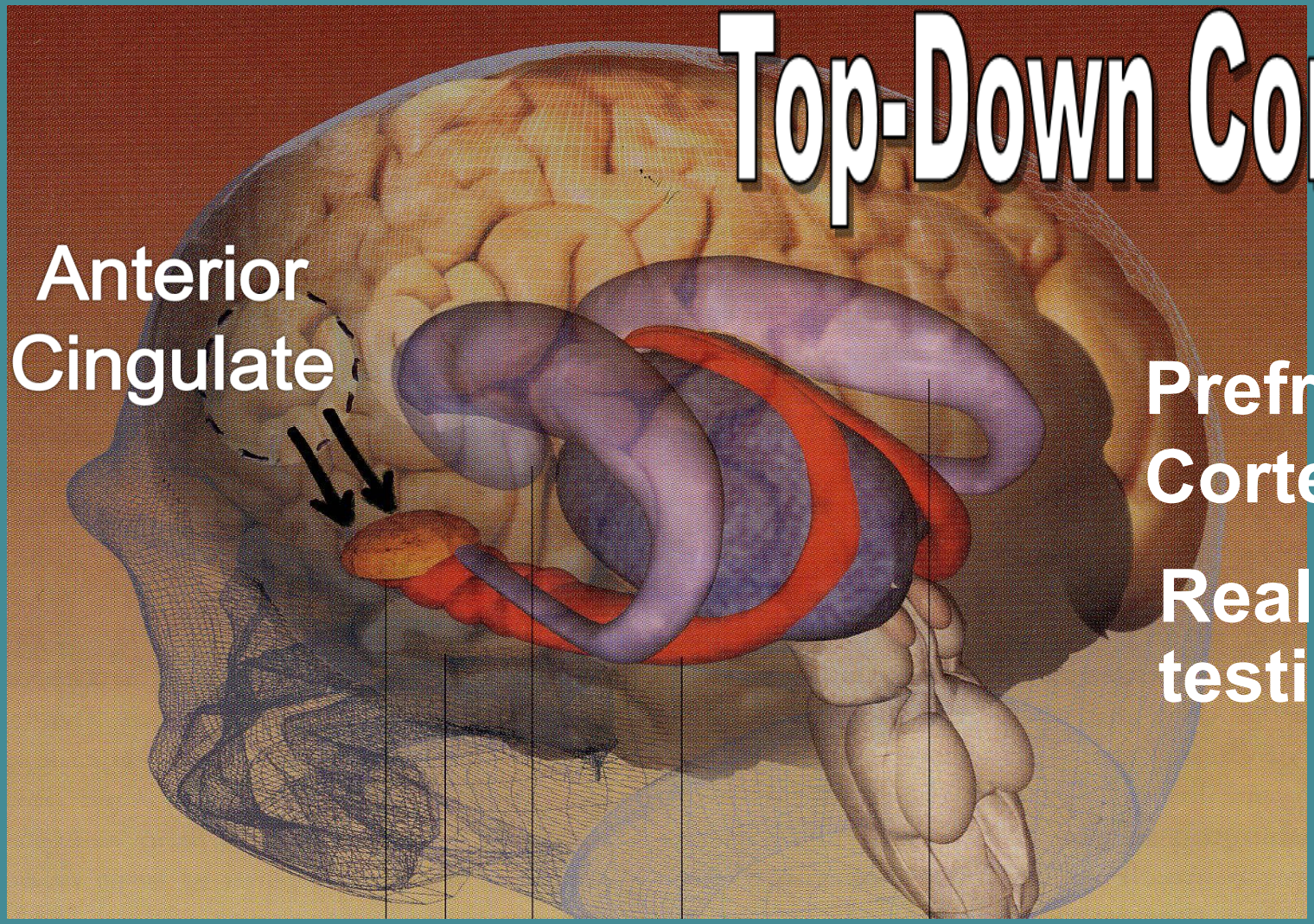
- **Worries and GAD**
- **Fears and Phobias**

Benefits:

- **Tames the Amygdala**
- **With exposure, New Thinking (cortex)**

"Top down"

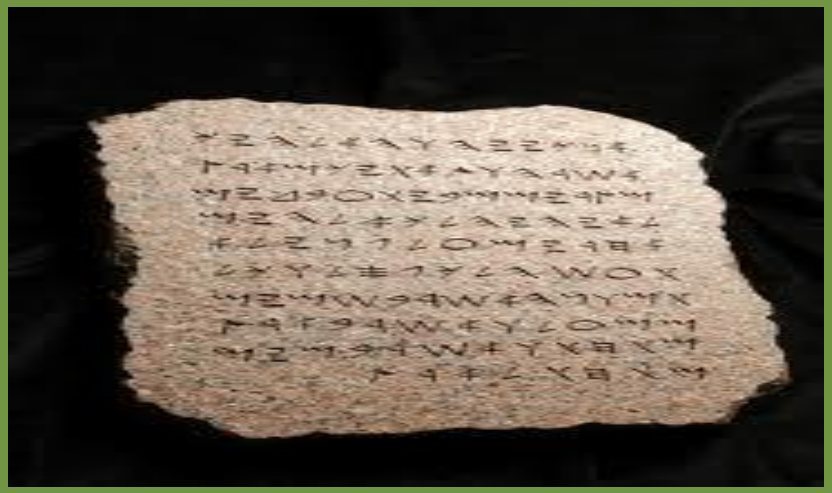
Cortical-level Appraisal



The Snake Temple—Top Down Control?

The Dynamics of Fear

- Amygdala memories are hard to forget ("Stone tablet")



- Hippocampal circuits tell us what to fear and in what context ("Etch-a-Sketch")

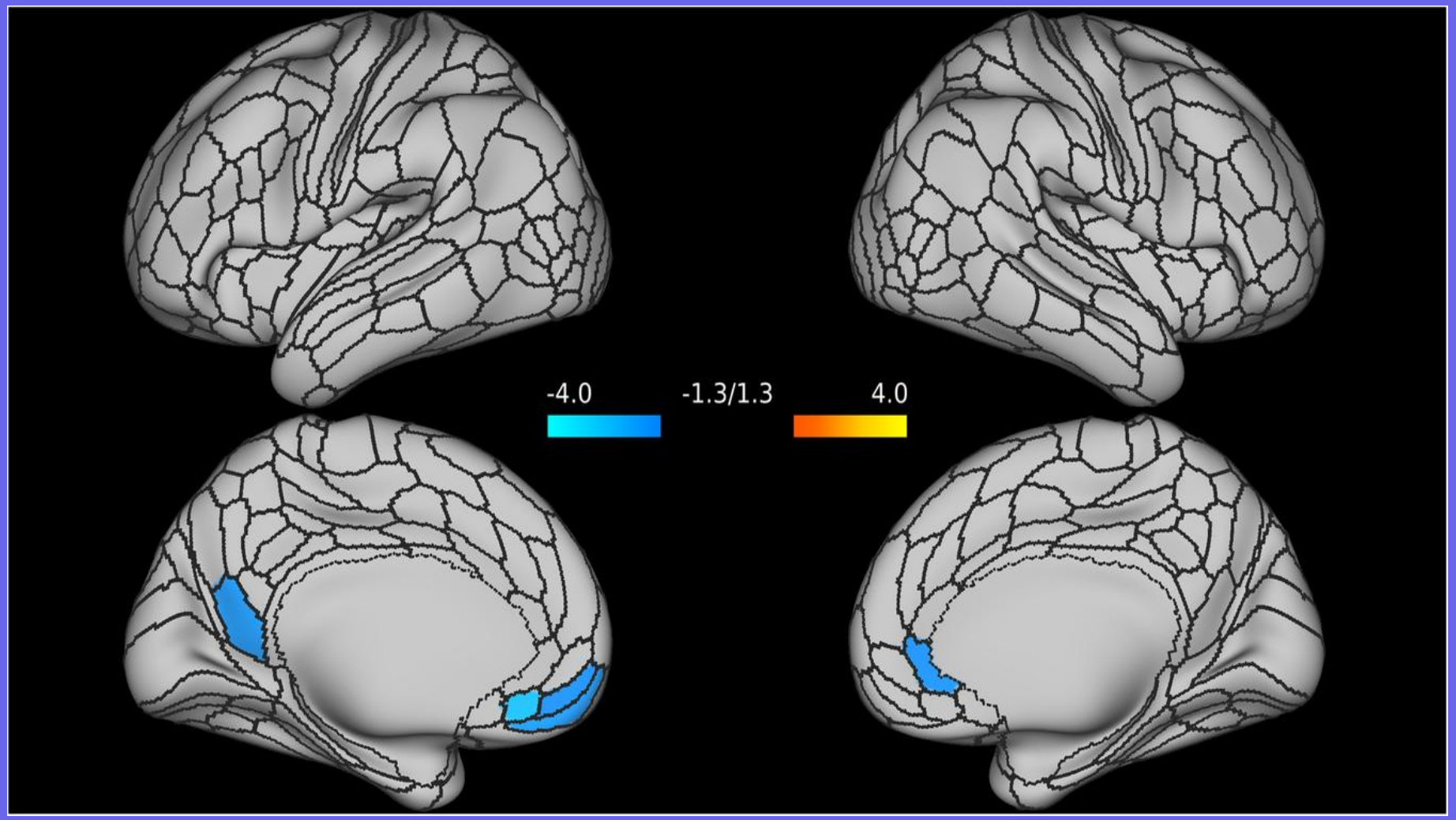
Allostasis

- Allostatic adjustments are adaptive over the short term with moderate and fluctuating levels of cortisol to help orchestrate adjustments by:
  - enhancing or inhibiting gene transcription
  - regulation of BDNF
  - up regulates amygdala activity
  - targets prefrontal systems involved in stress and the emotion (Sullivan & Gratton, 2002).
  - maintaining stability through a change (McEwen, 1998).
- *Allostatic load* --When demands exceed the balance of energy and regulatory gains from rest and recuperation. (McEwen and Wingfield, 2003).

Culture, DMN, and PTSD

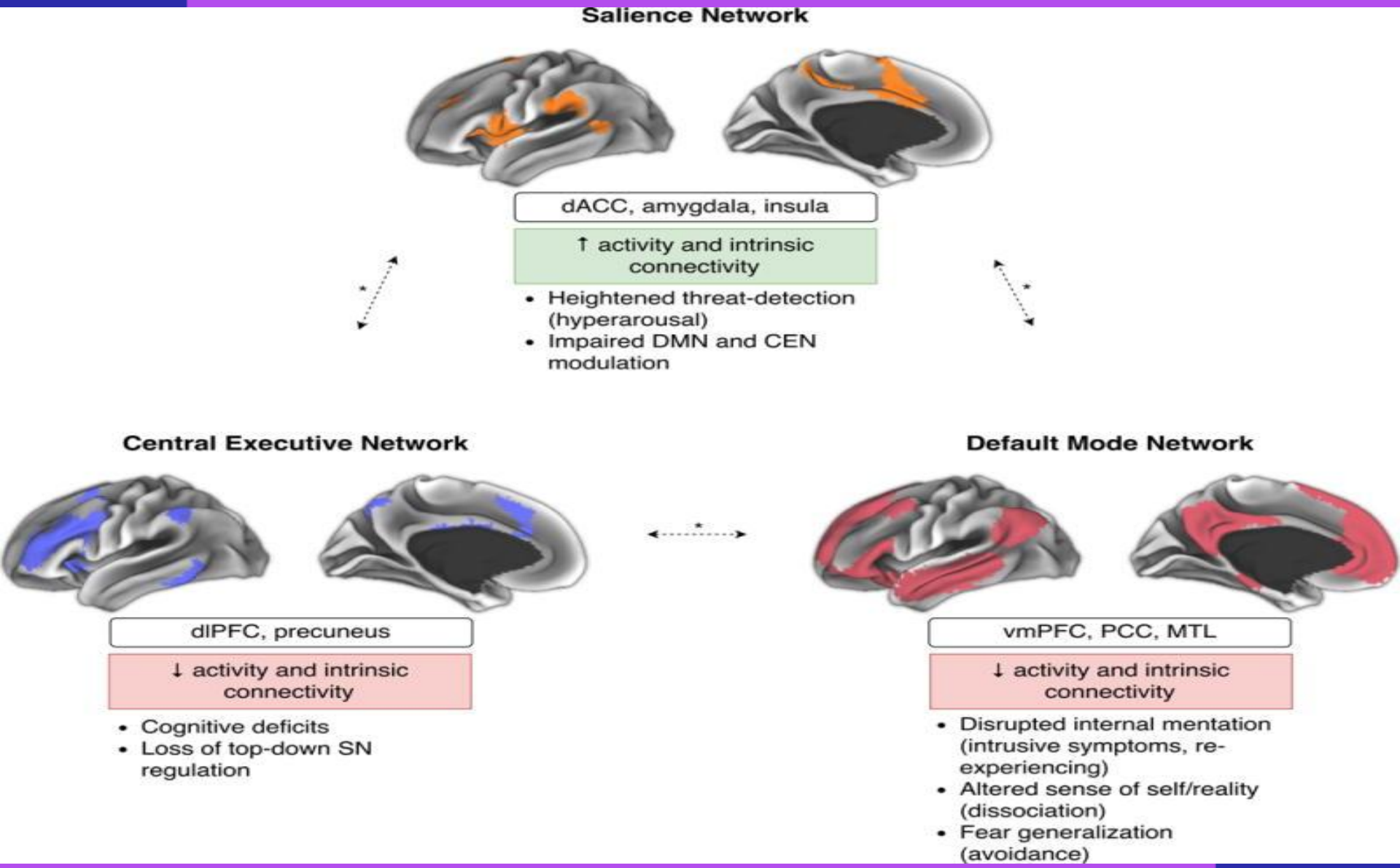
- People with high neural variability between the DMN, SN, and EN tend to enjoy wellbeing.
- A Collectivist orientation in DMN tend toward social connectiveness
- However, with PTSD diminished activity in the vmPFC (part of the DMN)
- The vmPFC is critical for affect regulation
- Self-identity undermined by emotional dysregulation
- Healthy DMN is bolstered by social connections

Alterations of the DMN connectivity strength are primarily localized in the vmPFC (specifically, nodes of the left medial orbitofrontal, and of the right rostral anterior cingulate) and in the left precuneus.



Averill, C.L., Averill, L.A., Akiki, T.J. *et al.* Findings of PTSD-specific deficits in default mode network strength following a mild experimental stressor. *NPP—Digit Psychiatry Neurosci* **2**, 9 (2024)

States of mind in conflict



Orienting Response and Somatic Stimulation

- First identified by Pavlov in 1927
  - *Shto takoe?* (Что такое? or *What is it?)*
  - Reorienting of attention -- triggered automatically when a sudden movement grabs attention or intentionally when you chose to look at an object
  - The reorienting of attention requires you to release your focus on one location so that it can shift to a new location
- Somatic stimulation of the orienting response (i.e. via EMDR, EFT, acupressure etc.) involve involves:
  - The orienting response (Sokolov, 1990)
  - facilitate cortical integration of memories

Orienting Response

"I have long thought that, if there is any analogy between psychic and physical processes, the orienting system of the brain must lie subcortically on the brainstem," (Jung, 1958).

- **Superior colliculus--**sensorimotor structure that is specialized for detecting, localizing, and orienting toward environmental events **–the "where"**
- **Periaqueductal gray (PAG)--** integrated behavioral responses to internal (e.g., pain) or external (e.g., threat) stressors—the "what"
- **Locus coeruleus**--modulating pain and stress, releasing norepinephrine—the "shock"

Orienting Response

- Amygdala—relevance, threat detector
- ATP—circulation of blood and energy
- Norepinephrine, dopamine, acetylcholine
- Hippocampus—context
- PFC—conscious attention

Orienting Prediction Error

- Surprise activates the dACC and amygdala which increases vigilance
- When stimulus is surprising and novel there is a causal link between prediction errors, dopamine neurons, and learning.
- The superior colliculus, positioned next to the thalamus, and connection to the amygdala
- Shifts in attention activates the PFC, hippocampus, and dopamine networks

Priming the DMN

- New narratives practiced in sessions between sessions
- Therapy anticipates the challenges—the different contexts that new narratives must be practiced
- Narratives maximized social connectiveness and post-traumatic growth

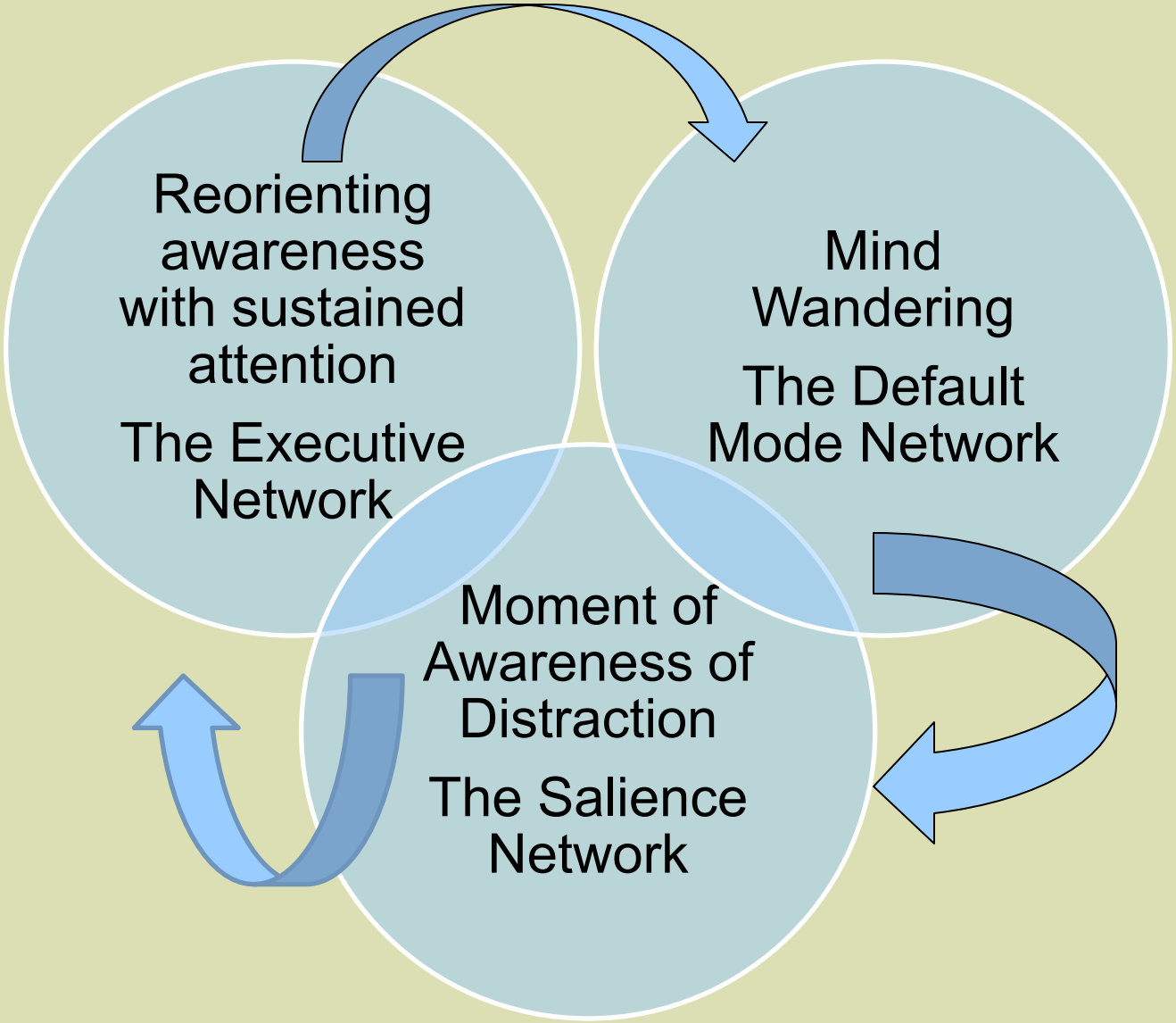
Orienting and Recoding

- A stimulus that prompts a person to notice what happens next primes PFC activity.
- Coding in novelty, an unexpected somatic sensation, integrates PFC, anterior cingular cortex, hippocampus, and basal ganglia circuits by moderate bursts of dopamine,
  - orienting serves as a sort of a kickstart to the connectivity between the executive and the salience networks

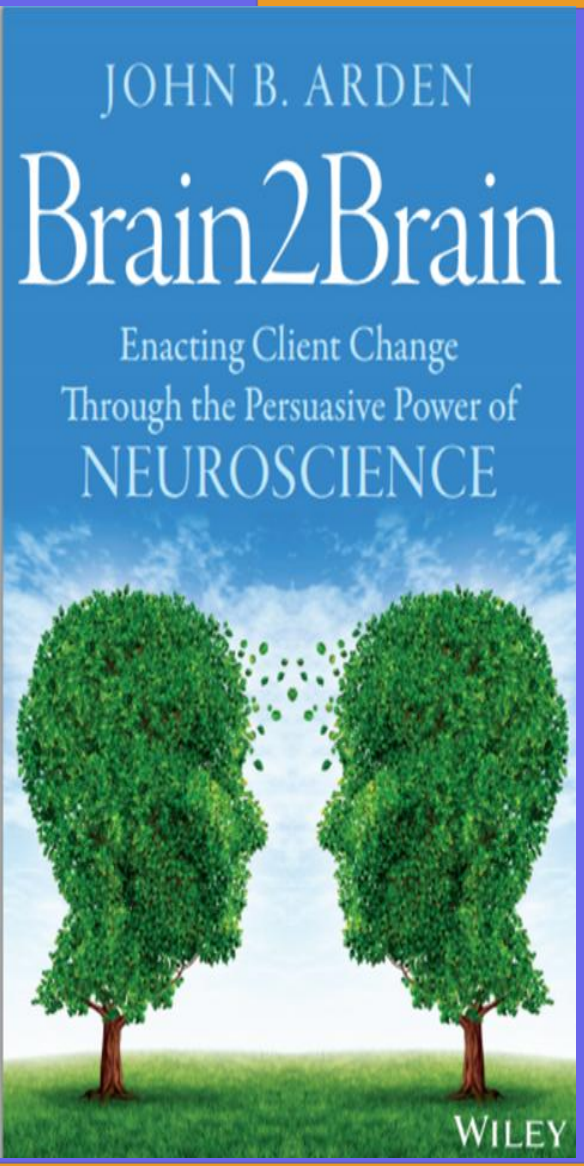
Shifts in attention and asymmetry

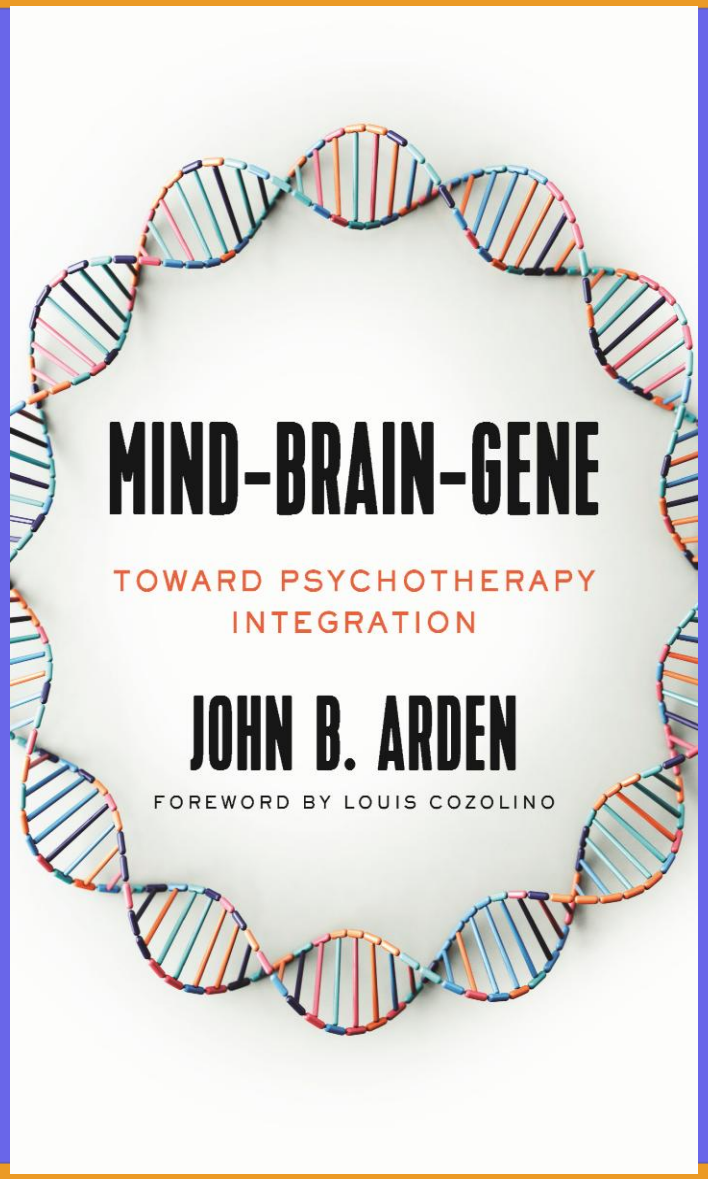
- **Why activate the RH when it is already overactive? How about tapping the right hand and/or foot?**
- **The right limb tapping method still includes:**
  - **reorientation response**
  - **attentional shift**
  - **grounding**
- **This method is portable—the client can practice on his own (neuroplasticity)**

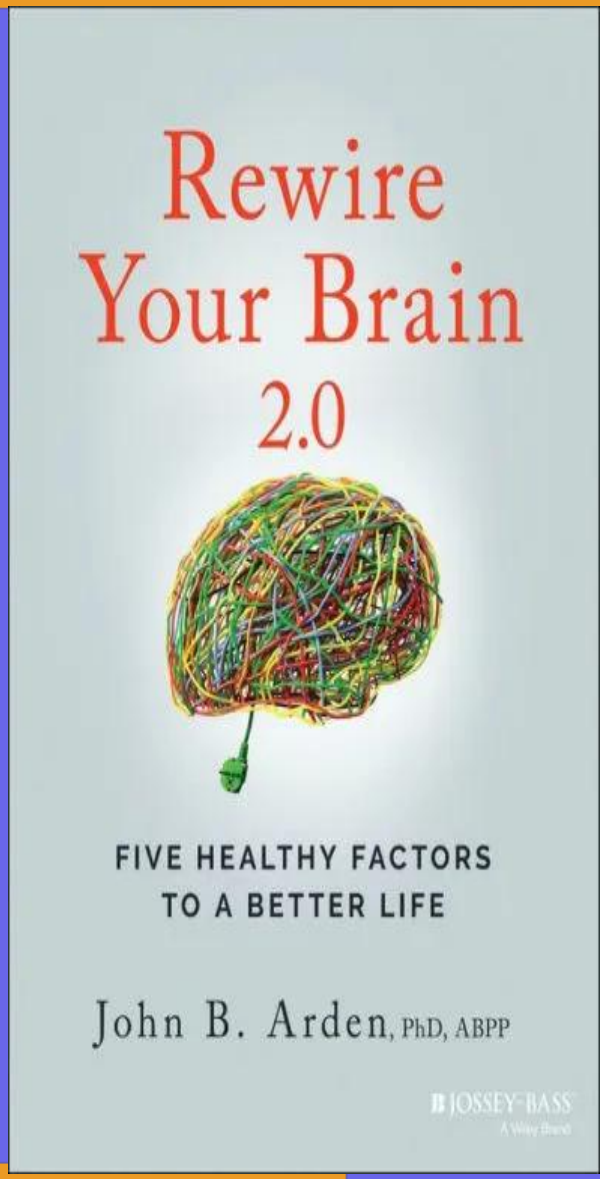
Contemplative Experiences



References


JOHN B. ARDEN
Brain2Brain
Enacting Client Change
Through the Persuasive Power of
NEUROSCIENCE
WILEY


MIND-BRAIN-GENE
TOWARD PSYCHOTHERAPY
INTEGRATION
JOHN B. ARDEN
FOREWORD BY LOUIS COZOLINO


Rewire
Your Brain
2.0
FIVE HEALTHY FACTORS
TO A BETTER LIFE
John B. Arden, PhD, ABPP
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Post-Traumatic Growth

Healing Emotional & Psychological Trauma

Dr. Carissa Muth, Psy.D.
April 15, 2026

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1

Adjustment Disorder

Development of psychological symptoms in a response to a specific stressor

Psychological Trauma

Distressing event

Impacts an individual in a significant manner

Can contribute to the development of a psychological disorder

PTSD

Specific criteria for traumatic event

- Avoidance
- Re-experiencing
- Hyperarousal

CPTSD

All PTSD symptoms plus disturbances of self organization

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2

Beliefs and PTSD

- Central to PTSD is that the traumatic event shatters the person's beliefs and assumptions
- Increased negative beliefs about self following the trauma
- PTSD associated with the belief that trauma has brought about a negative and permanent change in the self and likelihood of achieving life goals
- Negative interpretation of symptoms predicted a slower recovery from PTSD

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Brewin, C. R., & Holmes, E. A. (2003). Psychological theories of posttraumatic stress disorder. *Clinical psychology review*, *23*(3), 339-376.

3

PTSD Recovery

- Majority of people with PTSD have symptoms even after undergoing "gold standard" of treatment
- Symptoms tend to worsen after major life stressors, worsening symptoms lead to more stressors, and it often takes months or even years to return to baseline functioning after a symptom flare up
- Stress reactivity, stress generation, and stress persistence may reflect individual mechanisms that account for chronic PTSD symptoms

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Ringwald, W. R., Feltman, S., Cloutson, S. A., Mann, F., Ruggero, C., Bromet, E., ... & Kotov, R. (2025). Stress dynamics that maintain posttraumatic stress disorder across 20 years. *Psychological medicine*, *55*, e151.

4

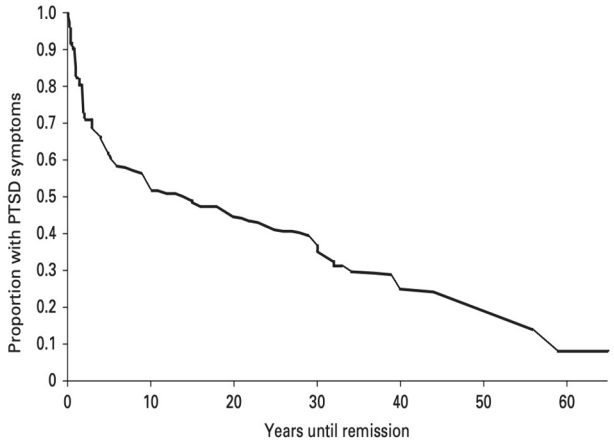

Fig. 1. Survival curve indicating years after onset until remission from post-traumatic stress disorder (PTSD) in the population.

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Chapman, C., Mills, K., Slade, T., McFarlane, A. C., Bryant, R. A., Creamer, M., ... & Teesson, M. (2012). Remission from post-traumatic stress disorder in the general population. *Psychological medicine*, *42*(8), 1695-1703.

5

Post Traumatic Growth

- Pathogenesis ⟶ Salutogenesis
- Individuals experience positive psychological changes as a result of the struggle with highly challenging life crises.
- Does not represent a simple return to baseline functioning, nor does it imply the absence of distress; rather, it signifies a fundamental restructuring of the individual's worldview, relationships, and self-perception that often leaves them at a higher level of functioning than existed prior to the traumatic event

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6

"Shattered Assumptions Theory"

- Individuals operate within an "assumptive world"—a conceptual system of fundamental beliefs that provide a sense of security, stability, and meaning.
- These assumptions are typically developed in infancy through early interactions with caregivers and are reinforced over a lifetime of experience
- Trauma occurs when an external event is so extreme and incongruent with these assumptions that it "shatters" the individual's conceptual system.

