Complex PTSD
2-Day Clinical Workshop

A Comprehensive Approach to Accurately Assess and Effectively Treat Clients with Chronic, Repeated and/or Developmental Trauma

Arielle Schwartz, Ph.D.

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

Complex PTSD: A Comprehensive, Mind-Body Approach to Treating Clients with Chronic, Repeated, and/or Developmental Trauma

Arielle Schwartz, Ph.D

Scope of Practice

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Statement of Accuracy and Utility

-Psychology is not an exact science. The theory and neuroscience included here is based on the knowledge available at this time. As the field evolves, our knowledge base will change.

-The theories shared within this course are ones that this speaker has chosen based upon her clinical experience, research about effective or evidence based trauma treatments, and research about modalities are ineffective or potentially re-traumatizing for clients with C-PTSD. Some modalities are on the cutting edge and do not have an extensive research base at this point.

-Not all, therapeutic modalities are right for all clients. This is especially true when working with dissociative clients.

-It is wise to seek further training, consultation, or supervision on any modality that is outside of your area of competence as a clinician.

Defining Complex PTSD

Acute Traumatic Stress

Normal response after exposure to a traumatic event. Includes anger, fear, sadness, and somatic symptoms.

The Enduring Effects of PTSD

- Physiological and psychological effects persist beyond 4 weeks
- Intrusive memories and sensations
- Avoidance of reminders of the trauma
- Negative emotional reactions
- **PTSD occurs when you do not have the resources to process the trauma leading to overwhelm and the shutting down of processing the event(s).**

Complex PTSD (C-PTSD)

- Repeated, prolonged exposure to traumatic events
- Often with childhood onset and interpersonal in nature:
  - Childhood Abuse
  - Childhood Neglect
  - Disrupted Attachment
  - Domestic Violence
  - Ongoing Social Stress (Bullying)
  - Community and Political Violence
  - Prolonged Captivity or Confinement

Diagnostic Clarification

- Construct validity of Complex PTSD as distinguishable from PTSD and BPD (Cloitre et al., 2014)
- Empirical evidence for the distinction of C-PTSD from PTSD in a clinical sample of children and adolescents (Sachser et al., 2016)
- Elevated disturbances in self-organization, interpersonal problems, and emotional dysregulation among the C-PTSD population as compared to those with PTSD.

C-PTSD and the DSM-V

- C-PTSD is not included in the DSM-V
- Committee argued for inclusion of C-PTSD, Developmental Trauma Disorder, or Disorder of Extreme Stress not otherwise specified (DESNOS).
- PTSD is the diagnosis that most closely matches the symptoms and effects of C-PTSD
- World Health Organization International Classification of Diseases includes C-PTSD in the ICD-11th, client must meet criteria for PTSD (Cloitre et al, 2013).

Differential Diagnosis

- Accurate diagnosis can be difficult because symptoms of C-PTSD are similar to and may be confused with other disorders.
- Other disorders may also be comorbid.
- **Assess differential diagnosis for:**
  - Major Depressive Disorder
  - Bipolar Disorder
  - Generalized Anxiety
  - Panic
  - OCD
  - Learning disabilities
  - Substance abuse
  - Personality disorders (especially BPD)
  - DID
  - Conversion disorders (psychogenic seizures)
  - Psychotic disorders

7 Contributing Factors to the Development of C-PTSD

1. Intensity, Duration, Timing of Trauma Exposure
2. Epigenetics and In-Utero Influence
3. Disruptions in Early Attachment
4. Poor Modeling of Health Promoting Behaviors
5. Presence of a Learning Disability
6. Social and Cultural Risk Factors
7. Lack of Resilience Factors

Factor 1: Intensity, Duration, and Timing

- C-PTSD is associated with longer duration, and greater Intensity of traumatic stress.
- Timing/Critical Growth Periods:
  - Children are most susceptible, especially the first three years of life
  - Adolescents are highly susceptible as they are forming their identity

Factor 2: Epigenetics and In-Utero Influence

PTSD tends to run in families

(Yehuda, 2016)

- Having a mother with unresolved PTSD is associated with a child's greater risk of PTSD after exposure to a trauma
- Having a father with unresolved PTSD is associated with a child's greater risk for depression

- Infants who were born to mothers diagnosed with PTSD during pregnancy:
  - Had lower birth weight
  - Were harder to soothe
  - Were more prone to colic
- Epigenetic changes in how the body responds to cortisol may be passed from mothers to their children.

Factor 3: Disruptions in Early Attachment

Mothers with PTSD are more likely to be both overprotective and reactive to their children, and as a result their children may develop less secure attachment (Yehuda, R).

Attachment Injuries

- **Avoidant Attachment:** Highly self-reliant and closed off emotionally
- **Ambivalent Attachment:** Highly reliant upon others for regulation
- **Disorganized Attachment:** Difficulty Trusting others, difficulties self-soothing, push-pull dynamics.

Attachment and Transgenerational Trauma

- One of the strongest ways that a transgenerational transmission of trauma occurs is during early attachment.
- Early attachment communications are nonverbal which are highly impacted by PTSD:
  - voice tone
  - facial expressions
  - body language

Factor 4: Poor Modeling of Health Behaviors

- Growing up in a home where medical care was not consistent or wasn't available.
- Insufficient modeling of hygiene practices
- Lack of encouragement of health-promoting behaviors such as exercise or healthy eating.
- There may also be excessive modeling of high-risk behaviors like smoking or substance abuse.

Factor 5: Presence of a Learning Disability

- 35% of individuals with dyslexia reported abuse before age 18. Bi-Directional Correlation (Fuller Thompson & Hooper):
- Abused children at greater risk for learning disabilities because of chronic stress and trauma.
- Children with learning disabilities at greater risk for abuse as parents misunderstand or are triggered by their child's cognitive differences or impulsivity.

Factor 6: Social and Cultural Factors

- Oppression, prejudice, and ongoing discrimination can lead individuals to become isolated, excluded, bullied, or harassed.
- Clients might have faced or be facing the chronic stress of uncertainty, the threat of deportation, poverty, disability, or the lack of a sense of social belonging.

Factor 7: Lack of Resilience Factors

- Resilience factors are those protective resources that alleviate the impact of childhood trauma:
  - A supportive individual or community who understood, nurtured, and protected the individual.
  - Additional protective factors include participation in activities outside of the home and developing positive peer relationships.
- When resilience factors are lacking, the impact of neglect or abuse can be amplified

7 Symptoms of C-PTSD

1. Intrusive Memories
2. Emotional Dysregulation
3. Avoidance Symptoms
4. Dissociation
5. Interpersonal Problems
6. Cognitive Distortions
7. Health Problems

1. Intrusive Symptoms

- Intrusive or “re-experiencing” symptoms including flashbacks and nightmares
- Intrusive symptoms from early childhood preverbal memories may come in the form of a vague uncomfortable sensations or pain.
- Hypervigilance: being on guard or highly sensitized to the environment or people’s body language

2. Emotional Dysregulation

- Overwhelming emotions disrupt the client's ability to function at work, home, or in relationships.
- High arousal emotions such as anxiety, rage, or fear
- Low arousal emotions such as helplessness, hopelessness, despair, and depression

3. Avoidance Symptoms

- Avoiding situations, people, or places that are reminders of trauma
- Avoidance is maintained by:
  - Denying the past
  - Repressing feelings
  - Idealizing parents
  - Minimizing the pain
  - Substance Use
  - Emotional Eating
  - Excessive Exercising
  - Dissociation

4. Dissociation

- Dissociation is a learned behavior that once helped the client survive and cope with a threatening environment.
- Dissociation is a built-in, biological protection mechanism that reduces the emotional and physical sense of a threat.
- Over time, dissociation becomes a well-maintained division between the part of the self involved in daily tasks of living and the part holding trauma related material.

Symptoms of Dissociation:

A continuum of symptoms:

- Disconnected from body, thoughts, or emotions
- Feeling fuzzy
- Having a hard time verbalizing about experience
- Feeling dizzy
- "Loss of control"
- Disoriented
- Lack of distinction between past and present.
- Lapses of memory or "lost time"
- Multiple parts or sub-personalities.

5. Interpersonal Problems

- Patterns learned within early attachment trauma tend to get repeated in adulthood until new and effective interpersonal strategies are developed:
- Withdrawal
- Blaming
- Pushing away
- Criticizing

6. Cognitive Distortions

- Inaccurate beliefs about oneself, others, and the world.
  - There's something wrong with me.
  - I'm so stupid.
  - I can't seem to do anything right.
  - It's all my fault
  - I do not deserve to exist
  - I'm unworthy
  - I can't trust anyone

7. Health Problems

- Unresolved PTSD is associated with the development of chronic illness and pain conditions (Scaer, 2014)
  - Seizures
  - Migraines
  - Gastrointestinal problems (GERD, IBS, etc.)
  - Autoimmune disorders
  - Fibromyalgia
  - Chronic fatigue
  - Medically unexplained symptoms

The ACE Study (Felitti et al., 1998)

- The Adverse Childhood Experiences study
- Assessed 17,000 Kaiser Permanente patients self reports of childhood events
- Interpreted results in collaboration with CDC (Center for Disease Control and Prevention)
- Results: Undeniable correlation between childhood events with physical and mental health problems in adulthood

The ACE Study: 10 Categories

(See Appendix A)

1. Physical Abuse
2. Verbal Abuse
3. Sexual Abuse
4. Emotional Neglect
5. Physical Neglect
6. Domestic Violence in which mother was treated violently
7. Household member abused substances
8. Household member was mentally ill
9. Household members was imprisoned
10. Parents were divorced

A Critical Mass of Stress

4 or more ACE Factors significantly increased risk for:

- Alcoholism
- Cancer
- Suicide Attempt
- Severe obesity
- Drug abuse
- Heart disease
- Smoking
- Physical inactivity
- Skeletal fracture
- Liver disease
- Lung cancer
- Depression

Resilience Factors offset ACEs

1. Belief that mother loved you as a child
2. Belief that father loved you as a child
3. Having other relatives or caregivers who cared for you as an infant
4. Having neighbors, friends' parents, teachers, coaches, or ministers who liked you and helped you
5. Having someone who cared for how you did in school
6. Having clear rules in your house that you could follow
7. Having someone you trusted to talk to when needed
8. Having people who saw you as capable
9. Being independent and a go-getter
10. Believing that life is what you make of it

Personal ACEs and Resilience Factors

Review the list of Adverse Childhood Experiences. What is your ACE score?

