Anna B. Baranowsky
J. Eric Gentry

Trauma Practice

A Cognitive Behavioral Somatic Therapy

4th edition

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Trauma Practice

About the Authors

Anna B. Baranowsky, PhD, CPsych, is a registered clinical psychologist and the founder and director of Traumatology Institute (Canada). She was instrumental in developing training materials for the Traumatology Institute Training Curriculum (TITC). She is the developer of www.psychink.com, the e-learning site for TITC; the Trauma Recovery Program – self-guided online trauma informed care (http://www.whatisptsd.com/trauma-care-online); the 30-day video stabilization program (http://www.whatisptsd.com/find-calm/); and the WhatIs PTSD YouTube channel, filled with tips and tools for trauma recovery (https://youtube.com/whatisptsd). She is the clinical director of Bear Psychology in Toronto, Ontario Canada (https://annabaranowsky.com) with her talented team of clinicians and a remarkable and dedicated administrative team.

Dr. Baranowsky received her doctorate in clinical psychology from the University of Ottawa, Canada. Her accomplishments include the co-development of the Accelerated Recovery Program (ARP) for Compassion Fatigue, national and international presentations on the ARP, trauma assessment, treatment, and interventions. She has published in the area of posttraumatic stress disorder, secondary traumatization, compassion fatigue, the ARP, and therapeutic relationships (the silencing response). Dr. Baranowsky served on the Board of Directors of the Academy of Traumatology's Commission on Certification and Accreditation. She has been recognized by the American Academy of Experts in Traumatic Stress with Diplomate status and is a board-certified expert in traumatic stress.

Dr. Baranowsky dedicates a large portion of her clinical practice on the emotional well-being of trauma survivors. She has been trained in many cutting-edge trauma treatments now being recognized as highly effective in resolving the emotional aftermath of exposure to trauma and works with a wide range of trauma survivors, from airplane crash survivors to victims of violence as well as first responders at trauma scenes. Her dedication to the emotional recovery of survivors is demonstrated by her passion for training and supervising professionals working on skills development in the field of trauma informed care. For information contact: office@annabaranowsky.com

The Trauma Practice for Healthy Communities is a charitable organization that she launched in 2017. Since that time TPHC has provided thousands of direct client service hours using a trauma informed care model for those in need. This has been particularly crucial during the COVID-19 Pandemic in 2020–2021 where services have been provided virtually for those isolated, while struggling with post-traumatic stress. For details visit: https://traumapractice.org

J. Eric Gentry, PhD, LMHC, is an internationally recognized leader in the study and treatment of traumatic stress and compassion fatigue. His PhD is from Florida State University where he studied with Professor Charles Figley – a pioneer of these two fields. In 1997, he co-developed the Accelerated Recovery Program (ARP) for Compassion Fatigue – the world's only evidence-based treatment protocol for compassion fatigue. In 1998, he introduced the Certified Compassion Fatigue Specialist Training and Compassion Fatigue Prevention & Resiliency Training. These two trainings have demonstrated treatment effectiveness for the symptoms of compassion fatigue, and he published these effects in several journals. He has trained over 100,000 health professionals over the past 25 years.

Dr. Gentry was original faculty, curriculum designer, and Associate Director of the Traumatology Institute at Florida State University. In 2001, he became the co-director and moved this institute to the University of South Florida where it became the International Traumatology Institute. In 2010, he began the International Association of Trauma Professionals. He is currently the co-owner and vice president of the Arizona Trauma Institute/Trauma Institute International.

Forward-Facing® Trauma Therapy: Healing the Moral Wound, a landmark text for re-imaging trauma treatment, was published in 2016. *Forward-Facing® Professional Resilience* detailing the evidence-based practices for developing resilience and professional well-being was published in 2020. *Forward-Facing® Freedom: Healing the Past, Transforming the Present and a Future on Purpose* is the book that will introduce Forward-Facing® practices to the lay public was published in 2021. In 2005, Hogrefe and Huber published *Trauma Practice: Tools for Stabilization and Recovery* – a critically acclaimed text on the treatment of traumatic stress for which Dr. Gentry is a co-author. The Second Edition was released in 2010 and the Third Edition in 2015. *Professional Resilience: Helping Doesn't Have to Hurt*, a compassion workbook for the Professional Resilience and Optimization Workshop was published in 2017. *Transformative Care: A Trauma-Focused Approach to Caregiving* was published in 2018. He is the author of numerous chapters, papers, and peer-reviewed journal articles in the areas of traumatic stress and compassion fatigue. In 2021, He co-authored *Trauma Competency for the 21st Century: A Salutogenic Approach*. In 2022, Dr. Gentry co-authored *Forward-Facing for Educators: A Journey to Professional Resilience and Compassion Restoration* and published the Second Edition of *Forward-Facing Trauma Therapy: Healing the Moral Wound*.

Dr. Gentry is owner of Compassion Unlimited, LLC – a private coaching, training, and consulting practice – that he began in Tampa., FL in 2004 and is now in Phoenix, AZ.

In 2020, Dr. Gentry incorporated the Forward-Facing Institute, LLC. This institute provides training, consultation, and credentialing in all things Forward-Facing.

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Library of Congress of Congress Cataloging in Publication information for the print version of this book is available via the Library of Congress Marc Database under the Library of Congress Control Number 2022949918

Library and Archives Canada Cataloguing in Publication
Title: Trauma practice : a cognitive behavioral somatic therapy / Anna B. Baranowsky, PhD, CPsych, J. Eric Gentry, PhD, LMHC.
Names: Baranowsky, Anna B., author. | Gentry, J. Eric, author.
Description: 4th edition. | Includes bibliographical references and index.
Identifiers: Canadiana (print) 20220470391 | Canadiana (ebook) 20220470456 | ISBN 9780889375925 (softcover) | ISBN 9781616765927 (PDF) | ISBN 9781613345924 (EPUB)
Subjects: LCSH: Post-traumatic stress disorder—Treatment. | LCSH: Psychic trauma—Treatment.
Classification: LCC RC552.P67 B37 2023 | DDC 616.85/2106—dc23

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PUBLISHING OFFICES

USA: Hogrefe Publishing Corporation, 44 Merrimac Street, Suite 207, Newburyport, MA 01950
Phone (978) 255 3700; E-mail customersupport@hogrefe.com

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UK: Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave.,
Milton Park, Abingdon, OX14 4SB
Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk

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Phone +49 551 99950 0, Fax +49 551 99950 111; E-mail publishing@hogrefe.com

OTHER OFFICES

CANADA: Hogrefe Publishing Corporation, 82 Laird Drive, East York, Ontario M4G 3V1

SWITZERLAND: Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern

Format: PDF

ISBN 978-0-88937-592-5 (print) • ISBN 978-1-61676-592-7 (PDF) • ISBN 978-1-61334-592-4 (EPUB)
http://doi.org/10.1027/00592-000

Foreword

This book, *Trauma Practice: A Cognitive Behavioral Somatic Therapy (CBST)*, represents a new generation of resources for traumatologists – those who study or treat the traumatized. A good indication of this comes in the first few chapters of background and history, because by now the assessment and treatment of the traumatized are far from novel.