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7

Core Assumption	Component	Description of Belief
Benevolence of the World	Benevolence of the World	The belief that the world is a good, virtuous place.
	Benevolence of People	The belief that people are generally kind, trustworthy, and helpful.
Meaningfulness of the World	Justice (Equity)	The belief that people get what they deserve and deserve what they get.
	Control/Contingency	The belief that one can prevent negative outcomes through "right" behavior.
Self-Worth	Individual Value	The belief that "I am a good, capable, and worthy person".
	Luck/Randomness	The belief that "bad things happen to others, but not to me" (Invulnerability).

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8

Post Traumatic Growth Inventory

Possible Areas of Growth and Change	0	1	2	3	4	5
1. I changed my priorities about what is important in life.						
2. I have a greater appreciation for the value of my own life.						
3. I developed new interests.						
4. I have a greater feeling of self-reliance.						
5. I have a better understanding of spiritual matters.						
6. I more clearly see that I can count on people in times of trouble. Text						
7. I established a new path for my life.						
8. I have a greater sense of closeness with others.						
9. I am more willing to express my emotions.						
10. I know better that I can handle difficulties.						
11. I am able to do better things with my life.						
12. I am better able to accept the way things work out.						
13. I can better appreciate each day.						
14. New opportunities are available which wouldn't have been otherwise.						
15. I have more compassion for others.						
16. I put more effort into my relationships.						
17. I am more likely to try to change things which need changing.						
18. I have a stronger religious faith.						
19. I discovered that I'm stronger than I thought I was.						
20. I learned a great deal about how wonderful people are.						
21. I better accept needing others.						

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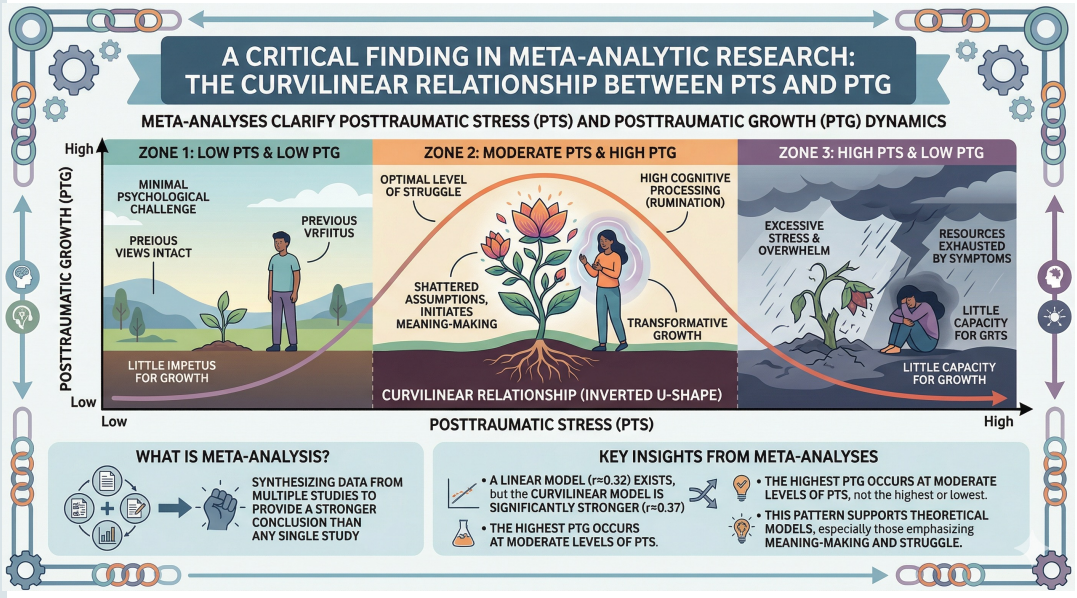

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Rumination

- **Intrusive Rumination:** Immediately following a trauma, individuals experience automatic, distressing thoughts and images. This indicates that the event has significantly challenged their core beliefs.
- **Deliberate Rumination:** Over time, the survivor ideally moves toward "deliberate rumination"—a voluntary effort to understand the cause and meaning of the event. This constructive processing is the primary predictor of sustained growth.

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Personal Strength

Focus: The realization that "I am stronger than I thought."

- "Looking back at who you were before this happened, and who you are now, do you see any differences in your ability to handle difficult things?"
- "You mentioned that you 'survived' the worst days. What does that survival tell you about your own resilience?"
- "If a friend were going through this, and they had the same strength you have shown, how would you describe them?"
- "Are there things you used to be afraid of that don't seem as scary anymore, now that you've faced this?"

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New Possibilities

Focus: The redirection of life path; new roles or interests.

- "Sometimes when one door slams shut, we are forced to look for other doors. Have you found yourself exploring any paths you never would have considered before?"
- "Since this event, have your priorities for the future shifted? Are there things you used to care about that don't matter as much, or vice versa?"
- "Have you developed any new skills or interests as a direct result of needing to cope with this situation?"

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Relating to Others

Focus: Increased empathy, compassion, or depth in relationships.

- "Trauma can sometimes make us feel isolated, but it can also deepen our connection to others who suffer. Do you feel a different kind of empathy for people struggling now?"
- "Have you noticed any changes in your relationships? Are some bonds tighter? Have you let go of shallow connections?"
- "Some people find that they are more willing to be vulnerable or express love after a crisis. Has that been true for you?"

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Appreciation of Life

Focus: Shifting from 'entitlement' to 'gratitude'; valuing the mundane.

- "Has your view of 'a normal day' changed?"
- "Do you find yourself paying attention to small things (nature, a meal, a moment of quiet) differently than you did before?"
- "When you realize how fragile life can be, it often changes how we spend our time. Have you changed how you spend your energy?"

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Spiritual & Existential Change

Focus: A shift in philosophy, faith, or the 'Why' of existence.

- "Has this experience challenged or deepened your understanding of the world or your spiritual beliefs?"
- "Have you found yourself asking different questions about the purpose of life?"
- "Do you feel a sense of having a 'mission' or a reason for having survived?"

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Focusing on Growth

- The goal of facilitating PTG is not to "fix" the survivor, but to serve as an "expert companion"
- Active Humble Listening
- Patience and Timing
- Tolerance of Distress
- Seed- Spotting

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Treatment

- Not empirically evidenced as a treatment intervention for PTSD yet
- Used as guide for Phase 3 in phased based treatment
- Phase based treatment recommended for CPTSD preliminary evidence that it is effective for PTSD

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Phase 3- Reintegration

- Focused on establishing a life worth living
- Reduces symptom relapse rates

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Treatment

- Education
  - Impact of trauma on physical and psychological functioning
  - Help survivors understand that their distressing symptoms (e.g., intrusive thoughts, anxiety) are not signs of "brokenness" but are the mind's automatic attempt to process a seismic event
  - The concept of PTG is introduced as a possibility, shifting the perspective from "What is wrong with you?" to "What happened to you?".

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Treatment

- Regulation
  - Mindfulness
  - Breath Control
  - DBT Skills

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Treatment

- Narrative Development
  - This is the "re-authoring" stage, where the survivor begins to pick up the pieces and write a new chapter
  - The goal is to move the narrative arc from one of victimization and loss to one of survival and transformation
  - Cognitive restructuring

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Treatment

- Areas of caution
  - Avoid Toxic Positivity
  - Be Aware of Developmental Factors
  - Have Cultural Humility

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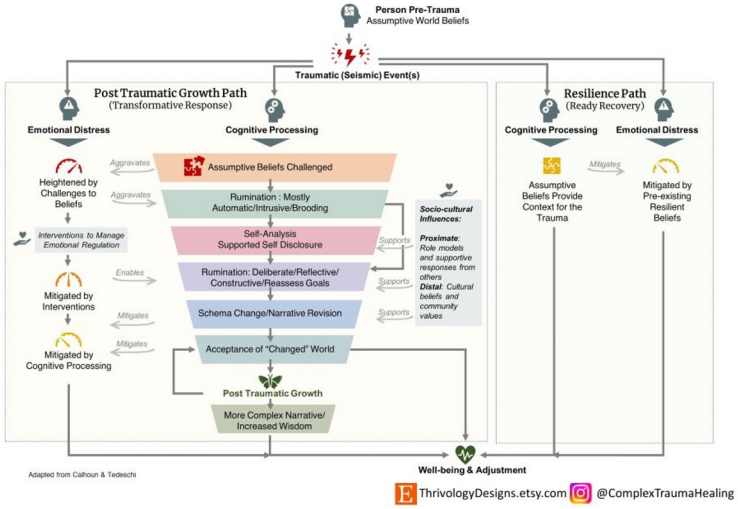
Theoretical Model of Post Traumatic Growth



ThrivologyDesigns.etsy.com @ComplexTraumaHealing

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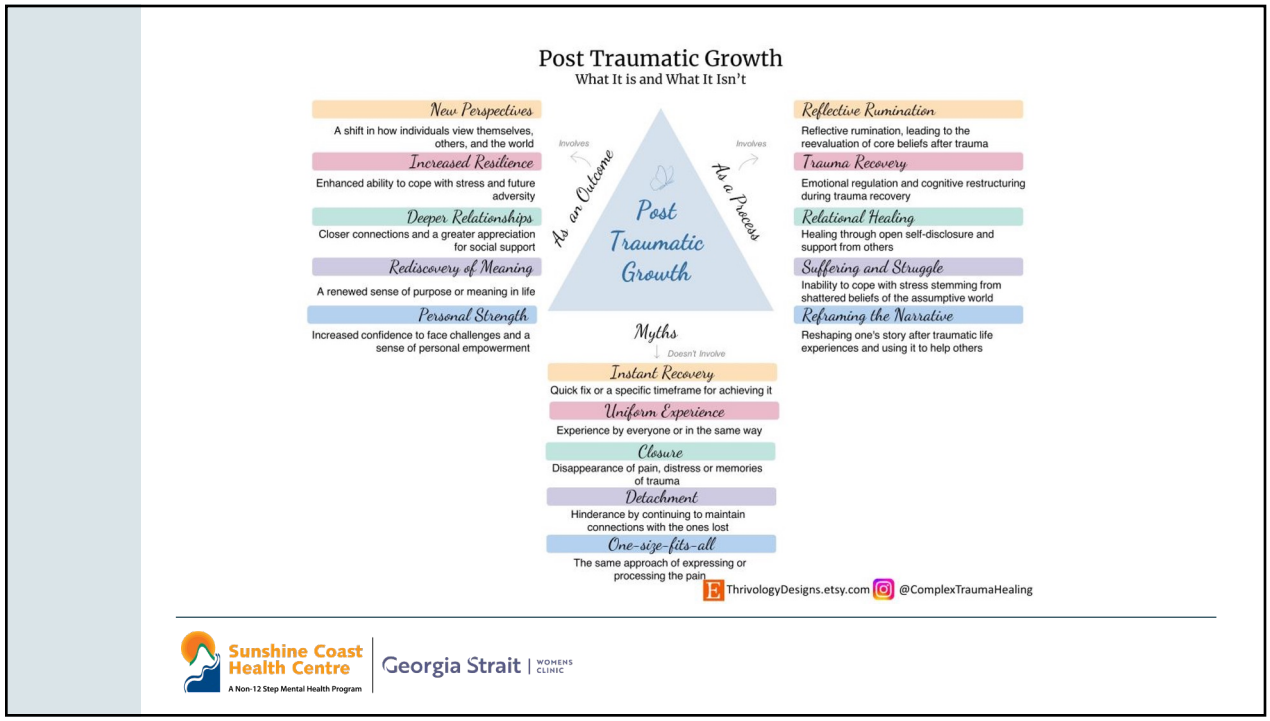

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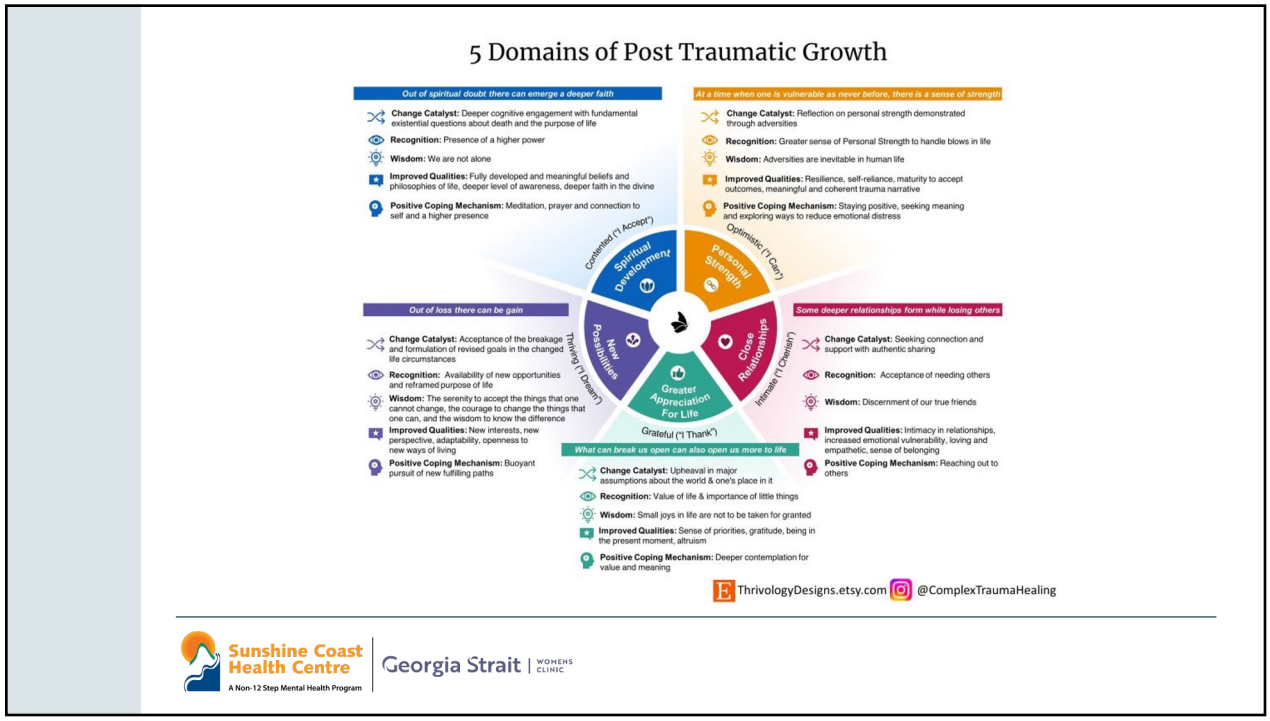

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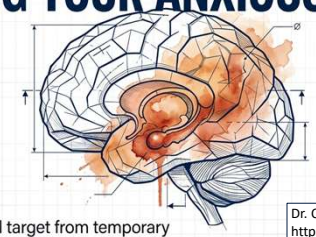
CONCRETE STRATEGIES FOR HELPING YOUR ANXIOUS CLIENT



Shifting the clinical target from temporary symptom reduction to lasting neuroplastic change.

Dr. Caroline Buzanko, R. Psych
https://drcarolinebuzanko.com/
info@korupsychology.ca

1

Questions for Caroline?

2

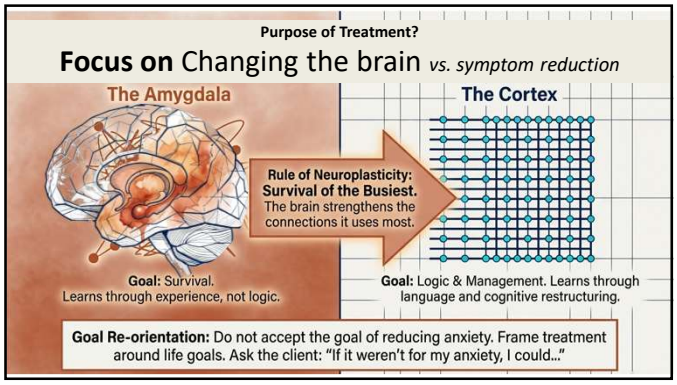
The therapist's instinct is to reduce pain.

However, the attempt to get rid of psychological conditions oftentimes exacerbates the problem.

Avoidance maintains the disorder. Promising anxiety reduction is a trap; it sets up a false goal that prevents exposure to necessary distress.

If you have a client with 'stuck' anxiety, check if you are treating their distress instead of retraining their brain.

3



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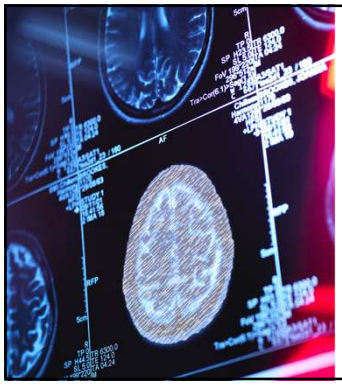


Glitchy security system

- Amygdala – Fast, automatic, detects threats
- Prefrontal Cortex – Slow, logical, problem-solving

Amygdala reacts to perceived threats faster than the prefrontal cortex can process them

5

6

Dimensionality Reduction

Integrates sensory input + body needs

↓

Too much data → brain compresses info

↓

Creates summaries of summaries

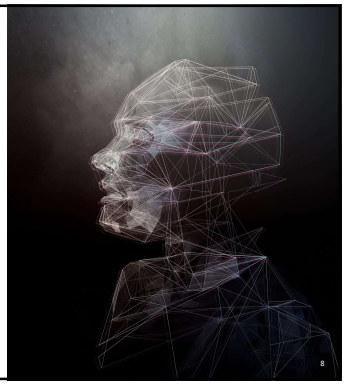
7

Knowledge Influences Sensory Information

(e.g., all faces are always convex)

Our knowledge/ experience/what we THINK misleads us

Bottom-up sensory information is overridden by top-down knowledge



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Brain: A Prediction Machine

Integrates sensory input + body needs

↓

SO much data (TOO much)→ brain compresses info

↓

Creates summaries of summaries

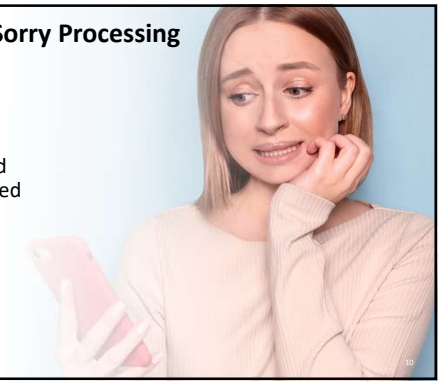
Makes quick guesses based on limited information

9

Better Safe Than Sorry Processing

Our brain doesn't care if its hazardous or not

- Our brain will respond based on what we need to survive
- Can react in error



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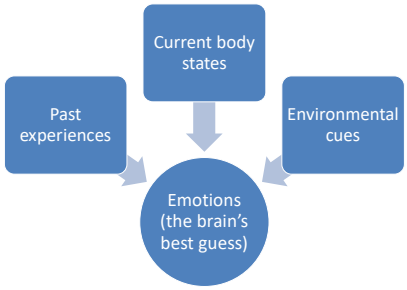
Emotions are Predictions (Not Reactions)



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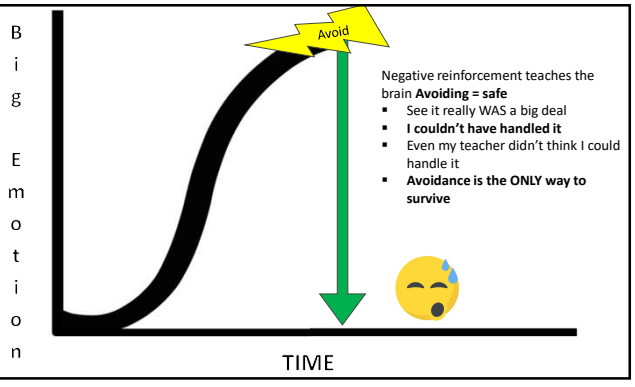

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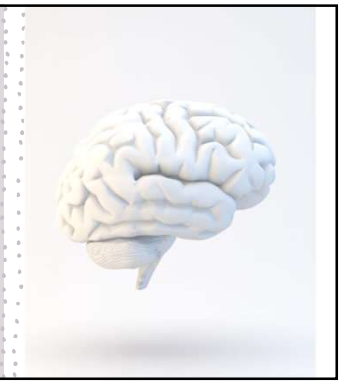
Remember:
The Brain is A Prediction Machine

QUICKLY DETERMINES WHAT BEHAVIOURS ARE MOST REWARDING



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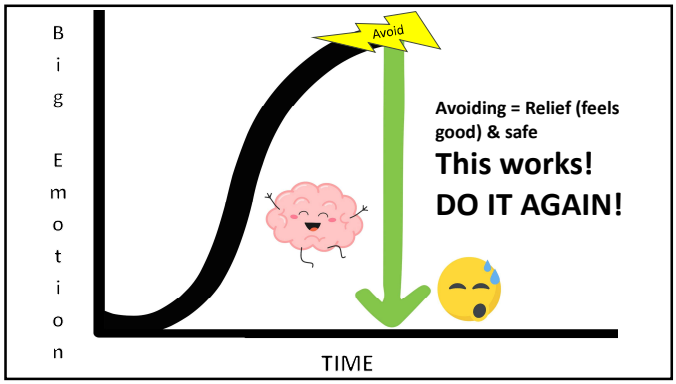

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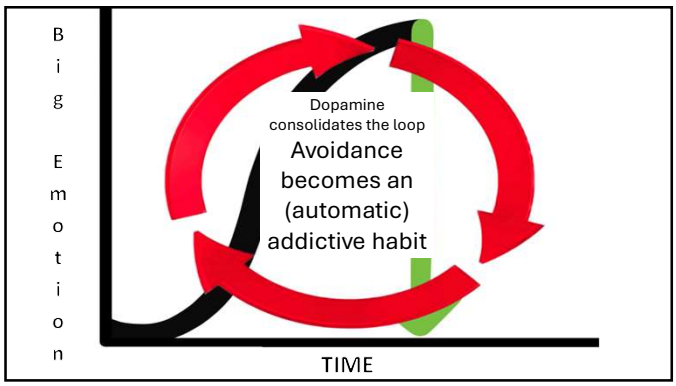

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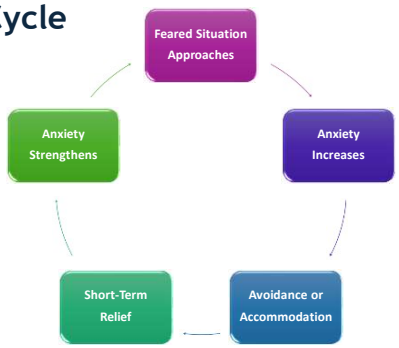
The Anxiety Cycle

Each cycle teaches the brain:

- The threat was real
- There's no way I could have handled it
- I survived only because I escaped.



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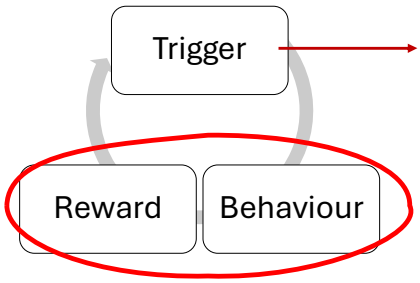
Anxiety Loop: Reward Based Learning

Negative reinforcement an evolutionary conserved process



Triggers NOT that important

- This does not drive reward-based learning
- Focusing on external stimuli leads to a rabbit hole of control.

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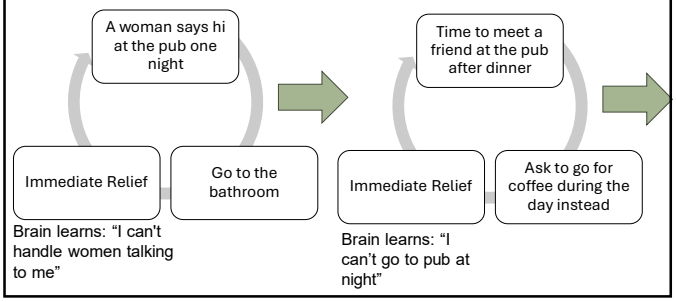
Reward Based Learning



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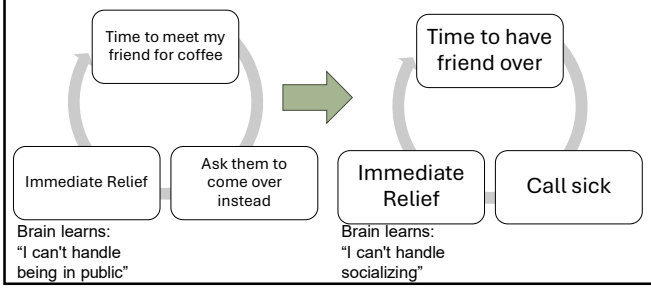
Anxiety Loop: Reward Based Learning



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Safety Behaviours are Hidden Maintenance Problems!

Any strategy used to control, avoid, or reduce anxiety. These trick the brain into thinking the safety aid is what prevented catastrophe.

Carrying medication "just in case"	Reassurance seeking	Over-preparing / perfectionism	Always knowing where the exits are
Phone charged at all times	Mental rehearsal before speaking	Checking Google repeatedly	Having a "safe" person nearby
Not eating before leaving	Arriving early to scope the room	Gripping water bottle in meetings	Avoiding eye contact

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Goal?

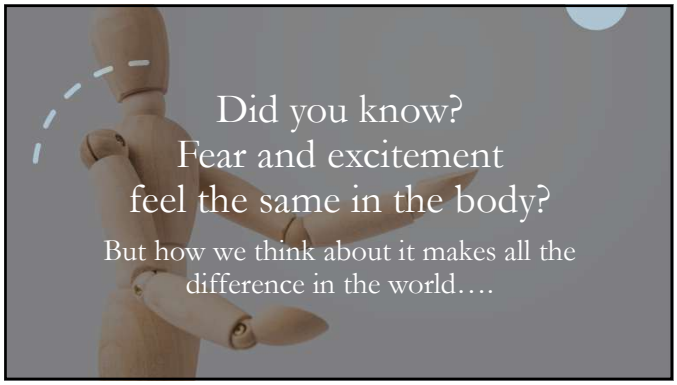
NOT the Goal

- Eliminate all anxiety
- Make the client feel calm
- Reduce SUDS to zero
- Convince them they're safe

THE Goal

- Change the brain's prediction system
- Build distress tolerance
- Increase willingness to feel
- Function despite discomfort

22



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When does the threat response trigger?

When does the challenge response trigger?

Threat vs. Challenge Response
Not good or bad, different purposes

Threat response
- Survival mode
- Situation we're not equipped for
- More cortisol (defend/protect)

Challenge response
- Growth opportunity
- Manageable but hard
- More adrenaline (achieve goal)

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Amygdala Relies on Past Experiences

The amygdala is often mistaken
- Doesn't have all relevant information
- Always rather be safe than sorry
- Does not know what will happen

Needs to be corrected!

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Anti-Therapeutic Traps for Clinicians

Co-Compulsing	Repeatedly answering reassurance-seeking questions to help the client feel better or gain certainty. You become part of the anxiety loop.
Distraction as Coping	Teaching distraction techniques during anxiety. Clients need to face and feel the emotion, not escape it. Distraction sends the message: this feeling is dangerous.
Relaxation as Escape	Using deep breathing or relaxation to reduce anxiety during exposure becomes a safety behavior. It reinforces the belief that anxiety itself is dangerous.
Endless Processing	Spending the session discussing triggers and feelings without behavioral change. The amygdala learns through experience, not conversation.

26

Emotions Are Adaptive!

Alert us to what's happening

Anger
- Alerts us to threats or injustices
- Protect our well-being

Fear
- Alerts us to danger
- Protects us from harm

Joy
- Positive reinforcement for doing things that promote our well-being and survival

Shame
- Prompts self-reflection, processing, and change
- Maintains social harmony

Sadness
- Alerts us to loss, separation, or unmet needs and allows us to process the event
- Promotes personal growth and deeper social connections

Excitement
- Propels resilience and growth
- Fosters curiosity, creativity, learning, and adaptability

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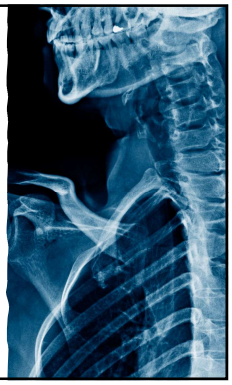
Physical Symptoms are a Problem

Defense response is FELT
WE MUST have physical reactions to alert us to what is happening

(*Cannot change reactions without this understanding)*

Many clients start to worry about the physical feelings, which are distressing, which they will do anything to stop

- Become reactive
- Misinterpret and leads to more sensations…



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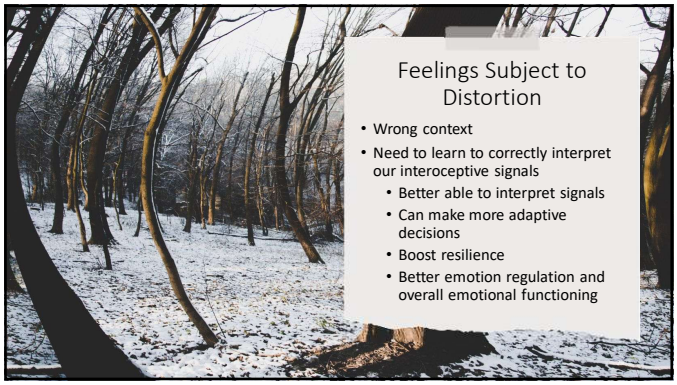

Feelings Subject to Distortion

- Wrong context
- Need to learn to correctly interpret our interoceptive signals
  - Better able to interpret signals
  - Can make more adaptive decisions
  - Boost resilience
  - Better emotion regulation and overall emotional functioning

29

The "Vitamin Shot" Study

Schachter & Singer, 1962

1 **Inject Epinephrine**

Participants received an injection that caused racing heart, trembling, and flushing — but were told it was a "vitamin."

→

2 **Manipulate Context**

Placed with either a euphoric confederate (laughing, playful) or an angry one (hostile, complaining).

→

3 **Result**

Same arousal, different emotion.

The physical sensations were identical. Their label was different.
Clients MUST understand that a racing heart before a presentation is the same chemistry as excitement before a concert. This alone already calms the amygdala.

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The "Vitamin Shot" Study
Schachter & Singer, 1962

Mood NOT affected by their environment WHEN THEY UNDERSTOOD WHAT WAS HAPPENING IN THEIR BODY

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Core skill

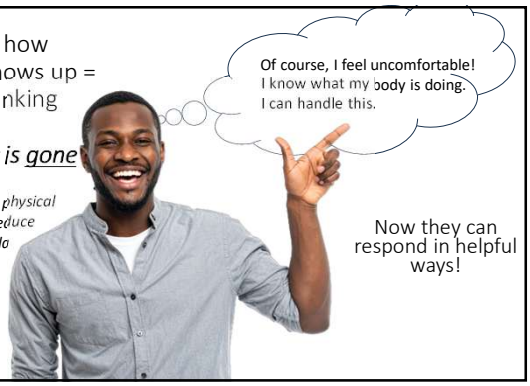
Mindful Awareness of Emotion:
What it feels like in the body!

32

Understand how emotions shows up = Adaptive thinking

The mystery is gone

BONUS: Expecting physical sensations helps reduce signals to amygdala



Now they can respond in helpful ways!

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With Awareness, Can Stop Fighting

"Clean" Anxiety

The natural, spontaneous fear response. Heart races, palms sweat. This is normal and temporary. It passes on its own.

