Certified Clinical Trauma Specialist Individuals
CCTS-I

Working with challenging trauma clients

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Resources

- Manual with PowerPoint
- The Arizona Trauma Institute YouTube page additional training videos.
- **Here is the link to** Dr. Rhoton's Resource page -- https://aztrauma.org/rhoton/ You will need to sign up for a user account to view the pages, but there is no fee or cost.

Contents

1. History of trauma
2. Basic physiology of traumatic arousal
3. Range of tolerance and metabolic generated symptoms
4. Threat response system
5. Bodily systems impacted by trauma, toxic stress and adversity
6. ACEs and the procedural memory of neurobiology
7. Self regulation
8. Key features of trauma treatment

Contents

History of Trauma

What is covered in this section

- Dualism's Impact on Trauma Treatment
- Pathogenic VS Salutogenic
- Names for trauma through history

What is covered in this section

Trauma in the 1800's

Trauma in the 1900's

Looking into the future of trauma

Dualism's impact on healing

- Separated the body from the emotions, thinking and behavior.
- Inadvertently promoting a pathogenic approach to resolving problems.
- Pathogenic focuses on acute symptoms, which in medical terms is great if the problem is localized in one organ or system of the body. This led to specializations to deal with acute disease.
- **Pathogenic approaches do not address environmental, whole person, life-style or prevention.** It is laser **focused on problems** and **deficits**.
- What emerged in the culture of mental health was a pathogenic view of emotions, thinking and behavior. Overly focused on **problems** and **deficits.**

Dualism's impact on healing 2nd slide

- The Salutogenic approach looks at the person as a complex being.
- Salutogenic is not designed for acute pathology (symptoms) it is designed for dealing with the whole person.
- Salutogenic approaches are necessary when the acuity is not centered in one part or system. Most situations we deal with in the mental health culture are Salutogenic (multifaceted), not Pathogenic (single incident).
- Truly trauma-informed approaches are **Salutogenic** not Pathogenic in nature.

Economic structure of mental health culture

- **Diagnostic system (DSM)**
- **The Pharmaceutic Industry**
- **Medical Insurance**
- **Most traditional treatment models**
- **Most agencies and programs**

Tend to be strongly Pathogenic, looking for acute causes

People with histories of trauma, toxic stress, and adversity are not generally dealing with the consequences of acuity. Instead they are dealing with the consequences of having multiple things effecting each other, creating changes in body, behavior, social/emotional, and spiritual aspects of life.

Most of us were trained from a Pathogenic ***not*** Salutogenic prospective in college programs and common clinical practice

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Attributes of Pathogenesis

- **Disease-centric**
- **Paternalistic (power and control from the top down)**
- **Curative (fixing a problem)**
- **Fixing discrete “broken” parts**
- **Authority figures, professionals possess a sense of entitlement**
- **Lower levels of collaboration and transparency about process or expectation**
- **Business and billing - efficiency-minded**
- **Absence of pain is equal to good health**

Attributes of being Salutogenic

- Thriving
- Self-efficacy
- Hardiness
- Locus of control
- Gratitude
- Social and emotional intelligence
- Connectedness
- Attachment
- Empowerment
- Learned optimism
- Coping skills
- Quality of life
- Flourishing
- Resilience

Be Mr Jensen

Most mental Health professionals

- Believe that to create well-being does take a Salutogenic Approach.
- However, most have only been trained in Pathogenic process and the accompanying oppression of a disease centric mental health Oligarchy

Another way of explaining this

- Most models of treatment are neocortex-centric in conceptualization
- Most therapists practice from an Amygdala-centric (emotion-focused) process.
- Meaning that many therapist/counselor are rarely congruent which is very challenging for a trauma client that needs predictability and safety.

Brief History of Traumatic Stress

Historical Vernacular of Traumatic Stress

- Nostalgia – Swiss military
- Homesickness – German military
- Estar Roto – Spanish “to be broken”
- Soldier's Heart/Irritable Heart – Civil War
- Hysteria – Janet
- Shell-shocked - WWI
- War Neurosis - Freud
- Combat Exhaustion - WWII
- PTSD – DSM III (1980)

Brief History of Traumatic Stress

1800's:

Jean Martin Charcot - symptoms of trauma (1860)

Jacob Mendes Da Costa –soldier's Heart (1871)

Pierre Janet – (1883) Dissociation, subconscious, psychasthenia. Developed effective treatment using hypnosis to narrate and integrate memory fragments (not discovered until 1980s). In 1913, Janet publicly charged Freud with plagiarism.

Freud & Breuer – relationship between traumatic life events and subsequent psychological problems.

Brief History of Traumatic Stress

1900's:

Joseph Wolpe – Reciprocal Inhibition (1958)

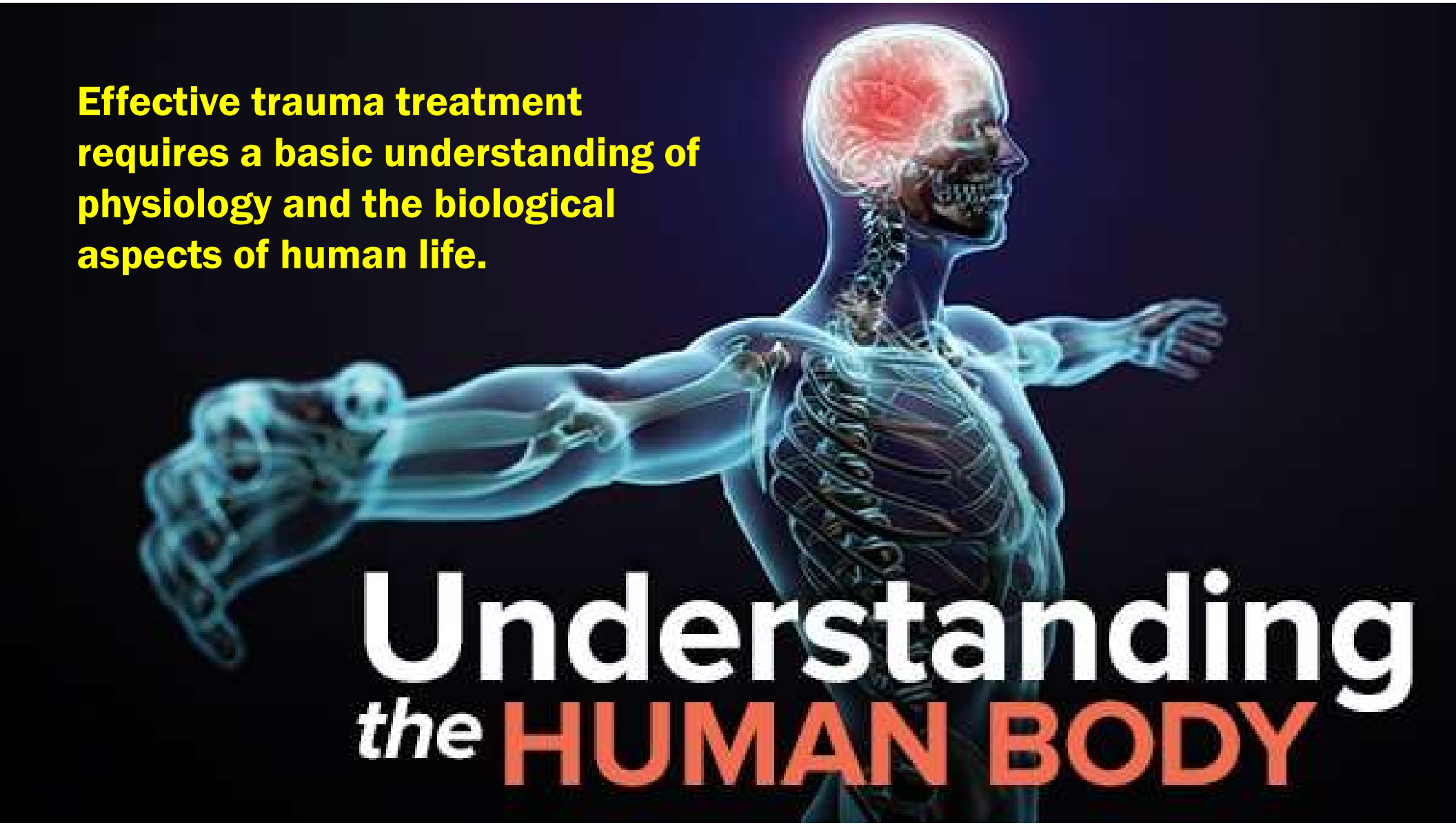
Herbert Benson – Relaxation Response (1968)

Charles Figley – Vietnam Stress Syndrome > PTSD (1980 -).

Onno van der Hart – Abreaction Re-evaluated (1992 -)

Bessel van der Kolk – Trauma = brain injury / Treatment & research pioneer (1989)

Judith Herman (1995) Triphasic model of treatment


Effective trauma treatment requires a basic understanding of physiology and the biological aspects of human life.
Understanding
the HUMAN BODY

Summary of this section

- Dealing with TRAUMA requires a Salutogenic thought process.
- A focus on pathology and acuity are going to consistently underserve client well-being
- Most systems (schools, juvenile probation, addiction treatment programs, mental health agencies, child protective services, and courts) are Pathogenic! Meaning that they focus on immediate acute resolution rather than in long-term well-being.

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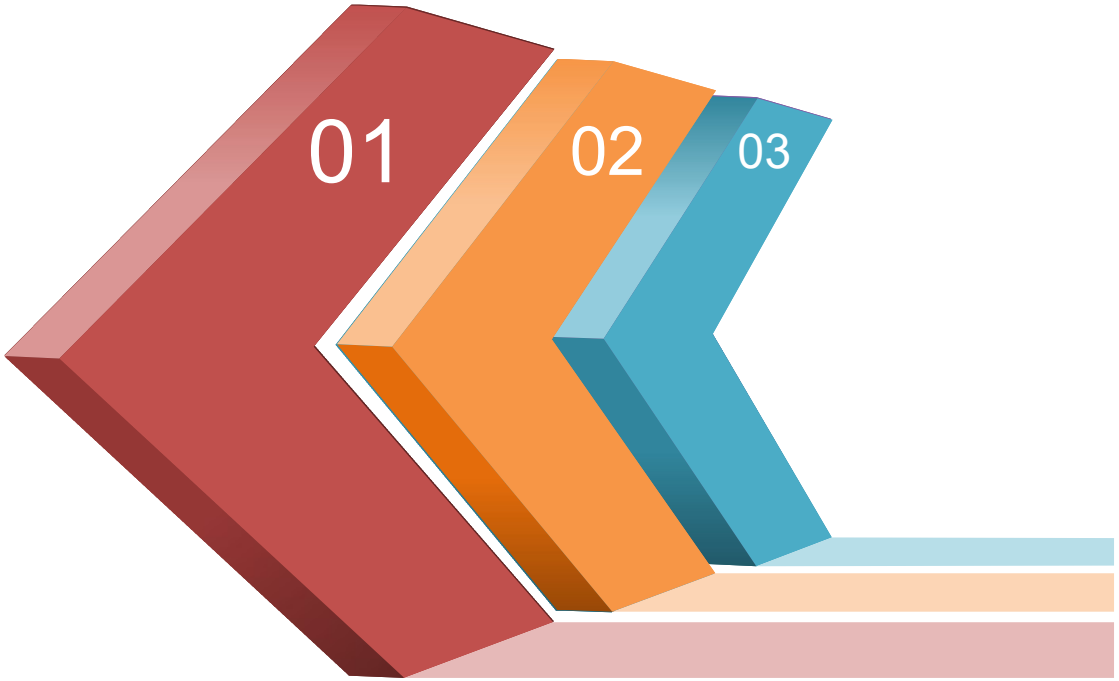
What you will learn in this section

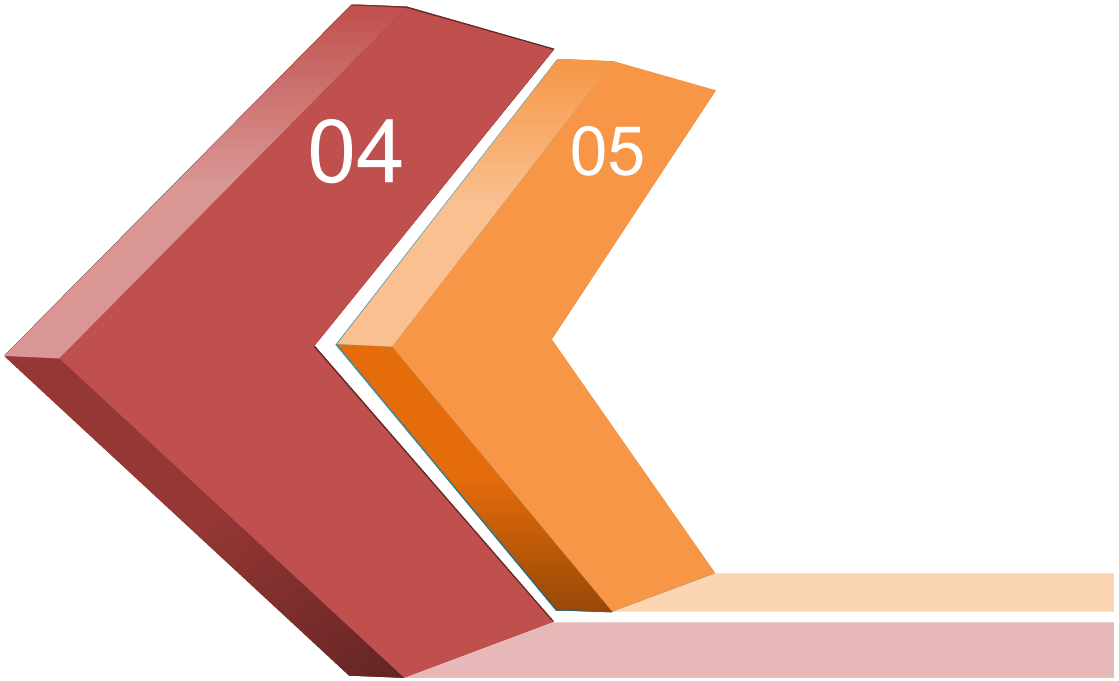
1. **What is Trauma, toxic stress and adversity?**
2. **What happens when the Central Nervous System Shifts**
3. **What changes in biology create an emotion thinking and action**



What you will learn in this section

4. **What is 100% correct response to trauma and toxic stress.**

5. **Stop seeing behavior, emotion and thinking as a purely volitional choice**



Starting point

The state of the body influences behavior, emotions and thinking

What does that really mean?

It is not a choice, it is biology

What is a large increase

1 Changes in metabolism	2 Emotional/behavioral change
Large increase in Noradrenalin	Anger, Aggression and Hostility
Large increase in adrenalin	Fear, Withdrawal, flight,

Why is this point important

The state of the body influences behavior, emotions and thinking

What are the bodies of your clients experiencing?

Why is this point important to you!

How would it change you and the way you look at things:

- **You would always give people the benefit of the doubt**
- **Realize that when you are angry that is *you* failing to manage you well, not anything to do with other people's actions**
- **Most often annoying behavior is not planned, or done with forethought**

The body's excitatory process


AAMC
KHAN
ACADEMY
A video in collaboration between the Association of
American Medical Colleges and Khan Academy
www.khanacademy.org

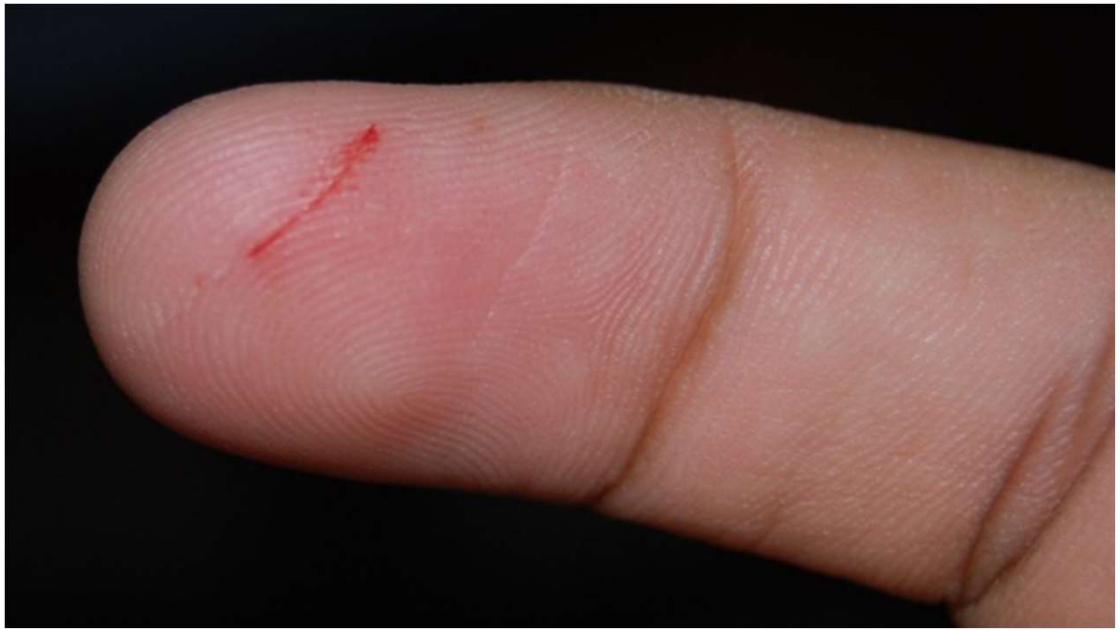
The Body has a Balance System

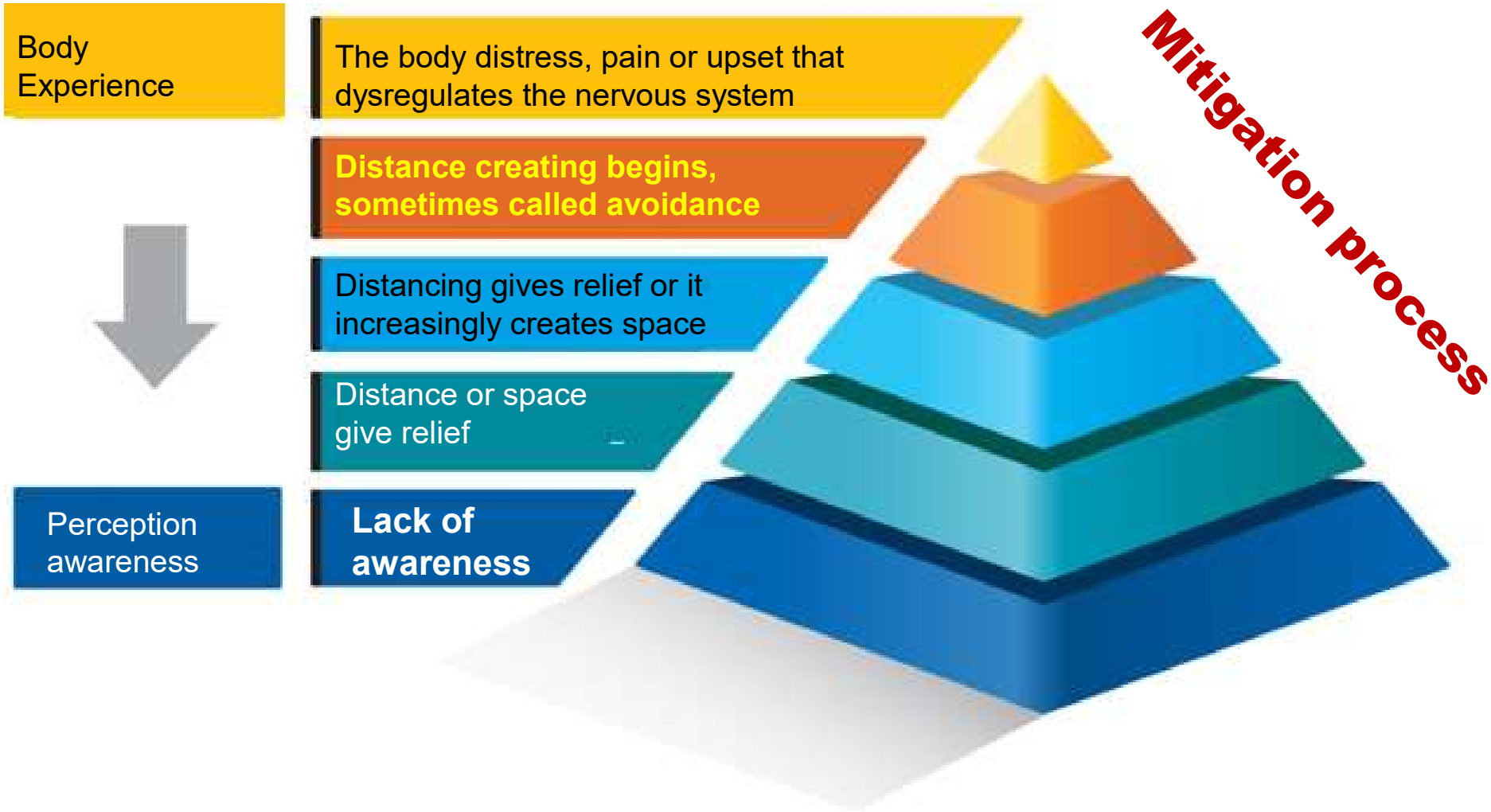
- Which regulates body processes striving for homeostasis
- Works automatically (autonomously), without a person's conscious effort.
- When out of balance the body ***ADAPTS*** or ***MITIGATES***
- Behavioral symptoms result from the over-use of the threat/stress response system and the body is struggling to have balance

