Trauma Competency:

From Acute to Complex

J. Eric Gentry, Ph.D., LMHC, CAC

Master Traumatologist

This training satisfies the training requirements for

IATP Certified Clinical Trauma Professional

Trauma Competency:
From Acute to Complex

Training Manual

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

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Trauma Competency: From Acute to Complex

This training is packed full of cutting-edge interventions and protocols that you can immediately implement to augment your work treating survivors of trauma. This course is offered in a refreshing “hands on” format by J. Eric Gentry, PhD, an internationally-recognized leader in the explosive field of traumatology. Addressing and resolving client’s traumatic stress—even when they have other primary diagnoses—can have a powerfully transformational effect that rapidly accelerates treatment and satisfaction.

With a balance between the science and art of treating traumatic stress, Dr. Gentry will stimulate you with both principles and techniques for rapidly and safely accelerating treatment with clients who suffer from traumatic stress. The day’s training focuses upon conceptualizing the specific tasks within each of the phases of the Tri-Phasic Model—the accepted standard of care for treating those who suffer from traumatic stress. Following this training you will be able to confidently manage the trajectory of treatment with survivors of trauma from diagnosis to termination.

During this training you will learn how to explain the symptoms of traumatic stress to your clients and their family in a way that helps makes “good sense” of their experiences and maximizes their participation in the healing process. You will develop skills for helping trauma survivors to rapidly stabilize and utilize skills for self-regulation. Developing and implementing these skills significantly reduces client crises and allows treatment to move forward at an accelerated pace. You will learn empirical markers to know when it is safe to transition from the safety/stabilization phase of treatment into the trauma memory processing phase without guesswork and minimal crises.

The centerpiece of this workshop is skills training in constructing verbal, graphic, and non-verbal trauma narratives—identified by research as one of the critical ingredients in resolving traumatic stress. You will learn these crucial skills, via hand-on practice. The training materials are drawn from *Trauma Practice: Tools for Stabilization & Treatment*, a text co-authored by Dr Gentry that has received critical acclaim.

The training concludes with state-of-the-art techniques and activities for supporting and facilitating healthy bereavement. You will learn when to support natural mourning processes and when to offer facilitation for when these processes become thwarted.

From this training you will…

- Learn the secrets to accelerated recovery for survivors of trauma
- Implement the Tri-Phasic Model—the standard of care for treating posttraumatic stress
- Understand how traumatic stress subtly affects *all* mental disorders including cognitive and relational impairment
- Discover empirically-based skills and principles for managing the treatment trajectory for trauma survivors.
- Leave this workshop with a toolkit chocked full of new treatment techniques for stabilization and recovery from PTSD
- Learn the six requirements for the safety and stabilization phase of treatment—a requirement before beginning any trauma processing.

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- Gain hands-on experience with many different techniques for traumatic memory processing.
- Learn to recognize and prevent treatment crises before they happen
- Help survivors learn how to heal the past by working in the present.
- Identify CBT techniques and protocols that utilize and honor the spiritual development of each survivor
- Acquire powerful tools to immediately integrate into your practice

Learning Objectives
Participants of this training will learn:

- How to explain trauma and traumatic stress to clients as an integral part of treatment;
- Integration of the "common factors" for maximizing successful prognoses;
- Self-regulation as the foundational cornerstone for all treatment;
- To conceptualize trauma treatment within Herman's Tri-Phasic Model;
- Reframing treatment of traumatic stress as developmental vs. pathological;
- The six requirements for "good enough" safety/stabilization;
- Interventions to assist clients' transition from the volatility of sympathetic dominance to the stabilization of parasympathetic dominance;
- Strategies to assist clients in moving toward personal/professional vision and mission instead of simply treating symptoms;
- Active ingredients for desensitization and reprocessing of traumatic memories;
- Skilled application of CBT techniques including reciprocal inhibition and trauma narrative construction;
- Techniques for addressing somatic symptoms of traumatic stress;
- Techniques and rituals for "reconnection phase" of treatment.

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

Dr. Gentry has published many research articles, book chapters, and periodicals in this maturing area of study. He is the co-author of *Trauma Practice: Tools for Stabilization and Recovery* published by Hogrefe and Huber in 2004. He has a private clinical and consulting practice in Sarasota, FL and is adjunct faculty at many universities. Dr. Gentry draws equally from his scientific study and from his rich history of 25 years of professional care giving to balance this training with current, empirically-grounded information and experienced-based compassionate intervention skills. You will be challenged, inspired, and uplifted by Dr. Gentry and this unique day of training.

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Outline of the Training

Day I

Introduction

Healing Trauma: Simple not Easy

Common Elements to ALL Treatment Effectiveness

- Relationship & The Therapeutic Alliance
- Expectancy
- Techniques & Protocols

Small Group Exercise

BREAK

Tools for Hope. What makes trauma symptoms

- Perceived Threat
- Autonomic Nervous System
- Self-regulation
- *Demonstration & Skills building*

LUNCH

Traumatic Event vs. Traumatic Response: What makes a trauma traumatic

Practice of Self-Regulation Exercises

BREAK

Trauma Assessment

- *Graphic Time Line*
- Video Narrative
- *TRS*
- *CAPS*

Closure

Day II

Opening Discussion

Tri-Phasic Model: Safety, Remembrance & Mourning, Reconnection

Safety & Stabilization

1. Getting out of the war zone
2. Am safe vs, feels safe
3. Intentionality and Mission
4. Self-regulation, Grounding, & Containment
5. Demonstration of Self-rescue
6. Commitment & Expectancy

BREAK

Skills Building: Demonstration & Practice

- *Self-regulation*
- *Safe-place visualization/non-verbal & verbal*
- *Anchoring*
- *Thought Field Therapy*
- *EMDR Safe-Place Technique*
- *Postural grounding*
- *5-second Mastery of Diaphragmatic Breathing*
- *Triggering and self-rescue from abreaction*

Anti-regression Algorithm: An Alternative to Hospitalization

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LUNCH

<u>Remembrance & Mourning: Trauma Memory Processing</u>

- Two Crucial Ingredients: Reciprocal Inhibition and Narrative
- Trauma Narratives: Structuring Chaos
- Practice
  - Graphic
  - Non-verbal
  - Verbal

BREAK

<u>Remembrance & Mourning: Trauma Memory Processing (con't)</u>

- Practice
  - Graphic
  - Non-verbal
  - Verbal

<u>Grief & Mourning</u>

<u>Reconnection</u>

- Reconnecting to what?
- Rituals & Techniques
- Practice: Letter-writing

Closure

What are your goals for this workshop?

Take a moment to jot down your thoughts about what you would like to get as a result of attending this training?

- ____
  ____
- ____
  ____
- ____
  ____
- ____
  ____

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Healing Trauma: Simple not Easy

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

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

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

In my doctoral coursework, I took the course that we all have to take—the one in which we learn to critically evaluate scientific writing. For my work in this particular course, I wanted to evaluate all the treatments for traumatic stress that had demonstrated effectiveness. In the process of doing this, I decided to ask the research question: "Are there any ingredients in trauma treatment that are demonstrated to be important to all effective treatments?" After completing a qualitative analysis of the all Discussion sections of each of the articles I reviewed, I discovered that there was a resounding "yes" answer to this question. Integral to almost every effective treatment is the combination of some form of exposure to the traumatic material paired with relaxation.

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

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

For a while I thought and taught that these were the ***only two*** crucial ingredients to effective treatment of traumatic stress—narrative/exposure and relaxation (reciprocal inhibition). In 1999, Hubble, Duncan, and Miller released, in my opinion, the single most import text of the past decade—*The Heart & Soul of Change*. This book is chocked full of paradigm-shifting information. One of the most important truths to come from their huge meta-analytic study was what they learned about predictors of positive outcomes in psychotherapy. They found that the MOST important predictor of positive outcomes in our patient's psychotherapy has nothing to do with the therapy itself—it is occurrences that happen outside of therapy that account for over 40% of positive outcomes. Then, of the 60% that we, as helpers, can influence we find that 30% is contingent upon the development and maintenance of a good therapeutic relationship. The remaining 30% is split equally between positive expectancy (which has also been called either "hope" or "placebo") and techniques/models. There is a good argument that the process of developing expectancy/hope/ placebo is also a relational function. If this is so, then that means the degree to we can influence positive outcomes for our clients, 75% is contingent upon relational factors and 25% is contingent upon technical and/or philosophical factors. This data confirms what I, as a professional care provider for nearly three decades, have always intuited—people heal people! It is not EMDR, or CBT, or psychopharmacology that accounts for most of the magical transformation that happens in our office. It is the quality of the relationships that we build with our clients. All we have to do is confirm the gravity of this truth is to think back upon a time in our own lives when we navigated through emotional difficulty and we'll see that it was the

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support, care, and presence of another that we recall as the active ingredient in our own successful resolution of this problem.

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

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

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Trauma Competency & Certification Training

J. Eric Gentry, Ph.D., LMHC
Master Traumatologist

International Association of Trauma Professionals

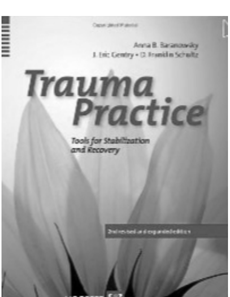
FREE MEMBERSHIP!!!!!

Certifications:

- CCTP: Certified Trauma Professional/Certified Clinical Trauma Professional
- CCFP: Certified Compassion Fatigue Professional (7/1/12)
- Expert & Master Levels coming

www.traumaprofessional.net

Trauma Practice: Tools for Stabilization & Recovery



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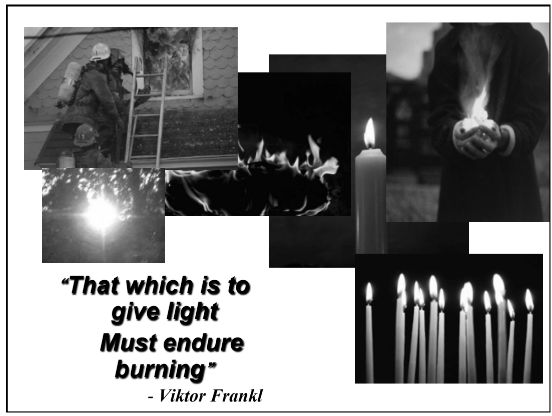
EXPERIENTIAL

- Pick-a-trauma to work with for the two days
- Can be your own, role play of a client, or completely made up
- SUDs ≤ 5
- All exercises are completely voluntary
- EMDR



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

- Viktor Frankl

Changing the Paradigm

The relative efficacy of bona fide psychotherapies for treating post- traumatic stress disorder: A meta-analysis of direct comparisons

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

Received 4 June 2007; received in revised form 8 October 2007; accepted 23 October 2007

Abstract

Psychotherapy has been found to be an effective treatment of post-traumatic stress disorder (PTSD), but metaanalyses have yielded inconsistent results on relative efficacy of psychotherapies in the treatment of PTSD. The present meta-analysis controlled for potential confounds in previous PTSD meta-analyses by including only bona fide psychotherapies, avoiding categorization of psychotherapy treatments, and using direct comparison studies only. **The primary analysis revealed that effect sizes were Homogenously distributed around zero for measures of PTSD symptomology, and for all measures of psychological functioning, indicating that there were no differences between psychotherapies**. Additionally, the upper bound of the true effect size between PTSD psychotherapies was quite small. **The results suggest that despite strong evidence of psychotherapy efficaciousness vis-à-vis no treatment or common factor controls, bona fide psychotherapies produce equivalent benefits for patients with PTSD.**

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Healing Trauma:

Active Ingredients

- **Therapeutic Relationship** – develop and maintain. Emotional bond + Completion of Tasks + Mutual Goals + Positive expectancy.
- **Relaxation** – Reciprocal Inhibition (exposure + relaxation). Parasympathetic dominance
- **Narrative** – sharing with safe other chronology of “micro-events” of traumatic experience

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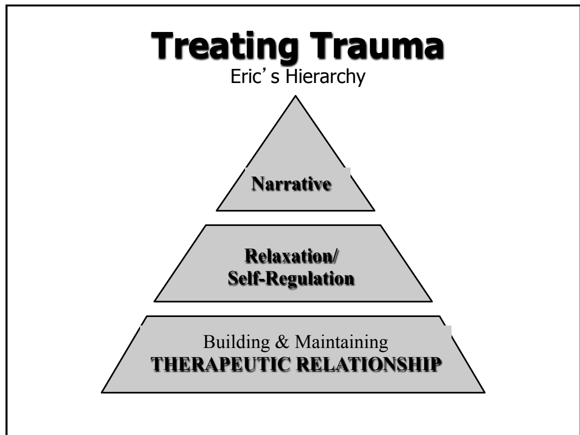

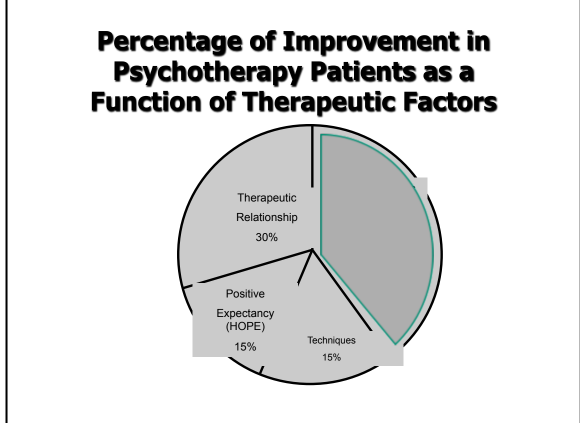

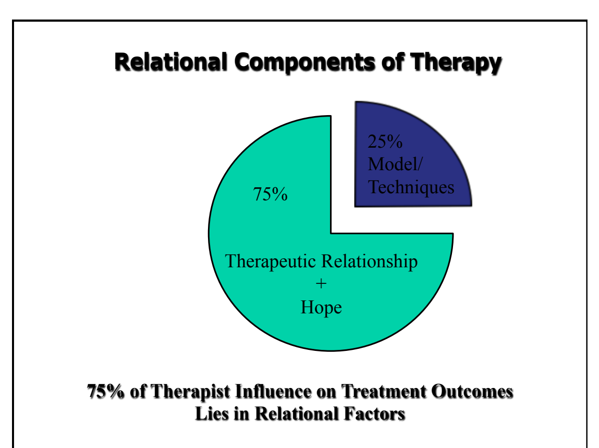

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Suggestions for Positive Outcomes

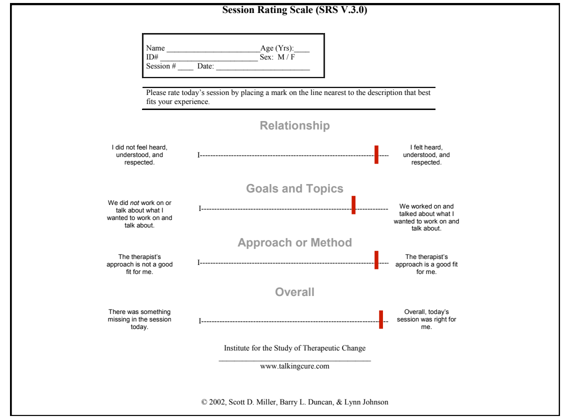
www.scottdmiller.com

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

Session Rating Scale

Miller (2007)

I did not feel heard, understood, and respected.	I felt heard, understood, and respected.
We did *not* work on or talk about what I wanted to work on and talk about.	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	The therapist's approach is a good fit for me.
There was something missing in the session today.	Overall, today's session was right for me.



Session Rating Scale (SRS V.3.0)

Name ______________________Age (Yrs):____
ID# ______________________ Sex: M / F
Session # ____ Date: ______________________

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

Institute for the Study of Therapeutic Change

www.talkingcure.com

© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson

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Suggestions for Positive Outcomes

Gentry, 2009

- Self-regulation
- Self-validation & Self-possession
- "Excellent" prognosis
- Develop and maintain MINIMAL safety and stabilization
- Rogerian Core Characteristics (Warmth, Caring, Authenticity, Transparency)
- Tolerance of symptoms

Making it Personal

UNDERSTANDING TRAUMA

STRESS
Cause & Effect

Causes	Effects

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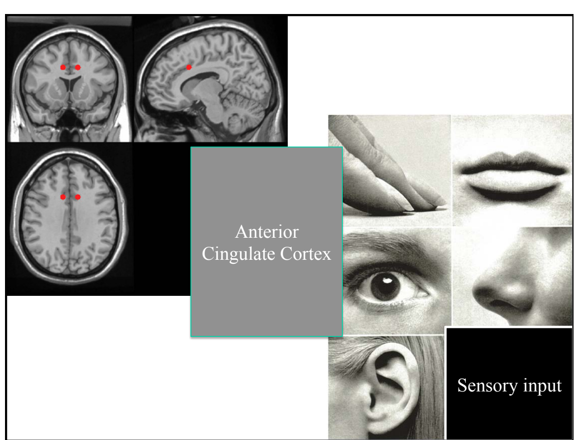

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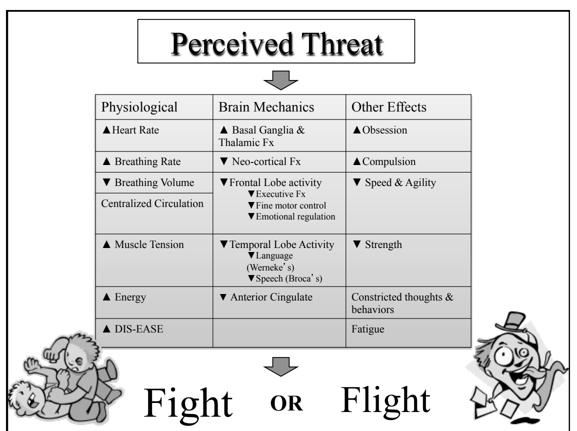
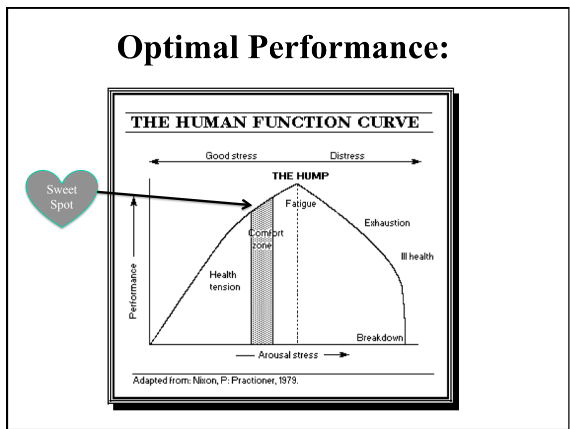


Perceived Threat

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

Fight OR Flight



STRESS

Cause & Effect

Causes	**Effects**

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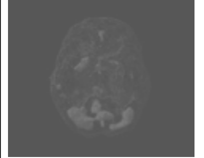
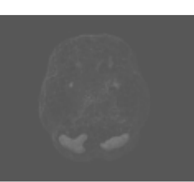


High Anxiety
Increased basal ganglia activity

Stress = Perception of Threat

Normal
Note the lessened activity of the basal ganglia



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

Self Regulation

- Peripheral vision
- Pelvic floor relaxation
- Soft-palate relaxation
- Diaphragmatic breathing

Self Regulation: Peripheral Vision

- Focus on a spot straight ahead
- Keeping your focus, widen your field of view and notice what you see in your peripheral vision

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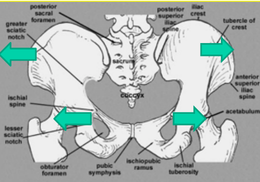
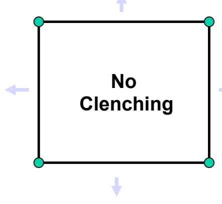
Self Regulation:
Pelvic floor relaxation

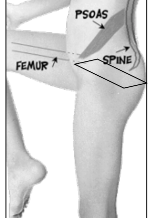
- Focus on 4 points: Bilateral Anterior Superior Iliac Spine and Ischial Tuberosities
- Imagine these 4 points pushing outward and muscles in-between softened



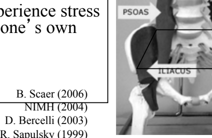
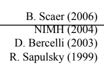
Self-Regulation