"Dirty" Anxiety

The suffering caused by trying to control or escape the clean anxiety. Fighting anxiety IS the problem. This is what we treat.

Curiosity is the best response to emotional experiences.

AND, focus on what matters most.

Ask: "Are you willing to have the anxiety to get what you want?"

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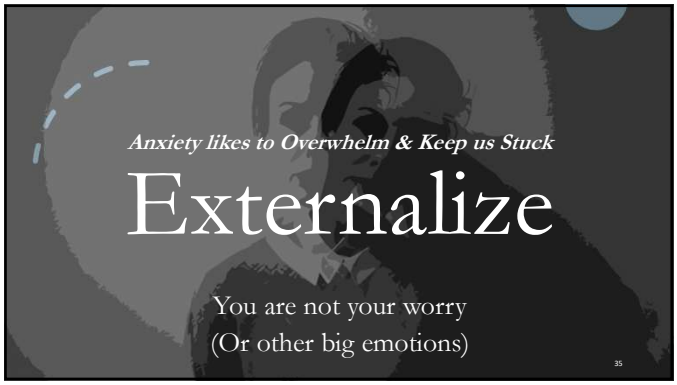

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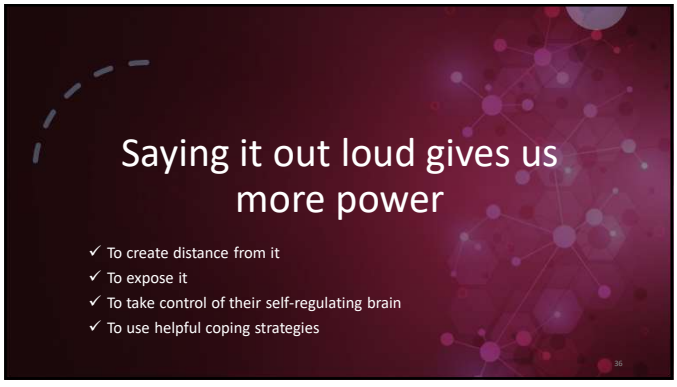

36

Get on Offense!

Naming it out loud creates distance, exposes the pattern, and activates the prefrontal cortex.

When the anxiety shows up, it will:	I am going to:
Tell me...	Say...
Make me feel...	Notice...
Want me to...	Do...

Visualization makes it concrete. Drawing or naming the anxiety pattern minimizes anxious noise and puts the client back in control of their self-regulating brain.

37

Talking & thinking does NOT retrain the amygdala

The ONLY way the thalamus and amygdala learn is by EXPERIENCING

The ONLY way to teach your alarm system that you're safe:

- **Face the scary thing**
- **Feel the feelings** without trying to escape or fix them.
- **Do nothing** to make the anxiety go away, just let it be there.

The more you practice, the more your brain learns

38

39

Feeling capable.
I can handle tough things even if I feel anxious!

40

Inhibitory Learning

Provoke STRONG EMOTIONS - MUST show up for learning to happen

- Build anxiety tolerance

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Inhibitory Learning

Emotion Exposure (with response prevention
Violate the catastrophic expectation.
Focus on what was LEARNED.
Anxiety reduction is NOT required.

BEFORE	DURING	AFTER
State specific catastrophic prediction. "What exactly do you expect will happen?"	Do NOT discuss anxiety levels. No SUDS tracking. Focus on the experience.	Debrief what was learned. "Did your prediction come true?"

42

Exposures to Change the Brain

1 Test Predictions

The client tests the accuracy of their catastrophic predictions. They make their own conclusions and create new expectations. Learning happens through experience.

2 Distress Is Tolerable

Anxiety and uncomfortable emotions are safe, tolerable, and temporary. The amygdala learns: this is not dangerous. And it stops sending the false alarm.

3 I Did It Anyway

Despite feeling anxious, I still did it . ON MY OWN. I can live life and do anything, even while feeling anxious.

43

Avoid False Fear Blockers During Exposure

Calming Strategies

- Taking deep breaths
- Relaxation techniques during exposure
- Distraction from the experience
- Anything designed to make the client feel better in the moment

Stay Present & Tolerate

- Notice what is happening without acting
- Let the anxiety be there
- Observe that nothing needs to happen for it to pass
- The amygdala learns by FEELING the discomfort and surviving it

If the client is comfortable, the amygdala is not learning!!!

Discomfort IS the treatment

44

Interoceptive Exposure: Facing the Body

Inducing feared physical sensations to decouple harmless body signals from catastrophic interpretation.

Exercise	Mimics	Targets Belief
Breathe through a straw (1 min)	Hyperventilation / air hunger	*"I can't breathe" panic*
Run in place (60 seconds)	Racing heart / pounding	*"I'm having a heart attack"*
Spin in a chair (30 seconds)	Dizziness / disorientation	*"I'm going to faint"*
Tense all muscles (60 seconds)	Muscle tension / shaking	*"I'm losing control"*
Hyperventilate (30 seconds)	Tingling / lightheadedness	*"Something is wrong with me"*

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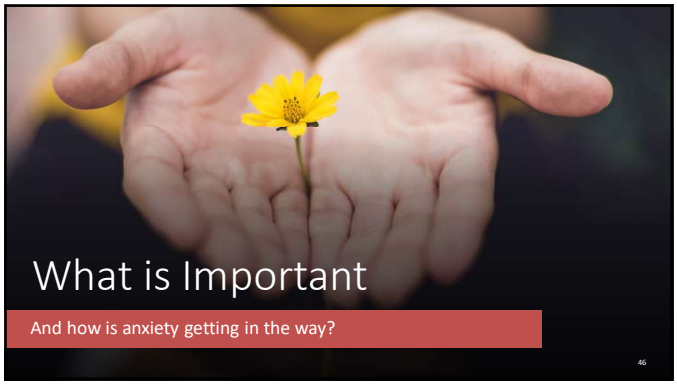

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Teach!
Long-term outcomes of adaptive coping strategies

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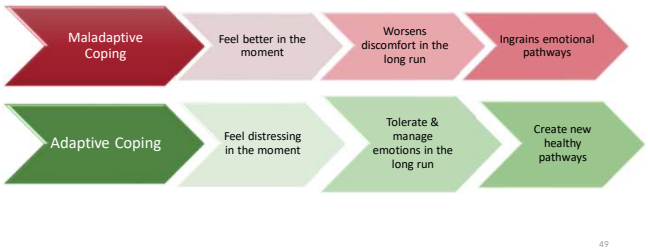
Teach!
Long-term outcomes of adaptive coping strategies



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Values-Based Motivation: Making Life Rich Again

What does anxiety prevent you from doing?

Career advancement	Intimate relationships	Travel and adventure
Parenting with presence	Social connection	Physical health
Creative expression	Financial decisions	Authenticity

The antidote to anxiety? Feeling capable. "I can handle tough things even when I feel anxious."

50

Recovery is when:

Clients are not worried about worries

END

51

52

Termination & Relapse Prevention

Recovery is never linear. Clients who expect a straight line to wellness are poorly equipped for the inevitable rough patches.

Lapse vs. Relapse

A **lapse** is a normal fluctuation (e.g., a bad week, a week, a spike in worry)

A **relapse** is a full return to pre-treatment functioning. functioning.
How a client *interprets* a lapse determines whether it whether it becomes a relapse. Reframe lapses as data as data

Build the Maintenance Plan

The goal was never to cure the amygdala.
It was to build the **"I Can Handle It" muscle.**

- **Normalize the journey** from Session 1: improvements, plateaus, and setbacks are all expected.
- **Define personal red flags:** early warning signs that anxiety is escalating again (e.g., returning to avoidance). avoidance).
- **Create a concrete action plan** listing skills, supports, and when to seek help — before it's needed.

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Remember!

Stop "Calming"	The goal is to help them function while anxious (vs. calm down).
Violate Expectations	Exposures should test specific catastrophic predictions (vs. distress reduction).
Drop Safety Behaviours	Exposures only work when the client drops the illusion of safety.
Debrief Every Time	Spend at least 10 minutes checking predictions, extracting learning, and celebrating bravery.
Assign Homework	Between-session practice is non-negotiable for retraining the brain. Clients must practice in the real world!!!

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Session Structure for Maximum Efficiency

Every minute counts. A disciplined agenda protects clients from their most reliable avoidance strategy: **talking around the work**.

- Mood Check
- Review
- Set Agenda
- Skill Building

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Learn more with me!

https://parentsoftheyear.buzzsprout.com/

OVERPOWERING EMOTIONS
with Dr. Caroline Buzanko

rebrand.ly/OverpoweringEmotionsPodcast

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BONUS INFO

https://koru-learning-institute.thinkific.com/products/courses/anxious-clients-bonus

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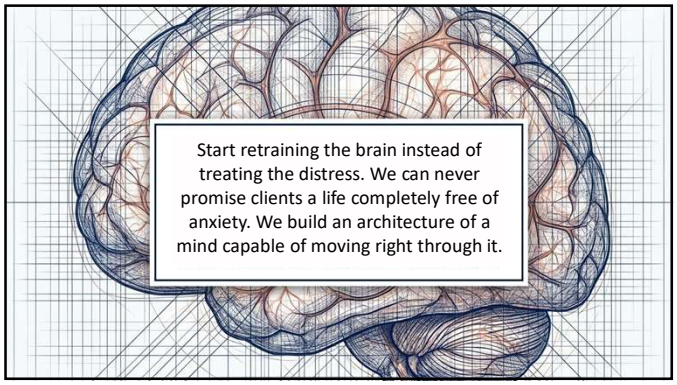
Start retraining the brain instead of treating the distress. We can never promise clients a life completely free of anxiety. We build an architecture of a mind capable of moving right through it.

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SKILLS TRAINING!

PRESENTED FOR:

CANADIAN HEALING AND TREATING TRAUMA CONFERENCE

APRIL 15, 2026

Jeff Riggenbach, PhD
jeffriggenbach.com
clinicaltoolboxset.com

Workshop Agenda

- Introductory Remarks
- Motivational Skills
- Relational Skills
- Standard CBT Skills
- DBT Skills

Borderline PD Skills Training

Introductory Remarks

- Relationship of BPD to Trauma and Addictions
- Role of Skills Training within BPD Protocol

Schema Based Cognitive Therapy: Components of Treatment and their roles

1. Individual Treatment

2. Group Treatment

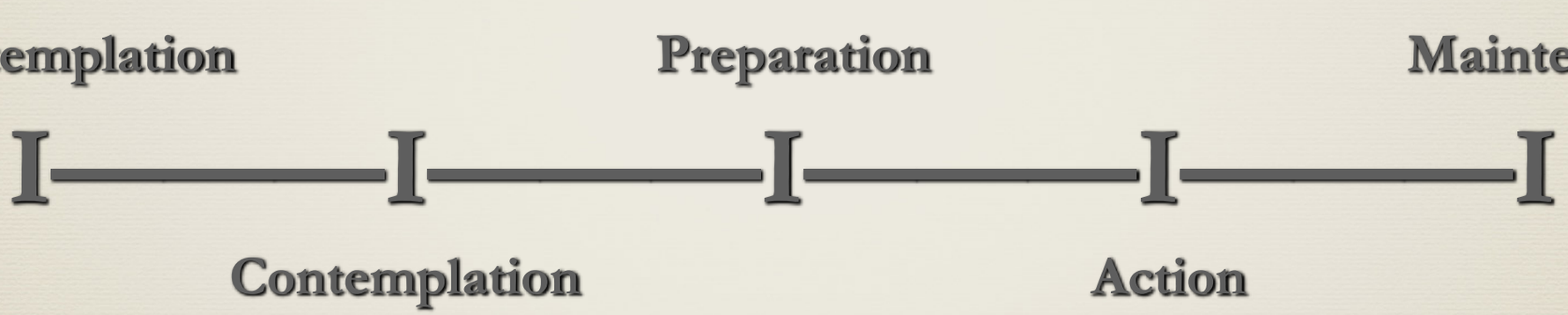
Borderline PD Skills Training

Introductory Remarks

- Relationship of BPD to Trauma and Addictions
- Role of Skills Training within BPD Protocol
- Function of Behavior Indicates Skills Utilised

Motivational Skills

Motivational Enhancement Therapy: Stages of Change



Expressions of Concern

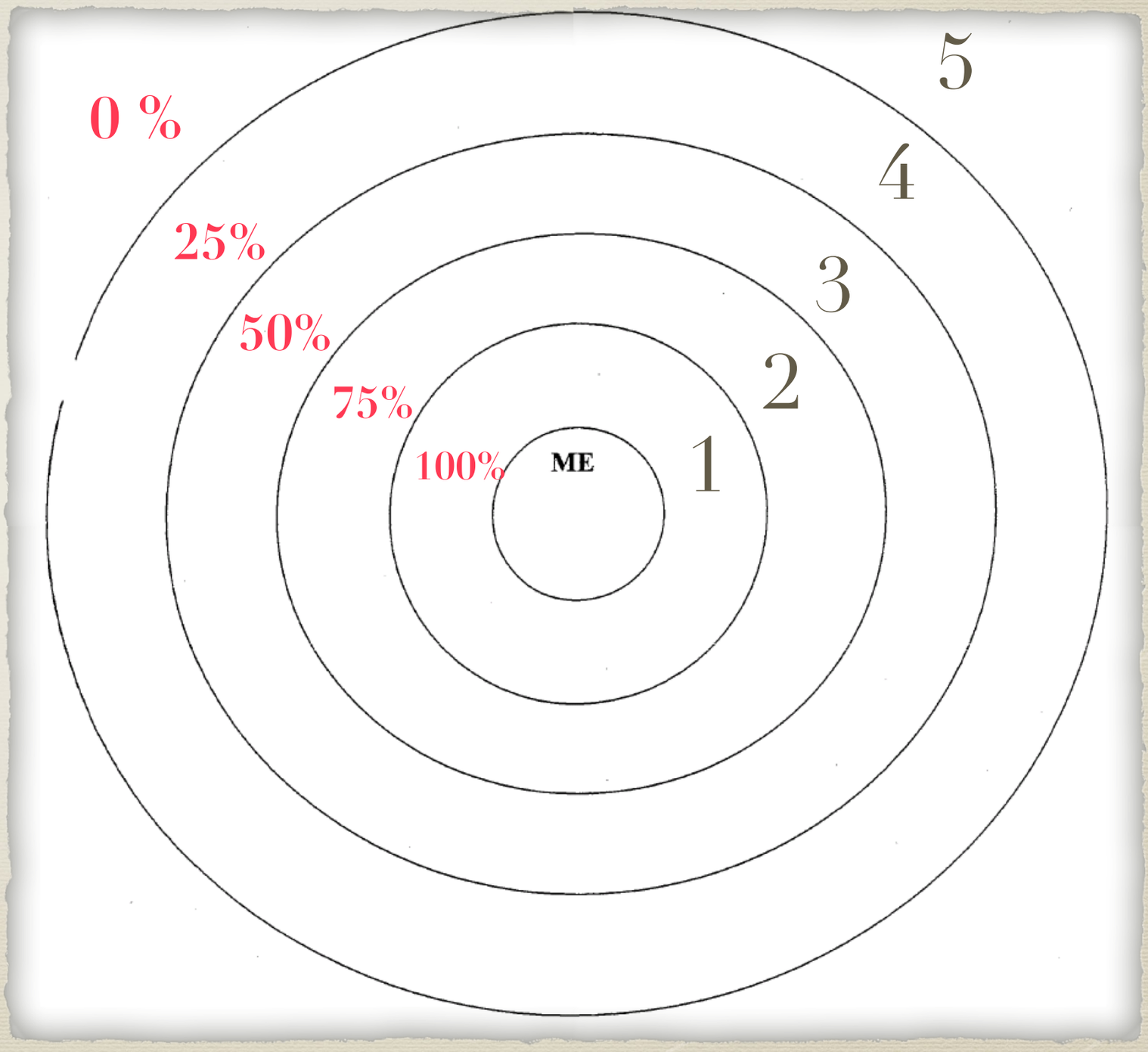
Relationship Skills

Relationship Circles

Intimacy

=

"Into - Me - See"



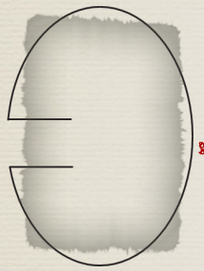
Standard CBT Skills

Cognitive Behavior Therapy (CBT)

Cognitive Behavior Therapy (CBT)

- Aaron T. Beck, 1960, University of Pennsylvania
- Principle that thoughts influence feelings

Cognitive Behavior Therapy (CBT)



Events → Thoughts → Feelings → Actions → Results

Standard CBT Strategies for BPD

- Cost-Benefit Analysis
- Labeling Distortions
- Cognitive Awareness Exercises
- Identifying and Challenging Automatic Thoughts
- Continuum Work - "shades of gray"
- Identity Development

Pros and Cons

Standard CBT Strategies for BPD

- Cost-Benefit Analysis
- Labeling Distortions
- Cognitive Awareness Exercises
- Identifying and Challenging Automatic Thoughts
- Continuum Work - "shades of gray"
- Identity Development

Identifying and Labelling Cognitive Distortions

1. Rationalization. In an attempt to protect yourself from hurt feelings, you create excuses for events in life that don't go your way or for poor choices you make. We might call these permission-giving statements that give ourselves or someone else permission to do something that is in some way unhealthy.

2. Overgeneralization. You categorize different people, places, and entities based on your own experiences with each particular thing. For example, if you have been treated poorly by men in the past, "all men are mean," or if your first wife cheated on you, "all women are unfaithful." By overgeneralizing, you miss out on experiences that don't fit your particular stereotype. This is the distortion on which all of those "isms" (e.g., racism, sexism) are based.

3. All-or-nothing thinking. This refers to a tendency to see things in black and white categories with no consideration for gray. You see yourself, others, and often the whole world in only positive or negative extremes rather than considering that each may instead have both positive and negative aspects. For example, if your performance falls short of perfect, you see yourself as a total failure. If you catch yourself using extreme language (best ever, worst, love, hate, always, never), this is a red flag that you may be engaging in all-or-nothing thinking. Extreme thinking leads to intense feelings and an inability to see a "middle ground" perspective or feel proportionate moods.

Cognitive Distortions

4. Discounting the positive. You reject positive experiences by insisting that they "don't count" for some reason or another. In this way, you can maintain a negative belief that is contradicted by your everyday experiences. The terms mental filter and selective abstraction basically describe the same process.

5. Fortune telling. You anticipate that things will turn out badly and feel convinced that your prediction is already an established fact based on your experiences from the past. Predicting a negative outcome before any outcome occurs leads to anxiety.

6. Mind reading. Rather than predicting future events, engaging in this distortion involves predicting that you know what someone else is thinking when in reality you don't. This distortion commonly occurs in communication problems between romantic partners.

7. Should statements. You place false or unrealistic expectations on yourself or others, thereby setting yourself up to feel angry, guilty, or disappointed. Words and phrases such as ought to, must, has to, needs to, and supposed to are indicative of "should" thinking.

8. Emotional reasoning. You assume that your negative feelings reflect the way things really are. "I feel it, therefore it must be true."

9. Magnification. You exaggerate the importance of things, blowing them way out of proportion. Often, this takes the form of fortune telling and/or mind reading to an extreme. This way of thinking may also be referred to as catastrophizing or awfulizing.

10. Personalization. You see yourself as the cause of some external negative event for which, in fact, you were not primarily responsible. You make something about you that is not about you and get your feelings hurt.

BPD - Specific Thoughts

- "Because he is late coming home, he is probably leaving me"
- "If I tell him everything about me on the first date I can test him to find out if he's really interested."
- "Since she pissed me off, I have to quit. I can't work with someone like her."
- "Since she betrayed me once, I can never trust her again - she really isn't even worth talking to again."
- "If I cut myself, he will not leave me"
- "If I cut myself, he will not leave me"
- "Since she"It's ok to cut myself, because cutting is better than other things I could do"

Standard CBT Techniques

Restructuring Self-Destructive Cognitions

Dysfunctional Thoughts Related to Self-harm

"If he/she sees my blood, they'll know I'm really sick. Cutting is the only way to get them to understand how bad I really hurt."	

Dysfunctional Thoughts Related to Self-harm

"If I hurt myself, that will show him. He hates it when I do it – since he hurts me all the time I'm gonna hurt him!	

Dysfunctional Thoughts Related to Self-harm

"It I hurt myself, he will show me he loves me/not leave me. Hurting myself is the only way to get him to show affection."	

Dysfunctional Thoughts Related to Self-harm

"Hurting myself is the only way to make me feel better. If I don't hurt myself, I can never reduce my anxiety."	

Dysfunctional Thoughts Related to Self-harm

"Since I screwed up, I deserve to be punished. If I hurt myself I get even."	

Dysfunctional Thoughts Related to Self-harm

"Since I screwed up, I deserve to be punished. If I hurt myself I get even."	

Dysfunctional Thoughts Related to Self-harm

"If I cut, she'll stop screaming at me. Cutting is the only way to end this argument."	

Dysfunctional Thoughts Related to Self-harm

"If I hurt myself, I can then problem solve better – I can't get out of this fog unless I burn."	

Standard CBT Skills:

Cognitive Continuum

"Since my parents have $ and help me, they have it Completely all together."

"Since mom is critical and nosy and drinks too much I don't know if I can be in her life anymore."

I————————————————I————————————————I

Standard CBT Skills:

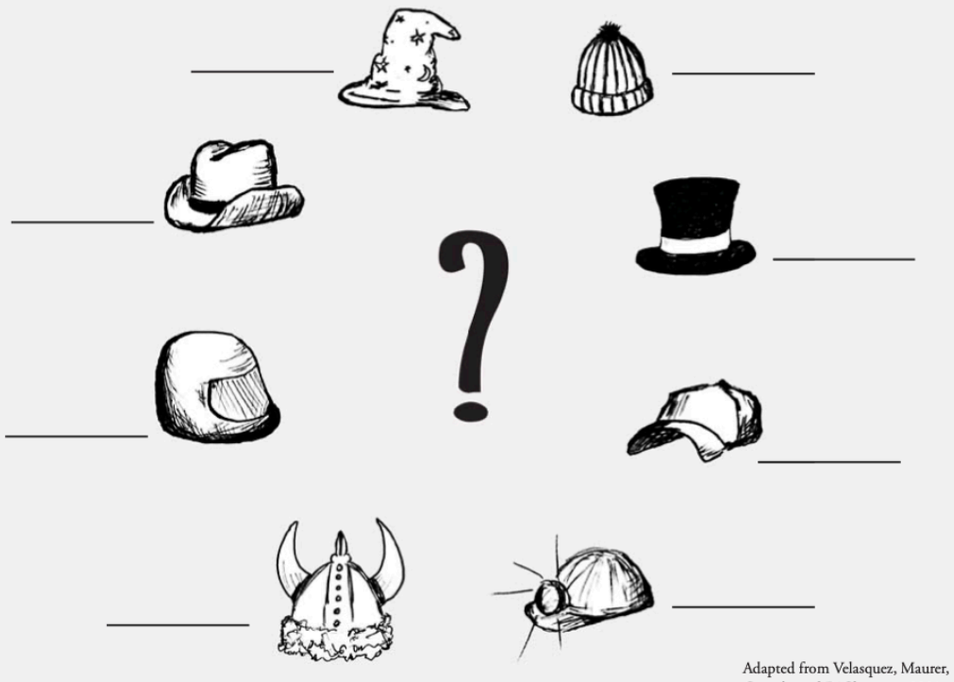
Cognitive Continuum

BPD Continuum Cue Card

"Mom is not perfect...she can be critical and nosy and aggressive and she drinks too much...but she has done a lot right as a parent over the years - even though some of her behaviors are unacceptable, I know she still loves me and I can still love her"

Standard CBT Skills:
IDENTITY HATS

Near each hat in the following illustration, put one of the ways you currently define yourself or a way that you may like to see yourself in the future. For instance, one particular participant's "hats" included being a *"niece, a sister, a friend, a Christian, a church member, a stamp collector, a chef, a taxi cab driver, a secretary, and a movie goer,"* etc.



Adapted from Velasquez, Maurer, Crouch, and DiClemente, 2001

The "hat" I most identify with is _____

The one I least identify with is _____

Three ways I can develop my identity as a _____ **are:**

1. _____

2. _____

3. _____

DBT Skills

Dialectical Behavior Therapy

- Developed by Marsha Linehan in the 1970s
- Looking for a method to treat chronically suicidal
- Found traditional CBT to be too invalidating
- Added validation to empirically supported CBT
- Concept of Dialectics

Dialectical Behavior Therapy

"Juxtaposes contradictory ideas and seeks to resolve a conflict; a method of examining opposing ideas in order to find truth"

Dialectical Behavior Therapy: Core Modules

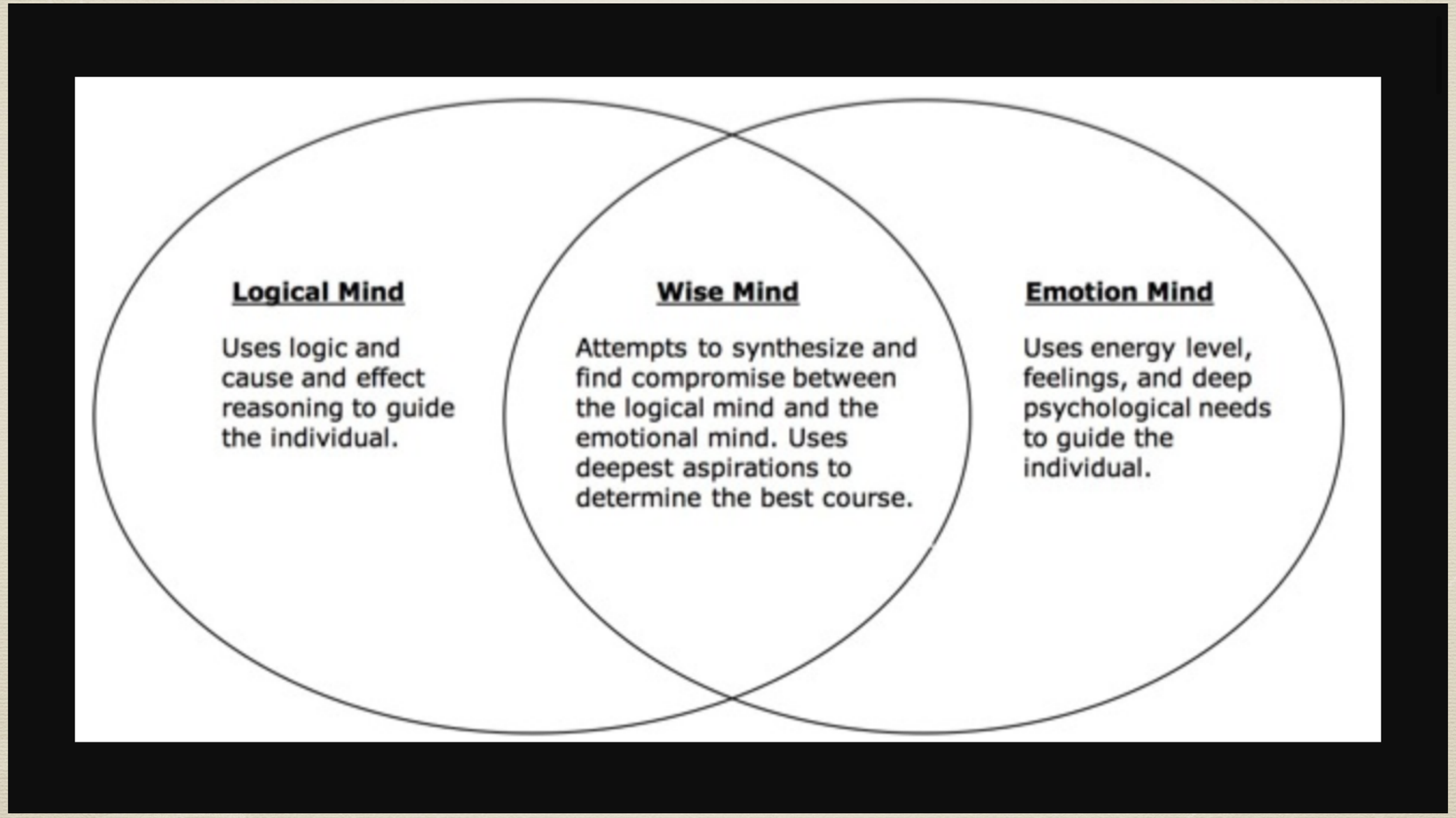
- Mindfulness Skills
- Emotion Regulation Skills
- Distress Tolerance Skills
- Interpersonal Effectiveness Skills

Mindfulness

Mindfulness

- "Being present in the moment focusing on the here & now in a non judgmental manner"

States of Mind



Reason Mind

- Logical part of brain
- Prefrontal cortex Involved
- Pros & Cons

Emotion Mind

- Emotionally Flooded
- More Reactive
- More Impulsive
- Pros & Cons

Wise Mind

- Acknowledge what we are feeling and at the same time able to process - acting a way consistent w goals & values

Goals of Mindfulness

- Experience and Learn that tolerable and way out of painful emotion is a willingness to relate to them
- Change qualitative relationship to emotions...not right or wrong way to feel in given situations
- Decrease pace of Cognitions

Grounding Exercise

Grounding Exercise

5

4

3

2

1

Emotion Regulation Skills

Emotion Regulation Principles

- Emotions education
- Types of emotions
- Intensity of emotions
- Function of emotions
- Pros and cons of emotions

Emotion Education

- Anxiety = Risk/Resources
- Depression - Selective Abstraction of Negative Data
- Anger - Values Violation/Shoulds

Goals of Emotion Regulation

- Reduce Vulnerability to negative emotions
- Decrease acting out on emotions
- Decrease emotional intensity experienced

Emotion regulation: “Please Master Skills”

P

L

E

A

S

E

Emotion Regulation: "Please Master Skills"

Build **Master**(Y)

- get good at something
- feel competent
- build positive experiences
- choose activities/people that will produce positive emotions

Opposite Action

Emotion Regulation Skills: Opposite Action

- Anxiety
- Depression
- Anger
- Shame

Distress Tolerance skills

Distraction Techniques

- Any coping skill that inherently requires thought

“Wise Mind Accepts”

A

C

C

E

P

T

S

Improve the moment

I

M

P

R

O

V

E

Take a Vacation!

- https://m.youtube.com/watch?v=pDKiMYgdxSs

Soothing Strategies

Engaging Through the 5 Senses

1. Vision
2. Hearing
3. Smell
4. Touch
5. Taste

Radical Acceptance

- "Pain is inevitable, suffering is optional"

3 choices

1) If you can change the situation, change it

2) if not, accept

3) stay miserable

Interpersonal Effectiveness Skills

Interpersonal Effectiveness Skills

1) Objectiveness/Goal Effectiveness

2) Relationship Effectiveness

3) Self-Respect Effectiveness

Interpersonal Effectiveness: Objective Effectiveness

D

E

A

R

M

A

N

Interpersonal Effectiveness: Relationship Effectiveness

G

I

V

E

Interpersonal Effectiveness: Self-Respect Effectiveness

F

A

S

T

Integrated DBT/SFT Case Study

Interpersonal Effectiveness Exercise
Key Cognitions/Schemas

Key Cognitions

- "Since you impose rules/requirements, you don't care"
- "Since you won't pay for this one, I am not willing to look for any others"
- "You should pay for anything i need - since you wont you probably wish I was dead (never born)"

Key Schemas

- "Others take advantage of you"
- "Others are Controlling/Uncaring"
- "I am Unlovable"
- Dependent Entitlement

BPD Skills Training

Integrated Case Study

Let's Connect!