Today we know that traumatic stress treatments work. We know that learning how to attend gently to our inner fear response with acceptance and compassion combined with exposure to the conditioned (fear) stimulus are critical elements to resolution of traumatic stress symptoms or active ingredients. We also know that a person's ability to tolerate exposure to what they fear varies greatly and that it is counterproductive, if not a breach of professional standards of practice, to not offer gentle ways for individuals to reach a therapeutic threshold for such exposure.

We know today that iatrogenic effects of trauma therapy are real and that practitioners must be extraordinarily cautious when interviewing a patient, developing a treatment plan, and ensuring that there is sufficient safety as well as retraumatization containment strategies. Remission is expected and, therefore, relapse prevention training is a requirement.

We also know that the individual presentation and assessment of traumatized persons is not an exact science. Extraordinary events that would traumatize most people have little effect on some. Conversely, exposure to rather noxious stimuli can cause extraordinary traumatic stress reactions for others. Children tend to appear rather hardy springing back with less apparent negative effects. Their parents, on the other hand, have lingering symptoms. Although women present as more symptomatic, a desire to be seen as emotionally and psychologically well may be a more significant motivator in male than female patients. However, war-related PTSD is actually less frequently seen in women than men. This may be a factor related to women harnessing social support within a community setting during times of strain.

Clients with PTSD can pose unique clinical challenges to the practitioner. Most PTSD patients, for example, are dual diagnosed. It is rare to find clients with PTSD who do *not* have at least one additional diagnosis (i.e., panic disorder, somatic symptom disorder, depression, borderline personality disorder, addiction, etc). It is also important to recognize that a common comorbidity exists with addictions (drug dependency) and PTSD.

This important book both addresses what we know today at a theoretical level and, equally importantly, explains clinical methods in the context of treatment. More than the typical book about why and how the cognitive behavioral treatment approaches work, Baranowsky and Gentry offer a comprehensive guide for clinicians working with the traumatized. This book presents clear instructions to traumatologists – even the most experienced in working with the traumatized – to help the traumatized. The guidance is detailed. The authors direct practitioners to focus on symptoms of the body as well as on behavior and emotions associated with trauma. They also link their guidance to a tri-phasic treatment model that starts with establishing Safety, continues with Working through Trauma, and ends with Reconnection. This book is also an excellent resource for trainers, teachers, and educators of trauma practitioners, providing a how-to manual to address the challenges of clinical traumatology.

These authors represent the current and future generation of clinical traumatologists who are well-equipped to handle the extraordinary challenges of traumatized clients. We have come a long way in nearly thirty years, as illustrated by this useful book.

Charles R. Figley, PhD
Florida State University Traumatology Institute
Tallahassee, November 2022

Acknowledgments

Anna B. Baranowsky – To my beloved parents who taught me love and life exist even after terrible losses. To my dear husband Chris, my compassionate warrior and companion in all life's joys. For Cassie, Jasper and Sukhi, who have enriched my every waking day. To Gold and the Golds, who are special in my heart; to Zahava, who showed me that love, strength, and intelligence live harmoniously together; to my dear Maj buddies; my incredibly talented team (Tamara, Betty Ann, Usha, Sandy, the BPPC, Ya'ara, and Jaime of the Trauma Practice Team). I am deeply fortunate to have found myself surrounded by incredible people. Without them I would be unable to dedicate my life to this work. In appreciation of Dr. Michael McCarrey, my ally and supervisor (University of Ottawa). To Marlene Mawhinney and B. K. S Iyengar, my yoga teachers of over 30 years, whose work has brought me the harmony and resiliency, which has enabled me to follow the call to trauma work.

I am grateful to Dr. Charles Figley for laying fertile ground at just the perfect time. To my friend and inspiration, Eric, who willingly joins me in challenging dialog and laughter. Mostly, to my clients, students, trainers, and friends over the years who have taught me more than they could imagine and helped me stay humble and continue to learn and grow... I am grateful.

J. Eric Gentry – Thanks go to the mentors in my life in order of their appearance: Charles "Charlie" Yeargan, PhD; Louis Tinnin, MD; Charles Figley, PhD; and Joseph Moore. Gratitude to N. A. and H. P. for keeping me alive long enough to write this work. Thanks to my support, in no particular order: Marjie, Jeffrey "Jim" Dietz, MD, Mike Dubi Mom, Bubbita, Augie, Rick O., Helen MaryJoan, PDR, Mason, Rosalina, TZap, Jennifer, Connor, Frank, Jim "Big Bro" Norman, Carlos & family, Eduardo & Maria, Jim Hussey, Joe Williams, Nacho & Lucy, ITI Site Directors, Sheryl Hakala, MD, Mason Hines & family, and my family. A special mention of gratitude for the creative and supportive relationship that I share with Anna – you are the BEST! I dedicate this text to all my clients and trainees – past, present, and future.

Dedication

This text is dedicated to unsung heroes, the caregivers who maintain the courage and the stamina to bear witness to the stories and selves of trauma survivors, making healing a reality.

See first that you yourself deserve to be a giver,
and an instrument of giving.
For in truth it is life that gives unto life –
while you, who deem yourself a giver,
are but a witness.

Khalil Gibran

Contents

Introduction to Trauma Practice: A Cognitive Behavioral Somatic Therapy

If you are perfect you don't need to learn anything
and if you don't need to learn anything, you wouldn't need to be a teacher.

Stuart Wilde, *The Secrets of Life (1990)*

The surprising act of arriving at 2023

After living through the unprecidented events of the COVID-19 pandemic, revelations of an encouraged white supremist mob, and the real cruelty to brown and black lives, my sense about the importance of human kindness, courage, and trauma-informed care has been reinforced. I could never imagine all of the complex layers of the last three years unfolding, but what I am aware of is the ongoing need for the use of the right tools, the ones that guide those in need toward their own growth and healing. After all, when you and I heal we are less likely to react from a place of fear and rigidity and more from a place of wisdom and kindness. At least that is what I have witnessed over the past 20 years of helping trauma survivors.

Since the last edition of *Trauma Practice* there has been awareness of post-trauma care. The public has become more educated on the need for specialized trauma-informed care and that clinicians need precise training in order to attend to trauma impact. It has been more than seven years since the authors collaborated together on *Trauma Practice*, yet independently we seem to have arrived at a similar place in terms of the meaning of our work, the new refinements in our field, and our sense of how to move the trauma practice approach forward. Although there are some differences in the use of language, the overall approach appreciates the need to face the ever-present moment and use it as the gift for growth while down-regulating the body to stay present and extinguish the past.

