



IATP

International Association of Trauma Professionals



Trauma Therapist Toolkit

TRAUMA THERAPIST TOOLKIT

Hello. We have compiled these resources to assist therapists who work regularly with clients who are survivors of trauma and who suffer from traumatic stress. Some of the materials included in this *Toolkit* will be more suited for therapists just beginning their career while other materials will be more appropriate for clinicians who are seasoned and more sophisticated working with traumatic stress. Whatever your interest in trauma, you are likely to find some useful materials contained in this *Toolkit*.

This is the first edition of the *Toolkit*. We plan to augment and update this resource regularly so check back frequently for new techniques, assessment instruments, articles, suggestions, and other helpful materials to assist you in your practice.

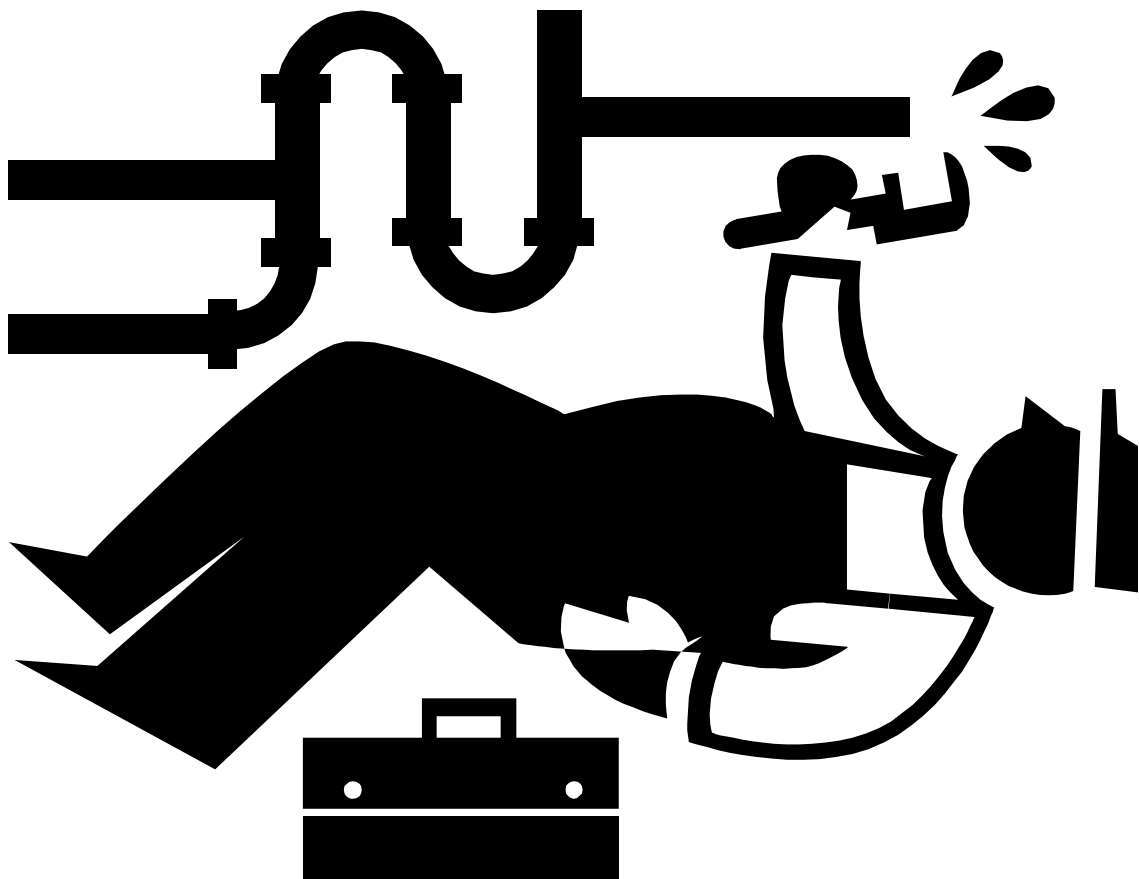
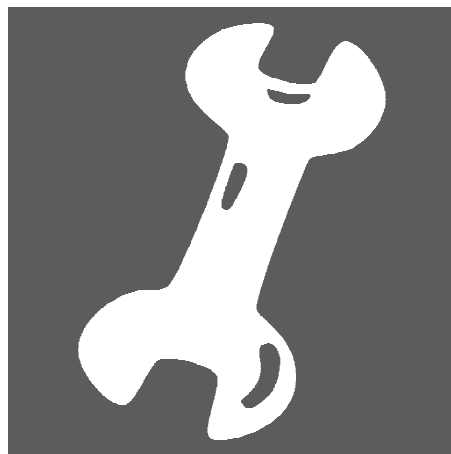


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National Center for PTSD
CLINICIAN-ADMINISTERED PTSD SCALE (CAPS)

Form 1 - Current and Lifetime Diagnosis Version

Patient: _____ Pt#: _____ Date: _____ Clinician: _____ .

Purpose: The CAPS-1 was developed to measure cardinal and hypothesized signs and symptoms of PTSD. This clinician-administered instrument provides a method to evaluate the frequency and intensity of individual symptoms, as well as the impact of the symptoms on social and occupational functioning, the degree of improvement since an earlier rating, the validity of the ratings obtained, and the overall intensity of the symptoms. Whenever possible, the CAPS-1 should be used in conjunction with self-report, behavioral, and physiological measures when assessing either baseline or post-treatment status.

Instructions: The time frame for each symptom is one month. Using the prompt questions or comparable alternatives, and appropriate follow-up questions, first assess the *frequency*, over the previous month, of the identified symptom. Next, using the same method evaluate the *intensity* of symptom occurrence. The descriptors for the anchor points of both the frequency and intensity dimensions can be read to the patient in arriving at the most accurate rating. **A frequency rating of one (1) or greater and an intensity rating of two (2) or greater reflect significant problems with particular symptom, and should be considered a symptom endorsement.** This symptom then can be counted toward the required total for a given criterion (i.e., one symptom for B, three for C, two for D). It is important to note that criteria C, D, and E require that the symptoms not be present before the trauma. The clinician should clarify with the patient that the onset of any of the symptoms for criteria C, D, or E occurred after the trauma. If the veracity or accuracy of the patient's report of a symptom is in doubt, the clinician should circle QV ("Questionable Validity") to the right of the corresponding item.

If the patient meets the PTSD diagnostic criteria for the past month, he or she automatically meets the criteria for a lifetime diagnosis. If not, use the "**Lifetime Symptom Query**" to establish a high-symptom one month period since the trauma for which to reassess the frequency and intensity of each symptom.

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National Center for Posttraumatic Stress Disorder
Behavioral Science Division - Boston
Neurosciences Division
West Haven
October 1990

National Center for PTSD
CLINICIAN-ADMINISTERED PTSD SCALE (CAPS)
 Form 1 - Current and Lifetime Diagnosis Version

A. Traumatic Event(s): _____

B. THE TRAUMATIC EVENT IS PERSISTENTLY REEXPERIENCED:

(1) Recurrent and intrusive distressing recollections of the event

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever experienced unwanted memories of the event(s) without being exposed to something that reminded you of the event? Did these memories occur while you were awake, or only in dreams? [Exclude if memories only occurred during dreams] How often in the past month?	At their worse, how much distress or discomfort did these memories cause you? Did these memories cause you to stop what you were doing? Are you able to dismiss the memories if you try?	Q V	QV
0 Never	0 None	F	F
1 Once or twice	1 Mild, minimal distress		
2 Once or twice a week	2 Moderate, distress clearly present but still manageable, some disruption of activities	I	I
3 Several times a week	3 Severe, considerable distress, marked disruption of activities and difficulty dismissing memories		
4 Daily or almost every day	4 Extreme, incapacitating distress, unable to continue activities and cannot dismiss memories		
<u>Description/Examples:</u>			

(2) Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever gotten upset when you were exposed to things that reminded you of the event(s)? [For example, particular males for rape victims, tree lines or wooded areas for combat veterans] How often in the past month?	At its worst, how much distress or discomfort did exposure to these reminders cause you?	Q V	Q V
0 Never	0 None		
1 Once or twice	1 Mild, minimal distress	-	-
2 Once or twice a week	2 Moderate, distress clearly present but still manageable	F	F
3 Several times a week	3 Severe, considerable distress		
4 Daily or almost every day	4 Extreme, incapacitating distress		
<u>Description/Examples</u>		I	I

(3) Sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever suddenly acted or felt as if the event(s) was happening again? How often in the past month?	At their worse, how much did it seem that the event(s) was happening again? How long did it last? What did you do while this was happening?	QV	QV
0 Never	0 Not at all	F	F
1 Once or twice	1 Mild, slightly more realistic than just thinking about the event		
2 Once or twice a week	2 Moderate, definite but transient dissociative quality; still very aware of surroundings	I	I
3 Several times a week	3 Severe, strongly dissociative (reports images, sounds, smells), but retained some awareness of surroundings		
4 Daily or almost every day	4 Extreme, complete dissociation (flashback), no awareness of surroundings, possible amnesia for the episode (blackout)		
<u>Description/Examples:</u>			

(4) Recurrent distressing dreams of the event

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever had unpleasant dreams about the event(s)? How often in the past month?	At its worst, how much distress or discomfort did these dreams cause you? Did these dreams wake you up? [if yes, ask:] What were you feeling or doing when you awoke? How long does it usually take to get back to sleep? [Listen for report of panic symptoms, yelling, posturing]	QV	QV
0 Never	0 None	F	F
1 Once or twice	1 Mild, minimal distress, did not awaken		
2 Once or twice a week	2 Moderate, awoke in distress but readily returned to sleep	I	I
3 Several times a week	3 Severe, considerable distress, difficulty returning to sleep		
4 Nightly or almost every night	4 Extreme, overwhelming or incapacitating distress, could not return to sleep		
<u>Description/Examples:</u>			

Current Symptoms from Criterion B = _____

Lifetime Symptoms from Criterion B = _____

C. PERSISTENT AVOIDANCE OF STIMULI ASSOCIATED WITH THE TRAUMA OR NUMBING OF GENERAL RESPONSIVENESS (NOT PRESENT BEFORE THE TRAUMA)

(5) Efforts to avoid thoughts or feelings associated with the trauma

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever tried to avoid thinking about the event(s)? Have you ever tried to avoid feelings related to the event(s) (e.g., rage, sadness, guilt?) How often in the past month? 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day <u>Description/Examples:</u>	How much effort did you make to avoid thoughts or feelings related to the event(s)? [Rate all attempts to cognitive avoidance, including distraction, suppression, and reducing awareness with alcohol or drugs] 0 None 1 Mild, minimal distress 2 Moderate, some effort, avoidance definitely present 3 Severe, considerable effort, marked avoidance 4 Extreme, drastic attempts at avoidance	QV F I	QV F I