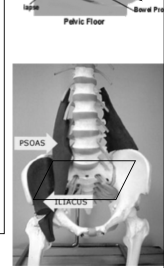
Self-Regulation



- Relaxing tension of pelvic floor muscles switches from sympathetic to parasympathetic dominance
- Psoas, Sphincter, and Kegels (anterior + posterior)
- Regaining of neocortical functioning in 20-30 seconds
- Relieves pressure on vagus nerve
- Impossible to experience stress – comfortable in one's own skin

B. Scaer (2006)
NIMH (2004)
D. Bercelli (2003)
R. Sapulsky (1999)



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Posttraumatic Stress

Illness or Injury?

www.giftfromwithin.org

PTSD
DSM-IV Criterion A

The person has been exposed to a traumatic event in which both of the following were present:

(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness or horror. **Note:** ***In children, this may be expressed instead by disorganized or agitated behavior***

The Trauma Response

The Event

- ***What makes an event traumatic?***

The Instinctual Trauma Response (Tinnin, 1998)

- **startle**
- **thwarted intention (*fight or flight*)**
- **freeze**
- **altered state (peri-traumatic dissociation)**
- **body memory**
- **resolution**

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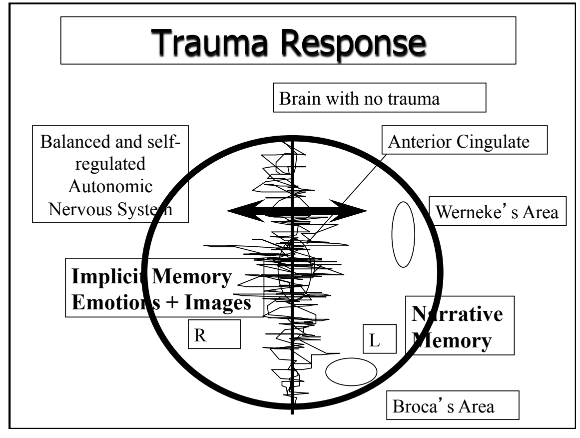

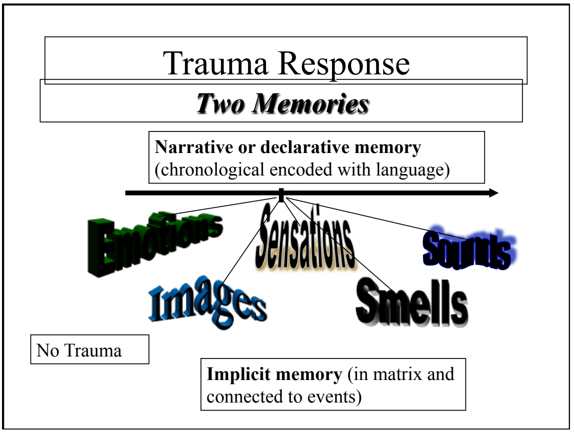

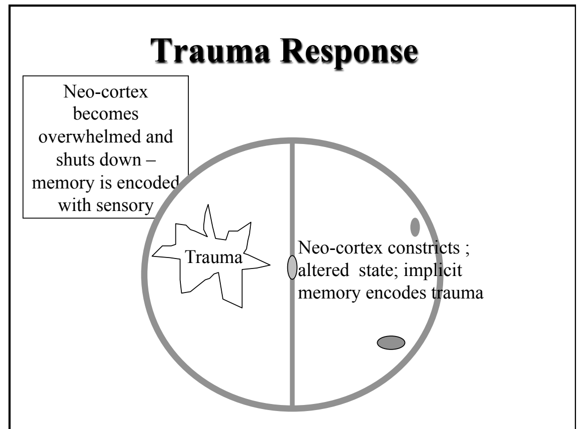

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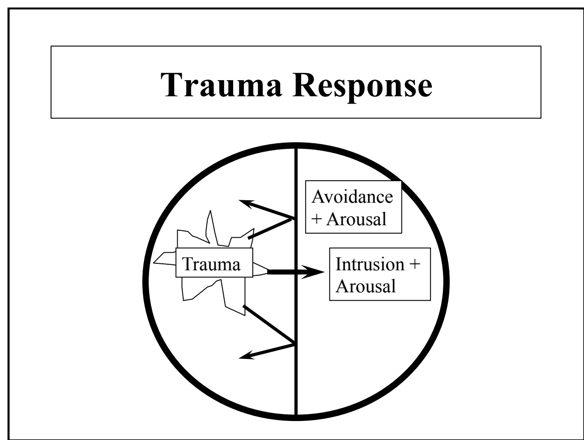

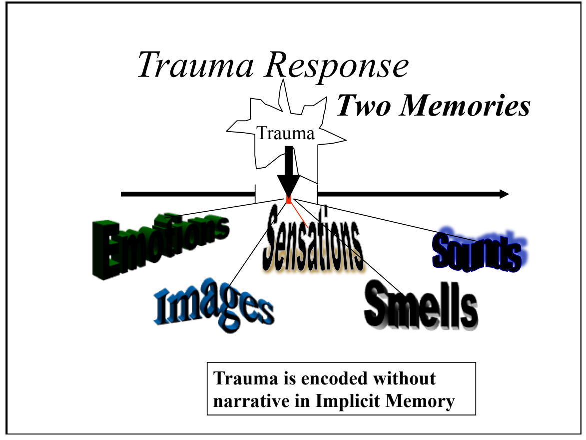

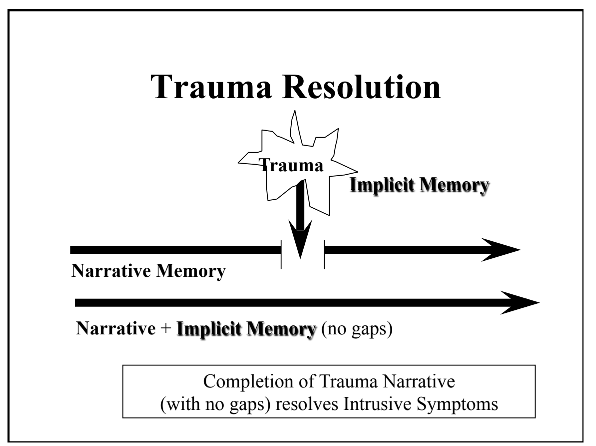

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Posttraumatic Adaptations (Symptoms)

- **Intrusion (1 for Dx of PTSD)**
  - Nightmares
  - Flashbacks
  - Physiological arousal when confronted with cues
  - Psychological disturbance
  - Increased Threat Perception

Posttraumatic Adaptations (Symptoms)

- **Avoidance (3 for Dx of PTSD)**
  - Efforts to avoid thoughts or feelings associated with event;
  - Efforts to avoid activities or situations which arouse recollection;
  - Inability to recall important aspects of the trauma
  - Diminished interest or participation in significant activities;
  - Feelings of detachment or estrangement from others;
  - Restricted range of affect;
  - Sense of foreshortened future

Posttraumatic Adaptations (Symptoms)

- **Arousal (2 for Dx of PTSD)**
  - Difficulty falling or staying asleep;
  - Irritability or outbursts of anger;
  - Difficulty concentrating;
  - Hypervigilance
  - Exaggerated startle response

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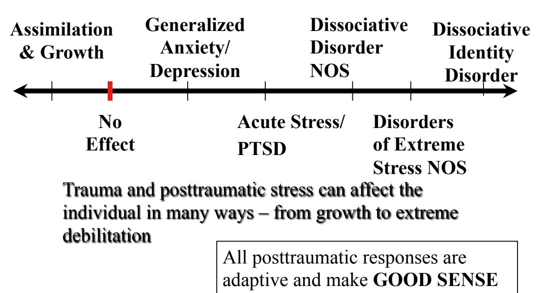

Eg

Other Diagnostic Information

- Criterion E. Duration of disturbance is more than one month
- Criterion F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- *Specify* if: **Acute:** less than three months. **Chronic:** more than three months
- *Specify* if: **With delayed onset:** if onset of symptoms is at least six months after the stressor.

Eg

Associated Features

- Painful guilt
- Phobic avoidance
- Impaired affect modulation
- Self-destructive/impulsive behavior
- Dissociative Sx
- Somatic complaints
- Ineffectiveness, shame, despair
- "Damaged goods"
- Loss of beliefs (safety)
- Hostility
- Social withdrawal
- Impaired relationships

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Traumatic Stress

ASSESSMENT & INTERVIEWING

Assessment & Diagnosis

- **Psychotraumatology Evaluation**
- Trauma Profile
- **Trauma Intake Assessment**
- ***CAPS***
- TRS
- IES
- SCL-45
- TSC-40
- DES
- DRS
- *TAS*

Impact of Events

+15 items
+Good reliability and validity
+Easy to use and score
+Works well with retesting/outcome measure

- Only measures Avoidance and Intrusion symptoms. Does not measure Arousal.

IES
IMPACT OF EVENTS SCALE
M. Horowitz, Dept. of Psychiatry, University of California at San Francisco

Name:____________________Occupation:____________

In ___(year) I experienced this life event: ____________________

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true during the past seven days. If they did not occur during that time, please mark "not at all".

	Not At All 0	Rarely 1	Sometimes 3	Often 5
1. I thought about it when I didn't mean to.				
2. I avoided letting myself get upset when I thought about it or was reminded of it.				
3. I tried to remove it from my memory.				
4. I had trouble falling or staying asleep, because of pictures or thoughts about it that came into my mind.				
5. I had waves of strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from reminders of it.				
8. I felt as if it hadn't happened or it wasn't real.				
9. I tried not to talk about it.				
10. Pictures about it popped into my mind.				
11. Other things kept making me think about it.				
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. My feelings about it were kind of numb.				

0 - 8 Subclinical
9 - 25 Mild
26 - 43 Moderate
Over 43 Severe

Intrusion: 1, 4, 5, 6, 10 ,11, 14
Avoidance: 2, 3, 7, 8, 9, 12, 13, 15

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IES revised (IES-R)

- 22 items
- Measures Intrusion, Avoidance, & Hyperarousal
- IES for children (8items/13items)

IES-Revised

1. Any reminder brought back feelings about it.
2. I had trouble staying asleep.
3. Other things kept making me think about it.
4. I felt irritable and angry (H)
5. I avoided letting myself get upset when I thought about it or was reminded of it (A)
6. I thought about it when I didn't mean to.
7. I felt as if it hadn't happened or wasn't real (A)
8. I stayed away from reminders of it (A)

IES-Revised

9. Pictures about it popped into my mind.
10. I was jumpy and easily startled (H)
11. I tried not to think about it (A)
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them (A)
13. My feelings about it were kind of numb (A)
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep (H)

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IES-Revised

16. I had waves of strong feelings about it.

17. I tried to remove it from my memory (A)

18. I had trouble concentrating (H)

19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart (H)

20. I had dreams about it.

21. I felt watchful and on-guard (H)

22. I tried not to talk about it (A)

IES-Revised

Item response anchors are:

0=not at all
1=a little bit
2=moderately
3=quite a bit
4=extremely

IES-Revised

Intrusion subscale is the mean item response of items 1,2,3,6,9,14,16,20

Avoidance subscale is the mean item response of items 5,7,8,11,12,13,17,22

Hyperarousal subscale is the mean item response of items 4,10,15,18,19,21

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Clinician Administered PTSD Scale (CAPS)

- Excellent Psychometrics
  - Reliability (*r* = .83 - .85)
  - Convergent validity (*r* = .77 - . 91)
- Good insight into symptoms and effects in the life of the client
- Excellent opportunity to build relationship and explain traumatic stress
- Excellent diagnostic tool

Intrusion	Avoidance	Arousal	Total
X	X	X	X
X / 32	X / 56	X / 48	X / 152
%	%	%	%

- Score of one (1) on Frequency and two (2) on Intensity is considered endorsement of symptom

CAPS Diagnostic Worksheet

PTSD SYMPTOMS

	Frequency	Intensity
A. Traumatic Event: ______		
B. The traumatic event is persistently reexperienced:		
(1) Recurrent and intrusive recollections	____	____
(2) Distress when exposed to events	____	____
(3) Acting or feeling as if event recurring	____	____
(4) Recurrent distressing dreams of event	____	____
Number of current symptoms for criterion B (need 1): ____ Cx met? Yes No		
C. Persistent avoidance of stimuli/numbing of responsiveness:		
(5) Efforts to avoid thoughts or feelings	____	____
(6) Efforts to avoid activities or situations	____	____
(7) Inability to recall trauma aspects	____	____
(8) Markedly diminished interest in activities	____	____
(9) Feelings of detachment or estrangement	____	____
(10) Restricted range of affect	____	____
(11) Sense of foreshortened future	____	____
Number of current symptoms for criterion C (need 3): ____ Cx met? Yes No		
D. Persistent symptoms of increased arousal:		
(12) Difficulty falling or staying asleep	____	____
(13) Irritability or outbursts of anger	____	____
(14) Difficulty concentrating	____	____
(15) Hypervigilance	____	____
(16) Exaggerated startle response	____	____
(17) Physiologic reactivity	____	____
Number of current symptoms for criterion D (need 2): ____ Cx met? Yes No		

PTSD Cx Met (circle): <u>Current:</u> Yes No

Early Sessions

- Graphic Time Line of life including ALL significant traumatic experiences
- Verbal Narrative using GTL as map
- Video-recording
- Asking client to view video (if they can tolerate) with attitude of ACCEPTANCE, COMPASSION & CURIOSITY

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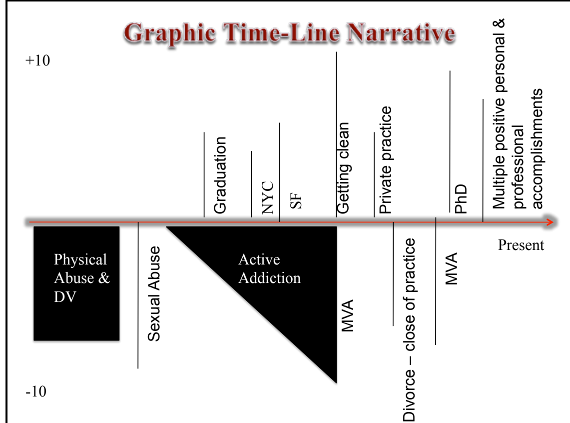

The Tri-Phasic Model

TREATING TRAUMA

Tri-Phasic Model

Herman, 1992

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

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Eg

What is Safety?

(Gentry & Schmidt, 1997)

I. **Resolution of impending environmental** (ambient, interpersonal and intrapersonal) **physical danger**;
- -Removal from "war zone" (e.g., domestic violence, combat, abuse)
- -Behavioral interventions to provide maximum safety;
- -Address and resolve self-harm.

II. **Amelioration of self-destructive thoughts & behaviors** (i.e., suicidal/homicidal ideation/behavior, eating disorders, persecutory alters/ego-states, addictions, trauma-bonding, risk-taking behaviors, isolation)

III. **Restructuring victim mythology** into intentional proactive survivor identity by development and habituation of life-affirming self-care skills (i.e., daily routines, relaxation skills, grounding/ containment skills, assertiveness, secure provision of basic needs, self-parenting)

What is Necessary?

Six Empirical Markers

1. Resolve (real) Danger
2. Distinguish between real vs. perceived threat
3. Develop battery of regulation/relaxation, grounding, and containment skills
4. Demonstrate ability to self-rescue
5. Contract (verbal) to address traumatic material
6. Non-anxious presence + good prognosis

What is Necessary?

1. **Resolution of impending environmental physical danger**
   - Abusive Environment
   - Ambient Danger
   - Violence
   - Active Self Harm

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What is Necessary?

2. Ability to distinguish between "Am Safe" and "Feel Safe."

Outside Danger		**Inside Danger**
Behavioral Intervention	←→	Self regulation
		Anxiety Reduction
Resolve Threat		Cognitive Restructuring

What is Necessary?

3. Development of a battery of self-soothing, grounding, containment and expression strategies AND the ability to utilize them for self-rescue from intrusions

Safety/Stabilization

Interventions

Suggested

- 3-2-1 Sensory grounding
- Diaphramatic breathing
- Safe-place visualization
- Flashback Journal
- Thought Field Therapy (TFT)
- Light Stream
- Icon in envelope

Additional

- Progressive Relaxation
- Anchoring
- Transitional Object
- Postural grounding
- Internal vault
- Timed/metered expression

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Thought Field Therapy (TFT)

Callahan

- Perturbations in the thought field contain the active information (see physicist David Bohm***) which triggers and forms the sequence of activities - neurological, chemical, hormonal and cognitive - which result in the experience of a negative emotion such as fear, depression, anger, etc.
- In TFT's unique diagnostic procedure the perturbations are revealed and quickly subsumed.
- The perturbations are of low inertial ladeness (contained in an energy form as the information on an audio or video tape has less inertial quality than the tape itself) and this fact explains the unusual speed of the therapy; the unusual effectiveness is explained by the fundamental nature of the perturbations.

Thought Field Therapy (TFT)

Callahan

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

Thought Field Therapy (TFT)

Callahan

- **Callahan Techniques®,Ltd.
78-816 Via Carmel
La Quinta, CA 92253
(760) 564-1008**
- **FOR ORDERS CALL 1(800)359-CURE Dept. WB
OR FAX Your Order to (760) 360-5258
E-Mail** joanne@tftrx.com

6. **SUDS**
   - **If decreased 2+ units then repeat until SUDS = 0**
   - **If decrease < 2, then:**
7. **Psychological Reversal**
   - tap on heel of hand
   - "I accept myself event though I still _______" (3x)

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EMDR Safe Place

- Step 1: *Image.*
- Step 2: *Emotions and sensations.*
- Step 3. *Enhancement.*
- Step 4. *Eye movements* (short sets 4-6).
- Step 5. *Cue word.*
- Step 6. *Self-cuing.*
- Step 7. *Cuing with disturbance.*
- Step 8. *Self-cuing with disturbance.*

What is Necessary?

4. Ability to demonstrate self-rescue.

5. Contract (verbal) with client to address traumatic material

6. **Non-anxious presence and good prognosis from clinician.**

Tri-Phasic Model: Remembrance & Mourning

Desensitization & Reprocessing

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Approaches

- **CBT (PE/DTE)**
- CPT
- **EMDR**
- Rx
- TIR
- **NLP – V/KD**
- Hypnosis
- Psychodymanic
- **SE/TRE**
- ART
- **TFT/EFT**
- TRI Method
- Bio//Neuro-feedback
- **Art/non-verbal**
- Group Therapy

COGNITIVE BEHAVIORAL THERAPY

- **Joseph Wolpe**
- **BF Skinner**
- **Ivan Pavlov**
- **Aaron Beck**
- **Edna Foa**
- **Terrence Keene**
- **Donald Meichenbaum**
- **Patricia Resick**

Cognitive-Behavioral Therapy

- **Systematic Desensitization**
- **Stress Inoculation Training**
- **Biofeedback**
- **Relaxation Training/Mindfulness**
- **Eye Movement Desensitization Reprocessing**
- **Direct Therapeutic Exposure (DTE)/ Prolonged Exposure (PE)/Flooding**

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COGNITIVE BEHAVIORAL THERAPY

Key Concepts

http://www.nacbt.org/whatiscbt.htm

Cognitive-Behavioral Therapy

Key Concept 1

CBT is based on the Cognitive Model of Emotional Response.

Cognitive-behavioral therapy is based on the idea that our *thoughts* cause our feelings and behaviors, not external things, like people, situations, and events.

The benefit of this fact is that we can change the way we think, to feel or act better even if the situation does not change.

Cognitive-Behavioral Therapy

Key Concept 2

CBT is Briefer and Time-Limited.

Cognitive-behavioral therapy is considered among the most rapid in terms of results obtained. The average number of sessions clients receive (across all types of problems and approaches to CBT) is only **16.** Other forms of therapy, like psychoanalysis, can take years. What enables CBT to be briefer is its highly instructive nature and the fact that it makes use of **homework assignments.** CBT is time-limited in that we help clients understand at the very beginning of the therapy process that there will be a point when the formal therapy will end. The ending of the formal therapy is a decision made by the therapist and client. Therefore, CBT is not an open-ended, never-ending process.

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Cognitive-Behavioral Therapy

Key Concept 3

A sound therapeutic alliance is necessary for effective therapy, but not the focus.

Some forms of therapy assume that the main reason people get better in therapy is because of the positive relationship between the therapist and client.

Cognitive-behavioral therapists believe it is important to have a good, trusting relationship, but that is not enough.

CBT therapists believe that the **clients change because they learn how to think differently and they act on that learning.**

Therefore, CBT therapists focus on teaching rational self-counseling skills.