This is no regular revised edition but rather our 20-year anniversary edition! We are excited, grateful and humbled to announce our 21st year of offering *Trauma Practice* to you, our readers. We published the first edition of *Trauma Practice: Tools for Stabilization and Recovery* in 2001. Over twenty years later, this is our fourth publication of this book. We have heard from hundreds of you, kind folks, providing feedback about how much this book has assisted you in helping trauma survivors to recover from their painful history and begin to live lives of choice instead of continuing to live in fear and self-defense. It has been joyful for us to contribute to your growth as clinicians and to our field's growth in treating trauma survivors using gentler, more effective and accelerated methods of healing. We have matured along with you and we are excited to share our combined 60 years of experience with you in this, our 4th edition.

Since the publication of the previous edition of *Trauma Practice*, much has changed in the field of trauma treatment. The organic emergence of complex posttraumatic stress disorder (C-PTSD) as something distinctly different from PTSD, and the demand for more sophisticated clinicians and treatment strategies for these clients has been a powerful catalyst for the evolution of our field. The discovery that traditional evidence-based treatments, driven by narrative exposure and cognitive processing, were not sufficiently effective for clients with C-PTSD (and in some cases exacerbated symptoms) has led to an awakening among clinicians working with this population. Teaching somatic (in previous texts simply referred to as body) self-regulatory skills – which we have advocated in each previous edition of this book – has become a primary focus of early treatment when working with C–PTSD. As

our clients develop competency with these skills of self-regulation and threat response interruption, we can then coach them to take these skills into their personal and professional lives to confront the plethora of perceived and real threats they encounter each day.

We have re-discovered the use of in vivo and imaginal exposure (Wolpe knew this in the 1950s) as a powerful mechanism for activating reciprocal inhibition that desensitizes and, ultimately, extinguishes intrusion and arousal caused by the trauma exposure (Criterion A in the DSM-5), including childhood attachment trauma. For us, the power and utility of in vivo and imaginal exposure paired with intentional self-regulation has become an essential triage for the treatment of *all* traumatic stress. We have discovered that teaching self-regulation skills early in treatment and then coaching our survivor clients to begin the process of confronting situations of perceived threat (instead of engaging the instinctual self-defense of avoidance in these contexts) provide a rapid relief of symptoms while simultaneously significantly augmenting well-being, a sense of accomplishment, and improved quality of life.

Thankfully, there has been an increased emphasis on addressing the somatic effects of trauma. For many, this somatic posttrauma impact metastasizes into instinctual procedural or "muscle" memory patterns of self-defense employed in situations where there is little or no danger (only perceived threat). In order to properly update this version of *Trauma Practice* we have begun to reference our approach as *Trauma Practice: A Cognitive Behavioral Somatic Therapy* (or CBST). In previous editions, where we have labeled the somatic response and related interventions as "body" interventions, in this edition we are now identifying them as "somatic-based" interventions. So, for this edition, interventions will include: cognitive, behavioral, somatic, and emotion-relational categories.

In addition to the emergence of C-PTSD as a catalyst for trauma treatment maturation over the past several years, there are many other phenomenon that have emerged that have also spurred us forward. The research by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente captured the original Adverse Childhood Experiences (ACE) data from 1995 to 1997. The reverberations and understandings of the ACE studies are now taking a more central role on reflections of lifetime trauma impact and posttrauma treatment. We have now witnessed that most of our clients have ACE scores above 5. This has led us to consider how much trauma contributes to the etiology of adult PTSD and other mental diseases and disorders. There are many clinicians that are discovering much of the distress experienced by our clients can be traced to an over-activation of their sympathetic nervous systems (SNS). We are also discovering that treating this over-active threat response with self-regulation is diminishing distress and enhancing quality of life with clients who have a trauma history but had actually been diagnosed with mood disorders or another psychiatric condition.

In 2017, we (along with Robert Rhoton, PsyD), published the article "Trauma Competency: An Active Ingredients Approach to Treating Posttraumatic Stress Disorder" in the *Journal of Counseling and Development*. In this article, we explored the integration of the "active ingredients/common factors" among *all* effective trauma treatment into a phased delivery that is fitted to the survivor's relational and processing style. This has been a focus of many researchers in the field of trauma treatment – looking for generic treatments that do not require adherence to treatment manuals and that are, instead, tailored to fit the individual needs of each client struggling with posttraumatic stress. In our article, we review several of the meta-analyses that have been conducted with evidence-based treatments for PTSD and have found four primary ingredients/factors embedded in each of these effective treatments. These are: (1) a good therapeutic relationship (using Miller's feedback informed treatment; Black et al., 2017; Duncan et al., 2010; Miller et al., 2015, 2020), (2) relaxation/self-regulation, (3) exposure (in vivo and imaginal), and (4) cognitive restructuring/psychoeducation. The intentional engagement and integration of these factors into a phased delivery with our clients, represents the nascent offering of a generic equivalent to evidence-based, manual-driven treatment. For sure, more research will be required before we can pronounce this delivery of the active ingredients/common factors as an evidence-based treatment, but we have found much success in our own application of these skills and principles with our clients.

The 2021 publication of *Trauma Competency for the 21st Century: A Salutogenic Active Ingredients Approach to Treatment* (Rhoton & Gentry, 2021) provides a deeper contemporary dive into these issues. In the first half of the book, the history and utilization of each of the four active ingredients/common factors is explored within current treatment models. In the second half, the salutogenic trauma treatment structure is presented as a semi-structured phased delivery for these factors. The four stages for delivery of treatment in the salutogenic trauma treatment structure are: (1) preparation and relationship-building, (2) psychoeducation and self-regulation (skills-building), (3) integration and desensitization, and (4) posttraumatic growth and resilience. *Trauma Compentency*, also

addresses clinician preparation as the first and primary intervention for trauma treatment.

Inspired by the work on *Trauma Competency*, this edition of *Trauma Practice*, has been updated and augmented to include the discussion of the active ingredients/common factors from these recent developments.

In 1997, during our early collaborative efforts, we began to develop products and protocols for compassion fatigue treatment and professional resilience (i.e., accelerated recovery program for compassion fatigue) and are consensual with the a priori importance of clinician preparation as the bedrock of effective trauma treatment. Add to this the recent development of a body of research around "deliberate practice" as a primary means for augmenting treatment outcomes (Chow et al., 2015; Rousmaniere, 2016). Our instincts were later affirmed by the current researchers, (i.e., Miller et al., 2013, 2016, 2020) who, for the past decade, have identified the potency of individual therapist's preparation and on-going development as an important predictor of positive change in clients.