What has helped you navigate the narrows of your own childhood?

Review the list of Resilience Factors. What resilience factors did you have as a child?

Additional Symptoms of C-PTSD

- Self-harm
- Suicidal thoughts, plans, or attempts
- Addictions
- Emotional eating
- Eating disorders
- Social anxiety
- Difficulty concentrating
- Impulsivity
- Excessive risk-taking

Realities of Working with C-PTSD

Evokes feelings of:

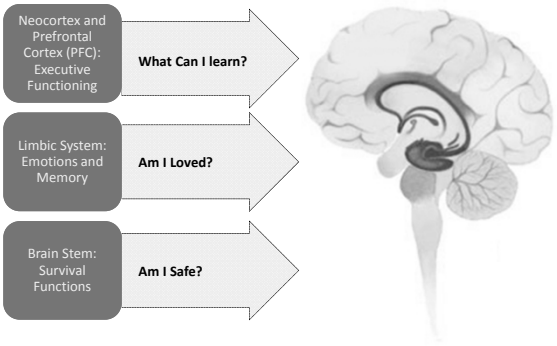
- Helplessness
- Hopelessness/Despair
- Isolation/Loneliness
- Injustice/Unfairness
- Suffering
- Rage
- Evil

Resource Yourself

- As therapists, we must attend to our own wounds or they will contribute to blind spots in our work with our clients.
- What resources help you stay present with your clients as they experience helplessness, despair, suffering, uncertainty, disappointment, and loss?
- What meaning making, spiritual perspectives, or self-care practices help you attend to the weight of trauma processing with clients?
- What support do you have to work with your own countertransference when it arises?
- What additional support do you need?

The Neurobiology of C-PTSD—Beyond Fight and Flight

Modeling the Brain



Key Brain Structures in Traumatic Stress

- **Prefrontal Cortex and Orbitofrontal Cortex:** Integrates sensations and emotions with memories of the past and goals for the future. Regulates limbic system activation.
- **Hippocampus:** Storage and retrieval of memories. Differentiates between past and present.
- **Amygdala:** "Hub in the wheel of fear." Detects threats and emotions in environment and people.
- **Brain Stem (Cerebellum, Medulla):** Initiates freeze, orienting response, startle reflex, and defense reactions
- **Anterior Cingulate Cortex:** Connects upper and lower brain via reciprocal inhibition.
- **HPA Axis:** Initiates stress response mobilization throughout the body by initiating the release of cortisol.

The nervous system detects whether situations or people are safe, dangerous, or life threatening.

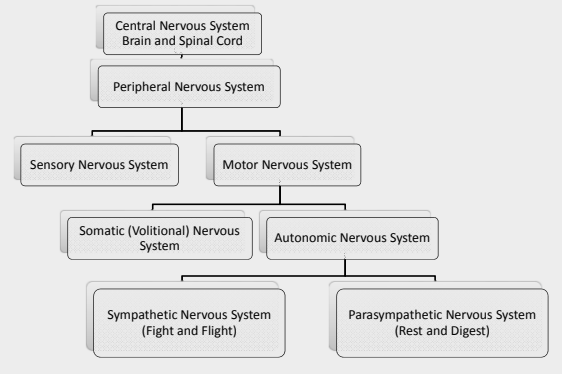
"Neuroception" occurs with and without conscious awareness (Porges, 2011)

Emotional Flooding

- **Post-cognitive Circuit:** Incoming sensory information is routed to the Prefrontal cortex to allow for an accurate assessment of situation.
- **Pre-cognitive Circuit:** Initiation of warning system without engaging the prefrontal cortex. Individual reacts without realizing why, only that there is potential danger.
- **Emotional Hijacking:** Limbic activation suppresses regulating functions of the prefrontal cortex initiating a full-body defensive reaction before the individual has fully assessed what is happening (Goleman, 1995)

Individuals with long-term, chronic trauma exposure can lose the ability to accurately perceive whether people or places are safe or trustworthy

Divisions of the Nervous System



Polyvagal Theory (Porges)

Social Nervous System: Most recently evolved (Ventral Vagal Complex). A fine-tuned response to your environment that creates choice.

Sympathetic Nervous System: Mobilization to facilitate safety and re-establish connection. Play when safe, flight and fight in threat.

Parasympathetic Nervous System: Oldest Evolutionary (Dorsal Vagal Complex). Immobilization to reestablish safety & connection. Relaxation response when safe or "faint" in threat.

What Happens in Vagus…

- **Connects Brain and Body**: Connects the brain to the gut, stomach, heart, lungs, throat, and facial muscles.
- **Information highway:** Communicates interoceptive information to the prefrontal cortex about changes in autonomic arousal to support self-regulation
- **Inhibitory Influence:** Reduces sympathetic NS activation and heart rate

The Social Nervous System

- Functions as a fine-tuned, refined brake
- Is strengthened by repeated practice which myelinates the nerve pathways and leads to increased speed and control.
- Is influenced by the attachment relationship (vagal tone of the mother)

Heart Rate Variability

- The social nervous system has a regulating, calming, and soothing effect reflected in rhythmic oscillations in heart rate variability.
- Low HRV is associated with anxiety and depression
- High HRV is associated with positive emotions and resistance to stress.

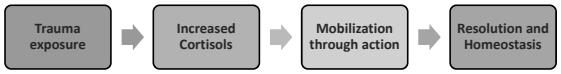
"Heart rate variability (HRV) provides the best available means of measuring the interaction of sympathetic and parasympathetic tone, that is, of brainstem regulatory integrity"

Bessel van der Kolk, 2006

3 Forms of Childhood Stress

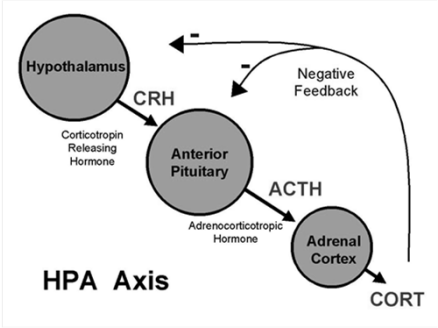
- **Positive stress response**: Is temporary and resolves into a positive connection to loving caregivers. Tones the nervous system to cope with stressful situations in adulthood.
- **Tolerable stress response**: A child faces a single-incident trauma. Loving caregivers in a supportive environment help the child process their experience. Associated with the development of positive coping skills in adulthood.
- **Toxic stress response**: Profound or ongoing traumatic events take place without support from loving adults. Associated with a negative outcome on emotional and physical health in adulthood.

Healthy Stress Response



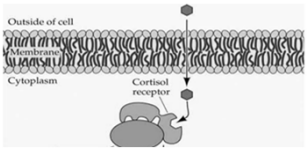
- **Exposure to a stressful (or traumatic) event**
- **Increase in cortisols**
- **Initiation of mobilization response-(fight/flight)**
  - **Feel, Move, Run, Protect, Shake**
- **Stress activated response systems achieve homeostasis (cortisol levels return to baseline)**

Hypothalamic-Pituitary-Adrenal (HPA) Axis

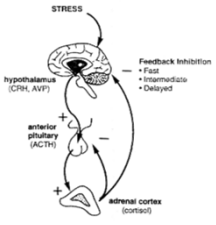


The Neurobiology of PTSD

Unresolved PTSD Recalibrates Stress Response Systems



Increased number of receptors for cortisols



Interference with the HPA Negative Feedback Loop

6 Stages of Trauma Response (Schauer & Elbert, 2010)

See Appendix B

When Immobilization Comes First…

- A small percentage of individuals progress immediately into immobilization (Ogden & Minton, 2014).
- In such cases, the social nervous system and sympathetic nervous system fail to engage
- More likely to occur in individuals with long-term, early onset trauma exposure in which the nervous system was shaped within a dangerous environment.
- An infant has no option to flee or fight and will resort to immobilization much earlier in the sequelae of trauma responses.
- Ongoing early developmental trauma primes the nervous system for immobilization.

"Failure to fight or escape, that is, the physical immobilization, becomes a conditioned behavioral response." (Bessel van der Kolk, 2006)

How we heal…

"Failure to fight or escape, that is, the physical immobilization, becomes a conditioned behavioral response." (Bessel van der Kolk, 2006)

- Over time, failure to fight or escape and the resulting physical immobilization can become a conditioned behavioral response.
- Healing involves safely processing the traumatic event with engagement of the social nervous system to achieve safe mobilization and safe immobilization.

Mind-Body Break…Move and Breathe

5 Point Check-in

- Mind: thoughts and mental focus or clarity
- Emotions: feelings and associations
- Breath: holding or restriction
- Body: notice sensations
- Energy: fatigued or energized

Respond and Regulate:

- How can you move and breath in a way to helps you stay alert, engaged, and connected to yourself now?
- What allows you to effectively reset your mind and body?

Interpersonal Neurobiology

Psychobiological Regulation

- The mother or caregiver provides external regulation for a child's immature physiology (Schore, 1994).
- The mother's autonomic nervous system, which includes vagal tone, influences the infant's physiology.
- These early influences on the child's nervous system have been demonstrated to have a long-lasting impact on later self-regulatory capacity (Bornstein & Suess, 2000).

Attunement and Mutual Regulation

- A sensitive caregiver attunes to the infant's nonverbal cues of facial expressions, vocalizations, gestures, and body movements (Stern, 1985).
- Such attunement guides their use of touch, amount of eye contact, quality of voice tone, and timing of interactions.
- Empathic attunement helps to reinforce the child's internal sense of self, which includes ownership of movement, body, and emotions.
- Note: Both infants and caregivers adjust and change to maintain a coordinated relational state.

Mutual regulation is the precursor for self-regulation

Rule of Thirds (Tronick, 2007)

Good Enough Mothers

- 1/3 • In sync
- 1/3 • Out of sync
- 1/3 • Trying to get back in sync

Rupture and Repair

- Errors in attunement followed by repair has a purpose.
- Helps the child handle the inevitable stresses of life—and trust that they can resolve into positive affect states (Beebe, 2010; Tronick, 2007).
- Repair:
  - Recognize the rupture
  - Attune to the child
  - Stay Engaged until reconnection is achieved

Over time, an infant internalizes the mother's influence, learns self-regulation, and learns to tolerate internal distress.

In the case of relational trauma, caregiver behaviors are dysregulating for the infant.

Caregivers who are dysregulated themselves are less available for repair behaviors which leaves the infant in intensely disrupted states for extended periods of time.