(6) Efforts to avoid activities or situations that arouse recollections of the trauma

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
Have you ever tried to stay away from activities or situations that reminded you of the event(s)? How often in the past month? 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day <u>Description/Examples:</u>	How much effort did you make to avoid activities or situation related the event(s)? [Rate all attempts at behavioral avoidance, e.g., combat veteran who avoids veteran activities, war movies, etc.] 0 No effort 1 Mild, minimal effort 2 Moderate, some effort, avoidance definitely present 3 Severe, considerable effort, marked avoidance 4 Extreme, drastic attempts at avoidance	QV F I	QV F I

(7) Inability to recall an important aspect of the trauma (psychogenic amnesia)

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you been unable to remember important parts of the event(s) (e.g., names, faces, sequence of events)? How much of the event(s) have you had difficulty remembering in the past month?</p> <p>0 None, clear memory of event(s) 1 Few aspects of event(s) not remembered (less than 10%) 2 Some aspects of the event(s) not remembered (approx 20-30%) 3 Many aspects of the event(s) not remembered (approx 50-60%) 4 Most of event(s) not remembered (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>How much difficulty did you have recalling important parts of the event(s)?</p> <p>0 No difficulty at recalling event(s) 1 Mild, minimal difficulty recalling event(s) 2 Moderate, some difficulty, could recall event(s) with concentration 3 Severe, considerable difficulty recalling the event(s) 4 Extreme, completely unable to recall the event(s)</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(8) Markedly diminished interest in significant activities

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you been less interested in important activities that once gave you pleasure, such as sports, hobbies, or social activities? As compared to before the event(s), how many activities in the past month have you had less interest in?</p> <p>0 No loss of interest 1 Few activities (less than 10%) 2 Several activities (approx 20-30%) 3 Many activities (approx 50-60%) 4 Most activities (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>At its worst, how strong was your loss of interest in these activities?</p> <p>0 No loss of interest 1 Mild, only slight loss of interest, probably would enjoy after starting activities 2 Moderate, definite loss of interest, but still has some enjoyment of activities 3 Severe, marked loss of interest in activities 4 Extreme, complete loss of interest, intentionally does not engage in activities</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(9) Feelings of detachment or estrangement from others

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you felt distant or cut off from those around? Is this different from how you felt before the event(s)? How much of the time have you felt this way in the past month?</p> <p>0 Never 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were your feelings of being distant or cut off from others? Who do you feel closest to?</p> <p>0 No feelings of detachment or estrangement 1 Mild, occasionally feels “out of synch” with others 2 Moderate, feelings of detachment clearly present, but still feels some interpersonal connection or belonging with others 3 Severe, marked feelings of detachment or estrangement from most people; most confide in only one person 4 Extreme, feels completely detached or estranged from others; not close with anyone</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(10) Restricted range of affect, e.g., unable to have loving feelings

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you had periods where you felt emotionally numb, or had trouble experiencing feelings such as love or happiness? Is this different from how you felt before the event(s)? How much of the time have you felt this way in the past month?</p> <p>0 Never 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were your feelings of emotional numbness? [In rating this item include observations of range of affect displayed in interview]</p> <p>0 No emotional numbing 1 Mild, slight emotional numbing 2 Moderate, emotional numbing clearly present, but still able to experience emotions 3 Severe, marked emotional numbing in at least two primary emotions (e.g., love, happiness) 4 Extreme, feels completely unemotional</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(11) Sense of a foreshortened future, e.g., does not expect to have a career, marriage, children or a long life

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you had times when you felt that there is no need to plan for the future, that somehow your future will be cut short? [if yes, rule out realistic risks such as life-threatening medical conditions] Is this different from how you felt before the event(s)? How much of the time have you felt this way in the past month?</p> <p>0 Never 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong was this feeling that your future will be cut short? How long do you think you will live? How convinced were you that you will die prematurely?</p> <p>0 No sense of a foreshortened future 1 Mild, slight sense of a foreshortened future 2 Moderate, sense of a foreshortened future definitely present, but no specific prediction about longevity 3 Severe, marked sense of a foreshortened future; may make specific prediction about longevity 4 Extreme, overwhelming sense of a foreshortened future; completely convinced of premature death</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

Current Symptoms from Criterion C = _____
 # Lifetime Symptoms from Criterion C = _____

D. PERSISTENT SYMPTOMS OF INCREASED AROUSAL (NOT PRESENT BEFORE THE TRAUMA)

(12) Difficulty falling or staying asleep

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you had any problems falling or staying asleep? Is this different from the way you were sleeping before the event(s)? How often have you had difficulty sleeping in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Nightly or almost every night</p> <p>Sleep Onset Problems? Y/N Mid Sleep Awakening? Y/N Early AM Awakening? Y/N Total #hrs Sleep/Night _____ Desired #hrs Sleep/Night _____ <u>Description/Examples:</u></p>	<p>[Ask probe items and rate overall sleep disturbance] How long did it take you to fall asleep? How many times did you wake up at night? How many hours total did you sleep each night?</p> <p>0 No sleep problems 1 Mild, takes slightly longer to fall asleep, or minimal difficulty staying asleep (up to 30 minutes loss of sleep) 2 Moderate, definite sleep disturbance, with clearly longer latency to sleep or clear difficulty staying asleep (30-90 min loss of sleep) 3 Severe, much longer latency to sleep or marked difficulty staying asleep (90 min-3 hrs loss of sleep) 4 Extreme, very long latency to sleep or profound difficulty staying asleep (greater than 3 hrs loss of sleep)</p>	<p>QV</p> <p>— F</p> <p>— I</p>	<p>QV</p> <p>— F</p> <p>— I</p>

(13) Irritability or outbursts of anger

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have there been times when you felt unusually irritable, or expressed feelings of anger and acted aggressively? Is this different from how you felt or acted before the event(s)? How often have you felt or acted this way in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p><u>Description/Examples:</u></p>	<p>How angry were you? In what ways did you express/show anger?</p> <p>0 No irritability or anger 1 Mild, minimal irritability, raises voice when angry 2 Moderate, irritability clearly present, easily becomes argumentative when angry, but can recover quickly 3 Severe, marked irritability, becomes verbally or physically aggressive when angry 4 Extreme, pervasive anger, episodes of physical violence</p>	<p>QV</p> <p>— F</p> <p>— I</p>	<p>QV</p> <p>— F</p> <p>— I</p>

(14) Difficulty concentrating

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you found it difficult to concentrate on what you were doing or on things going on around you? Has your concentration changed since the event(s)? How much of the time have you have difficulty concentrating in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>How difficult was it for you to concentrate? [In rating this item include observations of concentration and attention in the interview]</p> <p>0 No difficulty with concentration 1 Mild, only slight effort needed to concentrate 2 Moderate, definite loss of concentration, but could concentrate with effort 3 Severe, marked loss of concentration, even with effort 4 Extreme, complete inability to concentrate</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(15) Hypervigilance

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you been especially alert or watchful, even when there was no obvious need to be? Is this different from how you felt or acted before the event(s)? How much of the time have you been alert or watchful in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>How much effort did you make to try to be aware of everything around you? [In rating this item include observations of hypervigilance during the interview]</p> <p>0 No hypervigilance 1 Mild, minimal hypervigilance, slight heightening of awareness 2 Moderate, hypervigilance clearly present, watchful in public (e.g., chooses safe place to sit in a restaurant or movie theatre) 3 Severe, marked hypervigilance, very alert, scans environment for danger, exaggerated concern for safety of self, home and family 4 Extreme, excessive hypervigilance, efforts consume significant time and energy, and may involve extensive safety-checking behaviors, marked guarded behaviors during interview</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(16) Exaggerated Startle Response

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you experienced strong startle reactions to loud, unexpected noises (e.g., car backfires, fireworks, doorslams, etc.) or things that you saw (e.g., movement in the corner of your eye?) Is this different from how you were before the event(s)? How often has this happened in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p><u>Description/Examples:</u></p>	<p>At their worst, how strong were these startle reactions?</p> <p>0 No startle reaction 1 Mild, minimal reaction 2 Moderate, definite startle response, feels “jumpy” 3 Severe, marked startle response, sustained arousal following initial reaction 4 Extreme, excessive startle response, overt coping behavior (e.g., combat veteran who “hits the dirt”)</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(17) Physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you experienced any physical reactions when you were faced with situations that reminded you of the event(s)? [Listen for report of symptoms such as heart racing, tremulousness, sweating, or muscle tension, but do not suggest symptoms to patient] How often in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p><u>Description/Examples:</u></p>	<p>At their worst, how strong were these physical reactions?</p> <p>0 No physical reaction 1 Mild, minimal reaction 2 Moderate, physical reaction clearly present, reports some discomfort 3 Severe, marked physical reaction, reports strong discomfort 4 Extreme, dramatic physical reaction, sustained arousal</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

Current Symptoms from Criterion C = _____
#Lifetime Symptoms from Criterion C = _____

CAPS Global Ratings

- (18) **Impact on Social Functioning:** Have the symptoms you've told me about affected your social life? Rate the overall impact that the PTSD symptoms have had on the patient's social functioning, taking into consideration impressions of the patient's behavior as well as his/her report provided at other times during the interview.

0 = No Adverse impact on social functioning
1 = Slight/mild impact on social functioning, some impairment
2 = Moderate impact on social functioning
3 = Severe impact on social functioning
4 = Extreme impact on social functioning

- (19) **Impact on Occupational Functioning:** Are you working now? Have the symptoms you've told me about affected your work or your ability to work? Rate the overall impact that the PTSD symptoms have had on the patient's ability to obtain and maintain employment. Take into consideration the patient's reported work history, including the number and duration of jobs, as well as the quality of work relationships. Also consider work functioning problems due to reasons other than PTSD symptoms.

0 = No adverse impact on occupational functioning
1 = Slight/mild impact on occupational functioning, some impairment
2 = Moderate impact on occupational functioning, significant impairment, intermittent employment
3 = Severe impact on occupational functioning, chronically unemployed
4 = Extreme impact on occupational functioning, not employed since event

- (20) **Global Improvement:** Rate total overall improvement present since the initial rating. If no earlier rating, ask how the symptoms endorsed have changed over the past 6 months. Rate the degree of change, whether or not, in your judgment, it is due to treatment.

0 = Asymptomatic
1 = Very much improved
2 = Moderate improvement
3 = Slight improvement
4 = No improvement or not sufficient information

(21) **Rating Validity:** Total number of QV's circled on interview form:_____.

Estimate the overall validity of the ratings obtained. Factors that may affect validity include the patient's cooperativeness and his/her attempts to appear more or less symptomatic than is actually the case. Furthermore, the type and intensity of PTSD symptoms present may interfere with the patient's concentration, attention, or ability to communicate in a coherent fashion.