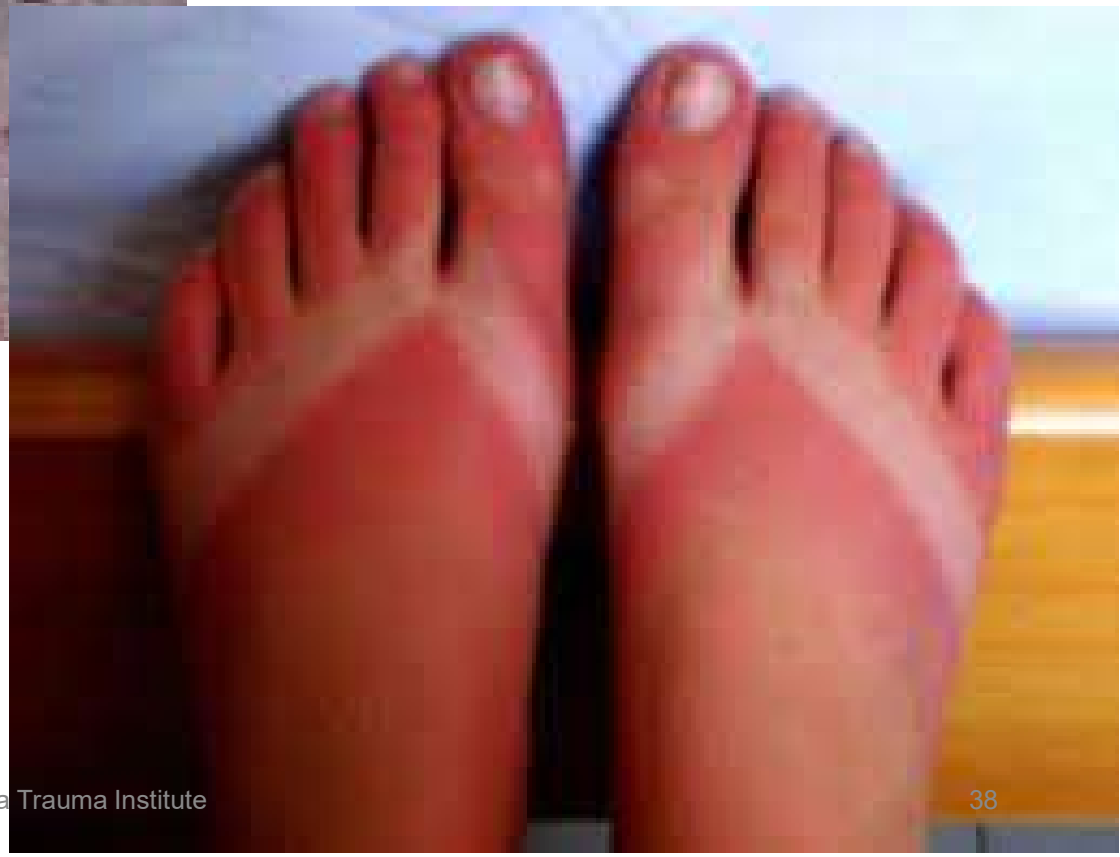
Adaptation (how the body self corrects)

- **Hemostasis Phase** is the process of the wound being closed by clotting
- **Inflammatory Phase** is the stage of wound healing causing localized swelling. Inflammation both controls bleeding and prevents infection.
- **Proliferative Phase** is when the wound is rebuilt with new tissue.
- **Maturation Phase** also called the remodeling is when the wound fully closes.

Ouch!!!!




Body Experience
The body distress, pain or upset that dysregulates the nervous system
Distance creating begins, sometimes called avoidance
Distancing gives relief or it increasingly creates space
Distance or space give relief
Perception awareness
Lack of awareness
Mitigation process



Ever had a sunburn?

If you have had a Sun Burn have you mitigated?

Do you change your behavior?

- ✓ Staying out of the sun
- ✓ The clothes you wear
- ✓ How much physical contact with others you will tolerate
- ✓ How you sit comfortably

Do you notice that you get angry more easily?

If someone looks like they might touch you are you more reactive?

Do you get a little extra snappish with people, even loved ones?

If you have had a Sun Burn have you mitigated?

Did you put something on the sunburn to reduce the pain?

- ✓ Aloe vera?
- ✓ Aloe vera with lidocaine (topical analgesic)?
- ✓ Vinegar?
- ✓ Hemorrhoid cream?
- ✓ hydrocortisone cream?
- ✓ Tea bags?
- ✓ Aspirin, Ibuprofen ?

Did you use some substance to give you relief from pain and distress?

Mitigating reduces the risk of further distress and pain!!!

Trauma/adversity cycle

R → **D** → **RR**

Regulated

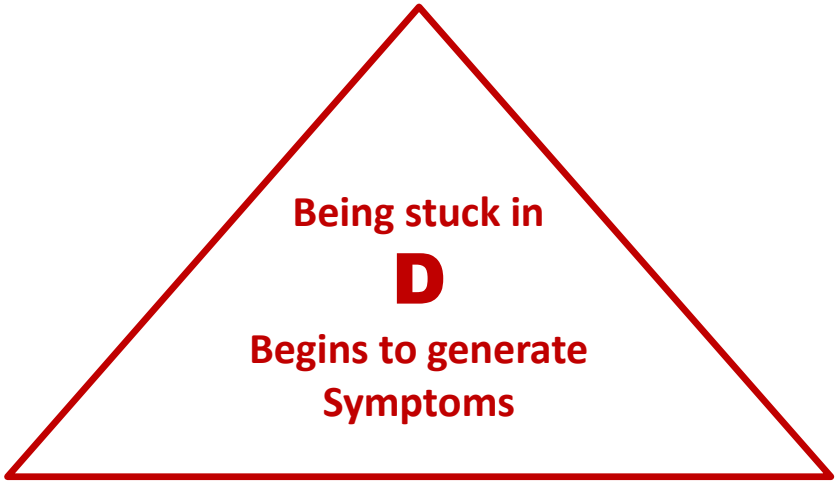
Bruce Banner Brain

Dysregulated

Hulk brain

Re-Regulated

Bruce Banner Brain



Trauma/adversity cycle

R → **D** → **RR**

Regulated

Bruce Banner Brain

Dysregulated

Hulk brain

Re-Regulated

Bruce Banner Brain

Traditional Types of Trauma

Natural disasters
Mass interpersonal violence
Domestic fires
Motor vehicle accidents
Rape & sexual assault
Physical assault
Partner/Family battery
Torture
War
Child Abuse
Emergency worker exposure

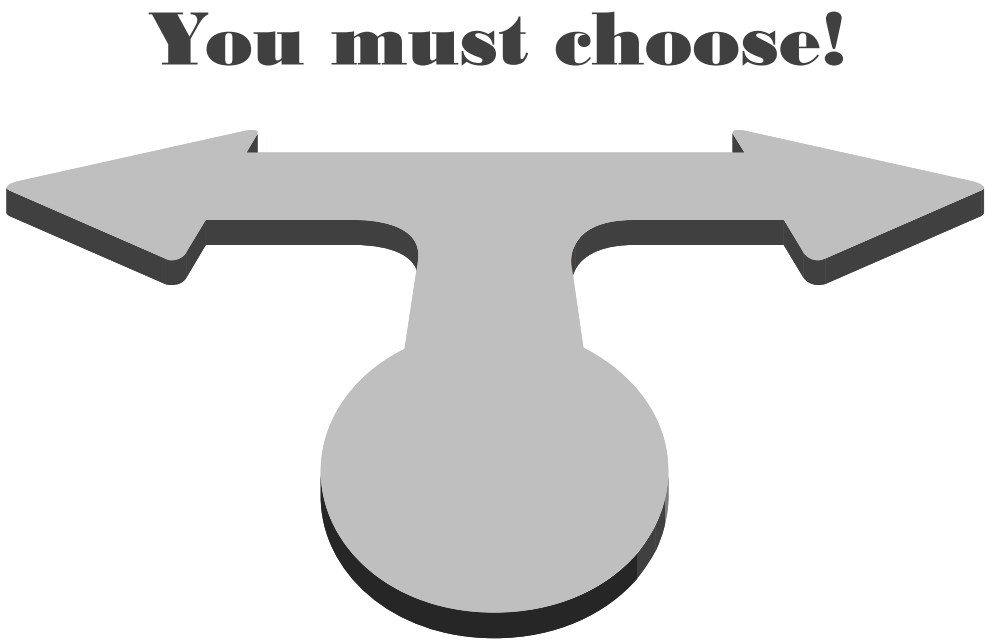
Most clients are not working with a single incident trauma!

They struggle because of multiple stressors

Please Understand

SALUTOGENIC

You see behavior, emotion and thinking as a form of communication that reflects people's movement through different environments



PATHOGENIC

That the problem is some acute single cause that is within the person and if that can be patched or fixed then everything will be better. Acuity and problem focused

What are the absolutely correct biological responses you should see?

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Nature of the sympathetic system

- Immediate
- No future
- Impulsive
- Irrational/illogical
- Little self reflection
- Little evaluation
- Poor ability to evaluate rewards

Change or transformation requires Bruce Banner not the HULK

A metaphor to use when thinking about how the body changes thinking, emoting and behaving

Perhaps a different way of looking at this might be nice kitty and mean kitty

What did you learn in this section?

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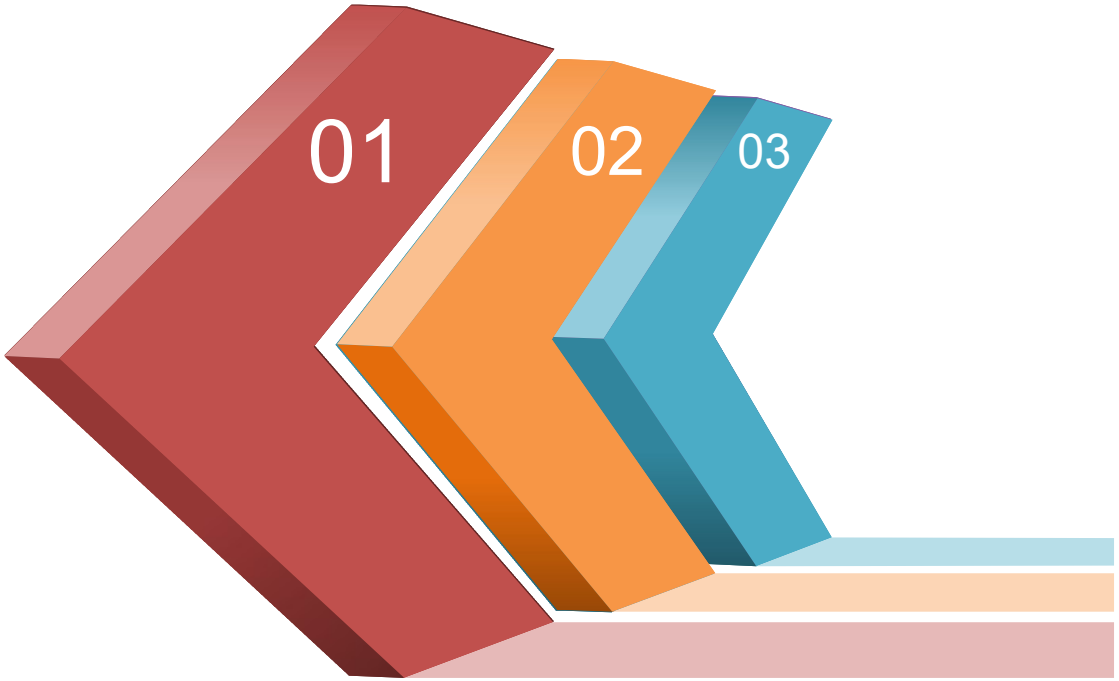

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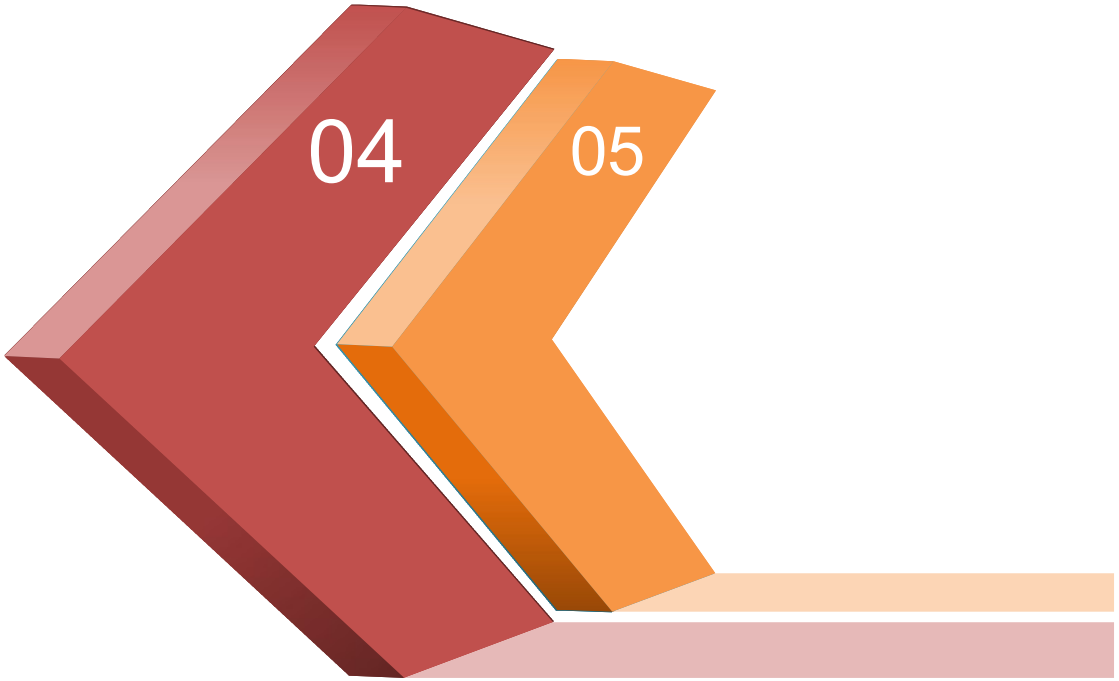


Basics of Trauma

What is covered in this section?

Range of tolerance

Trauma created when above threshold

Fiery Cocktail

Ladder of Dysregulation

Cortisol ‘s impact on thinking and memory

HOW LONG DOES IT TAKE TO METABOLIZE?

Symptoms more about biology than choice

Why talk therapy may not be best for Trauma clients

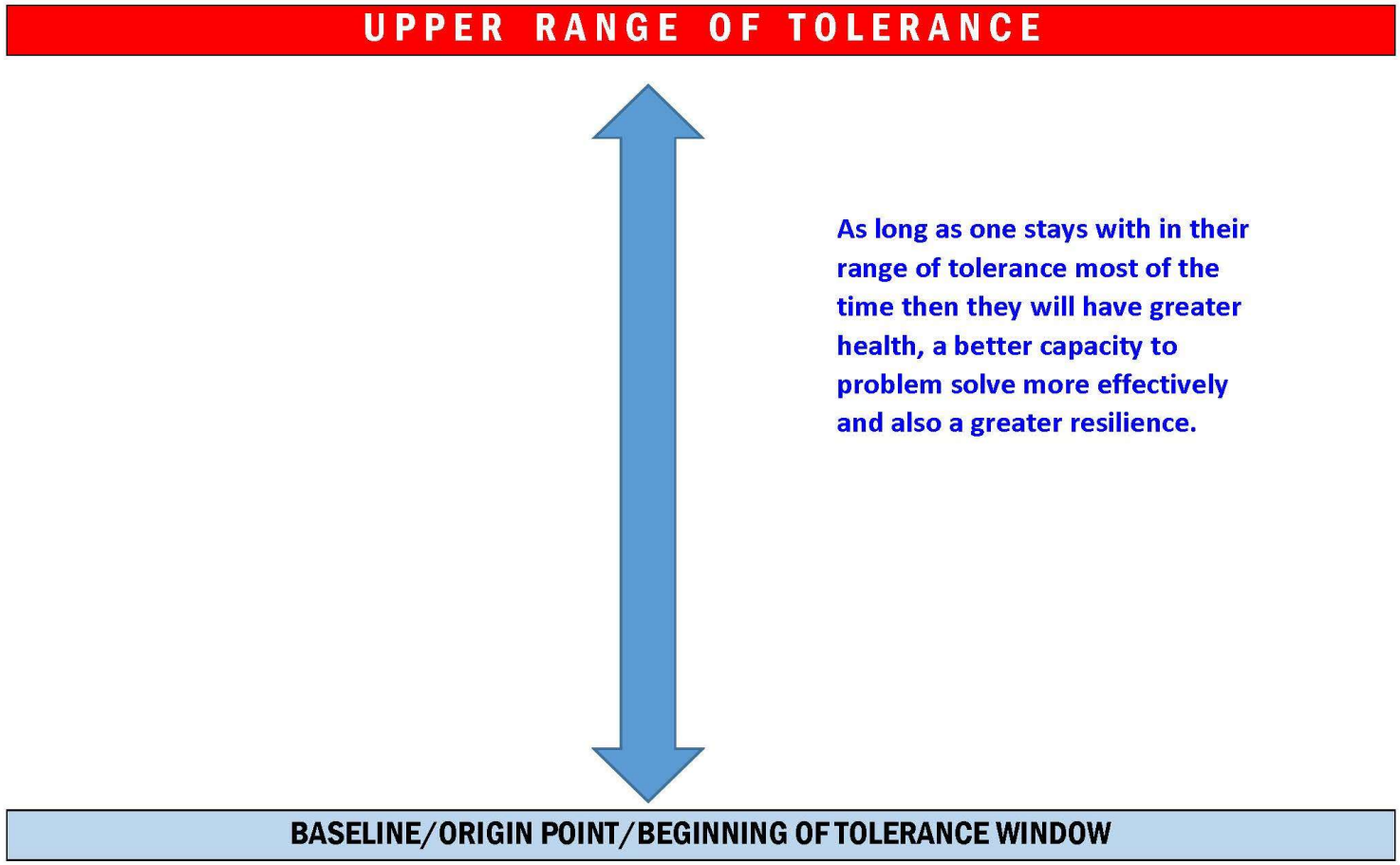
Why Hippocampus function matters

How does trauma get created?