Cognitive-Behavioral Therapy

Key Concept 4

CBT is a collaborative effort between the therapist and the client.

Cognitive-behavioral therapists seek to learn what their clients want out of life (their goals) and then help their clients achieve those goals.

The therapist's role is to listen, teach, and encourage, while the client's roles is to express concerns, learn, and implement that learning

Cognitive-Behavioral Therapy

Key Concept 5

CBT is based on aspects of stoic philosophy.

Not all approaches to CBT emphasize stoicism. Rational Emotive Behavior Therapy, Rational Behavior Therapy, and Rational Living Therapy emphasize aspects of stoicism. Beck's Cognitive Therapy is not based on stoicism.

Cognitive-behavioral therapy does not tell people how they should feel. However, most people seeking therapy do not want to feel they way they have been feeling. The approaches that emphasize stoicism teach the benefits of feeling, at worst, *calm* when confronted with undesirable situations. They also emphasize the fact that we have our undesirable situations whether we are upset about them or not. If we are upset about our problems, we have two problems -- the problem, and our upset about it. Most people want to have the fewest number of problems possible. So when we learn how to **more calmly accept a personal problem**, not only do we feel better, but we usually put ourselves in a better position to make use of our intelligence, knowledge, energy, and resources to resolve the problem

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Cognitive-Behavioral Therapy

Key Concept 6

CBT uses the Socratic Method.

Cognitive-behavioral therapists want to gain a very good understanding of their clients' concerns. That's why they ask open ended *questions.*

They also encourage their clients to ask questions of themselves, like, "How do I really know that those people are laughing at me?" "Could they be laughing about something else?“

Cognitive-Behavioral Therapy

Key Concept 7

CBT is structured and directive.

Cognitive-behavioral therapists have a specific agenda for each session.

Specific techniques / concepts are taught during each session.

CBT focuses on the client's goals.

We do not tell our clients what their goals "should" be, or what they "should" tolerate. We are directive in the sense that we show our clients how to think and behave in ways to obtain what they want.

Therefore, **CBT therapists do not tell their clients *what* to do – rather, they teach their clients *how* to do.**

Cognitive-Behavioral Therapy

Key Concept 8

CBT is based on an educational model.

CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned.

Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting.

Therefore, CBT has nothing to do with "just talking".
People can "just talk“ with anyone.

The educational emphasis of CBT has an additional benefit -- it leads to long term results. When people understand **how and why** they are doing well, they know what to do to continue doing well.

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Cognitive-Behavioral Therapy

Key Concept 9

CBT theory and techniques rely on the Inductive Method.

A central aspect of *Rational* thinking is that it is based on *fact.* Often, we upset ourselves about things when, in fact, the situation isn't like we think it is.

If we knew that, we would not waste our time upsetting ourselves. Therefore, the inductive method encourages us to look at our thoughts as being hypotheses or guesses that can be questioned and tested.

If we find that our hypotheses are incorrect (because we have new information), then we can change our thinking to be in line with how the situation really is.

Cognitive-Behavioral Therapy

Key Concept 10

Homework is a central feature of CBT.

If when you attempted to learn your multiplication tables you spent only one hour per week studying them, you might still be wondering what 5 X 5 equals. You very likely spent a great deal of time at home studying your multiplication tables, maybe with flashcards.

The same is the case with psychotherapy. Goal achievement (if obtained) could take a very long time if all a person were only to think about the techniques and topics taught was for one hour per week. That's why CBT therapists assign reading assignments and encourage their clients to practice the techniques learned.

Cognitive behavioral therapy

Template for Treatment Trajectory

1. **Assessment**
2. **Stabilization**
   - **Psychoeducation**
   - **Relaxation/Breathing**
   - **Mindfulness**
   - **Cognitive & Behavioral Strategies**
3. **Trauma Memory Processing**
   - **Exposure (imaginal or *in vivo*) + Relaxation**

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In vivo exposure

- In vivo exposure refers to the direct confrontation of feared objects, activities, or situations by a client/patient.
- For example, a woman with PTSD who fears the location where she was assaulted may be assisted by her therapist in going to that location and directly confronting those fears (as long as it is safe to do so).
- Likewise, a person with social anxiety disorder who fears public speaking may be instructed to directly confront those fears by giving a speech.

Cognitive behavioral therapy

Positive

- Brief treatment (usually 8-12 sessions)
- Easily measured and researched
- Clear and concise
- Many books and manuals for clients to read/homework
- Easy to find therapists
- Moderate training to gain mastery

Negative

- Clients sometimes experience CBT and practitioners as "overly technical"
- Can minimize affective/emotional experiences
- Therapist-driven

Eye Movement Desensitization & Reprocessing (EMDR)

- Francine Shapiro (1987)
- over 60,000 licensed mental health therapists in 52 countries

- An integrated model that draws from behavioral, cognitive, psychodynamic, body-based, and systems therapies, EMDR provides profound and stable treatment effects in a short period of time.
- an eight-phase treatment that includes the use of eye movements or other bi-lateral (i.e., left-right) stimulation
- **There are more controlled studies to date on EMDR than on any other method used in the treatment of trauma.**
- EMDR is the only well-researched treatment model capable of addressing multiple incidents of trauma simultaneously

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EMDR

8 Phases – 11 Steps

EMDR's effectiveness, like all psychotherapies, is contingent upon the development and maintenance of a good therapeutic relationship

EMDR Institute, Inc.
PO Box 51010
Pacific Grove
CA 93950-6010 USA
Tel: 831-372-3900
Fax: 831-647-9881
http://www.emdr.com
email: inst@emdr

Eight Phases

Treatment using EMDR is a highly structured form of psychotherapy organized into eight (8) discreet phases. The EMDR protocol utilizes 11 steps.

- **1. Client History/Treatment Plan**
- **2. Preparation**
- **3. Assessment**
- **4. Desensitization**
- **5. Installation**
- **6. Body Scan**
- **7. Closure**
- **8. Reevaluation**

EMDR

Key Concepts

- Accelerated Information Processing Model. Does not assume pathology – instead believes survivors are in process of adapting and self-healing. EMDR is said to facilitate and accelerate this self-healing. Thwarted self-healing is the cause of symptoms according to this model.
- Bilateral Stimulation assists with processing of traumatic material
  - Facilitating relaxation
  - Distraction
  - Diminished capacity for repression and inhibition
  - Dual focus

EMDR

Key Concepts

- **Multimodal.** EMDR utilizes cognitive, behavioral, somatic, schematic, affective, and self-assessment components.
- Client-driven
- All forms of bilateral stimulation equally effective
- Equal to classic CBT but more quickly achieves resolution with lowered drop out rates

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EMDR

11-Steps

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

Hypnotherapy/ Neuro-Lingustic Programming (NLP)

- **Pierre Janet**
- **Milton Erickson**
- **Richard Bandler & John Grinder**
- **Danny Brom**

- Uses imaginal and hypnotic protocols to assist the trauma survivor in confronting and mastering traumatic memories
- Has demonstrated effectiveness in the literature

Traumatic Incident Reduction

Traumatic Incident Reduction Association

- TIRA
  13 NW Barry Road, Suite 214
  Kansas City, MO 64155-2728
  USA
  Phone: 816-468-4945 or 800-499-2751
  FAX: 816-468-6656
  Email: info@tir.org or 104602.2551@compuserve.com

- Client-directed exposure technique
- Clinician is "interested and not interesting"
- "Bearing witness"
- Organic process of the "viewer" identifying what most captures his/her interest

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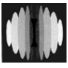
Somatic Experiencing

- Ron Kurtz
- Pat Ogden
- Babette Rothschild
- Peter Levine
- Bob Scaer
- Dave Bercelli

- Helps the survivor access, regulate and express the physiological effects of trauma.
- Body-centered
- Regulation and expression first, cognitive second



Trauma Recovery Institute

TRI Method

Trauma Recovery Institute
314 Scott Avenue
Morgantown, WV 26505
voice: (304) 291-2912
fax: (304) 291-2918
trauma@access.mountain.net

- Louis Tinnin & Linda Gantt
- Neo-Janetian, non-abreative theory-driven treatment
- Video-enhanced anamnesis
- Recursive review
- Trauma Art Therapy
- Focal Psychotherapy
- Self-soothing
- Video-dialogue

Trauma Memory Processing

The IATP 5-Narrative Model

(Gentry, 2004; 2011)

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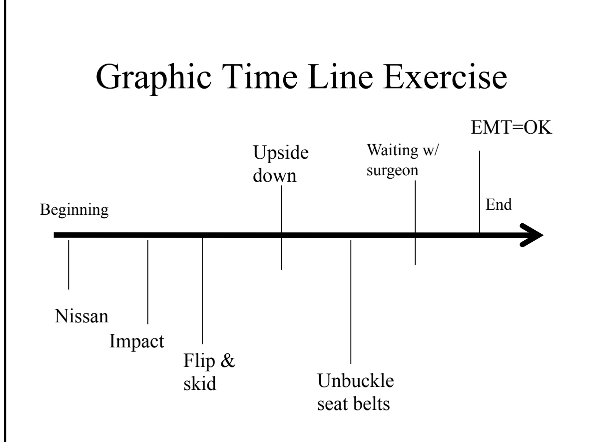

REMEMBRANCE & MOURNING
Traumatic Memory Processing

Trauma Memory Processing

Exercise I

Graphic Time Line

- Get "ICON" from envelope
- Use the "Graphic Narrative" sheet to map the microevents of traumatic event
- Identify SUDs, Beginning, End, Worst Part

REMEMBRANCE & MOURNING
Traumatic Memory Processing

Trauma Memory Processing

Exercise II

Written Exercise

- Write a chronological narrative of the trauma
- 5 minute halves

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REMEMBRANCE & MOURNING
Traumatic Memory Processing

Trauma Memory Processing

Exercise III

Graphic Narrative

- Use Large Paper
- Draw the events of the trauma in chronological order

REMEMBRANCE & MOURNING
Traumatic Memory Processing

Trauma Memory Processing

Exercise IV

Verbal Narrative (in dyads)

- Tell the story of your traumatic experience to a partner then switch
- Use drawings as a storyboard
- 15 minutes
- NAP & Bearing Witness by receiver

Pictoral Narrative

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REMEMBRANCE & MOURNING
Traumatic Memory Processing

Trauma Memory Processing

Exercise V

Communalization/Trauma Art Group

- Partner posts client's pictures
- Partner tells client's narrative (in 3rd person)
- Client remains a NAP while narrative is told
- Processing

Grieving allows us to heal, to remember with love rather than pain
It is a sorting process
One by one you let go of things that are gone
And you mourn for them
One by one you take hold of the things that have become part of
Who you are and build again

--Rachel Naomi Remen
In Worden, 2009

Counseling or Therapy?

GRIEF & MOURNING

Definitions

- **Grief/bereavement** – personal experience of loss
- **Mourning** – process one goes through in adapting to death/loss
- **Grief Counseling** – supporting "normal" adaptation to loss/death; supporting adaptation
- **Grief Therapy** – helping clients get "unstuck" in their mourning; facilitating adaptation

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Tasks of Mourning

(Worden, 2009)

1. Accept the Reality of the Loss
2. Process the Pain of Grief
3. Adjust to a World without the Deceased (Object)
   a. External Adjustments
   b. Internal Adjustments
   c. Spiritual Adjustments
4. Find an Enduring Connection with the Deceased in the Midst of embarking on a New Life

Grief Therapy

(Worden, 2009; Rando , 2007)

1. R/O Physical Disease/Illness
2. Set Up Contract/Establish Alliance
3. Revive Memories of the Deceased
4. Assess Which of 4 Tasks are Thwarted
5. Deal with Affect/Lack of Affect Stimulated by Memories

Grief Therapy

(Worden, 2009; Rando , 2007)

6. Explore and Diffuse Linking Objects
7. Help Acknowledge Finality of Loss
8. Help Design New Life Without the Deceased
9. Assess and Help Improve Social Relationships
10. Help Reframe Myth of Ending Grieving

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Completing Relationships

Accelerant (Tasks 5-7)

(Gentry, 2000)

- Ask client to write letter to deceased addressing following four tasks:
  1. Identify all the ways in which the deceased/lost caused you harm; move towards forgiveness;
  2. Identify all the ways in which you caused the deceased/lost harm; move towards amends;
  3. Articulate all the un-communicated emotional statements;
  4. Say good bye
- Use video camera to evoke presence of deceased/lost and ask client to read letter and speak extemporaneously into the eye of the camera

Reconnection

Welcome Home!

Reconnection

To what is it that trauma survivors are re-connecting?

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Reconnection

Exercise

Letter

1. Write letter to the "self" that has just experienced the trauma
2. From the perspective of the present self, who has resolved this trauma
3. What does s/he need to hear?
4. Reach toward reconnection

Reconnection

Memorials/Totems

"Make a bridge from the horrific past to a hopeful future" (Baranowsky)

Prayer circles

Monuments

Remote burial – canoe "passage"

MEANINGFUL RECONNECTION MEMORIALS?

Anti-Regression Strategy

(Tinnin, 1996)

Anti-Regression Strategy (Tinnin, 1996)

- No rumination
- No sedatives or stimulants
- No naps (no more than 8 hours in bed)
- Activation vs. retardation (walking, cleaning, gym, running, sports, etc)
- Time, Identity, & Volition
  - q30 min scheduling
  - Graphic time line
  - Meetings

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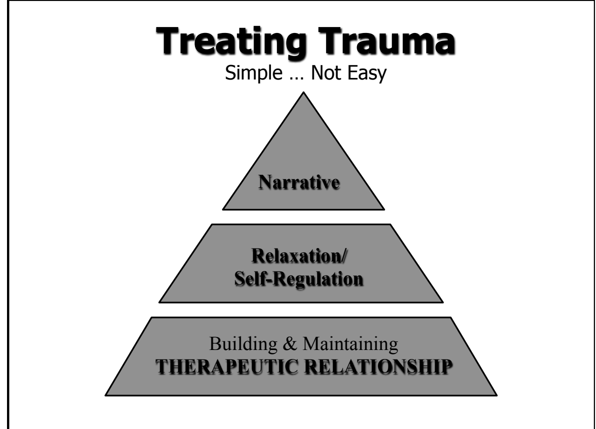

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(Dissociative) Regression

- Increasing Flashbacks/Escalating abreactions
- Overwhelming Affect
- Regressive Dependency
- Neo-cortical Shutdown
- Increased Rumination and motor retardation
- Autonomous executive ego functions, such as time, volition, identity and affect regulation begin to deteriorate
- Suicidal crises

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Anti-Regression Schedule

- Stop all trauma work
- Prohibitions
  - Alcohol, sedatives, or stimulants
  - No rumination
  - No naps
- Stimulus Barrier
  - Medication (short-term neuroleptic or anticonvulsant)
  - Interpersonal stimulation but avoiding over-stimulation
  - Avoid rumination by motor activity (aerobic)

Anti-Regression Schedule

- Reduce Ambiguity
  - Adopt a benign, authoritative manner with formalized role boundaries and careful, concrete communication, avoiding metaphor.
- Auxiliary Ego Function
  - "Therapeutic assistants" are enlisted from family, friends and significant others to perform specific tasks, for example, in keeping the patient on schedule completing therapeutic chores
  - Specific and prescribed – no "over helping"

Anti-Regression Schedule

- **Support Autonomous Ego Functions**
  - Daily schedule for sleep, meals and activities (q ½ hour) and hold patient to schedule;
  - patient keeps log of meals, sleep, activities, flashback journal;
  - video-taping of sessions to foster identity;
  - use of time-line narrative and graphic time-line to foster identity
  - scrapbook or bulletin board
  - Autobiography
  - "Right Brain" Programming
- **Grounding and Containment Skills**
  - For use with addictive reenactments and flashbacks.

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Anti-Regression Schedule

- Excellent and crucial stopgap to hospitalization
- Allows therapist to aggressively treat trauma without the worry of “breaking” patients
- 2-3 weeks client regains self-regulation

Whose squeezing?

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Exercises

Introduction

1. Name: ____

2. When I _____________ years old, I survived ________________

3. Some of the negative effects of this event upon my life were:

   a. ___________________________

   b. ___________________________

   c. ___________________________

4. The three most important things that helped me recover from the effects this event were:

   a. _______________________

   b. _______________________

   c. _______________________

5. Looking back, the most important thing that I have gained from this experience has been:

   a. _______________________

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PHASE I: SAFETY & STABILIZATION

Requirements

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

Skills

1. **Self-Regulation**
    a. Relax muscles of pelvic floor
    b. Relax muscles of soft palate
    c. Diaphragmatic breathing
    d. Peripheral vision
    e. “Stop squeezing”

2. **Safe-Place Picture with Anchoring & Transitional Object**
    a. Distribute paper and colored markers
    b. Tell client: *Draw a picture of a place that is safe and comfortable…it can be some place from your memory, that you been to before, or some place from your imagination, some place you've not yet been…just take the next five minutes to draw a picture that makes you feel safe and comfortable*
    c. Tell client “STOP” after 5 minutes
    d. Ask them: “*May I approach you?”*
    e. With permission, approach them and ask them to tell you about their drawing.
    f. Before they start hand them a polished stone and say to them: *“You know how you have memories and flashbacks of those BAD things that have happened to you? And how uncomfortable the feelings associated with those memories can be? Well some scientists found out several years ago that you can make flashbacks of GOOD memories also—so that you can call up to the present those positive feelings associated with this drawing in times when you are scared or overwhelmed. Would you like to give it a try?* If so, ask them: “*Then I would like for you to squeeze all those positive feelings from that drawing into that stone while you are telling me the story of that picture. Ready to start?”*
    g. Participate in the narrative…ask questions and provide support.
    h. When done ask how they are feeling.

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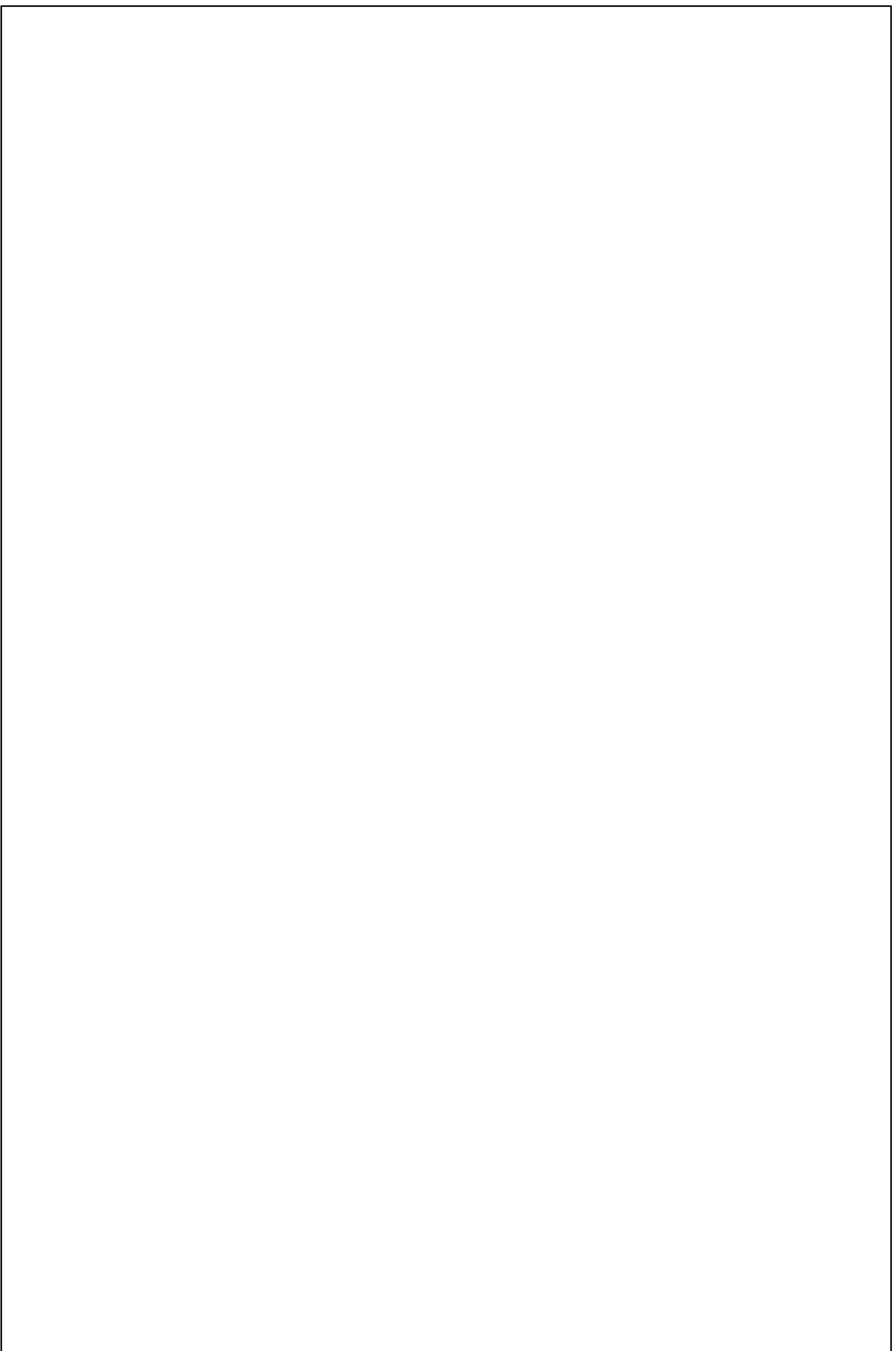

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3. **Postural Grounding**
   a. While the client is exhibiting the constricted and fetal posture, ask her/him, "How vulnerable to do feel right now in that posture?" You will usually get an answer like "very."
   b. Ask them to exaggerate this posture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

4. **Containment with Envelope (Trauma Containment or Session Close)**
   a. When a client is either overwhelmed by a trauma memory or has accessed some difficult material in the last 1/3 of a session you can use this technique to contain the traumatic material or safely bring a session to a close.
   b. (FOR SESSION CLOSURE) Give client paper and colored markers…ask them to draw what it feels like inside right now. 2 minutes only.
   c. (FOR TRAUMATIC CONTAINMENT) Give client paper and colored markers…ask them to draw what it feels like inside right now. 2 minutes only.
   d. After two minutes say: *STOP. Put your marker down and look at me.*
   e. While client has been drawing, retrieve a 9 x 12" envelope. Ask client to place their drawing in the envelope. Next, hand client a stapler and tell them: *Put as many staples in the top of this envelope as you need to make certain that this drawing stays in here.* Allow client to staple as many times as they wish.
   f. Say to client something like: *OK. You and I both know that you still have some work to do on this material and we'll get to it. However, therapy happens here, in my office, and life happens out there. If it is OK with you, I would like to hold on to this drawing and all the fear and feelings associated with it. I will keep it safe, locked in my*

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filing cabinet. When you are ready to work on it, we will take it out and address it. But until then, will it be OK if I hold on to it?

g. Remember to show to client upon their first return to your office following this session and ask them if they wish to address this material today or wait until another day.