- 0 = Excellent, no reason to suspect invalid responses
- 1 = Good, factor(s) present that may adversely affect validity
- 2 = Fair, factor(s) present that definitely reduce validity
- 3 = Poor, very low validity
- 4 = Invalid responses, suspect deliberate "faking bad" or "faking good"

(22) **Global Severity:** Interviewer's judgment of the overall intensity of the patient's PTSD symptoms. Consider the degree of distress reported by the patient, the symptoms observed, and the functional impairment reported. Your judgment is required with respect to the emphasis placed on particular information as well as the accuracy of patient reporting. This judgment should be based on information obtained during this interview only.

- 0 = Asymptomatic
- 1 = Slight/mild symptoms, little functional impairment
- 2 = Moderate symptoms, but functions satisfactorily with effort
- 3 = Severe symptoms, limited functioning even with effort
- 4 = Extreme symptoms, pervasive impairment

Current Symptoms

	Criterion A met?	No	Yes
_____ # current symptoms for criterion B - Cx B met (≥ 1)?		No	Yes
_____ # current symptoms for criterion C - Cx C met (≥ 3)?		No	Yes
_____ # current symptoms for criterion D - Cx D met (≥ 2)?		No	Yes
	PTSD Citerion A-D Met?	No	Yes

[If PTSD Criteria are met, skip next section and go on to "Associated or hypothesized features". If Criteria are not met, assess for Lifetime Diagnostic Status.]

Lifetime Symptom Query

Has there been any time period since the trauma in which you were significantly more troubled than in the past month by the symptoms that I've just asked you about?

No Yes

Did this period or these period last for at least one month?

No Yes

Approximately when did this/these period(s) begin and end?

_____ to _____

_____ to _____

_____ to _____

For multiple time periods:

During which of these time periods were you most troubled by or experienced the greatest number of symptoms?

_____ to _____

[For period indicated above, inquire about each symptom by reviewing items 1-17. Change frequency questions to start with "During the month you identified as the worst time, did you experienced (symptom)? How often did (symptom) occur?]

Lifetime Symptoms

_____ # current symptoms for criterion A met?	Criterion A met?	No	Yes
_____ # current symptoms for criterion B - Cx B met (≥ 1)?		No	Yes
_____ # current symptoms for criterion C - Cx C met (≥ 3)?		No	Yes
_____ # current symptoms for criterion D - Cx D met (≥ 2)?		No	Yes
	PTSD Citerion A-D Met?	No	Yes

Associated or hypothesized features

(23) Guilt over acts of commission or omission

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Since the event(s), have you felt guilty about behavior you engaged in or about your failure to act in a specific way during the event(s)? How much of the time in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were these feelings of guilt</p> <p>0 No guilt 1 Mild, minimal guilt 2 Moderate, guilt clearly present but still manageable 3 Severe, considerable guilt, marked discomfort not readily managed 4 Extreme, excessive guilt, feels tormented by self-condemnation</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(24) Survivor guilt

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Since the event(s), have you felt guilty about surviving the event(s) when others (around you) did not? How much of the time in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were these feelings of guilt?</p> <p>0 No guilt 1 Mild, minimal guilt 2 Moderate, guilt clearly present, but still manageable 3 Severe, substantial guilt, marked discomfort not readily managed 4 Extreme, excessive guilt, feels tormented by self-condemnation</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(23) Homicidality

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have there been times when you felt like seriously harming or even killing someone? Is this different from how you were before the event(s)? How often have you felt this way in the past month?</p> <p>0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were these feelings of wanting to harm or kill someone?</p> <p>0 No homicidal ideation 1 Mild, only slight homicidal ideation 2 Moderate, definite homicidal ideation, but no actual homicidal intent 3 Severe, strong homicidal ideation, has seriously considered homicide, but has not formulated definite plan 4 Extreme, very strong homicidal feelings, has formulated plan or acted with homicidal intent</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(24) Disillusionment with previously esteemed authority and authority figures

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Since the event(s), have you had thoughts that you were let down, misled, or betrayed by authority figures during or after the event(s)? How much of the time in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>At their worst, how strong were these feelings of being let down by authority?</p> <p>0 No disillusionment 1 Mild, minimal disillusionment 2 Moderate, definite disillusionment, but can still effectively interact with those in authority 3 Severe, considerable disillusionment, difficulty interacting with those in authority 4 Extreme, complete disillusionment, unable to interact with those in authority</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(27) Feelings of hopelessness

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you felt that there was little or no hope of improving how you feel or improving the situation in which you find yourself? Is this different from how you were before the event(s)? How much of the time have you felt this way in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were these feelings of hopelessness? [Consider patient's plans for treatment, goals for occupational and social endeavors]</p> <p>0 No hopelessness 1 Mild, slight loss of hope 2 Moderate, definite loss of hope, but still able to function effectively 3 Severe, considerable loss of hope, feels like "giving up" 4 Extreme, complete loss of hope, sees any attempt to improvement as futile</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(28) Memory impairment, forgetfulness

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have you had difficulty remembering things from the recent past? Is this different from how you were before the event(s)? How much of the time have you had difficulty remembering things in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>How much difficulty did/do you have remembering things from the recent past? [In rating this item include observations of short-term memory deficits interview]</p> <p>0 No difficulty 1 Mild, slight memory impairment, minor forgetfulness 2 Moderate, definite memory impairment, but still able to remember most things well 3 Severe, considerable memory impairment, forgets many things easily 4 Extreme, profound memory impairment, forgets even important events or appointments</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(29) Sadness and depression

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have there been times when you felt sad, blue, or down in the dumps? Is this different from how you were before the event(s)? How much of the time have you felt sad or blue in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples</u></p>	<p>At their worst, how strong were these feelings of sadness or depression?</p> <p>0 No sadness or depression 1 Mild, minimal sadness or depression 2 Moderate, definite sadness or depression, but still manageable 3 Severe, considerable sadness or depression, reports feeling stuck in sad or depressed mood 4 Extreme, overwhelming or incapacitating depression</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

(30) Feelings of being overwhelmed

<u>Frequency</u>	<u>Intensity</u>	<u>C</u>	<u>L</u>
<p>Have there been times when you felt overwhelmed or unable to handle the pressure on you? Is this different from how you were before the event(s)? How much of the time have you felt this way in the past month?</p> <p>0 None of the time 1 Very little of the time (less than 10%) 2 Some of the time (approx 20-30%) 3 Much of the time (approx 50-60%) 4 Most or all of the time (more than 80%)</p> <p><u>Description/Examples:</u></p>	<p>At their worst, how strong were these feelings of being overwhelmed?</p> <p>0 No feelings of being unable to handle pressure 1 Mild, slight feelings of being unable to handle pressure 2 Moderate, definite feelings of being unable to handle pressure, but still able to function 3 Severe, strong feelings of being unable to handle pressure 4 Extreme, immobilizing feelings of being unable to handle pressure, feels completely overwhelmed</p>	<p>QV</p> <p>F</p> <p>I</p>	<p>QV</p> <p>F</p> <p>I</p>

**END OF CAPS-1 INTERVIEW
 CODE SUMMARY SHEET**

CAPS-1 SUMMARY SHEET

Patient _____ Pt# _____ Clinician _____ Date _____

PTSD SYMPTOMS

A. Traumatic Event: _____

	Current Sx		LifetimeSx	
	Frq	Ints	Frq	Ints
(1) Recurrent and intrusive recollections	_____	_____	_____	_____
(2) Distress when exposed to events	_____	_____	_____	_____
(3) Acting or feeling as if event recurring	_____	_____	_____	_____
(4) Recurrent distressing dreams of event	_____	_____	_____	_____

Number of current symptoms for criterion B (need 1): _____ **Cx met?** **Yes** **No**
Number of lifetime symptoms for criterion B (need 1): _____ **Cx met?** **Yes** **No**

C. Persistent avoidance of stimuli/numbing of responsiveness:

(5) Efforts to avoid thoughts or feelings	_____	_____	_____	_____
(6) Efforts to avoid activities or situations	_____	_____	_____	_____
(7) Inability to recall trauma aspects	_____	_____	_____	_____
(8) Markedly diminished interest in activities	_____	_____	_____	_____
(9) Feelings of detachment or estrangement	_____	_____	_____	_____
(11) Restricted range of affect	_____	_____	_____	_____
(10) Sense of foreshortened future	_____	_____	_____	_____

Number of current symptoms for criterion C (need 3): _____ **Cx met?** **Yes** **No**
Number of lifetime symptoms for criterion C (need 3): _____ **Cx met?** **Yes** **No**

D. Persistent symptoms of increased arousal:

(12) Difficulty falling or staying asleep	_____	_____	_____	_____
(13) Irritability or outbursts of anger	_____	_____	_____	_____
(14) Difficulty concentrating	_____	_____	_____	_____
(15) Hypervigilance	_____	_____	_____	_____
(16) Exaggerated startle response	_____	_____	_____	_____
(17) Physiologic reactivity	_____	_____	_____	_____

Number of current symptoms for criterion D (need 2): _____ **Cx met?** **Yes** **No**
Number of lifetime symptoms for criterion D (need 2): _____ **Cx met?** **Yes** **No**

PTSD Cx Met (circle): **Current:** Yes No **Lifetime:** Yes No

CAPS Global Ratings

	<u>Current</u>	<u>Lifetime</u>
(18) Impact on social functioning	_____	_____
(19) Impact on occupational functioning	_____	_____
(20) Global improvement	_____	_____
(21) Rating validity	_____	_____
(22) Global severity	_____	_____

Hypothesized or Associated Features

	<u>Current Sx</u>		<u>Lifetime Sx</u>	
	<u>Frq</u>	<u>Ints</u>	<u>Frq</u>	<u>Ints</u>
(23) Guilt over acts of commission or omission	_____	_____	_____	_____
(24) Survivor guilt	_____	_____	_____	_____
(25) Homicidality	_____	_____	_____	_____
(26) Disillusionment with authority	_____	_____	_____	_____
(27) Feelings of hopelessness	_____	_____	_____	_____
(28) Memory impairment, forgetfulness	_____	_____	_____	_____
(29) Sadness and depression	_____	_____	_____	_____
(30) Feelings of being overwhelmed	_____	_____	_____	_____

Number of associated or hypothesized symptoms - current: _____

Number of associated or hypothesized symptoms - lifetime: _____

Score: _____

TRS

Name _____

TRAUMA RECOVERY SCALE

PART I

- ___yes___no I have been exposed to a traumatic event in which **both** of the following were present:
- a. experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, **AND**
 - b. my response involved intense fear, helplessness or horror.
- If **yes** is answered please complete Part II & III;
 - If **no** is answered complete Part III (omit Part II)

PART II

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

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

Comments: _____

TRSTRAUMA RECOVERY SCALE

J. Eric Gentry

PART III

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

- 1. I make it through the day without distressing recollections of past events.
0% _____ 100% of the time
- 2. I sleep free from nightmares.
0% _____ 100% of the time
- 3. I am able to stay in control when I think of difficult memories.
0% _____ 100% of the time
- 4. I do the things that I used to avoid (e.g., daily activities, social activities, thoughts of events and people connected with past events).
0% _____ 100% of the time
- 5. I am safe.
0% _____ 100% of the time
- I feel safe.
0% _____ 100% of the time
- 6. I have supportive relationships in my life.
0% _____ 100% of the time
- 7. I find that I can now safely feel a full range of emotions.
0% _____ 100% of the time
- 8. I can allow things to happen in my surroundings without needing to control them.
0% _____ 100% of the time
- 9. I am able to concentrate on thoughts of my choice.
0% _____ 100% of the time
- 10. I have a sense of hope about the future.
0% _____ 100% of the time

AS – FS

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

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

Mean Score

g e

DES

(Eve Bernstein-Carlson, Ph.D., Frank Putnam, MD)

DIRECTIONS

This questionnaire consists of twenty-eight questions about experiences you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experiences described in the question applies to you and circle the number to show what percentage of the time that you have the experience.