Traumatic Stress in Infancy and Early Childhood (Perry, 2001)

- Reduced size of the hippocampus
- Loss in gray matter in the prefrontal and orbitofrontal areas of the brain, impairing affect regulation.
- Impairments in the wiring of the ACC, leading to deficits in play behavior and attachment behaviors such as flattened emotional expression within voice, face, and body.
- Changes in HPA axis functioning and related changes in cortisol levels.

Neuroplasticity and Healing C-PTSD

- Neuroplasticity continues throughout the life span and is shaped by our ongoing social and behavioral experiences (May, 2011)
- In psychotherapy, the therapist acts as an external psychobiological regulator for the client (Schore, 1996)
- Therapist attunement to clients arousal states and application of polyvagal theory through a moment-to-moment interactive process.
- Therapists work with relational ruptures and repair as needed to help clients tolerate relational stress.
- Therapists work to regulate their own nervous system as a model and resource for the client.

Preverbal and Nonverbal Memories

Our earliest preverbal memories are neither verbal nor stored as images. Instead, they exist as motor patterns and sensations. They are blueprints of our earliest relationships represented by psychophysiological arousal and emotion.

Implicit and Explicit Memory

- **Implicit Memory**: Dominant from birth until age 3, provide the foundation for a **felt sense** of self, stored as representations of motor patterns and sensations.
- **Explicit Memory**: Knowledge of facts, time, and place. Provides basis for a **verbal narrative** that helps us develop a coherent sense of self across time.

Preverbal and Nonverbal Memories

- **Preverbal Memories:** Earliest attachment memories that exist prior to age 3. Amygdala online at birth. Brain structures (hippocampus, prefrontal cortex) necessary for explicit verbal memories develop later.
- **Nonverbal Memories:** Traumatic stress can impair the brain structures involved with explicit memory (van der Kolk, 2015) in which later (after age 3) memories are stored as fragments of disconnected sensory and bodily experiences.

In times of extreme stress or trauma, high arousal states can disrupt hippocampal functioning, leading to hypermnesia (enhanced memory) for affect or sensations and amnesia (loss of memory) for facts.

Are Implicit Memories Accurate?

- Implicit memories do not represent an exact replay of the original set of events.
- When retrieving an implicit memory, there might only be a felt sense, or gist, of the original experience.
- We fill in missing elements of memories—these adaptations are influenced by current emotions, setting, social cues, relationships, and imagination.

As human beings, we are storytellers.

We have a fundamental need to develop a narrative that is consistent with our current beliefs, theories, or hypotheses.

Disruptions to memory consolidation and retrieval can lead to a disorganized and fragmented sense of self, with possible dissociation as the coherent narrative of the self is compromised.

Dissociation and Dysregulation

Understanding Dissociation

- Dissociation is a biological survival mechanism that disconnects an individual from threatening experiences.
- Patterns of dissociation that once saved a child will become a hindrance to the adult who might continue to dissociate as a learned coping mechanism.
- As a result, the individual feels cut off and disconnected from emotions, body sensations, and other people.

Dissociation: Disorder of Perception

Challenge in recognizing that:

- The traumatic event happened
- That the traumatic event happened to "me"
- The traumatic event is over
- I am here and now (not then and there)
- My body is part of me
- The me of then is part of the me now
- My actions in the present belong to me

Phobias Maintain Dissociation

Phobia of:

- Traumatic memories
- Parts of self that carry shame
- Attachment, relationship, and loss
- Inner experience (arousal state, affect, body sensations)

Shame and Learned Helplessness

- Persistent childhood trauma is characterized by a state of learned helplessness and the emotion shame.
- When there is no way to stop abuse, end a situation of domestic violence, or convince a parent to stop drinking, a child feels powerless.
- When children witness something bad, they feel bad leading them to feel confused about who is at fault.
- Shame is characterized by the belief, "I am bad." This emotion is based upon a distorted sense of self as being unworthy, damaged, or a failure.
- Adults who were abused as children often continue to blame themselves for the abuse.

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- Adults who were abused as children often continue to blame themselves for the abuse.

Self-blame is a direct link to childhood logic—children often develop a fantasy that they are bad kids relying upon good parents to avoid confronting the terrifying reality that they are good kids relying upon bad parents.

(Jim Knipe, 2015)

The Divided Self

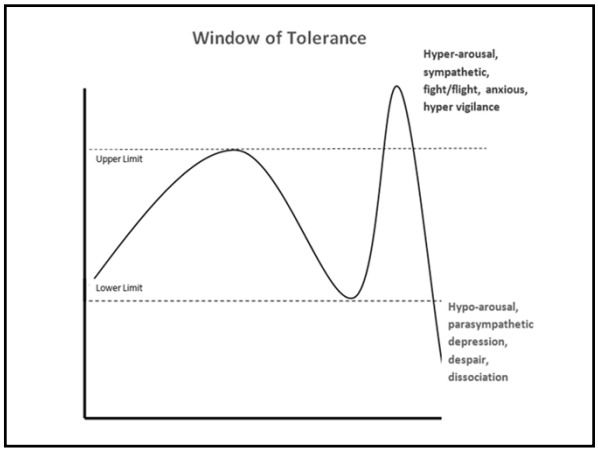
Structural Dissociation Theory (van der Hart, Nijenhuis, Steele, 2006)

- **Apparently Normal Part**: Feels disconnected or as if "going through the motions"
- **Emotional Part(s)**: Holds unrealized emotions and memories
- **Defensive Part(s)**: Keeping the EP(s) away from awareness

Dissociation occurs when a traumatic event cannot be fully realized or accommodated by the client.

The affect or arousal associated with the traumatic memory cannot be tolerated.

The client may experience both hypoarousal and hyperarousal nervous system states



The Window of Tolerance

- **Window of Tolerance:** an optimal zone of nervous system arousal where clients are able to respond effectively to their emotions and sensations (Siegel, 1999)
- **Above the Window:** Feeling anxious, overwhelmed, or panicked is a sign that the client is hyper- or over-aroused.
- **Below the Window:** Feeling shut down, numb, or disconnected is a sign that you are hypo- or under-aroused.

Hyper-arousal Symptoms (Excessive Sympathetic Response):

- Irritability
- Anxiety
- Restlessness
- Aggression or Rage
- Crying uncontrollably
- Hypervigilance
- Feeling "overwhelmed"

Hypo-arousal symptoms (Excessive Parasympathetic Response):

- Fatigue
- Lethargy
- Helplessness
- Emotional dullness
- Fawning (Obedience)
- Numbing
- Feeling "depressed"

Working within the Window of Tolerance

- It is common for individuals with C-PTSD to feel stuck in hyper-arousal, hypo-arousal, or to alternate between the two extremes.
- Well-paced therapeutic interventions help the client work through traumatic memories without becoming overwhelmed or shutting down in the process.

Effective trauma treatment involves a balance between the regulating function of top-down processing and the accessing function of bottom-up processing.

Top-Down or Bottom-Up Interventions

Top-Down Interventions:

- Engages upper brain centers in the neocortex to provide regulating, conscious, thought-based tools for addressing trauma symptoms.
- Pressing on the brakes-slows down processing

Bottom-up Interventions:

- Engages the lower brain centers in the limbic system and brain stem to help the client access emotional and sensory components of traumatic material.
- Pressing on the gas-speeds up processing

Top-Down Interventions

- Psychoeducation
- Mindfulness
- Cognitive interventions such as identifying negative and positive beliefs or challenging thinking errors
- Resourcing interventions (grounding, establishing safety, containment)
- Talking about traumatic events
- Conscious Breathing

Bottom-Up Interventions

- Focus on affect and emotions while processing traumatic events
- Focus on body sensations (e.g. body scan) while processing traumatic events
- Follow movement impulses
- Invite movement to facilitate somatic release
- Pendulation: oscillate between feeling distress and feeling safe or calm
- Conscious Breathing

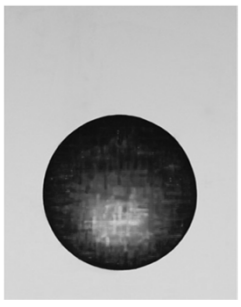
Signs of a Regulated Nervous System

- Feeling calm and alert
- Expresses a range of emotions without feeling "stuck" in feelings or in numbness
- Ability to think clearly and logically
- Ability to reflect upon choices and make healthy decisions
- Feeling "grounded"
- Aware of body and breath
- Healthy sleep cycle
- Able to communicate to others clearly

Mind-Body Break…Conscious Breathing for Self-Regulation

- **Up-regulating Energizing Breath**: Short, quick, upper chest breathing
- **Down-regulating Calming Breath**: Long, slow, diaphragmatic breathing

The Neurobiology of C-PTSD— Neural Networks and Trauma Recovery



What are Neural Networks?

- A neural network is a group of interconnected neurons in the brain that work together
- Neural networks form the basis of all learning.
- Every time we learn a new behavior, we create a new neural circuit.
- Frequent repetitions of the behavior myelinate nerve pathways which allows the signals to move quickly and smoothly.
- All memories are patterns of neural networks.

Integration of neural networks across left and right hemispheres of the brain to help us express feelings with words and assimilate positive resource into negative perceptions of emotions

Integration of neural networks between upper brain centers (neocortex) and lower brain centers (limbic system and brain stem) helps with managing impulses and developing greater self- control.

Neural Networks in Trauma Treatment

- Traumatic memories can be thought of as impaired encoding of neural networks (Shapiro, 2018).
- Traumatic memories are not integrated with positive experiences and are limited in their ability to accommodate new information
- During trauma treatment we reactivate the neural networks of traumatic events and to offer a reparative experience that can facilitate integration throughout the brain and body.

Remember: Neuroplasticity continues throughout the lifespan.

Implications for Therapy

Treating C-PTSD

- **Increase your client's capacity to stay present with and effectively respond to (regulate):**
  - **States of mind**
  - **Emotions**
  - **Sensations**
  - **Interpersonal exchanges**

Develop Tolerance For:

- Uncertainty
- Ambiguity
- Disappointment and loss
- Conflict and Compromise
- Difference
- Competing needs and desires
- Conflicting ideas and emotions

Goals of Treatment

The client is able to say:

- The trauma happened to me
- I am aware of my past and how it affects me in the present
- The past is differentiated from the present (It is over now)
- I can be mindful of the present moment
- I can sense and feel my body now
- I have choices now about my thoughts, emotions, and behaviors.
- I can orient toward the future

"Loss of control is at the core of PTSD"
Babette Rothschild (2010)

An essential component in healing trauma involves helping clients reclaim a sense of control in their lives, now.