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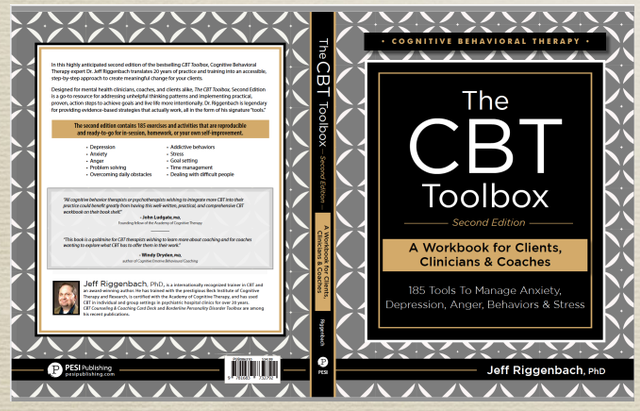

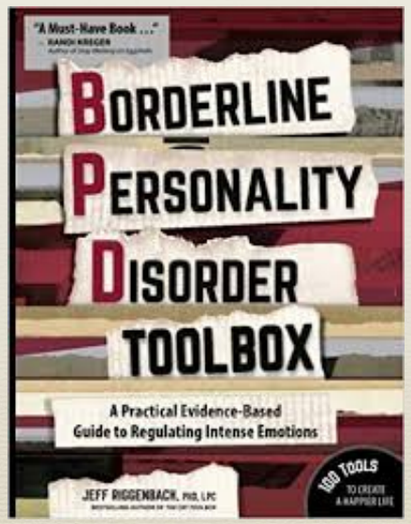

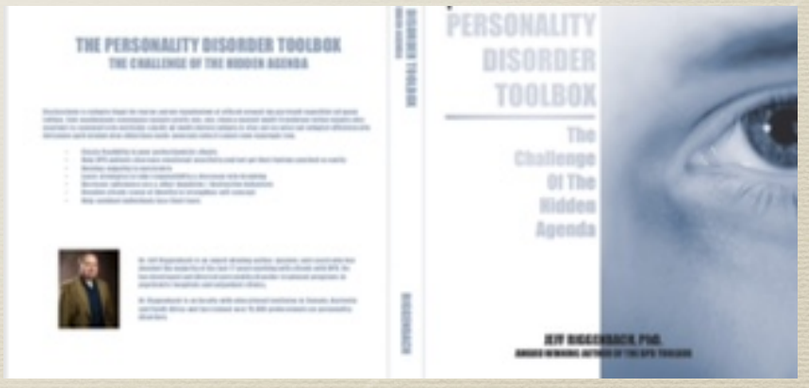

Thank You!

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Integrating Indigenous Healing Through Spiritual Traditions, Cultural Practices, and Storytelling

Dr. Varleisha Lyons Phd OTD OTR/L FNAP FAOTA

Owner

1

Ancestral Honoring
Land Acknowledgement

▶ *We acknowledge that we are gathered on ancestral lands. We acknowledge the source of our land and water and those who have cared for it since the beginning of time.*

2

Haliwa Saponi!

3

Learning Objectives

1. Understand intergenerational trauma
2. Explore Indigenous spirituality
3. Reclaiming our power
4. Create trauma-responsive, culturally responsive environments

4

Understanding Intergenerational Trauma

- Definition
- Historical context
- Colonization impacts

5

- **A**cknowledge and be **A**ware of trauma
- **C**reate growth from trauma
- **T**each neuroeducation and steps toward growth
- **I**ntergenerational factors
- **O**rganizations and systems re-traumatization
- **N**ow is the time to take ACTION to create growth from trauma

6

What Does a Power Dynamic Mean to You?

7

Reclaiming Power Trauma Responsive Care

Define what power means for survivors and outline what we will reclaim through trauma responsive soul-centered healing rooted in Dr. Varleisha's approach

- What power means
  - Power as self-agency voice boundaries and embodied safety—core outcomes of trauma-responsive care and soul work.
- What we reclaim
  - Reclaim autonomy emotional regulation trust in the body and creative purpose through intentional spiritual practices.
- Trauma-responsive method
  - Grounded in Dr. Varleisha's trauma-responsive care from Trauma Treatment in Action—practical compassionate and body-centered interventions.

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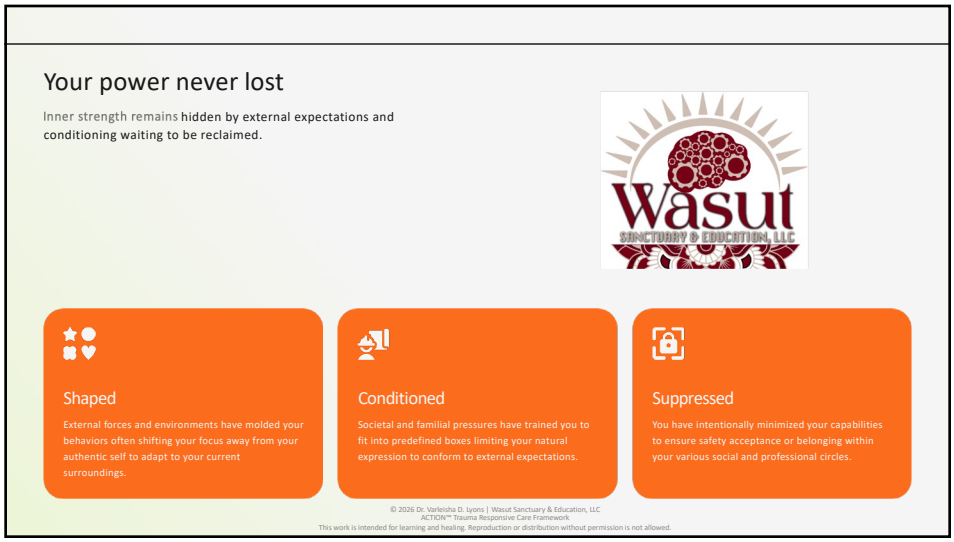

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10

Breathwork *Pause. Breathe. Arrive.*

Take a moment to exist. Connect with your life force and shift from your busy mind into the body.

Pause

Stop external noise. Create space to disconnect from distractions and center your attention on the present moment.

Breathe

Connect with your life force. Focus on deep rhythmic breaths to calm your nervous system and stabilize your internal energy.

Arrive

Shift from mind into body. Bring awareness to physical sensations grounding your focus into your feet to find stability.

11

You are not broken.

Your perceived flaws are survival mechanisms developed to protect you when you felt threatened.

01

Brilliant Adaptation

Your responses are not signs of failure but intelligent adjustments made to ensure your survival during difficult past experiences.

02

Protective Response

Your mind and body recognized threats and activated defense mechanisms to keep you safe when you were unable to defend yourself.

03

Restored Power

By acknowledging these as protective choices rather than flaws you begin to reclaim the power you once felt was threatened.

12

Are You Carrying Other's Burdens?

Many of us unknowingly hold emotional weight that isn't ours from inherited trauma to the needs of those around us. Identify the source to begin releasing it.

Intergenerational Trauma

Inherited patterns or emotional wounds passed down through family lines that you did not personally create but are currently struggling to process and resolve within your own life today.

External Expectations

Burden created by partners parents or society that shapes your actions. These pressures often conflict with your authentic self and require you to perform roles that are not your own.

Environmental Stress

Absorbing the emotional dysregulation of people in your immediate surroundings. You may feel responsible for stabilizing a volatile environment at the expense of your own mental health.

Honest Inquiry

The practice of asking yourself whose weight you are supporting. This critical reflection helps distinguish your own burdens from the projections and emotional needs of other people.

13

“Even in spaces where care was taken it was not always freely given. And today we reclaim the right to choose where our energy our care and our bodies go. Your

Your body mirrors your environment. Thoughts signal your cells influencing your state of being.

01

Neural Processing

Your habitual thought patterns create chemical signals that dictate hormonal health energy levels and overall vitality in your daily life.

02

Environmental Input

Your surroundings—from social interactions to physical spaces—constantly impact your nervous system either draining or fueling your reserves.

03

Cellular Feedback

Cells act as receivers for environmental data translating stress or calm into physical tension or relaxation throughout your musculature.

14

Healing Path

Transition from high-alert protection to authentic soul alignment.

15

Survival vs Spirit

Explore the shift from reactive **safety-driven states to intentional purposeful authentic living.**

State	Characteristics	Primary Focus
Survival	Guarded hyper-vigilant reactive; Flexed posture	Safety and protection
Aligned with Spirit	Aligned open intentional; Openness	Authenticity and purpose

16

The Heavy Bag Concept

Expectations

Living according to scripts written by others rather than your own internal compass.

Fear

The primary barrier that prevents honest vulnerable communication and authentic self.

Silence

The intentional suppression of your own truth and voice to maintain perceived safety.

Trauma

Stored physical and emotional wounds that unconsciously dictate your current reactions.

The 'Heavy Bag' defines internal conflict. These four pillars act as barriers to authentic expression. Recognizing them is the essential first step to relief.

17

What Are You Carrying?

Physical Tension

Chronic strain and persistent fatigue manifesting deep within the body. The constant weight of carrying these unnecessary items wears you down significantly limiting your natural daily energy levels.

Emotional Weight

Deep-seated feelings of guilt shame and excessive obligation. These invisible burdens act like heavy anchors preventing you from moving forward and keeping you trapped in old negative patterns.

Mental Clutter

Constant intrusive worry regarding the needs and expectations of others. Your mind remains filled with chaotic noise making it difficult to focus on your own goals or find any sense of personal clarity.

Accumulation

The gradual unconscious process of filling your metaphorical bag over many years. What started as small manageable choices has slowly evolved into a heavy unmanageable burden demanding your attention.

Your life is a journey but your bag has grown heavy with items that aren't yours. You carry burdens you didn't sign up for weighing down your health and peace.

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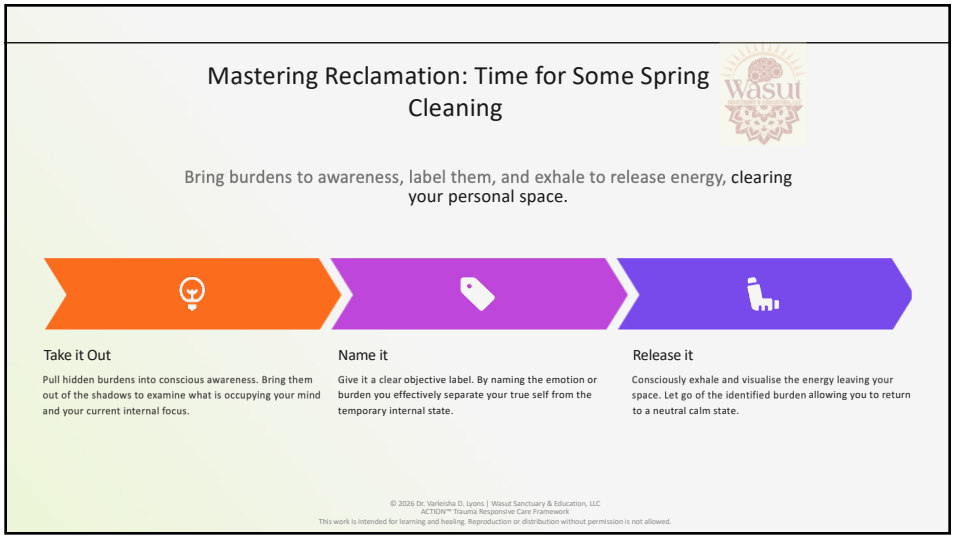

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Mechanisms of Trauma Transmission

PSYCHOLOGICAL

CULTURAL

SOCIAL PATHWAYS

21

Impacts on Identity

- Loss of language
- Disconnection from traditions
- Stigma and internalized oppression

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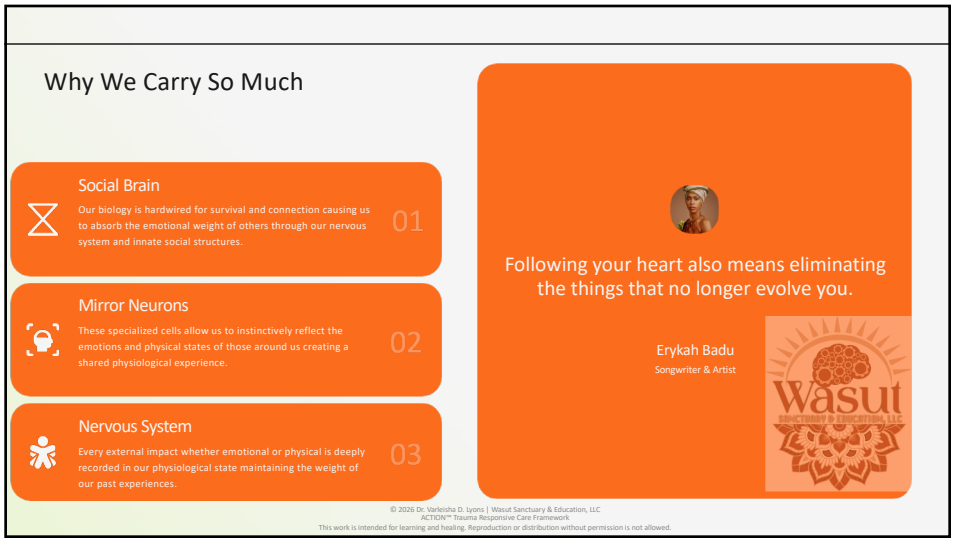

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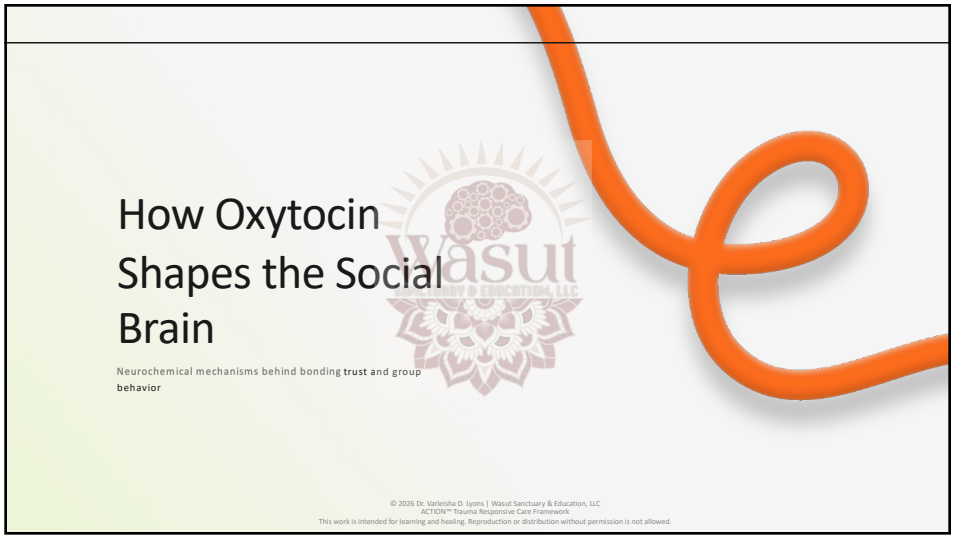

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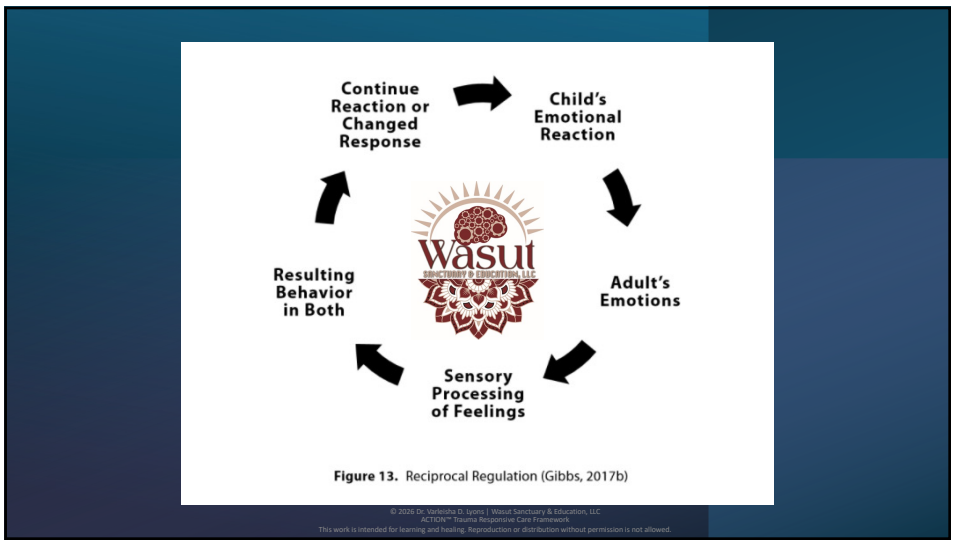

Figure 13. Reciprocal Regulation (Gibbs, 2017b)

25

Reciprocal Regulation

Varleisha's Contagion

Dr. Varleisha identifies how we unconsciously absorb the stress or emotional state of those around us shifting our internal climate without awareness. We are not always aware of this flow.

Invisible Transfer

Subtle cues like body language and tone create a silent conduit allowing feelings to travel between individuals effortlessly creating shared emotional states without a single word spoken.

Managing Adopted Burdens

We often mistake someone else's stress for our own unknowingly carrying emotional weight that does not belong to us which can lead to exhaustion and a feeling of being constantly overwhelmed.

Boundary Porosity

Without intentional regulation our personal emotional borders become porous making us highly susceptible to external states and the turbulent energy of those we encounter throughout the day.

Conscious Regulation

By identifying the exchange we reclaim our autonomy learning to observe others' states without internalizing their load effectively maintaining our own balance despite external pressures.

26

Impact of Oxytocin and the Epigenetic Connection

Physiological behavioral and social effects of oxytocin in women with implications for bonding stress regulation and reproductive health

- Promotes maternal bonding and enhances social attachment
- Impacts appetite and metabolism
- Reduces stress by modulating HPA axis and lowering cortisol
- Influences reproductive processes: uterine contraction and lactation
- Enhances social cognition and trust in interpersonal interactions
- May affect anxiety and depressive symptoms; context dependent
- Interacts with sex hormones and varies across menstrual cycle
- Clinical uses include augmentation of labor and management of postpartum hemorrhage
- Research shows variable outcomes depending on dose timing and social context

27

Mental Health Implications

High rates of PTSD, depression

Suicide and substance use trends

28

Social Brain Chemicals

Key neurochemicals governing human social interactions group dynamics and bonding.

29

Body Chemistry of Relationships

How Reciprocal Regulation shapes your nervous system—safety or stress based on who and what surrounds you

"Your body is not just reacting emotionally—it is responding chemically to your relationships."

Dr. Varleisha

30

Blending Traditions and Therapy

Integrated models such as CBT and mindfulness with ceremonies

Storytelling

- Transmission of knowledge
- Oral history
- Cultural resilience

31

Healing Through Connection

- Connection to land
- Ancestors
- Community

32

Using the ACTION from Trauma Approach:

Part I- ACT

33

A: Acknowledge and be Aware of Trauma

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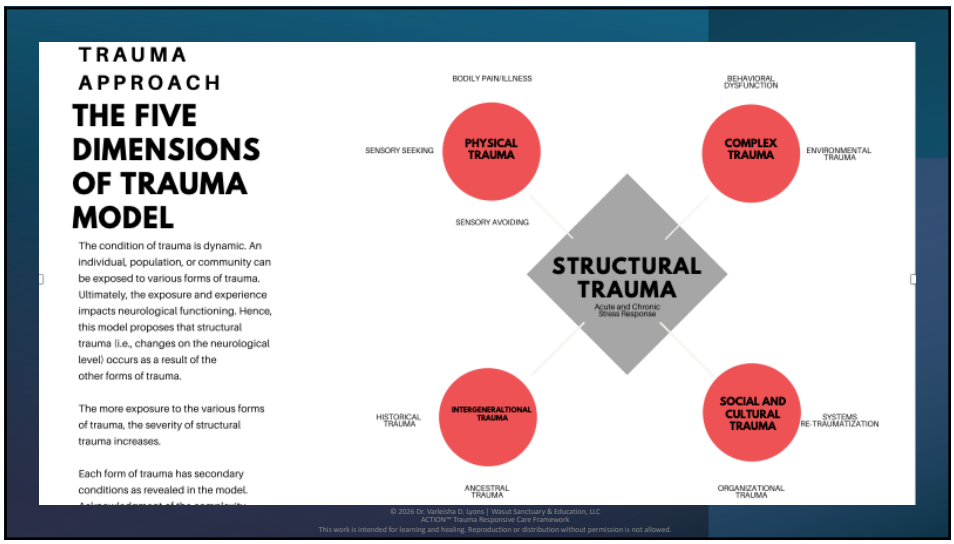

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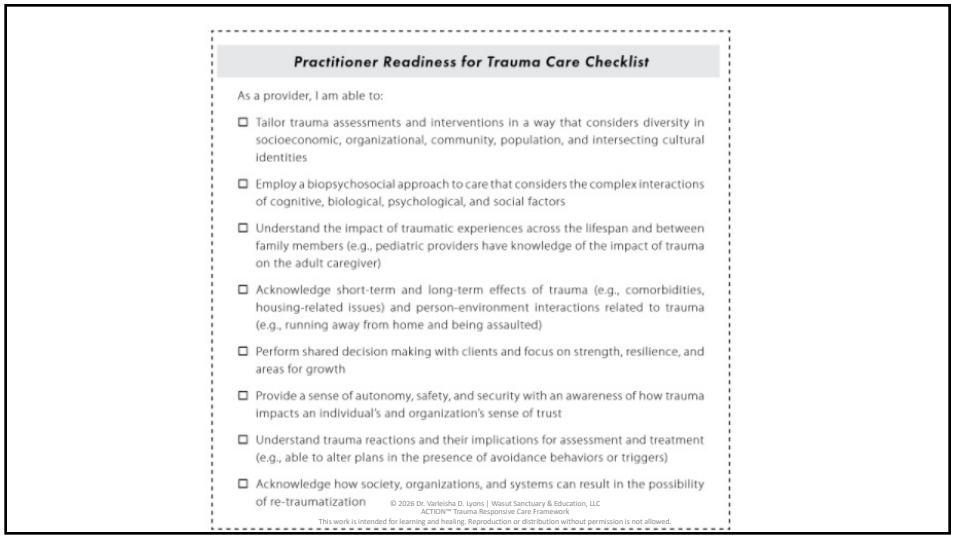

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Respect and Empathy Language	Gratitude and Growth Statements
Children	
◦ "What do you need?" ◦ "Do you need a break?" ◦ "How can I help?" ◦ "All done? Or do you need more?" ◦ "I want to help you." ◦ "What you experienced is not okay. What support do you need?"	◦ "Thank you!" ◦ "I like your hard work!" ◦ "Wow! Look at how you grew today by finishing your work!" ◦ "You have grown so much!"
Adolescents, Adults, and Older Adults	
◦ "That is really challenging, and I see you are upset. Can I suggest some strategies to assist with your anxiety?" ◦ "Would it be okay for us to discuss how that made you feel?" ◦ "While it may not have been the best choice, your response matches how you felt." ◦ "How can I help you grow from here?" ◦ "Did that make you feel uncomfortable? That was not my intent." ◦ "I see that may not have been the best way to phrase that. What I meant was..."	◦ "That was brave of you." ◦ "Your sharing shows your strength." ◦ "Look at all you have done since and despite of..." ◦ "That is tough to talk about. I appreciate your openness and trust."

Table 4. ACTION Language

37

C: Create Growth

38

Setting the Stage

- ☐ Creating a Growth Contract and Needs Plan
- ☐ Grounding Activities and Practitioner Check-Ins
- ☐ The Sensory Connection
- ☐ Contextual Sensory Investigation
- ☐ ACTION Creating Growth Tools
- ☐ Case Scenario

39

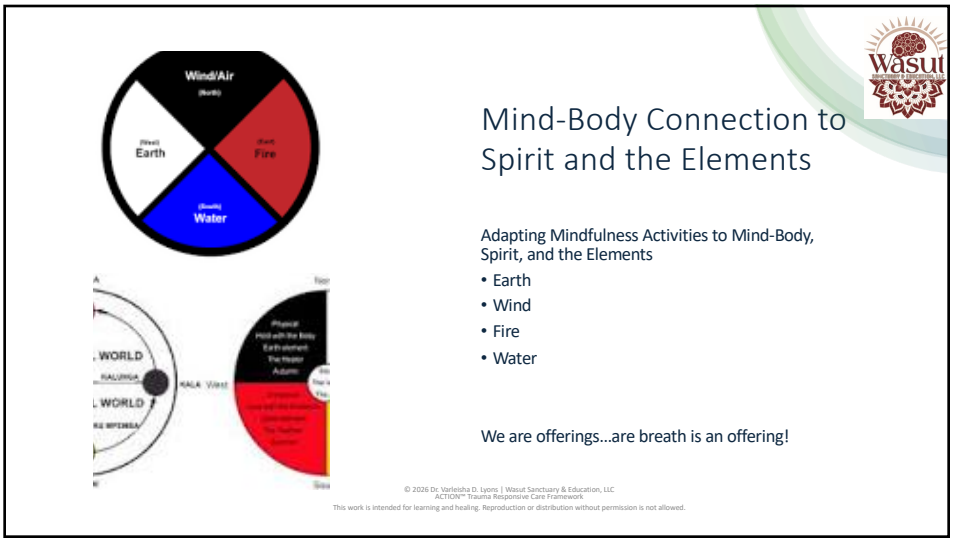
Spirituality in Indigenous Healing

Role of ceremony and ritual

Belief systems

Holistic worldviews

40



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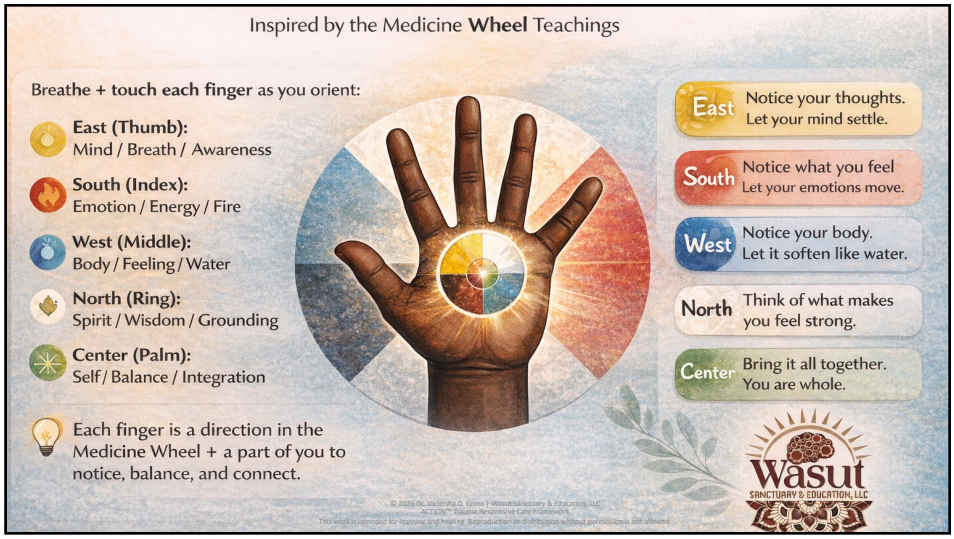

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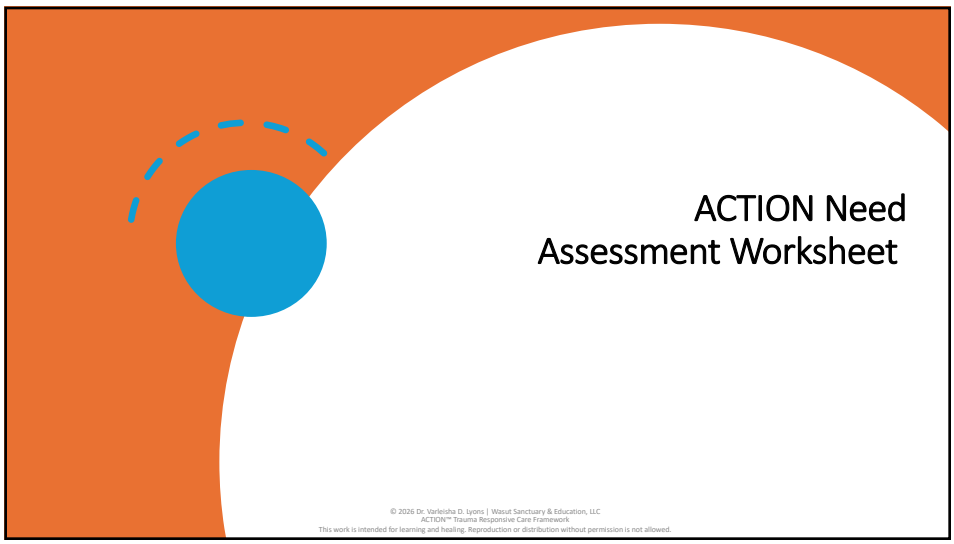

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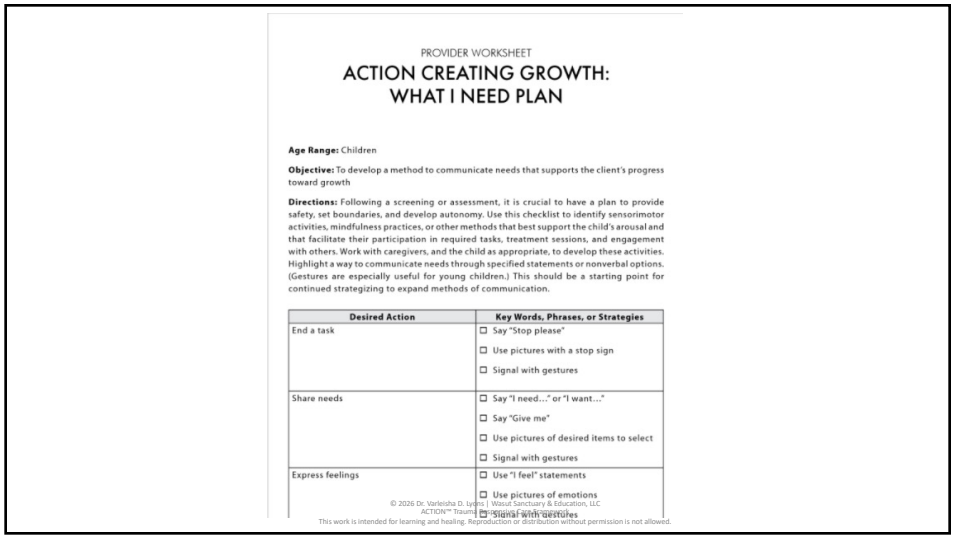


PROVIDER WORKSHEET

ACTION CREATING GROWTH: WHAT I NEED PLAN

Age Range: Children

Objective: To develop a method to communicate needs that supports the client's progress toward growth

Directions: Following a screening or assessment, it is crucial to have a plan to provide safety, set boundaries, and develop autonomy. Use this checklist to identify sensorimotor activities, mindfulness practices, or other methods that best support the child's arousal and that facilitate their participation in required tasks, treatment sessions, and engagement with others. Work with caregivers, and the child as appropriate, to develop these activities. Highlight a way to communicate needs through specified statements or nonverbal options. (Gestures are especially useful for young children.) This should be a starting point for continued strategizing to expand methods of communication.