OR

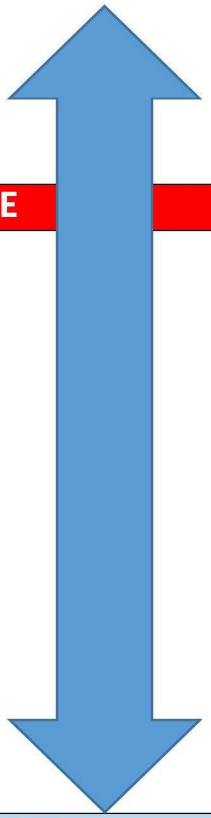
How does the body get “pushed” to the point that it must adapt or mitigate?

Range of Tolerance Graphic



Range of Tolerance Graphic

UPPER RANGE OF TOLERANCE



BASELINE/ORIGIN POINT/BEGINNING OF TOLERANCE WINDOW

Range of Tolerance Graphic

The body begins to break down from the sympathetic system being over utilized

Reactive Mitigation

Reactive Adaptations

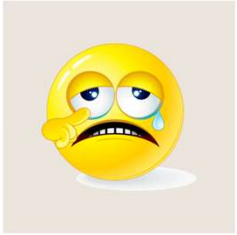
UPPER RANGE OF TOLERANCE

Attempting to heal and restore balance to the system

Ventral Vagal Complex: Signaling System
for motion, emotion & communication.
(Our Social Engagement System)

Sympathetic Nervous System: Mobilization
System for Flight or Fight Behaviors.
(Our Aggressive Defense System)

Dorsal Vagal Complex: Immobilization
System for Conservation Withrawal.
(Our Passive Defense System)

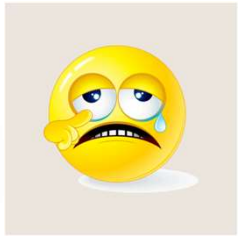


The ladder of dysregulation and our ability to move up and down the ladder

Assertive, self-reflective, genuine, good relationships and boundaries

Aggressive, angry, controlling, sarcastic, threats, name calling, intimidation to gain control

Opinions, thoughts, feelings and ideas are withheld. Try to make one's self smaller and less noticeable. Shut down emotionally, and avoidance



The ladder of dysregulation and our ability to move up and down the ladder

A single dose of the fiery cocktail regardless of dose size may take hours to

Cortisol
Another player in the fiery cocktail

- **CORTISOL**

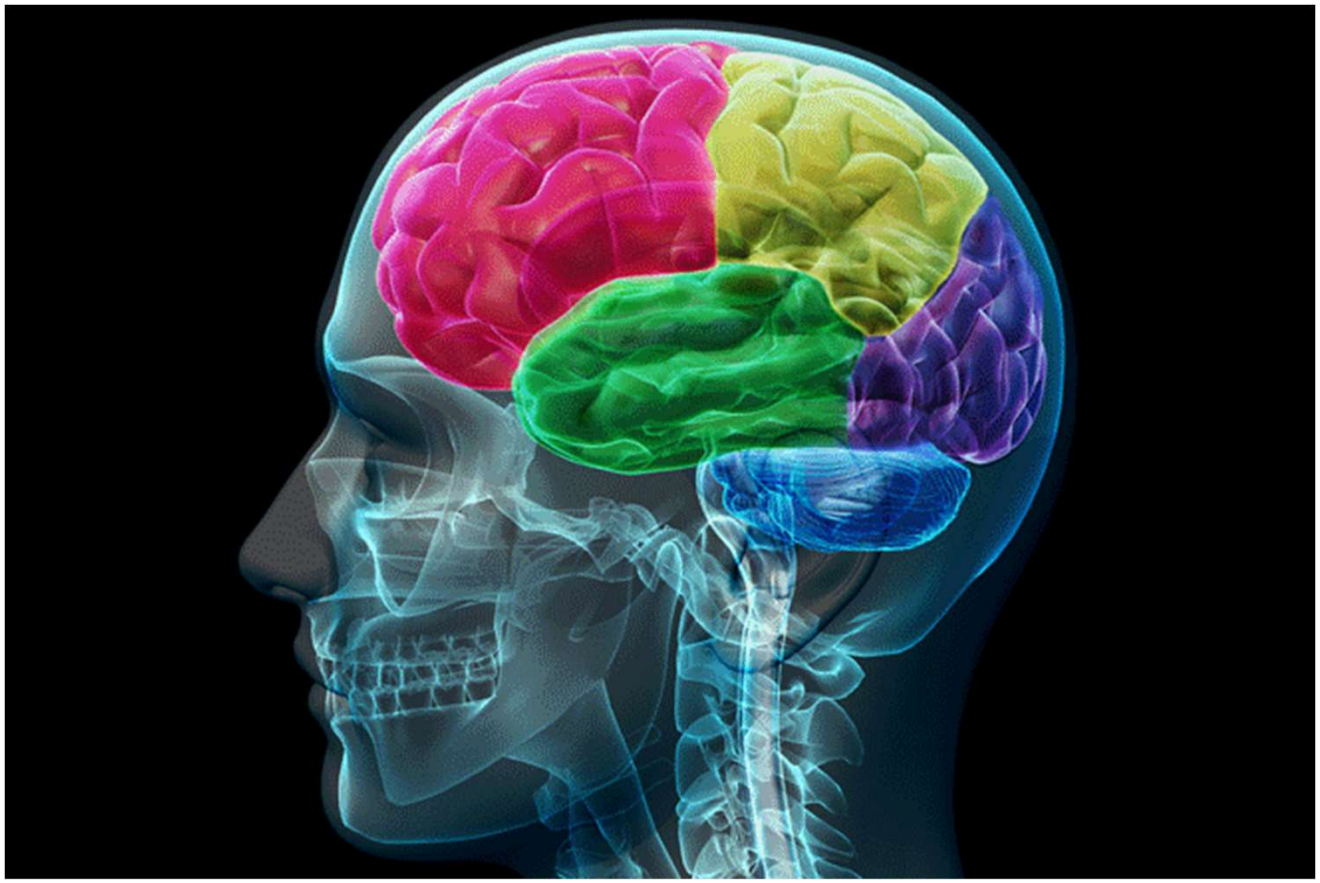
a. Reduces

- ✓ Hippocampal activity
- ✓ Executive functioning
- ✓ The ability to create sequential memory
- ✓ Ability to see differences or distinctions (reality checking)

b. Restricts access to the (impulse control center)

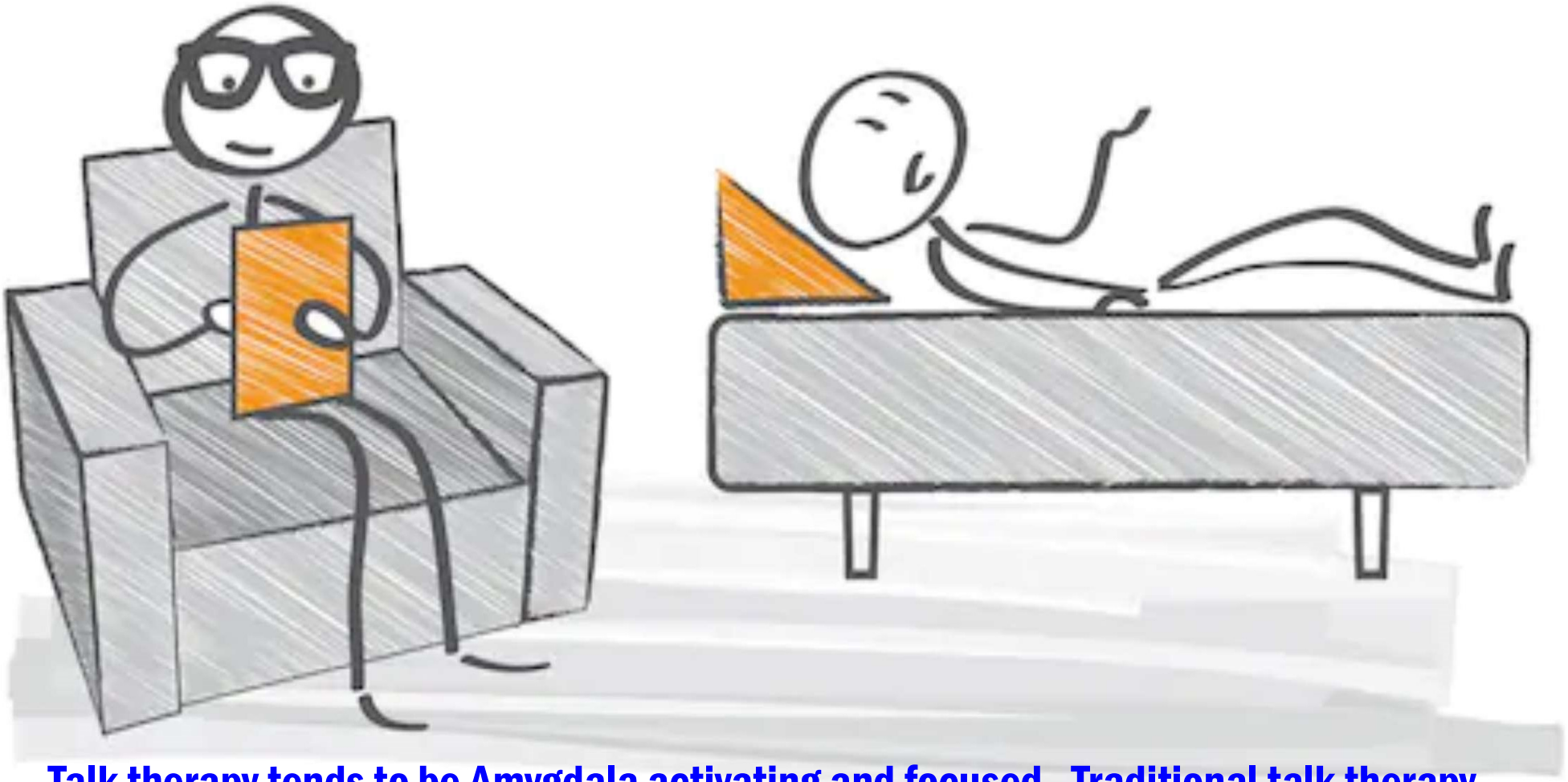
c. Can act as a neurotoxin

When the whole brain works together



Hippocampal function

- Creates discrete/distinct elements from experience
- Necessary for reality checking
- Modifies and governs amygdala function
- Serialize and/or sequence time within a context
- Connect separate brain regions as part of active integration
- Enhance executive functioning
- Enhances cognitive flexibility
- Increases ability to inhibit behavior
- Greater sequential memory
- Logic
- Reason
- Reward Evaluation
- Planning



Talk therapy tends to be Amygdala activating and focused. Traditional talk therapy likely to be ineffective with treating PTSD or complex trauma

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Symptoms more about biology than choice

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Basics of Trauma #2

What is covered in this section?

Completely correct, biologically driven and predictable

Cortisol ‘s impact on thinking and memory

Most Trauma we treat is not from one big bad event

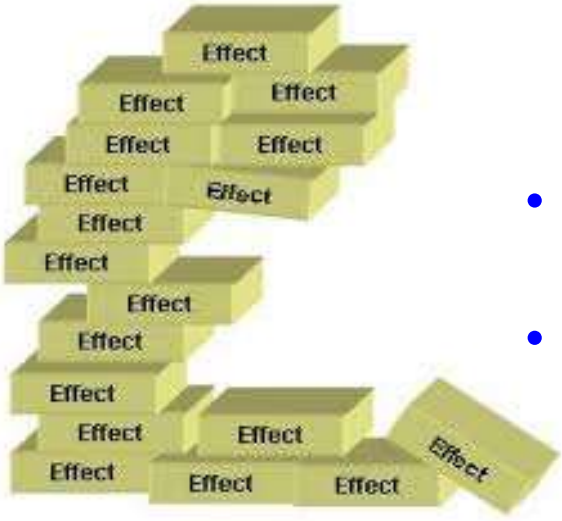
Why isn't dysregulation mental illness?

Symptoms more about biology than choice

Changes in Social behavior when dysregulated

So are big bad events necessary to have the symptoms of trauma?

Small repeated events: The cumulative harm effect



- Chaotic environments
  - What are chaotic environments
- Aggressive environments
  - What is an aggressive environment (anytime rules come before relationship)
- Punitive environments
  - Where there is a demand for performance that is valued more highly than attachment or relationship
  - When the rules for operating constantly flux based on the annoyance of those in charge
- Inconsistent practices
  - What does this look like
- Instability
  - Lack of predictability
  - Inability to trust situation

What absolutely correct, though possibly unfortunate behavior, thinking and emotion

would you expect to see when some one shifts into sympathetic system dominance?

What are the absolutely correct biological responses you should see?

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These are not bad behaviors –just proof of the system in use

(action-oriented behaviors fight or flight)

- Angry
- Aggressive
- Defensive
- Reactive
- Impulsive
- Hostile
- Irrational
- Self-centered
- Poor focus

- Inattention
- Sleep disturbances
- Fidgety
- Hyperactive
- Anxiety
- Irritability
- Delays in reaching physical, language, or other milestones on time

Physiological congruent and predictable behaviors

These are not bad behaviors just proof of the system is in use

(passivity-oriented behaviors related to mitigating behaviors)

- Freezing, stuck, paralysis of action
- ***Dissociation***
- Emotional numbing
- ***Distraction***
- Self-soothing
- ***Addictions***
- ***Self-injury***
- ***Suicidality***
- ***Compulsive behavior***
- Reactive
- Impulsive

- Emotional and psychological distancing
- Self-centered
- Sad
- Withdrawn
- Difficulty attaching securely
- Reluctance to explore the world

Physiologically congruent and predictable behaviors

Impact of dysregulation on Social Behavior

- Insert Roderick video https://www.dropbox.com/s/i49ay6xn5lp3nvz/Creating%20Safety%20%26%20Stability%20-%20Section%203.mp4?dl=0
- For the online version

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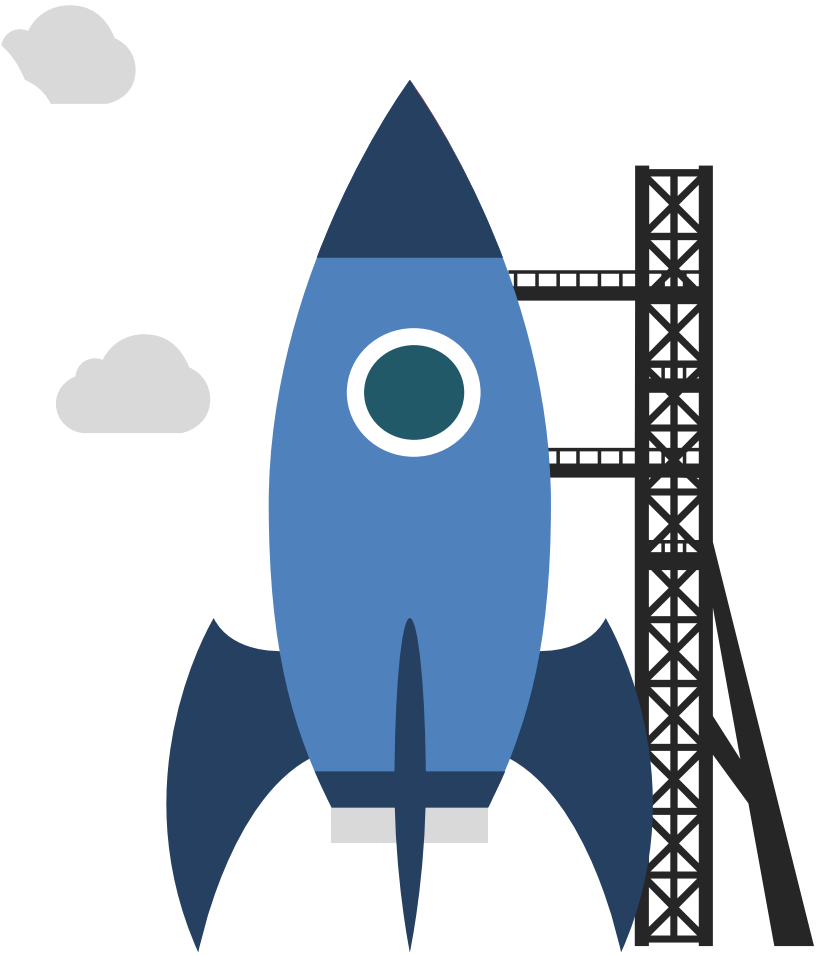
The Polyvagal system #1

Checklist

- ✓ Hierarchy of functioning
- ✓ Organizing principles
- ✓ The nervous system is the foundation
- ✓ 4 Typical human responses
- ✓ Story or narrative follows state



Threat/Stress Response System of the Body

Polyvagal System and the Anterior Cingulate of the Cortex (ACC):

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Three Organizing Concepts

1. Hierarchy
2. Neuroception
3. Co-regulation

Hierarchy

Hierarchy (nervous system responds to the sensations in the body signals from environment through three specific avenues)

1. Dorsal Vagal (immobilization)
2. Sympathetic Nervous System
3. Ventral Vagal (Social engagement and connection)

Neuroception

Autonomic nervous system of our bodies experience the environment and send signals of safety, danger, life-threat.

These signals influence our relationship with others, non-conscious, subcortical—automatic response – not a volitional choice.

Co-regulation

Co-regulation we must be able to connect to others and use those connections to regulate our systems. Basis of attachment, relationship pleasure.

Fundamental to quality of life, since humans are social creatures that do not thrive in its absence

Our nervous system is the foundation of our lived experience and the meaning that we give those experiences.

Our Neural scaffolding allows us to learn from our experiences.

- Each relationship, experience, action is leading the Autonomic nervous System (ANS) to learn more about the world
- Every response is in the service of survival. No matter how incongruous an action might seem to others from the outside, all action in the ANS is survival oriented first.
- **This is why Trauma Therapists will always seek safety and stability of their client first!**

Generally people respond to their environment by taking repeated actions that become habitual

- Turning toward
- Backing away
- Connection or isolation
- Attuning and mis-attuning

Early life experiences shape our brain's architecture (the experiences of our lives are becoming flesh and blood structures in our brain and nervous system)

Even before the brain makes meaning out of an experience, the ANS has assessed the environment and initiated an adaptive or mitigating response. (STORY FOLLOWS STATE)

Neuro-prepared to act and make meaning

- We come into the world wired to connect. With our first breath, we embark on a quest to feel safe in our bodies, in our environments, and in our relationships with others. The autonomic nervous system is our personal surveillance system, always on guard, asking the question “Is this safe?” Its goal is to protect us by sensing safety and risk, **LISTENING** moment by moment to what is happening in and around our bodies and in the connections, we have to others. (Deb Dana, 2018)
- This **listening** happens far below awareness and far away from our conscious control. Dr. Porges, understanding that this is not awareness that comes with perception, coined the term *neuroception* to describe the way our autonomic nervous system scans for cues of safety, danger, and life threat **without involving the thinking parts of our brain**.