Memory Retrieval vs. Trauma Recovery

- With C-PTSD and Developmental Trauma, preverbal trauma and nonverbal memories more common.
- A focus on memory retrieval can be detrimental as these memories are not always accessible and are more vulnerable to influence.
- Trauma Recovery involves actively distinguish the past from the present and helping the client recognize that they are at choice about how to respond to current events in an effective manner.

Goal Of Therapy: To Experience Self as Resilient

3 Stages of Treatment
(See Appendix E)

- **Stage I**: Establish stability and safety
- **Stage II**: Process traumatic material in a well-paced, regulated manner
- **Stage III**: Re-Integration of new experiences into identity and relationships

When working have clients with dissociative symptoms or somatic sensations that lack explicit memories facilitate processing by helping clients describe their present-moment experience rather than emphasizing a need to apply a story to the sensations.

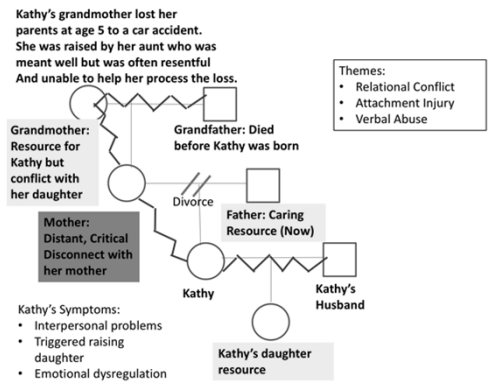
Assessing C-PTSD: Identifying Chronic, Repeated, and/or Developmental Trauma
(See Appendix C)

Transgenerational Themes

Unresolved trauma of one generation becomes a legacy that is passed down to the next generation until someone is able to feel and heal the loss.

- Trauma is passed on when parents re-enact attachment dynamics and evoke emotional responses in children.
- Reflection upon transgenerational themes helps clients mindfully reflect upon patterns and emotions, allowing them to be owned and healed.
- Use genogram to identify themes across generations
- Address role reversals
- Engage embodied awareness of felt sense related to themes.

"Kathy's" Genogram



Transgenerational trauma will be carried in families until until someone is ready to feel it.

We do not heal the wounds by carrying them for our family. We heal by releasing them for ourselves.

Mind-Body Break: Practice Containment

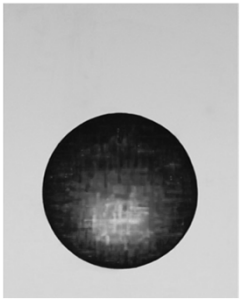
- Loss of Choice is key component of trauma
- Develop Imaginal Container as resource for clients who are under-contained and overwhelmed by emotions or traumatic memories.

Integrative Mind-Body Approach to Treating C-PTSD

Integrative Mind-Body Approach to Trauma Treatment

- **Psychodynamic:** Relational, Interpersonal therapy
- **Parts Work:** Ego States and attending to dissociation
- **EMDR Therapy:** Adaptive Information Processing, Dual Attention, 8-Phase model, Bilateral Stimulation
- **Somatic Therapy:** Embodiment Interventions
- **CBT:** Relationship between thoughts and behaviors
- **DBT:** Distress Tolerance & Emotion Regulation skills
- **Complementary and Alternative Medicine (CAM):** Mindfulness, Yoga, Relaxation, Massage, Acupuncture, Nutrition, etc.

Psychodynamic Therapy and the Healing Relationship



Relational Work

- Your task is to accept what the client cannot and to facilitate greater integration at a pace that the client can tolerate
- Explore transference and countertransference
- Re-enactments are inevitable
- Ruptures and repair provide opportunities for new learning

Identify Defenses

- **Repression**: "If I don't talk about or acknowledge my painful past it doesn't exist."
- **Denial**: "Yeah, I was abused but it wasn't a big deal"
- **Avoidance**: "If I just stay in bed and sleep I don't have to face reality"
- **Fantasy**: "If I just act like everything is okay then it will be okay."
- **Self-Blame/Idealization**: "If only I hadn't been so bad I wouldn't have been abused"

Projection and Introjection

- **Projection:** Attributing personal feelings or characteristics onto another person.
  - Believing that other's view them critically
  - Idealization or devaluation of another
- **Introjection:** Internalizing the beliefs of other people so that they cannot separate that person's voice from themselves.
  - Self-criticism
  - Feelings of unworthiness and incompetence
  - Identifying with the abuser: take over qualities of the abuser to feel in control rather than helpless

Relationship and Mutual Regulation

- Therapist and client mutually influence each other throughout therapy.
- When we as therapists attune to our own embodied awareness during sessions, we can sense subtle changes that may provide insight into the experience of the client…and offer a modeling of regulation.

Relationship is not just about the "other"—Allow yourself to be moved, touched, and ultimately changed by the exchange. Our work is to "Receive the gift of the client" (Phillip Bromberg, 2011)

Countertransference and Somatic Resonance

Clients evoke disowned emotions and relational expectations within the therapeutic relationship.

- **Somatic Resonance:** Somatic reactions that a therapist feels in response to a client (Keleman, 1987)
- **Objective Countertransference:** Evoked experience provides insight into the inner world of the client.
- **Subjective Countertransference:** Evoked experience parallels is related to material from your own life.

Once you feel it, it is your responsible to attend to the sensations with self-care.

Relational Re-Enactments

- **Re-Enactment**: Clients recreate relationship patterns that match what they know and expect.
- **Know Thyself:** As therapists, our own attachment history can also lead to enactments in therapy.
- **Mindful reflection:** Allows the therapist to differentiate between subjective and objective countertransference. (Sometimes it's both)
- **Rupture and Repair:** Helps clients form new relationship expectations

The mindful therapist provides a safe space to help clients mindfully reflect upon these emotions and patterns—to own the disowned parts of self.

Attachment in Therapy

Caregiver (and therapist) behaviors that foster Secure attachment:

- Predictable
- Attuned
- Consistent
- Congruent
- Trustworthy
- Reflective
- Good Enough

Secure Attachment

- Regulates affect and arousal
- Promotes the expression of feelings and communication
- Serves as a base for exploration and differentiation
- Facilitates self-regulation
- Provides the ability to form relationships with boundaries and sense of self
- Provides a sense of congruence for the individual

Attachment Wounds

- **Types of wounds:**
  - Invasion, intrusion, or abuse
  - Abandonment or neglect
  - A combination of the above
- **Avoidant Attachment**
- **Anxious-Ambivalent Attachment**
- **Disorganized Attachment**

Avoidant Attachment

- The insecure avoidant child has grown up with a distant or disengaged caregiver.
- This child adapts by avoiding closeness, disconnecting emotionally, or becoming overly self-reliant.
- Insecure avoidant adults tend to be dismissive of their own and other people's emotions and face challenges when their partners long for a deeper, more intimate connection.

Anxious-Ambivalent Attachment

- The infant is raised by an inconsistent primary caregiver, who is at times highly responsive and perceptive, but can also be intrusive and invasive.
- The child cannot depend upon the caregiver for predictable attunement and connection, and consequently develops uncertainty and anxiety.
- Insecure ambivalent adults tend to feel overly dependent and suffer from abandonment anxiety and an overall sense that relationships are unreliable.

Disorganized Attachment

- This child has grown up with a parent whose behavior is a source of alarm, chaotic, and/or abusive.
- Fright without solution—an unsolvable dilemma.
- A paradox between the child's biological drive to seek closeness from a source of terror that he/she is trying to escape.
- Disorganized adults rely upon impulsive or aggressive behaviors when intolerable emotions arise. Relationship interactions can mimic the abuse experienced during childhood. They might act abusive themselves or choose abusive partners because it feels familiar.

Attachment Style or Strategy?

- Attachment is not a fixed style
- Attachment is a strategy that helped the child survive which can be modified to meet the needs of the adult.
- We can develop different attachment strategies within different relationships in childhood.
- Current relationships can evoke different attachment strategies at different times.
- As therapists, it is our work to recognize our own attachment wounding and related relational strategies
- Neuroplasticity research reminds us that we continue to be shaped by our ongoing experiences helping us develop new relational expectations.

Goal of Therapy: Learned the behaviors that foster Secure Attachment within Self

Therapist Attachment Strategies

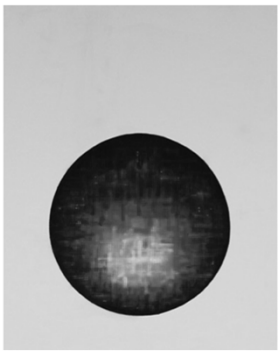
- **The Secure Therapist:** Centered and mindfully aware of emotions, sensations, and thoughts.
- **The Avoidant Therapist:** Focuses on client's thoughts rather than feelings, distant, possibly dismissive, and might inadvertently push client away.
- **The Anxious Therapist:** Over-identifies or merges with the client, may have difficulty setting boundaries, might attempt to rescue the client.
- **The Disorganized Therapist:** Anxious, unsettled, angry, or uncomfortable prior to, during, or after sessions. Can have feelings of aggression toward client or may feel victimized by the client.

Different Clients will pull upon different attachment strategies in us as therapists.

Mind-Body Break…Working with Countertransference

- Self-Reflection about a Client
- Take Responsibility for your Experience
- Resource yourself
- Integration of Insight

Ego States and Parts Work



Ego State Therapy (Watkins & Watkins, 1997)

- **Ego states:**
  - Child part of the client
  - Internalized parents (Critical, Abusive, Permissive, Neglectful)
  - Healthy adult self
- **Ego State Therapy:**
  - Recognizing disowned parts of self
  - giving these parts a voice.

Internal Family Systems (IFS, Schwartz, 1997)

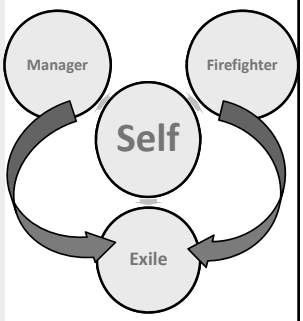
Exile: Carries burdens of trauma, including emotions and memories.

Manager: Maintains control of exile through excessive control (working hard, inner critic, perfectionism).

Firefighters: Prevents Exile from emerging by acting out (addictions, self-harming behaviors)

Goal: Connect to Self

The Confident and compassionate core of the individual. A source of wisdom.