Desired Action	Key Words, Phrases, or Strategies
End a task	☐ Say "Stop please" ☐ Use pictures with a stop sign ☐ Signal with gestures
Share needs	☐ Say "I need…" or "I want…" ☐ Say "Give me" ☐ Use pictures of desired items to select ☐ Signal with gestures
Express feelings	☐ Use "I feel" statements ☐ Use pictures of emotions ☐ Signal with gestures

44

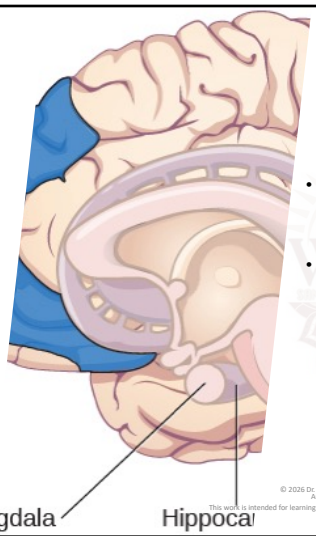
T: Teaching Neuro! Trauma in the brain

45

Teaching Younger Children About Their Brain

- There is a part of our brain that is really smart and playful, kind of like a small dog.
- Sometimes, things happen that make that part of our brain angry, mad, sad, or afraid. It has trouble listening, playing, or learning. We do not feel like ourselves. That little dog starts to get really loud and active.
- That part of your brain tries to get happy and will run around, bark, or jump—whatever it takes to get happy! It loves feeling good!
- Like having a small dog as a pet, you have control. Not only can you train that part of your brain to feel good, but you can feel good too! You have a leash and other training tools we will share.

46



Intellectual Reactions

- Front Part of the Brain versus Reptilian brain
- Challenges with:
  - Concentration
  - Problem Solving
  - Remembering

47

Addressing the Impact on Memory

IN-SESSION WORKSHEET

ACTIVITIES OF DAILY LIVING: MEMORY ACTIVITIES

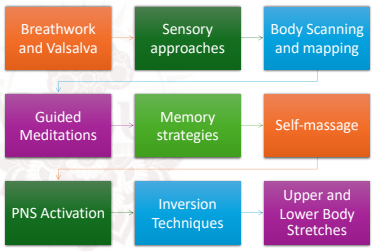
Age Range: All

Objective: To improve working memory, assist in planning to prepare for necessary tasks, and decrease daily stress

Directions: Identify an activity of importance that may be causing the client challenges. For example, perhaps they are struggling to arrive to work on time or to maintain appointments, which is leading to additional dysfunction and stress. Discuss the needed steps to complete that particular activity, and write down each step in sequential order. As a follow-up activity, write the steps out of order and have your client place them in the correct sequence. Here is a sample memory activity for getting to their therapy appointments on time, followed by blank spaces for you to use with your client.

48

Connection to the ACTION from Trauma Interventions



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Activity

Shiatsu Self-Massage

While sitting down, instruct the client to use their thumbs to provide pressure to the soles of the feet, moving in a circular manner. Then have them use their thumbs to provide a pressure massage to each toe on their feet. Instruct them to apply pressure and to massage the webbed spaces of their hands. Next, have them apply pressure to their palms, using their thumb and working down to the wrist area, continuing with gentle pressure. Then have them use their opposite hand to pull the other hand backward to stretch the wrist area. Lastly, invite them to massage their scalp using their fingertips. (Note to provider: If performing self-massage on the feet, ensure the client is comfortable with removing their shoes.)

50

Aromatherapy

Essential Oil	Potential Uses
Sweet orange	Improves mood, increases alertness, and assists with digestion
Lemon	Improves mood and digestive issues
Sandalwood	Has a calming effect and increases focus
Bergamot	Reduces stress and improves dermatological conditions
Rose	Decreases anxiety and enhances mood
Lavender	Decreases stress and has a calming effect
Chamomile	Improves mood and enhances positive emotions
Peppermint	Increases energy levels and improves nausea
Ginger root	Improves appetite and boosts immunity
Mandarin	Decreases anxiety and improves dermatological conditions
Ylang-ylang	Decreases nausea and improves dermatological conditions
Tea tree	Boosts immunity and improves dermatological conditions
Jasmine	Improves mood

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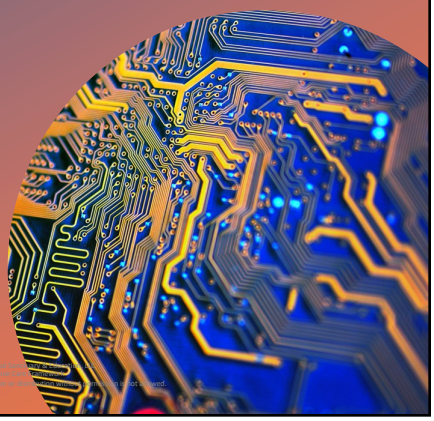
Part 2: ION



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INTEGENERATIONAL FACTORS

Intergenerational trauma, this type of trauma affects generations of a specific group of people and does not require directly experiencing a traumatic event. The hearing of stories, learned behaviors, and subsequent rules that emerge all feed into the well-being of generations that follow. Indeed, there are stories within our history riddled with trauma. Survivors carry that trauma not only in their minds but in their bodies. The cells in their body hold onto the trauma and serve as a history book to be shared with offspring.

53

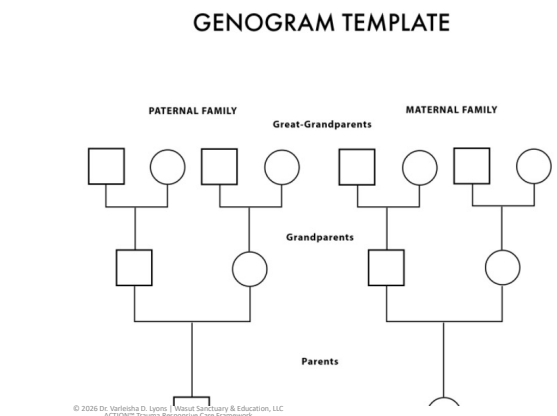
Early Intervention

Recognize Risk factors!

- ☐ Provide skin-to-skin contact during the first days and months of life.
- ☐ Perform a caregiver-provided massage, which has been shown to not only calm the infant but to decrease parental stress and anxiety. Addressing reciprocal regulation prior to such techniques is vital.
- ☐ Participate in shared experiences, such as reading to the child.
- ☐ Ensure consistent play with the child at least once daily.
- ☐ Feed the child based on their needs rather than doing so at scheduled mealtimes.

54

Review Family History: Genogram



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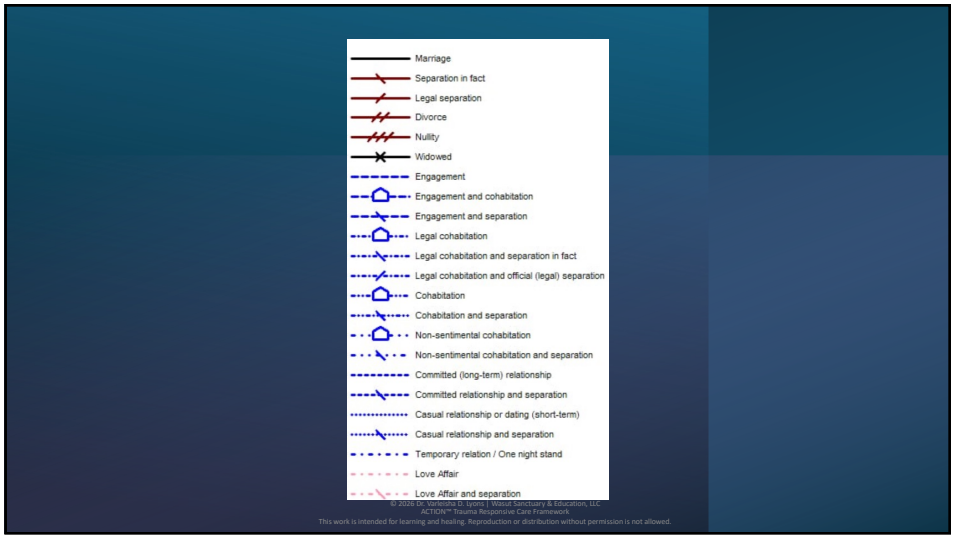

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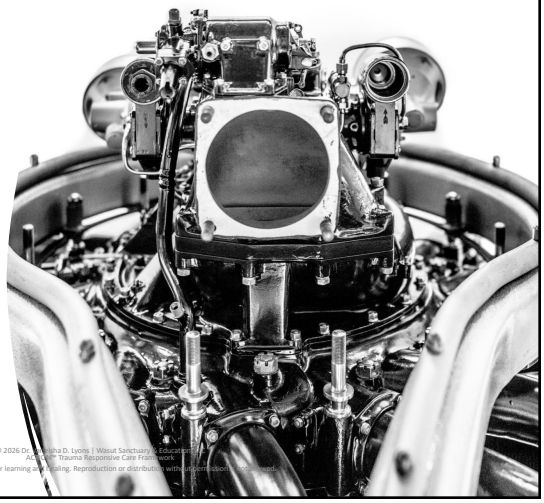
ORGANIZATIONS AND SYSTEMS

RE-TRAUMATIZATION

Nikki Harley



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Emotional Reactions	Temporary feelings of shock, fear, grief, anger, resentment, guilt, shame, helplessness, hopelessness, emotional numbness
Cognitive Reactions	Confusion, disorientation, indecisiveness, worry, shortened attention span, difficulty concentrating, memory loss, unwanted memories, self-blame
Physical Reactions	Tension, fatigue, edginess, difficulty sleeping, bodily aches or pain, starling easily, racing heartbeat, nausea, change in appetite, change in sex drive
Interpersonal Reactions	Feelings of distrust or irritability toward others; conflict, withdrawal, or isolation; feeling rejected or abandoned; being distant, judgmental, or overcontrolling of others

Table 9. Symptoms of Organizational Trauma During a Crisis (Young, Ford, Ruzek, Friedman, & Gusman, 1998)

Collective Trauma

58

Creating Safe Spaces

1. Routinely screen for trauma exposure and related symptoms
2. Use culturally appropriate evidence-based assessment and treatment
3. Make resources available to children, families, and providers on trauma exposure, impact, and treatment
4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
5. Address parent and caregiver trauma and its impacts on the family system
6. Emphasize continuity of care and collaboration across systems
7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress and that increases staff resilience (National Child Traumatic Stress Network, 2016)

59

Sanctuary Space

Breathwork	Breathwork is a general term used to describe any type of therapy that utilizes breathing exercises to improve mental, physical, and spiritual health.
Yoga or mindful movement	The gentle movement associated with yoga helps develop body awareness and reduces over-reactivity to internal sensations. These practices recalibrate the threat detection system from the top down and bottom up, giving individuals with trauma control of their healing.
Mindfulness	Mindfulness activities can mitigate symptoms of PTSD by increasing activity in the prefrontal cortex and hippocampus and toning the amygdala. At its core, mindfulness is simply the basic human ability to be present. A simple mindfulness exercise involves the use of a stethoscope to center on the beauty of our heartbeat. For those who struggle with formal meditation or mindfulness practices, you can simply incorporate mindful awareness into your daily routines.
Gentle music	While music cannot cure PTSD, it has demonstrated positive results in helping to alleviate secondary symptoms of trauma, such as depression and insomnia (Blanaru et al., 2012).
Diet and exercise	Good nutrition and physical activity are important parts of leading a healthy and balanced lifestyle, which can dramatically assist in maintaining overall health and well-being.
Regular sleep	Lack of sleep can lead to insulin resistance, cardiovascular disease, mood swings, poor immune function, hormonal imbalances, and lowered life expectancy. Therefore, get on a regular sleep-wake schedule, and keep a journal by your bedside to capture any last-minute thoughts for the day. You can also perform light stretching or yoga before bed to prepare the body for sleep.

Table 13. Practical Ways for Practitioners to Re-Center

60

NOW is the time to take ACTION

- ☐ **Communication:** We must change our language and personal biases. Instead of ne
our previous training, we must expand our view. Statements such as "He should
to..." or "She just does not want to listen and chooses not to" must exit our voc
Replace that language with statements of empathy, respect, gratitude, and growth
- ☐ **Person first:** We must focus on the person first—not the trauma that happened t
Individuals are resilient and have strengths that supersede trauma. Therefore,
strengths-based and evidence-based strategies in your work. While we have pres
multitude of activities in this book, make sure that your treatment plans are pers
family-centered as well.
- ☐ **Advocacy:** Attending expensive workshops and trainings is a beginning, not an
Reading this book is a start. The real work is in advocacy at every level. Advocate
clients by acknowledging their unique needs and by aligning resources that fit thos
Educate those who work with individuals with trauma. Advocate for resources to
the financial and social impacts of trauma. Establish mentorship programs and
for primary care, childcare, and eldercare providers.
- ☐ **Avoid re-traumatization:** Employ the use of de-escalation techniques versus th
physical restraints. Many of the challenges individuals present with occur when
not feel validated. Start by acknowledging their perspective and by recognizing the
lens of protection through which they view the world. Listen to what they have
Avoid making assumptions and judgments. Ask for and provide clarification by re
and rephrasing statements. Apologize for any misunderstandings or misinterpre
Provide choices rather than dictating rules.
- ☐ **Assess your knowledge of trauma:** Be aware of your personal experiences. As y
with clients, check in to see your level of acute stress. Utilize some of the tec
provided here to keep your mind-body connection healthy.
- ☐ **Establish a team:** Develop trauma stewardship, and establish a team of champion
a unified vision. Identify key individuals to be advocates for the family or clie

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buy-in, and provide mentorship for team members (Fette, Lambdin-Pattavina, & Weaver, 2019).

- ☐ **Promote physical activity:** Performing gross motor activities, such as sports, can improve positive outcomes and behaviors. Support the development of structured activities and access to such programs (Cahill, Egan, & Seber, 2020).
- ☐ **Address organizational trauma:** Complete organizational assessments for trauma-informed care. Develop a mission statement that includes inclusivity; cultural sensitivity and values around safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.
- ☐ **Incorporate a reflective practice:** With any clinical practice, it is necessary to incorporate a reflective practice on the services you provide. Be sure to revisit the events of therapy sessions by maintaining proper notes. Revisit your own thoughts and feelings during the session. Analyze what seemed to work and what did not. Consider other activities and approaches you could have taken to assist in revising treatment plans. In addition, revisit the Practitioner Readiness for Trauma Care Checklist from chapter 1 to make sure you are best supporting your clients' needs.

Now is the time for you to call others to ACTION!

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Community Healing Worksheet

Go to: DrVarleisha.com

https://www.drvarleisha.com/education/resources

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Call your energy back.

Reclaim power from past events and others returning to your center to be whole and sovereign again.

01

Identify External Drains

Recognize that your energy is currently scattered across past events and the needs of others. Pause to acknowledge these connections to reclaim your focus.

02

Call Your Spirit Home

Actively visualize every thread of your power returning to your center. This conscious intent shifts your awareness from external obligations back to yourself.

03

Restore Sovereign Wholeness

Once your threads of energy return settle into your newfound alignment. Accept your state of being complete centered and fully present within your own life.

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What You Carry from Here: Peace • Power

By releasing what no longer serves you you create essential space for the core principles of peace power and purpose allowing you to move forward with newfound intention and clarity.

01

Embracing Peace

Find the deep calm that comes from being unburdened allowing your mind to rest and gain clarity without the weight of past baggage or unnecessary complexity slowing you down.

02

Finding Power

Discover the strength found in true alignment with your values and honesty providing a solid foundation to take decisive action and command your path with authentic conviction.

03

Living Purpose

Move forward with clear intention by defining what truly matters ensuring your daily actions directly contribute to your long-term vision and meaningful goals for your future.

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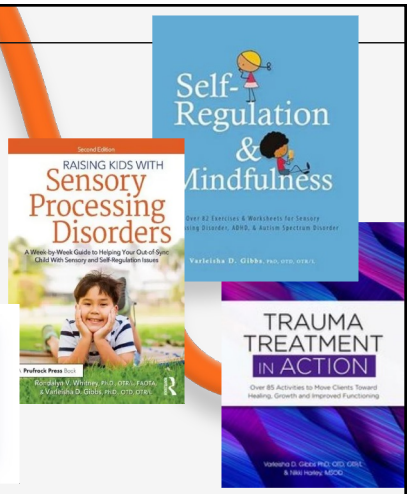
Let's Connect — Stay in Touch for Resources Events and Book Releases

After the talk please visit my website to explore available books sign up for newsletters access free resources and event updates request speaking engagements and connect on social media to continue the conversation and receive future announcements.



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The journey continues. Thank you for your courage.Your power was never lost; it was just waiting for your return.

And Remember YOU don't have to carry it anymore. Doctor's orders from...Dr. Varleisha

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Traumatic Memories: Evidence-Based Approaches to Trauma Processing

Daphne Fatter, Ph.D.
Licensed Psychologist
EMDR CERTIFIED & EMDRIA Approved Consultant

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Presentation Outline

- **What is Trauma Processing?**
  - Nature of Traumatic Memory
  - Latest Proposed Mechanism of Change
- **Decision-Making Factors in Choosing Which Model to Offer**
- **Brief review of Evidenced-based trauma processing models**
  - Contraindications to offer trauma processing
  - How to know when you are making progress

2

2

3

What is Trauma Processing?

- **Desensitization** to traumatic memory + feelings &physical sensations associated with re-experiencing memory.
- **Construction of new meaning** –> a more adaptive view of self, others and traumatic events.
- **Integrating both rational and linguistic processes** to raw unmetabolized fragmented traumatic experiential data.
- Indicator of resolution = **trauma narrative is coherent and fits into larger life narrative.**
  - Survivor can reflect on it and know experientially its in past and can be "lived with". *(Paivio & Pascual-Leone, 2010)*
- **Structured process**: Client can make an informed choice, give informed consent and have a sense of what will happen next in process(within reason).
- **Focus on the hard parts:** Typically focus on aspects of trauma that clients would avoid on their own.

(APA, 2024; Courtois & Ford, 2015)

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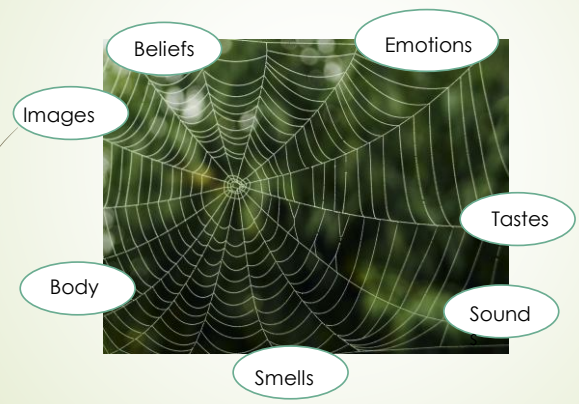
Fragmented Nature of Traumatic Memory

(van der Kolk, 1994; van der Kolk & Fisler, 1995; Fisher, 2017)



2 Signs of Hippocampus Impairment in PTSD:

- Contextual memory is impaired
- Memory of Sensory details is enhanced

(Marlatte et al., 2022)

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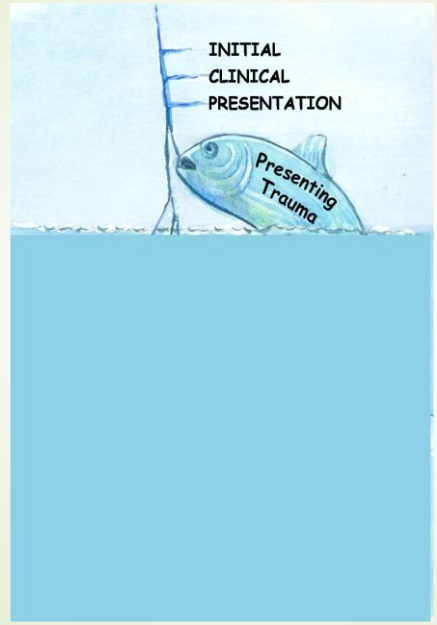

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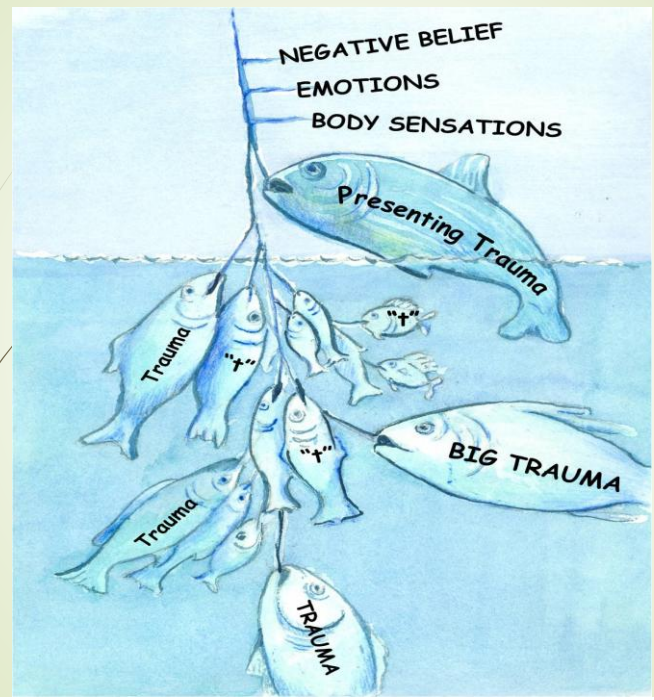

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Traumatic Memories vs Non-traumatic Memories

Adapted from van der Kolk et al., 1994; van der Kolk & Fisler, 1995, Van der Kolk et al., 1996.

Traumatic Memories	Non-traumatic Memories
Stored as raw sensorimotor data in forms of smells, sounds, images, body sensations, emotions.	Integrated into consciousness with sensory experience intact (sensory exp. Is not stored separately).
Not connected to language and not "encoded" with context.	Context to Memory =Meaningful narrative. Beginning, middle and end to story.

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What Helps a Traumatized Brain Heal?

- Make autobiographical more conscious & elaborative (e.g. integrated with sensory data) (Damis, 2022).
- Integrating contextual information of the explicit memory system with sensory-fear related memories in implicit memory (Damis, 2022).
- Learning to tolerate feelings, sensations; Learning to modulate arousal (van der Kolk, 2014):
  - Helping brain learning to be flexible by adapting to situation in present – ability to take in new information and learn from it.
  - Learning to tolerate attending to internal experience.
- Vestibular Input that supports balance at the brain-stem level (critical to have sense of embodiment and interoception) (Kearney & Lanius, 2022).

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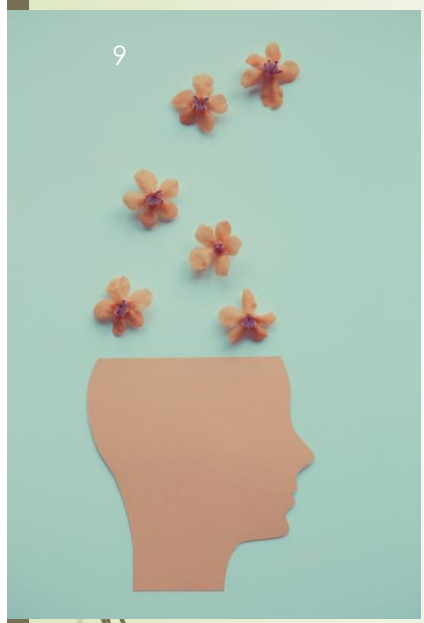

What Occurs During Trauma Reprocessing?

Memory Reconsolidation

- Proposed as a mechanism of change across therapy modalities in psychotherapy (Ecker & Vaz, 2022).
- Proposed as the new frontier of understanding trauma therapy (Usikalua & Unciano, 2025)
- Memory Reconsolidation refers to brain's natural neuroplastic ability to (Ecker, Ticic, & Hulley, 2012; Ecker & Bridges, 2020; Ecker & Vaz, 2022):
  - Pause a patterned response to a stimulus.
  - Make the pattern response susceptible to edit & update to having a new kind of experience.
  - Synapses on a memory network are unstable for approximately a 6 hour window (Bayer et al., 2025). More research is needed.

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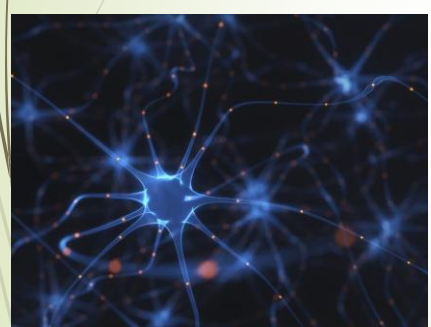
Three Steps to Elicit Memory Reconsolidation

(Ecker, Ticic, & Hulley, 2012; Ecker & Bridges, 2020; Ecker & Vaz, 2022)



1. Activation of Traumatic Memory
2. Experiential data from the present that creates a mismatch
3. Mismatch unlocks synapses in existing memory network so it becomes unstable & malleable; it can be updated & become less distressing

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First Step in Trauma Treatment

- **Informed Consent: THIS IS THE #1 most important initial step in trauma processing!**
  - Treatment plan is based on shared decision-making.
  - Client can stop at any time including mid-session.
  - Know risks and side effects and benefits of procedure.
  - What to expect emotionally (short term increase of symptoms).
  - Plan for how to manage arousal during processing and in between sessions.
  - Procedure for how to stop during processing.

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What If Trauma Exposure is On-Going?

Need to Assess for Oppression-based Trauma

Current DSM PTSD Criteria A may lead to under detection of impact of traumatic experiences related to discrimination (Williams et al., 2018; Williams et al. 2023)

Various experiences of oppression (e.g. racism, sexism, heterosexism, poverty) are associated with PTSD, but typically used trauma assessments don't assess oppression (Holmes et al., 2023).

Assessments:

https://www.mentalhealthdisparities.org/measures.php

Racial Traumas & Oppression-based traumas

Racial traumas (Archer, 2020; Ashley & Libscomb, 2020)

- Oppression-based traumas reinforces powerlessness and helplessness.
- May need to assess if therapy appropriately addressed other oppression-based memories that are not the presenting problem but may re-enforce powerlessness, unworthiness, hopelessness.
- Any rationalization or minimization by therapist = re-victimize client.
- Need to consider how client will manage activation in between sessions.

Hyper-vigilance-necessary to cope with an unsafe world (***do not pathologize***) (Sue, 2010).

- Consider CBT-Based Therapies for Racial Trauma: 12 session CBT protocol working with Racial Trauma (Williams, 2024).

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Evidenced-Based Trauma Processing Models

PTSD Clinical Practice Guideline Across the Globe
APA (2025)
VA/DOD (2023)
International Society of Traumatic Stress Studies (2020)
Phoenix Australia (2022)
NICE (2018; 2025)

"Top Down" Processing Models:

- Prolonged Exposure Therapy (PE)
- Cognitive Processing Therapy (CPT)
- Trauma-focused CBT
- Narrative Exposure Therapy (NET)

"Bottom Up" Processing Models:

- Eye-Movement Desensitization & Reprocessing (EMDR)

- All can be adapted given population and be used for cultural or racial traumas.
- All can be offered in person or via telehealth.

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Implementing Evidenced-based Practice

- Choosing the best treatment choice:
  - Benefits outweigh risks
  - Shared-decision making and respecting client preference, culture and context of client seeking treatment and lived experience of client.
  - On-going monitoring of patient outcomes

Canadian Psychological Association Task Force on Evidence-Based Practice, 2012

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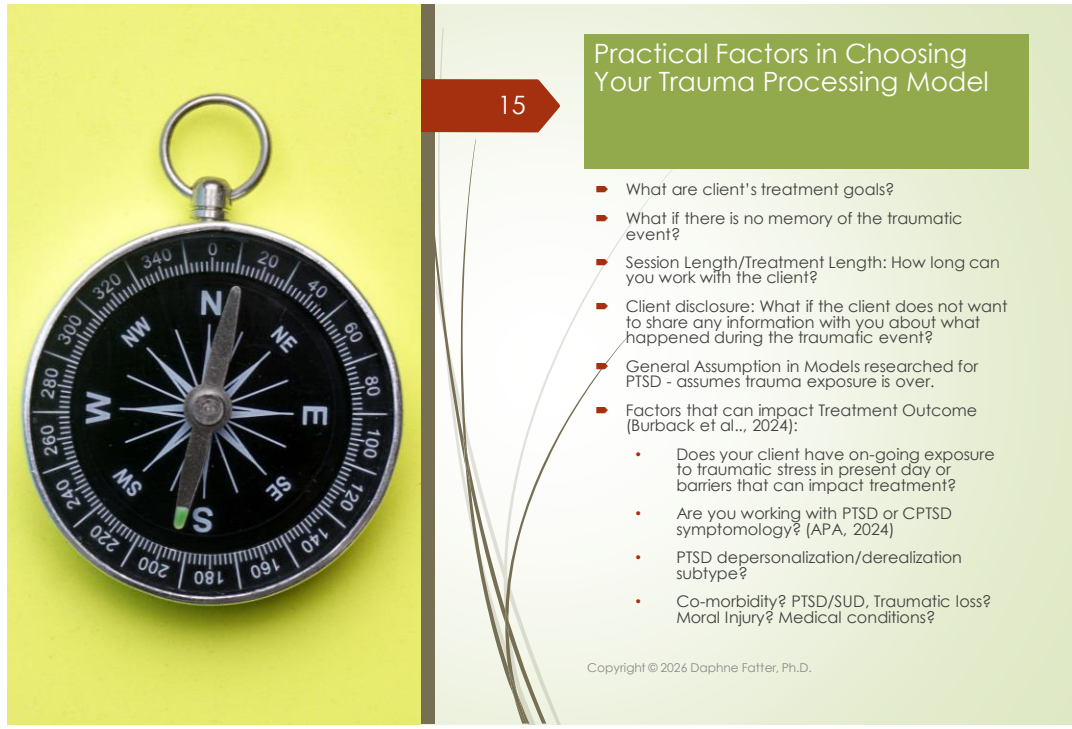

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Decision Making Factors:	PE	CPT	TF CBT	NET	EMDR
Adult Clients Talk or write about trauma	X	X	X (Adapted for adults)	X	
Homework Outside of Session	X (e.g. in vivo exposure)	X	X (e.g. in vivo exposure)		
Address multiple traumas at once				X	X
Only focus on one trauma at a time.	X	X	X		X
Can be used with Children			X	X	X
Can be used with Teens (13-18)	X	X	X	X	X
What if no memory?		Possibly (only CPT, not CPT +A)		Possibly	Possibly
Session Length (all available via telehealth)	10-15 sessions (can be adapted for primary care)	12 sessions	8-25 sessions	6-12 sessions (condensed an be only 3 sessions)	Depends (most research on 12 sessions)

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Prolonged Exposure Therapy

(Foa & Kozak, 1986; Foa, Hembree & Rothbaum, 2019)

Treatment Goal: Diminish fear response via extinction process.

Methodology: Manualized exposure therapy including repeated in vivo and imaginal exposure to reach extinction through habituation (Foa, Hembree & Rothbaum, 2019).

- Repeated in vivo and imaginal exposure aims to support the client in emotionally processing traumatic events including the emotions, thoughts and details of the event.
- Considered a Cognitive Behavioral Therapy – also emerged from exposure therapies for anxiety disorders (confronting situations vs avoiding them) and from Emotional Processing Theory.
- PE Coach Phone App can be used as resource for client throughout treatment.

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Benefits, Limitations, & Risks of PE

Benefits: Strong research on military populations, adults with sexual assault related PTSD, and mixed-trauma PTSD (McLean, & Foa, 2024).