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- ✓ Organizing principles
- ✓ The nervous system is the foundation
- ✓ 4 Typical human responses
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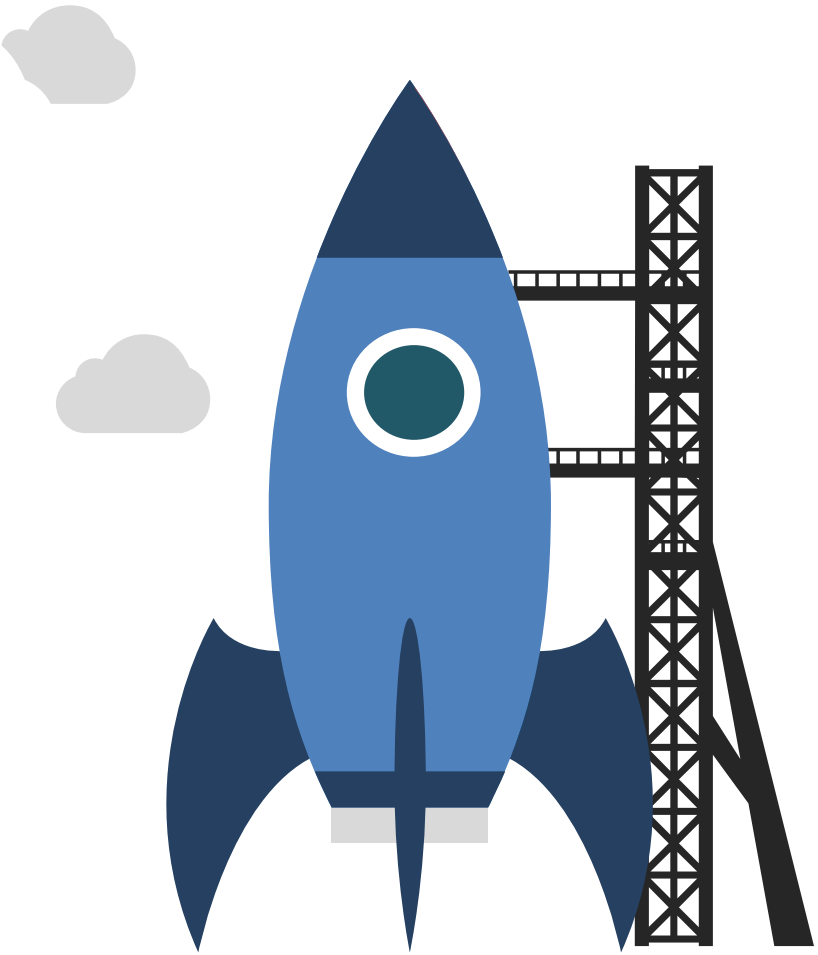
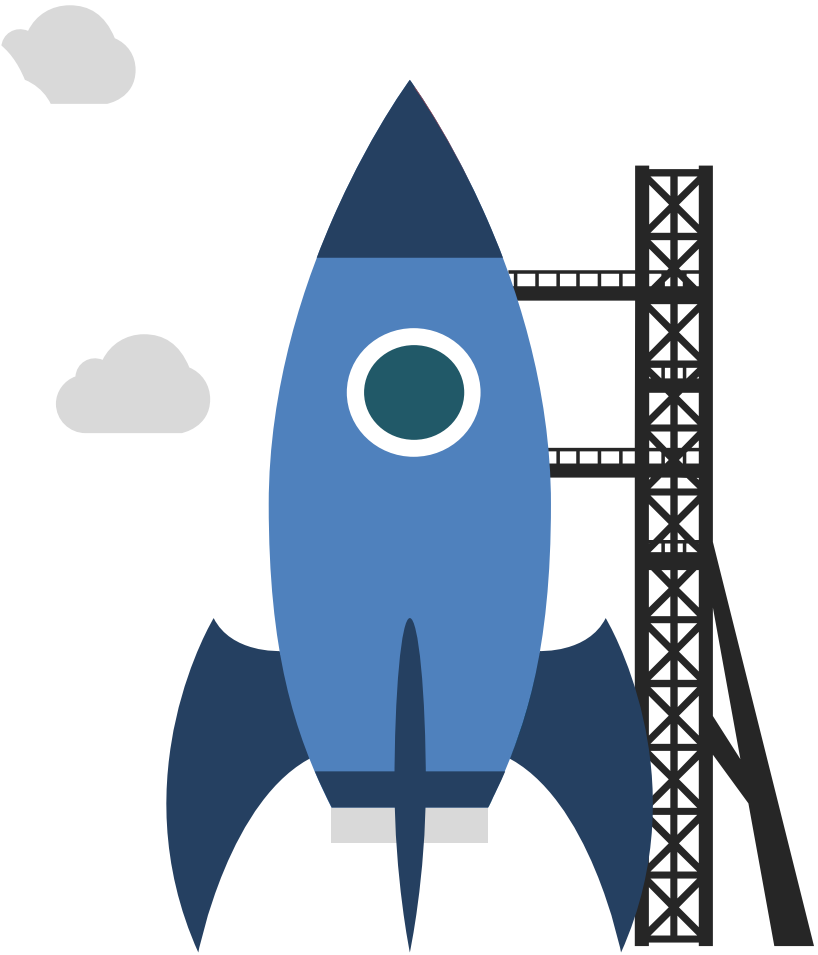


What we cover in this section

The Polyvagal system #2

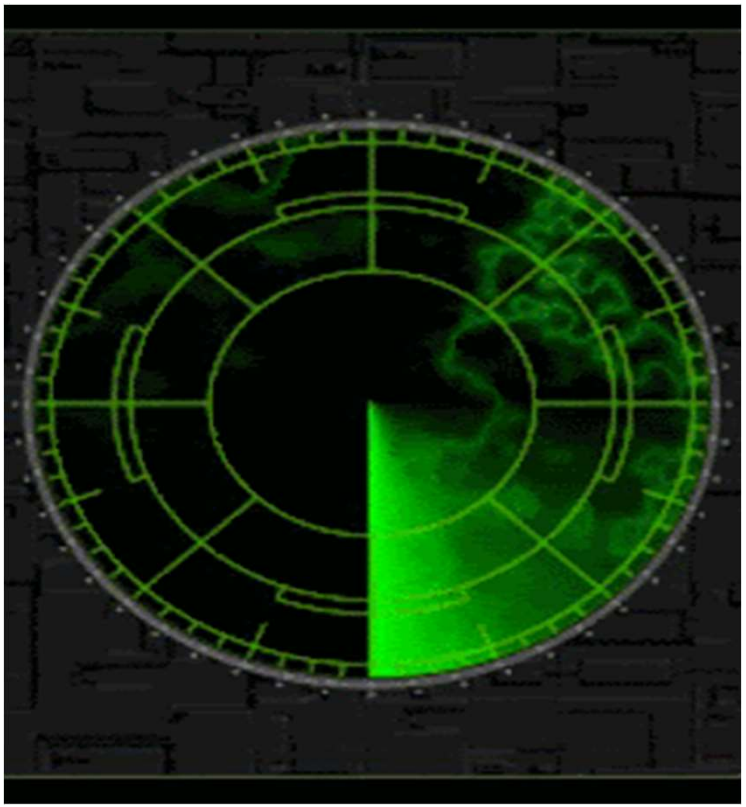
Checklist

- ✓ ACC and the relevancy system
- ✓ Trauma and relevance
- ✓ Memory impact
- ✓ Potentiated reactivity
- ✓ Survival and self-centered behavior




SALIENCE
WHAT'S RELEVANT

The Body's Radar System:
Anterior Cingulate of the Cortex (ACC)



- ***An active relevancy system that is totally individualized based on one's history.***
- ***Arousal impacts the relevancy process***
- ***Those things that activate arousal create attentional competition based on the relevancy***

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Repeated Activation of the *Relevancy System* (ACC)

Attentional competition, having one's attention always focused on the immediate relevancy or salience of a thing. Relevance/salience is always based on our history of experience and meaning making!

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Repeated Activation of the *Relevancy System* (ACC)

Is memory reliable?

- Where Salience is high (significance energy in the brain) it is focused on attending to what is of ***(personal significance)*** and little else in the environment.
- Attention is always focused on the relevant, memory is built on the foundation of relevance.
- Energy competition in the brain is high in sympathetic dominant states, meaning that only a few things will be even noticed.

Repeated focus leads to enhanced or expanded threat awareness, threat (real, perceived or imagined) becomes the dominant focus of what is noticed.


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Repeated Activation of the *Relevancy System* (ACC)

Increased potentiated reactivity --- faster to react, where other people might be able to pause before reacting.

- The space between stimulus and response gets shorter
- This space between stimulus and response is maximized in an integrated brain (Bruce Banner mode) and becomes increasingly diminished as the Sympathetic system becomes dominate (Hulk mode is in charge)
- The more often and/or the longer the person is in HULK mode, the shorter that space between stimulus and response will become.
- Making it almost impossible to exercise consistent self-control, think before one acts or to see and weigh consequences before acting.

A terribly inconvenient truth!

Successful change can only occur with Bruce Banner Brain.

Change will not be effective with the Hulk Brain

How do you get people in the Bruce Banner Brain and out of the Hulk Brain is where helping and healing start. ***NOT. . .behavior, thinking or emotions!!!!***

Dr. Robert Rhoton Robert.Rhoton@aztrauma.org

Dysautonomia

- a disorder of the autonomic nervous system that causes disturbances in all or some autonomic (sympathetic and parasympathetic) functions
- may result from the course of a disease (such as diabetes) or from injury, poisoning or trauma and adversity.

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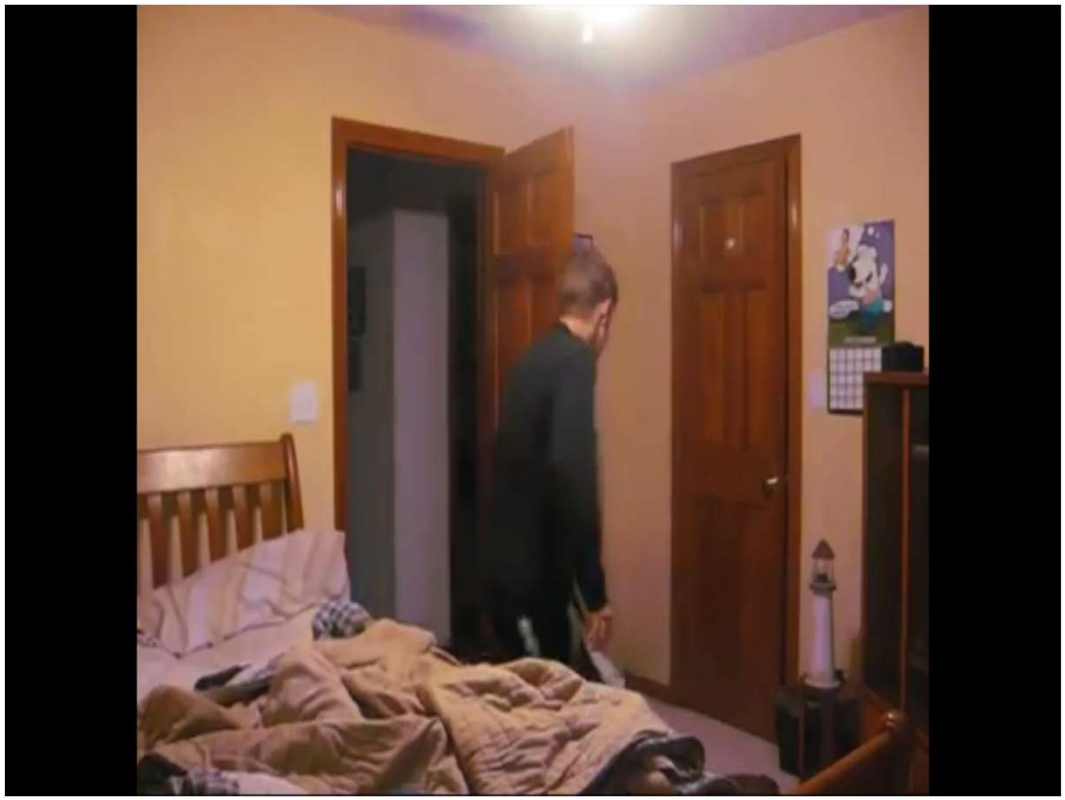
Behaviors Associated


/KOLLEGEKI

Is this person ready to be logical and calm



We must stop trying to teach, have logical discussion with, expect pro-social behavior, labeling as mentally ill, or oppositional, or personality disordered those people who spend most of everyday in their own personal HULK system.

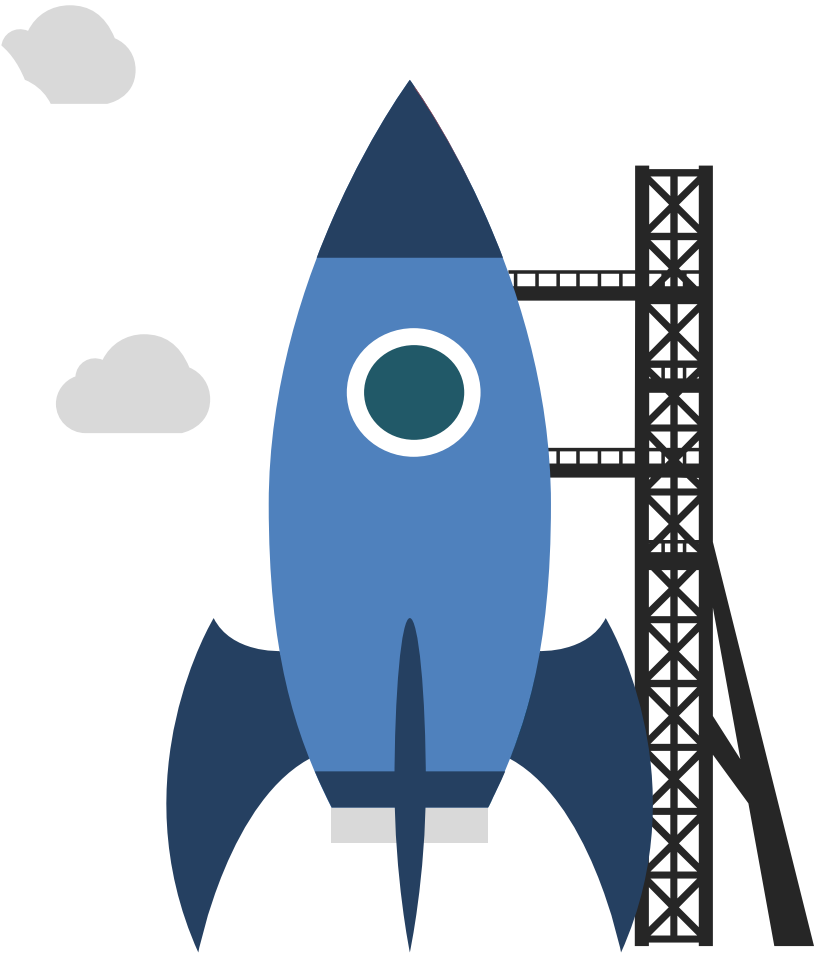
Learning, treatment, growth, sustainable change all require SELF-REGULATION FIRST, then you can do those other functions.

What we covered in this section

The Polyvagal system #2

Checklist

- ✓ ACC and the relevancy system
- ✓ Trauma and relevance
- ✓ Memory impact
- ✓ Potentiated reactivity
- ✓ Survival and self-centered behavior



What will be covered in this section

1

Quick review of the Threat response system

2

Sub-diaphragmatic systems and their impact on health

3

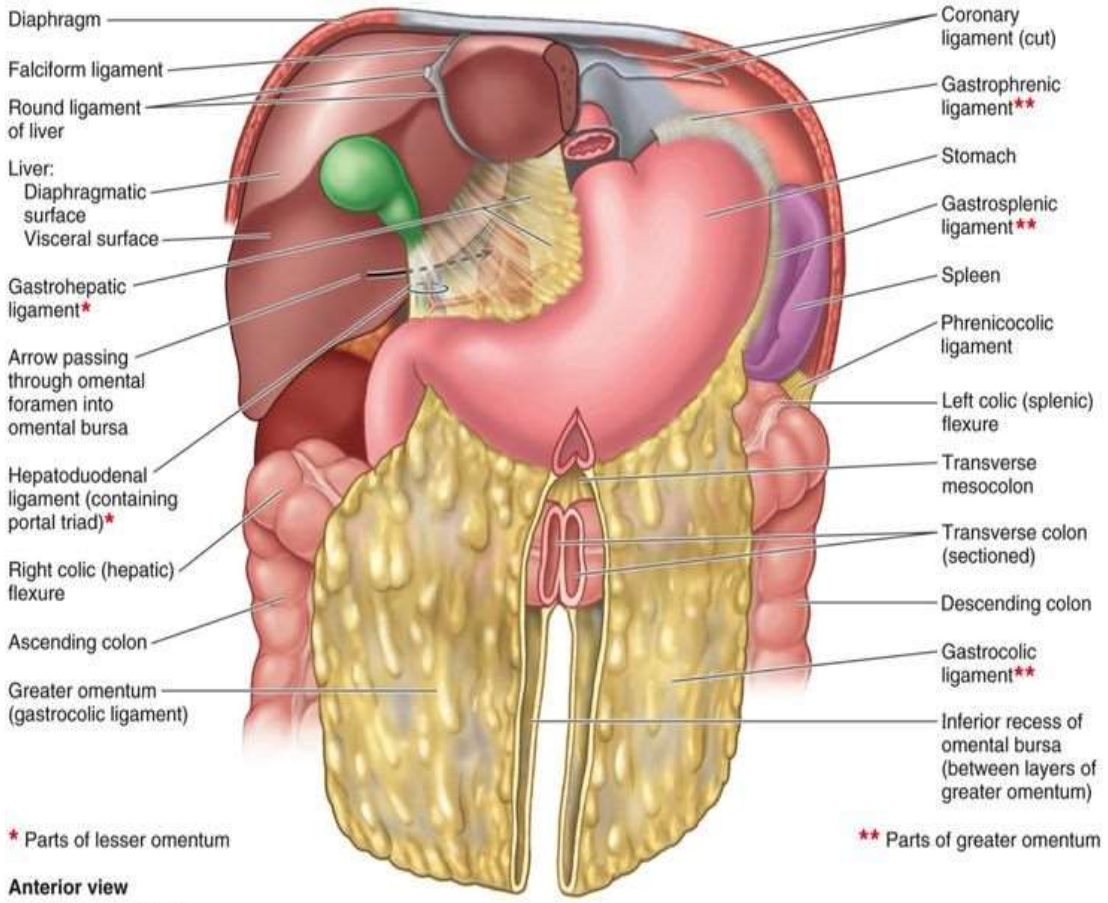
Ventral Vagal Complex or the social/relation ship system

4

What happens to the executive functioning system

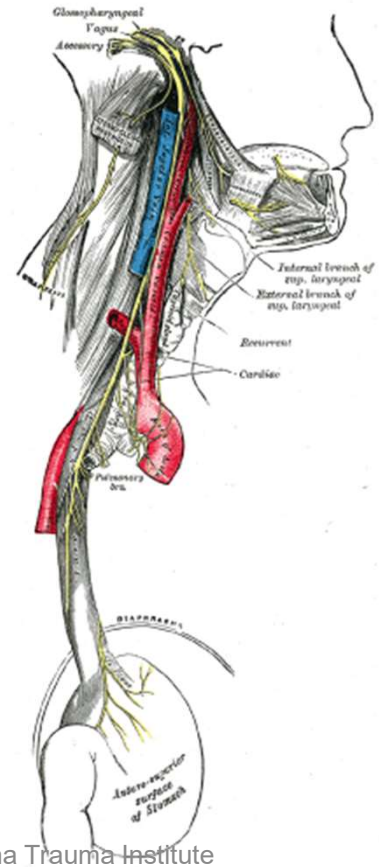
What are some of the suppressed systems?