Structural Dissociation Model (van der Hart, Nijenhuis, Steele, 2006)

Apparently Normal Part (ANP): Maintains daily talks, can feel disconnected or as if "going through motions"

Defenses to keep EPs our of awareness: perfectionism, control, idealization, intellectualization, addictions

Emotional Part (EP): emotions, sensations, or memories associated with traumatic event(s)

Parts Work

- **Assessment of and treatment of dissociation:** Look for subtle signs as well as overt symptoms
- **Observe cues of parts**:
  - Body symptoms such as the onset of a headache, nausea, dizziness, or pain
  - Changes in voice tone
  - Changes in body posture
  - Changes in eye contact
  - Repetitive movements, such as hair twirling, skin picking, or nail biting
  - Changes in breathing patterns such as holding the breath

Working with Parts

- **Identify the function of the part:**
  - Managing or controlling intolerable emotions with perfectionism or rigidity
  - Sabotaging Part may be identified with abuser and acting out with impulsive, addictive, or self-harming behaviors.
  - Exiled or Young Part
- **Identify the need of the part:**
  - Protection
  - Boundaries
  - Nurturance
  - Wisdom

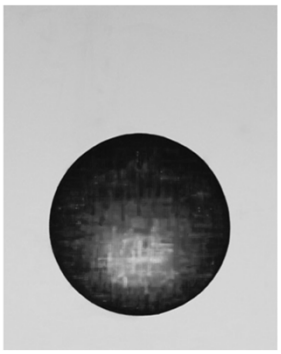
Working with Shame

- Name the Shame
- Regulate Yourself: Notice any tendency to shutdown with the client.
- Differentiate “I am bad” from “I feel bad”
- Reframe the situation: “you were just a child, they were the adults”
- Help client talk back to the ”shame bully”
- Explore resources for shame (relational, somatic, imaginal allies)
- “Shame is my safe place” (Knipe, 2016)

Mind-Body Break…Self-Compassion Practice

- Reflect on yourself within the context of your family of origin
- Choose one image: A snapshot of a moment in time
- Imagine your today self going into that image and looking at your young self with compassion
- What emotion do you see on the face of your young self?
- What does that young part of you need most?
- Can you allow your today self to meet that need? Are there other allies (people, animals, spiritual figures) who could be with you?
- Make an agreement to return to this part of you in your own therapy or supervision as needed.

Cognitive Behavior Therapy (CBT)



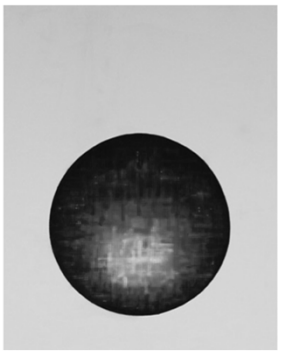
Cognitive Behavioral Therapy (CBT)

- **Identify Negative Beliefs**
- **Challenge "thinking errors"**
- **Develop more effective beliefs and resourcing behaviors (exercise, relaxation strategies)**
- **Review the traumatic event-tell the story, write the narrative**
- **Caution regarding use of exposure therapy as this can be re-traumatizing for the client**

Beliefs Linked to Developmental Trauma
See Appendix C

Negative Beliefs	Positive Beliefs
I am not lovable	I am lovable
I am not important	I am important
I am unworthy	I am worthy
I do not deserve to exist	I deserve to exist
I don't belong	I belong
I am helpless or powerless	I can take care of myself now
I cannot trust anyone	I can choose whom to trust
I cannot protect myself	I can protect myself now
I am alone (lonely)	I can connect to others now

EMDR Therapy



EMDR Therapy

- **EMDR Therapy:** Eye Movement Desensitization and Reprocessing
- **8 Phase model:** comprehensive theoretical approach to trauma treatment.
- **Resource Development Installation:** Emphasis on safety and stabilization prior to processing traumatic events.

Adaptive Information Processing

- **Adaptive Information Processing (AIP Model): Inherent capacity in the person to heal given sufficient support.**
- **Provides the ability to process information and learn from all experiences, even difficult ones.**
- **Integrates new information with existing experiences such as memories, thoughts, feelings, and sensations.**
- **Reprocessing involves consciously accessing the traumatic memory to bring about a more adaptive experience.**

Dual Attention State and Dual Attention Stimulation

- **Dual Attention:** Client remains aware of the present moment experience while simultaneously addressing memories related to the traumatic event
- **Dual Attention Stimulation (DAS)/Bilateral Stimulation (BLS):** bi-lateral eye movements, pulsers, taps, or tones that alternate between the left and right side of the body

8 Phases of EMDR Therapy

Phase 1 History Taking: Develop case conceptualization of client within context of life, identify trauma history, set treatment goals.

Phase 2 Preparation: Establish therapeutic relationship, Stabilize and build skills, Resource Development Installation (RDI). Clients practice feeling connected to positive states in the body and mind through imagery and somatic awareness:

- **Safe Place**
- **Containment**
- **Moments of feeling loved by or loving others**
- **Times you felt competent or successful**
- **Imaginal Allies (protectors, nurturers, wise figures)**

Mind-Body Break…Safe Place in Practice

- Identifying a safe or peaceful place is of primary importance because we will not release the effects of trauma until we feel safe now.
- Reflect on a time or place where you have felt comfortable and relaxed. Your place can be a real place you have been, a scene from a movie, or something entirely imagined.
- Use your senses to enhance your imagery. What do you see? What do you hear? What are the smells?
- Strengthen safety as needed and add DAS/BLS if experience is positive.

8 Phases of EMDR Therapy

Phase 3 Assessment: Develop the "Target" out of a persistent symptom or traumatic memory

- **"Light up" the neural network:** Identify the worst image, emotions, beliefs, and body sensations associated with the symptom.
- **Identify the Touchstone Target**: The earliest memory related to the presenting issue.
- **Facilitate a "floatback" or "affect bridge"**: Invite the client to recall related earlier memories that are associated with the presenting issue (may not be logical)
- **Set up the Target:** Have the client describe the related worst picture/image, NC, PC, VoC, emotions, SUDS, and body sensations

8 Phases of EMDR Therapy

Phase 4 Desensitization: Uses DAS to reprocess the disturbing material related to trauma target until the client reports no disturbance (SUDS).

- **Attune to somatic cues:** watch for signals of dysregulation or dissociation, work in window of tolerance.
- **Watch for flooding:** Clients who struggle to sustain positive states are generally not ready for desensitization and reprocessing as the negative trauma material is more likely to lead to flooding or overwhelm.
- **Working with Dissociation:** Apply modified protocols.
- **Pendulation**: Oscillate between resource and distress for clients who struggle with maintaining positive state.

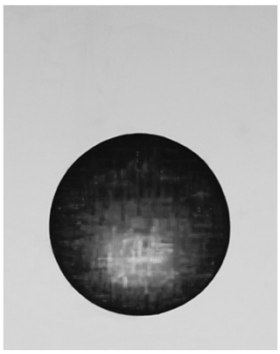
8 Phases of EMDR Therapy

- **Phase 5 Installation:** Strengthens positive beliefs that arise after the successful completion of desensitization.
  - Anchor the new Embodied Experience
- **Phase 6 Body Scan**: Release lingering tension
- **Phase 7 Closure:** Ensures client is resourced prior to ending the session, Containment and Light Stream.
- **Phase 8 Re-evaluation:** Review of efficacy of treatment from previous session, apply client driven feedback, identify new or unresolved targets.

Mind-Body Break…Pendulation in Practice

- Scan your body
- Notice area of discomfort
- Notice area of ease and relaxation in body
- Take a few breaths and allow the positive feeling to get stronger (Add BLS if positive feeling is strong)
- Bring your awareness back to the distressing sensation (No DAS/BLS)
- Now go back and forth between the resource and disturbance for a few rounds on your own.
- Notice how you feel in your body and mind.

Somatic Psychology



Somatic Psychology

The study of the interactions among brain, mind, body, and behavior and how this directly affects psychological and physical health.

Body Based Psychotherapies

- Integrative Body Psychotherapy (Rosenberg & Rand)
- Moving Cycle (Caldwell)
- Authentic Movement (Adler, Whitehouse)
- Body-Mind Psychotherapy (Aposhyan)
- Focusing (Gendlin)
- Hakomi Method (Kurtz)
- Sensorimotor Psychotherapy (Ogden et al.)
- Somatic Experiencing (Levine)

A Unified Approach

- A unified approach to somatic psychology (Geuter, 2015)
- Has shared theoretical and methodological elements
- Integrates interpersonal neurobiology (Siegel, 1999; Schore, 2012)
- The science of embodiment in action (Fogel, 2009)

Embodiment

Embodiment: the combined experience of sensations, emotions, and movement impulses in the present moment (Fogel, 2009)

Integration of sensory feedback systems:

- Exteroception
- Interoception
- Proprioception

Embodiment: An experience in which a primarily physical sensation becomes an experience of emotional depth replete with transformational power and meaning.

Embodiment in Trauma Treatment

- We are taught to override instinct and disconnect with the body.
- Stillness is a sign of obedience and respect (in our homes, in school)
- This can inhibit how clients process throught traumatic events in therapy.
- It is necessary to listen to the body and respond to sensations with movement during trauma treatment.

Somatic awareness can help clients avoid the harm that comes with ignoring your body.

Discomfort is your body's wake-up call that can guide you to move in a way that resolves tension naturally (Fogel, 2009)

Somatic Intelligence

Over time, embodiment practices, build **a reservoir of bodily-kinesthetic awareness** that:

- Facilitates affect-regulation
- Guides decision making
- Enhances interpersonal relationship and communication
- Strengthens empathy
- Informs trauma resolution

Core Principles in Somatic Psychology

- **Embodied Self Awareness:** Attention and invitation to follow sensations, breath, movement impulses
- **Working Experientially:** Work in the here and now with an intention of self-study
- **Bi-Directional Influence:** Changes in thoughts and behaviors influence physiology and changes in the body influence thoughts, feelings and actions

Nonverbal Communications

- Nonverbal Communications: account for 60-70% of all communication
- Use of space, facial expressions, eye contact, gestures, posture, voice tone, timing of speech
- Culturally and socially determined
- Look for congruence between words and body
- Therapist congruence = trustworthiness
- Attend to use of space, use of speech, posture, gesture, eye contact

Proxemics, Kinesics, Paralanguage

- **Proxemics:** an individual's perception of and use of space
- **Kinesics:** use of body language including posture, use of gestures, facial expressions, and amount of eye contact.
- **Paralanguage:** Nonlinguistic components of speech including voice volume, tempo, pitch, intensity, emphasis, timing, and use of pauses in speech.