5. **Self-Rescue from Abreaction**
   a. Signs of abreaction: shaking leg, wringing hands, fetalization of posture, downward fixation of eyes, tearfulness, flat or pressured speech, describing trauma with present-tense verbs.
   b. If you have a spontaneous abreaction, go to step "c". If your client does not spontaneously exhibit an abreaction during the first few sessions, it will be important for you to attempt to elicit or trigger one. You can do this by asking you client: *Tell me the worst part of that trauma* (look/listen for the above signs).
   c. After about 5-10 seconds of you client exhibiting progressive signs of an abreaction, get their attention by whistling or waving your hands followed by saying their name out loud. Ask them: *Would you like some help out of that place and to learn how you never again have to get stuck there…so you can always pull yourself back out?* Elicit "yes" response from client.
   d. Ask client to describe, out loud, three (3) objects that they can see in the room that are above eye level. (Make certain that these are physical, not imaginal, objects).
   e. Ask them to identify, out loud, three (3) "real world" sounds that they can currently hear sitting in the room (the sound can be beyond the room, just make certain that they are empirical and not from the traumatic material).
   f. Hand them any item (a pen, notebook, Kleenex), and ask them to really feel it and to describe, out loud, the texture of this object. Repeat this with two additional objects.
   g. Return to objects that they can see and ask them to identify now two (2) objects that they can see, above eye level. Do the same with things that they can hear and feel (instead of handing items to the client, ask them to reach out, touch, and describe the texture of two objects). Repeat this now with one object each for sight, sound, and texture.
   h. When completed, ask the client: *What is different than it was 90 seconds ago?* Most of the time your client will describe a significant lessening of negative feelings, thoughts and images associated with the traumatic material.

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PHASE II: Remembrance & Mourning (Memory Processing)

TRAUMA NARRATIVES

IATP 5-Narrative CBT Model for Desensitizing & Reprocessing Trauma Memories (Gentry, 2004, 2010).

Contained in the next four pages you will find templates for four exercises. In each of these exercises we will be desensitizing and reprocessing a real event from your life. It is important that you select an event that has a little bit of a charge but not so much that it is going to overwhelm you as we work on reprocessing this material (SUDs >2 and <5).

1. **Graphic Time-Line.** Complete this exercise in 15 minutes over lunch. This exercise should help you to begin to structure the experience into a chronological narrative. You should first identify two discreet points--the beginning point (when the trauma started) and the end point (when the danger was over). With these two points constructed, identify each micro-event during the traumatic experience that you identify. If the event *currently* feels negative, then a downward line should be drawn perpendicular to the time line. The lower the line, the more Subjective Units of Distress (SUDs) you are *currently* experiencing and the closer the line should approach the bottom of the page (-10). If the micro-event *currently* feels positive, then the line should be drawn upward from the perpendicular to the time line. The higher the line, the more *currently* positive the experience feels. Complete a line for each micro-event until all the significant micro-events of the trauma have been catalogued on the page. (5 min)
2. **Written Time-Line.** Draw a vertical line in the middle of the graphic time line, separating it into two halves. For the first five minutes, write a narrative of the micro-events of the first half and for the second five minutes write a narrative of the second half. The facilitator will inform you when you have 3, 2, and 1 minutes remaining on each half. (5 minutes halves with relaxation between)
3. **Pictorial Narrative.** Draw a cartoon-like sequence of six (6) of the primary micro-events of your trauma. Start with a pictorial representation of the beginning of the trauma. Next, draw the end of the trauma. Then fill in the narrative between in pictures. Do not worry about the quality of the pictures, just allow yourself to capture and express the with images the micro-events of this experience (10 min)
4. **Verbal Narrative.** Tell you narrative to a partner in dyads. Use the graphic time line and pictorial narrative to help your partner understand the chronology of the event. Take 10 minutes each. When you are in the receiver's role, practice self-regulation so that you remain relaxed and without charge (15 min)
5. **Recursive Narrative.** Ask your partner to hold their pictures for a few minutes. Hold pictures so that client/partner can see them. Tell their story back to them in as much detail as possible, using their words and descriptions. Use their name and third-person pronouns, not “you”.

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Graphic Time Line Narrative

Positive + 10

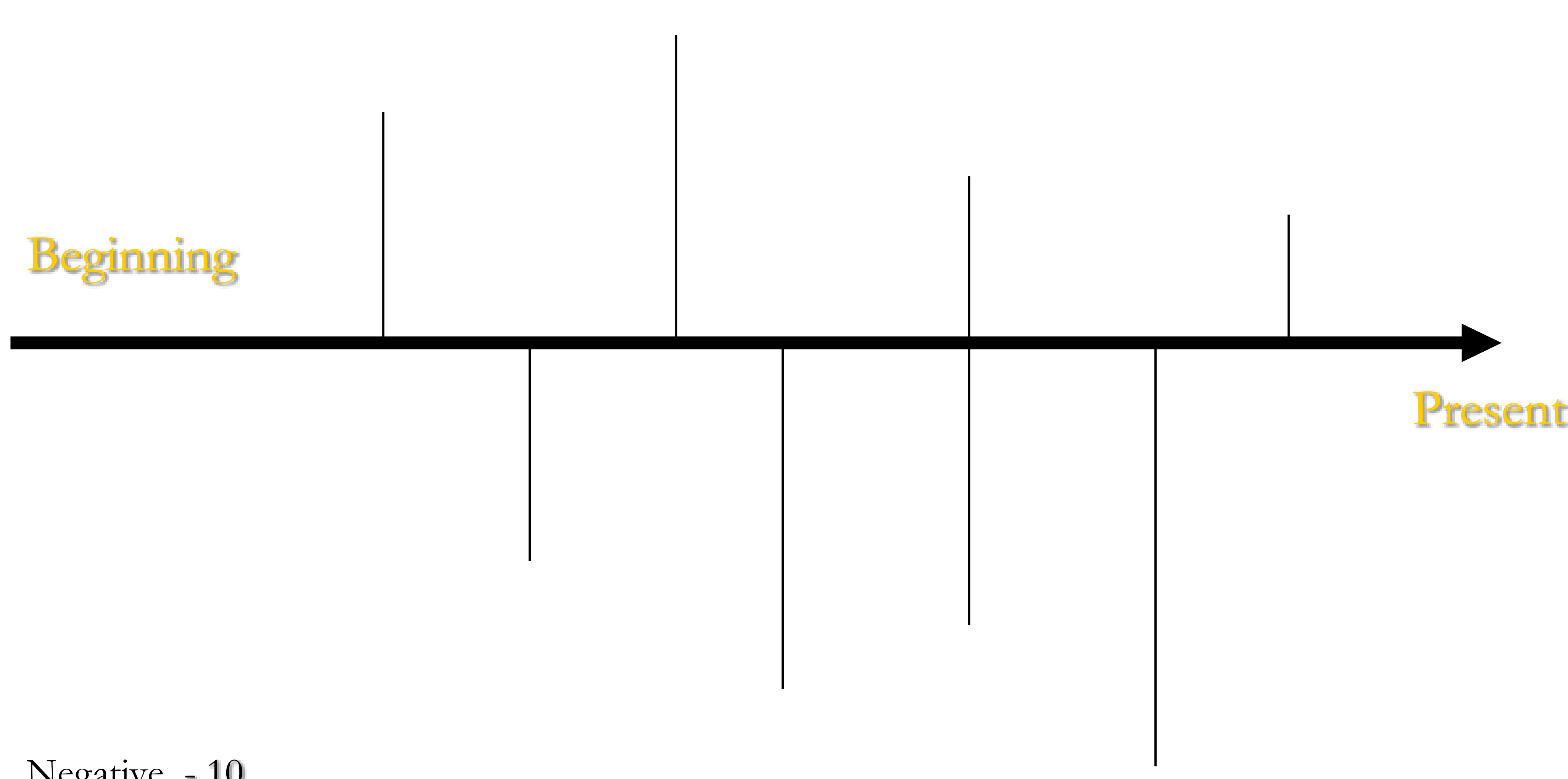
Beginning

Present

Negative - 10

Graphic Time Line Narrative

Positive + 10



Negative - 10

Graphic Time Line Narrative

Positive + 10

Beginning

Present

Negative - 10

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Written Narrative

First Half

Second Half

1	3	4
5	6	2

Assessment Materials

SESSION RATING SCALE. SRS. Developed by Scott Miller to measure and enhance therapeutic alliance with your clients. Instrument and more information available at www.scottdmiller.com.

TRAUMA RECOVERY SCALE (TRS; GENTRY, 1996, 1999). Parts I & II provide a traumatic experiences inventory. Part III measures relative recovery from traumatic experiences. Can be used as a regularly administered tool for tracking treatment effectiveness. Psychometrics: r = .91; convergent validity (with IES) = .71

CLINICIAN ADMINISTERED PTSD SCALE. CAPS. Most valid and utilized instrument to confer diagnosis of PTSD. Manual and copies of the instrument available at: www.ptsd.va.gov

Session Rating Scale (SRS V.3.0)

Name ________________________Age (Yrs):____
ID# _________________________ Sex: M / F
Session # ____ Date: ________________________

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

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

© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson

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Score:	**TRS**	Name

TRS

TRAUMA RECOVERY SCALE

PART I

___yes___no I have been exposed to a traumatic event in which ***both*** of the following were present:

a. experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, ***AND***

b. my response involved intense fear, helplessness or horror.

- If **yes** is answered please complete Part II & III;
- If **no** is answered complete Part III (omit Part II)

PART II

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

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

Comments: ____

____

____

____

____

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PART III

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

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

0% 100% of the time

2. I sleep free from nightmares.

0% 100% of the time

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

0% 100% of the time

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

0% 100% of the time

5. I am safe.

0% 100% of the time

I feel safe.

0% 100% of the time

6. I have supportive relationships in my life.

0% 100% of the time

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

0% 100% of the time

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

0% 100% of the time

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

0% 100% of the time

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

0% 100% of the time

AS – FS

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

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

Mean Score

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National Center for PTSD

CLINICIAN-ADMINISTERED PTSD SCALE FOR DSM-IV

Name: _____________________________ ID # :__________________

Date: __________________

Interviewer: _____________________________

Study: _____________________________

Dudley D. Blake, Frank W. Weathers, Linda M. Nagy,
Danny G. Kaloupek, Dennis S. Charney, & Terence M. Keane

National Center for Posttraumatic Stress Disorder

Behavioral Science Division -- Boston VA Medical Center
Neurosciences Division -- West Haven VA Medical Center

Revised July 1998

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Criterion A. The person has been exposed to a traumatic event in which both of the following were present:
(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

I'm going to be asking you about some difficult or stressful things that sometimes happen to people. Some examples of this are being in some type of serious accident; being in a fire, a hurricane, or an earthquake; being mugged or beaten up or attacked with a weapon; or being forced to have sex when you didn't want to. I'll start by asking you to look over a list of experiences like this and check any that apply to you. Then, if any of them do apply to you, I'll ask you to briefly describe what happened and how you felt at the time.

Some of these experiences may be hard to remember or may bring back uncomfortable memories or feelings. People often find that talking about them can be helpful, but it's up to you to decide how much you want to tell me. As we go along, if you find yourself becoming upset, let me know and we can slow down and talk about it. Also, if you have any questions or you don't understand something, please let me know. Do you have any questions before we start?

ADMINISTER CHECKLIST, THEN REVIEW AND INQUIRE UP TO THREE EVENTS. IF MORE THAN THREE EVENTS ENDORSED, DETERMINE WHICH THREE EVENTS TO INQUIRE (E.G., FIRST, WORST, AND MOST RECENT EVENTS; THREE WORST EVENTS; TRAUMA OF INTEREST PLUS TWO OTHER WORST EVENTS, ETC.)

IF NO EVENTS ENDORSED ON CHECKLIST: *(Has there ever been a time when your life was in danger or you were seriously injured or harmed?)*

IF NO: *(What about a time when you were threatened with death or serious injury, even if you weren't actually injured or harmed?)*

IF NO: *(What about witnessing something like this happen to someone else or finding out that it happened to someone close to you?)*

IF NO: *(What would you say are some of the most stressful experiences you have had over your life?)*

EVENT #1

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(Were you very anxious or frightened? Horrified? Helpless? How so? Were you stunned or in shock so that you didn't feel anything at all? What was that like? What did other people notice about your emotional response? What about after the event -- how did you respond emotionally?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

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EVENT #2

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(Were you very anxious or frightened? Horrified? Helpless? How so? Were you stunned or in shock so that you didn't feel anything at all? What was that like? What did other people notice about your emotional response? What about after the event - - how did you respond emotionally?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

EVENT #3

What happened? *(How old were you? Who else was involved? How many times did this happen? Life threat? Serious injury?)*	*Describe (e.g., event type, victim, perpetrator, age, frequency):*
How did you respond emotionally? *(Were you very anxious or frightened? Horrified? Helpless? How so? Were you stunned or in shock so that you didn't feel anything at all? What was that like? What did other people notice about your emotional response? What about after the event - - how did you respond emotionally?)*	*A. (1)* *Life threat? NO YES [self ___ other ___]* *Serious injury? NO YES [self ___ other ___]* *Threat to physical integrity? NO YES [self ___ other ___]* *A. (2)* *Intense fear/help/horror? NO YES [during ___ after ___]* *Criterion A met? NO PROBABLE YES*

For the rest of the interview, I want you to keep (EVENTS) in mind as I ask you some questions about how they may have affected you.

I'm going to ask you about twenty-five questions altogether. Most of them have two parts. First, I'll ask if you've ever had a particular problem, and if so, about how often in the past month *(week)*. Then I'll ask you how much distress or discomfort that problem may have caused you.

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Criterion B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. (B-1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

Frequency	Intensity	
Frequency **Have you ever had unwanted memories of (EVENT)? What were they like?** *(What did you remember?)* [IF NOT CLEAR:] *(Did they ever occur while you were awake, or only in dreams?)* [EXCLUDE IF MEMORIES OCCURRED ONLY DURING DREAMS] **How often have you had these memories in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	***Intensity*** **How much distress or discomfort did these memories cause you? Were you able to put them out of your mind and think about something else?** *(How hard did you have to try?)* **How much did they interfere with your life?** 0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities 4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

2. (B-2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

Frequency	Intensity	
Frequency **Have you ever had unpleasant dreams about (EVENT)? Describe a typical dream.** *(What happens in them?)* **How often have you had these dreams in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	***Intensity*** **How much distress or discomfort did these dreams cause you? Did they ever wake you up?** [IF YES:] *(What happened when you woke up? How long did it take you to get back to sleep?)* [LISTEN FOR REPORT OF ANXIOUS AROUSAL, YELLING, ACTING OUT THE NIGHTMARE] *(Did your dreams ever affect anyone else? How so?)* 0 None 1 Mild, minimal distress, may not have awoken 2 Moderate, awoke in distress but readily returned to sleep 3 Severe, considerable distress, difficulty returning to sleep 4 Extreme, incapacitating distress, did not return to sleep ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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3. (B-3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

Frequency	***Intensity***	***Past week***
Have you ever suddenly acted or felt as if (EVENT) were happening again? *(Have you ever had flashbacks about [EVENT]?)* [IF NOT CLEAR:] *(Did this ever occur while you were awake, or only in dreams?)* [EXCLUDE IF OCCURRED ONLY DURING DREAMS] **Tell me more about that. How often has that happened in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much did it seem as if (EVENT) were happening again?** *(Were you confused about where you actually were or what you were doing at the time?)* **How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No reliving 1 Mild, somewhat more realistic than just thinking about event 2 Moderate, definite but transient dissociative quality, still very aware of surroundings, daydreaming quality 3 Severe, strongly dissociative (reports images, sounds, or smells) but retained some awareness of surroundings 4 Extreme, complete dissociation (flashback), no awareness of surroundings, may be unresponsive, possible amnesia for the episode (blackout) ***QV (specify)*** ________________________________	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

4. (B-4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Frequency	***Intensity***	***Past week***
Have you ever gotten emotionally upset when something reminded you of (EVENT)? *(Has anything ever triggered bad feelings related to [EVENT]?)* **What kinds of reminders made you upset? How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much distress or discomfort did (REMINDERS) cause you? How long did it last? How much did it interfere with your life?** 0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, marked disruption of activities 4 Extreme, incapacitating distress, unable to continue activities ***QV (specify)*** ________________________________	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

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5. (B-5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Frequency	Intensity	Past week
Frequency **Have you ever had any physical reactions when something reminded you of (EVENT)?** *(Did your body ever react in some way when something reminded you of [EVENT]?)* **Can you give me some examples?** *(Did your heart race or did your breathing change? What about sweating or feeling really tense or shaky?)* **What kinds of reminders triggered these reactions? How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	***Intensity*** **How strong were (PHYSICAL REACTIONS)? How long did they last?** *(Did they last even after you were out of the situation?)* 0 No physical reactivity 1 Mild, minimal reactivity 2 Moderate, physical reactivity clearly present, may be sustained if exposure continues 3 Severe, marked physical reactivity, sustained throughout exposure 4 Extreme, dramatic physical reactivity, sustained arousal even after exposure has ended ***QV (specify)*** ______________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

Criterion C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

6. (C-1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

Frequency	Intensity	Past week
Frequency **Have you ever tried to avoid thoughts or feelings about (EVENT)?** *(What kinds of thoughts or feelings did you try to avoid?)* **What about trying to avoid talking with other people about it?** *(Why is that?)* **How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	***Intensity*** **How much effort did you make to avoid (THOUGHTS/FEELINGS/CONVERSATIONS)?** *(What kinds of things did you do? What about drinking or using medication or street drugs?)* [CONSIDER ALL ATTEMPTS AT AVOIDANCE, INCLUDING DISTRACTION, SUPPRESSION, AND USE OF ALCOHOL/DRUGS] **How much did that interfere with your life?** 0 None 1 Mild, minimal effort, little or no disruption of activities 2 Moderate, some effort, avoidance definitely present, some disruption of activities 3 Severe, considerable effort, marked avoidance, marked disruption of activities, or involvement in certain activities as avoidant strategy 4 Extreme, drastic attempts at avoidance, unable to continue activities, or excessive involvement in certain activities as avoidant strategy ***QV (specify)*** ______________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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7. (C-2) efforts to avoid activities, places, or people that arouse recollections of the trauma