- **Sub-diaphragmatic systems**
  a. Gastro-intestinal functions
  b. Reduced nutrition from foods eaten
  c. Elimination difficulties
  d. Inflammation leading to a host of illnesses and pain
  e. Painful sexuality



What are some of the suppressed systems?

- **Relational/social engagement system (VVC)**
  a. Poor quality attachments
  b. Self-centered and narcissistic behaviors
  c. Poor understanding of social cues
  d. Unstable friendships and family relationships



Effecting Ventral Vagal Activity

- Touch
- Voice
- Eye contact
- Listening for attunement
- Facial expressions
- Body posture
- Pleasant level of warmth
- Relaxed muscles
- Rhythmic movement

What about Executive Function

Sympathetic system or the (HULK BRAIN) blocks access to executive functioning

1. Avoid (real or perceived) threat through flight
2. Shut down and freezes the body, paralyzing any action
3. Reduce (real or perceived) threat through aggression
4. Alter body tension and muscle readiness to act
5. Tension and muscle readiness to act


The loss of executive function is a biochemical and hormonal reaction to changes in the body, NOT a volitional, chosen action.

What about Executive Function

Parasympathetic and Ventral Vagal systems give access to executive functioning

1. Bodily regulation and coordination of physiological responses
2. Attuned communications
3. Emotional balance and regulation
4. Flexibility in response (pause before reacting)
5. Fear modulation --- (RRR) response
6. Empathy
7. Insight/discernment/judgment
8. Moral awareness
9. Intuition/spiritual feelings
10. Identity

What was covered in this section

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4

What happens to the executive functioning system

Text here

In this section we will cover

1

ACEs study and the long-term impacts to health and well-being

2

Understand implicit memory and the need to be regulated to create sustainable change

3

Neuroception and understanding the need for intentionality

The Adverse Childhood Experiences Study (ACE)

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

The Adverse Childhood Experiences (ACE) Study

Examines the health and social effects of ACEs throughout the lifespan among 17,421 members of the Kaiser Health Plan in San Diego County

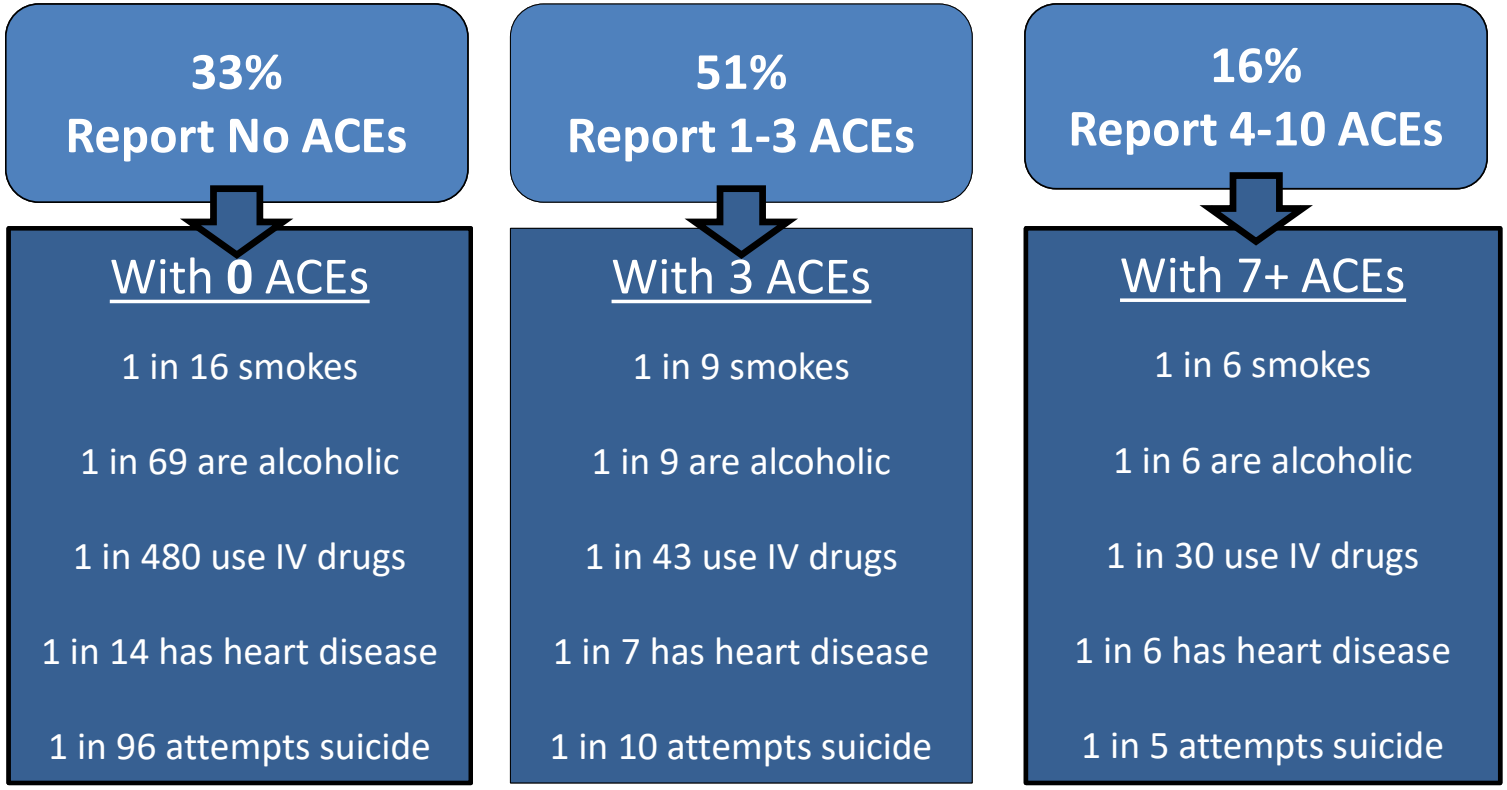
What do we mean by Adverse Childhood Experiences?

- **childhood abuse and neglect**
- **growing up with domestic violence, substance abuse or mental illness in the home, parental discord, crime**

Adverse Childhood Experiences Are Common

Household dysfunction:	Substance abuse	27%
	Parental sep/divorce	23%
	Mental illness	17%
	Battered mother	13%
	Criminal behavior	6%
Abuse:	Psychological	11%
	Physical	28%
	Sexual	21%
Neglect:	Emotional	15%
	Physical	10%

Out of 100 people…



Hear what a pediatrician has to say about ACEs

So why are these early life experiences so challenging to get past?

ACES measures here

Building the neuro-structure

We are Neuroceptive to our environments

The concept of being ***Neuroceptive***

- ✓ Cellular awareness
- ✓ A child's nervous system is looking for stimulus to create procedural tendencies or templates. Those templates will be developed in:
  1. **Relational patterns** – meaning and view of self and others
  2. **Emotional patterns** – reduced array of emotional expression as habituated patterns emerge
  3. **Cognitive patterns** – not the content of thought, but the how one thinks and perceives
  4. **Physical patterns** – Tension, movement, posture, coordination, etc.

Human beings look for conformation not disconfirmation regardless if the pattern built is it useful or helpful. Very little self-reflection or self-evaluation exists on habituated neuro-networks!


Three Core Concepts in Early Development
1
Experiences Build Brain Architecture
NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
Center on the Developing Child HARVARD UNIVERSITY

Some patterns in people raised with an early life history of trauma, toxic stress and adversity.

- Fear of trusting people, yet desiring to trust people
- Loneliness
- Difficulty regulating emotions
- Memory and emotional flashbacks
- Hypervigilance
- Loss of Faith and Hope
- Unmet needs drive behavior
- Intense shame
- Self-blame
- Lack of personal worthiness
- Dissociated
- Anxiety without specific obvious reason

Once a pattern is built

- It becomes **NON-CONSCIOUS** where it occurs without conscious decision making or awareness
- Even when new patterns are built – earlier or more primitive patterns are still available and will come forward when the body experiences stress
- It requires a great amount of attention and focus to build new patterns and becomes more difficult when we get distracted, dysregulated or fail to maintain focus and attention.
- Change is difficult because it requires (on-purpose) intentional focus and anything that interrupts that focus interrupts our intentionality

The patterns built in Toxic Stress or High ACE score environments interfere with self-regulation and being able to use an integrated brain and nervous system

Person & environment interaction builds implicit (procedural) memory which is tough to overcome

What is procedural (implicit) memory?

- Sensory experience and expectations
- Emotions experienced
- Behavioral (how your body actually moved)
- Meaning making
- Body and muscle memory

Typical procedural habits in those with early life trauma

- Often thought to be difficult to be around
- Doubts information and wants concrete proof
- Guarded in most social situations
- Mistrustful of others
- Harsh when provoked
- Use praise to control others
- Prefers own company, and large amounts of time by themselves
- Loves their personal time and need a lot of it
- Tend to paint themselves as victims
- Expects betrayal in intimate relationships
- Aloof, rarely will volunteer information about the self. When asked for information feel invaded
- Believes disclosures will be used against them
- Very emotional, but tends not to express them
- Has a few friends, and rarely discloses or shares much with them
- Self focused, often do not look at what is going on around them
- The often do not attune to others well

How many of you were taught that when people have these symptoms and patterns, they are mentally ill and can be given a diagnosis?

Why do we make them mentally ill, instead of focusing on helping them to be able to regulate their systems and manage their own physiology and natural responses?

YOU
WERE
MIS-INFORMED!

In this section we covered

1

ACEs study and the long-term impacts to health and well-being

2

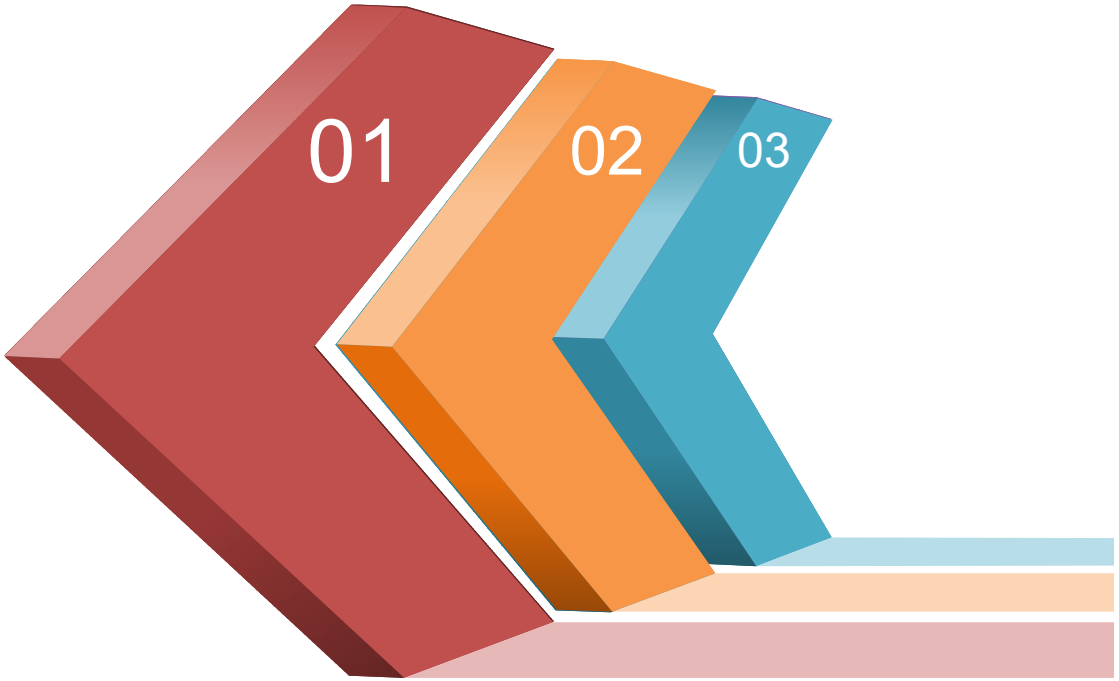
Understand implicit memory and the need to be regulated to create sustainable change

3

Neuroception and understanding the need for intentionality

In this section we will cover

1. **The need for self-regulation first**
2. **You understand the need for assuming possibility and competency**
3. **Interoception and what it takes to create balance in aroused states**



Neuroscientists have observed!

The practice of various forms of relaxation, stress reduction, meditation, practicing calm focusing of attention, prayer, and being intentional increase the following:

1. Manage and control destructive and negative emotions
2. Improve cognitive functioning (learning, reasoning, logic, and memory)
3. Increase social awareness
4. Expressions of empathy and kindness
5. Ability to use language to communicate more effectively
6. Mass and volume of neural circuits needed for thinking and planning
7. Moral decision making

Assumptions

- People are acting exactly as their history has wired them to act, perceive, emote.
- Most poor or problematic behavior is the consequence of reactive adaptation and mitigation, founded in procedural memory.
- Growth and change require intentional, and sustained ability to stay in the cool system. ***Bruce Banner brain***
- **Self-regulation is always the starting point for intervention.** Behavior should never be the starting point of treatment ***(except for immediate danger of death or injury)***

Change and growth cannot happen if the environment is constantly, or repeatedly activating the HULK system.

Our first goal in working with any client is to increase the stability (Bruce Banner Brain) of their environment.

What are you going to have to change about you, your relationships, your work and home environments to keep you out of the hulk?

Interoception

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

- Bessel van der Kolk

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

Steps to Interoception

1. Recognize when experiencing a limbic shift
2. Detect what in the inner or outer environment is activating the limbic system
3. Learn to calm, relax and reduce arousal in your limbic system quickly
4. Practice detecting and reducing limbic shifts at lower thresholds. Maybe you can recognize it at 8 of 10 at first, but we eventually want to recognize it at 1 of 10.

- Insert Camea's presentation on self-regulation
- For the online version include https://www.dropbox.com/s/8cbnr3n6lrtjudq/CFTP%20-%20Section%206.mp4?dl=0

In this section we covered

1. **The need for self-regulation first**
2. **You understand the need for assuming possibility and competency**
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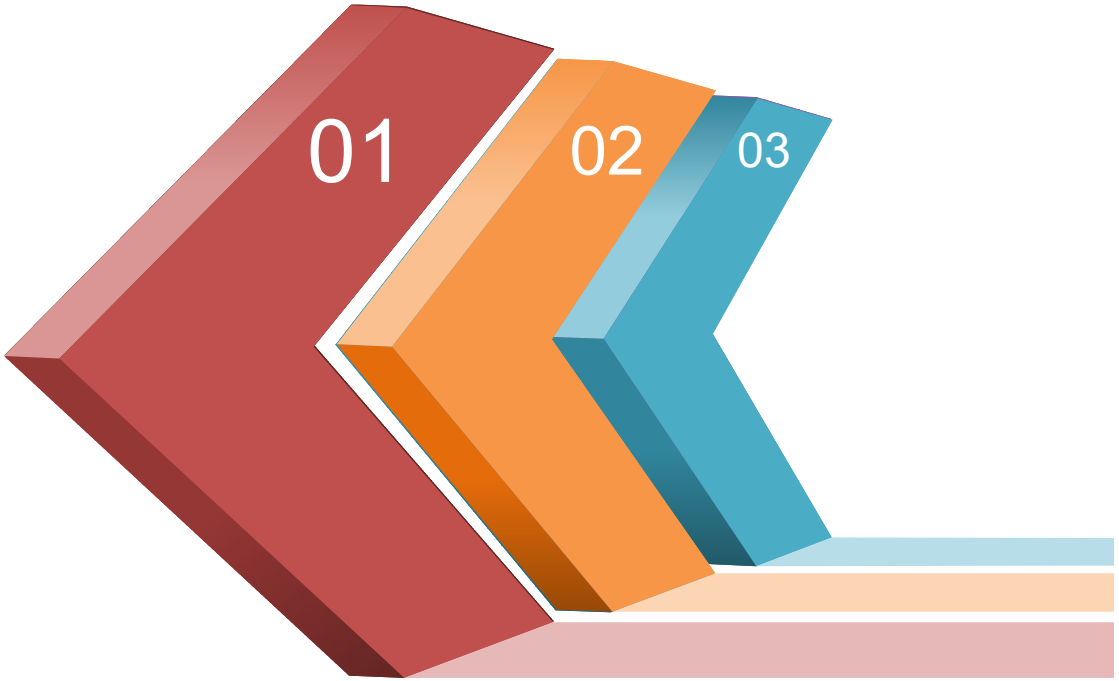


What is covered in this section

1. The key features necessary to treat trauma
2. Applying the science to the provision of treatment
3. What works in trauma therapy
4. Review of some of the science
5. Building a scaffolding for client momentum and success

What was covered in this section

6

Empower and resilience structure of treatment

7

Our job is to lift the client with each exchange

8

What you will have to do differently

Wampold & Imel (2015)

"Given the evidence that treatments are about equally effective, that treatments delivered in clinical settings are effective (and as effective as that provided in clinical trials), ***that the manner in which treatments are provided are much more important than which treatment is provided"***

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

- Many approaches or guidelines for treating trauma offer oversimplified representation of the evidence-based models that result in **service constraints** such as session duration, funding, or requiring the use of the techniques that will give the most rapid symptomatic relief regardless of the depth of healing achieved. **(Novotny & Thompson-Brenner, 2004. Coping with trauma-related dissociation)**
- Psychotherapy therefore is often protocolized. Which means that clients unable to make use of time limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance. **(Novotny & Thompson-Brenner, 2004. Coping with trauma-related dissociation)**

Calls for ‘evidence-based’ treatments can sound ‘common-sense’ as well as authoritative and scientific. But it is important to understand the many ways in which such treatments may not be optimal, and especially for complex trauma clients. **Corrigan, F. & Hull, A.M. ‘Recognition of the neurobiological insults imposed by complex trauma and the implications for psychotherapeutic interventions’, *BJPsych Bull*. (39, 2, 2015), pp.79-86.**

What about diagnosis specific treatment?

Results cast doubt on the power of the medical model of psychotherapy ***(pathogenic thinking),*** which posits specific treatment effects for patients with specific diagnoses. Furthermore, studies of other features—such, adherence to a manual, or theoretically relevant interaction effects—have shown little support. The preponderance of evidence points to the widespread operation of common factors that are not specific models of delivery.

Messer, Stanley B. & Wampold, Bruce E. 2006. Let's Face Facts: Common Factors Are More Potent Than Specific Therapy Ingredients https://doi.org/10.1093/clipsy.9.1.21

Where is the science taking us?

- Rapidly expanding research and new insights into the brain, body and memory raise new issues which repeatedly challenge what we do in therapy
- There is a growing recognition that physiology and somatic processes and experiences are a major part of creating well-being. Understanding the relationship between mind and body, normal emotions, thinking and behavior that is a natural response to the functioning of the body is a game changer for therapist.

Labels

Common Factors
Common Elements
Component Parts
Core Features
Active Ingredients

What are the active ingredients?

- Facilitate client safety at ALL times
- Understand how experience has shaped the brain and nervous system.
- Understand the impacts of trauma on the brain
- Acknowledge the extensive impacts of childhood trauma
- Know and adjust treatment to fit the client
- Expect a variety of client response based on how the body works, including shame and dissociation.
- Understand that dissociation underlies many diverse presentations
- Learn to recognize the client's window of tolerance and focus on staying within that window.