Intercorporeality (Merleau-Ponty, 1962)

- Embodiment is an ever-changing, dynamic *relationship* between self, other people, and our environment.
- Challenges the idea of the self as a discrete, interior consciousness.
- We are informed (shaped) within relationship.

4 Types of Somatic Interventions

- Awareness Interventions
- Resourcing Interventions
- Trauma Processing Interventions
- Integrating Interventions

Awareness Interventions

- Build Somatic Vocabulary
- Body Scan
- Proximity Awareness
- Boundaries Development
- Explore Posture
- Body Mapping

Resourcing Interventions

- Grounding
- Containment
- Conscious Breathing
- Mindfulness and Yoga
- Build Sensation Tolerance

Mind-Body Break…Grounding

- **Approach grounding with mindfulness and curiosity**
- **Bring awareness to your legs and feet**
- **Explore mindful movements**
- **Feel your connection to the earth**
- **Engage your senses**
- **Mindful use of self-touch**
- **Bring awareness to your breath**

Build Affect and Sensation Tolerance

- Phobia of inner experiences such as arousal states, affect, and body sensations.
- Assist the client build tolerance for emotions and their accompanying somatic sensations.
- Explore memories or messages received about emotions and accompanying sensations
- Define the kind of supports that the client needs to stay with the emotion and sensation such as breath, movement, grounding, imaginal, or relational resource.

In Practice:
Building Affect and Sensation Tolerance

- **Choose emotion or sensation that you would you like to build a greater capacity to tolerate.**
- **Can you use your breath to support the feeling of…?**
- **Are there any movements that could support you in this feeling of…?**
- **Is there a statement that you can say to yourself to help you be with this feeling of…?**
- **What happens when you press into your feet and legs?**
- **Can you imagine an ally who could help you with this?**
- **You are in charge of how much and when to feel and you can take breaks from this feeling as necessary.**

Trauma Processing Interventions

- Story without Words
- Titration
- Pendulation
- Sequencing and Somatic Repatterning
- Somatics and Ego States

Titration, Sequencing, and Somatic Re-Patterning

- **Titration:** experiencing small, tolerable amounts of sensation and seeking resolution of distress.
- **Sequencing:** movement from core through periphery
- **Somatic Re-patterning**: Completion of movement sequence—explore movements slowly and mindfully

Preverbal and Nonverbal Trauma

- Attachment trauma, Pre or Perinatal trauma, and transgenerational trauma
- Explore strong sensations that arise related to childhood or birth stories and stories from family history
- Trust the process that arises through sensations, images, thoughts, and emotions.

Somatic Interventions for Stuck Sensations

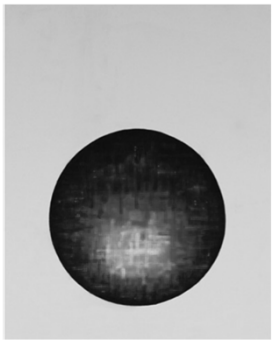
- If sensation could move, how would it move?
- Is there a sound or words for the sensation?
- Place hands over and breath into the sensation.
- Allow your hands and arms to express sensation
- Allow whole body to take over the sensation
- Pushing with arms and legs
- Stepping movements with legs and feet
- Scrunching face, moving jaw, tongue, and lips
- Reaching and pulling with hands and arms
- Could you tell the story of what happened without words?

Integrative Interventions

- **Self-Acceptance**
- **Forgiveness and Gratitude**
- **Insight into Action**

- Anchor positive changes in body and mind
- Recognize barriers to change (e.g. family, socially) and explore the support needed to overcome
- Identify areas of life that client would like to bring new embodied experience:
  - Set a boundary in your life outside of session
  - Feeling of confidence in public speaking
  - Communicate with spouse with an open heart

Dialectical Behavior Therapy



Dialectical Behavior Therapy (DBT, Linehan, 1993)

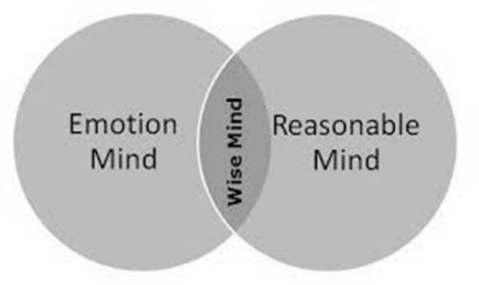
- **Zen Buddhist** philosophy, contemplative practice
- **Dialectic:** refers to a synthesis of opposites
- **Primary Dialectic**: Radical acceptance is a necessary condition for change and growth.
- **Skills**:
  - Mindfulness
  - Emotional Regulation
  - Distress Tolerance
  - Interpersonal Effectiveness

Mindfulness

- **Mindfulness:** Focus on developing a capacity to observe experience (thoughts, emotions, somatic experience) while cultivating acceptance.
- **Acceptance:** Recognize that uncomfortable experiences do not necessitate escape tactics or reactivity.
- **Wise Mind:** The optimal balance of the thinking or "reasonable mind," and the feeling or "emotional mind".

An integration of logic and intuition that can help you feel calm and centered.

Wise Mind



DBT in Practice

DBT Half Smile:

- Engage a "half-smile" to change your mental state and cultivate a serene feeling in the moment.
- Relax your face and slightly turn up your lips. As you smile, imagine your jaw softening and a relaxed feeling spreading across your face, your entire head, and down your shoulders.

Emotional Regulation

- **Emotion Regulation:** The goal is not to get rid of emotions, rather it is to reduce suffering related to ineffective reactions to emotions.
- **Feelings vs. Action Urges:** Reflect on thoughts and emotions before jumping to reactions or behaviors.

Difficult feelings are not destructive or the result of a bad attitude. These emotions are simply meant to be felt.

Distress Tolerance

Pain and distress are a basic part of life; they cannot be entirely avoided.

- **Distress Tolerance:** Handle painful emotions skillfully.
- **Skillful Action:** Distinguish between when it is important to accept reality as it is and when skillful action requires change, such as recognizing when it is important to leave an unhealthy situation.

Interpersonal Effectiveness

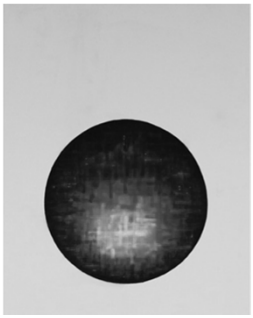
- **Assertiveness:** Help clients develop their capacity to ask for what they need and tolerate rejection. Practice asking for what they need even though they may be told no or risk feeling rejected.
- **Coping with Conflict:** Help clients learn to address conflicts with wisdom by respecting self and others and behaving fairly. Keep their side of street ”clean”.
- **Healthy Boundaries:** Help clients recognize their “yes” and “no.” Invite them to practice saying “no.”

DBT in Practice

Interpersonal Effectiveness—Challenge Common ”myths”

- **I am weak if I make a mistake**
- **I can’t make a request unless I know someone will say yes**
- **If I ask for what I need, I am pushy (bad, selfish)**
- **Saying no is selfish**
- **I automatically feel at fault if someone is angry with me**
- **It is more important to sacrifice my needs than to say no**

Complementary and Alternative Medicine (CAM)



Complementary and Alternative Medicine (CAM)

- **Integrative Healthcare**:
- **Nutrition**
- **Massage**
- **Acupuncture**
- **Trauma Sensitive Yoga**
- **Tai Chi, Qigong**

Inflammation and Mental Health

Cortisol has an inverse relationship with immunity

- **High Cortisol is associated with Stress.**
  - Over time, High Cortisol (Hypercortesolemia) leads to immuno-suppression and has an anti-inflammatory action.
- **Low Cortisol is associated with Chronic PTSD.**
  - Over time, Low Cortisol (Hypocortesolemia) leads to immuno-enhancement and has a pro-inflammatory action.

Chronic Stress/High Cortisol

- **Blood sugar elevated:** Increased risk for Type II diabetes
- **Blood pressure increased:** hyper tension and heart disease
- **Food cravings:** sweets, carbohydrates, salt, vinegar, and spices
- **Suppressed Immunity:** associated with cell growth and an increased susceptibility to cancer.

Chronic Trauma/Low Cortisol

- **Overactive digestive functioning:** IBS, GERD, and Ulcerative Colitis.
- **Interference with the Circadian Rhythm**: Poor sleep wake cycle.
- **Immunity is unchecked:** Associated with auto-immune and inflammation conditions such as Rheumatoid Arthritis, Hashimoto's Thyroiditis, Grave's Disease, Systemic Lupus , Crohn's Disease, Fibromyalgia, and Chronic Fatigue Syndrome

The Gut-Brain Axis

- **Enteric Brain:** The neurons that line the stomach and intestines that communicate with the central nervous system. Emotional wisdom.
- **Microbiome:** The microorganisms that live inside of the human gut. Imbalances are associated with depression, anxiety, panic disorders, age related cognitive decline.
- **Balance the Gut—Balance the Brain:** Stress reduction, Exercise, Vagus Nerve Stimulation, Nutritional Support (eliminate food sensitivities, increase probiotics and nutritional support).

Natural Vagus Nerve Stimulation

The Ventral Vagal Complex (social nervous system) regulates sympathetic and parasympathetic nervous system states.

- **Conscious Breathing:** Slow down the breath from 10-14 breaths per minute to 5-7 breaths per minute.
- **Humming:** Vagus nerve passes by vocal chords and inner ear. Produces calming effect.
- **Valsalva Maneuver**: Exhale against a closed airway. You can do this by keeping your mouth closed and pinching your nose while trying to breathe out which increases pressure inside of the chest cavity influencing vagal tone.
- **Connecting in Relationship**: Relax into social connection.

Self-Acceptance

- Radical self-acceptance (Brach, 2004) involves befriending the body, recognizing that not all symptoms can be changed.
- Working with chronic pain or illness: bringing focused attention and loving-kindness to symptoms

Mindfulness and Yoga

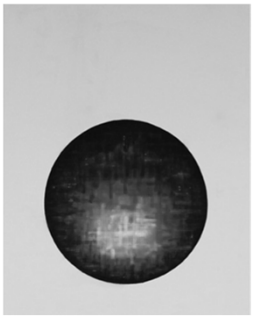
Mindfulness and trauma sensitive yoga reduce autonomic sympathetic activation, reduce blood pressure, improve neuroendocrine activity, increased heart rate variability (HRV) and decrease reported symptoms of PTSD (Emerson & West, 2015, Tyagi & Cohen, 2016; van der Kolk et al., 2014)

8 Principles of Yoga for Trauma Recovery
See Appendix D

Mind-Body Break…Gratitude in Practice

- Health benefits of maintaining gratitude journal:
  - An increase in positive moods, greater feeling of connection to others, better sleep more optimistic about the coming week, report fewer physical symptoms, and feel better about their lives when compared to a control group (Emmons, 2007).
- Even if it is difficult to find something to be thankful for, the positive results are associated with simply remembering to look for things to be grateful for (Korb, 2015).