Individual therapist effects account for between 5–9 times more of the outcome variable than the difference between theory and techniques (Baldwin & Imel, 2013; Firth et al., 2019; Wampold & Imel, 2015). Embracing this contemporary research, we have addressed this important factor by adding a Phase 0 (or pre-phase) to the triphasic presentation of interventions in this book. In Phase 0, we focus upon the importance of trauma-specific training – beyond that of only developing expertise in any particular evidence-based model for treatment. We advocate that trauma clinicians develop expertise in also delivering the four active ingredients *inside* the models which they use. We also argue that a crucial clinician capacity is the ability to self-regulate the sympathetic nervous system so that they are able to remain ventral vagal dominant throughout their encounter with clients. This capacity is both catalytic for positive change with our clients (i.e., produces co-regulation and secure attachment) while, simultaneously, affording us *de facto* professional resilience – you cannot get (secondarily) traumatized while remaining in a relaxed-muscle body. In addition to these benefits, self-regulation also maximizes our cognitive and motor functioning, helping to optimize our performance with each client. In Phase 0 we also discuss the importance of on-going personal and professional development, consultation, connection/support, and self-care/revitalization.

We are also excited to add to this edition an exploration of the important work of Lawrence Calhoun and Richard Tedeschi (1996) who have been quietly working away for the past 25 years on one of the most important discoveries in the field of trauma treatment – posttraumatic growth. In their 2013 book *Posttraumatic Growth in Clinical Practice,* the researchers invite the move away from treating the "disease" of PTSD or even the symptoms and, instead, advocate a coaching process of helping trauma survivors suffering from either acute stress or posttraumatic stress to acquire resilience and growth-catalyzing skills, practices, and perceptions. This evidence-based protocol has helped thousands of survivors to lessen the effects of trauma in their lives and begin to find effective living here in the present. Posttraumatic growth and Forward-Facing® trauma therapy (introduced in the previous edition of this book) are both s*alutogenic* approaches to the treatment of trauma.

The allopathic – or medical model – of treatment focuses upon the diagnosis of disease and then using prescribed treatments that have demonstrated effectiveness for a particular diagnosis. In contrast, Salutogenic approaches eschew (at least initially) the medical model treatment focus on disease and instead attempt to immediately catalyze and address the impediments to health. With trauma survivors the primary impediment to health seems to be their chronically activated threat response – *it is difficult to heal and repair while we are busy surviving our lives*. By helping trauma survivors to develop skills and practices that interrupt and then minimize the activation of their threat responses throughout the day, we have found their symptoms begin to ameliorate and their sense of comfort and well-being flourish in a relatively short amount of time. In this volume, we suggest that these salutogenic approaches may prove themselves to become increasingly useful in the treatment of trauma, especially in early treatment, as mentioned before, and as part of a generic triage process for everyone.

For many, it will be sufficient to aid individuals to acquire self-regulation skills along with the capacity to face in vivo and imaginal exposure to life stressors. This alone, can be the main step toward a personal and deep shift in self-care and the beginning a life-long process of independent healing. There will be, of course, trauma survivors whose symptoms remain recalcitrant to this self-engaged solution and will need more traditional phased trauma treatment with ongoing imaginal exposure approaches. However, even these clients with high acuity symptoms will benefit moving into this more intensive therapy with the capacity to self-regulate their own autonomic nervous systems (ANS).

This edition also brings to the forefront probably the *most* important emergence in the treatment of trauma over the past decade and that is the polyvagal theory. Although Stephen Porges has been busy developing this

work since the late 1980s, it has become increasingly central to working with traumatic stress over the past several years. The polyvagal theory provides a framework to understand the neurophysiology of traumatic stress both for the clinician and the survivor. While the research and depth of understanding is quite complex, it can be tooled into a simple understanding. Specifically, how traumatic stress and the subsequent self-defense behaviors manifest in those suffering with posttraumatic stress. This edition incorporates the use of the polyvagal theory to understand the dual-polar and biphasic nature of traumatic stress, contrasting arousal vs. shut-down. It also provides a platform for understanding the neurobiology of relationships, or as Porges states: "All relationships are a neural exercise" (Porges, 2018, April 23) Teaching clinicians both self-regulation and then co-regulation immediately augments their effectiveness and resilience.

Finally, for this edition we have updated and overhauled our references and citations to provide you with the latest and relevant clinical research for use in your practice. We are extremely grateful to our dedicated readers whose continued interest in our work have allowed us to continue to bring these materials to each of you. As such we are able to continue to carry out our mission of the past 20 years: to help those who help trauma survivors. It is a privilege for us to provide this text. In great appreciation, thank you for joining us in this work.

Anna B. Baranowsky, PhD, CPsych.
J. Eric Gentry, PhD, LMHC, DAAETS, FAAETS

Purpose of This Book

This book has been written for the trained clinician and the novice-in-training as a means of enhancing skilled application of cognitive behavioral somatic trauma therapy (CBST). The term *trauma practice* was conceptualized after many years of reflection on the trauma work and training experiences that the authors have encountered. It became clear to us that a practical approach was needed for practitioners who apply themselves in the field of trauma treatment. Recent books and current research on CBT or CBST for trauma stabilization and recovery are focused more on outcome than application and we have made it our mission to produce a practical "how-to" text. In addition, this text draws upon the development and implementation of many trauma training programs that have been ongoing since the fall of 1997 through the Traumatology Institute. We have been training students in trauma recovery within this CBST trauma therapy framework and have found both a great need for and a warm response to this very practical approach.

This book will provide both the novice and advanced trauma therapist with much of the knowledge and skills necessary to begin utilizing CBST in their treatment of trauma survivors. In addition to presenting a foundational understanding of the theoretical tenets of CBST, this book will also provide step-by-step explanations of many popular and effective techniques of CBST. Some of these techniques include: trigger list development, breath training, layering, systematic desensitization, exposure therapy, storytelling-approaches, assertiveness training, thematic map, and relaxation training. The book is packed with practical approaches that we have used with our clients for many years. In this updated edition, we have replaced some less useful approaches with interventions that have proven more effective with clients and students of the Traumatology Institute. We also include approaches inspired by current research on neuroplasticity (i.e., picture positive, corrective messages from old storylines, and hands over heart space).

The materials in this book are organized and presented from the perspective of the tri-phasic model (Herman, 1992) for the treatment of trauma. In 2000, the International Society for Traumatic Stress Studies (ISTSS) adopted Herman's tri-phasic Model as the standard of care for clinicians working with clients diagnosed with posttraumatic stress disorder (ISTSS, 2000). The expert clinician survey findings of Cloitre et al. (2011, 2012) strongly endorsed a phase-oriented approach for complex PTSD that remains patient centered with attention to prominent symptoms. This is consistent with the trauma practice approach outlined in this book.

These three phases of treatment: Phase I: Safety and Stabilization, Phase II: Working Through Trauma, and Phase III Reconnection are thoroughly explored in this edition. The three phases are the organizing structure and foundation for the trauma practice approach. Specific treatment goals and techniques are offered for each of these three phases of trauma care, making this text a "hands-on" reference and guidebook for clinicians as they navigate through the potentially difficult treatment trajectory with clients who have survived trauma.