EXAMPLE:

0% 10 20 30 40 50 **60** 70 80 90 100%
(never) (always)

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realize that they don't remember what happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

4. Some people have the experience of finding themselves dressed in clothes they don't remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

5. Some people have the experience of finding new things among their belongings that they don't remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were another person. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

8. Some people are told that they do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

9. Some people find that they no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

17. Some people find that when they are watching television or a movie that they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

18. Some people find that they become so involved in a fantasy or daydream that it feels as if it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

22. Some people find that in one situation that they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

23. Some people sometimes find that in certain situations that they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

24. Some people find that they cannot remember whether they have done something or have just thought about doing this (for example, not knowing whether they have just mailed a letter or just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

27. Some people sometimes find that they hear voices inside their heads that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

0% 10 20 30 40 50 60 70 80 90 100%
(never) (always)

Total: _____

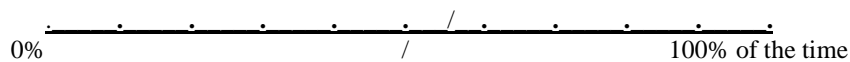
DRS
(Tinnin, 1995)

Mean: _____

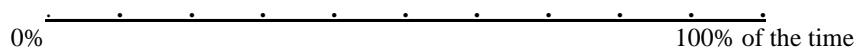
DIRECTIONS

This questionnaire contains six items about experiences you may have had in your daily life. To answer these items, please determine to what degree the experiences described in the questions applies to you and mark a place on the line with a vertical slash at the appropriate place, as shown in the example below.

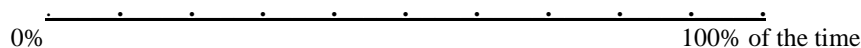
Example:



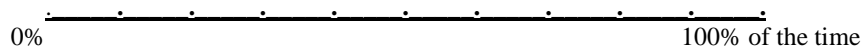
1. Some people sometimes feel that they are not their usual self but are two or more different selves. Mark the line to show what percentage of the time this happens to you.



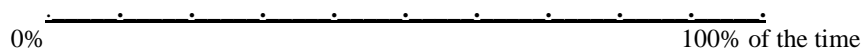
2. Some people have the feeling that their actions are being directed or controlled by others. Mark the line to show what percentage of the time this happens to you.



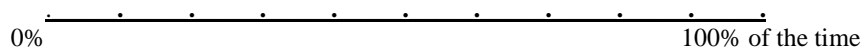
3. Some people sometimes lose their sense of time, duration and sequence of events during the day. Mark the line to show what percentage of the time this happens to you.



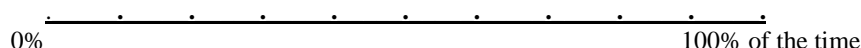
4. Some people experience changes in their body image as if their body were different or did not belong to them. Mark the line to show the percentage of time this happens to you.



5. Some people have the experience that other people, objects, and the world around them are not real. Mark the line to show the percentage of time this happens to you.



6. Some people find that they are sometimes literal-minded and have difficulty understanding jokes or figures of speech. Mark the line to show the percentage of time this happens to you.



Score: _____

IES

IMPACT OF EVENTS SCALE

M. Horowitz, Dept. of Psychiatry, University of California at San Francisco

Name: _____ Occupation: _____

In _____(year) I experienced this life event: _____

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

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

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

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

SWLS

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Slightly disagree
- 4 = Neither agree nor disagree
- 5 = Slightly agree
- 6 = Agree
- 7 = Strongly agree

- _____ 1. In most ways my life is close to ideal.
- _____ 2. The conditions of my life are excellent.
- _____ 3. I am satisfied with my life.
- _____ 4. So far I have gotten the important things I want in life.
- _____ 5. If I could live my life over, I would change almost nothing.

35-31	Extremely satisfied
26-30	Satisfied
21-25	Slightly satisfied
20	Neutral
15-19	Slightly dissatisfied
10-14	Dissatisfied
5-9	Extremely dissatisfied

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PTSD Diagnosis and Treatment for Mental Health Clinicians

by Matthew J. Friedman, M.D., Ph.D.
Executive Director, National Center for PTSD
Professor of Psychiatry and Pharmacology,
Dartmouth Medical School

While this article is a bit dated, it provides an excellent primer for diagnosing and treating PTSD.

Abstract

This article focuses on four issues: PTSD assessment, treatment approaches, therapist issues, and current controversies. Important assessment issues include the trauma history, co morbid disorders, and chronicity of PTSD. Effective intervention for acute trauma usually requires a variant of critical incident stress debriefing. Available treatments for chronic PTSD include group, cognitive-behavioral, psychodynamic, and pharmacological therapy. Therapist self-care is essential when working with PTSD patients since this work may be functionally disruptive and psychologically destabilizing. Current controversies include advocacy vs. therapeutic neutrality, eye movement desensitization and reprocessing (EMDR), the so-called false memory syndrome, and the legitimacy of complex PTSD as a unique diagnostic entity.

Originally published in *Community Mental Health Journal* 32(2):
173-189, (April 1996).

PTSD is an easy diagnosis to make when the patient tells you that s/he has been badly traumatized and believes that such exposure has precipitated current psychological problems. Thanks to a massive psychoeducational program provided by the print and electronic media, the public has become familiar with the concept of PTSD and recognizes that it can be caused by war trauma, domestic violence, sexual assault, industrial accidents, and natural disasters. Media coverage of major recent events such as the Persian Gulf War, Hurricane Andrew, cases of child abuse, and the genocide in Bosnia have often underscored the psychological impact of such events thereby contributing to the growing sophistication of a public that knew little about PTSD until the late 1980s. Furthermore, PTSD is an attractive explanatory model for many people because it places responsibility for their suffering on factors outside themselves, factors over which they often had neither responsibility nor control.

Clinicians have also found the PTSD construct attractive and useful. It provides an explanatory model that is easy to address therapeutically and that promotes empathic patience, even with the most difficult and demanding clientele. Although the growing acceptance of trauma-focused assessment and treatment strategies has created clinical options that were not exercised as recently as ten year ago, such options have also generated a number of potential problems. In this article I will address four issues: PTSD detection and diagnosis; treatment approaches; therapist issues; and current controversies.

Making the Diagnosis

The switch from DSM-III-R (American Psychiatric Association, 1987) to DSM-IV (American Psychiatric Association, 1994) will bring few changes in the diagnostic criteria for PTSD. As shown in Table 1, the stressor criterion (A1) will no longer characterize trauma as outside the range of normal human experience since we have been forced to recognize that exposure to catastrophic stress is an unwelcome but not unusual aspect of the human condition. Furthermore, the stressor criterion (A2) now requires that in addition to exposure, the patient need also have an intense emotional reaction to the traumatic event such as panic, terror, grief, or disgust. (In DSM-III (American Psychiatric Association, 1980) and DSM-III-R, Criterion A was restricted to exposure per se [A1] and did not address the subjective response [A2].) Otherwise, the B, C, and D, symptoms have remained the same with the exception of a slight rearrangement such that D6 in DSM-III-R has become B5 in DSM-IV.

PTSD patients are stuck in time and are continually re-exposed to the traumatic event through daytime recollections that persistently interrupt ongoing thoughts, actions, or feelings. They are assaulted by terrifying nightmares that awaken them and make them afraid to go back to sleep. They cannot tolerate any reminders of the trauma since these often trigger intense fear, anxiety, guilt, rage, or disgust. In some cases, they suffer PTSD flashbacks, psychotic episodes in which reality dissolves and they are plunged back into the apparent reality of a traumatic event that has haunted them for years or decades. During such episodes they find themselves fighting off rapists, being attacked by enemies, or fleeing from explosions with the same intense feelings they experienced during the initial trauma. Such intrusive recollections (Criterion B) can persist for over 50 years (Schnurr, 1992) and may get worse, rather than better, with time (Archibald and Tuddenham, 1965).

PTSD patients develop avoidant/numbing symptoms (Criterion C) to ward off the intolerable emotions and memories recurrently stirred up by these intrusive recollections. Sometimes they develop dissociative or amnesic symptoms that buffer them from painful feelings and recollections. They also adopt obsessional defenses and other behavioral strategies such as drug and alcohol abuse, eating disorders, sexual acting out and workaholism, to ward off intrusive recollections.

Finally, PTSD patients suffer from autonomic hyperarousal (Criterion D). Such symptoms include insomnia, irritability that may progress to rage, agitation and jumpiness manifested by an exaggerated startle response, and hypervigilance that may become indistinguishable from frank paranoia. PTSD patients are always on guard, dedicated to avoiding ever being re-exposed to the terrifying circumstances that changed their lives forever. It is difficult for them to trust other people or the environment. The need for safety and protection may outweigh all other considerations including intimacy, socialization and other pleasurable pursuits.

In other words, the clinician attempting to engage the PTSD patient in treatment is asking the patient to take a tremendous risk. S/he is asking the patient to give up all the protective behaviors and psychological strategies that have emerged to ward off intrusive recollections and hyperarousal symptoms. Therefore, the therapist must recognize that assessment and treatment are potentially destabilizing. Therapy can only succeed in an environment of sensitivity, trust, and safety (Herman 1992). Therapists must recognize that it may take a long time for patients to shed the many layers of protective symptoms that have evolved over countless years since the trauma. It is important for the therapist to let the patient know as soon as possible that s/he recognizes that the prospect of therapy is frightening and painful. It is also important that therapists suppress their own need to get a trauma history as soon as possible and set a pace that the patient can tolerate. In my own work, I always tell patients to signal me when our trauma-focused therapy has become too upsetting. I promise to back off whenever they signal me that therapy has become too distressing. And I always keep my promise. In this way, I fortify the atmosphere of trust and safety and preserve the forward momentum of therapy despite a momentary pause or two.