•Modified version of PE for primary care settings (i.e. 4-6 thirty-minute sessions; (Rauch et a., 2017).

Practical Considerations: Is it realistic for your client to follow through with homework? (e.g. in vivo exposure)?

Limitations: Most of the research on PE is on veteran populations.

- Limited research on specifically on marginalized communities (esp limited on LGBTQIA+)
- e.g. culturally adapted PE for Spanish-speaking Latino clients in Puerto Rico, (Vera et al., 2022)

Drop out: rates for PE is between 24-40% (Brown et al., 2022; higher if comorbid severe mental illness)

- •Most participants (Veterans): multiple reasons for dropping out; rates and reasons were similar across delivery modalities (online/in person) (Wells et al., 2022).
- •E.g. scheduling difficulties, stigma, attitudes about therapy and toward mental health providers, perceived worsening of symptoms and/or physical pain, and not liking aspects of PE(Wells et al., 2022).

•Less drop out during PE therapy when participants had two sessions per week (Levinson et al., 2021).

•Important to note that normal drop out rates for PTSD treatment range between 16 % (Lewis et al., 2020) to 21% (Varker et al., 2021).

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Cognitive Processing Therapy

(Resick & Schnicke, 1993; Resick, Monson, & Chard, 2017)

Treatment Goal: Identify and resolve distorted belief systems/stuck points related to why trauma occurred.

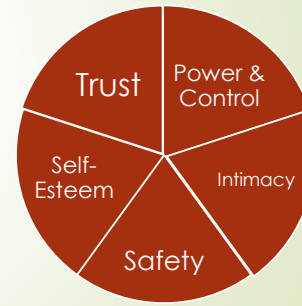
- Enables processing of natural emotions of traumatic event.

Methodology: Address the meaning making of traumatic event enables the processing of natural emotions related to the traumatic event.

The change in the meaning making is active mechanism of change rather than exposure to traumatic memory (Resick et al., 2008).

- CPT +A = 4 writing assignments for homework.
- CPT= 2 writing assignments for homework.

CPT Coach Phone App can be used as resource for client throughout treatment.



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Benefits, Limitations, & Risks of CPT

Benefits: In meta-analysis, CPT and EMDR as having the greatest symptom reduction in short-term and long-term (Yunitri et al., 2023):

In recent systematic review of research, indicates Cognitive Processing Therapy and EMDR as having robust evidence in PTSD treatment (Lewis et al., 2020).

- **Practical Considerations:** Can use CPT in different settings and be adapted for setting (e.g. used active war zones (e.g. Resick et al, 2021).
- Research has shown that clients with high levels of dissociation did better with CPT+A than with CPT, while those with medium and low levels of dissociation did better with CPT (Resick, Suvak, et al., 2012).
- Research has shown that those who had experienced high-frequency child sexual abuse did better with CPT+A (Resick et al., 2014).
- Need for more research on CPT with marginalized populations; scholarship recommends use of CPT principles and culturally responsive adaptations (need for more research) (Collazo et al., 2025).

Side Effects: In looking at side-effects, normal for most participants (67.3%) to experience at least one temporary symptom increase during CPT (only 1.6% of sample continued to have higher symptoms by the end of treatment) (Larsen et al., 2022).

Drop out: High drop out (39.7%) ; when there was a physiological impact from clients emotional reactions in the written trauma narrative, there was a higher drop out (Alpert et al., 2020)

- Higher dropout was predicted by more avoidance (Shayani et al., 2023).

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Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

(Cohen, Mannarino, Deblinger, 2024; Cohen et al., 2012a; Cohen et al. 2012b; Cohen et al., 2006)

- Originally designed for children and teens (3-18) with PTSD and their caregivers .

Goals:

- 1) Child's PTSD symptoms and co-morbid symptoms (e.g. depression, anxiety, behavioral challenges)
- 2) Improve the child client's adaptive functioning.
- **Methodology:** Manualized phase-oriented treatment in which there is a stabilization phase (coping skills are taught & psychoeducation);
  - Exposure & Cognitive process/restricting occurs: Child describes their trauma experience and unhelpful thoughts about trauma can be modified using cognitive strategies;
  - Practice on current or future trauma reminders: Child client practices coping with in vivo trauma reminders.

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Benefits, Limitations, & Risks of TF-CBT

(Cohen, Mannarino, Deblinger, 2024; Cohen et al., 2012a; Cohen et al. 2012b; Cohen et al., 2006)

Benefits: Can use this in individual and in group settings.

- The child client has individual and sessions with caregiver.
- Adaptations for youth with intellectual or developmental disabilities, youth in foster care; youth in residential treatment, sex trafficked children, LGBTQ youth, Black youth, Latino youth, indigenous youth and military children.
- Translated treatment materials in multiple languages.
- Meta-analysis shows TF-CBT effective for children and teens with PTSD and to decrease depression, anxiety, and grief symptoms (Thielemann, et al., 2022).

Limitations: There are many misconceptions about cognitive-based trauma-processing models including TF-CBT – these misconceptions can prevent therapists from providing these models to clients (e.g. myth that cognitive therapies aren't experiential or are only talk therapy) (Murray, et al, 2022).

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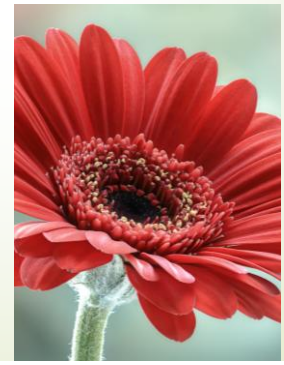
Narrative Exposure Therapy

Treatment Goals:

- 1)decrease fear and avoidance through exposure to traumatic memories in re-telling the story.
- 2) Create a written testimony in chronological order.
- **Methodology:** Brief trauma-focused therapy in which client shares orally their life narrative chronologically including their narrative of the traumatic events.
- Based on principles from exposure therapy, testimony therapy, and cognitive behavioral therapy (Neuner, Schauer, Elbert, & Roth, 2002; Schauer et al., 2011).



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Benefits, Risks & Limitations of NET

(Schauer, Neuner, & Elbert, 2011)

- The therapist records the autobiography contextualizing trauma within whole life and identity; trauma exposure through present moment focuses of trauma responses (Mauriz et al., 2022).
  - The "hot" sensory traumatic details are integrated with "cold" contextual facts (e.g. facts, dates, who/what/when/where).
- **Benefits:** Can offer to clients who are in unstable situationsand/or low-resource settings (does not require skill-learning) (e.g. refugee camps, post-crisis situations, homeless shelters, etc).
  - Can honor client's entire life experience including complex trauma and cumulative impact of trauma.
  - Can integrate genealogy to increase sense of belonging – and re-frame client's narrative beyond immediate family (strategy effective used in indigenous health and among homeless populations in Canada).
  - Can integrate cultural rituals; sensitivity to disaster context; appropriate for marginalized groups.
- Effective across a variety of populations in more than 30 countries in both children and adults and used in community-implanted indigenous populations (e.g. Bedard-Gilligan et al., 2022)
- Decrease in PTSD symptoms among homeless populations (sample in Ottowa, Canada; Edgar et al., 2022).
- Non-professionals can be trained and offer this in cultural context of client.

Limitations: limited amount of therapists are trained in NET – need more access to training.

- Limited research on co-morbidity (most studies on small sample sizes in specific settings/populations).
- Need more research on larger positive impact of NET on one's community and family and in legal cases in human rights advocacy (Cooper, et al., 2019).

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Eye Movement Desensitization & Reprocessing (EMDR)

(Shapiro, 2018)

Treatment Goal: Decrease reactivity to traumatic memory by supporting completion of neurobiological information processing cycle in brain

- Unmetabolized distressing memories are reason for client's cognitive/emotional/somatic reactions

Methodology: Exposure to traumatic memories with bi-lateral stimulation for desensitization, decreasing emotional and somatic reactivity, and changing meaning making.

- Working memory is taxed which helps support memory reconsolidation process (Matthijssen et al., 2021). When there is greater working memory load, desensitization is greater; (de Jongh et al., 2013; Little & Schie, 2019; van Veen et al., 2015).
- Eye movements (and/or other bilateral stimulation) helps clients process memories and make adaptive associations between memory networks by accessing new information into memory network.

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Benefits, Risks & Limitations of EMDR

Benefits: In a systematic review of meta-analysis on PTSD treatments, EMDR and TF CBT were only treatments to show benefit at one month post-treatment (Kip et al., 2025).

- Research supports its effectiveness for telehealth with CPTSD (Bongaerts et al., 2021).
- Over 80 percent of the clients in study no longer met the diagnostic criteria of PTSD and Complex PTSD after EMDR (Bongaerts et al 2022).
- EMDR as rated most cost-effective treatment for PTSD in adults (Mavranezouli, et al, 2020)
- Childhood-related PTSD, depression, dissociation; International multi-site research showed after 12 sessions of EMDR for chronic PTSD, showed treatment gains maintained for 12 months after treatment (Boterhoven et al., 2020; Boterhoven et al., 2021)

- **Treating traumatic memories decrease distress of related memories via EMDR** (Greenwald et al., 2026)
  - The effect was greatest for treating earlier memory first.
- **Practical Considerations: Many different protocols to use; Can use in different settings** (even single incident or short-term use to decrease acute distress).
  - Client does not need to disclose trauma details. Can use translators; Can be adapted for culture trauma or racial-based traumas (e.g. Nickerson, 2023) and there are specific recent events protocols.

Limitations: Client needs to have dual awareness (e.g. client focuses on the worst image of a traumatic memory while also engaging in an external task of eye movements/Bi-Lateral Stimulation) (Shapiro, 2018).

Limited outcomes if client is not taking Propranolol due to it impacting memory reconsolidation (See Steenen et al., 2025 for review regarding EMDR and medications).

Side Effects: Fatigue (Shapiro, 2018).

Drop out: 17.21 % (van Schie & van Veen, 2026)

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When is Trauma Processing Not Appropriate?

Contraindications:

- Substance dependence.
- Current Psychosis.
- Uncontrolled/Unmedicated bipolar disorder.
- Active suicidality or homicidally: Research on CPT (Resick, et al., 2017) and EMDR (Fereidouni et al., 2019; Jamshidi, Rajabi, & Dehghani, 2020; Proudlock & Peris, 2020) suggest you can proceed offering trauma reprocessing if suicidal ideation only).
- If ideation, plan or ideation, plan, intent – need to do crisis counseling

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PTSD & SUD Treatment

(Burback et al., 2024)

- Growing research suggests using an integrated Model:
  - **clients simultaneously receive treatments for PTSD and SUD rather than being sober before beginning in PTSD treatment (Burback, et al. 2024).**
- Increased risk of treatment resistance and dropout
- Increased working memory and neurocognitive deficits
- Poorer coping skills
- Recommended by APA PTSD guidelines (APA, 2025):
  - Trauma-Focused CBT
  - Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (e.g. COPE).

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Three Phases In Trauma Recovery

- **Phase I: Stabilization**
  - Skill building and self-care.
  - Increasing window of tolerance.
- **Phase II: Trauma Processing & Grieving**
- **Phase III: Present Day Life**
  - Now what? Who am I besides a trauma survivor? Relationships, career, moving on

(Courtois & Ford, 2016 developed from -> van der Hart, Brown, & van der Kolk,1989; Herman, 1992a, Herman, 1992b -> developed from Janet 1889/1973's model).

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Benefits, Risks, Limitations of Three Phase Model

Benefits	Limitations/Risks	On-going debate
Rationale: • Client learns coping skills first before reprocessing traumatic memories. • Helps with emotion regulation & support/less risk of decompensation. • Research supports the effectiveness of phase-oriented models for PTSD treatment (APA, 2024; Corrigan, et al., 2020; Coventry, et al., 2020; Dyer & Corrigan, 2021).	• Without addressing safety concerns and client being stable, reprocessing traumatic memories too soon can cause harm (APA, 2024).	• Need more research as some CPTSD clients can benefit from trauma treatment without in depth stabilization phase (APA, 2024; De Jongh et al., 2016; van Vliet, et al., 2024). • Practical consideration: Some clients needs more stabilization first more than others.

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Clinical Decision

- If your client has a complex trauma history, research and clinical practice guidelines currently recommend multi-modal treatment approach (i.e. integrated treatment plan) based on three-phase model (APA, 2025).

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Trauma Processing is Complete When…

- Client isn't overwhelmed by traumatic memory (Courtois & Ford, 2016; APA, 2017).
- PTSD symptom reduction (Canadian Psychological Association, 2012).
  - Monitor symptoms regularly (APA, 2021).
- Decrease emotional and sensorimotor reactivity to traumatic memories:
  - The memory may not become neutral, but no longer experienced as currently a threat.
- Are benefits of processing generalizing to daily life, relationships, mood?
  - Does traumatic event now fit into larger life narrative in coherent way?

Consider Termination When…

- Treatment Goals have been met (APA, 2021)
- Client may focus more on present day, have increased hope/sense of future.
- Apply Therapeutic gains to daily life and future.
- Client has sense of agency to cope with on-going or anticipated future triggers/situations.

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Questions?

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Comparing Biomedical Versus Psychedelic Ketamine Treatments for Depression:

The Importance of Connectedness

Sara Klinkhamer MA, RCC

1:45 - 2:45 PM PST

April 16, 2026

Sunshine Coast Health Centre
A Non-12 Step Mental Health Program

Georgia Strait | WOMENS CLINIC

Presentation Outline

- Introduction to the proposed **Disconnectedness Theory of Depression**
- Depression
- Ketamine
- Ketamine for Depression
- Ketamine-Assisted Psychotherapy (KAP) for Depression
- Connectedness
- Ketamine and Connectedness
- Conclusions and Proposed Research
- Q&A

Introduction

Disconnectedness Theory of Depression

- One among several *Maladies of Disconnection;* any mental health diagnosis or struggle that has a sense of disconnection as part of its etiology including (but not limited to) addiction, PTSD, depression and anxiety.
- Not an official theory (yet) but many experts appear to be proponents (as outlined in Johann Hari's book, Lost Connections)
- Viktor Frankl stated in his widely read book Man's Search for Meaning that:
    - addiction, **depression**, and aggression can only be understood as responses to an existential vacuum; a complete lack of meaning an purpose in life.
        - I argue that a lack of meaning and purpose is synonymous to a lack of a sense of connection.

Depression

- In the DSM-5-TR there are multiple types of depressive disorders, but common features of all of them are “the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual’s capacity to function” (American Psychiatric Association, 2013, p. 155).
- Unfortunately has been treated more and more merely as a brain disease.
- O'Donnell et al. (2017) used data from 3361 responders to a 2014 survey in Canada asking about medication and counselling for people with mood disorders and found that 47.6% were taking medications only, 6.9% were receiving counselling only and 27.3% were engaged in both.
- This is concerning considering that Cuipers et al. (2020) meta-analysis, including 101 studies and 11,910 patients, found conclusive evidence that combining psychotherapy and medication is more effective than either alone.
- Depression is associated with a 20-fold increase risk of suicide (Bachman, 2018)
- The burden on society is estimated in the billions of dollars (Zhdanava et al., 2021)

Depression as Disconnection

Well recognized expert in Loneliness, Cacioppo et al. (2006) conducted two studies, the second longitudinal, to determine “the possible causal role of loneliness and related psychosocial variables in depressive symptoms (and vice versa) in middle-aged to older adults” (p. 142). They concluded that “influences between loneliness and depressive symptoms are reciprocal in middle-aged and older adults” (p. 148).

Fuchs (2013) proposed that:

- The depersonalization in severe depression culminates in… patients no longer sense their own body; taste, smell, even the sense of warmth or pain are missing, everything seems dead. Having lost the background feeling of the body that conveys a sense of connectedness and realness to our experience, the patients may contend that the whole world is empty or does not exist anymore. (pp. 229-230)

- Osler (2021) argues that “depression is a bodily intense experience that leaves the body saturated, thus disrupting effective ways of feeling connected to and together with others” (p. 50)

Ketamine

A Very Versatile Medicine

- First synthesized in 1962, ketamine is an N-methyl-D-aspartate (NMDA) antagonist that has traditionally been used as a dissociative anesthetic (Jansen, 2004).
- Domino (1980) explains, this definition was originally suggested as a way to avoid ketamine being characterized as a psychedelic in a time when psychedelics were being made illegal.
- Ketamine is both water and lipid (fat) soluble, it can be administered many different ways with different doses for various reasons ranging from anesthesia, analgesia, to anti-suicidal and anti-depressive (Gao et al., 2016).
- Esketamine, a derivative of ketamine, has been approved as a nasal spray (Spravado) by the FDA for depression. Interestingly Bahji et al. (2022) did a meta-analysis comparing intranasal esketamine and IV ketamine and found the latter to be more effective in treating depression.

Ketamine

Psychedelic Properties

- At sub-anesthetic doses ketamine induces a dream-like state and has been found to promote brain plasticity similar to psilocybin.
- The psychedelic effects are considered an adverse event in need of mitigating in the bio-medical application of ketamine treatments for depression (typically the IV infusions).
- In contrast, KAP considers these effects an important component of the treatment and conceivably why KAP lasts longer than ketamine administered alone.
- Ketamine has a higher reinforcing effect on the reward system which explains its higher risk of addiction, and has a greater risk for physical harm than classic psychedelics (Nutt et al., 2010).
    - Interestingly, this is not reflected in how it is Scheduled compared to classic psychedelics (but that is another presentation entirely!).

Ketamine for Depression

- Ketamine's antidepressant effects were first discovered in the 1970's but were not studied in humans until later due to concerns that it was an illicit drug (Domino, 1980).
- Berman et al. (2000) reported on the first double-blind placebo-controlled study of IV ketamine for depression. Results reported significant improvement in symptoms within 72 hours.
- Murrough et al. (2013) measured the long-term effects of repeated ketamine infusions for TRD and found the median time to relapse was 18 days with a range of 4 to 83 days.
- After ample research and a decade worth of meta-analyses and systemic reviews a similar pattern emerged with biomedical ketamine treatments for depression showing rapid acting, robust, but unfortunately short-term treatment outcomes (Bahji et al., 2022; Conley et al., 2021; Dean et al., 2021; Jawad et al., 2022; Kishimoto et al., 2016; Marcantoni et al., 2020; Nikolin et al., 2023; Wilkinson et al., 2018).
- Ketamine is clearly a powerful anti-depressant medicine that can be used as a tool to help people, particularly those who are suicidal, get on to regular anti-depressants. However, considering those do not work for everyone, ketamine-assisted psychotherapy (KAP) is worth considering.

Ketamine-Assisted Psychotherapy (KAP) For Depression

- It was ketamine's psychedelic-like effects at lower doses that spurred its use in conjunction with psychotherapy decades ago when the other classic psychedelics were first made illegal (Jansen, 2004).
- There is no set model for KAP, however loosely, it is a psychotherapy that utilizes ketamine as an adjunct and incorporates three (potentially repeating) stages including preparation, medicine session, and integration.
- All KAP practitioners need to consider *set* and *setting*.
- Difference routes and different doses promote different (desired) effects, from talk-therapy enhancer to full transcendent experience which is integrated after.
- The length of the ketamine-assisted session also varies depending on route of administration and dose, with higher doses lasting longer and intravenous administration clearing quicker than other routes.

Ketamine-Assisted Psychotherapy (KAP) For Depression

Research Findings

- Dore et al. (2019) evaluated data from 235 patients across three practices of KAP.
    - ability to titrate the dose to induce a range of effects from a mild trance to a full out-of-body experience, or transformational state as they called it, is advantageous for addressing the "human gamut" (p. 190).
    - clinically significant decreases in the Beck's Depression Inventory (BDI) and the Hamilton Anxiety Scale (HAM-A) with stronger improvement in more symptomatic participants.
- Gomes and Novais (2025) did a systemic review of KAP for TRD with the express purpose of comparing it to biomedical ketamine treatments. The review included 421 participants across eight studies and found that although “preliminary findings are encouraging, the current evidence is insufficient” (p. 14).
- Currently recruiting is underway for an RCT through Mount Sinai (2024) that will compare KAP with ketamine monotherapy for depression for 4-weeks with an 8-week follow-up period. Researchers plan to measure depression severity, wellness, and neurocognitive functioning (Mount Sinai, 2024).

Ketamine-Assisted Psychotherapy (KAP) For Depression

Understanding How it Works

- To try and address the lack of understanding of how KAP works, Sumner et al. (2021) explored the psychedelic like effects of ketamine treatment for people with TRD.
    - Using a crossover design with 32 volunteers they administered an 11-dimension Altered States of Consciousness questionnaire and did two qualitative interviews with the last one 3-weeks post-ketamine.
    - Nearly half of the participants reported a change in how they felt about other people, including an increased feeling of connectedness.
- Recognizing the likelihood of connectedness being a moderating variable in treatment for TRD, Muscat et al. (2022) present a well-reasoned case for the integration of ketamine protocols with trauma and attachment informed psychotherapy for TRD.

Connectedness

- Connectedness is a construct that has many definitions, depending on the author, and depending on the focus, be it connection to self, others, or the world.
- As an overall construct, Hagerty et al. (1993) described the state of connectedness as occurring “when a person is actively involved with another person, object, group, or environment, and that involvement promotes a sense of comfort, well-being, and anxiety-reduction” (p. 293).
    - Hagerty et al. were some of the first to recognize disconnectedness as a transdiagnostic factor in their statement that “the theory of human relatedness evolved initially from the researchers’ clinical observations that psychiatric clients seemed to demonstrate various states of connectedness and disconnectedness” (p. 291).
- Watts et al. (2022) built on this work in their development of the Watts Connectedness Scale (WCS), and defined connectedness as a felt sense of connection to self, others and the world at large.
- KAP synergistically combines psychotherapy and psychedelic medicine, which have both been implicated as promoting a sense of connectedness.

Ketamine and Connectedness

A few highlights from the minimal research done so far:

- From a bio-medical perspective, this is not often considered with Hess et al. (2024) providing an exception. Hess et al. measured the acute effects of ketamine over five points in time following infusion to one week later and concluded that in patients with TRD, ketamine treatment was correlated with pleasure from social situations including helping others.
- Mollaahmetoglu et al. (2021) did a qualitative study also looking at the subjective effects of ketamine infusions paired with either psychotherapy or psychoeducation for alcohol use disorder. They conducted semi-structured interviews with 12 participants and did a thematic analysis that revealed six key themes and one of the common experiences was feelings of connection.
- Cornfield et al. (2024) did a study of ketamine-assisted group couples therapy and found what could be described as an improved sense of connectedness between couples; enhanced conversation, insight, empathy, mood, and lowered defences.

Conclusions and Proposed Research

- Although not an official theory yet, I hope to have made a cogent case for the Disconnectedness Theory of Depression by elucidating the importance of connectedness for our mental health and wellbeing.
- My dissertation research proposal comparing two models of ketamine treatment for depression is currently under review, and if approved I plan to:
    - Do a mixed-methods research design using a confidential online survey
    - The survey will include the PHQ-9 self-report depressive symptom scale, the Watts Connectedness Scale (WCS), and one open-ended question asking participants to “describe your ketamine treatment for depression outcomes; length of symptom remission and what you think helped you maintain any positive outcomes or contributed to negative outcomes” in 50-200 words.
    - I am hypothesizing that people who took part in KAP will have longer-lasting treatment outcomes than those who had ketamine administered alone. In other words, KAP participants will have lower PHQ-9 and higher WCS scores for longer and their written answers will provide evidence for the disconnectedness theory of depression.

Q&A

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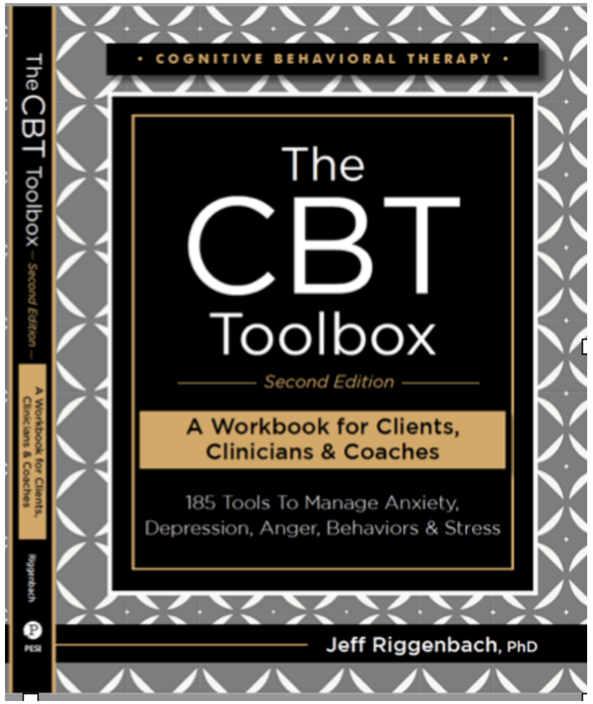
CBT Strategies for Evidence-Based Care



Prepared for:

The Canadian Healing and Treating Trauma Conference

April 16, 2026

Jeff Riggenbach, PhD

clinicaltoolboxset.com

CBT Skills Training for Healing Trauma and Addiction

Session Agenda

- **Introductory Remarks**
- **Transdiagnostic CBT Skills**
- **CBT Skills for Treating Trauma**
- **CBT Skills for Treating Addiction**

CBT Skills Training for Healing Trauma and Addiction

The Cognitive Triangle

CBT Strategies for Evidence-Based Care:

Origins of CBT Model

- Developed by Dr. Aaron Beck, University of Pennsylvania
- Based on principle that thoughts influence feelings

CBT Skills Training for Healing Trauma and Addiction

General Model

Events ➡ Thoughts ➡ Feelings ➡ Actions ➡ Results

CBT Skills Training for Healing Trauma and Addiction

Skill #1: Socialization to Model

Events ➡️ Thoughts ➡️ Feelings ➡️ Actions ➡️ Results

CBT Skills Training for Healing Trauma and Addiction

Type of Interventions

1. Environmental Interventions
2. Behavioral Interventions
3. Cognitive Interventions
4. Pharmacological Interventions

CBT Skills Training for Healing Trauma and Addiction

General Model

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Cognitive Interventions

1. Mindfulness
2. Distraction
3. Cognitive Restructuring

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Mindfulness

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Distraction Techniques

- **“Changing the Channel in your Mind”**

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Identifying and Labelling Cognitive Distortions

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Identifying and Labelling Cognitive Distortions

1. Rationalisation. In an attempt to protect yourself from hurt feelings, you create excuses for events in life that don't go your way or for poor choices you make. We might call these *permission-giving statements* that give ourselves or someone else permission to do something that is in some way unhealthy.

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Identifying and Labelling Cognitive Distortions

2. Overgeneralisation. You categorize different people, places, and entities based on your own experiences with each particular thing. For example, if you have been treated poorly by men in the past, "all men are mean," or if your first wife cheated on you, "all women are unfaithful." By overgeneralizing, you miss out on experiences that don't fit your particular stereotype. This is the distortion on which all of those "isms" (e.g., racism, sexism) are based.

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Identifying and Labelling Cognitive Distortions

3. All or Nothing Thinking - This refers to a tendency to see things in black and white categories with no consideration for gray. You see yourself, others, and often the whole world in only positive or negative extremes rather than considering that each may instead have both positive and negative aspects. For example, if your performance falls short of perfect, you see yourself as a total failure. If you catch yourself using extreme language (best ever, worst, love, hate, always, never), this is a red flag that you may be engaging in all-or-nothing thinking. Extreme thinking leads to intense feelings and an inability to see a "middle ground" perspective or feel proportionate moods.

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Identifying and Labelling Cognitive Distortions

4. Discounting the Positive. You reject positive experiences by insisting that they "don't count" for some reason or another. In this way, you can maintain a negative belief that is contradicted by your everyday experiences. The terms *mental filte*r and *selective abstraction* basically describe the same process.

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Identifying and Labelling Cognitive Distortions

5. Fortune telling. You anticipate that things will turn out badly and feel convinced that your prediction is already an established fact based on your experiences from the past. Predicting a negative outcome before any outcome occurs leads to anxiety.

6. Mind reading. Rather than predicting future events, engaging in this distortion involves predicting that you know what someone else is thinking when in reality you don't. This distortion commonly occurs in communication problems between romantic partners.

9. Magnification. You exaggerate the importance of things, blowing them way out of proportion. Often, this takes the form of fortune telling and/or mind reading to an extreme. This way of thinking may also be referred to as *catastrophizing* or *awfulizing*.

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Identifying and Labelling Cognitive Distortions

7. Should Statements. You place false or unrealistic expectations on yourself or others, thereby setting yourself up to feel angry, guilty, or disappointed. Words and phrases such as *ought to, must, has to, needs to*, and *supposed* to are indicative of "should" thinking.

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Identifying and Labelling Cognitive Distortions

8. Emotional reasoning. You assume that your negative feelings reflect the way things really are. "I feel it, therefore it must be true."

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Identifying and Labelling Cognitive Distortions

10. Personalisation - You see yourself as the cause of some external negative event for which, in fact, you were not primarily responsible. You make something about you that is not about you.

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Identifying Automatic Thoughts

- **Pt language**
- **“What was going through your mind?”**
- **Thought Logs**
- **Journaling**

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Rational Responding - Dealing with Your “Internal Roommate”

CBT Skills Training for Healing Trauma and Addiction

Cognitive Interventions: What are You Telling Yourself?

CBT Skills Training for Healing Trauma and Addiction

Questions/Skills for Cognitive Restructuring

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Addictive-Behavior Disorders

- **Managing Urges and Cravings**
- **Identify and Restructure Permission-Giving Beliefs**
- **Complex Chain Analysis**
- **Addict Letters**

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Addictive-Behavior Disorders

Complex Chain Analysis

CBT Skills Training for Healing Trauma and Addiction

Complex Chain Analysis - Coping Card

CBT Skills Training for Healing Trauma and Addiction

Complex Chain Analysis - Cue Card

CBT Skills Training for Healing Trauma and Addiction

Addict Letters

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma

- Psychoeducation re Neurobiology of Trauma and PTSD
- Identifying Stuck Points and Maintenance Behaviors
- Grounding Exercises,Distraction Techniques and Soothing Strategies
- Restructuring Cognitions Related to Guilt and Shame
- Restructuring Threat-Based Appraisals and Constructing Safety-Related Schemas
- Stimulus Discrimination
- Trauma-Taken Tool
- Silver Lining Technique

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma - Psycho Ed

EXAMPLE OF MAINTENANCE CYCLE

CBT Skills Training for Healing Trauma and Addiction

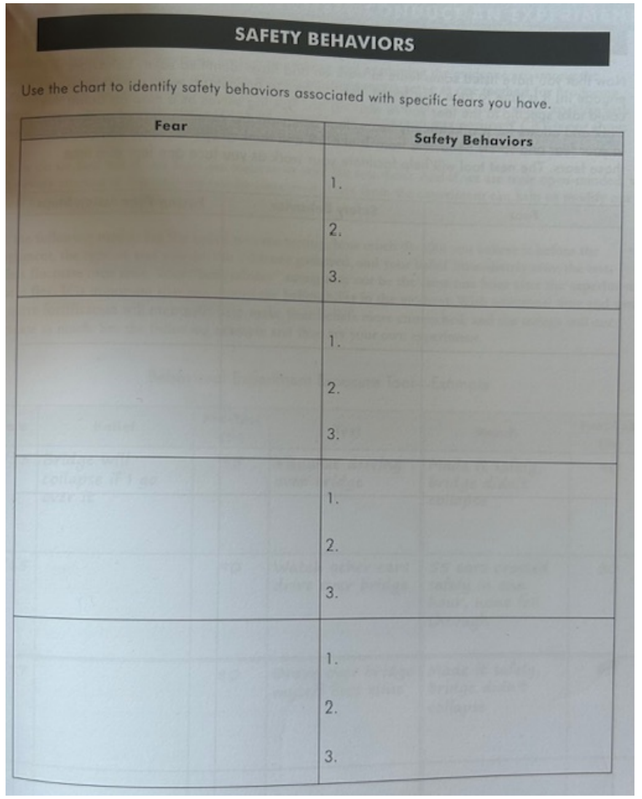
Skills for Treating Trauma - Psych ed

EXAMPLE MINI-CONCEPTUALIZATION

- **Trauma (s):** Raped by cousin 10 yrs older
- **Cognitive Themes:** “I am vulnerable,” “All men are untrustworthy,” “I am Bad”
- **Presenting Sx:** Hypervigilance, flashbacks to 1 rape, avoidance behaviors
- **Maintenance Behaviors** - Thought suppression, not talking to men, female only support groups “bashing” men

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma - Stuck Points



SAFETY BEHAVIORS

Use the chart to identify safety behaviors associated with specific fears you have.