Frequency	Intensity	
Have you ever tried to avoid certain activities, places, or people that reminded you of (EVENT)? *(What kinds of things did you avoid? Why is that?)* **How often in the past month *(week)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How much effort did you make to avoid (ACTIVITIES/PLACES/PEOPLE)?** *(What did you do instead?)* **How much did that interfere with your life?** 0 None 1 Mild, minimal effort, little or no disruption of activities 2 Moderate, some effort, avoidance definitely present, some disruption of activities 3 Severe, considerable effort, marked avoidance, marked disruption of activities or involvement in certain activities as avoidant strategy 4 Extreme, drastic attempts at avoidance, unable to continue activities, or excessive involvement in certain activities as avoidant strategy ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

8. (C-3) inability to recall an important aspect of the trauma

Frequency	Intensity	
Have you had difficulty remembering some important parts of (EVENT)? Tell me more about that. *(Do you feel you should be able to remember these things? Why do you think you can't?)* **In the past month *(week)*, how much of the important parts of (EVENT) have you had difficulty remembering?** *(What parts do you still remember?)* 0 None, clear memory 1 Few aspects not remembered (less than 10%) 2 Some aspects not remembered (approx 20-30%) 3 Many aspects not remembered (approx 50-60%) 4 Most or all aspects not remembered (more than 80%) ***Description/Examples***	**How much difficulty did you have recalling important parts of (EVENT)?** *(Were you able to recall more if you tried?)* 0 None 1 Mild, minimal difficulty 2 Moderate, some difficulty, could recall with effort 3 Severe, considerable difficulty, even with effort 4 Extreme, completely unable to recall important aspects of event ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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9. (C-4) markedly diminished interest or participation in significant activities

Frequency	Intensity	
Frequency **Have you been less interested in activities that you used to enjoy?** *(What kinds of things have you lost interest in? Are there some things you don't do at all anymore? Why is that?)* [EXCLUDE IF NO OPPORTUNITY, IF PHYSICALLY UNABLE, OR IF DEVELOPMENTALLY APPROPRIATE CHANGE IN PREFERRED ACTIVITIES] **In the past month *(week)*, how many activities have you been less interested in?** *(What kinds of things do you still enjoy doing?)* **When did you first start to feel that way?** *(After the [EVENT]?)* 0 None 1 Few activities (less than 10%) 2 Some activities (approx 20-30%) 3 Many activities (approx 50-60%) 4 Most or all activities (more than 80%) ***Description/Examples***	***Intensity*** **How strong was your loss of interest?** *(Would you enjoy [ACTIVITIES] once you got started?)* 0 No loss of interest 1 Mild, slight loss of interest, probably would enjoy after starting activities 2 Moderate, definite loss of interest, but still has some enjoyment of activities 3 Severe, marked loss of interest in activities 4 Extreme, complete loss of interest, no longer participates in any activities ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

10. (C-5) feeling of detachment or estrangement from others

Frequency	Intensity	
Frequency **Have you felt distant or cut off from other people? What was that like? How much of the time in the past month *(week)* have you felt that way? When did you first start to feel that way?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How strong were your feelings of being distant or cut off from others?** *(Who do you feel closest to? How many people do you feel comfortable talking with about personal things?)* 0 No feelings of detachment or estrangement 1 Mild, may feel "out of synch" with others 2 Moderate, feelings of detachment clearly present, but still feels some interpersonal connection 3 Severe, marked feelings of detachment or estrangement from most people, may feel close to only one or two people 4 Extreme, feels completely detached or estranged from others, not close with anyone ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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11. (C-6) restricted range of affect (e.g., unable to have loving feelings)

Frequency	Intensity	
Frequency **Have there been times when you felt emotionally numb or had trouble experiencing feelings like love or happiness? What was that like?** *(What feelings did you have trouble experiencing?)* **How much of the time in the past month *(week)* have you felt that way? When did you first start having trouble experiencing (EMOTIONS)?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How much trouble did you have experiencing (EMOTIONS)?** *(What kinds of feelings were you still able to experience?)* [INCLUDE OBSERVATIONS OF RANGE OF AFFECT DURING INTERVIEW] 0 No reduction of emotional experience 1 Mild, slight reduction of emotional experience 2 Moderate, definite reduction of emotional experience, but still able to experience most emotions 3 Severe, marked reduction of experience of at least two primary emotions (e.g., love, happiness) 4 Extreme, completely lacking emotional experience ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

12. (C-7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Frequency	Intensity	
Frequency **Have there been times when you felt there is no need to plan for the future, that somehow your future will be cut short? Why is that?** [RULE OUT REALISTIC RISKS SUCH AS LIFE-THREATENING MEDICAL CONDITIONS] **How much of the time in the past month *(week)* have you felt that way? When did you first start to feel that way?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How strong was this feeling that your future will be cut short?** *(How long do you think you will live? How convinced are you that you will die prematurely?)* 0 No sense of a foreshortened future 1 Mild, slight sense of a foreshortened future 2 Moderate, sense of a foreshortened future definitely present, but no specific prediction about longevity 3 Severe, marked sense of a foreshortened future, may make specific prediction about longevity 4 Extreme, overwhelming sense of a foreshortened future, completely convinced of premature death ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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Criterion D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

13. (D-1) difficulty falling or staying asleep

Frequency	***Intensity***	***Past week***
Have you had any problems falling or staying asleep? How often in the past month *(week)*? When did you first start having problems sleeping? *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day Sleep onset problems? Y N Mid-sleep awakening? Y N Early a.m. awakening? Y N Total # hrs sleep/night _____ Desired # hrs sleep/night _____	**How much of a problem did you have with your sleep?** *(How long did it take you to fall asleep? How often did you wake up in the night? Did you often wake up earlier than you wanted to? How many total hours did you sleep each night?)* 0 No sleep problems 1 Mild, slightly longer latency, or minimal difficulty staying asleep (up to 30 minutes loss of sleep) 2 Moderate, definite sleep disturbance, clearly longer latency, or clear difficulty staying asleep (30-90 minutes loss of sleep) 3 Severe, much longer latency, or marked difficulty staying asleep (90 min to 3 hrs loss of sleep) 4 Extreme, very long latency, or profound difficulty staying asleep (> 3 hrs loss of sleep) ***QV (specify)*** ______________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

14. (D-2) irritability or outbursts of anger

Frequency	***Intensity***	***Past week***
Have there been times when you felt especially irritable or showed strong feelings of anger? Can you give me some examples? How often in the past month *(week)*? When did you first start feeling that way? *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was your anger?** *(How did you show it?)* [IF REPORTS SUPPRESSION:] *(How hard was it for you to keep from showing your anger?)* **How long did it take you to calm down? Did your anger cause you any problems?** 0 No irritability or anger 1 Mild, minimal irritability, may raise voice when angry 2 Moderate, definite irritability or attempts to suppress anger, but can recover quickly 3 Severe, marked irritability or marked attempts to suppress anger, may become verbally or physically aggressive when angry 4 Extreme, pervasive anger or drastic attempts to suppress anger, may have episodes of physical violence ***QV (specify)*** ______________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

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15. (D-3) difficulty concentrating

Frequency	Intensity	
Frequency **Have you found it difficult to concentrate on what you were doing or on things going on around you? What was that like? How much of the time in the past month *(week)*? When did you first start having trouble concentrating?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How difficult was it for you to concentrate?** [INCLUDE OBSERVATIONS OF CONCENTRATION AND ATTENTION IN INTERVIEW] **How much did that interfere with your life?** 0 No difficulty with concentration 1 Mild, only slight effort needed to concentrate, little or no disruption of activities 2 Moderate, definite loss of concentration but could concentrate with effort, some disruption of activities 3 Severe, marked loss of concentration even with effort, marked disruption of activities 4 Extreme, complete inability to concentrate, unable to engage in activities ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** ***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

16. (D-4) hypervigilance

Frequency	Intensity	
Frequency **Have you been especially alert or watchful, even when there was no real need to be?** *(Have you felt as if you were constantly on guard?)* **Why is that? How much of the time in the past month *(week)*? When did you first start acting that way?** *(After the [EVENT]?)* 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How hard did you try to be watchful of things going on around you?** [INCLUDE OBSERVATIONS OF HYPERVIGILANCE IN INTERVIEW] **Did your (HYPERVIGILANCE) cause you any problems?** 0 No hypervigilance 1 Mild, minimal hypervigilance, slight heightening of awareness 2 Moderate, hypervigilance clearly present, watchful in public (e.g., chooses safe place to sit in a restaurant or movie theater) 3 Severe, marked hypervigilance, very alert, scans environment for danger, exaggerated concern for safety of self/family/home 4 Extreme, excessive hypervigilance, efforts to ensure safety consume significant time and energy and may involve extensive safety/checking behaviors, marked watchfulness during interview ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***Past week*** ***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

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17. (D-5) exaggerated startle response

Frequency	***Intensity***	***Past week***
Have you had any strong startle reactions? When did that happen? *(What kinds of things made you startle?)* **How often in the past month *(week)*? When did you first have these reactions?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong were these startle reactions?** *(How strong were they compared to how most people would respond?)* **How long did they last?** 0 No startle reaction 1 Mild, minimal reaction 2 Moderate, definite startle reaction, feels "jumpy" 3 Severe, marked startle reaction, sustained arousal following initial reaction 4 Extreme, excessive startle reaction, overt coping behavior (e.g., combat veteran who "hits the dirt") ***QV (specify)*** _______________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current _____ Lifetime _____*	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

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

18. onset of symptoms

[IF NOT ALREADY CLEAR:] **When did you first start having (PTSD SYMPTOMS) you've told me about?** *(How long after the trauma did they start? More than six months?)*	________ ***total # months delay in onset*** ***With delayed onset (≥ 6 months)? NO YES***

19. duration of symptoms

		Current	***Lifetime***
[CURRENT] **How long have these (PTSD SYMPTOMS) lasted altogether?**	*Duration more than 1 month?*	***NO YES***	***NO YES***
	Total # months duration	________	________
[LIFETIME] **How long did these (PTSD SYMPTOMS) last altogether?**	*Acute (< 3 months) or chronic (≥ 3 months)?*	***acute chronic***	***acute chronic***

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

20. subjective distress

		Past week
[CURRENT] **Overall, how much have you been bothered by these (PTSD SYMPTOMS) you've told me about?** [CONSIDER DISTRESS REPORTED ON EARLIER ITEMS] [LIFETIME] **Overall, how much were you bothered by these (PTSD SYMPTOMS) you've told me about?** [CONSIDER DISTRESS REPORTED ON EARLIER ITEMS]	0 None 1 Mild, minimal distress 2 Moderate, distress clearly present but still manageable 3 Severe, considerable distress 4 Extreme, incapacitating distress	____ ***Past month*** ____ ***Lifetime***

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21. impairment in social functioning

[CURRENT] **Have these (PTSD SYMPTOMS) affected your relationships with other people? How so?** [CONSIDER IMPAIRMENT IN SOCIAL FUNCTIONING REPORTED ON EARLIER ITEMS] [LIFETIME] **Did these (PTSD SYMPTOMS) affect your social life? How so?** [CONSIDER IMPAIRMENT IN SOCIAL FUNCTIONING REPORTED ON EARLIER ITEMS]	0 No adverse impact 1 Mild impact, minimal impairment in social functioning 2 Moderate impact, definite impairment, but many aspects of social functioning still intact 3 Severe impact, marked impairment, few aspects of social functioning still intact 4 Extreme impact, little or no social functioning	***Past week*** ____ ***Past month*** ____ ***Lifetime*** ____

22. impairment in occupational or other important area of functioning

[CURRENT -- IF NOT ALREADY CLEAR] **Are you working now?** IF YES: **Have these (PTSD SYMPTOMS) affected your work or your ability to work? How so?** [CONSIDER REPORTED WORK HISTORY, INCLUDING NUMBER AND DURATION OF JOBS, AS WELL AS THE QUALITY OF WORK RELATIONSHIPS. IF PREMORBID FUNCTIONING IS UNCLEAR, INQUIRE ABOUT WORK EXPERIENCES BEFORE THE TRAUMA. FOR CHILD/ADOLESCENT TRAUMAS, ASSESS PRE-TRAUMA SCHOOL PERFORMANCE AND POSSIBLE PRESENCE OF BEHAVIOR PROBLEMS] IF NO: **Have these (PTSD SYMPTOMS) affected any other important part of your life?** [AS APPROPRIATE, SUGGEST EXAMPLES SUCH AS PARENTING, HOUSEWORK, SCHOOLWORK, VOLUNTEER WORK, ETC.] **How so?** [LIFETIME -- IF NOT ALREADY CLEAR] **Were you working then?** IF YES: **Did these (PTSD SYMPTOMS) affect your work or your ability to work? How so?** [CONSIDER REPORTED WORK HISTORY, INCLUDING NUMBER AND DURATION OF JOBS, AS WELL AS THE QUALITY OF WORK RELATIONSHIPS. IF PREMORBID FUNCTIONING IS UNCLEAR, INQUIRE ABOUT WORK EXPERIENCES BEFORE THE TRAUMA. FOR CHILD/ADOLESCENT TRAUMAS, ASSESS PRE-TRAUMA SCHOOL PERFORMANCE AND POSSIBLE PRESENCE OF BEHAVIOR PROBLEMS] IF NO: **Did these (PTSD SYMPTOMS) affect any other important part of your life?** [AS APPROPRIATE, SUGGEST EXAMPLES SUCH AS PARENTING, HOUSEWORK, SCHOOLWORK, VOLUNTEER WORK, ETC.] **How so?**	0 No adverse impact 1 Mild impact, minimal impairment in occupational/other important functioning 2 Moderate impact, definite impairment, but many aspects of occupational/other important functioning still intact 3 Severe impact, marked impairment, few aspects of occupational/other important functioning still intact 4 Extreme impact, little or no occupational/other important functioning	***Past week*** ____ ***Past month*** ____ ***Lifetime*** ____

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Global Ratings

23. global validity

ESTIMATE THE OVERALL VALIDITY OF RESPONSES. CONSIDER FACTORS SUCH AS COMPLIANCE WITH THE INTERVIEW, MENTAL STATUS (E.G., PROBLEMS WITH CONCENTRATION, COMPREHENSION OF ITEMS, DISSOCIATION), AND EVIDENCE OF EFFORTS TO EXAGGERATE OR MINIMIZE SYMPTOMS.	0 Excellent, no reason to suspect invalid responses 1 Good, factors present that may adversely affect validity 2 Fair, factors present that definitely reduce validity 3 Poor, substantially reduced validity 4 Invalid responses, severely impaired mental status or possible deliberate “faking bad” or “faking good”

24. global severity

ESTIMATE THE OVERALL SEVERITY OF PTSD SYMPTOMS. CONSIDER DEGREE OF SUBJECTIVE DISTRESS, DEGREE OF FUNCTIONAL IMPAIRMENT, OBSERVATIONS OF BEHAVIORS IN INTERVIEW, AND JUDGMENT REGARDING REPORTING STYLE.	0 No clinically significant symptoms, no distress and no functional impairment 1 Mild, minimal distress or functional impairment 2 Moderate, definite distress or functional impairment but functions satisfactorily with effort 3 Severe, considerable distress or functional impairment, limited functioning even with effort 4 Extreme, marked distress or marked impairment in two or more major areas of functioning	***Past week*** ____ ***Past month*** ____ ***Lifetime*** ____

25. global improvement

RATE TOTAL OVERALL IMPROVEMENT PRESENT SINCE THE INITIAL RATING. IF NO EARLIER RATING, ASK HOW THE SYMPTOMS ENDORSED HAVE CHANGED OVER THE PAST 6 MONTHS. RATE THE DEGREE OF CHANGE, WHETHER OR NOT, IN YOUR JUDGMENT, IT IS DUE TO TREATMENT.	0 Asymptomatic 1 Considerable improvement 2 Moderate improvement 3 Slight improvement 4 No improvement 5 Insufficient information

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Current PTSD Symptoms

Criterion A met (traumatic event)? *NO* *YES*

_____ *# Criterion B sx (≥ 1)?* *NO* *YES*

_____ *# Criterion C sx (≥ 3)?* *NO* *YES*

_____ *# Criterion D sx (≥ 2)?* *NO* *YES*

Criterion E met (duration ≥ 1 month)? *NO* *YES*

Criterion F met (distress/impairment)? *NO* *YES*

____

CURRENT PTSD (Criteria A-F met)? *NO* *YES*

IF CURRENT PTSD CRITERIA ARE MET, SKIP TO ASSOCIATED FEATURES.

IF CURRENT CRITERIA ARE NOT MET, ASSESS FOR LIFETIME PTSD. IDENTIFY A PERIOD OF AT LEAST A MONTH SINCE THE TRAUMATIC EVENT IN WHICH SYMPTOMS WERE WORSE.

Since the (EVENT), has there been a time when these (PTSD SYMPTOMS) were a lot worse than they have been in the past month? When was that? How long did it last? *(At least a month?)*

IF MULTIPLE PERIODS IN THE PAST: **When were you bothered the most by these (PTSD SYMPTOMS)?**

IF AT LEAST ONE PERIOD, INQUIRE ITEMS 1-17, CHANGING FREQUENCY PROMPTS TO REFER TO WORST PERIOD: **During that time, did you (EXPERIENCE SYMPTOM)? How often?**

Lifetime PTSD Symptoms

Criterion A met (traumatic event)? *NO* *YES*

_____ *# Criterion B sx (≥ 1)?* *NO* *YES*

_____ *# Criterion C sx (≥ 3)?* *NO* *YES*

_____ *# Criterion D sx (≥ 2)?* *NO* *YES*

Criterion E met (duration ≥ 1 month)? *NO* *YES*

Criterion F met (distress/impairment)? *NO* *YES*

____

LIFETIME PTSD (Criteria A-F met)? *NO* *YES*

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Associated Features

26. guilt over acts of commission or omission

Frequency	Intensity	Past week
Frequency **Have you felt guilty about anything you did or didn't do during (EVENT)? Tell me more about that.** *(What do you feel guilty about?)* **How much of the time have you felt that way in the past month *(week)*?** 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) ***Description/Examples***	***Intensity*** **How strong were these feelings of guilt? How much distress or discomfort did they cause?** 0 No feelings of guilt 1 Mild, slight feelings of guilt 2 Moderate, guilt feelings definitely present, some distress but still manageable 3 Severe, marked feelings of guilt, considerable distress 4 Extreme, pervasive feelings of guilt, self-condemnation regarding behavior, incapacitating distress ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

27. survivor guilt [APPLICABLE ONLY IF MULTIPLE VICTIMS]

Frequency	Intensity	Past week
Frequency **Have you felt guilty about surviving (EVENT) when others did not? Tell me more about that.** *(What do you feel guilty about?)* **How much of the time have you felt that way in the past month *(week)*?** 0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%) 8 N/A ***Description/Examples***	***Intensity*** **How strong were these feelings of guilt? How much distress or discomfort did they cause?** 0 No feelings of guilt 1 Mild, slight feelings of guilt 2 Moderate, guilt feelings definitely present, some distress but still manageable 3 Severe, marked feelings of guilt, considerable distress 4 Extreme, pervasive feelings of guilt, self-condemnation regarding survival, incapacitating distress ***QV (specify)*** ________________________________	***Past week*** *F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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28. a reduction in awareness of his or her surroundings (e.g., **"**being in a daze")

Frequency	***Intensity***	***Past week***
Have there been times when you felt out of touch with things going on around you, like you were in a daze? What was that like? [DISTINGUISH FROM FLASHBACK EPISODES] **How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Was it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was this feeling of being out of touch or in a daze?** *(Were you confused about where you actually were or what you were doing at the time?)* **How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No reduction in awareness 1 Mild, slight reduction in awareness 2 Moderate, definite but transient reduction in awareness, may report feeling "spacy" 3 Severe, marked reduction in awareness, may persist for several hours 4 Extreme, complete loss of awareness of surroundings, may be unresponsive, possible amnesia for the episode (blackout) ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