Some patients may be so relieved that they finally have an opportunity to discuss long suppressed, painful, and possibly shameful past events that they cannot wait to review such material with a therapist. A second group may be equally motivated but may appear resistant because of fears that therapy will stir up intolerable feelings. They require the safety mentioned earlier. A third group may have sought treatment for depression, anxiety,

chemical dependency, eating disorders, somatic complaints, or adjustment disorders rather than for PTSD. Indeed, among cohorts of treatment seeking PTSD patients, up to 80% have at least one additional psychiatric diagnosis including affective disorders (26-65%), anxiety disorders (30-60%), alcoholism or drug abuse (60-80%), or personality disorders (40-60%) (Friedman, 1990; Jordan, et al., 1991; Kulka, et al., 1990). For such patients, PTSD sometimes emerges as a diagnostic possibility only after the clinician has obtained a careful trauma history as part of a comprehensive assessment. Finally, there is a group of difficult patients who present, because of disruptive or self-destructive behaviors and who initially appear to suffer primarily from a personality disorder.

Patients in this latter category may be adult survivors of protracted childhood sexual abuse whose trauma history may be obscured by DSM-III-R labels such as borderline personality disorder (BPD), multiple personality disorder (MPD), and somatoform disorder. In addition to PTSD symptoms, they often present with problems of affect regulation, impulsive behavior, dissociative symptoms, problems of trust, inappropriate sexual behavior, and a wide variety of somatic complaints (Herman, 1992). These latter problems may demand the lion's share of therapy. Treatment of these patients may be further complicated by fragmented thought processes, incomplete memories, and dissociative symptoms.

The trauma history is essential. Given high rates of comorbidity mentioned earlier, and given a significant amount of overlap between symptoms seen in PTSD, depression, and other anxiety disorders, the trauma history is the major vehicle through which PTSD can be diagnosed and distinguished from other major mental disorders. There are many anecdotes about severely traumatized patients whose therapists never bothered to ask about childhood or adult trauma. They followed their therapists' leads and spent countless hours reviewing Oedipal conflicts, family dynamics, or here-and-now interpersonal conflicts. Belated discovery of the centrality of sexual abuse, combat stress, or domestic violence provided the key to understanding their current symptoms and became a productive focus for therapy.

It is usually not difficult to obtain a trauma history. Patients are generally forthcoming and frequently pleased to finally have an opportunity to tell their trauma story to someone who appears sufficiently knowledgeable and sensitive to ask about it. For all the reasons mentioned earlier, however, telling the trauma story can be difficult. The first trauma story to emerge is often only the tip of the iceberg. More distressing material will come later after the therapist has established trust and safety and has shown that he or she has the courage, wisdom, and empathy to listen to such material and sufficient positive regard for the patient to encourage further disclosure. Therapists can signal patients through their questions and responses that they understand the behavioral and emotional impact of a rape, natural disaster, or war. Such signals are readily perceived by patients who usually respond positively now that they have been reassured that it will be safe and productive to tell the full trauma story to this therapist at this time.

As with other medical and psychiatric disorders, PTSD patients may exhibit a wide spectrum of impairment. At one extreme, affected individuals may exhibit a high level of interpersonal, social, and vocational function. At the other extreme, some PTSD patients may be totally incapacitated by this disorder and may appear to have a chronic mental illness. Such patients may be misdiagnosed as having chronic schizophrenia and may be indistinguishable from such patients unless the clinician has undertaken a careful trauma history and diagnostic assessment. Two reports on psychotic female state hospital inpatients (Beck & Van der Kolk, 1987; Craine et al., 1988) indicate that those with a history of childhood or adolescent sexual abuse were more likely than non-abused patients to have intrusive, avoidant/numbing and hyperarousal symptoms associated with the abuse. In fact, 66% of these previously abused and currently psychotic patients met criteria for PTSD although none had ever received that diagnosis. Furthermore, they could be distinguished from non-abused state hospital patients by the prominence of sexual and abusive themes in their thoughts and behavior.

To summarize, detection of PTSD can be difficult because of patient fears that therapy will reactivate intolerable symptoms, because of the many co-morbid Axis I and Axis II DSM-III-R disorders that frequently accompany PTSD, and because some patients may be too fragmented, amnesic, dissociative, and otherwise impaired to participate in therapy. Assessment can only succeed in a safe therapeutic environment that promotes a comprehensive review of each patient's trauma history at a pace and intensity that is tolerable.

Treatment

Many therapeutic approaches have been advocated for PTSD. The reader is referred to a number of comprehensive reviews of the most prominent treatments for PTSD including psychodynamic therapy (Marmar, et al., 1993), cognitive-behavioral therapy (Foa, et al. 1995), pharmacotherapy (Friedman & Southwick, 1995), group, family, couples, and inpatient treatment (Williams & Sommer, 1995), and treatment for patients dually diagnosed with PTSD and alcoholism/ substance abuse (Kofoed, et al., 1993). Therapists working with patients who have survived a variety of traumatic events (war, natural disasters, etc.) generally agree that therapy can be divided into three phases:

- a. establishing trust, safety, and "earning the right to gain access" to carefully guarded traumatic material (Lindy, 1993; p. 806);
- b. trauma-focused therapy: exploring traumatic material in depth, titrating intrusive recollections with avoidant/numbing symptoms (Horowitz, 1986); and
- c. helping the patient disconnect from the trauma and reconnect with family, friends, and society.

It should be noted that patients who reach the third phase have integrated post-traumatic events and are ready to concentrate, almost exclusively, on here-and-now issues concerning marriage, family, and other current issues (Herman, 1992; Lindy, 1993; Scurfield, 1993).

Marmar, et al. (1995; 1993) have suggested that there are five identifiable post-traumatic syndromes, each requiring a different treatment approach: normal stress response; acute catastrophic stress reaction; uncomplicated PTSD; PTSD co-morbid with other disorders; and post-traumatic personality.

The normal stress response occurs when healthy adults who have been exposed to a single discrete traumatic event in adulthood experience intense intrusive recollections, numbing, denial, feelings of unreality, and arousal. Such individuals usually achieve complete recovery following individual or group debriefing (Armstrong, et al., 1991) derived from critical incident stress debriefing, CISD, models initially developed by Mitchell (1983) and Raphael (1986). Often a single two-hour group debriefing experience is all that is needed. Such sessions begin by describing the traumatic event. They then progress to exploration of survivors' emotional responses to the event. Next, there is an open discussion of symptoms that have been precipitated by the trauma. Finally, there is a resolution in which survivors' responses are normalized and adaptive coping strategies are identified.

Acute catastrophic stress reactions are characterized by panic reactions, cognitive disorganization, disorientation, dissociation, severe insomnia, tics and other movement disorders, paranoid reactions, and incapacity to manage even basic self care, work, and interpersonal functions (Marmar, 1991). Treatment includes immediate support, removal from the scene of the trauma, use of anxiolytic medication for immediate relief of anxiety and insomnia, and brief supportive aggressive dynamic psychotherapy provided in the context of crisis intervention.

Uncomplicated PTSD may respond to group, psychodynamic, cognitive behavioral, pharmacological, or combination approaches. During the past ten years we have come to appreciate the powerful therapeutic potential of positive peer group treatment as practiced in Vet Centers for military veterans and in rape crisis centers for sexual assault and domestic violence victims. It can be argued that the peer-group setting provides an ideal therapeutic setting for trauma survivors because their post-traumatic emotions, memories, and behaviors are validated, normalized, understood, and de-stigmatized. They are able to risk sharing traumatic material in the safety, cohesion and empathy of fellow trauma survivors. It is often much easier to accept confrontation from a fellow sufferer who has impeccable credentials as a trauma survivor than from a professional therapist who never went through those experiences first-hand. As group members achieve greater understanding and resolution over traumatic themes, they are remoralized. As they climb out of the pit of trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past (Herman, 1992; Scurfield, 1993).

Brief psychodynamic psychotherapy focuses on the traumatic event itself. Through the retelling of the traumatic event to a calm, empathetic, compassionate and non-judgmental therapist, the patient achieves a greater

sense of self-cohesion, develops more adaptive defenses and coping strategies, and more successfully modulates intense emotions that emerge during therapy (Marmar, et al., 1995). The therapist needs to constantly address the linkage between post-traumatic and current life stress. S/he needs to help the patient identify current life situations that set off traumatic memories and exacerbate PTSD symptoms.

There are two cognitive-behavioral approaches, exposure therapy and cognitive-behavioral therapy. Exposure therapy includes systematic desensitization on the one hand and imaginal and in-vivo techniques such as flooding, on the other. In general, flooding has been much more effective than systematic desensitization. The second approach, cognitive-behavioral therapy, includes a variety of anxiety management training strategies for reducing anxiety such as relaxation training, stress inoculation training, cognitive restructuring, breathing retraining, biofeedback, social skills training, and distraction techniques (see Hyer, 1994; and Foa, et al., 1995 for references). Foa and associates (Foa, et al., 1991; Rothbaum, et al., 1992) have shown flooding and anxiety management training (stress inoculation therapy) are both effective for rape victims with PTSD. They have also speculated that a combination of both treatments might be more effective than either treatment alone.

Given our expanding understanding of the many neurobiological abnormalities associated with PTSD (see Friedman, 1991.; Southwick, et al., 1992; Murburg, 1994; Friedman, Charney, & Deutch, 1995), pharmacotherapy appears to have a place in PTSD treatment. From a practical perspective, there is no question that drugs can provide some symptomatic relief of anxiety, depression, and insomnia, whether or not they ameliorate core PTSD intrusive and avoidant/ numbing symptoms. In most but not all trials, improvement has been achieved with imipramine, amitriptyline, phenelzine, fluoxetine, and propranolol. A quantitative analysis by Southwick, et al. (1992), suggested that tricyclic antidepressants and monoamine oxidase inhibitors are generally efficacious in PTSD patients, especially with regard to intrusion and avoidant symptoms, although fluoxetine, amitriptyline, and possibly valproate have shown efficacy against avoidant symptoms (Fesler, 1991; Davidson, et al., 1990; Van der Kolk, et al., 1994). At this time no particular drug has emerged as a definitive treatment for PTSD although medication is clearly useful for symptom relief thereby making it possible for patients to participate in group, psychodynamic, cognitive-behavioral, or other forms of psychotherapy.

PTSD comorbid with other DSM-III-R Axis I disorders is actually much more common than uncomplicated PTSD. As noted earlier, PTSD is usually associated with at least one other major psychiatric disorder such as depression, alcohol/substance abuse, panic disorder, and other anxiety disorders (Friedman, 1990; Jordan et al., 1991; Breslau et al., 1991; Kofoed, et al., 1993). Sometimes the co-morbid disorder is the presenting complaint that requires immediate attention. At other times, the PTSD appears to be the major problem. In general, the best results are achieved when both PTSD and the co-morbid disorder(s) are treated concurrently rather than one after the other. This is especially true for PTSD and alcohol/substance abuse (Abueg & Fairbank, 1991; Kofoed, et al., 1993). Treatment previously described for uncomplicated PTSD should also be used for these patients.