With our contemporary look at trauma-informed care, we have already discussed the need to add a Phase 0 as a fundamental element in training trauma focused clinicians. The required prescription for training would include competence, excellence, and mastery. There is a recognition of the crucial element of capacity to self-regulate and then to co-regulate with clients and this demands that the

clinicians have inner resources for down-regulating in times of personal strain. It asks that you dedicate yourself as diligently to caring for yourself as you would for your clients.

This edition of *Trauma Practice* also includes the section introducing Forward-Facing® trauma therapy. This form of therapy is an exciting treatment process for rapidly and effectively addressing traumatic stress and all anxiety disorders that do not require accessing and processing survivor's painful trauma memories. Instead, this method teaches and coaches clients to master the regulation of their own autonomic nervous systems (ANS) as the primary focus of treatment. As clients learn and practice these skills, they find their symptoms diminishing and their quality of life maximizing. In addition to mastering self-regulation capacities, the method also assists clients in developing intentional living. The survivor defines for themselves their integrity and then the therapist, through coaching them to confront the perceived threats in their daily lives with regulated bodies, helps them to live principle-based lives with an internal locus of control. This method allows the client to experience immediate and profound treatment effects that quickly lead to an enhanced quality of life. Forward-Facing® trauma therapy also focuses upon helping the client to become more and more purposeful and intentional as they practice self-regulation. The combination of these two factors rapidly accelerates trauma treatment for many survivors.

The authors wish to make a clear statement that this book is only a guidebook and does not act as a substitute for the training and supervised practice necessary to integrate these principles and techniques into practice. The authors have presented the materials found in this book in an e-learning program available or as a two-day intensive training program through the Traumatology Institute (Canada; http://www.psychink.com) and Forward-Facing Institute, LLC (USA; www.forward-facing.com). Please see Appendix 2 for more information on these training courses. Additional trauma training is now available online at psychink.com for those individuals who do not have direct access to face-to-face training programs or the opportunity to bring institute trainers to their locations. We believe that proper training and supervision is required to safely and successfully integrate these powerful techniques into practice with trauma survivors. We offer these principles and techniques based upon the belief that the primary responsibility of the clinician is to "*above all else, do no harm*." While persons suffering with posttraumatic stress have demonstrated their strength and resiliency by having survived some of the most painful and heinous experiences known to mankind, it is possible for the well-intended but untrained therapist to engage in treatment with survivors that can actually retraumatize their clients, thus resulting in failed treatment and rendering future treatment even more difficult and painful for the survivor.

For those interested in adjunctive therapy with clients using a tri-phasic approach, visit: http://www.whatisptsd.com. Details of the Trauma Treatment Online Program and the use of adjunctive trauma care programs, systems, and online applications are available for your use with clients.

A further complication within trauma care are personality changes that establish themselves rigidly over time, which form interpersonal skills from a reactive position in the attempt to keep one out of harm's way (Cloitre et al., 2011, 2012). Trauma survivors may have developed concurrent personality disorders and resulting behaviors that may have been useful at the time of the trauma but no longer serve the individual well. Although as clinicians we may aid our clients to resolve the traumatic memories, harness improved self-care skills, and establish systems for reconnecting with meaningful community and activities, our clients may then have to tackle the personality structures or themes that no longer work for them once trauma is extinguished.

Self-of-the-Therapist

In Friedman's (1996) landmark article entitled "PTSD Diagnosis and Treatment for Mental Health Clinicians," he argues strongly that the development and maintenance of the "self-of-the-therapist" may be one of the most important aspects of treatment with traumatized individuals. We have found, in our own practices and in our training programs, that the ability to develop and maintain a nonanxious presence while working with trauma survivors is a key ingredient to successful treatment outcomes and in maximizing the resiliency of the therapist.

The article of Baldwin (2013) certainly does an excellent job of explaining the underpinnings of nervous system ignition and the brain among trauma survivors and this reinforces our belief that the clinician must be well suited or suitably prepared for exposure to those experiencing PTSD. This will prove helpful not only for the clinician but also for those working with the therapist. Trauma ignition can work both ways and if the clinician is unprepared to bear witness to the trauma content without extreme reactivity neither the client nor the therapist will benefit.

Confronting traumatic material is painful and can be debilitating for the therapist. Many of the techniques presented in this text involve, in one way or another, the confrontation and narration of traumatic experiences by the trauma survivor with support and guidance from the therapist. It is theorized that the ability of the trauma survivor to access, confront, and self-regulate while narrating traumatic experiences may be one of the active ingredients leading to the resolution of traumatic stress. Developing trauma competency is of critical importance in the emerging maturity of any trauma therapist (Gentry, Baranowsky, & Rhoton, 2017). The ability of the therapist to elicit, assist, and self-regulate while the survivor struggles through these narrations is, in our opinion, an a priori requirement for effective treatment. Indeed, we have all worked with posttraumatic clients who have "failed" in previous therapy attempts because they were unable to complete these narratives with their therapists. We believe that a courageous, optimistic, and nonanxious approach, tempered with safety and pacing, to be the key to rapid amelioration of traumatic stress symptoms.

In our training programs, we work diligently toward helping therapists develop the capacity for self-regulation and the maintenance of a nonanxious presence. Research demonstrates that high levels of anxiety can diminish cognitive and motor functioning (Baldwin, 2013; Scaer, 2001, 2014) and this diminished capacity may account for some of the symptoms associated with traumatic stress. It may also point toward some of the difficulties encountered by therapists who work with clients who suffer from traumatic stress. Compassion fatigue resiliency is the focus of the article that you can review at https://psychink.com/blog/2019/06/25/compassion-fatigue-resiliency-a-new-attitude/. Clinician stress when working with trauma survivors is a reality that we all need to reflect on and work through. We hope that you will make a commitment to your own well-being as a trauma care provider.

Core Objectives

Upon completion of this book readers will be:

- Aware of the underlying principles of cognitive behavioral and somatic trauma therapy (CBST) that are reported to lead to the resolution of posttraumatic stress symptoms
- Aware of the psychophysiology of posttraumatic stress
- Aware of how to apply CBST in accordance with the specific criteria in each of the phases in the tri-phasic model of treatment with trauma survivors
- Able to apply effective trauma stabilization and resolution interventions that best fit the unique requirements of any survivor
- Able to utilize many different CBST techniques to help trauma survivors resolve the effects of their trauma memories and posttraumatic stress symptoms
- Able to utilize CBST techniques to assist trauma survivors in developing more satisfying lifestyles in the present

Book Description

CBT is one of the most researched and most effective treatments for PTSD and we believe that all skilled traumatologists should have at least rudimentary understanding and skills in this important area of treatment. This book will focus upon the utilization of the principle of *reciprocal inhibition* (exposure + relaxation) as a core knowledge and skill that readers will acquire following a thorough reading and integration of the materials covered in this book. Nearly all of CBST is organized around this principle and we believe it can be found in most *effective* treatments of posttraumatic stress.