What are the active ingredients?

- Know what physical as well as psychological symptoms come from trauma
- Foster client resources from the first to last contact
- Regard symptoms as adaptive or mitigating responses, not pathology
- Utilize coping strategies as potential resources.
- Attend to attachment issues, starting with secure attachment of the therapeutic alliance
- Establish appropriate boundaries while being transparent and collaborative
- The approach promotes an integrated neurological functioning (focus on wellbeing)
- Realize most therapies designed for a single event are going to be marginally useful

What are the active ingredients?

- Promote dual awareness (divided consciousness)
- Recognize that mindfulness and dissociation are rival brain functions
- Do nothing to move your client out of the window of tolerance
- Distinguish between acknowledging and focusing on traumatic material or narrative
- Assist client to befriend sensations of arousal
- Distinguish between real danger and past threat
- Know and understand the science of memory, and let go of the habituated mental health view of memory
- Know how implicit or procedural memory works and how much focus and intentionality it takes to move past.
- ***Treatment should be tailored, individualized and attuned to the client***

What are the active ingredients?

- Understand that self-harm is a risk reduction and coping strategy
- Distinguish between “getting better” and feeling better
- Cultural competency and sensitivity to all dimensions of diversity (intense compassion and acceptance)
- End all sessions safely
- Engage in supervision and consultation as needed
- Tailor duration of session for client comfort

Cloitre M, Courtois CA, Charuvastra A, Carapezza R, Stolbach BC, Green BL. (2011). **Treatment of complex PTSD: results of the ISTSS expert clinician survey on best practices.** J Trauma Stress. 2011 Dec;24(6):615-27. doi: 10.1002/jts.20697. Epub 2011 Dec 6.

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

Psychotherapies for PTSD: what do they have in common?

Schnyder, U., Ehlers, A., Elbert, T., Foa, E. B., Gersons, B. P. R., Resick, P. A., … Cloitre, M. (2015). European Journal of Psychotraumatology, 6, 10.3402/ejpt.v6.28186. http://doi.org/10.3402/ejpt.v6.28186

- Psychoeducation
- emotion regulation and coping skills
- imaginal exposure
- cognitive processing
- restructuring
- meaning making
- emotions
- memory processes

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

- psychoeducation
- emotional regulation and coping skills
- some form of exposure to memories of traumatic experiences
- cognitive processing, restructuring, and/or meaning making
- tackling emotions
- altering memory processes.

Gentry, Baranowsky & Rhoton (July 2017). **Trauma Competency: An Active Ingredients Approach to Treating PTSD** Journal of Counseling and Development

- cognitive restructuring/psychoeducation
- a deliberate and continually improving therapeutic relationship
- relaxation and self-regulation
- exposure via narrative of traumatic experiences

The Empowerment & Resilience Structure: An Active Ingredients Approach

I. Preparation & Relationship

II. Psycho-education & Self-regulation

III. Integration & Desensitization

IV. Post Traumatic Growth & Resilience

Rhoton & Gentry, 2014

Preparation & Relationship

Stage #1

- Orientation and acculturation around the therapy process ***(example in the next slide)***
- Discovering capacities and strengths while instilling faith and hope in the therapy process
- Formal and Informal assessments used to increase relationship and connection
- Assessing patterns and themes
- Developing global goals that will be fine-tuned through the process

Stage #1

- **What is the healing process?**
  a. What does it look like as people are successful in moving through service
  b. Create as many success visuals as possible as you explain the healing process
  c. Review pacing differences: regular, slow and then fast

  We suggest that you write out an orientation so you are including important material only. Remember that the orientation is giving you safe ground to build a therapeutically secure attachment.

- **What is it like to work with you?**
  a. What are the things anyone that works with you are likely to discover and be transparent
  b. Share some of your weaknesses and strengths

  We suggest that you write out which aspects of your personal character are going to be transparent about and how to share those things with clients in a way that encourages them? Continued building and stabilizing a therapeutically secure attachment.

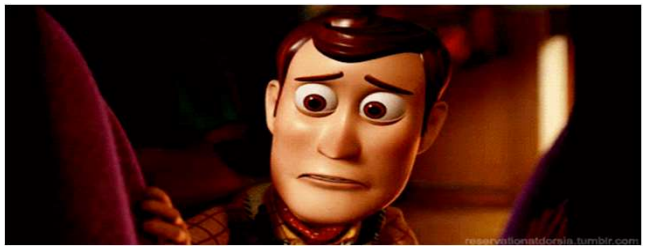
Stage #1

- **Format of sessions**
  a. Creating routine and predictability for the client sessions
  b. Discuss the fact that the sessions are formatted differently than most counseling
  c. Feedback driven treatment
  d. Discuss the use of concurrent documentation

"Why" do this?
Remember that the orientation is giving you safe ground to build a therapeutically secure attachment, by ensuring that you achieve the following:
- ***Safety***
- ***Seen as being trustworthy***
- ***Create and reinforce choice***
- ***Collaboration and inclusion***
- ***Empowerment and competency focused***

Feedback driven treatment

A narcissistic wound for the counselor



If you are successful at collecting feedback your evaluations will decline, worsen and be more critical.

1. Criticism for most people creates fear and dysregulates us
2. We tend to avoid things that make us afraid or uncomfortable
3. As trust builds so does the client's honesty
4. As the client becomes more self-regulated they will become more accurate at self-reflection and self-evaluation
5. Self-reflecting and self evaluating people will want higher performance and accountability from others

Discuss the use of concurrent documentation

The problem with post service documentation

- Doesn’t work under fee for service and/or capitated actuarial based funding models
- Increases documentation to direct service ratio
- Greater risk of noncompliance
- High documentation to direct service ratios creates need for No Show/Cancellations to “Catch Up”
- High documentation ratio reduces number of scheduled appointments in clinic and in community
- High documentation ratio creates “overwhelmed” feeling by staff
- High documentation ratio negatively impacts service capacity

Why are these two processes part of the Empowerment and Resilience treatment structure?

1. Constantly attends to the quality of the relationship
2. Focused on truly being genuine
3. Requires helper to keep themselves regulated and calm
4. Leads to less critical judging of clients
5. Attenuates mutual human differences
6. Encourages and empowers the client

Stage #1

- **Biases, rules and healing philosophy**
  a. Biases are to connect you to the client, not create distance
  b. Rules are to connect people relationally, not create distance or add demand to the process
- **Limitations, if any, because of the setting and rules if there are any**
- **Give as many choices as possible**
  a. Whenever a choice is made, explore for highlighting their competency and capacity
  b. Choice is more than just being respectful
- **Talk about how you approach transitions in treatment**
  a. Give visual descriptions of what people will see as they transition, including likely changes in how their lives outside of therapy can change
  b. Clarify that transitions are not rigid, and that when they move forward sometimes they may need to move back to the prior stage, and that is normal

Stage #1

- **Formal and informal assessments discussed and selected**

  Please sit down and write out detailed information about the use, construction, focus, purpose of the assessments so you are including important material only. Explain and let your client choose the one that makes sense to them

- **Talk about the importance of being able to self-regulate before tackling the resolution work**

- **Setting the stage for modeling self-regulation by the helper**

Psycho-education & self-regulation stage

This training is organized to help you structure treatment for Trauma

Working in stage #2

- **How does the threat response system work?**
  a. What that means is that the knowledge base needs to be possessed by the therapist/counselor.
  b. This isn't taught like a class, it is broken into small pieces and then ties client experience to the knowledge.
  c. Tie emotions, thinking and behavior to the threat response system.
- **Creating a common language by connecting the client experience to the physiology?**
  a. Help client come up with personalized names for the manifestations of physiology that they experience. (***how physiology = change in thought, emotion and behavior)***
  b. Tie resilience to management of the arousal system

This training is organized to help you structure treatment for Trauma

Working in stage #2

- **Explaining why the impact of environment is so important?**
  a. Vital that people understand that we as humans are designed to respond to the environment….we do not have a choice in that.
  b. Environment must be emotionally well regulated to foster secure attachment.
- **How are you going to convert discussions of anger, sadness, fear etc., to physiological dysregulation?**
  a. First, must recognize it in your own body
  b. Help them attach dysregulation of their physiology to their individual and family experiences.
  c. Less stigmatizing to address particularly strong thoughts, feelings and actions from the prospective of physiological arousal

This training is organized to help you structure treatment for Trauma

Working in stage #2

- **How will you explain and normalize internal negative messages and perceptions of self, significant relationships and the world?**
  a. Understand first that negative messages and critical beliefs are part of a repeated arousal process.
  b. When they are in a relaxed body, can they prove the messages true?
- **What specific self-regulation skills must you possess and use daily in your own life before you try and teach them to others?**
  - Must possess 15-20 that you do every day, at work or not
  - You cannot suppose you can help a client be more calm and regulated than you are

Integration & Desensitization

Integration & Desensitization Stage #3

- **Orient the clients on the models of treatment available in detail. After explaining, ask them for a decision.**
  a. Remember to walk through the process they have used to decide, so you can confirm their competencies.
  b. You will have to know how to explain each model, and give multiple examples of what it "looks" like when it is working as intended.
- **Explain that in the beginning it is your job to keep the brakes on, so that things don't go too fast, and overwhelm the ability to stay regulated.**
  a. Describe the self-rescue or re-regulation process
  b. Let them know that is always Ok to go back to one of the prior steps

Integration & Desensitization Stage #3

- **Creating narratives that can expand as needed and in the process lessen the reactivity to the event/events.**
- **Normalize difficulties, unwanted emotions, thoughts, behaviors and beliefs**
  a. Share images/stories of how people have had strong emotions, thoughts and behaviors during this stage and how they have successfully moved forward.
  b. Help the client regulate as needed
- **Focus on discovering and highlighting strengths and capacity**
- **Mourning or working through grief**

Post Traumatic Growth & Resilience

Your Road to the Future

Post Traumatic Growth & Resilience Stage #4

Post traumatic growth

- Consolidate change in the Perception of Self
- Consolidate change in the Interpersonal Relationships
- Consolidate changed in Philosophy of Life

Core features in resilience

- Relating to others, reconnecting or creating new connections
- Exploring new possibilities
- Intentional applications of personal strengths
- Spiritual Change and maturity of integrity
- Appreciation of life even when faced with stressors

What was covered in this section

1. The key features necessary to treat trauma
2. Applying the science to the provision of treatment
3. What works in trauma therapy
4. Review of some of the science
5. Building a scaffolding for client momentum and success

What was covered in this section

6

Empower and resilience structure of treatment

7

Our job is to lift the client with each exchange

8

What you will have to do differently

Text Here

Assessment of trauma

What is covered in this section?

What was covered in this section

Keys to assessment

History of the DSM

PTSD as a diagnosis

What was covered in this section

DSM Pathogenic labels

What do you really know when you have a diagnosis

How do you create wellness

Key steps for conducting a comprehensive assessment of trauma:

Key Steps

1. Assess for a wide range of traumatic events, toxic stress environments and consistent or repetitive adversity. ***Do not get over focused on one event***
2. Determine if they have a developmental (complex trauma) history linked to developmental stages.
3. Assess for a wide range of symptoms, risk behaviors, functional impairments. Look for how they are functional as well
4. Gather information from a variety of perspectives if possible
5. Try to make sense of the adaptations and mitigations that have become procedural memory and functioning.
6. Understand cultural and intergenerational features of personal history's impact
7. Make sure you do not move the client out of their window of tolerance

Key Steps

8. Engaging, empowering, and partnering with client throughout all the assessment processes
9. Developing a mutual trust, respect, honesty, and open communication
10. Providing individualized culturally responsive, flexible, and relevant services for each client

Mitigation to dissociation relationship

Multiple lines of evidence support a powerful relationship between dissociation and psychological trauma, especially cumulative and/or early life trauma.

Loewenstein R. J. (2018). Dissociation debates: everything you know is wrong. *Dialogues in clinical neuroscience*, *20*(3), 229–242.

Dissociation and Risk Reduction

Dissociation—a common feature of posttraumatic stress disorder (PTSD)

- Involves disruptions in the usually integrated functions of consciousness, memory, identity, and perception of the self and the environment.
- Acute dissociative responses to psychological trauma have been found to predict the development of chronic PTSD.
- A chronic pattern of dissociation in response to reminders of the original trauma and minor stressors has been found to develop in persons who experience acute dissociative responses to psychological trauma.

Lanius, R. A., & Hopper, J. W. (2008). Reexperiencing/hyper-aroused and dissociative states in posttraumatic stress disorder. Psychiatric Times, 31

Dissociation is not an act of volition

2 subtypes of acute trauma response that represent unique pathways

A. **Primary dissociative**
B. **Predominantly intrusive and hyper aroused.**

Using neuroimaging studies show that these 2 subtypes of response can persist in persons with chronic PTSD. Also that they are associated with distinct patterns of neural activation upon exposure to reminders of traumatic events.

Lanius, R. A., & Hopper, J. W. (2008). Reexperiencing/hyper-aroused and dissociative states in posttraumatic stress disorder. Psychiatric Times, 31.

Some of the kinds of things you will see

Dissociative symptomatic responses to trauma-related stimuli in PTSD—particularly states of depersonalization and derealization. If you want to see to what degree your client is dissociating, here are four questions:

- **Did what you were experiencing seem unreal to you, like you were in a dream or watching a movie or play?**
- **Did you feel like you were a spectator watching what was happening to you, like an observer or outsider?**
- **Did you feel disconnected from your body?**
- **Did you feel like you were in a fog?**

For most clinicians, these are familiar descriptions of some of their PTSD patients' responses to trauma-related stimuli and situations, this is very much an indicator if the client is dissociating

Some of many Assessment tools for trauma

- Clinician Administered PTSD Scale (CAPS)
- PTSD Checklist for DSM-5 (PCL-5)
- Global Psychotrauma Screen (GPS)
- Posttraumatic Stress Disorder Checklist (3 versions) This 17-item self-report scale for PTSD is based on DSM-IV criteria and takes five to seven minutes to complete. There are slightly different versions for use with military (M) or civilian (C) populations, as well as a version focused on a "specific stressful experience" (S).
- Dissociative Subtype of PTSD Scale (DSPS)
- Posttraumatic Maladaptive Beliefs Scale (PMBS)
- Brief Trauma Questionnaire (BTQ)
- Life Events Checklist for DSM-5 (LEC-5)
- Life Stressor Checklist - Revised (LSC-R)
- Trauma History Screen (THS)

DSM V

POSTTRAUMATIC STRESS DISORDER

Disorder Class: Trauma- and Stressor-Related Disorders

- Trauma- and stressor-related disorders involve exposure to a traumatic or stressful event. Two of the trauma-related disorders are acute stress disorder and posttraumatic stress disorder (PTSD). Acute stress disorder and PTSD are similar except that acute stress disorder typically begins immediately after the trauma and lasts from 3 days to 1 month, whereas PTSD lasts for > 1 month, either as a continuation of acute stress disorder or as a separate occurrence that begins up to 6 months after the trauma.

DSM history

- The first collections of diagnoses were called the "statistical manual," not the "diagnostic and statistical manual."
- There were also parochial reasons. As the rest of medicine became oriented toward diagnosing illnesses by seeking their causes in biochemistry to claim to authority of any medical specialty hinged on its ability to diagnose. Psychiatry was unable to do that and was in danger of being discredited.
- As early as 1886, prominent psychiatrists worried that they would be left behind, or written out of the medical kingdom. For reasons not entirely clear, the government turned to the **American Medico-Psychological Association**, (later the American Psychiatric Association, or APA), to tell them how many mentally ill people were out there. The APA used it as an opportunity to establish its credibility.

ABC News: DSM-5 Criticized for Financial Conflicts of Interest—70% of task force members have ties to Pharma

Controversy continues to swell around the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, better known as DSM-5. A new study suggests the 900-page bible of mental health is ripe with financial conflicts of interest.

http://www.cchrint.org/2012/03/13/abc-news-dsm-5-criticized-for-financial-conflicts-of-interest-70-of-task-force-members-have-ties-to-pharma/

Psychiatric diagnosis 'scientifically meaningless'
https://www.sciencedaily.com/releases/2019/07/190708131152.htm

The Trouble With The DSM
https://www.popsci.com/science/article/2013-05/trouble-dsm/

Are mental health diagnoses 'scientifically meaningless'?
https://www.medicalnewstoday.com/articles/325723

DSM-5: PTSD Criterion A

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

1. Direct exposure
2. Witnessing, in person
3. Indirectly, *(why not stop here??)* by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.

DSM-5: PTSD Criterion A

Criterion A (*continued):*

4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). **This does not include indirect non-professional exposure through electronic media, television, movies or pictures.**

DSM-5: PTSD Criterion B

Intrusion (1/5 symptoms needed)

1. Recurrent, involuntary and intrusive recollections. (children may express this symptom in repetitive play) ***(worrisome fantasies of sympathetic dominance)***
2. Traumatic nightmares. (children may have disturbing dreams without content related to trauma) ***(worrisome fantasies of sympathetic dominance)***
3. Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. (children may re-enact the event in play) ***(mitigating behaviors, an attempt of the body to balance the CNS)***
4. Intense or prolonged distress after exposure to traumatic reminders. ***(how long is the cocktail working on the system?)***
5. Marked physiological reactivity after exposure to trauma-related stimuli ***(how long is the cocktail working on the system?)***

DSM-5: PTSD Criterion C

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

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

DSM-5: PTSD Criterion D

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

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs) (C3 in *DSM-IV)* ***(mPFC disruption)***
2. Persistent (& often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "the world is completely dangerous") (C7 in *DSM-IV)* ***(worrisome fantasies of sympathetic dominance)***
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences (new) ***(worrisome fantasies of sympathetic dominance)***
4. Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame) (new) ***(active adaptive behaviors to correct when threshold of tolerance exceeded and Sympathetic dominance occurs)***

DSM-5: PTSD Criterion D

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

DSM-5: PTSD Criterion E

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

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

DSM-5: PTSD Criterion F-H

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

G. Significant symptom-related distress or functional impairment

H. Not due to medication, substance or illness

Key Points

- We use physiological evidence of arousal and dysregulation to justify labeling (diagnosing) a disease.
- We have been traditionally trained to focus our efforts on treating the annoying consequences of physiological arousal rather than teaching clients to calm their own body and system. **WHY?**
- ***It is systemic misdirection***