29. derealization

Frequency	***Intensity***	***Past week***
Have there been times when things going on around you seemed unreal or very strange and unfamiliar? [IF NO:] *(What about times when people you knew suddenly seemed unfamiliar?)* **What was that like? How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Was it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was (DEREALIZATION)? How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No derealization 1 Mild, slight derealization 2 Moderate, definite but transient derealization 3 Severe, considerable derealization, marked confusion about what is real, may persist for several hours 4 Extreme, profound derealization, dramatic loss of sense of reality or familiarity ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

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30. depersonalization

Frequency	***Intensity***	***Past week***
Have there been times when you felt as if you were outside of your body, watching yourself as if you were another person? [IF NO:] *(What about times when your body felt strange or unfamiliar to you, as if it had changed in some way?)* **What was that like? How often has that happened in the past month *(week)*?** [IF NOT CLEAR:] *(Did it due to an illness or the effects of drugs or alcohol?)* **When did you first start feeling that way?** *(After the [EVENT]?)* 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples***	**How strong was (DEPERSONALIZATION)? How long did it last? What did you do while this was happening?** *(Did other people notice your behavior? What did they say?)* 0 No depersonalization 1 Mild, slight depersonalization 2 Moderate, definite but transient depersonalization 3 Severe, considerable depersonalization, marked sense of detachment from self, may persist for several hours 4 Extreme, profound depersonalization, dramatic sense of detachment from self ***QV (specify)*** ________________________________ ***Trauma-related?*** *1 definite 2 probable 3 unlikely* *Current* _____ *Lifetime* _____	***F*** ____ ***I*** ____ ***Past month*** ***F*** ____ ***I*** ____ ***Sx: Y N*** ***Lifetime*** ***F*** ____ ***I*** ____ ***Sx: Y N***

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CAPS SUMMARY SHEET

Name:________________ ID#:________ Interviewer:________________ Study:___________ Date:_______

A. Traumatic event:

B. Reexperiencing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(1) intrusive recollections									
(2) distressing dreams									
(3) acting or feeling as if event were recurring									
(4) psychological distress at exposure to cues									
(5) physiological reactivity on exposure to cues									
B subtotals									
Number of Criterion B symptoms (need 1)									

C. Avoidance and numbing symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(6) avoidance of thoughts or feelings									
(7) avoidance of activities, places, or people									
(8) inability to recall important aspect of trauma									
(9) diminished interest in activities									
(10) detachment or estrangement									
(11) restricted range of affect									
(12) sense of a foreshortened future									
C subtotals									
Number of Criterion C symptoms (need 3)									

D. Hyperarousal symptoms	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(13) difficulty falling or staying asleep									
(14) irritability or outbursts of anger									
(15) difficulty concentrating									
(16) hypervigilance									
(17) exaggerated startle response									
D subtotals									
Number of Criterion D symptoms (need 2)									

Total Freq, Int, and Severity (F+I)	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
Sum of subtotals (B+C+D)									

E. Duration of disturbance	*CURRENT*	*LIFETIME*
(19) duration of disturbance at least one month	***NO YES***	***NO YES***

F. Significant distress or impairment in functioning	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(20) subjective distress			
(21) impairment in social functioning			
(22) impairment in occupational functioning			
AT LEAST ONE ≥ 2?	***NO YES***	***NO YES***	***NO YES***

PTSD diagnosis	*CURRENT*	*LIFETIME*
PTSD PRESENT -- ALL CRITERIA (A-F) MET?	***NO YES***	***NO YES***
Specify: **(18) with delayed onset (≥ 6 months delay)**	***NO YES***	***NO YES***
(19) acute (< 3 months) or chronic (≥ 3 months)	***acute chronic***	***acute chronic***

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Global ratings	*PAST WEEK*	*PAST MONTH*	*LIFETIME*
(23) global validity			
(24) global severity			
(25) global improvement			

Associated features	*PAST WEEK*			*PAST MONTH*			*LIFETIME*		
	Freq	*Int*	*F+I*	*Freq*	*Int*	*F+I*	*Freq*	*Int*	*F+I*
(26) guilt over acts of commission or omission									
(27) survivor guilt									
(28) reduction in awareness of surroundings									
(29) derealization									
(30) depersonalization									

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Ancillary Materials

Managing Dissociative/Traumatic Regression. This template will help the clinician navigate through difficult periods in the trajectory of treatment with trauma survivors.

Transformation: From Sympathetic to Parasympathetic. This document is a "how to" for self-regulation.

TraumAddiction: Safety and Stabilization for the Addicted Survivor of Trauma. This article appears in publications and on the website for Gift From Within (www.giftfromwithin.org) .

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Managing Dissociative/Traumatic Regression

(adapted from Tinnin, 1995)

What is dissociative/traumatic regression? This phenomenon has been described by Tinnin (1995) as the condition that ensues when the ego functioning (i.e., neocortex) has become overwhelmed by the bombardment of intrusive symptoms (i.e., flashbacks, affect, abreactions, pain). Autonomous executive ego functions, such as time, volition, identity, and affect regulation begin to deteriorate or regress. This is the condition that is often referred to as a "nervous breakdown."

What are sign/symptoms of a dissociative regression? When the scores of the DRS are significantly higher than the scores on the DES, or when the DRS score is over 50, you should be alerted to the possibility of dissociative regression. Also, the following can indicate the presence of regression:

- Suicidal crises that dominate the focus of therapy and invoke rescue by the therapist.
- Escalating abreactions that involve uncontrolled, recurrent dissociative states and switching to alter personalities. This is a repeated reenactment, or reliving, of past traumas. It generates high arousal in the body's physiology and may be complicated by addiction to endogenous opiates secreted by the brain. This may require an intervention designed for addictive conditions.
- Regressive dependency involves "ego regression" or loss of self-regulation of basic ego functions (Tinnin, 1990). It is manifested as a diffusion of *identity* with a weak sense of self-constancy. The patient's *volition* is also weakened with a turning to wish fulfillment instead of willed action. The patient's sense of *time* is diffused and may affect the subjective time of day, sense of duration, and sequence of events. The patient's *body image* may be affected with the loss of a feeling of ownership and constancy of the body. The person's *reality perception* and capacity for *verbal symbolization* (alexithymia) may be weakened. Finally, the patient's capacity to manage affect is diminished.

What should I do if my client exhibits dissociative regression? Stop all trauma work immediately. The client cannot process traumatic materially effectively while experiencing a dissociative regression and such work may cause further harm to the already weakened ego. The following represents an effective treatment plan for dealing with dissociative regression:

Treatment Orientation

- Active and supportive
- Benign authoritative (Therapist assumes ego-functioning for short time. *"You will need to do the following things for the next week or two.")*
- Increase session to at least 2x/week
- Good prognosis and prediction of complete recovery if treatment protocol is followed.

Prohibitions

- No alcohol or sedatives or stimulants (no intoxication but also not withdrawal)
- No rumination – activation instead (MOST IMPORTANT!)
- No naps – In bed only maximum of 8 hours for sleeping

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Stimulus Barrier

- Medication (short-term neuroleptic or anticonvulsant)
- Interpersonal stimulation but avoiding over-stimulation
- Avoid rumination by motor activity (aerobic)

Reduce Ambiguity

- Adopt a benign, authoritative manner with formalized role boundaries and careful, concrete communication, avoiding metaphor.

Auxiliary Ego Function

- "Therapeutic assistants" are enlisted from family, friends and significant others to perform specific tasks, for example, in keeping the patient on schedule completing therapeutic chores;
- Specific and prescribed – no "over helping"

Support Autonomous Ego Functions

- Daily schedule for sleep, meals and activities (q ½ hour) and hold patient to schedule;
- patient keeps log of meals, sleep, activities, flashback journal;
- video-taping of sessions to foster identity;
- use of time-line narrative and graphic time-line to foster identity
- scrapbook or bulletin board
- autobiography

Grounding and Containment Skills

- For use with addictive reenactments and flashbacks.

How long will this take? If the client is cooperative with the treatment tasks described above, most dissociative regressions abate within two - three weeks. If it continues longer, consult psychiatrist and/or short-term hospitalization.

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Transformation

From Sympathetic to Parasympathetic

Recent brain imaging research has begun to demonstrate that anxiety is a brain killer--the more anxiety a person experiences, the less effectively our brains operate. It is becoming increasing apparent that professional and personal effectiveness requires self-regulation skills. By relaxing the muscles of the pelvic region (i.e., kegels, sphincter, and psoas), we are able to affect profound systemic muscle relaxation. This relaxation facilitates a shift in the autonomous nervous system from the *sympathetic* system (i.e., fight-or-flight reflex utilized during periods of perceived threat) to the *parasympathetic* system (i.e., relaxation and optimal functioning utilized during period of safety). By maintaining this pelvic relaxation, we are able to thwart the autonomous nervous system from shifting to sympathetic dominance each time we perceive even the mildest threats (i.e. criticism).

By practicing the release and relaxation of these muscles, we can gradually shift from sympathetic to parasympathetic dominance. The rewards of this transformation include comfort in our bodies, maximal motor and cognitive functioning, ability to tolerate intimacy, self-regulation, internal vs. external locus of control, ability to remain mission/principle driven, increased tolerance, increased effectiveness, and increased health of our body's systems.

What happens when my sympathetic nervous system is dominant?

When you perceive a threat, your body responds to either neutralize or move away from this perceived threat. This is true for all species of living things and is known as the "fight or flight reflex." If we are truly in danger of loosing our lives, then this reflex is arguable useful. However, we are rarely confronted with threats and circumstances that are this dyer in our daily lives. Instead, we perceive some mild threat and our sympathetic nervous systems activates and we find ourselves

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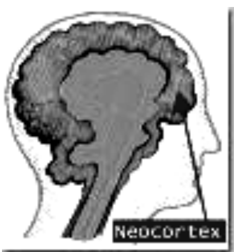
trying to either kill or run away from our boss, co-worker, or spouse. This over-active and very sensitive threat identification and early warning system is the cause of all stress.



When our sympathetic nervous system is activated and dominant, we are preparing for battle or flight. Our circulation becomes constricted, heart rate increases, and our muscles become tense and ready to act. Inside our brains, the neocortex becomes less functional while the brain stem, basil ganglia, and thalamus become more active. This is because the perceived need to survive has superseded all other brain functioning. As we become more "stressed" and the longer we are in this state of sympathetic dominance, the more likely we are to compromise the functioning of higher order brain systems such as language, speech, motor activity, filtering, and compassion. This loss of functioning may partially account for why people have trouble thinking logically during "stressful" times, or why they have trouble being kind when they perceive threat, or even why they have trouble with peak physical performance (i.e., sports) when they are "nervous." By simply relaxing and keeping relaxed our pelvic muscles we can reverse this process of sympathetic dominance and return to parasympathetic systems. This return to parasympathetic dominance will allow the individual to regain optimal functioning of speech, language (remember intentional thought is simply talking to ourselves—something for which we need to be able to create language and speech), motor coordination, filtering, and compassion. Once the individual has been able to successfully transition from sympathetic to parasympathetic dominance, without external agents (i.e., drugs) and without regard for the external events (i.e., crises) then the individual has become self-regulatory. A person who becomes skilled in making this transition has developed an internal locus of control and is no longer a victim of circumstances.

Where are the Pelvic Muscles? How do I find them?

While conducting seminars students often ask me this question. I cannot help but to feel a twinge of sadness when this question is asked. The sadness comes from the awareness that the person asking this question has learned to be unaware of these muscles. People who are not aware of the muscles in their mid-body are not aware for good reason—it has been a coping strategy since childhood. Children who grew up in anxious and dangerous environments learned to keep their bodies tight in anticipation of danger. With no skills for self-regulating, these children often learn to numb and dissociate their awareness away from the pain in their bodies. These children grow into adults that have difficulty being "in" their bodies—difficultly in monitoring and regulating muscle tension and, ultimately, anxiety[1].

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[1] Note - For the person who is unable to locate their pelvic muscles, I suggest that they visit a massage therapist and ask the therapist for assistance in locating and releasing their pelvic muscles. This use of therapeutic touch will help to make the abstract concrete.

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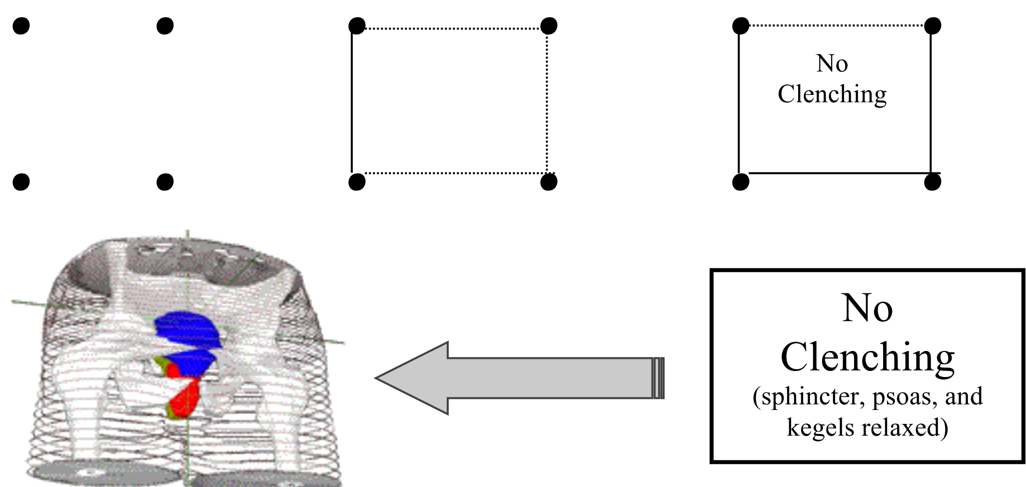
EXERCISE:
1. While sitting, put your hands under your butt.
2. Feel the two pointed bones upon which you are sitting .
3. Now, touch the two bony points on your right and left side just below the waist.
4. You have made a touch memory for four distinct points. Connect those four points to make a square.
5. Now, allow your breath to get to the area in the middle of the square. Also, allow the square to expand.
6. Release and relax all muscles that traverse the area of the square so that there are NO CLENCHED muscles in the square.



What now the my Pelvic Muscles are relaxed?

Simple, keep them that way. If you are able to keep your pelvic muscles released and relaxed for 20 – 30 seconds then you will begin to notice the clear differences in yourself as you transition from sympathetic to parasympathetic dominance. You will first notice comfort in your body. As you release the tension and stress that you yourself have been generating you will become aware that your body is comfortable—no matter what is going on around you. Your thoughts may still be racing and producing warning messages. If this is happening, DO NOTHING; just concentrate on keeping your pelvic muscles relaxed. This will be difficult for many people because since childhood we have taken action when we experience this alarm. However, if we are able to keep our pelvic muscles relaxed then we will be rewarded with a lessening of "stress" and the restoration of optimal functioning in our thinking and actions. With this self-regulation, we will be able to comfortably seek creative solutions to problems and situations that used to leave us baffled, exhausted, and frustrated.

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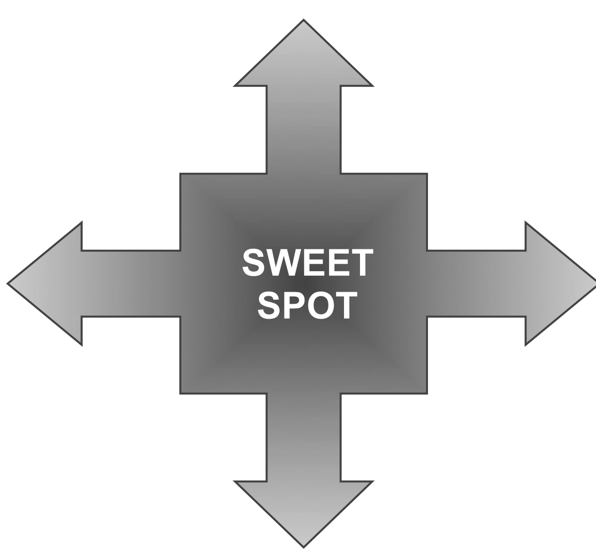
By developing and practicing the skills of self-regulation we will find ourselves able to maintain fidelity to our intention--our mission. We will find that we no longer need to react to every little crisis as though it is a life-or-death situation. We will become free from our pasts to live for ourselves the lives that we create without having to be perpetually "on guard" for the next danger. We will be able to function at peak effectiveness anytime we choose—a transformation indeed.

Sympathetic = Reactive = Stress = Diminished Functioning= No Choice



Parasympathetic = Intentional = Comfort = Optimal Functioning = Choice

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TRAUMADDICTION: SAFETY AND STABILIZATION FOR THE ADDICTED SURVIVOR OF TRAUMA

by

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APRIL 1, 2004

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TRAUMADDICTION: SAFETY AND STABILIZATION

Erica is an attractive, 30-year-old woman who recently completed a 28-day recovery program for substance abuse. Erica is a survivor of childhood abuse and has experienced sexual trauma as an adult. She has been in and out of therapy for years with a variety of therapists. She began using alcohol in her mid-teens as a way of coping with her feelings. Her use progressed as she became older and she eventually began to abuse prescription drugs as an adult. When Erica was in her late-twenties, she was raped in a park while jogging. Shortly after the rape, Erica's substance abuse intensified dramatically as this became her primary way of managing her fear, anxiety, nightmares, and the disturbing childhood memories that began to surface.

As she brushes her teeth this morning, she notices the color in her face. Today she is able to look in the mirror with a sense of self-respect knowing that she is recovering from the deadly disease of addiction which she has been struggling with for years. With newfound confidence and gratitude, she gets ready for work looking forward to the day ahead.

Her neighbor, Brad, is a teller at the bank with Erica. A few months ago he was severely beaten while attempting to purchase drugs in a dangerous neighborhood. The terror he felt during the beating and the subsequent consequences became a "bottom" for Brad. He began attending Narcotics Anonymous (NA) meetings and has been drug-free for two months now. This morning Brad wakes up from having a dream about the night he was severely beaten. He has dreamt about how they robbed him of the large amount of money and how the assailants continued to beat him. He also dreamt of using cocaine again—a relapse. Just yesterday he was talking to his therapist about how these "using" dreams had nearly ceased. Last night's was the first he has experienced in over a month and he is relieved that they are becoming rare. As he gets into his car, he feels grateful that he is not using drugs or putting himself in dangerous situations any longer.

When Brad arrives at work, he makes a quick phone call to his girlfriend before the bank doors open. She has been supportive throughout this process and has even attended some open NA meetings with him. They plan dinner tonight. At the same time, Erica makes a phone call to her sponsor with whom she has daily contact. They agree to go to an Alcoholics Anonymous meeting this evening and then out for coffee.

INTRUSIVE SYMPTOMS

This morning, Brad routinely assists each customer taking deposits and distributing money. After lunch, Brad receives a large amount of cash to deposit. As he places the cash in the drawer, he starts to think about how many drugs he could buy with that amount of money. This thought comes unexpectedly and he starts to fantasize about getting high again. Brad shakes his head and thinks about the ridiculousness of this thought. He has been clean for two months now. He shrugs off these crazy thoughts and attributes them to the extra cup of coffee he drank this morning, which is making him jittery.

At the next counter over, Erica looks up at her next customer, believing she recognizes the beard of the man who raped her. She jumps back, but then quickly realized the customer is Mr. Martini, a longtime bank customer. Even so, she begins to feel discomforted by an encroaching fear and disturbing physical sensations. She is feeling some of the same feelings she felt during the rape and is involuntarily remembering some of the events from this trauma. She becomes so anxious that she is unable to finish the transaction and retreats to the break room. Erica feels upset and angry. She doesn't understand why now that she is sober and supposed to be feeling

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healthier, she keeps having nightmares of the rape, shadowy visions of her childhood and experiences like she had today in the bank. She thinks, "These things never happened to me when I was drinking."

What is it that caused these two individuals to react to these normally benign experiences in ways they did not choose? How were they, in one minute, coping well in their newfound recovery and, in the next, nearly debilitated? In Brad's situation, addiction professionals recognize these phenomena as becoming "triggered" and as "euphoric recall" which are considered relapse warning signs. Trauma specialists would identify that Erica has experienced a flashback, or intrusive symptoms, from her previous trauma. In both cases, we see how Brad and Erica react to situations in ways they did not want. Brad had no intentions in the beginning of the day to fantasize about using cocaine and Erica did not intend to becoming incapacitated by the sight of someone whose beard reminded her of the man who raped her. Prior to this, both were planning on a peaceful evening of continued recovery.