This book will begin with a brief outline of the history and the theoretical underpinnings of CBT. A brief discussion of possible physiological pathways to account for the identified behavioral phenomena will be included. This will be followed by an introduction to Herman's (1992) tri-phasic model for the treatment of posttraumatic stress conditions. The tri-phasic approach is recognized as the highly effective approach we have used in the trauma practice approach since we first developed it in 1999 (Cloitre et al., 2011, 2012). This is followed by a thorough exploration of *Phase I: Safety and Stabilization* in the treatment, with an opportunity to practice and learn several skills for use at this stage.

After the reader has learned the skills necessary for the essential development of safety and stabilization with their clients, the book will focus on techniques useful for the successful resolution of traumatic memories in *Phase II: Working Through Trauma*. Readers will learn several specific CBST techniques for assisting their clients with accessing, confronting, and resolving their traumatic memories. These techniques will be presented in a step-by-step process with the goal of skills development. We hope this text will provide readers with a comfort level that will allow them to begin using these interventions in their service to trauma survivors.

In *Phase III: Reconnection*, we will focus on developing skills to assist trauma survivors in further re-integration of skills developed and the resolution of the residual sequelae from their trauma history. Often, even after a survivor has successfully resolved a trauma memory, symptoms such as survivor guilt, distorted and self-critical thinking styles, relational dysfunction, addiction, or painful affect remain unresolved. This last phase of treatment is focused on helping the trauma survivor reconnect with themselves, their families, and loved ones in the present and to connect to their goals for the future. Several approaches will be presented to the reader for their use in helping their clients navigate successfully through this important phase of treatment (Baranowsky, 2000; Baranowsky & Lauer, 2013).

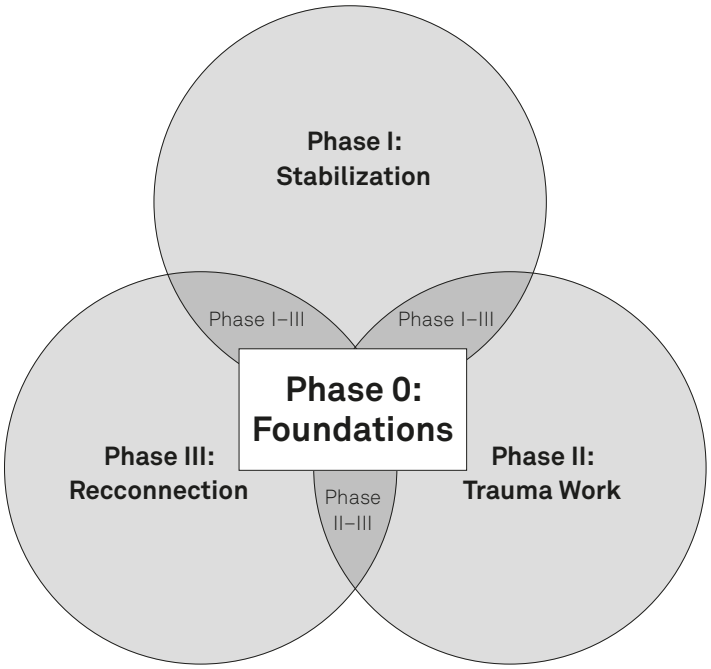
New in this edition, we provide, where possible, audio and video material demonstrating how the different techniques are carried out. These are available via the YouTube links in the text or practitioners can also download them from the publisher's webpage (see Notes on Supplementary Materials, p. 225).

With the completion of this book, the reader will have gained sufficient knowledge and skills to integrate the principles and techniques of CBST into their practice with survivors of trauma.

Phase 0:
Foundations of the Trauma Practice Model

For fast-acting relief from stress, try slowing down.

Lily Tomlin



Summary

Section 1 provides some of the current theories explaining both the cognitive and physiological underpinnings of the symptoms and successful interventions for the treatment of trauma. The symptoms that manifest from trauma are natural and normal sequelae to exposure to extraordinary events. Understanding the mechanism by which these occur will provide a much better ability to understand the variety of symptoms seen in practice. Understanding how the interventions are logically linked to the mechanism by which symptoms occur should provide a better ability to utilize the techniques presented and increase confidence in their effectiveness with clients. This understanding will help in the creation of on-the-spot interventions to also address the immediate needs of clients.

1. Emotion regulation strategies
2. Narration of trauma memories as an exposure process
3. Cognitive restructuring
4. Anxiety and stress management
5. Interpersonal skills development

The survey results provided a strong rationale for conducting research focused on the relative merits of traditional trauma therapies and sequenced multicomponent approaches applied to different population. Echoing similar sentiments, the 2017 and 2010 VA/DoD Clinical Practice Guideline (Management of Post-Traumatic Stress Working Group, 2010; Management of Post-Traumatic Stress Disorder Working Group, 2017) also pointed out exposure, cognitive restructuring, anxiety management, and psychoeducation as key components of recommended EBTs, and emphasized the importance of the therapeutic relationship in treating trauma survivors.

The efforts taken above have led to the identification of active ingredients (for effective treatment) along with a generic clinical structure for addressing posttrauma conditions that integrate the four common elements for successful trauma treatment in a phasic model (Gentry et al., 2017; Rhoton & Gentry, 2021). By utilizing the phasic structure of this model, counselors will be able to efficiently complete these four therapeutic tasks while still employing the evidence-based trauma resolution methods of their choice (see Video 1 available in the supplementary material for this book, p. 226, or Baranowsky, 2020, December 5, *Recovery Now Trauma* – audio recording https://youtu.be/DvzwJ614frM). In the same way that generic medication still produces the same outcome as a name brand, we're proposing a model that is malleable, easy to personalize to each particular client, and equipped to navigate a wide range of clinical challenges effectively.

The Four Active Ingredients

We believe health professionals who treat trauma can greatly benefit from developing understanding and skills associated with each of these active ingredients. By developing expertise in delivering these common factors of effective treatments, the clinician is rewarded with a de facto generic treatment that embraces the best of what all trauma treatments have to offer. Skilled application and delivery of these four ubiquitous components will provide the clinician with a pathway forward when the evidence-based protocols are not well-tolerated or ideal for the client. Moreover, the implementation of the active ingredients as a primary focus of treatment allows the practitioner to deliver a treatment that is tailored to the survivor's informational processing and relational style. Thus, treatment can be designed to fit the individual instead of requiring the survivor to fit themself to the treatment manual.