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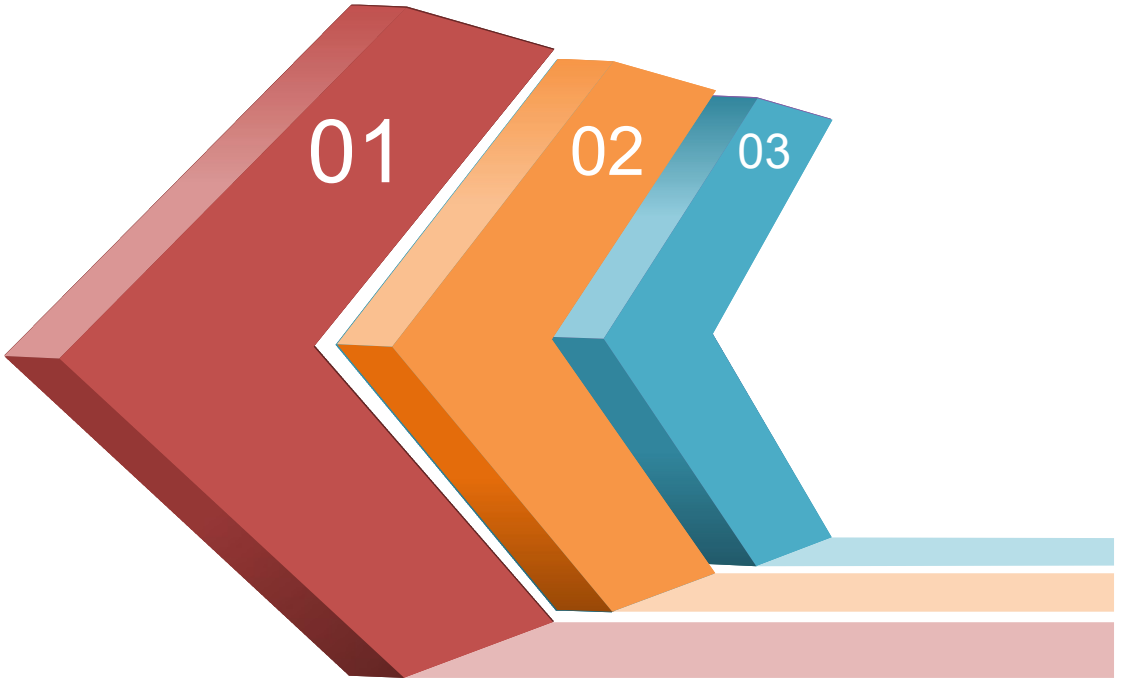
What will be covered in this section

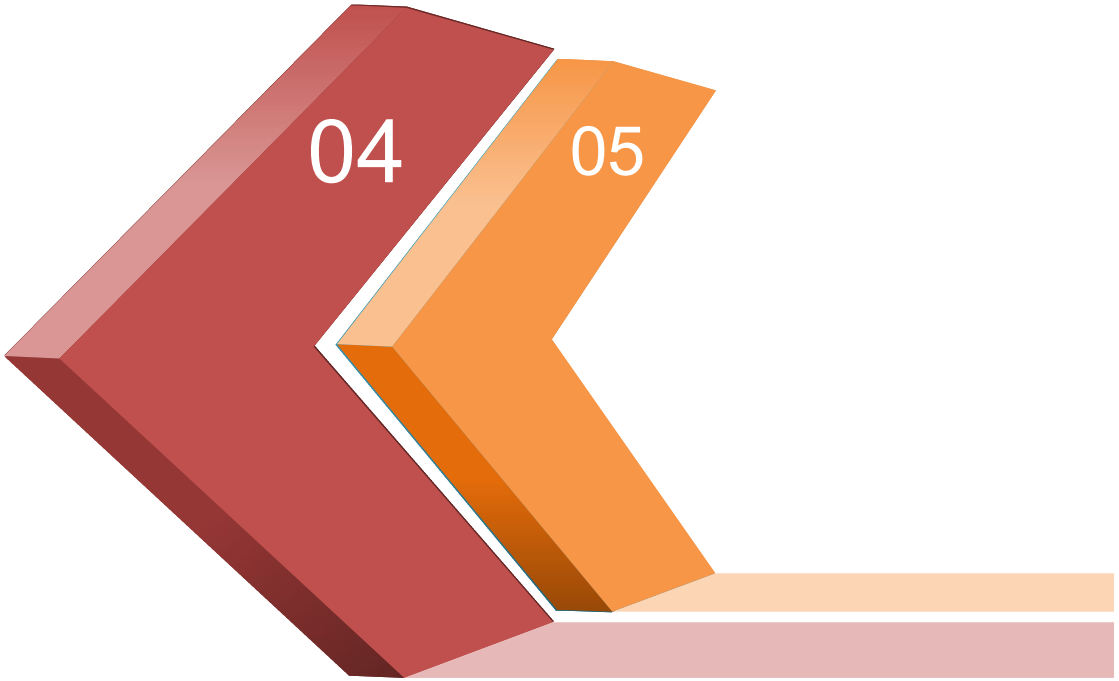
1. **What is best and evidence-based practice?**
2. **Common attributes of successful treatment approaches**
3. **Review of models of treatment**



What will be covered in this section

4. **Understanding that traditional talk therapies are not terribly useful**

5. **Requires more intentionality, self-education and continued personal development of therapists**



Important point about any evidence based/best practice model of treatment.

- Models are only relevant as long as the science they are based on is relevant. Meaning that is what is true will change over time.
- Models that have become products convey the idea that they will always be relevant, because there is an economic benefit to marketing the model. However that is no more true than any field of science, it is only relevant as long as the supporting science is viable.
- Models that do not reflect current science, are not necessarily wrong, but familiarity and popularity do not mean that they are especially good either.

Effective models of treatment include:

- Application of brain science
- Safety and transparency
- Understanding of physiology and that symptoms are normal responses to dysregulation of the physiology
- Models that focus on sustaining Hippocampal functioning and reduce activation of the amygdala system
- Divided consciousness
- Understand that standard “talk” therapies are not that useful

Cautionary tale

- The limitations of standard ‘talk therapy’ for treatment of trauma are increasingly acknowledged.
- The majority of psychotherapies have traditionally emphasized ‘cognitive, critical functioning – or a ‘top-down’ process primarily engaging the pre-frontal cortex’.
- This does not address subcortical areas of the brain in which trauma is located, activated, and stored.
- Trying to ‘talk about trauma’, even when words are available, can profoundly destabilize clients. For this reason, the ‘neurobiological revolution’, ‘bottom-up’ (as well as ‘top-down’) reorientation and attention to somatic processes continues to define the evolving treatment landscape.

Approaches

- CBT
  - Prolonged Exposure
  - Direct Therapeutic Exposure
  - Stress Inoculation Therapy
- EMDR (bilateral stimulation)
- TFT/EFT
- Somatic Experiencing

Cognitive-Behavioral Therapy

- ✖ Systematic Desensitization
- ✖ Stress Inoculation Training
- ✖ Biofeedback
- ✖ Relaxation Training/Mindfulness
- ✖ Prolonged Exposure (PE)/Flooding

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

Dr. Robert Rhoton Robert.Rhoton@aztrauma.org

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

Dr. Robert Rhoton Robert.Rhoton@aztrauma.org

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

I need to do an introduction for Eric and the NET training

I need to do an outro for NET training and the rationale for including it.

What you learned in this section

1. **What is best and evidence-based practice?**
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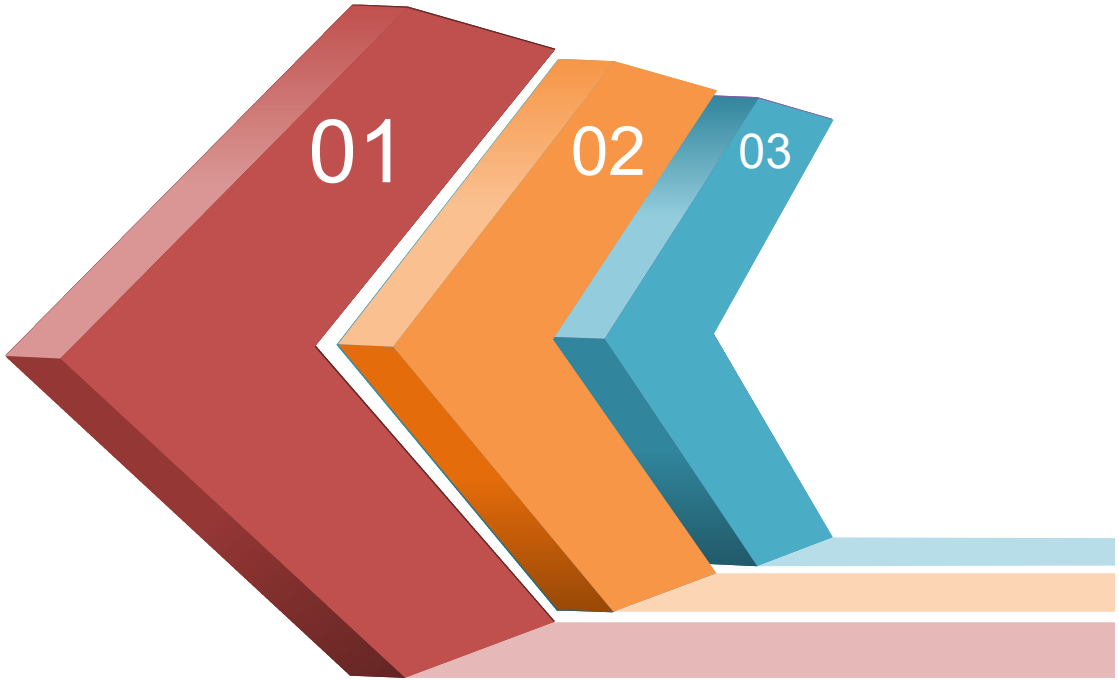

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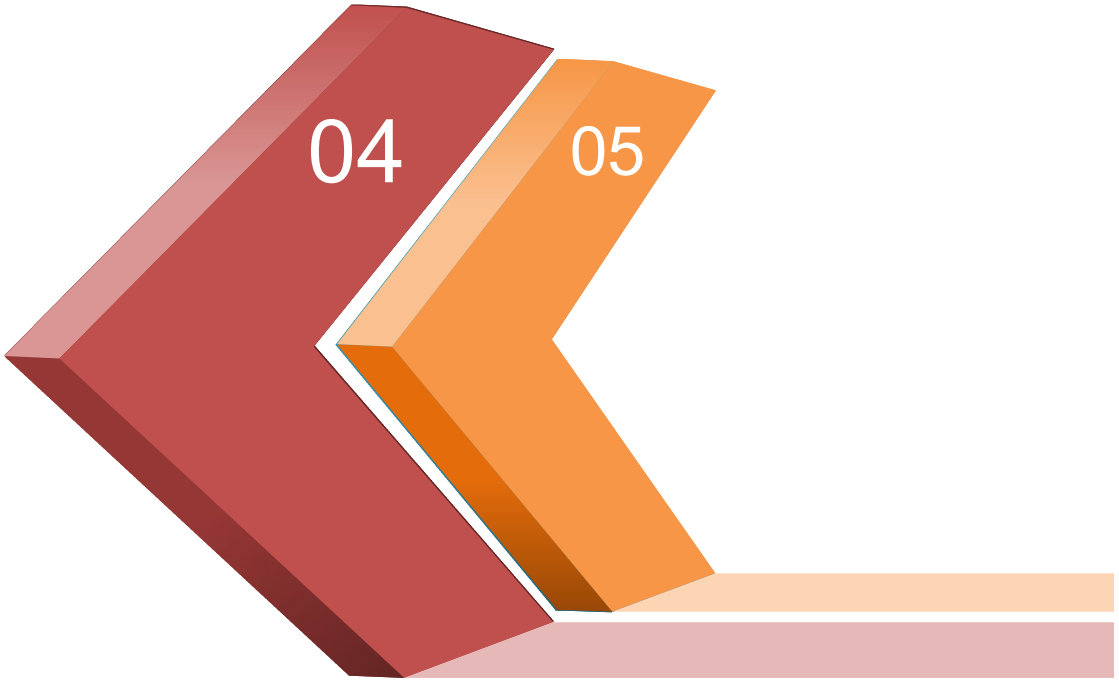



BEING
the change

Optimal Living Environment (OLE)

- Optimistic thinking in general
- Purpose (action is relevant and purposive) not a series of tasks
- Self-aware and use that awareness to monitor our own behavior, emotion and thinking
- Goals that inspire personal and professional growth
- Action takers (choose right action)
- Pay attention to energy
- Look for wisdom (what is lesson that can be learned in each situation)
- Faith (the ability to act when the outcomes are uncertain)
- Love (attach and/or attune to) others
- Connect with the spiritual, or universal

Now that you know, what can you do?

Active in daily personal growth

We work on our own self-regulation, self-awareness, courage, compassion toward others, and personal integrity in our own daily lives.

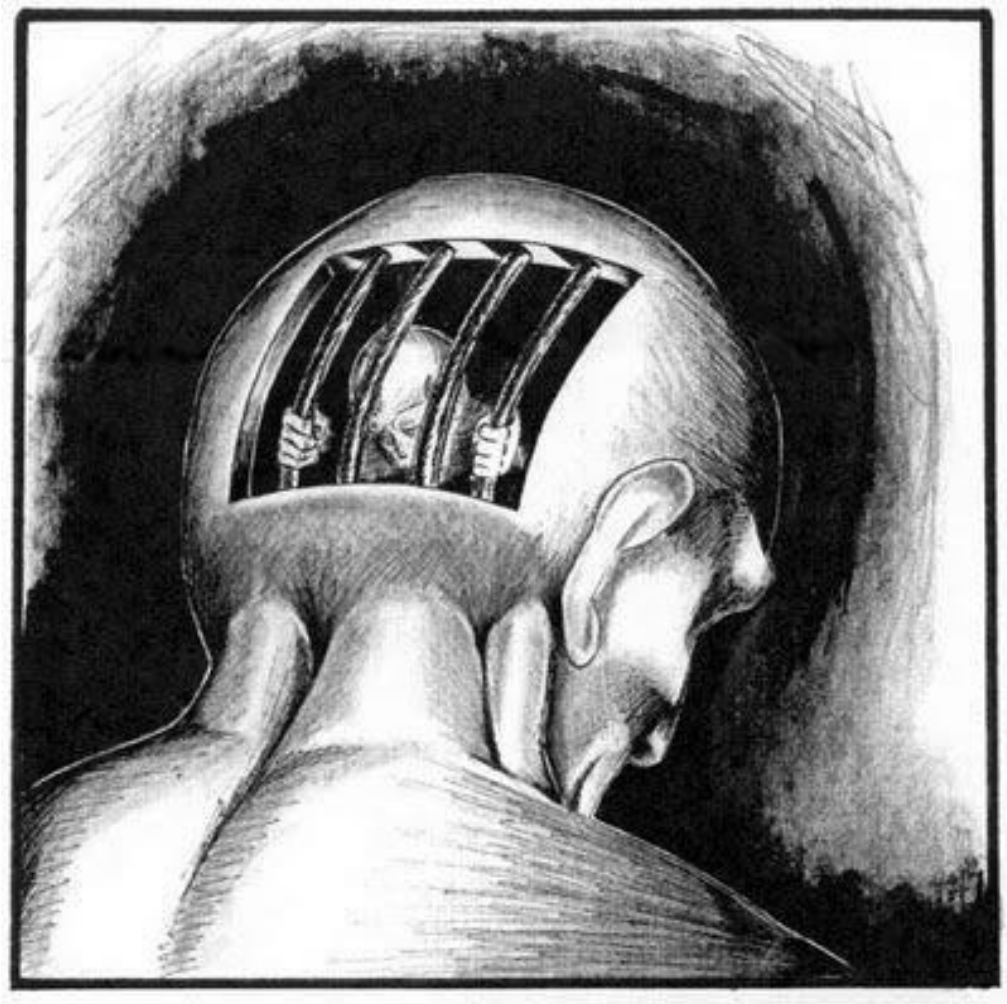
- *What have you done today "on purpose with a plan" to improve your character, talents, skills, relationships*
- *How do make sure you grow past your upsets, failures or disappointments*
- *What is your PLAN to grow tomorrow and then the next day, and so on*

Do you really want to help?

Activate the inner resources in self and others

Focus on helping others find their inherent competency and capacity, emphasizing wholeness and possibility over pathology or weakness. Use our daily interactions with others to lift them up and empower.

- What are you doing everyday to keep and enjoy relationships
- What things do you do to build your inner resources daily
  - Faith
  - Learning
  - Moving your body/exercising
  - Actively practicing compassion and kindness, even in the most annoying circumstances



Free yourself from your addiction to yourself, your way of being with people, your habits of thinking.

Become Integrated in your own brain and nervous system and live each day that way as much as possible.

Every interaction designed to create integration of the brain

1. **To avoid poking people's sunburns and activating their sore spots**
   - ✓ Never rely on your assumptions, they are wrong
   - ✓ Never judge the behavior, thinking or emotions of other
   - ✓ Never put additional demands on someone that is not integrated
2. **To help those with large and painful Sore Spots and Sunburns to feel safe, accepted and respected by you.**
   - ✓ They feel liked by you
   - ✓ They feel like you care, not because you say so, but that you act so
   - ✓ Never explore their painful past or activate their memories in a body that isn't relaxed

Every interaction designed to create integration of the brain

3. **To help those trying to avoid real or perceived (possibility of) pain find ways to adapt in more healthy ways.**
   - ✓ Do not confront emotions, thinking and behaviors that are designed to create space, doing so drives them to do more mitigating.
   - ✓ Never confront when you are not well regulated and in an integrated brain
4. **To help people heal from the pain, distress, and fear associated with sunburns and sore spots by helping them find competence and value.**

What do you need to be aware of in others that have a history of toxic stress, trauma, and adversity?

Now that you know, what can you do?

- People with histories of adversity have less processing capacity because they have many broken links. ***Get the brain and nervous system calm first, restoring the links!!!!***
  - Think through what to say before saying
  - Make sure you are in Bruce Banner mode, before you open your mouth
  - Make sure you can stay in Bruce Banner mode, no mater what others do or say
  - Realize no one can solve problems well in HULK mode, stop trying to intervene with the Hulk and invite others to live Bruce Banner lives.

Now that you know, what can you do?

- Be brief and clear, give many vivid descriptive examples of success, that show real effort!
  - ☒ Think it through, and say it with as few words as possible
  - ☒ Give vivid examples of how people succeed, (what it looks like)
    - ✓Include the efforts necessary
    - ✓The challenges that are common
    - ✓And how people triumphed
  - ☒ Talk about real stumbling blocks and how people deal with them

Now that you know, what can you do?

- **Logic and reason systems will likely be off-line *unless* the brain and nervous system are calm.**
  - Stop trying to get logic, and reason out of the HULK brained folks
  - Always go for regulation and stability first, so that you can be effective
- **Focus on the environment and its qualities more than behavior and emotion.**
  - Pay attention to the environment, is it one that invites Bruce Banner or the HULK, not for you but for the others that you are dealing with
  - Learn to calm environments and people

Now that you know, what can you do?

- Do not ask anyone to do something outside of being together that they haven't clearly done ***competently*** while with you.

- Think about the underlying assumptions of what is being said… **does it empower, strengthen or add competence?**

- **No lists…one item at a time**. As the person with a history of adversity develops the ability to self-regulate you may be able to give more at a time, but it may be a while.

Now that you know, what can you do?

- **Genuinely like and care for the person/people you are with *(stop making their compliance or performance a criteria of liking).***
- **When giving information follow this format:**
  1. Overview/orient
  2. Show how this "activity/part" fit in the overviewed material
  3. Give examples of how people are successfully achieving this activity/part
  4. Summarize by embedding them in their success story
  5. Ask for their feedback, *"so as you move through this situation what do you expect you will experience?"*

Now that you know, what can you do?

- Be organized and planful
- Develop and maintain faith in the people you work with
- Be predictable and routine
- Be reliable and transparent
- Collaborate on all documentation and disposition reports
- Build in breaks. . . “I have been writing for 5 minutes, and my hand is cramping, would you be ok with me just taking a break and shaking it out for a minute”
- Always follow-up on requests, questions, suggestions, and any feedback

Now that you understand more about neurobiology and physiology how do you need to structure the delivery of therapy differently?

Managing one's self

Grow daily

Strive to be genuine

What comes next?

- Communicate in a trauma sensitive way with everyone
- What do you need to know to communicate with trauma clients?
- How do you make communication come together and be powerful?

Trauma-informed or sensitive communication

- To communicate with sensitivity requires that we, ourselves be in the Bruce Banner Brain (or) in a calm and balanced central nervous system (CNS)
- To communicate in a trauma-informed way requires deliberate intentionality and focus on our part.