What has caused the ghosts of the past to haunt these two individuals in their early recovery? Both perceived the benign events of their day as a threat—a menace to their survival--which activated their sympathetic nervous systems, or the "fight or flight" responses. Brad's brief inflamed desire to use drugs was challenged by his knowledge that addiction is a serious disease and that if he used again he would suffer unwanted and possibly dyer consequences. His mind perceived his desire to use drugs as a threat. As this internal struggle escalates, tension and bodily discomfort are the result. Often this tension and bodily discomfort create a desire to find relief. For a long time Brad's primary means of attempting to accomplish this has been drug use. In the past, cocaine had temporarily cloaked his awareness of his emotional and physical pain, providing him with temporary relief from his state of internal discomfort. Now, all the tragic consequences he suffered as the result of his habitual use begin to fade into the background as the drug siren ever more loudly promises relief. He is trapped in the negative and painful quicksand of TraumAddiction.

Erica also perceives a threat when she sees the customer's beard and involuntarily recalls her rape. When she was attacked one of the first things that she saw was the rapist's beard. Seeing someone with a minor resemblance to the man who raped her produced thoughts and images of the rape. Even though she was perfectly safe at her job in the bank, she felt a life-or-death threat while she reexperinced the memories and sensations associated with her rape. Erica too was suffering from tension and bodily discomfort that clamors for soothing and/or escape . For years alcohol has been her most successful way of coping. Shortly after this incident, Erica begins to think that a little wine might help her feel better. She is trapped in the web of TraumAddiction.

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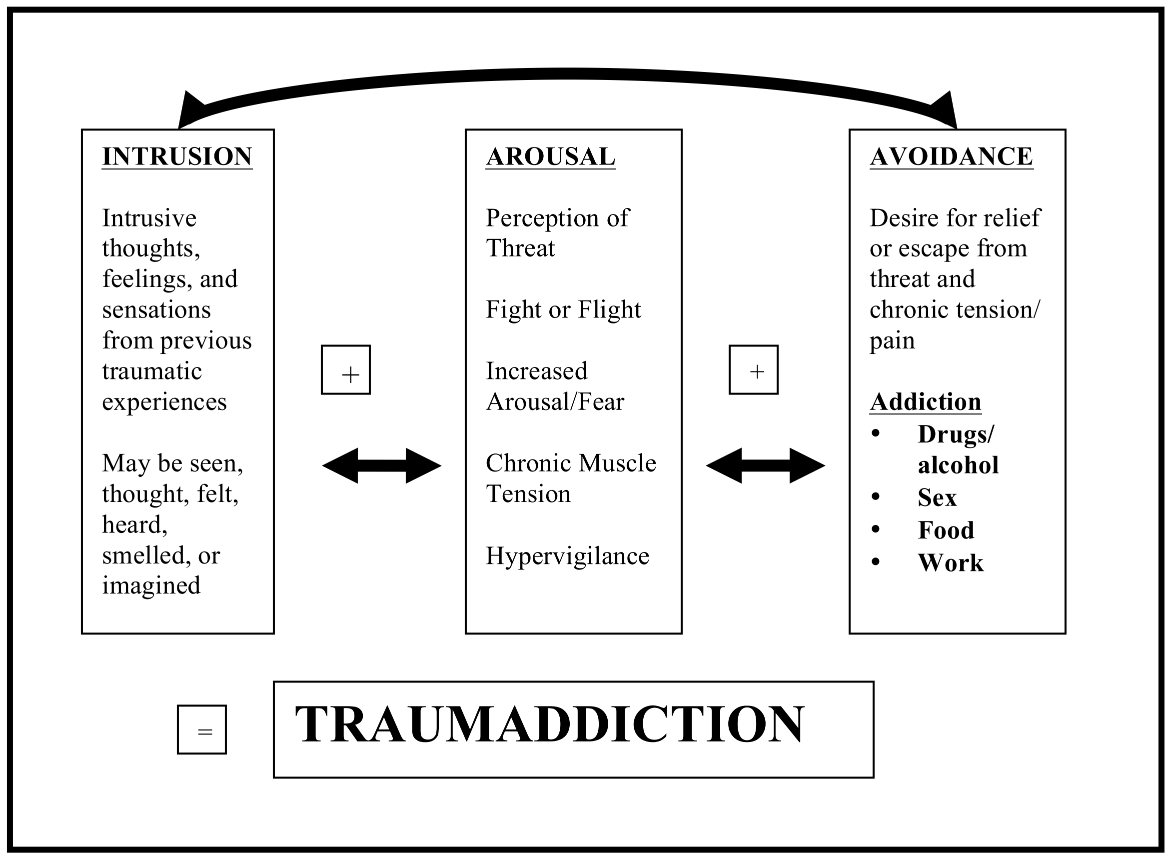
Fig 1. TraumAddiction



AROUSAL SYMPTOMS

Brad feels anxious and decides to smokes a cigarette hoping it will calm his nerves. He can feel his heart racing and is afraid that he will have a panic attack. His lighter is not working in the wind and he becomes increasingly agitated. As he returns to work he is irritable and starts to notice his coworkers "not doing anything." His heart rate rises and he feels pressure in his chest. There is a sinking feeling in the pit of his stomach that will not go away.

Brad, seeking someone to talk with, comes up behind Erica and taps her on his shoulder. She jumps back and turns around ready to defend herself as she was taught in self-defense class. He is annoyed by her reaction and tells her to "just relax." Erica's response was far more intense than she would have anticipated. Her level of arousal was high to begin with and Brad unexpectedly approaching her from behind simply put her over the edge. Erica feels that she needs a break. She, too, goes out to smoke a cigarette only she cannot hold the lighter because she is trembling. Her heart races and she takes a deep breath to calm the pounding of her chest.

Brad is experiencing a great deal of discomfort and is unable to relax. He is experiencing what is known in the addiction realm as being *restless, irritable, and discontent*. He is plagued by thoughts and physical urges to satisfy his craving. It is as if his insides are screaming for the temporary relief drugs can bring him. He begins to "romance" the idea of using again without a thought towards many of the negative consequences he has suffered from his drug use.

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Erica continues to feel the pressure in her chest and finds it hard to take a full breath. She is constantly scanning the room as the feeling of danger lingers. With respect to trauma, these are known as *arousal symptoms*. Her body has become 'on alert' as she perceives her safety has been threatened. She find that she is plagued with a nagging yet comforting thought that a drink would "calm her nerves."

AVOIDANCE SYMPTOMS

Erica decides that she is too "stressed out" to continue work. She tells her boss that she is having stomach problems and needs to go home. She plans on cooking a nice dinner and then relaxing the rest of the evening. Because she has had such a difficult day, she calls her sponsor and leaves a message saying she is unable to make the AA meeting.

Brad also chooses to take the rest of the day off. He calls his girlfriend to cancel their dinner plans telling her that he is too tired. Brad cannot seem to stop his inner trembling. He is extremely agitated and continues to reminisce about the relief cocaine would provide. On the way home, he decides to go to a movie, hoping this will help distract him from his thoughts of using drugs.

Earlier this morning, both Brad and Erica had good intentions for the day. Although they had some difficulties throughout the night, they woke up with a strong commitment to recovery. Both were able to maintain their *intentionality*—in this case, continued recover--throughout the morning. During the morning, both were able to direct their behaviors in ways that they wanted to behave. However, throughout the day they became *reactive* and began to fall victim to environmental cues (smells, thoughts, images, feelings) that provoked memories of their previous traumatic experiences. This recall of trauma, either consciously or unconsciously, produced feelings of increased arousal, fear, and muscle tension. This fear and tension involuntarily compels Brad and Erica to shift from the parasympathetic nervous system (relaxation, comfort, and intentionality) to the sympathetic nervous system (fight-or-flight, survival, irritability, and escape).

Brad and Erica's good intentions for the day have been thwarted. They are now experiencing such high anxiety that escape feels necessary. Both are experiencing the dissolve of their commitment to recovery as thoughts of using drugs/alcohol promise escape from the fear, irritability, and tension—they are in a reactive state. As the perceived threats and the accompanying discomfort escalate, their perceived options diminish until it feels like reckless escape is all that remains.

On the way home, Erica drives by the park where the rape had taken place. She often avoids this route as it reminds her of the rape, but today there is road construction and she has no other choice. As she unwillingly glances over at the park she thinks she smells the scent of the cologne the rapist had worn. She remembers the strong musky smell and feels as if she cannot breathe. She cannot believe this feeling of overwhelming fear is happening to her twice in one day. She feels as though she may be "going crazy". Believing in the moment that she has no other way to survive these feelings of panic, she turns into the liquor store parking lot. She buys a bottle of her favorite wine and starts drinking it on her way home. Almost immediately she experiences a feeling of warmth throughout her body. As her body begins to relax from the effects of the alcohol, the intensity of her emotions begins to lessen.

Brad left work intending to go a movie. However, his anxiety was so high, he felt he would be unable to sit still. On a whim he decides to go for a drive and heads for the beach to relax and

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walk off some nervous energy. Instead, his car takes the exit to the area where he used to buy drugs. Before he knows it, he is driving down the same street where he was so violently beaten just months before. He starts to reconsider, realizing how much better his life has become since he has stopped using drugs. Suddenly he sees the alley where he was left for dead and begins to re-experience the terror he felt then. His anxiety heightens and Brad frantically scans the street for a drug dealer. All he can think about now is his desperate need for relief. He agitatedly finds his old drug dealer and purchases crack cocaine. Smoking it on the way home, he finally quiets the inner turmoil.

Both Brad and Erica find themselves again embroiled in their addiction. "How did this happen?" they both ask themselves. "What is wrong with me? I should know better. I am a hopeless failure," become the familiar refrain of thoughts that now plague each of them. They have become hopeless, depressed, and accelerating into the desperate tailspin of TraumAddiction.

TREATMENT OF THE ADDICTED SURVIVOR OF TRAUMA

The vignettes above portray the common phenomenon of trauma leading to addiction and addiction leading to trauma. A survivor of trauma is at a significantly greater risk of developing some type of addiction and the reverse is also true. Having this awareness, it is imperative that we look at more effective ways of treating this unique condition.

The challenge of providing effective treatment and interventions for persons with both posttraumatic stress and addiction has caused many a seasoned clinician to shudder. "Dually diagnosed," seems to rank with "Borderline Personality Disorder" as one of the more pejorative and emotionally laden labels that saddle clients. Addicted survivors of trauma are often the recipients of the anger, frustration, and trepidation of health care workers due to the difficulty in both conceptualizing and administering effective treatment to this population.

Sullivan & Evans (1995) describe the trajectory of treatment and recovery for an addicted survivor or trauma as one fraught with potential pitfalls and disappointment for the clinician. They discuss a process frequently experienced within this population as they begin their treatment/recovery. It seems as addicted survivors begin to gain periods of abstinence from chemicals (or behaviors) upon which they have been dependent, they find the intrusion, avoidance and arousal symptoms of their traumatic stress becoming more florid. Conversely, to compound this conundrum, as the addicted survivor becomes ready to begin the process of resolving the traumatic material, they often find themselves with elevated and irresistible cravings for their drug or addictive behavior of choice.

So, what constitutes safe and effective treatment for the addicted survivor of trauma? A few writer/clinicians have tackled this question and we recommend reading the excellent works of Sullivan and Evans (1995), Miller and Guidry (2001) and Dayton (2001). Each of these popular texts is written for clinicians but may be easily read and understood by survivors.

Sullivan and Evan (1995) discuss the impact of abuse and the absence of safety in their book *Treating Addicted Survivors of Trauma.* This book gives an excellent overview of the effects of abuse and trauma suggesting that the missing element is safety. Addictive behaviors are

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framed as "unsafe behaviors" which need to be worked through vs. punished (i.e. discharged immediately from treatment). In their book, they also provide an overview of interventions to assist the client in achieving and maintaining safety such as safe planning, contracts, and environmental concerns.

Tian Dayton's book *Trauma and Addiction* (2000) is easy reading for a client and discusses the idea of "emotional literacy." Dayton gives an overview of the traumatic response as well as the connection between trauma and addiction. She discusses the four stages of emotional literacy beginning with the ability to feel the fullness of the emotion. Very often trauma survivors are overwhelmed by emotions to the point where their method of coping is to dissociate. For addicted survivors of trauma, addiction is the primary method of dissociating.

She goes on to describe the remaining phases of emotional literacy as labeling the feeling, exploring the meaning and function within the self, and then making a choice to communicate it to another person. Through feeling the full sense of the emotion, one can use it as an inner guide for recovery. With a more fluid sense of one's emotions, one is better equipped to determine whether they are safe.

SAFETY AND TRAUMA RESOLUTION

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

What is Safety?

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

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

Level 2.
AMELIORATION OF SELF-DESTRUCTIVE THOUGHTS & BEHAVIORS

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(i.e., suicidal/homicidal ideation/behavior, eating disorders, persecutory alters/ego-states, process addictions, trauma-bonding, risk-taking behaviors, isolation)

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

What is Safety for the Addicted Survivor

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

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

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

MINIMUM STANDARDS OF SAFETY

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

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

Active addiction IS active danger. The addicted survivor must arrest active addiction before treatment for recovery to be effective. This needs be clearly communicated to the addicted survivor and may be articulated as: "*Safety is the requirement for resolving both your addiction and your traumatic stress. This safety will require that you bring your using behavior under*

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control (i.e., abstinence) and that you develop ways of effectively regulating your own anxiety, without the use of chemicals or self-destructive behaviors."

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

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

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

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

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

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

It is useful to ask the client to begin to narrate the traumatic experience(s) and as their emotions intensify, the clinician may challenge the client to rescue themselves from these overwhelming feelings by implementing the skills above. This successful experience can then be utilized later in treatment to empower the client to extricate him/herself from overwhelming traumatic

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memories. It is also a testament to the client now being empowered with ***choice*** to continue treatment and confront trauma memories.

4. POSITIVE PROGNOSIS AND CONTRACT WITH CLIENT TO ADDRESS TRAUMATIC MATERIAL.

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

SKILLS FOR DEVELOPING, MAINTAINING & ENHANCING SAFETY

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

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

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

Progressive Relaxation

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

Now tighten both fists, and tighten your forearms and biceps … Hold the tension for five or six seconds … Now relax the muscles. When you relax the tension, do it suddenly, as if you are turning off a light … Concentrate on the feelings of relaxation in your arms for 15 or 20 seconds … Now tense the muscles of your face and tense your jaw … Hold it for five or six seconds …

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now relax and concentrate on the relaxation for fifteen or twenty seconds … Now arch your back and press out your stomach as you take a deep breath … Hold it … and relax … Now tense your thighs and calves and buttocks … Hold … and now relax. Concentrate on the feelings of relaxation throughout your body, breathing slowly and deeply (Ehrenreich, 1999, Appendix B).)

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

> Jamieson (1996) begins with:
> "Now slowly, in your mind, repeat to yourself each of the phrases I say to you. Focus on each phrase as you repeat it to yourself" (p. 73).
>
> I am beginning to feel calm and quiet
> I am beginning to feel quite relaxed.
> My right foot feels heavy and relaxed.
> My left foot feels heavy and relaxed.
> My ankles, knees, and hips feel heavy, relaxed, and comfortable.
> My stomach, chest, and back feel heavy and relaxed.
> My neck, jaw, and forehead feel completely relaxed.
> All of my muscles feel comfortable and smooth.
> My right arm feels heavy and relaxed.
> My left arm feels heavy and relaxed.
> My right hand feels heavy and relaxed
> My left hand feels heavy and relaxed
> Both my hands feel heavy and relaxed.
> My breathing is slow and regular.
> I feel very quiet.
> My whole body is relaxed and comfortable.
> My heartbeat is calm and regular.
> I can feel warmth going down into my right hand.
> It is warm and relaxed.
> My hands are warm and heavy.
> It would be very difficult to raise my hands at this moment.
> I feel very heavy.
> My breathing is slow and deep.
> My breathing is getting deeper and deeper
> I am feeling calm.
> My whole body is heavy, warm, and relaxed.
> My whole body feels very quiet and comfortable.
> My mind is still, calm, and cool.
> My body is warm and relaxed.
> My breathing is deeper and deeper.
> I feel secure and still.
> I am completely at ease.
> I feel an inner peace.

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I am breathing more and more deeply (Jamieson, 1999, p.73-74).

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

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

Diaphramatic Breathing

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

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

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

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

3-2-1 Sensory Grounding & Containment

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

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

<u>Postural Grounding</u>

Postural grounding is a technique drawn from practice with clients who have dissociative symptoms. As a trauma survivor begins to experience the images and feelings associated with a flashback, they can often be observed to migrate into a constricted and fetal posture of protection. In addition, the clinician can usually notice psychomotor agitation in the form of shaking legs, tremors, either fixated or scanning eyes, and shallow breathing.

When the client begins exhibiting these signs of re-experiencing and arousal, ask them "Would you like some help in getting out of there [those images and feeling]?" If the client says, "yes," follow the script below to help them develop the capacity for self-rescue from flashbacks.

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

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Anchoring: Safety

This exercise is an anchoring process that enables the individual to gain access to a safety state without the use of "hypnosis" type exercises.

1) Identify resource (e.g., safety, courage, fear)
2) Identify historical experience where resource was present
   a) "Describe context" (i.e., at the cottage with the fireplace warming the room)
   b) Find the exact second that the place, time, objects, people present, etc.
   c) "Close eyes and re-experience" (10 – 15 seconds)
3) Clinician makes note resource/problem state was most intense
4) Behavioral
   a) "Close your eyes and imaging you are watching a videotape of this moment…"
   b) "What would we see you doing…specifically?"
   c) "What would be the look on your face?"
   d) Make note
5) Cognitive
   a) "Imagine that there is a tiny microphone that can listen to your thoughts at this moment…"
   b) "What would we hear your mind say at the moment of _____ (resource) is the strongest?"
   c) Make note
6) Affective/Sensory
   a) "At the moment that _________ is the strongest…"
   b) "What do you feel in your body?"
   c) "What sensations do you experience?"
7) Establish Anchor
   a) "Close your eyes and begin to experience ___________about 15 seconds before it reaches its 'peak intensity."
   b) Clinician narrates context
   c) Clinician narrates behavioral
   d) Clinician narrates cognitive
   e) Clinician narrates affect/sensory
   f) "Allow this experiences of ____________ (resource state) to intensify even more…feel it expanding in your chest…in your mind…"
8) Trigger
   a) Now, squeeze together the thumb and forefinger of your dominant hand (5 seconds)…put all of the ___________ into that squeeze."
9) Back to normal consciousness
   a) Test trigger ("How much of that feeling comes back when you squeeze your thumb and forefinger together now?") ____%

Safe Place Visualization

The next exercise, although NOT hypnosis is a technique that does utilize some elements that are like "hypnotherapy". It is therefore limited for use by those who have had formal training and appropriate educational background to offer that type of work.

This next exercise is adapted from the Treatment Manual for Accelerated Recovery from Compassion Fatigue (Gentry & Baranowsky, 1999).

Pre-visualization information

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Find a place and position where you can relax. This should be a place where you can be assured of minimal interruptions. Take the time to set the space for your maximum benefit. Once you are satisfied with the environment and feel it will be one that is safe and relaxing we will be ready to begin.

During this exercise you will have the opportunity to enjoy a sense of deep relaxation through a guided exercise. Through the exercise you will be instructed in the inner imagining of a Safe Place that may be a place you have been to before or one entirely made up in your imagination.

It is important to remember that this is NOT hypnosis but instead a guided relaxation and imagery exercise in which you are in control while being deeply relaxed. You CAN stop at any time if you need to BUT we recommend that you experience the entire exercise without interruptions to enjoy the greatest benefit and insight.