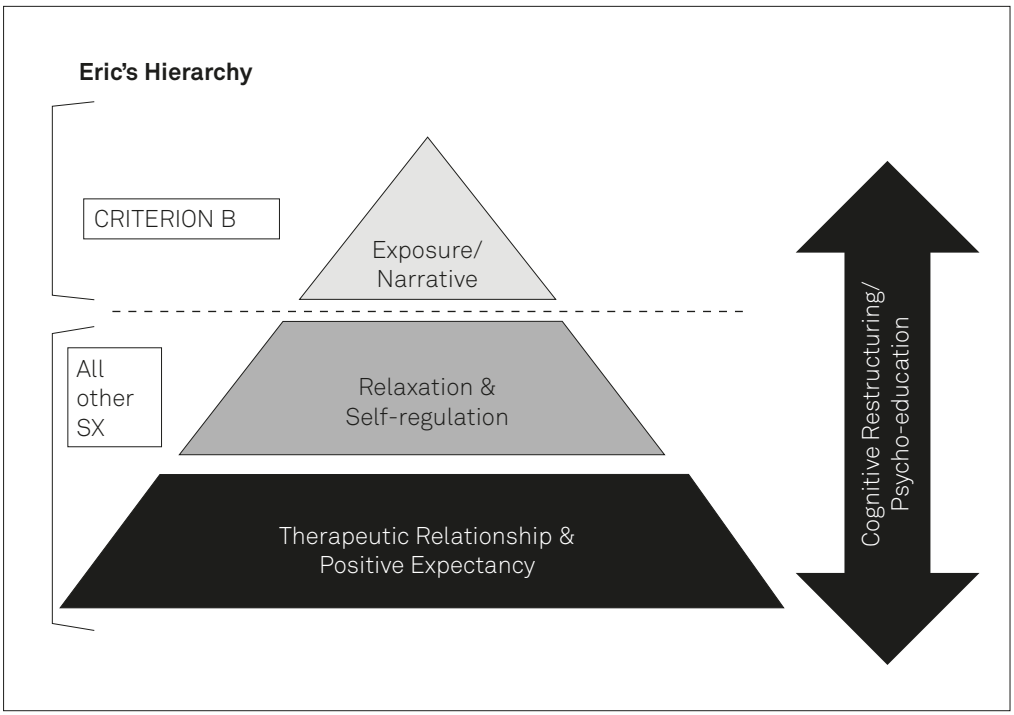


Figure 1.
The active ingredients

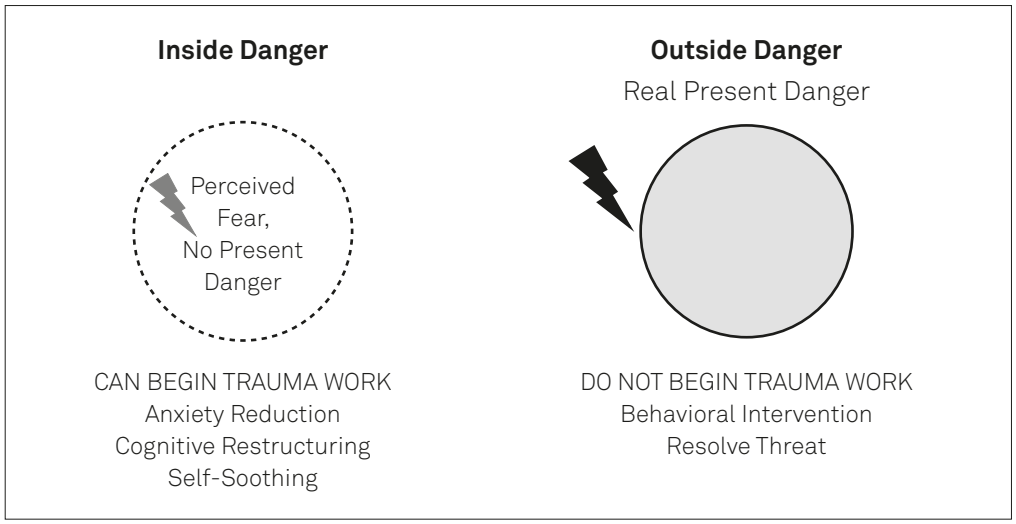


Figure 6.
Dealing with inside and outside danger.

from this danger. Inside danger, or the fear resultant from intrusive symptoms of past traumatic experiences, must be met with interventions designed to lower arousal and develop awareness and insight into the source (memory) of the fear (see Figure 6).

3. Development of a battery of self-soothing, grounding, containment, and expression strategies and *the ability to utilize them for self-rescue from intrusions.* These techniques should be taught during the early sessions prior to beginning Phase II of treatment. At a minimum, clients should be taught the following skills:

- 3-2-1 sensory grounding technique
- visualization of a "safe place"
- progressive relaxation (and/or other anxiety-reduction skills)
- development of self-soothing discipline (e.g., working out, music, art, gardening, etc.)
- containment strategy(ies)
- expression strategy(ies)

These skills are explained in detail throughout this book.

4. Ability to practice/demonstrate self-rescue. It is useful to ask the client to begin to narrate their traumatic experience(s), and when they begin to experience intensifying affect, the clinician should challenge them to implement the skills above to demonstrate the ability to self rescue from a full-blown flashback. This successful experience can then be utilized later in treatment to empower the client to extricate themselves from overwhelming traumatic memories. It is also a testament to the client now being empowered with *choice* to continue treatment and confront trauma memories. The metaphor of teaching a novice sailor the procedures of sailing mechanics prior to casting off so that they can assist with the management of the boat, instead of becoming a liability during rough seas, is a useful tool for explaining this important skill.

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

It is not necessary that the client meet all the objective criteria before moving to Phase II; however, the clinician should be able to interpret any shortcomings to ensure that there is no danger in moving ahead with treatment. Red flags or concerns about dissociative symptoms or potential regression should alert the clinician that movement forward might be premature. Warning signs may indicate that (a) the client needs more work toward the development of stabilization skills and/or (b) the client is experiencing a dissociative regression.

What follows are a variety of techniques useful for self-soothing, grounding, containment, and self-rescue. These are not the only techniques available, merely examples. Notice that they either subtly begin to incorporate the

Now it is possible to work with both the memories and the core beliefs that have been established as a result of these pivotal life experiences.

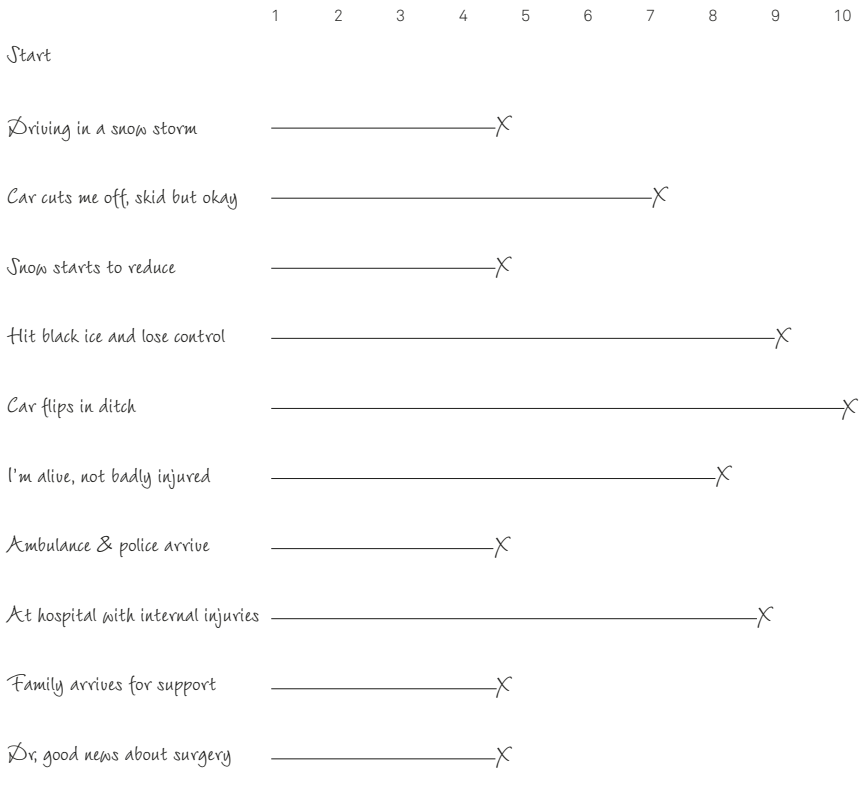
Note: This approach is similar to the time-line approach in the Phase II: *Working Through Trauma*, but is strictly used to capture the memory rather than to process at this stage.