What does Trauma-informed communication look like?

- Relaxed in body
- Stays in the present
- Cultivates comfort with inner silence
- Pause and reflect on deepest or primary values
- Increase our positive expectations
- Access pleasant
- Be observant
- Express appreciation
- Speak warmly
- Speak slowly
- Be brief (sentences no more than 7-10 words)
- Listen deeply with intent

The nature of human communication

Once connected we move into reliance on subtext rather than content as our primary communication.

What does that really mean?

We use subtext in intimate relationships

Typical statements:

- **The trash is full**

Subtext???

- Some action should be taken to change this status
- Someone should take the action to change the status
- Assumes one's knowledge of a process of moving from empty to full
- Assigns some value to fullness/emptiness

Benign subtext assumptions:

- They have acted in some way before
- They have acted on multiple occasions
- They can recognize distinction in their bodily experience
- They can recognize distinction in their emotional experience
- They can recognize distinction in their thinking experience
- They can recognize distinction in their sensory experience
- They can order their own experience
- They can articulate their own history
- They have competence in self-examination
- They have competence in self-reflective
- They can evaluate their own history
- They can articulate their experience

Ask a typical mental health question!

1. How many day per week do you use. . .
2. How many different street drugs have you used in the last three months . . .
3. What is your history of being abused emotionally, sexually, physically or by neglect?

Questions taken from psychiatric intake document

SUBTEXT example explorations

When was the very first time… you remember waiting … before you used. . . . ?

Assumptions:

- They have waited before acting
- They have waited before acting on multiple occasions
- They can order their own experience
- They can articulate their own history
- They have competence in self-examination
- They can be self-reflective
- They can evaluate their own history

SUBTEXT example explorations

Where in your body…. do you first notice the sneaky rage monster creeping up on you?

When was the last time… that the Rage monster wasn't peaking around a corner hoping you would ask them in?

Difference between strength based and capacity based questions

Strength based ????

- What is working well?
- Can you think of things you have done to help things go well?
- What have you tried? And what has been helpful?
- Tell me about what other people are contributing to things going well for you?

Capacity based ????

- What is the first thing you noticed working well?
- What is one of the essential things you have done to get things going forward?
- What is a key thing have you tried that has been helpful?
- How did you first learn to let other people contribute help and support to move you forward?

Difference between strength based and capacity based questions

Strength based ????

- How have you faced the challenges you have had?
- How have people around you helped you overcome challenges?

Capacity based ????

- How did you first decide to face the challenges you had?
- What was the most important thing you decided that has helped you accept help from other people?

Question examples

- What is the first thing you discovered about yourself that has helped you . . . . ?
- How did you begin to discover the first thing that helped you?
- What essential things did you have to look at before you found that thing that has helped?
- When you were evaluating the different things that you might be able to do, what seemed to be the most essential?
- When you found that you could do . . . you gave yourself permission to act on it…what was the first thing you did to give yourself that permission
- As with all experiments somethings work better and others work less well, what was the first thing you discovered worked well for you?
- As you look at the difference between (then) and (now) what is the (first, most important, the essential, surprising, most valuable, meatiest) thing you (did, thought about, felt, discovered, created, explored, experimented with) to move to this lower number?

Question examples

- What was the next (most important, the essential, surprising, most valuable, meatiest) thing that you (did, thought about, felt, discovered, created, explored, experimented with) to move to this lower number?
- When you discovered that you could act in this way to reduce the (lower SUD) what were the one or two things you had to give yourself permission on to act?
- What was the first part of this process you went through to give yourself permission to act in your own best interest?
- Letting go of familiar ways of thought can really be uncomfortable, how did you get yourself to tolerate moving through the discomfort.
- What was one of the most important things you thought of doing and decided not to act on?
- What is the most significant thing about this one that makes it attractive to be repeated?

Creating a time line

- **Never use the prejudicial words:**
  - **Trauma**
  - **Issues**
  - **Problem behaviors**
  - **Rape**
  - **Assault**
  - **Domestic Violence**
  - **Diagnosis**
  - **Fear**
  - **Anxiety**

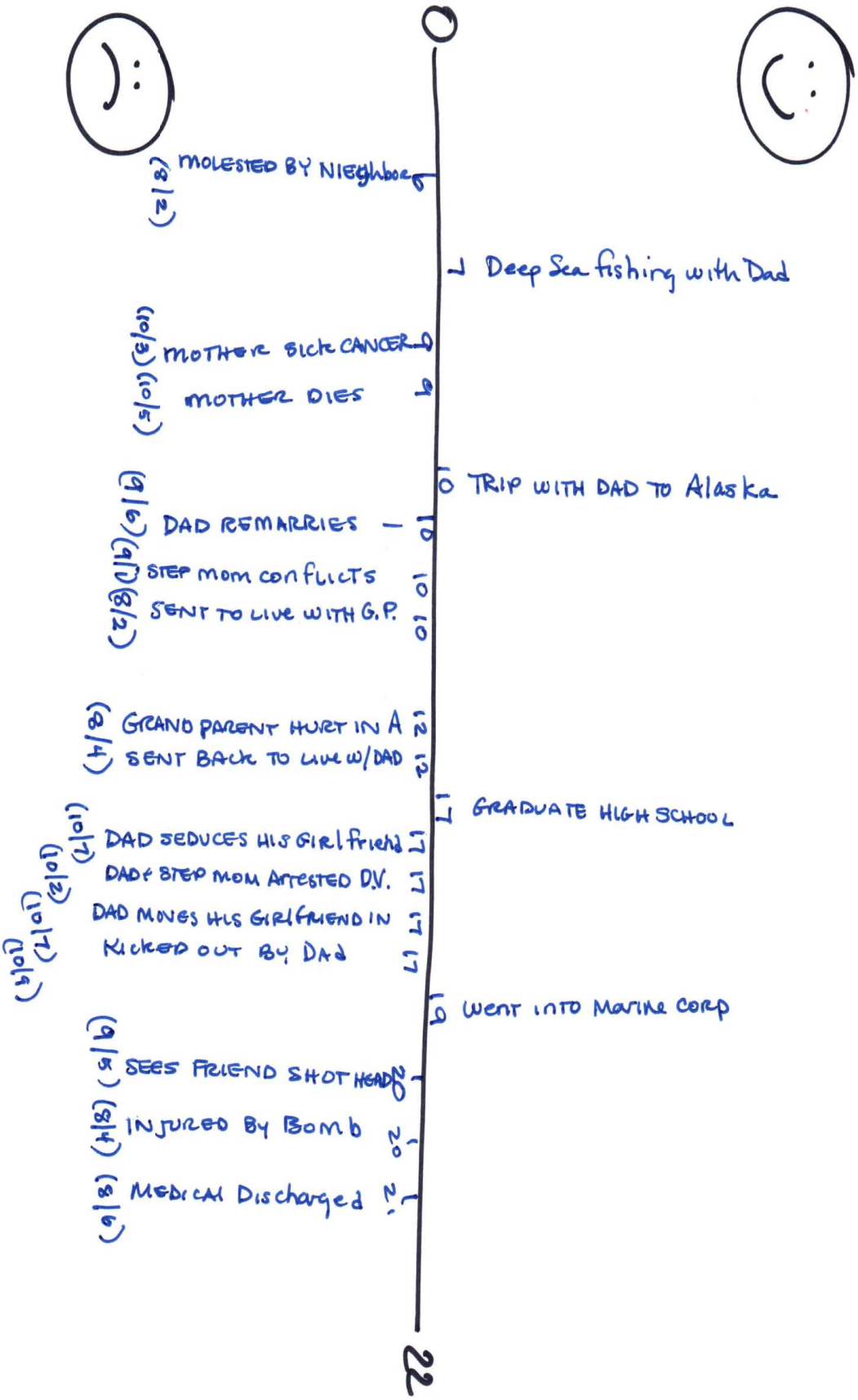
Because of the way we use language in Mental Health; clients report:

- 64% anticipate discrimination and marginalization that stops them applying for work, training or education
- 55% stop looking for a close relationship
- 80% claim having a diagnosis made life more difficult.
- 88% think the public associated diagnosis with violence and/or danger to the public

Institute of Psychiatry, Psychology & Neuroscience -- King's College London

Beginning a trauma timeline

- Never the prejudicial words of:
- Explain that a timeline is a list of positives and negatives that have happened to each person:
- Begin with the safe items:
- Go back over the items one at a time. Focus on the negative ones – ask on a scale of 0-10, 10 being the strongest let's rank these experiences.
- When you have them ranked….go back and look at things that have significantly changed 4-5 points


(2/8) MOLESTED BY NIEghbor
7 Deep Sea fishing with Dad
(5/01)(10/5) MOTHER SICK CANCER
MOTHER DIES
9
10 TRIP WITH DAD TO Alaska
(9/6)(11/8)(8/2) DAD REMARRIES
STEP MOM CONFLICTS
SENT TO LIVE WITH G.P.
10
10
10
(8/4) GRAND PARENT HURT IN A
SENT BACK TO LIVE W/DAD
12
12
11 GRADUATE HIGH SCHOOL
(10/1) DAD SEDUCES HIS GIRLfriend
(10/2) DAD+ STEP MOM ARRESTED D.V.
(10/7) DAD MOVES HIS GIRLFRIEND IN
(10/9) KICKED OUT BY DAD
17
17
17
17
19 WENT INTO MARINE CORP
(9/5) SEES FRIEND SHOT HEAD
(8/14) INJURED BY Bomb
(9/13) MEDICAL Discharged
20
21
22

As therapeutic alliance increases you can move into subtext which is more effective and efficient for helping the client discover and recover capacity and strength.

Since we already use subtext as human beings communicating… …what if we used it intentionally with clients?

Skill Building

COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

Deconstruct an experience with a focus on uncovering ACTION oriented movement through adaption and mitigation.

a. Every situation is full of data. The client has been focused on the pain, misery and hurt of their experiences based on what their system tells them is relevant.
b. Deconstruct the situations in "great" detail focusing on process rather than emotion.
c. Focus on actions over thinking and emoting
d. Since the natural focus is on the situation and the related distress, be careful to keep the client focused on their actions

COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

Let the client then connect and make meaning out of the action pieces of their adaption and mitigation narrative.

a. Do not tell or instruct the client. Instead have them make the action-oriented connections between the parts of their story.
b. Encourage the client make connections with multiple parts

Summarize the connected ideas, themes, patterns into a short statement

a. Create a brief summary statement that captures all of the elements of the connected parts
b. Clarify the statement

COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

Fine tune the statement until it is a clear statement, *then* ask them to give examples of it (what would someone see you doing that would suggest you are . . . .?)

a. Generate 4-5 action statements that are descriptors of the summary statement in action.
b. Review the action statements and make certain that they reflect actions

Now that we understand the competency, give it a name…the more personally meaningful to the client the more effect this will be.

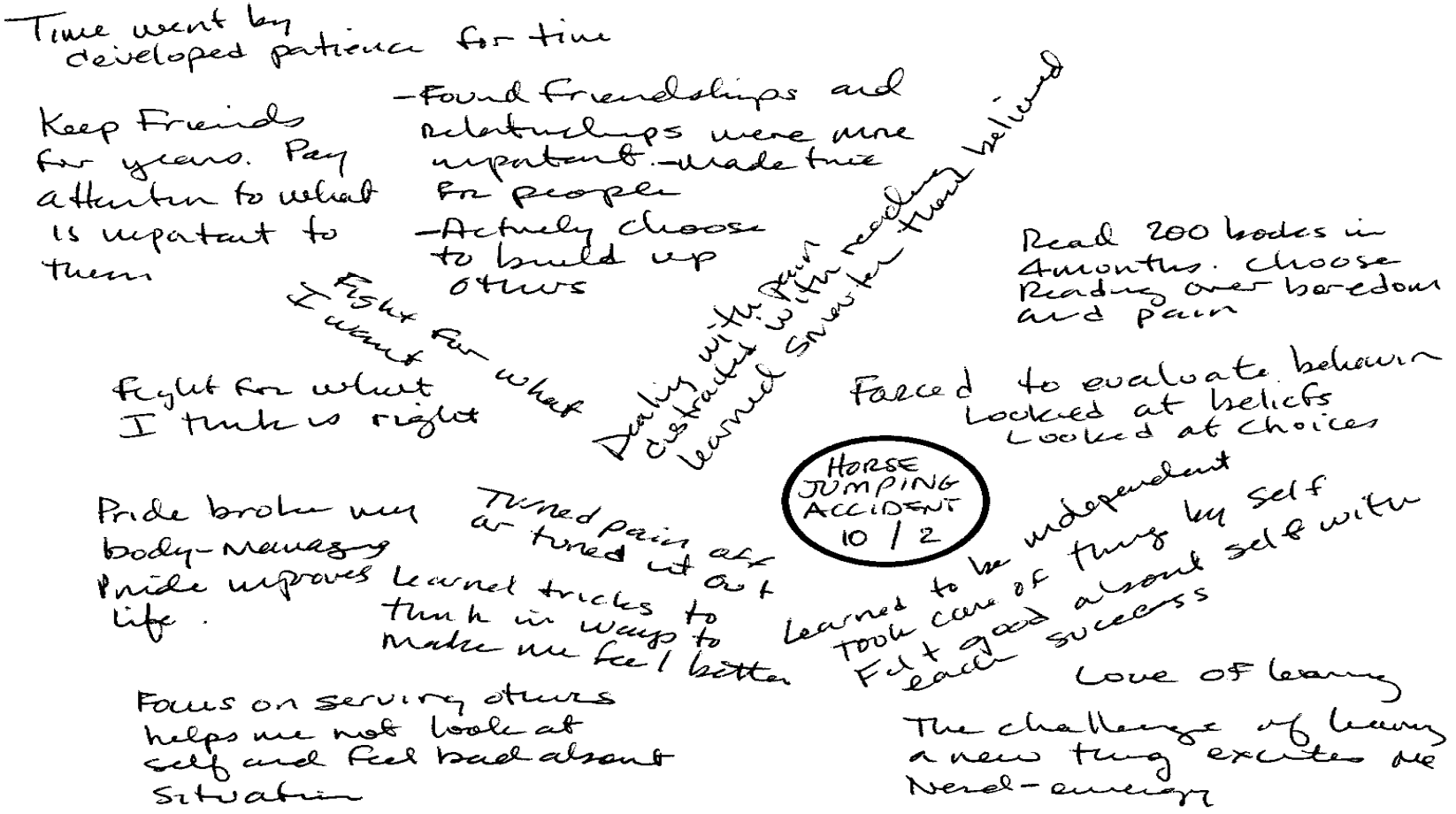
a. Humor or well-known characters work well
b. Creative names are also easy for people to remember

Like-a-tude-us
Taz-tastic
Speedy Gonzales
Bump, bump and sway
Pepe' Le Pew

COMPETENCY AND CAPACITY DISCOVERY WORKSHEET

If I said….would you immediately think of….. (review the 4-5 action steps) if I were to use the label, would you be able to recall the action steps.

a. Walk them through 2-3 examples of how they could apply this process to a situation
b. If you could see yourself apply (“. . . . . .”) whenever you needed to, how would that change how you see yourself?



Capacity described

Capacity labeled

Clinical Example

Traumatic Memory Processing

Trauma Memory Processing

Exercise

Graphic Narrative

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

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Before any idea that anything was going to happen		
	Worst possible moment	
		When the fear and upset were over or manageable

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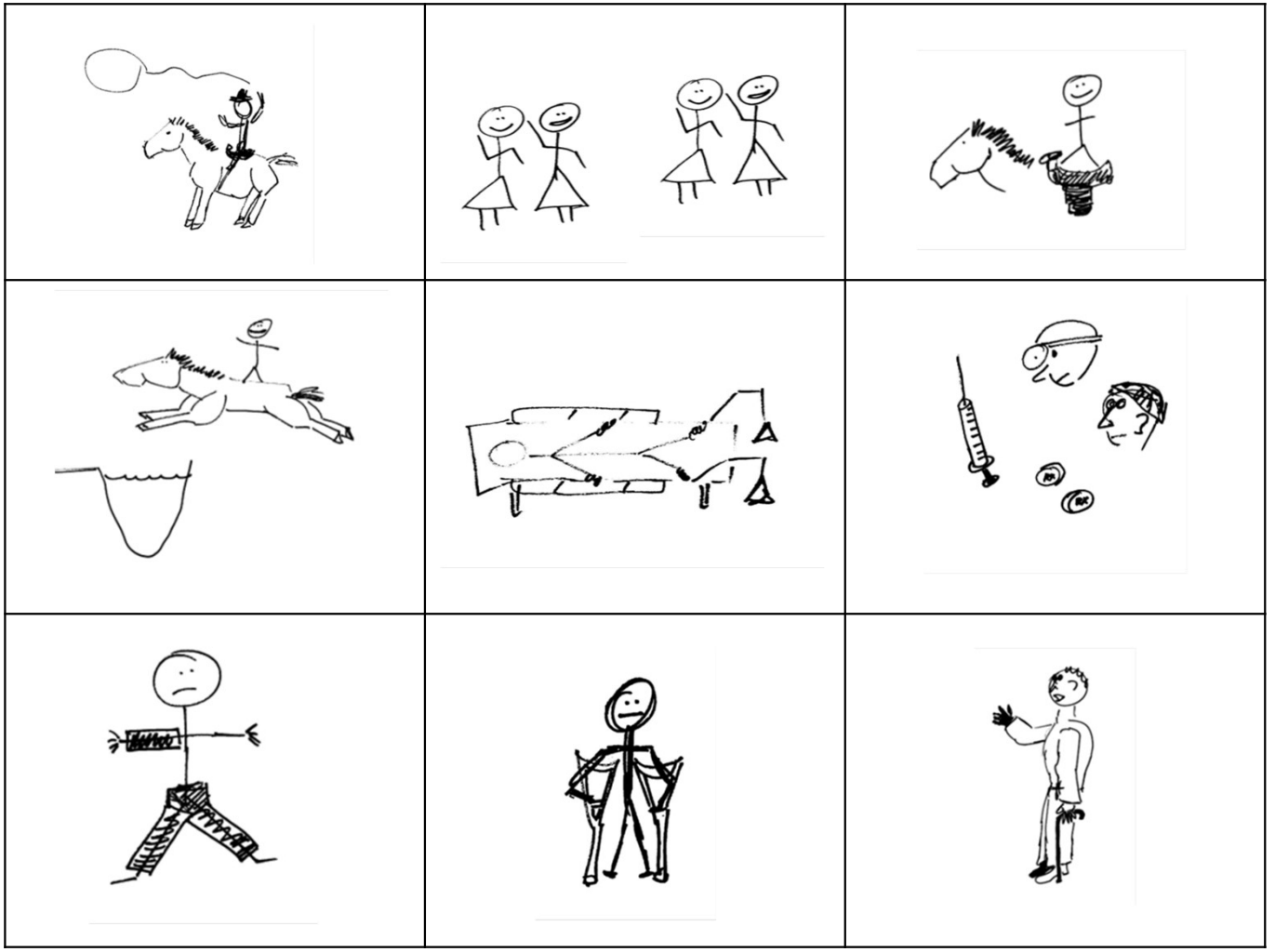

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Story Board Reprocessing

1. **Establish a timeline**. Establishing when and where the story takes place, and deciding in which order the events of the story happen chronologically.
2. **Identify the key scenes in your story.** A storyboard is meant to give the gist of the story. The point isn't to try to recreate the entire experience, but to demonstrate important key parts.
3. **Draw out of what each cell will show.** Now that you know what main scenes you want to show, think about how to write about it.
4. **Write a description of what each cell shows.**

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