Post-traumatic personality disorder is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. These individuals often meet DSM-III-R criteria for diagnoses such as borderline personality disorder, somatoform disorder, and multiple personality disorder. Such patients exhibit behavioral difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional difficulties (such as affect liability, rage, depression, panic) and cognitive difficulties, (such as fragmented thoughts, dissociation, and amnesia). Treatment generally focuses on behavioral and affect management in a here-and-now context with emphasis on family function, vocational rehabilitation, social skills training, and alcohol/drug rehabilitation. Long-term individual and group treatments have been described for such patients by Herman (1992), Koller, et al. (1992), and Scurfield (1993). Trauma-focused treatment should only be initiated after long therapeutic preparation. Inpatient treatment may be needed to provide adequate safety and safeguards before undertaking therapeutic exploration of traumatic themes. The three phases of treatment, described earlier, apply to these patients as well as those with uncomplicated PTSD, but treatment may take much longer, may progress at a much slower rate, and may be fraught with much more complexity than with other traumatized patients.

Therapist Issues

Trauma work is difficult. Traumatized patients have suffered greatly and the therapeutic process often opens old wounds with alarming intensity. It is difficult, if not impossible, to maintain a stance of therapeutic neutrality when a patient tells you how s/he was brutally abused as a child, tortured by political enemies, or was forced to watch loved ones be murdered. Such narratives generate powerful emotions in therapist as well as patient. Therapists sometimes find themselves having intrusive thoughts or nightmares about the events recounted by their patients. Therapists may experience guilt that they were personally spared from such horrors. They may feel profoundly powerless because they could not protect patients from previous trauma and present distress. Such feelings can produce a number of inappropriate responses that interfere with therapy and disturb the therapist on a personal level. Herman (1992) notes that powerful emotions generated during therapy may prompt the therapist to engage in rescue attempts, boundary violations, or attempts to control the patient. Therapists may also activate a number of avoidant/numbing coping strategies such as doubting, denial, avoidance, disavowal, isolation, intellectualization, constricted affect, dissociation, minimization, or avoidance of traumatic material (Danieli, 1988; Herman, 1992; Lindy, 1988). McCann and Pearlman (1990) have called this phenomenon "vicarious traumatization," while Figley (1995) has called such secondary traumatization "compassion fatigue."

In my opinion, it is useful to separate out three different, but not mutually exclusive, circumstances in which therapists working with traumatized clientele may become distressed, immobilized, and symptomatic. First, therapists who have never been traumatized themselves may become overwhelmed by the material generated during the course of treatment with PTSD patients. They may experience (secondary) traumatic nightmares, guilt, feelings of powerlessness, rescue fantasies, or avoidant/numbing behavior as described above. This can set up a vicious cycle in which the more symptomatic, maladaptive, and ineffective therapists become, the more they plunge themselves into their work. When this occurs they are less likely to recognize that they have a serious problem and, unfortunately, are less likely to seek supervision or assistance from colleagues. Second, therapists experience a bona fide countertransference reaction in which the patient's material triggers intrusive recollections of traumatic experiences that happened to them in the past. Since exposure to trauma is not a rare event and since mental health professionals have no more immunity from such exposure than anyone else, such countertransference reactions should be expected to arise often enough to warrant careful monitoring by therapists and supervisors alike. Third, therapists are themselves exposed to the same kind of traumatic experiences for which they attempt to assist others. An example would be offering treatment to survivors of a natural disaster to which the therapist him or herself has also been exposed. Under such circumstances, the therapist must seek debriefing or treatment for his or her own post-traumatic symptoms before s/he can expect to assist others.

It is not enough for therapists to recognize these occupational hazards. They must make a conscious sustained and systematic effort to prevent such secondary traumatization through self-care activities. Such measures include developing a supportive environment, monitoring case loads in terms of size and number of trauma cases, making boundaries between personal and professional activities, having regular supervision, and establishing an institutional structure that will address this problem (Courtois, 1988; Gusman, et al., 1991). For example, Yassen (1993) has recommended time-limited group treatment for therapists and human service professionals who work with victims of sexual abuse and who themselves have previously been exposed to sexual trauma.

Controversial Issues

Although the PTSD diagnosis, itself, was controversial when it first appeared in 1980, that is no longer the case. However, there are currently four controversies in the trauma field that are worth noting: advocacy, eye-movement desensitization and reprocessing (EMDR), the false memory syndrome, and complex PTSD.

Many trauma patients have been victimized by an overpowering aggressor such as a rapist or terrorist. Most therapists are privately outraged by the violence that has been perpetrated on their clientele. Under such circumstances it can be exceedingly difficult to balance one's stance as a neutral professional with one's humanistic values concerning justice and abusive power. Some argue that advocacy is an essential component of the therapist role when your clientele are victims, while others insist that one must always maintain therapeutic neutrality despite

one's personal beliefs. It is crucial for each clinician to acknowledge this issue and to strive to achieve the proper balance for him or herself.

EMDR is a controversial therapy developed by Shapiro (1989) in which the patient is instructed to imagine a painful traumatic memory while visually focusing on the rapid movement of the therapist's finger. Shapiro believes that such saccadic eye movements reprogram brain function so that the emotional impact of the trauma can finally be integrated. She and her followers are convinced that patients can achieve resolution of previously disruptive trauma-related emotions through this procedure. Others have suggested that EMDR is really an exposure therapy in disguise and that eye movements may be irrelevant (Foa et al., 1995, Pitman, et al., 1993). Well-controlled empirical support for EMDR is lacking, the few completed controlled studies have been equivocal, and methodological questions have been raised (Boudewyns et al., 1993; Foa et al., 1995; Pitman et al., 1993). What's remarkable, however is that a number of seasoned PTSD clinicians are convinced that EMDR is the most effective available treatment for PTSD despite the fact that many others are highly skeptical of this approach.

Therapists working with adults who had been sexually assaulted as children have reported that such patients have sometimes had no memories of these childhood assaults at the start of treatment. During the course of therapy, however, such repressed traumatic memories reportedly emerge so that patients regain access to discrete recollections of childhood events such as father-daughter incest (Herman & Schatzow, 1987). Patients who claim to have regained traumatic memories of this nature have confronted parents whom they now regard as perpetrators of childhood sexual trauma. In some cases they have taken parents to court for these alleged abuses. Sometimes the accused parents vehemently deny that such events ever occurred and maintain that these "traumatic memories" are really emblematic of a "false memory syndrome" that has of therapy. Loftus (1993) has written extensively about the problem of authenticating such rediscovered previously repressed memories. Williams (1994), on the other hand, has shown that women who were sexually assaulted during childhood, (documented by recorded visits to hospital emergency rooms), are sometimes unable to recall that traumatic event. This hotly debated issue has theoretical, clinical, and forensic implications which will need to be sorted out in the future.

Finally, clinicians who work with victims of prolonged trauma such as incest and torture argue that such patients suffer from a clinical syndrome that is not adequately characterized by the PTSD construct (Herman, 1992). Although most patients in this category meet PTSD diagnostic criteria, it is argued that their primary problem is not PTSD. Instead, Herman (1992) has proposed that their major problems concern impulsivity, affect regulation, dissociative symptoms, self-destructive behavior, abnormalities in sexual expression, and somatic symptoms and has called this syndrome, complex PTSD. Identification and treatment of these patients has been described previously (post-traumatic personality). The controversy is whether complex PTSD is distinct from PTSD and whether it should have its own diagnostic identity. After much discussion, it was decided not to include complex PTSD in the DSM-IV. The controversy has stimulated a number of research initiatives. It is expected that this issue will be revisited during development of the next revision of the DSM-IV, the DSM-V.

Summary

PTSD is not difficult to detect if the clinician includes a careful trauma history as part of his or her comprehensive assessment. The major current diagnostic questions concern the possibility that there are a number of acute and chronic post-traumatic syndromes of which PTSD is the most distinct and identifiable example. Complex PTSD has been suggested as another post-traumatic syndrome which affects individuals who have protracted exposure to trauma, especially childhood sexual trauma. Another diagnostic issue concerns the relative importance of PTSD when it is associated with other co-morbid diagnosis such as depression, alcohol/substance abuse, anxiety disorders, and Axis II diagnoses. A third but related diagnostic issue concerns the fact that PTSD can progress to a chronic mental illness. Such patients are so impaired that they are superficially indistinguishable from other chronic patients and can often be found on the fringes of society, in homeless shelters, and enrolled in programs designed for patients with chronic mental illness such as schizophrenia.

The most widely used treatment for acute traumatic exposure is some CISM-type approach administered in an individual or group format. Among the treatments for chronic PTSD, group, psychodynamic, cognitive-behavioral, and pharmacologic approaches are used widely although few randomized clinical trials have been

conducted on any of these treatment approaches. When PTSD is associated with Axis I disorders, both PTSD and the co-morbid problems should be treated concurrently. When PTSD is associated with a personality disorder, treatment usually needs to be long-term and complicated.

There are a number of issues that must be acknowledged and addressed by therapists who work with traumatized clientele, which stem from the powerful emotions generated in the therapists during treatment. Inappropriate coping strategies by therapist may interfere with treatment and produce a disturbing syndrome which has been called vicarious victimization or compassion fatigue. Therapist self-care is an essential priority for these reasons.

Four controversies in the trauma field have attracted considerable attention. They are the proper balance between advocacy and therapeutic neutrality, the efficacy of EMDR as a treatment, the so-called false memory syndrome, and the possibility that complex PTSD is a unique diagnosis in its own right that is distinct from PTSD.

Table 1
DSM-IV Criteria for PTSD

- A. The person has been exposed to a traumatic event in which both of the following have been present:
- (1) the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed
 - (2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g., unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating

- (4) hypervigilance
- (5) exaggerated startle response

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

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

Self-Of-The-Therapist

You have already read Dr. Friedman’s article in the *Diagnosis and Treatment of PTSD* in which 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. Not enough can be said about the importance of this aspect of treatment.

In my own experience in working with traumatized individuals, groups and families, I have found there is a direct correlation between my ability to remain non-anxious, self-validated and empathetically connected with positive treatment outcomes.

We will begin with skills-building in this area before moving on to other areas assessment and treatment skills. If you are able to develop and maintain a non-anxious presence throughout your work with traumatized individuals, you are half-way to clinical mastery (the most difficult half, I’ll add). All other skills can be learned—the development of SELF must be lived and practiced.

I have constructed a series of exercises to develop awareness and to build skills in this area and they follow. I have also included an excerpt from James Masterson’s Book, (1988) *The search for the real self: Unmasking the personality disorders of our age*. Look over these “ten key capacities” and identify where you are strong and what capacities that you need to develop. This can be the start of your own personal and professional development plan.

When you have completed these tasks, go on to the exercises that follow.