Table 6. Trigger-List Exercise (Multiple Events) – Example

Life stage	Trigger list	SUDS
Early childhood*		
1. Age 10	Teased in school yard because of weight	8
2. Age 12	Three young males, corner me and molest me on way home from school	10
3. Age 12	Parents do not want to talk about what happened after police leave the house	10
4. Age 27	Weight-loss doctor shames me for being unable to stay on a diet	7

Trigger-List Exercise (One Event – Multiple Hot Points) – Example

Use this Trigger List in a graphical manner when there is one event that occurred over a long period of time with multiple "hot points" or disturbing moments related to the same event.



USING THE TOOLS 1

Trigger-List Exercise (Multiple Events)

Life stage	Trigger list	SUDS
Early childhood*		
1.		
2.		
3.		
Middle childhood to adolescence*		
1.		
2.		
3.		
Young adulthood*		
1.		
2.		
3.		
Adulthood to present day*		
1.		
2.		
3.		

List of themes (or core beliefs):

1. _____

2. _____

3. _____

* Use additional pages if necessary

USING THE TOOLS 1:
Trigger-List Exercise (Multiple Events)

Relaxed Breathing Guided Meditation (R)

Time required: 5 minutes.

Materials required: None.

Indications for use: Use when the primary need is to enhance physical coping skills in Phase I: Safety and Stabilization of trauma recovery.

Counterindications: Deficits related to the respiratory system or nasal airway.

Relaxed breathing is a helpful breathing exercise that is designed to help settle the nervous system and find a sense of calm in the storm that is trauma recovery.

Delivery of Approach

WITHOUT AUDIO: Below is a script that can be utilized to facilitate the Relaxed Breathing Guided Meditation exercise:

Script: Relaxed Breathing Guided Meditation

Find a quiet and comfortable place where you can sit or lie down without being disturbed. Allow yourself to focus attention within, letting go of anything related to the past or future.

Notice how the breath moves in and out of the body without changing anything. Allow the breath to slow down. Inhale, allowing the breath to be nourishing to the body. Release, letting go of tension and tightness in the body.

Notice your inside world. Allow yourself to feel whatever you feel inside your body, without any judgement.

Inhale, allowing the breath to move slowly and smoothly into the belly. Exhale, letting the breath fully release. Enjoy the release.

Pay attention to the sensation of breath. Bear witness to the sensation of the breath, moving in and out of the body without any struggle. Focus on the simple sensation of the breath entering and leaving the body. Let any thoughts you might have come and go. Gently concentrate in a relaxed manner with minimal effort.

Notice that the mind can slow down and settle. Feel yourself release tension and stress in the body. Allow yourself to release more and more with every exhalation.

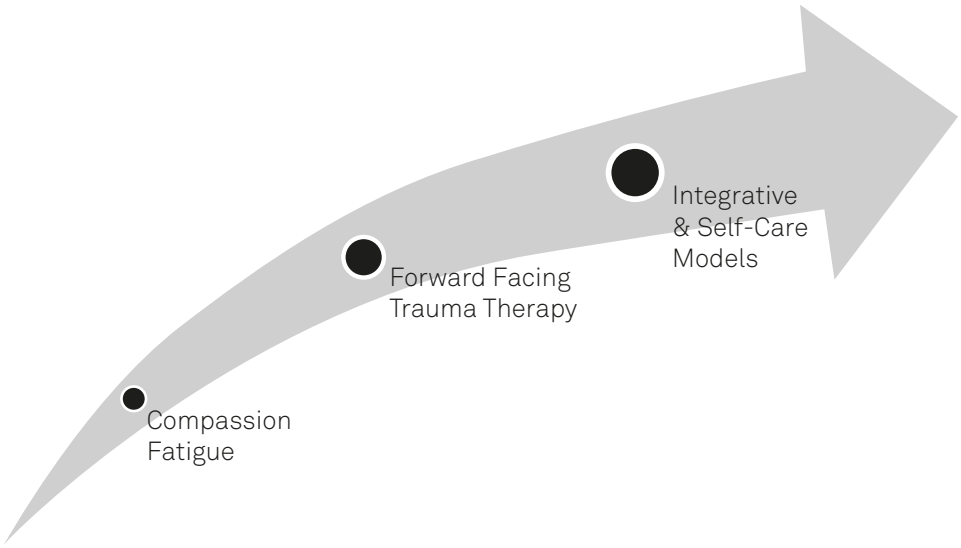
Allow the body and mind to relax, as the breath slows down. Let yourself notice, how focusing on relaxation can lay a foundation of calm. Recognize that you are increasing your self-awareness, as well as the wisdom of your body.

WITH AUDIO: Please watch a guided facilitation of this exercise as part of the Trauma Recovery Online Program in Video 21 in the supplementary material (p. 227, or Baranowsky, 2015, September 24, https://youtu.be/XxoLhLvdscw).

Integrative and Clinician Self-Care Models

Opportunities are usually disguised as hard work,
so most people don't recognize them.

Ann Landers



Summary

This chapter on Forward-Facing® Trauma Therapy (FFTT) introduces a safe, effective, and accelerated method of treating trauma that does not require the survivor to revisit painful memories in order to heal the distress they experience from their past. Instead, drawing upon recent research from brain science, physiology, stress studies, and trauma treatment, FFTT teaches users to monitor and regulate their own over-enervated and dysregulated nervous systems. By helping trauma survivors to confront the perceived threats of their daily lives in the present using the pairing of exposure and relaxation to desensitize the negative effects of past traumas, clients can enjoy immediate relief from their symptoms. FFTT fully exploits this integral component of all effective trauma treatment to help survivors to heal their traumatic stress – and all stress – by a simple set of skills practiced in the present. In addition, survivors who develop this disciplined process of confronting perceived threats begin to find themselves able to lessen their reactivity and begin to live intentional and fulfilling lives.