Fear	Safety Behaviors
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.
	1. 2. 3.

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma - Stimulus Discrimination

1. Describe the triggering situation
2. What is THE SAME as when the event happened
3. What is DIFFERENT that when the event happened
4. Amplifying CURRENT Safety Related Cognitions

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma -

Post-Traumatic Growth: Coming out of Hiding and Silencing Shame

- Coming out of hiding and making meaningful connections

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma - Trauma Taken Tool

CBT Skills Training for Healing Trauma and Addiction

Skills for Treating Trauma - Silver Lining Technique

LET'S CONNECT!

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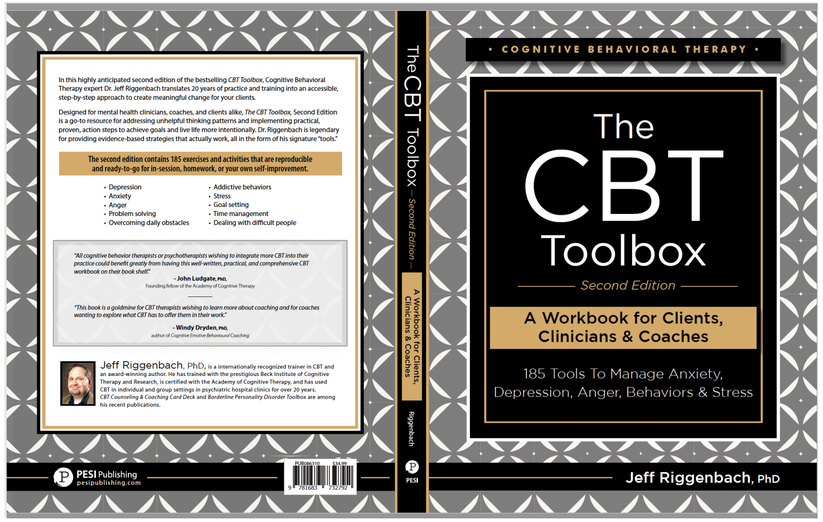
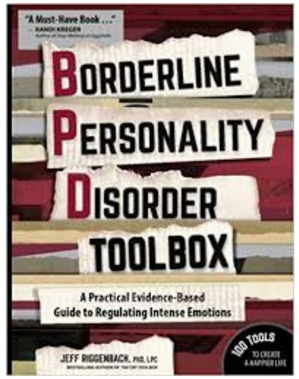
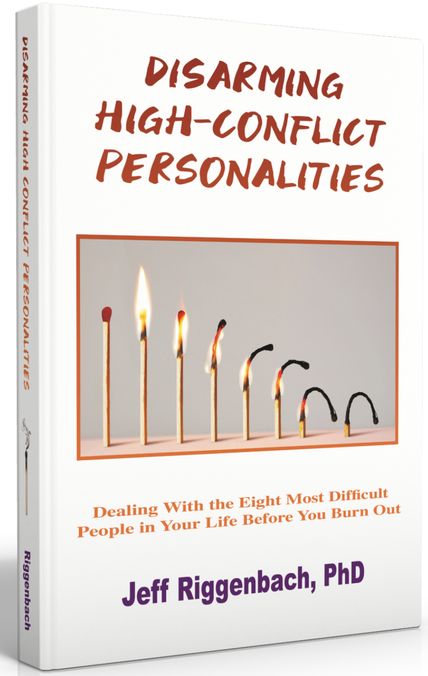
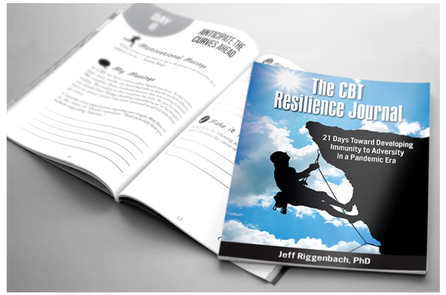
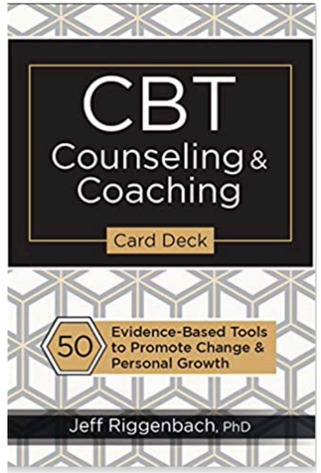
Facebook: DrJeff Riggenbach











Thank you!

The Trauma Toolkit

Thanks For purchasing the trauma Toolkit. I have found throughout my 15 years of doing live trainings, webinar events, and coaching programs, that many people are not interested in the "whole package" of what I am teaching or offering. Thus I decided to provide a series of toolkits that contain only the worksheets, handouts and exercises for particular symptom sets.

Anyone wanting the entire package of areas addressed along with more detailed explanations needs to purchase one of the books in Toolbox series. But I wanted to make something available for those who were just interested in specific problem areas. Also these toolkits provide handouts in a format that can be printed separately and photocopied as many times as you like without copyright issues for use with your clients (which is not always the case with the formatting in some of the other books or e-books).

The contents of this booklet address the area of trauma. It should be noted these exercises are best used as part of treatment with a licensed provider. This is NOT an entire protocol for treating PTSD – but it does offer user-friendly versions of worksheets that can accompany trauma based therapy you offer your clients. I hope you find these worksheets and handouts helpful Should you need additional assistance, feel free to contact us for corresponding video teachings, webinar opportunities, or 1:1 Coaching packages at admin@jeffriggenbach.com

Best,

Jeff

Jeff Riggenbach, PhD
President, CBT Institute of OK
jeffriggenbach.com
clinicaltoolboxset.com

Jeff Riggenbach, PhD

Grounding Tool

I will be honest. I was taught this exercise by a client one time. It worked so well for her, I then began teaching it to others and continues to amaze me how this helps people.

Grounding techniques by the way can be helpful when one is so overwhelmed by emotion that the mind attempts to "go somewhere else." These exercises can be helpful to assist with increasing one's awareness of the present moment. This particular tool asks people to pay attention to their surroundings with heightened focus on their senses. Specifically, identify 5 things you see, 4 things you can touch, 3 things you can hear, 2 things you can smell, and 1 thing you taste. For obvious reasons, I have heard it called the 5-4-3-2-1 exercise. Give it a try.

5 things you can see _____

_____

_____

4 things you can touch _____

_____

_____

3 things you can hear _____

_____

_____

2 things you can smell _____

_____

_____

1 thing you can taste _____

_____

_____

Jeff Riggenbach, PhD

Trauma Timeline Tool

Some victims of trauma have only one incident (one is too many). Others may have 10+. Use this tool to generate a list of traumatic events you have experienced. If you have less than 10, just record however many you have experienced. If you have more than 10, list the *MOST difficult/painful* 10.

Sequence #	Age	Brief Description of Trauma
Example: Trauma #1	9	Assaulted in the parking lot at grocery store (no specifics)
#1		
#2		
#3		
#4		
#5		
#6		
#7		
#8		
#9		
#10		

Hierarchy of Traumatic Events Tool

If you are watching my corresponding video teaching, (and hopefully if you are trauma provider even if you are not), you know that when doing this work it is important to pick one event at a time to process. The next step then in confronting your trauma is to look at your trauma timeline tool and pick the specific event you would like to work with. Unlike many anxiety disorders, where it can be helpful to start with the ***LEAST*** bothersome event, when doing trauma exposure work it is important to start with the ***MOST*** bothersome that a person is willing to confront. Note I did not say what they are ***COMFORTABLE*** confronting. This work is not comfortable. Anyone unwilling to experience discomfort will not do this effectively.

The most important reason for this is that change generalizes down, but does not generalize up. For instance, if you identified 4 traumas in your history and you are willing to work this process with the 3rd most troublesome one, you likely will NOT have to go back and repeat this work with traumas one and two, but you would likely, at some point, need to go back through this work with trauma #4. With that in mind, identify which trauma you would like to work on first. Consult your practitioner you are working with. Give your thoughts as to why you made the choice you did.

_____
_____
_____
_____
_____
_____
_____

"Who You'd Be Today" Tool

Many people think about who they would be without having experienced trauma. In doing this work, however, it can be helpful (although again painful), to thing about HOW YOU ARE DIFFERENT TODAY AS A RESULT OF GOING THROUGH WHAT YOU DID. Consider the following areas, and use the tool to guide you to explore different areas:

My trauma affected my views on each of these areas in the following way(s):

1. Trust _____
   _____
   _____

2. Intimacy _____
   _____
   _____

3. Vulnerability _____
   _____
   _____

4. Competence _____
   _____
   _____

5. Power _____
   _____
   _____

Other _____
_____
_____
_____

“Who I Was” Tool

Use this tool to “piggy back” off of the previous one. What positives did you have BEFORE you went through the traumatic event? You may use these later ☺

Pre-Trauma Positives

1.

2.

3.

4.

5

Trauma Taken Tool

Thinking about trauma is painful. And in doing so, many are only able to see how it devastated their lives. However, people who recover from a traumatic events are able to recognize what the trauma DID take from them and genuinely grieve those losses, but also see what the trauma DID NOT take from them. Use this tool to help facilitate that process.

What the Trauma **DID TAKE** from Me	What the Trauma **DID NOT** Take from Me

I can use the strengths, areas of expertise, and giftedness the trauma did NOT take from me today to reclaim my former self in the following ways…

“My Story”

Telling your story is the most difficult, but the most empowering part of the “overcoming” process. Be sure you have found a safe place to do this. Then write it out, step by step, per the instructions provided in the video. Remember, leave no detail out. The share it with your “safe person”

Jeff Riggenbach, PhD

Trauma Thought Log

Trauma-Related Thoughts	Rational Responses

Silver Lining Tool

Given a choice, nobody would choose to go through a traumatic experience. But one of the attributes of resilient people who overcome traumatic experiences is their ability to as themselves the following question:

- Given that I did experience what I did, what unique opportunity, ministry, service am I now "uniquely qualified" to offer the world that I was not before going through the events related to my trauma?

That "silver lining" motivates many to not only survive, but thrive!

Spend some time reflecting on what your "silver lining" might be and record your thoughts in the area provided.

Nightmare Rescript Tool

Nightmares are essentially stories we tell ourselves during our sleep about past life events. Sometimes either changing the *content* of our nightmares or the meaning associated with the nightmare can curb recurring nightmares. I have had clients who were having recurring nightmares never have one again For others the result is not as dramatic, but this tool has been helpful for many people suffering from recurring nightmares.

Write out your recurring nightmare. If it is too long, write out the most troubling aspect of the nightmare.

_____

_____

_____

_____

_____

_____

How did you feel emotionally?

_____

What bodily sensations did you notice?

_____

_____

How would you like to feel instead? _____

How would your dream/nightmare have to change in order for you to feel those feelings? Write re-write your nightmare with this ending.

_____

_____

_____

_____

_____

_____

The Addictions Toolkit

Thanks for purchasing the Addictions Toolkit. I have found throughout my 15 years of doing live trainings, webinar events, and coaching programs, that many people are not interested in the "whole package" of what I am teaching or offering. Thus I decided to provide a series of toolkits that contain only the worksheets, handouts and exercises for particular symptom sets.

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The contents of this booklet address the areas of full blown addictions as well as other bad habits. I hope you find these worksheets and handouts helpful for working with your clients. Should you need additional assistance, feel free to contact us for corresponding video teachings, webinar opportunities, or 1:1 Coaching packages at admin@jeffriggenbach.com

Best,

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TOOL # 1 Identification of Triggers

People engage in “impulsive” and addictive behaviors for different reasons. The term “addictive” in in quotation marks because there is still some debate regarding its use. Brain scans to differ in some significant ways from people who are addicted to substances, for instance, vs people who suffer from “gambling addiction Treatment approaches however are fairly similar. They all follow an impulse control model. Some motives for engaging in addictive or other impulsive behaviors include: a quick “feel good” response, the need to stay in control, and an attempt to regulate shame based emotions Understanding these can sometimes provide insight into triggers. Use the following tool to answer questions that may guide you in identifying some of your triggers.

The last time I acted in an impulsive manner was _____

_____

_____

I did it in response to

_____

_____

_____

Themes in time I have acted impulsively include

_____

_____

_____

Emotions I notice I feel before engaging in my addictive behaviors or bad habits include

_____

_____

_____

_

People I notice I am around when or just before engaging in my addictive behaviors or bad habits include:

_____

_____

_____

My Triggers for Addictive Behaviors/Bad Habits

1. _____

2. _____

3. _____

4. _____

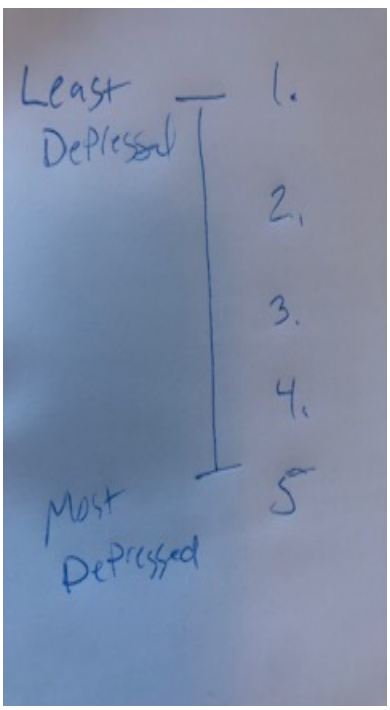
5. _____

Tool # 2 Identification of Feelings

Emotions have been described by some in terms of being in discrete "feelings families" based upon different *types* of emotional state human beings experience. Unlike previous tools, Impulsive or addictive behaviors can be influenced by a number of different feelings families. Pick from the following emotions that commonly precipitate addictive behaviors or bad habits, or come up with your own words. Then list them on the continuum below with "1" being the least agitated and "5" being the most intense agitation for you.

Unsettled	**Urge**	**Agitated**	**Powerless**
Craving	**Stressed**	**Discouraged**	**Shame**

See below for graphic



1. _____

2. _____

3. _____

4. _____

5. _____

- It should also be noted that we can experience any of these feelings with varying ranges of intensity. When doing chain analysis, it can be helpful to rate the intensity of a feeling in response to a given situation and thoughts in the moment.

Tool # 3 Identification of Addiction-Related Thoughts

The following questions are designed to help you identify your distorted thoughts specifically related to depression. Remember, these thoughts will often be related to negativity, loss, or discounting some positive aspect of self, others, or the world.

When _____happens, and I feel _____,

(Trigger) (Emotion)

What kinds of things am I often telling myself?

If I were in a cartoon, what would the bubble above my head be saying?
Thought bubble?

If there were a tape recorder in my head recording my every thought, what would it be saying when someone pushed "play?"

Use the tool 1.3 to log the thoughts you identify to be going along with your depression related feelings

Thoughts/Feelings Awareness Log - Example

Example

I felt ...	...because I thought...
Vengeful	It's OK to act spiteful because she made me mad.
Sense of urgency	I have to have that item now.
Unmotivated	It's OK to binge, because I felt upset–food will soothe me, and nothing else will help. I can't stand feeling this way.

Thoughts/Feelings Awareness Log

I felt ...	...Because I Thought...

Tool # 4 Unhealthy "Go To" Coping Skills

Most people develop a set of standard "go-to" coping skills when they feel that need for a quick "feel good." Perhaps you have heard the term *autopilot*, referring to just falling back on the same old skills that in some way feel comfortable but often don't help. Usually, these behaviors "worked" in the past but no longer work in the present. Also, some may continue to work in the short term but be making problems worse in the long term. A few such examples people turn to include alcohol, drugs, promiscuous sex, spending, or shopping. Before figuring out healthy skills to use when these urges creep up, it is often useful to generate a list of what we have been trying that has *not* been working. In the case of this chapter, this simply means evaluating and identifying behaviors that could be addictive, impulsive, or constitute bad habits for you.

Identifying My Addictions Tool

The last time I engaged in an addictive, impulsive or habitual behavior was _____
_____

I believe the behavior has become an addiction or bad habit because _____
_____

The behavior, bad habit or addiction I will be targeting is _____
_____

I believe the habit or addiction first started _____

I engage in the behavior _____
(how often)

The place I usually do it is _____

The emotions I feel frequently prior to engaging in the behavior are _____
_____

The people in my life that have the power to trigger me to an emotional state I may be tempted to engage in these behaviors are _____
_____

Other circumstances often present when I engage in the behavior include _____
_____

Tool # 5 Awareness of Consequences

All unhealthy coping skills, including bad habits and addictions, "work" in the short term. We get something out of them, or we would not continue to do them. However, that is the main criteria used in this book for determining to what extent a behavior "healthy" vs "unhealthy" – the degree to which it causes long term consequences, or what the DSM calls *functional impairment.* As you do this tool, ask yourself how the habit has hurt you physically, emotionally, relationally, spiritually, financially, and occupationally. Glance at the example, then list all the habits or addictions you can think of that you struggle with and present or future consequences of those.

Awareness of Consequences Log – Example

Autopilot Coping Skill (habit)	Current or Past Negative Consequences
Alcohol	*$100/month I could put towards rent or education* *Pisses off my partner* *Parents threaten to cut me off*
Pot	Suspended from football team Affected my scholarship offers $ Grades dropped 4 straight years

Your Awareness of Consequences Log

Autopilot Coping Skill (habit)	Current or Past Negative Consequences

Tool # 6 CBT Chain Analysis

Here is where the rubber meets the road. This is where you get to put it all together. Now that you have the skills covered in the tools above, identify a specific situation/trigger in your life that precipitated a specific episode of engaging in your habit behavior. See if you can identify specific thoughts that you had, feelings that you experienced, choices that you made, and consequences of those choices. Use the following tool to help you follow the sequence to analyze your response in a particular episode. Also, when you identify your feelings, rate the feeling on a scale of 0-10 with zero being "none" and 10 being "extreme". For instance if you identify "irritation" and it was as irritated as you have ever felt, your entry would look like: irritation – 10."

Once you have done enough of these, you will start to be able to identify some patterns, which can facilitate some powerful insight for recovery.

Chain Analysis

Event (Trigger)	Rationalizing Thought	Feelings	Habit Behavior	Results

Tool # 7: Desired Results

This one in pretty simple. When you look at the undesired consequences of choices in your usage or other habit behavior, what are some alternative outcomes you would have liked to have had? What desired results do you have for your future.

Results I would like to create in my future in similar situations:

1. _____

2. _____

3. _____

4. _____

5. _____

Tool # 8: New Coping Skills

Now that you know how you would like these habit trigger situations to end, how might you need to change your behavior in response to that trigger to create your desired result? This tool offers you an opportunity to brainstorm a "menu of general options" you can choose from to use to manage future cravings and urges. Write as many coping skills as you can think of here. The cards in a later tool will be situation specific.

Some coping skills I could try next time I am tempted to engage in one of my habit behaviors:

1. _____

2. _____

3. _____

4. _____

5. _____

Tool # 9: Challenging Addiction/Habit - Related Thoughts

In the same way that recognizing but continuing to engage in unhealthy behaviors rarely gets us far along in recovery, recognizing distorted thoughts but not changing them also keeps us stuck. Here is your opportunity to identify specific permission giving thoughts (the excuses you tell yourself) and generate a list of challenges. This often consists of reminding yourself why the behavior is not ok. Review the example and try your own!

Thought Log - Example

Permission-Giving Thoughts	Rational Responses
It's OK to act spiteful because she upset me.	It's not OK. I am working toward building healthy relationships. I am angry, but acting this way would only hurt me and sabotage my goals.
I have to have that item now.	I want it, but I don't need it. We need $ for prescriptions. We can't afford it. I can walk away.
It's OK to binge eat because I felt upset. Food will soothe, me and nothing else will help. I can't stand to feel this way.	It's not OK to binge for any reason. I can now tolerate intense emotions better than before. I'll hate myself afterward. I'll feel fat. I'll feel depressed. I have other skills I can use.

Thought Log

Rationalization/Permission-Giving Thoughts	Rational Responses

Tool # 10 : Re-examining Urges

Now that you have attempted to challenge your thoughts, reflect for a few minutes on your feelings. Ask yourself if the urges or cravings have diminished in any way? have If so, how much has the intensity changed before vs after the new thinking. Are you feeling any new feelings completely? Which rational responses seemed to have the most effect on your feelings? The least? Use to tool provided to examine the differences and then record your observations,

Automatic Thoughts	Initial Feelings	Intensity
Rational Responses	**Current Feelings**	**Intensity**

My Observations: _____

_____

_____

Tool #11: Chain Analysis with Rational Responses

Finally, use the chain analysis tool with your rational responses to see the impact that your new thinking had on your feelings. Be sure to include the new feelings intensity ratings. For instance you may still be experiencing sadness, but it is important to recognize that if after your initial automatic thoughts your sadness was a "10" and after your rational responses your sadness was a "6" that the new thinking made an impact. Don't make the mistake many depressed individuals with black and white thinking make by saying "I was sad then and I am sad now – this didn't do anything." See how changed thinking, feeling, and behavior affected current results and could affect future results.

Mini-Chain/Challenges

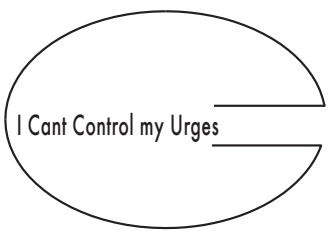
EVENT	AUTOMATIC THOUGHTS	FEELINGS	ACTIONS	RESULTS
	RATIONAL RESPONSES	**FEELINGS**	**ACTIONS**	**RESULTS**

Tool # 13: Identifying Alternate Healthy Beliefs

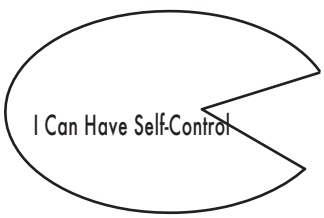
Remember, beliefs come in pairs. I teach in my workshops and conferences that it is kind of like a sheet of paper. It inherently has a front and a back side. For each unhealthy belief you identified, you also have an alternate opposite belief. Tool #13 asks you to formulate in your own words what you would you're your opposite belief. Then, similar to how you rated intensity of emotions above, use percentages to rate how much you believe your core belief vs how much you believe your alternate belief. These will be used in a later tool to subjectively measure your belief change as you move forward in your recovery. Be mindful that while other core beliefs may be present, an initial belief to target with addictions and bad habits is the insufficient self-control belief. Use the tool below to write out your unhealthy belief, alternate healthy belief, and baseline believability ratings for each. The next tool will help you use these as a starting place to subjectively measure your ongoing belief change.

Example

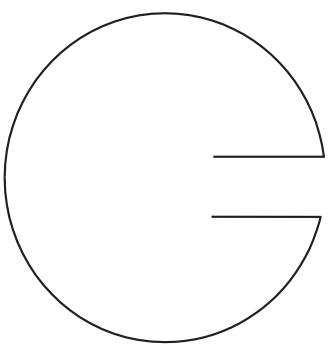
UNHEALTHY

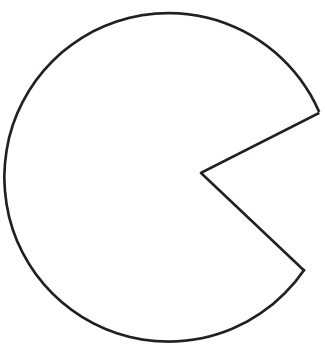


HEALTHY



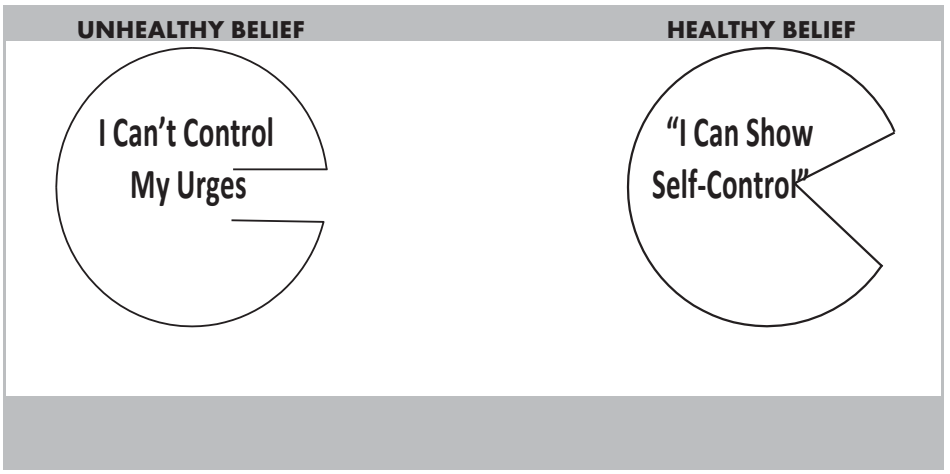
My Beliefs





Believability Ratings

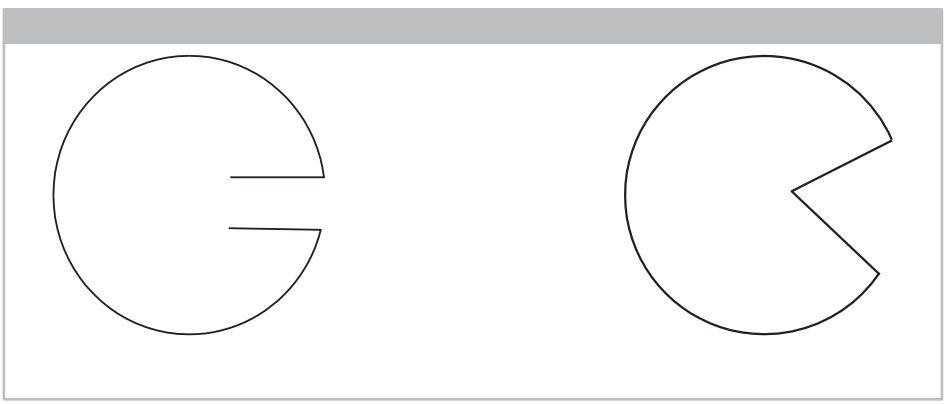
Example



80%
STRENGTH _____%

20%
STRENGTH _____%

Rating the Strength of My Beliefs



STRENGTH _____%

STRENGTH _____%

Tool #14: Identifying Components of the Beliefs

As has been addressed, beliefs are formulated based upon the meaning we assign to events or experiences in life. These experiences then become "evidence" to support our beliefs. "Evidence" is in quotation marks, because certain people "count" data as "evidence" that others do not. It is understandable to many people that those who live through different types of life experiences are more likely to develop different beliefs. Although every person's life experiences are in some ways unique, another phenomenon practitioners encounter is that some clients have strikingly similar backgrounds but develop different types of beliefs. The explanation is that even though the experiences themselves may have been similar, the meaning assigned to them was quite different.

Leslie Sokol with The Beck Institute of Cognitive Therapy and Research shares a visual for a belief that compares it to a table. In the same way that a table top needs legs to support it, beliefs also need supporting structures. Experiences in life serve as "evidence" to support these beliefs, based upon the meaning that is attributed to them. So the "Legs of the Evidence one uses to support a belief, in this tool, is represented by the "legs of the table."

This visual can be used in different ways. One way involves looking back at past experiences in life to examine the conclusions we came to in formulating the beliefs we currently have. A different exercise involves looking at the alternate beliefs we are aiming to construct and examining evidence as we move forward in life. Evidence log tools can be vital for recording this evidence as we increase our awareness and pay attention to it. However *WHAT* we log is vital and relates to how we assign meaning.

For instance in a previous example, a belief combination of "worthless" vs "have value" was used. What is valuable to one person is not necessarily valuable to another. This is the reason this components of the belief tool is so important. Failing to identify what "counts" for you will lead to you logging evidence that makes no meaningful difference for you and will hinder your

process. Use the table visual to identify your components of your beliefs. These will help you know very specifically what types of experiences will be necessary to create and/or expose yourself to moving forward and what kinds of things to look for as you use your evidence logs to construct your new belief.

The first part of this tool facilitates thinking historically to analyze how current beliefs might have been formed. The second part asks you to identify the “legs” as you do your work moving forward.

Historical Evidence

The following questions may be helpful in reflecting back on different periods of life to uncover some of the experiences you counted as evidence to support your belief (legs to hold up your table). You may need assistance from your therapist to get the most out of this tool.

The first time I ever remember feeling _____[belief]

was

_____

__ The people in my life who influenced me to feel that way were:

Family members _____
_____

Friends/Peers _____

_____

Other significant people _____
_____

Experiences during my elementary school years _____
_____
_____

Experiences during my junior high years _____
_____
_____

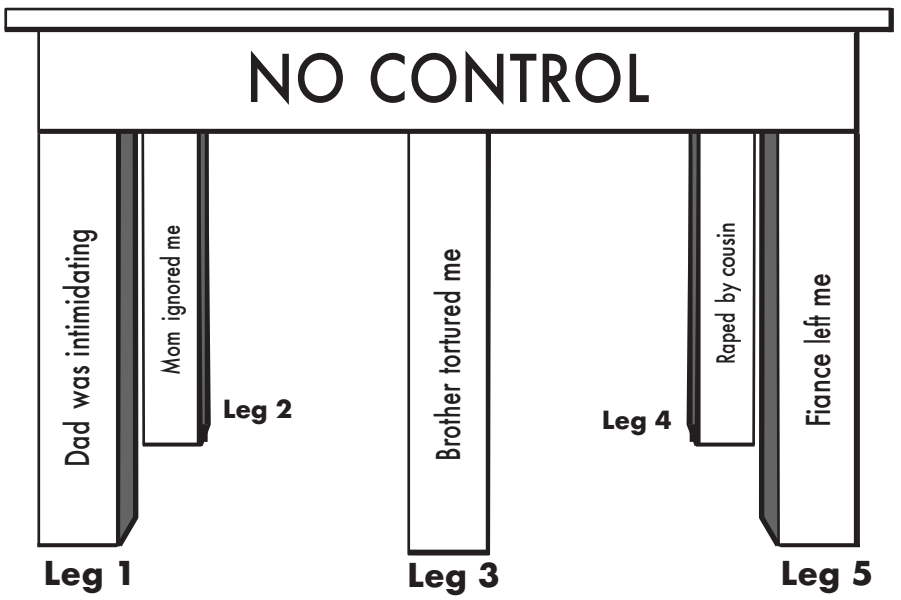
Experiences during my high school years _____
_____
_____

Experiences during my college/young adult years _____
_____
_____

Significant experiences since then _____
_____
_____

Use the exercise on the previous page to try to insert some of the "evidence" from your past that you have "counted" to support your unhealthy/belief. Consult the example, and then try your own historical "legs of the table" exercise.