Ten Key Capacities of the Real Self

James F. Masterson, MD

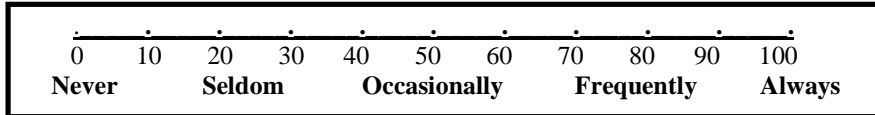
1. **Capacity to experience a wide range of feelings deeply** with liveliness, joy, vigor, excitement and spontaneity.
2. **Capacity to expect appropriate entitlements.** From early experiences of mastery, coupled with parental acknowledgment and support of the real self, healthy individuals build a sense of entitlement to appropriate experiences of mastery and pleasure, as well as the environmental input needed to achieve these objectives.
3. **Capacity for self-activation and assertion.** This capacity includes the ability to identify one's own unique individuality, wishes, dreams, and goals and to be assertive in expressing them autonomously.
4. **Acknowledgment of self-esteem.** This capacity allows a person to identify and acknowledge that he has effectively coped with a problem or crisis in a positive and creative way.
5. **The ability to soothe painful feelings.** The real self will not allow us to wallow in misery. When things go wrong and we are hurt, the real self devises means to minimize and soothe the painful feelings.
6. **The ability to make and stick to commitments.** The real self allows us to make commitments to relationships and career goals. Despite obstacles and setbacks, a person with a strong sense of real self will not abandon her goal or decision when it is clear that it is a good one and in her best interest.
7. **Creativity.** Based on helping people allow their real selves to emerge, is the ability to replace old familiar patterns of living and problem-solving with new and equally or more successful ones.
8. **Intimacy.** The capacity to express the real self fully in a close relationship with another person with minimal anxiety about abandonment or engulfment [ability to self-soothe this anxiety].
9. **The ability to be alone.** The real self allows us to be alone without feeling abandoned. It enables us to manage ourselves and our feelings on our own through periods when there is no special person in our lives and not confuse this type of aloneness with the psychic aloneness, springing from an impaired real self, that drives us to despair or the pathological need to fill up our lives with meaningless sexual activity or dead-end relationships just to avoid coming face to face with the impaired real self.
10. **Continuity of self.** This is the capacity to recognize and acknowledge that we each have a core that persists through space and time.

Masterson, J.F. (1988) *The search for the real self: Unmasking the personality disorders of our age.* New York: Free Press.

DIFFSU

J. Eric Gentry, MA, CAC, CTS
Connor Walters, Ph.D.

Directions: Identify a number between 0 - 100 from the scale below that best represents your experience the listed items.



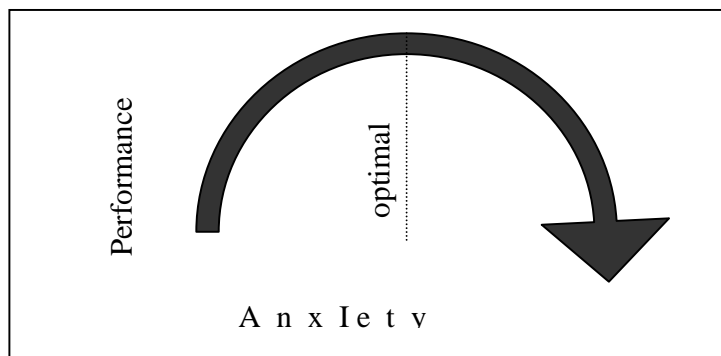
- _____ 1. I remain calm when people I care about are upset with me.
- _____ 2. It is more important for me to be satisfied with myself than to gain the approval of others.
- _____ 3. My words and my behaviors match each other.
- _____ 4. I can hold my point of view when someone I care about wants me to adopt their point of view.
- _____ 5. In decision -making, I can still think and reason while my feelings are intense.
- _____ 6. I can share my deepest thoughts and feelings without expectation that my partner share his/hers.
- _____ 7. I welcome difficulty when I know I will grow from the experience.
- _____ 8. When I am anxious I am able to soothe myself independently.
- _____ 9. I solve the problems of my relationships without bringing into focus a third person, object or activity.
- _____ 10. I am able to choose which of my family's beliefs and values I make my own.

SCORE

With acknowledgment to Mary Hicks, Ph.D.; Paul Gilbert, MA.; Blake Horne, MA; Ron Hankins, MA October 20, 1997

Self-Soothing (Anxiety Reduction) Skills

Recent research on brain activity has indicated that high levels of anxiety impede cognitive and motor skills. The higher an individual's anxiety rises beyond optimal levels, the more reactive (and less skilled) this individual becomes. Performance, language skills, information accessing, motor coordination and judgment all suffer from high levels of anxiety.



What does this mean for the helper working with trauma survivors? It means that unless you become an expert at lowering your own anxiety, you are likely to become *victimized* by your clients – that you will find yourself overwhelmed, de-skilled and even traumatized by your client's stories and affect.

Maintaining a non-anxious presence means that you will be more able to access and utilize all of your training, that you will be able to continue to “bear witness” to your clients' heinous stories and that you will be able to create and maintain a safe environment for healing. There is little that you can do, when working as a helper, that is more important than the maintenance of a non-anxious presence.

As you begin to develop mastery with self-soothing skills and are able to remain non-reactive to other's reactivity and your own emotions, chances are you will find yourself being much less reactive in other areas of your life. This is known as the principle of isomorphism – when you affect change in one area of life and it has a generative effect across the board to all other areas.

One last note on developing and maintaining a non-anxious presence. This is different than appearing calm while anxiety rages on the inside. Even while *appearing* calm, the helper whose anxiety has crossed over the optimal level will suffer a decrease in cognitive and motor performance. So, self-soothing involves the ability to use cognitive, affective and behavioral skills to create relaxation and lowered reactivity.

If you gain nothing else from this course, enhancing your ability to self-soothe will improve both you and your client's experience in therapy. Let's get busy.

Self-Soothing Skills

Cognitive

It has been demonstrated that feelings are generated by what we think. Often feelings seem to erupt spontaneously, however, upon closer inspection we find that there is usually a belief system, or schema, associated with the advent of a particular emotion. Cognitive theorists and therapists have long known that by attending to and replacing the negative, fear-based ways in which we talk to ourselves with more positive, life-affirming language we can improve the way we feel.

Take a minute to recall the times in which you have become anxious in working with another person. What types of things was your mind saying to you and about the situation. You will probably find some pretty dark images, coercive language and self-defeating thoughts associated with that anxiety. You are the owner of your thoughts and you are invited to begin to become intentional, instead of reactive, with your thinking during times of anxiety.

Reactive	Intentional
<i>Example:</i> <i>"I am going to screw this up...this is too much for me to handle!"</i>	<i>"I am doing the best that I can. I can remain calm and help."</i>

Affective/Body

Probably the most effective way to establish relaxation and to remain non-anxious is by releasing the tension in our bodies. Many of the most seasoned therapists will report that they find themselves having to release tension from their bodies dozens of time each session. Our bodies seem to tense up, preparing to fight or flee, even before we perceive that we have been threatened in some way. Sometimes a simple deep breath can be very effective in lowering our anxiety.

The pelvic floor muscle group (sphincter, gluteus, abdominal, hamstring and lower back) seems to be the “seat of anxiety.” Acknowledging and then releasing the tension in these areas can be very effective in lowering anxiety. Laughter always results in lessening of tension in this muscle group.

Where do you hold your tension? What ways can you begin to release tension in these and other muscles? Take a minute to jot down where you most frequently hold tension and some strategies for releasing this tension.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Behavioral

Joseph Wolpe was the developer of systematic desensitization and one of the first clinician/researchers to focus upon the lowering of stress. He realized that there is a host of behaviors that one can do which mitigate the effects of stress. Some of these include: taking a drink of water, Thought Field Therapy (tapping down), stretching, changing postures, prayer, talking, etc.

Think of some of the things that you can do to begin to lower your anxiety, *in vivo*, or in the moment. This is the most important skill to learn. We will talk later about self-care and the ability to replenish and refuel yourself during down times, however for now, it is important that you begin to develop ways to lower your anxiety while you are face-to-face with a client.

It can be easily argued that your first intervention in treating traumatized individuals is with yourself, assuring your own non-anxious presence, before moving on to interventions with your client.

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Developmental/Traumatic Issues

It is only a matter of time, if it hasn't happened already, before a client sits down across from you and begins to describe issues with which you yourself are dealing. Chances are, you will find it more difficult during these times to develop and maintain a non-anxious presence. This is not something from which you need to feel shame. It is, however, a wake-up call. For many it means that you will have to work doubly hard to develop and maintain your non-anxious presence. For others, it means that you may need to seek further help from your supervisor and/or therapist. These instances are precisely for what the individual and group meetings of the T-105 practicum are designed. Please address these difficulties with your supervisor and s/he will help you design a plan to resolve these issues.

- _____
- _____
- _____



Intake & Assessment:

Pre-Session Ritual

The initial session with the trauma survivor is, in many ways, the most crucial. In the previous sections we have discussed the importance of non-anxious presence and self-of-the-helper phenomena. In this first session is where these concepts are made concrete and put into practice.

Many therapists who have been doing therapy for some time and who could be considered “successful” by both their clients and their own level of satisfaction with their work have identified the need to have a pre-session ritual in which they prepare themselves for the meeting with their client(s). During this ritual some therapists work on lowering their anxiety to insure a non-anxious presence, others take a moment to review *their* goals for the session, while others choose to pray and/or meditate. The results are similar...a therapist who is prepared and empowered to assist their clients.

So, take a moment to think about how you would like to develop or enhance your pre-session ritual(s). How can you lower your anxiety to assure a non-anxious presence? What can you do to empower yourself as a sanctuary and change agent for your client? What behaviors can you implement that will assist you with these tasks?

My Ritual

- _____

- _____

- _____

- _____

- _____

- _____

Intake

It has been said that we will never again see our client as clearly as we do the first time that we meet them. After we have met our client, the projection process, replete with transference and countertransference, begins to distort our perceptions of which our clients really are. If we are our “best selves” while we are doing therapy, then we can minimize these distortions, however we are never as free from them as we are in the initial meeting.

It is important that we create an atmosphere of safety, integrity and the capacity for change for our incoming clients. How can we be intentional in this process? What are some of your ideas about how this can be accomplished?

The Greeting. The first opportunity that you have to speak with or meet your client will be an opportunity to establish this environment. Some things that we have found to be helpful in this process is to make eye contact, establish a relaxed and attending posture, shake hands and to welcome the client to the session. Taking care of any physical needs, such as temperature, location of bathrooms, comfortability of seating and other physical comforts (i.e., water, tea, etc) can demonstrate an immediate attendance to your client.

What is your particular style for greeting your clients? Is there anything that you do to personalize this greeting?