Self-Care for Therapists



The Burnout Continuum

- Stress
- Compassion Fatigue
- Vicarious Trauma
- Secondary Trauma
- Burnout

Therapist Risk Factors of the Burnout Continuum

- Lack of support from supervisors or colleagues
- Dysfunctional or negative work environment
- Working in a position that is not fulfilling
- Lack of self-care routine
- Personal stress, loss, or grief
- Unresolved personal trauma or attachment injury
- Working in an open, engaged, empathic, dedicated, and responsible manner

Signs and Symptoms of the Burnout Continuum

- Avoiding work
- Avoiding friends, family, and social gatherings
- Use of sugar, food, alcohol, or other substances to cope with stress
- Difficulty focusing on clients
- Feeling cynical about the work
- Blaming or resenting clients for not improving
- Feeling exhausted often
- Feeling sad, anxious, or helpless about work
- Physical symptoms such as headaches or changes in sleep patterns

The best way to address the burnout continuum is through a firm commitment to basic self-care.

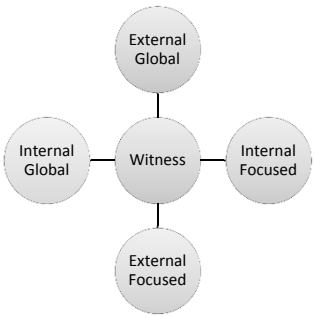
Letting Go of a Client after a Session

- I let go and release anything that doesn't serve me.
- I have given enough support for today.
- I trust that [client's name] can handle their own thoughts, feelings, and sensations.
- I respectfully return to [client's name] anything that I am holding consciously or unconsciously that belongs to them.

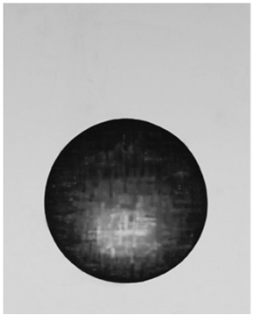
Embodied Self-Care Activities for During a Session

- Take several deep breaths
- Engage personal body awareness
- Engage personal meaning making/spiritual awareness
- Imagine allies in room to nurture or protect you
- Uncouple mirroring body language
- Place your hands over belly or heart
- Engage personal containment practice if triggered
- Engage Loving Kindness to Self first then to client
- Focus on grounding self with senses or into legs and feet
- Oscillation of Attention Practice

Mind-Body Break: Oscillation of Attention Practice (Caldwell, 1997)



Integration, Resilience, and Post Traumatic Growth



Integration and Grief work

- **Stages of Grief:**
  - **Denial**
  - **Anger**
  - **Bargaining**
  - **Depression**
  - **Acceptance**
  - **Resilience**

Acceptance, Serenity, and Forgiveness

Accepting circumstances that cannot be changed helps you focus on circumstances that you do have control over and can change.

Forgiveness is an act of letting go of your own negative feelings, whether or not the other person deserves it. Never a forced process…it is a choice.

Integration of New Sense of Self

- Positive change is still change.
- Clients with long-term traumatic symptoms often have lives that reflect this disabling condition.
- "I know myself as sick…who will I be now?"
- Attend to Secondary Gain and Secondary Losses
- "Will I be…(cared for, loved, supported) if I am no longer sick"?

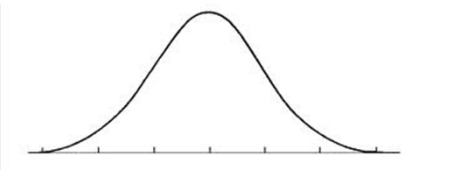
The final phases of treatment help clients work through any potential barriers to integration of a new or emerging sense of self into the world. (Schwartz & Maiberger, 2018)

Resilience In Therapy

- **Strength Based**: What is already working?
- **Resilience:** Resilience is adapting well in the face of adversity. Psychological and Physiological capacity to flexibility respond to difficult events.
- **Post Traumatic Growth:** Improved self-perception, enhanced relationships, and a strengthened life philosophy that occur after a traumatic event.

Trauma Recovery and the Bell Curve

PTSD | Resilience | PTG



(Martin Seligman, Positive Psychology)

Questions of Resiliency

- Why do some people respond better to traumatic experiences than others?
- What coping strategies and behaviors are associated with the greatest **adaptation** to traumatic life events?
- What are the most effective means of integrating these strategies into our lives?

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts, and actions that can be learned and practiced.

Factors of Resilience

- **Challenge**: Believing that growth and wisdom are gained from difficult or challenging experiences.
- **Control**: Rather than lapse into passivity and powerlessness; the belief that with effort you can influence the course of events in your life
- **Commitment:** The ability to stay involved; staying engaged in ongoing events rather than isolating.

(Salvidore Maddi, The Hardiness Institute)

Resilience is both a Process and an Outcome

- **Being resilient does not mean that we don't experience difficulty.**
- **The path to resilience involves the capacity to respond effectively to difficult experiences.**

Resilience as a Process

- **Work through vulnerable emotions**
- **Challenge negative thought beliefs**
- **Explore meaning making**
- **Transform Learned Helplessness into Learned Optimism**

Resilience as an Outcome

Greater sense of Choice in the Here and Now

Increased freedom

We are no longer defined by the past

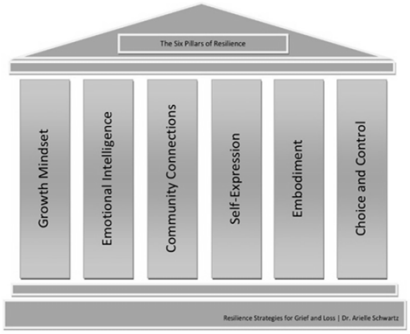
Capacity to live in the world as it is

The outcome of Resilience is that we can say, "This happened to me, and it is over now."

Factors of PTG

- Enhanced interpersonal relationships
- Increased willingness to ask for and accept help
- Increased willingness to be vulnerable
- Increased recognition of social supports that had previously been ignored.
- Increased appreciation of life
- Increased ability to "take it easy"
- Newly found interests or passions
- Spiritual discoveries

6 Pillars of Resilience



Growth Mindset:

- Explore how difficult life events have strengthened you. How have you grown as a result of your struggles in life?

Emotional Intelligence:

- Expressing vulnerable or painful emotions allows greater access to acceptance, compassion, and joy.
- Talk about it and write about it.

Community Connections:

- Good relationships with close family members, friends, or others.
- Seek out and actively build your social circle.
- Stay involved (make the phone calls, reach out, go to social events and meetings)

Self Expression:

- Paint, dance, write a poem, make music, listen to music.
- Don't worry that it looks or sounds good for anyone else; It is the process not the product that is important.

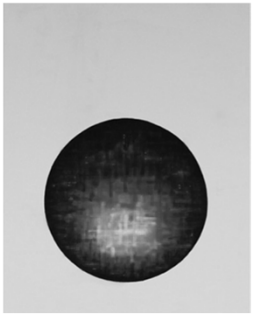
Embodiment:

- Engage in activities that you enjoy.
- Take care of your body.
- Get back to basics: Exercise, Eat well, Relaxation, Sleep well

Choice and Control:

- Remain involved and engaged in life. Develop realistic goals and ask yourself what steps you can accomplish each day that help move you towards achievement of your goals.

The Weekend in Review
See Appendix B and C



3 Stages of Treatment
(See Appendix)

- **Stage I**: Establish stability and safety
- **Stage II**: Process traumatic material ina well-paced, regulated manner
- **Stage III**: Re-Integration of new experiences into identity and relationships

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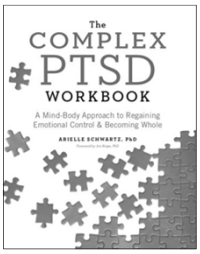
Trainings & Presentations

Consultation & Supervision

Psychotherapy

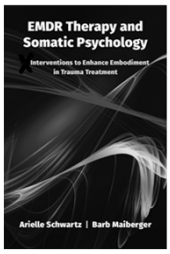


Stay In Touch…

Sign up for Blog

LinkedIn

facebook



Appendix A

Assessing your ACE Score and your Resilience Factors

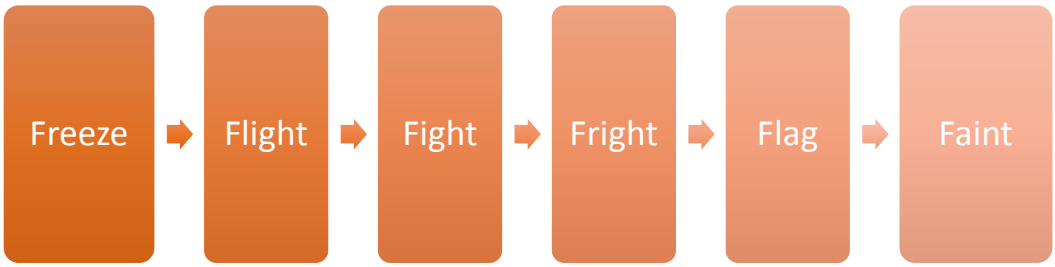
Adverse Childhood Experiences
(ACE Study, Felitti et al., 1998)

1. Physical Abuse
2. Verbal Abuse
3. Sexual Abuse
4. Emotional Neglect
5. Physical Neglect
6. Domestic Violence in which mother was treated violently
7. Household member abused substances
8. Household member was mentally ill
9. Household members was imprisoned
10. Parents were divorced

Resilience Factors
(Adapted from Acestoohigh.com)

1. Belief that mother loved you as a child
2. Belief that father loved you as a child
3. Having other relatives or caregivers who cared for you as an infant
4. Having neighbors, friends' parents, teachers, coaches, or ministers who liked you and helped you
5. Having someone who cared for how you did in school
6. Having clear rules in your house that you could follow
7. Having someone you trusted to talk to when needed
8. Having people who saw you as capable
9. Being independent and a go-getter
10. Believing that life is what you make of it

Appendix B
6 Stages of Trauma Response
(Schauer & Elbert, 2010)



1. **Freeze:**
   - Sympathetic Nervous System activation
   - Engages orienting reflex

2. **Flight:**
   - Sympathetic Nervous System dominant
   - Engages a mobilization response toward escape

3. **Fight:**
   - Sympathetic Nervous System dominant
   - Engages a mobilization response of self-defense and protection

4. **Fright:**
   - Dual autonomic activation with abrupt alternations of sympathetic and parasympathetic (DVC) Nervous System States.
   - Feelings of panic, dizziness, nausea

5. **Flag:**
   - Parasympathetic nervous system (DVC) dominant
   - Blood pressure drops, loss of speech & vision, numbness
   - Somatic response of collapse
   - Feelings of powerlessness and helplessness

6. **Faint:**
   - Parasympathetic nervous system (DVC) dominant
   - Vasovagal syncope—loss of bowel control, nausea, vomiting, and fainting
   - Can occur after either experiencing or witnessing horrific events.