Legs of Table – Unhealthy Belief Example



Evidence that I couldn't control my impulses:

Leg 1: I couldn't stand pain of divorce

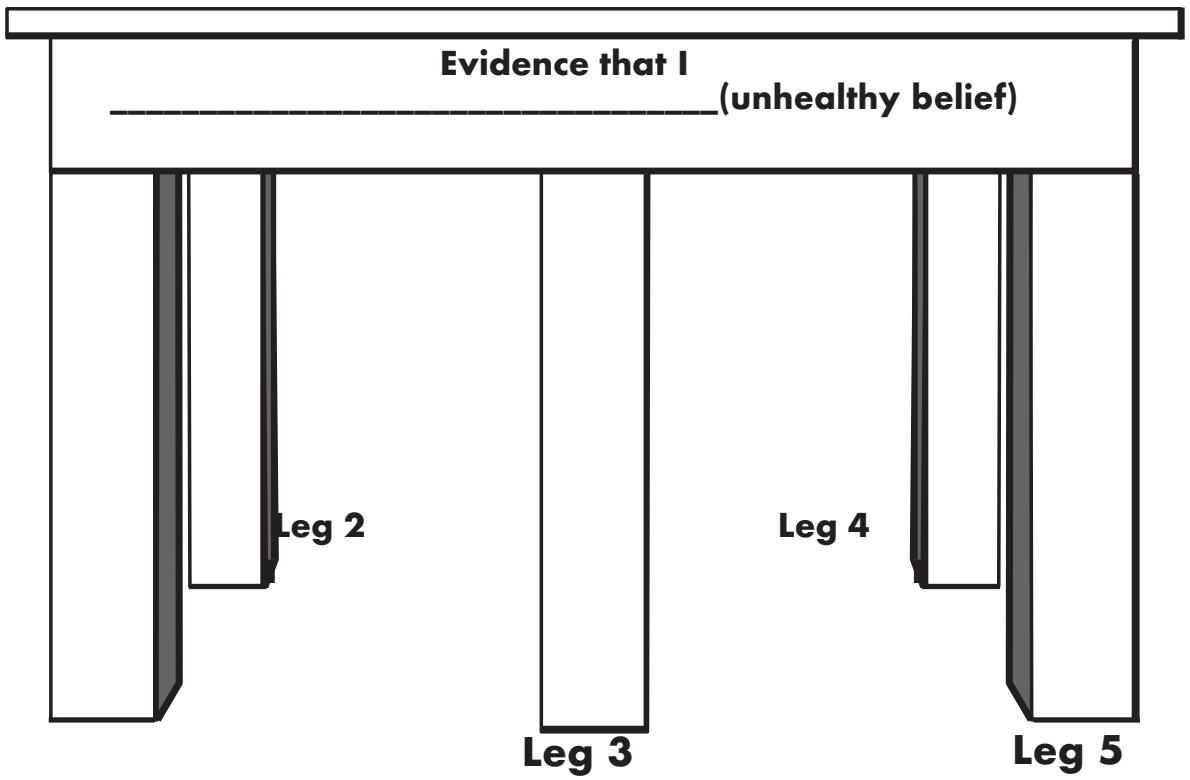
Leg 2: Felt I had to drink.

Leg 3: Peer pressured to smoke pot.

Leg 4: Felt need to be loved.

Leg 5: Had sex at first opportunity.

Legs of Table – Unhealthy Belief



Evidence I Could Not Control My Impulses

Leg 1:

Leg 2:

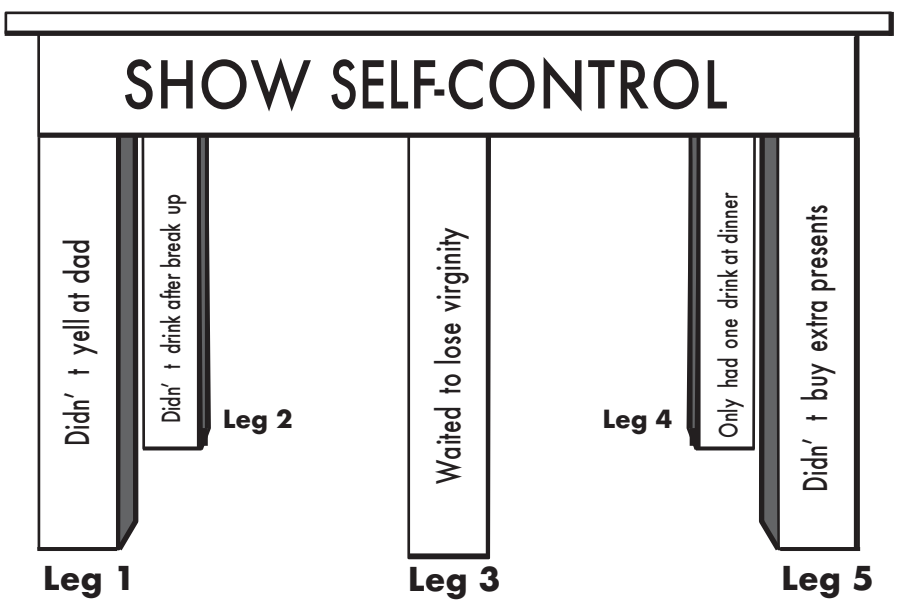
Leg 3:

Leg 4:

Leg 5:

Because of how our filters are set up, we often notice instances that support unhealthy beliefs more than we notice experiences that may support our opposite, healthy beliefs. But almost always that "evidence" exists as well. One valuable tool involves forcing ourselves to look back over those very same periods of life purposefully looking to see the evidence that supports our healthy beliefs. Many people often use family members or friends who were around them during each period of life to help them "notice" such evidence. Even if they share things they see as "counting" that you don't think "should count" write them down anyway for now. Consider the example, and then try your own.

Legs of Table – Healthy Belief Example



Evidence that I can show self-control:

Leg 1: Was tempted to yell at my dad when he grounded me in the 9th grade but didn't

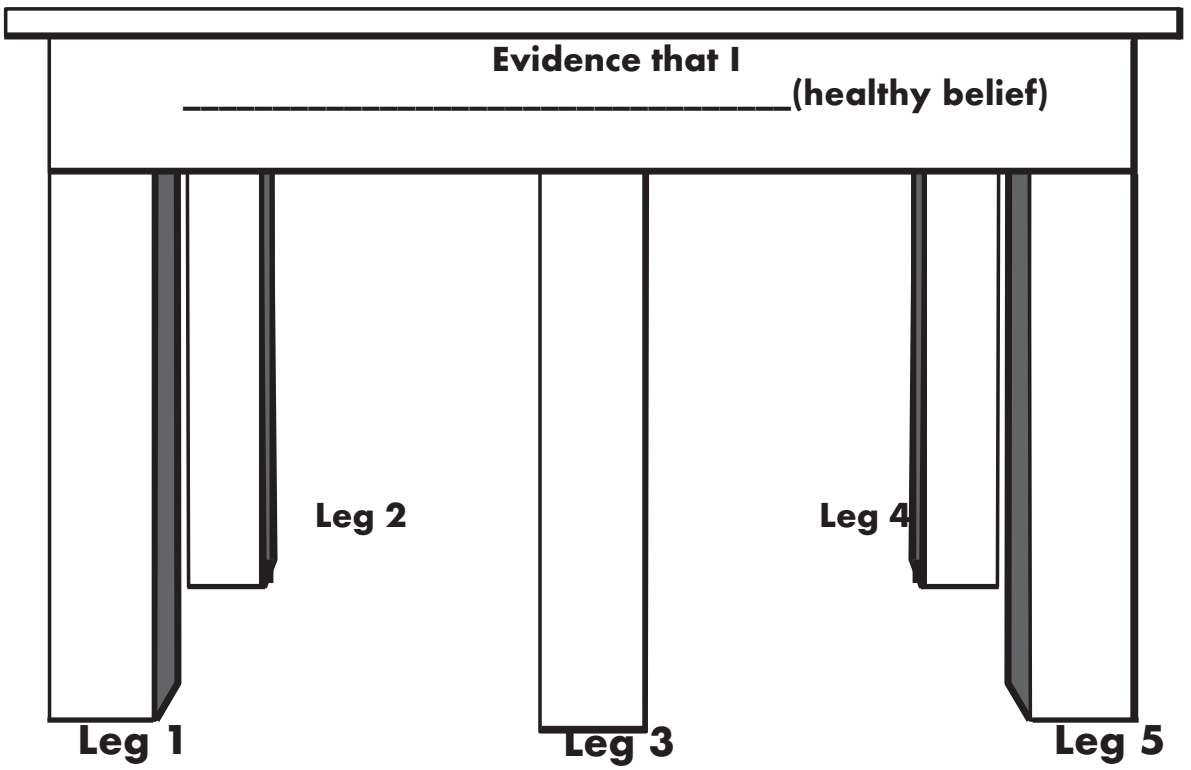
Leg 2: Wanted to drink until I was numb when first boyfriend broke up with me but didn't

Leg 3: Had chance to lose my virginity at age 16 but decided not to and said no

Leg 4: Tempted to buy extra presents for Christmas but didn't

Leg 5: Only had one margarita with Mexican food

Legs of Table – Healthy Belief



Leg 1: Was tempted to yell at my dad when he grounded me in the 9th grade but didn't

Leg 2: Wanted to drink until I was numb when first boyfriend broke up with me but didn't

Leg 3: Had chance to lose my virginity at age 16 but decided not to and said no

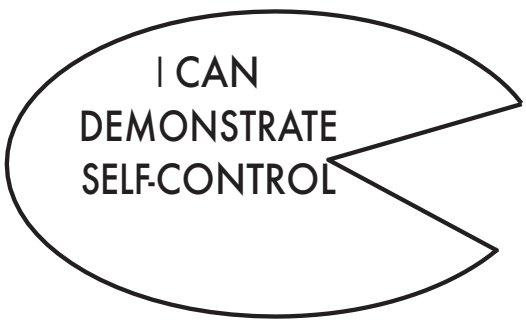
Leg 4: Tempted to buy extra presents for Christmas but didn't

Leg 5: Only had one margarita with Mexican food

Tool #15: Evidence Logs

Now that you have identified your "legs of the table" for the belief you are working on, you know very specifically what to look for. Purposefully pay attention to experiences in life that support the healthy belief you are constructing. This may involve noticing evidence that was always there you didn't notice before due to the dominant role of your old belief filtering your thinking away from it. You may also work with your practitioner on exercises that actually create new evidence that wasn't there before. Purposefully paying attention to does not mean making it up. You have to be intellectually honest. If it legitimately isn't there, it doesn't count. Just remember that due to your filter you will be prone to discount things that really do support the belief, so having an open mind is vital.

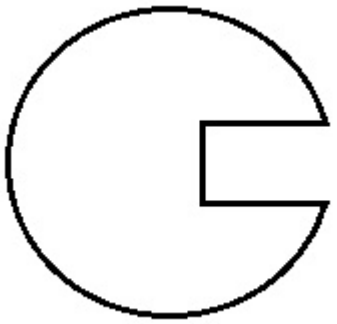
Use the following evidence log tool to record evidence over time that supports your new belief (with addictions and bad habits, fist on the agenda is believing that you can have self-control over your urges. Your tool allows your to rate the believability in the moment as uou log each piece to evidence to track if your belief if moving the right directions over time..



Date	Evidence
12/12	Drank no alcohol at Christmas Party
12/13	Only had one margarita with Mexican food
12/16	Stayed within budget at mall
12/20	Tempted to buy extra presents but didn't
12/24	Chose not to eat pie at Christmas dinner

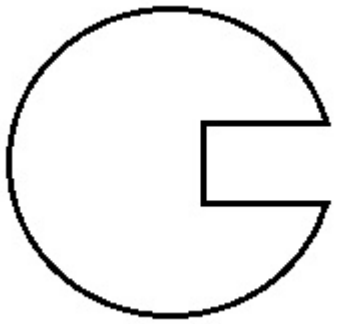
Evidence Log

Unhealthy Belief: _____



Starting Belief %: _____

Healthy Belief: _____



Starting Belief %: _____

Date	Evidence Supporting Healthy Belief	Belief %

Conclusions: _____

_____

Tool # 16: Pros and Cons

There are many versions of "Pros and Cons" exercises available to the public. This one was prepared by Jonathan von Breton, LCMHC, LCDP, who is a Professional Advisor to SMART Recovery and is reprinted with permission, specifically to help people work through and grow out of addictive behaviors. Complete the following exercise and answer the questions that follow.

FOUR QUESTIONS ABOUT MY ADDICTION

What do I enjoy about my addiction? What does it do for me? (Be specific.)	**What do I think I will like about giving up my addiction? What good things might happen when I stop my addiction?**
What do I hate about my addiction? What bad things does it do to me and to others? (Give specific examples.)	**What do I think I won't like about giving up my addiction? What am I going to hate, dread or dislike about living without my addiction?**

FOUR QUESTIONS ABOUT MY ADDICTION:

A COST/BENEFIT EXERCISE

These 4 questions can provide you with a lot of useful information with which to grow out of your addiction(s).

The more honest and complete your answers, the more this exercise will help you.

1. What do I enjoy about my addiction? What does it do for me (be specific)?

List as many things as you can that you liked about whatever you are/were addicting yourself to.

1. Where possible, find alternative ways of achieving the same goals.
2. Recognize positive thinking about the addiction as a potential relapse warning sign.
3. Realize that there are some things you liked about the addiction you will have to learn to live without.
4. List what you enjoy about your addiction so you can ask yourself if it is really worth the price.
5. Realize that you aren't stupid; you did get something from your addiction. It just may not be working on your behalf anymore.

2. What do I hate about my addiction? What bad things does it do to me and to others (give specific examples)?

List as many of the bad, undesirable results of your addiction as you can. Here it is extremely important that you use specific examples. Specific examples have much greater emotional impact and motivational force!

a. Ask yourself honestly "If my addiction was a used car, would I pay this much for it?" If you wouldn't pay this much for it, why not?

b. Review this list often, especially if you are having a lot of positive, happy thoughts about all the great things your addiction did for you and how much fun you had in pursuing it.

3. What do I think I will like about giving up my addiction?

List what good things you think/fantasize will happen when you stop your addiction.

1. This provides you with a list of goals to achieve and things to look forward to as a result of your new addiction-free lifestyle.
2. This list also helps you to reality test your expectations. If they are unrealistic, they can contribute to relapse based on disappointment, depression, or self-pity.

4. What do I think I won't like about giving up my addiction?

List what you think you are going to hate, dread, or merely dislike about living without your addiction.

a. This list tells you what kinds of new coping skills, behaviors, and lifestyle changes you need to develop in order to stay addiction free.
b. It also serves as another relapse warning list. If all you think about is how much life sucks now that you are not doing your addiction, you are engaging in a relapse thought pattern that is just as dangerous as only focusing on what you liked about your addiction.

This is not a do once and forget about it exercise. It is an ongoing project. Most people simply can't remember all of the positive and negative aspects of addiction and recovery at any one time. Furthermore, seeing all the negative consequences of addiction listed in one place is very powerful. On the positive side, most people do not absolutely know for certain what they will like or will not like about living free of their addictions until they have done so for some time. I know of people who continued to add items to all four questions for a full 6 months.

Tool # 17 - Identifying My Habits and Addictions

The habit or addiction I will be targeting is _____
_____
_____

The habit or addiction first started _____
_____
_____

I typically engage in the behavior _____
(How Often?)

The place I usually do the behavior Is _____

The time of day I usually do the behavior is _____

The emotions I usually feel before I do the behavior are _____
_____
_____

The people in my life that have the power to trigger those emotions in me include
_____
_____
_____

Other circumstances often present when I engage in the behavior include
_____
_____
_____

My habit or addiction has hurt me in the following ways in each area

My Physical Body _____
_____
_____

My Sleep Habits _____
_____
_____

My Relationships _____
_____
_____

My Emotions _____
_____
_____

My Spiritual Life _____
_____
_____

Medically _____
_____
_____

Financially _____
_____
_____

Tool # 18: What's Your Why?

One of the keys to overcoming addictions and bad habits is to identifying the function of the behavior. People often do things for good reasons. So identifying the reason is essential for finding replacement behaviors that can fill a similar function with less damaging consequences. Use the example below to complete your own tool to help you identify what ***your*** why is.

What's Your Why? Tool - Example

What (Habit or Addiction)	Why? (What I Get out of It)
Adderall	Helps me focus Gives me Energy
Smoke Pot	Helps me relax Helps me "numb out"
Bit fingernails	Gives me something to do when I'm stressed

Your What's Your Why? Tool

What (Habit or Addiction)	Why? (What I Get out of It)

Tool # 19: SSS Tool (Substance Specific Strategies)

As noted above, identifying function of behaviors can give us a window into what replacement behaviors may be the most effective. Certain behaviors may be helpful coping skills in general, but if they don't help us meet the need that is behind the problem behaviors, they likely won't work in our effort to reverse that particular habit. Use the example below to brainstorm some replacement behaviors for you to choose from to do instead of your habit behaviors that could meet your specific need with less damaging consequences.

Need (My "Why")	**SSS (**alternate strategies that could meet that need)
1. *" I need energy to do my job"*	- *5 hour energy* - *Change my diet* - *Increase my exercise* - *Get blood tests to see if I need vitamins, minerals, or other supplement or medicine* - *Start my work project even though my energy level is lower than I'd like it to be*
2. *"I want to feel numb and not think about something bad"*	- *Learn distress tolerance techniques* - *Deal with my problems so intrusive thoughts don't keep coming back* - *Take a hot bath* - *Read a moving story* - *Talk about how proud I am of my daughter* - *Listen to a funny podcast* - *Listen to one of my go to songs* - *Call my friend and go out to a movie*
3. *"I need something to do when I get anxious*"	- *Use a distraction technique* - *Count to 100 in my head* - *Get on treadmill* - *Clench my stress ball* - *Remind myself all the reasons I will be ok*

My SSS Tool (Substance Specific Strategies)

Need (My "Why")	SSS
1. 2. 3.	

Tool # 20: Self-Monitoring

Self-monitoring is an important tool to have whether striving to break a bad habit or addiction, managing a full blown mental illness, or working toward achieving any type of personal goal. First, monitoring is a way of increasing our awareness to our triggers, thoughts, moods, and habit behaviors. It is only after we gain awareness to the presence of these sooner that we can intentionally work to change them. Especially early in the process, many people with say things like "that's just the way I am," or "That's just me." Viewing it in this way makes it *seem* unchangeable (like our eye color vs like dietary habits). As we get better at developing awareness as to when these things come and go and our environment and thought processes as they do, we can change who we thought we "Just were" for the better.

Secondly, monitoring is a way for us to tell if we are growing. As we get better at paying attention to certain thoughts, moods, and habit behavior we can get better at noticing if they are improving over time.

Perhaps the easiest way to get started is to start with behaviors you have no desire to change. Some people start with going to the bathroom, brushing their teeth, or eating. Start by observing *frequency* and *duration*; that is, how *often* you do the behavior, and once you do it, how *long* the behavior continues.

Self-monitoring does not come easily, and most people believe they are better at it than they really are. But the more you practice, the more self-aware you become. The more self-aware you become, the better insight you have into habit behaviors that you might want to change that could have a profound positive impact on your recovery and personal growth.

The following tool can help you get better paying attention to a behavior that you choose to start with, even if you have no desire to change it. You will then use this skill in completing your Habit Tracker targeting actual bad habits

Behavior(s) of Focus: _____

I will pay attention to this more in the following way _____

_____

_____

One morning practice I can implement into my daily routine that can help me shift my focus to paying attention to the behaviors I am trying to catch myself in is _____

_____

_____

How often do I notice myself doing this behavior? _____

_____

_____

Do I observe themes in specific emotions when I catch myself doing the behavior? _____

_____

_____

What can I use to help bring my attention to this when I start to do it? (a reminder on the toilet, a sticky note on the pantry door, dip my hands in a flavor I don't like so I notice every time I start to put one in my mouth)

_____

_____

_____

A person who lives or works with me that could be a support in this by pointing out to me when they observe me engage in the behavior is

_____

_____

_____

A practical way I will use to keep track how many times I do the behavior a day is (ie little note pad in pocket, "notes" section in smartphone, use a step counter or clicker _____

_____

_____

Other factors that might be important for me in improving my monitoring and increasing my awareness are _____

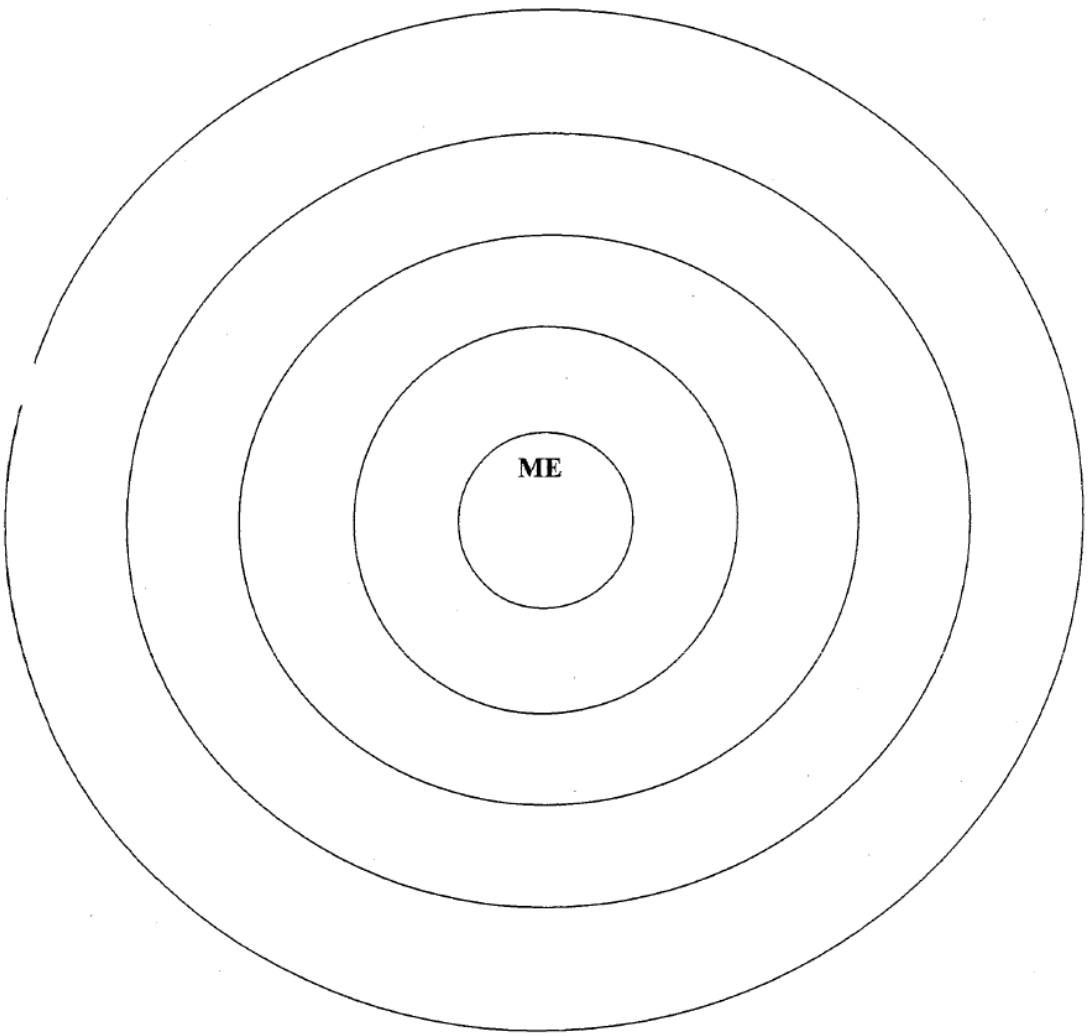
_____

_____

Tool # 21: Relationship Circles and Accountability

All people need people. However this can be a "catch 22." On one hand, we need human interaction for support, encouragement, touch, fun, and a sense of connectedness. But on the other hand, relationships can be very difficult for a variety of reasons, and triggering for people who struggle with addictions or bad habits. While it is not necessary that you become "the life of the party" if that is not "you," it is vital to have a support system to help you face overcoming your obstacles in life created by your target behaviors.

Use the following tool to help you identify the relationships that you have in your life. The more you trust a person, the closer they go on your circles. The less you trust a person the further out they go. After listing people where you view them on your circles, answer the questions that follow.



Relationship Circles Questions

What changes would I like to make to my circles?

_____

_____

_____

Are there people I would like to have closer in? Further out? Who and why?

_____

_____

_____

Some hurtful things I have done that have damaged one or more relationships:

_____

_____

Some helpful things I have done that have helped me in maintaining relationships:

_____

_____

_____

Changes I could make in the way I relate to people may include:

_____

_____

Would I like to add people to my circles who currently aren't there? Why or why not?

_____

_____

_____

What are some qualities of the people I would like to add?

_____

_____

_____

What are some “red flag” qualities of people I may be drawn to but that I have learned from experience are NOT good candidates for my circles?

_____

_____

I commit to talk to the following 3 people from my “circles” to be part of my accountability team that I can call for support in times I am having a hard time managing my urges. I will put their names and number somewhere that is readily accessible and that I can find easily in times of need.

Name	**Phone #**
_____	_____
_____	_____
_____	_____

Tool #22: Habit Tracker

Here is where the rubber meets the road! Use your awareness skills ***to pay attention to every time you have an urge to do the behavior. , whether you did it or not.*** You will not catch every time – that is ok. Do the best you can. Log the date, time, what your urge was to do, what emotion you were experiencing and how strongly you felt it, if you did the habit behavior or not, and if not, on a scale of 0-10, how close you came to giving into the urge and acting. This is a royal pain to being with. But the more consistent you become with this over time, the better you will get at reversing unwanted habits. If you quit completing these, you are unlikely to succeed. Use the example to start completing your own.

Habit Tracker - Example

Date	Time	Urge	Emotion/Strength	Did I Do Y/N	If No, How Close? 0-10
4/13	0700	Drink Alcohol	Agitation (7)	N	9

Your Habit Tracker

Date	Time	Urge	Emotion/Strength	Did I Do Y/N	If No, How Close? 0-10

Tool # 23: BOB (Behavior Over Belief)

As you start to develop some mastery in the use of your habit tracker closely monitoring your behaviors and urges, an additional step to integrate involves thoughts and beliefs. Most reading this are likely familiar with the term *rationalization.* This term has actually been used differently by different theorists over the years. A version of it even shows up on some of the cognitive distortion lists floating around out there. A cognitive term for this specific use of rationalizing is *permission-giving beliefs.* Every time any human being engages in a behavior that is against our moral values or in any way that we are consciously aware of not in our best interest, we do so only after giving ourselves permission to first. A general template for identifying permission-giving beliefs could be:

It's OK to _____, *because* _____.
(behavior) *(Excuse)*

One common example I hear working with clients in the area of addictions is

"It's OK to use drugs, because I think they should be legal."

They may believe this, but the reality is that the substance in question is NOT legal at this time at this place. So in helping the client examine potential pros and cons, it is important to consider potential sociological, legal, and related family consequence. Use the BOB (Behavior over belief) Tool to identify some of your permission giving beliefs that could be facilitating your bad habit or addictive behavior, aw well as to consider how you might increase your effectiveness by behaving in spite of what you believe.

BOB Tool

Date	Permission - Giving Belief	Habit Behavior Tempted To Do	SSS (Alternate Behavior)
8/11	"Its ok to take a drink because what she said made me depressed"	Vodka	Call a Friend Have a Nice Meal Sit in the Jacuzzi

Tool # 24: Burning The Bridge

Once you have identified your triggers, your addictive or bad habit behaviors, and increased your awareness regarding your temptations to engage in them, the next step is getting more effective "in the moment" at not acting on your urges. The Cards we will look at in tool 25 can be helpful with this.

A crucial first step is to *safeguard your environment.*
This "bridge Burning," as Dr. Lane Pederson Calls it, is a term that is often associated with clients with suicidality.

Whether it means killing oneself, going to the casino, or using heroin, the reality is that adults can choose to do just about whatever they want to. People with addictions often have urges to do things the "rational side" of them knows is not in their best interest. So, if part of you wants to indulge while the other part of you knows its best to restrain, you are not alone. Bridge burning is simply doing anything you can that will make it less likely for you to engage in the behavior in the moment.

Some safeguarding can be done preemptively. For instance, if you are in your first month without alcohol trying to break a 20-year habit, you can ensure your safety by not keeping any alcohol in the house. Other safeguarding must be done "in the moment," which is much harder. For people who have urges to self-harm, it means making sure all objects that could be used to do so are removed. For people who are having suicidal thoughts, it might mean having high-lethality medications locked up under someone else's supervision. If you are having an urge to binge eat and you have the food you like to binge on at the house (for some necessary reason), it may mean your leaving the house. If your urge is to spend, you could limit your access to funds. Depending on the area your unhealthy urge involves, your steps will be different. One client of mine made sure he was with other people when his urges increased because he knew he would not engage in the behavior if someone else was there. After connecting with them and participating in some form of joint activity, he noticed the urge, no matter how strong, eventually passed.

Spend some time considering specific areas for which you may need to safeguard and what that might look like for you.

Areas it would be helpful for me to consider safeguarding include

Specific steps I could take preemptively (ahead of time) that would make my environment safer and less tempting are

_____

_____

_____

Things I could do "in the moment" to safeguard when an urge overcomes me are

_____

_____

_____

For me, safeguarding might include

_____

_____

_____

Use the following tool to list the specific habit behaviors you heave identified, and think of some specific ways your could "burn the bridge" that will buy you a little more time to change your mind about engaging in the behavior you are desiring to change.

Habit Behavior	Steps I Will Take to Safeguard

Tool # 25: Coping and Cue Cards

The final two tools are different types of cards. The first is what is called a *behavioral coping card,* and the final tool is what is called *cognitive cue card.* To make use of the coping card, you can simply copy a habit behavior you are targeting and Identify 3 of your SSS (alternate coping skills) behaviors that you think would work in a specific situation.

Since these are to be used "in the moment," it is best to keep them succinct so as not to overwhelm yourself as you will often be using them in a time of emotional upset.

Consult the following example using the client from the previous tool, and then try one yourself!

Example Coping Card

The next time I feel hurt and am tempted to drink vodka, Instead I will:

1. Call a friend
2. Have a nice meal
3. Sit in the Jacuzzi

My Cue Card

The next time I am tempted to _____ I will:
(Habit or addiction)

1.
2.
3.

The final card has a slightly different purpose. Unlike the coping cards, the cue cards don't deal with any behaviors. They are more about your mindset. At least, these should pick out a rational response you used (in tool #9) related to why it is not in your best interest to engage in the habit behavior.

Even more powerful yet would be to deal with your thoughts about your setback. Relapse is a part of recovery. Whether trying to stick to a certain diet or kick a meth habit, almost everyone has setbacks of some kind along the way. But the way one thinks about their failures (in this case relapse into habit behaviors) is crucial for overcoming the obstacle you are battling.

Consider the following example, then try a cue card of your own. With both types of cards, use the template provided to practice, but then to transpose your answers onto actual 3x5 cards you can strategically move to places you will see them most that will benefit you "real time".

Cue Card – Example

Just because I gave in and drank the vodka doesn't mean I am a Horrible person who will not achieve my goal. I went 11 straight days and now I had one slip. I am a valuable person that is loved by God and a few people in my support system. I am going to meet With my sponsor, tweak my relapse plan, and get back on the Horse and start riding again. I will beat this thing!

My Cue Card

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