> Focus on the sense of relaxation now in the muscles in the back of your eyes and notice how this relaxation can spread. Now as your eyelids softly rest over your eyes notice how you are able to soften your facial muscles -- first those that are closest to your eyes but then more and more as you sense a smoothing, soothing, warming sensation spread across your face. Notice this warming, soothing sensation spread greatly across your forehead -- across your eyes -- through your hairline. Notice as it warms and softens the lines of your face. Just notice and let the gentle warmth calm your face. This calming sensation moves down your face ... your nose ... lips ... chin ... until your whole face becomes a numb mast of relaxation. Even the mind takes on a soothing a mellow position … until the mind feels very quiet. Listen to the sound of my voice and any other sounds without doing anything. Let these sounds be signals to let you know that you are safe, here in this room. Allowing you now to pay even closer attention to the INSIDE world. Simply let the sounds assure you that you are in a safe place in this room. Feeling that safety allow yourself to relax and slowly let the soothing warmth spread through to your neck muscles helping you to release any tensions. The warmth now moves down through your arms all the way to your fingertips. As it does you can release tension in your upper body by imagining it spilling out through the tips of your fingers and into the ground below. Allow the warmth to spread through to your chest and fill up your lungs … relaxing your muscles, relaxing your stomach, softening the muscles of the back and warming and releasing any tensions there. Continue to pay attention to my voice. Notice any points of tension and bring the soothing warmth to those points so they too can soften and relax. Bring the warmth through to your lower back, thigh, calves, feet, and toes. Become aware now that you can release even more tension from your lower body by imagining it spilling down through all the way to the tips of your toes and spilling out and into the ground. Just let your body relax as deeply as it wants letting your conscious mind stray where it might ... and while your body relaxes it brings a feeling of calm detachment ... and a feeling that time doesn't matter, time is not important ... you feel calm and emotionally detached.
>
> <u>Safe Place Imagery</u>
> Now allow your mind to find a relaxed and soothing space -- a safe place. This is a place from the past that you have been to before or one from your imagination. Either way is OK, because it all belongs to you. Begin to develop a picture as a Polaroid film would develop. Watch as the safe place develops exposing itself to you. Notice how the lights, colors, textures, that surround you are now soothing to you. Notice what is above and below you. Walk around this place taking notice of all the sounds of relaxation ... those that are close and those sounds that are far away. Notice the soothing fragrances

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in this safe place ... those that are distinct and those that seem subtle. Be aware of all the safe fragrances. Now notice the temperature and quality of the air…reach out and touch some of the objects in this place of safety…notice all the textures. Be aware that anything that is safe can be imported into this place by you. If anything seems unsafe or threatening, allow yourself to send it out and notice how you are able to do this. Feel and appreciate all the relaxing sounds ... assuring smells... and the sight of safety ... feel it, appreciate it. Take it all in and memorize it so that if someone asked you to draw it at a later date you could do this in great detail ... or can call it up at any time (5-10 seconds of silence). Also notice how you can begin to move about…moving about with the feeling of relaxed joyfulness … relaxed joyfulness …this is our natural state. Remember what it feels like to be relaxed…and joyful. Take a moment now to give yourself permission…full permission to enjoy this state of comfort…of relaxation…of peace (be silent for about 10 seconds).

Slowly begin to bring your awareness back into this room realizing that shortly but not just yet you will open your eyes. Before you do this realize that you will feel more relaxed and better able to get on with the rest of your day. Make small movements in your fingers and toes … make small movements in your arms and legs. Whenever you are ready slowly begin to bring your awareness fully into this room – opening your eyes when you are ready.

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Flashback Journal

The following journal format is useful as a functional analysis of triggers and symptoms. It allows the survivor to chart their progress and identify some of the most effective ways of coping. Thoughts of using and impulses can also be included in this journal.

Flashback Journal

Symptom	Trigger	Memory	SUDS	Self-soothing Skill(s) used	SUDS

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Rituals
Ritualistic methods for safety and stabilization can vary widely. The key is to create a form of practice or ceremony that reinforces the individual's sense of reassurance, safety or security. One lovely ritual is to have a "marriage" ceremony with oneself. This effectively strengthens the internal tie – the person is now responsible for themselves and fully empowered to act on their best behalf. If things are not going well or goals have been set, they must look to themselves to move their lives forward in the direction that is desired. This takes an act of will but it is much more likely that one will achieve ones greatest hopes and dreams if we take full responsibility for these dreams. After all, who else is as fully informed of what we truly wish from life if not ourselves.

The ceremony is to be orchestrated in the vision of the individual. This can be completed alone or in the company of trusted counselors or friends/family. In one example, the individual chose to complete the ritual alone. Candles were lit, paint and paper was available for creative expression, a colorful silk robe was worn and meaningful music was played. The individual wrote their wishes for the future and their commitment to themselves. They wrote a "self-marriage" ceremony in which they made a strong and earnest vow to "care for themselves in a manner that met their inner desires, hope and dreams". In effect, this ceremony was a joyous occasion one of personal commitment to future and self-support. The individual came to the conclusion that if they treated themselves in this manner they would have nothing to feel disappointed about and if they did not they would have no one to "blame" other than themselves.

Another approach is to make a concrete commitment or contract in writing to move toward healing. This can serve as a mantra for the client as s/he makes a commitment to healing and moving through her the part of the self that has been holding him/her back. Some of these commitments take place as affirmations, songs, mission statements, and the like. Again, this is an opportunity for the client to become creative in her/his healing process.

Below is an example of a commitment contract. The contract may be used between clinical sessions or by the survivor independently. uBy operationally defining what their goals are, their progress can be easily identified and they begin to recognize their own capacity for healing.

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Contract for Safety and Self-Care

Name: ____Date:____________________________

Safety Goal Area:____

____(My goal)

I care about myself and am committed to my healing. I realize that to do this I have to make changes in my life and the way I live it. By making these changes, no matter how small, I am affirming my choice to become the person I want to be.

I want (to):____

____(My goal)

I will prove to myself that I am committed to becoming my best self by completing the following behavioral objectives (tiny achievable steps):

Self-Care:____

Connection with Others:____

Self-soothing Skills Acquisition:____

I will complete these affirmations of myself on or before:_____________________________

____ ___________________________
Signature date

____ ___________________________
Witness date

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Buddha's Trick
This is an awareness technique to assist clients by improving their understanding of the necessity for processing time and the level of energy required for suppression. Many people who have been exposed to traumatic events attempt to "push bad thoughts out of their minds." It is also not uncommon for addicted survivors to have thoughts of using while in early, or even late recovery. Again, the thoughts are met with judgement and feelings of inferiority or failure. In significant numbers, this approach tends to result in the unfortunate outcome of post-trauma symptoms (i.e., intrusive thoughts, poor sleep, anxious feelings, avoidance). By refusing to think about difficult events we fail to establish a complete narrative, make sense of our experiences, desensitize through exposure and recognize that we are now safe. Baer (2001) provides an excellent illustration of this technique in his publication the Imp of the Mind (p. 95-99).

When we are feeling very badly about something that has occurred or that we worry might occur, we sometimes make a big effort to "suppress" our thoughts, feelings, memories associated with the disturbing recollection. Many research studies show that this type of thought suppression does not work. In addition, it uses a lot of energy to keep thoughts out of our mind and is therefore exhausting. It also increases the fear factor - as we are hiding this thing from our thoughts, reducing our ability to review and resolve our feelings and thus making it seem even more unbearable than it is. Recall someone saying to you that something terrible has happened and then not telling you right away what it is ... your mind arrives at a conclusion that is even worse than the actual reality, in most cases.

Thought Exercise
Instruct the individual to think of a "Stone Buddha" for 1 minute keeping their mind as focused as possible during this time. If at any time, they lose their focus they are to lift a finger alerting both themselves and you that they have lost their focus. Now discuss what this exercise was like, what they observed and how much energy it took to keep their mind focused.

Next, the individual is instructed to keep "Stone Buddha's" out of their mind for a full minute. Again, they are to lift a finger every time "Stone Buddha" comes into the mind. When the minute is over they are given time to reflect on the difficulty of this exercise and the amount of energy it takes to keep the mind focused.

Now they are asked to notice if "Stone Buddha's" come to mind at an even greater rate than prior to thought suppression. This is called the *rebound effect* and is noted in a number of research studies. The studies show that the object of suppression surfaces more often and more vigorously than prior to suppression.

Explain this phenomenon to the individual so they understand the importance of reflection and resolution as opposed to the tendency to want to suppress our negative thoughts, feelings, memories or fears.

This is an extremely useful approach when preparing the individual for trauma review and reducing treatment resistance as the individual begins to recognize that suppression does not work efficiently and is likely the reason for ongoing feelings of distress. This exercise is also a practical clarification as to why "Thought Stopping" is frequently unsatisfying for individuals seeking relief from trauma-related thoughts.

Centering
This exercise springs from the increasingly familiar work on "mindfulness" or reflection and

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acceptance. Or as Jon Kabat-Zinn (1990) explains in his grounded breaking book *Full Catastrophe living*, "Mindfulness is cultivated by assuming the stance of an impartial witness to your own experience" (p.33). He goes on to state that as we begin to pay attention to the internal dialogue "it is common to discover and to be surprised by the fact that we are constantly generating judgments about our experience" (p. 33).

The next important piece of mindfulness is "acceptance". Without this we will make no progress, as we cannot live peacefully within our own bodies if we are unable to gracefully accept its natural fragility along with its strength. If we are plagued with chronic headaches following a traumatic event we will certainly be worse off if we grow angry and frustrated every time we have a headache. Our anger and frustration will fuel our headache feeding it into a much worse bodily felt experience.

Thich Nhat Hanh (1990) explains a five-step process for centering that opens a dialogue between the individual and their own internal bodily felt experiences. He recommends that we allow ourselves to get to know and reflect on our internal processes whether it is fear, pain, sadness, confusion, irritation, etc. The first step is to just notice what comes up leaving judgment aside.

The second step is to greet the internal experience (i.e., Hello sadness. What is happening with you today? Why are you here?). This is in contrast to the common response which may be "hey, get out of here sadness, you have no place inside of me, who invited you!" In this way we are no longer battling with ourselves. It becomes acceptable to for us to feel whatever surfaces. The mindfulness is present and can moderate our internal experience of sadness – we are to just watch and let our attachment to judgment drop. Conscious breathing is an integral component to centering.

In the third step, you coax an inner calmness just as you would soothe a young child who is feeling sadness or pain. You might say, "I am here sadness and I will not abandon you. I am breathing into my sadness with calm cooling breath." Being one with the feeling allows it the space and time to be nurtured, explored, expressed, acknowledged and provides the opportunity for respectful recovery.

The fourth step begins the process of releasing the feeling. You have faced the fearful emotion living in your body. It is now time to recognize that as you add a calm mindfulness the sadness begins to transform. You have taught your body to feel ease even in the presence of deep sadness. You have sent a new message to your body – that you are ready to remain present and care for yourself even when faced with disturbing internal messages. Make a conscious decision to soften the feeling even more noticing that it can become a gentler expression. Imagine yourself smiling calmly at your feeling and letting it go with willingness to release.

The fifth step involves a deeper look. Bring your mindfulness to the source of the discomfort. Even if it has fully dissipated, the body will have a memory of its existence. Ask, "What is this feeling about? Where did it come from? What internal or external causes form this experience?" With questions like this, we can better understand ourselves. With understanding we can find the source of our internal distress. We can offer our own wise counsel, offering words of kindness and support, self-acceptance and transformation.

This self-directed exercise can add to the richness of anyone's life. The ability to be compassionate and patient with one's self when learning these techniques is helpful. The key to mastering these techniques is practice and self-acceptance. Lingering feelings of distress may

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be met as continued invitations for practice and growth vs. signs that you are not getting any better or that the self-soothing techniques are not working.

CLOSURE

Previously, this article introduced two individuals, Brad and Erica, both struggling with trauma and addiction. For individuals confronting the dual challenge of trauma and addiction, there is an even greater need for the ability to develop a feeling of safety. Trauma-related triggers for the addictive behaviors are often not identified until after the behavior occurs and the damage is done. For Brad and Erica, an awareness of how their desire or compulsion to use substances to cope was connected to past trauma may have enabled them to find alternative ways of coping. With greater understanding and more resources for coping at their disposal, each may have been able to respond with healthier means of self-regulation. Based on a foundation of safety and stabilization, traumatic material can be resolved and the continuation of self-destructive behaviors will gradually dissipate.

With the ability to self-regulate anxiety, impulsive behavior and traumatic material can be mastered and addicted survivors can move to the next phase of trauma resolution. However, without a strong foundation of safety, addicted survivors often resort to old patterns of coping and self-soothing, i.e., addiction--as these behaviors were at one time a means of survival. By offering new coping strategies, addicted survivors of trauma can learn to live life without the use of mood altering substances or behaviors and still manage the traumatic symptoms that may resurface in their absence.

Treating the addicted survivor of trauma can be debilitating for the clinician as well as the system that provides this treatment. Individuals with co-occurring unresolved trauma and addiction tend to have more conflicts and act out more often when attempting to address the trauma or to maintain abstinence. Without an understanding of how trauma and addiction are interrelated and an integrated treatment approach, the cycle of retraumatization and relapse will likely continue. For an optimal outcome when treating addicted survivors of trauma, it is essential that treatment begin with a strong foundation of safety. With this foundation solidly in place, the chances of a sustained recovery increases and the individual can lead life free from traumatic memories and addiction--TraumAddition become recovery.

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Trauma Practice: Tools for Stabilization & Recovery
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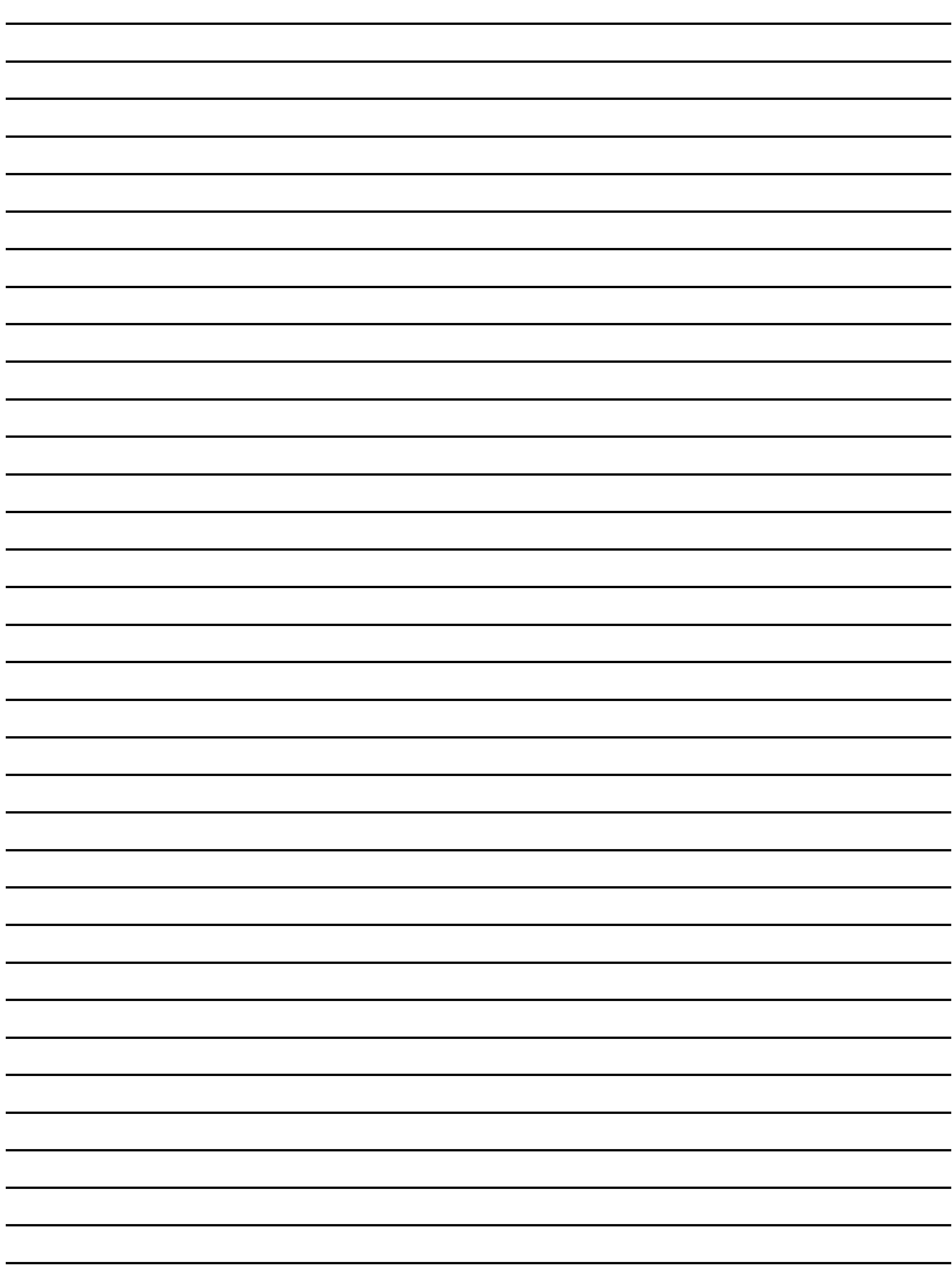

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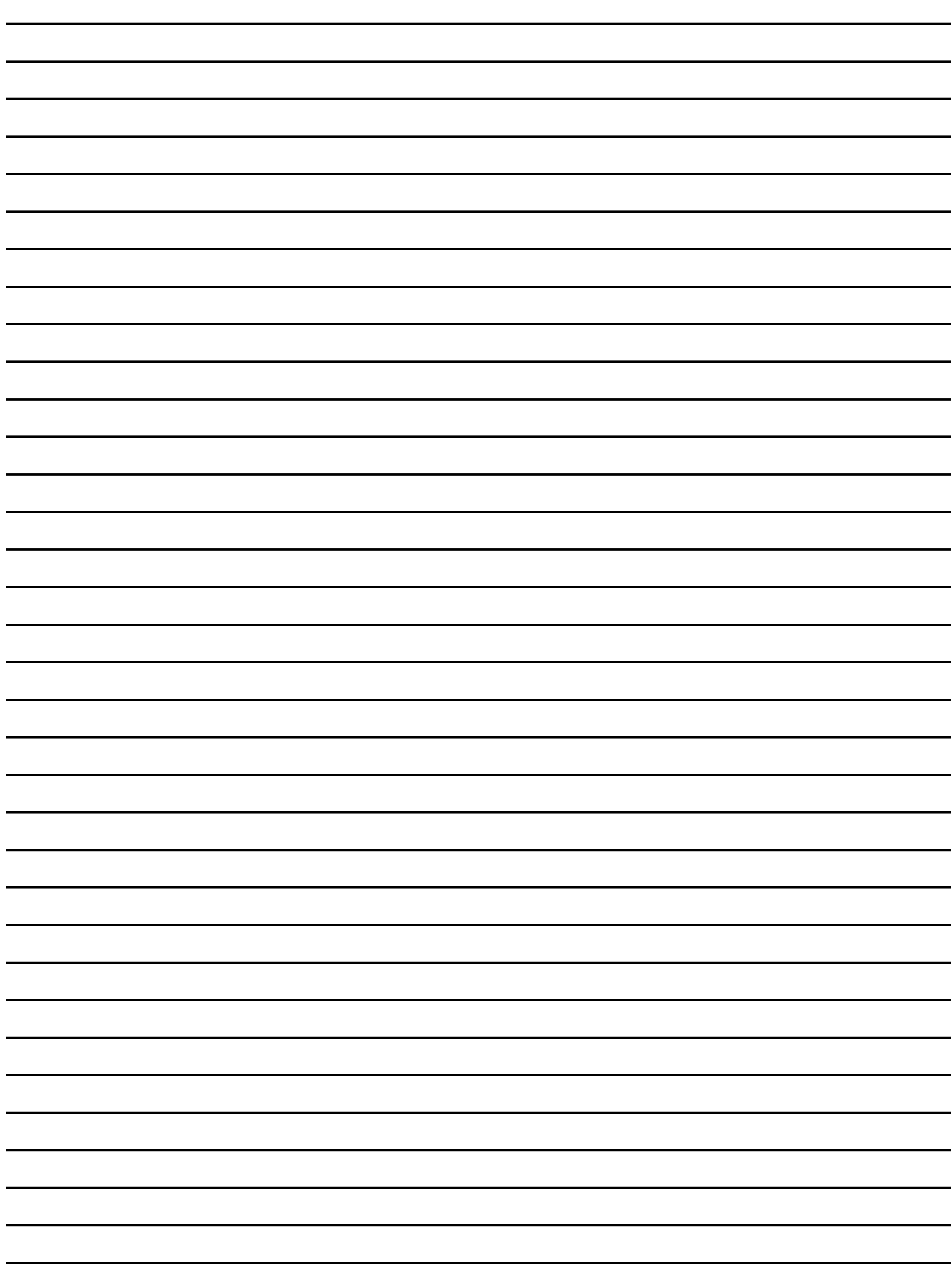

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