Appendix C
Trauma History Assessment Tools

List of Developmental Trauma Events
(adapted from Schwartz & Maiberger, 2018)

- Result of unwanted pregnancy
- Mother was abused
- Drug or alcohol use in home
- Lack of medical care in childhood
- Mother had post-partum depression
- Extended separation after birth
- Adoption related concerns
- Rejected by mother or father
- Medical complications during/after birth
- Neglect as an infant or child
- Abused as infant or child
- Parent with PTSD, overprotective
- Narcissistic Parent, need to perform
- Lack of nurturing, deficient resources
- Competition among siblings
- Not understood in the family
- Chronic power struggles in family
- Lack of emotional safety in family
- Lack of boundaries, cannot differentiate
- Chronically discounted or shamed

Early Childhood Development Questions
(adapted from Schwartz & Maiberger, 2018)

- How would you describe your childhood?
- Who was in your family and who took care of you?
- What do you know of your mother's pregnancy?
- Do you know if you were wanted?
- What were the stories told to you about your childhood?
- How would you describe your mother?
- How would you describe your father?
- Did you have any other significant caregivers?
- How were your emotions (anger, fear, sadness, joy) responded to by family members?
- How did family members express their emotions?
- Did you have any mentors or community members who were invested in your wellbeing?

Trauma History Questions
(Adapted from THQ, Hooper et al., 2011)

- Have you been the victim of a crime or robbery?
- Have you been in a serious accident?
- Have you been in a natural disaster in which you or a loved one were in danger?
- Have you experienced a life threatening illness?
- Have you ever been seriously injured?
- Have you ever been in a situation where you feared you would be seriously injured or killed?
- Have you seen someone else be injured or killed?
- Have you ever engaged in combat during military service?
- Have you had forced or unwanted sexual experiences?
- Have you ever been held against your will where you were unable to escape?

Dissociative Symptoms Questions
(Adapted from DES-B, Dalenberg & Carlson, 2010)

- Do you sometimes find yourself staring into space and thinking of nothing?
- Do people, objects, or the world around you sometimes feel strange or unreal?
- Do you sometimes discover things you've done without remembering doing them?
- Do you ever feel as though you are looking at the world through a fog so that people or things seem far away or unclear?
- Do you ever feel like you act differently from one situation to another that it is almost like you are two different people?

Pain and Illness History Questions
(adapted from Schwartz & Maiberger, 2018)

- Do you have any current or historical medical diagnoses?
- Do you have any physical injuries?
- Do you experience symptoms of pain or illness?
- Is your pain under control with treatment?
- Do you currently take any medications?
- How do you feel about your body?
- Do you have a history of any invasive medical procedures?
- Have you experienced any damaging medical treatment?
- Do you experience barriers to accessing medical care?
- What do you know about family health history?
- Were your medical needs attended to as a child?
- What models of self-care did you have in your family?

Social and Cultural History Questions
(adapted from Schwartz & Maiberger, 2018)

- How do you identify yourself socially or culturally?
- What aspects of your culture are most important to you?
- Are there any aspects of your culture that you dislike or hide?
- Have you ever felt discriminated against, harassed, or bullied?
- Have you or members of your family experienced traumatic events related to social or cultural identity such as war, displacement, refugee experiences, fear of deportation, or discriminatory events?

Negative and Positive Beliefs Linked to Developmental Trauma
(adapted from Schwartz & Maiberger, 2018)

Negative Beliefs	Positive Beliefs
I am not lovable	I am lovable
I am not important	I am important
I am unworthy	I am worthy
I do not deserve to exist	I deserve to exist
I don't belong	I belong
I am helpless or powerless	I can take care of myself now
I cannot trust anyone	I can choose whom to trust
I cannot protect myself	I can protect myself now
I am alone (lonely)	I can connect to others now

Appendix D:
The 8 Principles of Therapeutic Yoga

Safety	• Emphasis on inner experience vs. outer shape • No mirrors • A language of invitations vs. directives
Choice and Control	• A practice in making choices • Choice is empowerment • Exploration of body, breath, and movement
Intention for practice	• Intention is the container for practice (has fluidity and can change) • Focus on mindset and emotional tone • Sankalpa: A tool to harness will by uniting heart and mind
Community	• Trauma needs to be healed interpersonally • Repair wounds of feeling exiled or not belonging
Nervous System Flexibility	• Increase tolerance of sympathetic and parasympathetic actions. • Balance of effort and ease • Know thyself: up-regulation and down-regulation tool
Cultivate Equanimity	• Connect to Senses • Grounding anchors mind in somatic awareness • Move from thinking to feeling • Build dual awareness strategies
Awaken Instinct and Intuition	• Posture is a secure base for intuitive movement • Sensations are the guide • Allow for Sequencing frozen or truncated movements out endpoints
Transformation and Awakening	• Practice in the transitional space between who you have always been and the person you are becoming • Yoga and the edge • Practice tools that help you embrace change

Appendix E:
3 Stages of Treatment

Stage 1: Stability and Safety

- **Assess Developmental and Trauma History:**
  - Identify Adverse Childhood Experiences (See list of ACES)
  - Assess attachment history and strategies (See List of Developmental Trauma Events and Early Childhood Development Questions)
  - Identify trauma history (Trauma History Questions, Pain and Illness History Questions Social, and Cultural History Questions)
  - Identify existing resources (See list of Resilience Factors)

- **Diagnostic clarification:**
  - Acute trauma
  - Single incident PTSD
  - Chronic trauma (ongoing)
  - Complex PTSD
  - Dissociation or DID (See Dissociative Symptoms Questions)

- **Establish Therapeutic Relationship:**
  - Build rapport
  - Attunement
  - Work with Transference and Countertransference
  - Rupture and Repair
  - Attend to re-enactments with compassion

- **Develop Client Resources:**
  - Mindfulness skills
  - Self-Regulation
  - Acceptance and Compassion practices
  - Imaginal resources (Safe place, allies, Containment)
  - Somatic Resources (Grounding, Conscious Breathing)
  - Increase Affect and Sensation Tolerance
  - Interpersonal Skills

- **Identify Parts and Personality Structure**:
  - Parts work (Ego States, Internal Family Systems, Structural Dissociation)
  - Identify the function of a part
  - Identify the need of a part
  - Working with Shame

Stage 2: Trauma Processing

- **Integrative Approach to Processing Traumatic Event(s):**
  - EMDR Therapy (Assessment of Target, Bilateral Process, Dual Awareness State)
  - Somatic Psychology (Titration, Pendulation, Sequencing, Somatic Re-patterning)

- **Complex PTSD:**
  - Focus on trauma "themes" rather than specific traumatic events
  - Work through preverbal and nonverbal trauma in a safe manner
  - Identify chronic negative beliefs about self. (See List of Negative and Positive Beliefs Linked to Developmental Trauma)

- **Regulation Based:**
  - Prevent flooding from interoceptive experience (affect and arousal)
  - Stay in window of tolerance.

- **Engage "Dual Awareness"**
  - Attention to memories related to traumatic event(s) and alternately(simultaneously) attending to present-moment experiences of safety by identifying a resource in the internal or external environment.

Stage 3: Re-Integration

- **Assimilate positive changes into self-identity**
- **Working through Grief:**
  - Grieving loss (Attending to resentment and regret).
  - Working toward acceptance of life as it is.

- **Work through secondary gains:**
  - Attend to the positive advantages that accompany symptoms and interfere with recovery.
  - Recognize and legitimize underlying losses.

- **Resilience and Post Traumatic Growth:**
  - 6 Pillars of resilience

Appendix F:
Lists of Mind-Body Practices

List of Mind-Body Practices for Clients with C-PTSD

- 5 point Check-In…Respond and Regulate (CAM)
- Conscious Breathing for Self-Regulation (CAM)
- Containment (EMDR Therapy)
- Practices for working with Shame (Parts Work)
- Self-Compassion Practice (Parts Work)
- Imaginal Allies—Protectors, Nurturers, Wise Figure (Parts Work and EMDR Therapy)
- Identify Negative beliefs—Replace with Positive (CBT)
- Safe Place Resource (EMDR Therapy)
- Pendulation between disturbance and resource (EMDR and Somatic Psychology)
- Grounding (Somatic Psychology)
- Dual Attention and Bilateral Stimulation (EMDR)
- Titration, Sequencing, and Somatic Re-Patterning (Somatic Psychology)
- Mindfulness (CAM and DBT)
- Half-Smile (DBT)
- Challenge Interpersonal Effectiveness Myths (DBT)
- Vagus Nerve Stimulation Exercises (CAM)
- Self-Acceptance (CAM)
- Yoga for Trauma Recovery (CAM)
- Gratitude Practice (CAM)

List of Self-Care Practices for Therapists

- Self-Knowledge: Personal ACEs, Resilience Factors, and Attachment Strategies
- Move and Breathe—Respond and Regulate
- Containment (of countertransference)
- Self-Compassion Practice
- Grounding
- Embodied Self Care during a Session
    - Take several deep breaths
    - Engage personal body awareness
    - Engage personal meaning making/spiritual awareness
    - Imagine allies in room to nurture or protect you
    - Uncouple mirroring body language
    - Place your hands over belly or heart
    - Engage personal containment practice if triggered
    - Engage Loving Kindness to Self first then to client
    - Focus on grounding self with senses or into legs and feet
    - Oscillation of Attention Practice
- Letting Go of a Client after a Session

Appendix G:
Complex PTSD References

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