Informed Consent, Therapy Contracts & Limits of Confidentiality. Early in the first session it is important to inform the client about the expectations and requirements from him/her while in therapy. It is important to teach them how to be clients. Many people, especially trauma survivors, come to therapy without having ever been to therapy or, even more challenging, have had previous unsuccessful experiences in therapy. It is important to take some time, in an unhurried and non-anxious countenance, to explain these important aspects to your client. There are several sources that can assist you in developing your own handouts for clients that further explain these important aspects of therapy.¹ It is not enough to simply have your client sign an informed consent document, it must also be discussed. The following questions can be utilized as a template to discuss these important issues (Zuckerman, 1997). Take a moment to read through them and decide how you would answer them for one of your clients.

¹ *The Paper Office* (Zuckerman, 1997) provides the clinician with several templates which will allow you to create an informed consent document, an informational brochure about you and your practice, as well as other important forms for release of information, billing, etc. Guilford Press. ISBN 1-57230-104-X

Client Information

Information You Have a Right to Know

When you come for therapy, you are buying a service to meet your individual needs. You need good information about therapy to make the best choice for yourself and your family. I have written down some questions you might want to ask me about how I do therapy. We may have talked about some of them already. You are free to ask me any of these questions, and I will try my best to answer them for you. If my answers are not clear, or if I have left something out, or if you have more questions, just ask me again. You have the right to full information about therapy.

A. About Therapy

1. What will we do in therapy?
2. What will I have to do in therapy?
3. Could anything bad happen because of therapy?
4. What will I notice when I am getting better?
5. About how long will it take for me to see that I am getting better?
6. Will I have to take any tests? What for? What kind?
7. How many (that is, what fraction) of your clients with my kind of problem get better?
8. How many (that is, what fraction) of your clients get worse?
9. How many (that is, what fraction) of people with the same kinds of problems I have get better without therapy? How many get worse?
10. About how long will therapy take?
11. What should I do if I feel therapy isn't working?

B. About Other Therapy and Help

1. What other types of therapy or help are there for my problems?
2. How often do these other methods help people with problems like mine?
3. What are the risks or limits of these other methods?

C. About Our Appointments

1. How will we set up our appointments?
2. How long will our sessions last? Do I have to pay more for longer ones?
3. How can I reach you in an emergency?
4. If I can't reach you, to whom can I talk?
5. What happens if the weather is bad or I'm sick and can't come to an appointment?

D. About Confidentiality

1. What kinds of records do you keep about my therapy?
2. Who is allowed to read these records?

3. Are there times you have to tell others about the personal things we might talk about?
(LIMITS OF CONFIDENTIALITY)

E. About Money

1. What will you charge me for each appointment?
2. When do you want to be paid?
3. Do I need to pay for an appointment if I don't come to it, or if I call you and cancel it?
4. Do I need to pay for telephone calls to you?
5. Will you ever raise the fee that you charge me? When?
6. If I lose some of my income, can my fee be lowered?
7. If I do not pay my bill, what will you do?

F. Other Matters

1. How much training and experience do you have? Do you have a license? What are your other qualifications?
2. What kind of morals and values do you have?
3. To whom can I talk if I have a complaint about therapy that you and I can't work out?

The list above deals with the most commonly asked questions, but many people want to know more. Feel free to ask me any questions you have at any time. The more you know, the better our work will go. You can keep the "Information for Clients" brochure (if given) and this list. Please read them carefully at home, and if any questions come up, write them on this page so we can talk about them when we meet next time.

These questions can be a helpful guide in establishing an environment of mutual respect with your clients. You may choose to create a document similar to this to present to your clients upon intake and ask them which questions they would like answered. Of course this will require that you be prepared to answer them. You should always document discussion on these topics.

What have we missed? What other important ingredients go into the making of a successful initial meeting? Please take a moment to jot down your thoughts on this.

Intake & Assessment:

Psychotraumatology Evaluation -

With the completion of the greeting, information for clients, informed consent and the decision to continue with therapy, it is now time to initiate the evaluation. This is a multi-step process which utilizes a structured clinical interview format and includes several self-report and one clinician administered instruments, a mental status exam, an inventory of symptoms, the criteria for stabilization and recovery, a treatment plan, goals of treatment and outcome criteria. All of this information becomes synthesized into one report that we have called **The Psychotraumatology Evaluation** (Tinnin, 1996; Gentry, 1998).

The **Psychotraumatology Evaluation** was developed at West Virginia University's School of Behavioral Medicine for use in the Psychotraumatology Intensive Outpatient Program. This evaluation/assessment process has been established to conform to the scientist/practitioner model of psychotherapy and, at once, provides a structured clinical interview with solid diagnostic information and baseline data for outcome measurement. While some of the measurement instruments have not yet demonstrated empirical statistical validity, they have great clinical utility.

In this section, we will be instructing you in the step-by-step use of the **Psychotraumatology Evaluation** – from initial interview to the completion of the report. Moreover, you will be challenged to conduct and report at least one of these evaluations over the next month. Let's get started.

Step One: Becoming Familiar with the Tools

You will find at the end of this section everything you need to complete the **Psychotraumatology Evaluation**. These tools include the following:

- Psychotraumatology Evaluation – Structured Clinical Interview (template)
- Data Summary
- Psychotraumatology Evaluation Sample
- Trauma Profile
- Clinician Administered PTSD Scale (CAPS)
- Dissociative Experiences Scale (DES)
- Dissociative Regression Scale (DRS)
- Impact of Events Scale – Revised (IES-R)
- Symptom Check List – 45 (SCL-45)
- Satisfaction With Life Scale (SWLS)
- Trauma Recovery Scale (TRS)

Take a few minutes to look through each of these pages, allowing yourself the opportunity to get familiar with each of these tools. Don't worry that you do not yet understand everything in this assessment package yet, we will progress through it at a pace that you can integrate all this complex information. So start by just looking through the materials and

when you have completed this, turn to the Psychotraumatology Evaluation – Structured Clinical Interview (template).

The Psychotraumatology Evaluation – Structured Clinical Interview

This template is designed to provide the clinician with a “road map” through the first, or evaluation, session. It is recommended that you allow yourself 120 minutes for this session to begin with. As you progress in skill and knowledge, you will find this time diminishing.

It is helpful to describe to the client this process of assessment and evaluation. Let them know that you will be asking several questions about their history and the way that they have adapted and coped with these experiences. It is important to let them know that they may refuse to answer any question and that, if they should become overwhelmed at any time, they may stop the evaluation.

This template begins with demographic data. Some of you will have your own or your agency’s forms to collect this data and will therefore be able to skip this section. It is included so that you can have all this information on one document.

Helpful Hint – *We have found it helpful, whenever possible, to give the self-report instruments to the client **before** this session so that they are completed when you meet with the client. This will allow you to refer to them for helpful information.*

If you are able to make arrangements for your client to complete the self-report scales prior to your meeting, take a glance at Part I and Part II of the **Trauma Recovery Scale (TRS)**. Many appropriate and necessary questions can come from the clients’ answers on this instrument. *What traumatic experiences have they had in their history? How may? How old were they? How have they coped with these experiences? What effects do they suffer now from them?* All of these are important questions to include in the evaluation.

The evaluator should begin with questions aimed toward the level of distress and discomfort that the client is experiencing in the present. Asking them the simple question, “*What is going on with you that has motivated you to come to therapy **now**?*” while it may be trite is an important early question to ascertain the experiences that have precipitated the client coming to therapy.

This question should be followed by a thorough and exhaustive discussion of the current symptoms that the client is suffering. The evaluator will begin to get a sense of the **intensity, frequency & duration** of the client’s posttraumatic and other symptoms from these early questions. Exploring these parameters of the client’s symptoms will also help the clinician to begin to make hypotheses about appropriate treatment (i.e., *Are the symptoms this client is experiencing from one single traumatic experience or are they from multiple exposure to traumatic events. How volatile is this client? Will s/he need extensive work toward stabilization?*).

After a reasonably thorough history, including discussion of all traumatic experiences depicted in the TRS, the clinician should make an effort to “normalize” the client’s symptoms as

normal adaptive responses of a normal person to abnormal and overwhelming experiences. It is helpful here to provide a brief psychoeducational overview of how trauma and traumatic stress affects the brain and personality of the survivor.

This is followed by a brief review of the client's medical history. The client should be asked to discuss all previous psychiatric treatment (including previous psychotherapy). This will allow the clinician to discuss with the client the positive and negative experiences of previous therapy to glean some understanding of what types and styles of treatment have worked best with this client. It will also potentially help the clinician to avoid the same mistakes made by previous therapists. All current medical difficulties should be recorded and diagnosed on Axis III. Also the clinician should inquire into the current medication that has been prescribed for the client and how regularly that they take this medication. If the client is currently being treated by a physician and is prescribed psychotropic medication, then the clinician should record these medications and dosage. The clinician should also pursue a release of information from the client so that s/he can contact the physician to inform him/her that the client is seeing you for psychotherapy. It is important to cultivate strong professional relationships with the client's attending physician and move towards a multi-disciplinary team approach to treatment in which you keep the physician apprised of progress in the client's care.

A section on ***Family History*** has been included in the **Psychotraumatology Evaluation**. The completion of this section is optional but provides important information for the clinician about the client's family-of-origin. Much of the work towards the end of therapy will probably focus around these developmental issues and, for many clients, will become figural even before then. It is important for clients to begin to understand how their resiliency to trauma was enhanced or diminished as a result of the family dynamics and interventions that interpret these dynamics can provide a powerful tool towards the resolution of shame and other cognitive distortions.

Trauma Profile

This section involves the scoring and interpretation of the assessment instruments. This is a skill that takes months of utilization to master, so be patient with yourself in the beginning as you are learning the meaning of these scales. A brief explanation and interpretation of each of the instruments follows:

Clinician Administered PTSD Scale (CAPS). This scale becomes the "centerpiece" of the assessment/evaluation session. The scale is a 17-item clinician administered scale that has very high reliability and validity in assessing and diagnosing PTSD. It provides a step-by-step structured interview for each of the criteria of PTSD. Criterion A, *The Event*, section of the CAPS has already been answered by the client in the TRS and the clinician is directed to Part I of that instrument to ascertain whether or not the client meets the criteria for this area of diagnosis. The CAPS then leads the clinician through a series of questions which probe the three clusters of symptoms that comprise the diagnosis of PTSD: intrusion, avoidance and arousal. There is one question for each symptom identified in each criterion. These questions should be read directly from the CAPS and the client may be engaged in a discussion about the frequency and intensity of each symptom. The answers should be recorded directly on the scale itself and

will be utilized heavily in arriving at a diagnosis as well as the writing of the Psychotraumatology Evaluation report. The CAPS will provide a step-by-step diagnostic worksheet for the clinician that will allow him/her to make an accurate and reliable diagnosis of PTSD if the client meets sufficient criteria.

Trauma Recovery Scale (TRS). This scale was created as a client-friendly outcome measure for an intensive outpatient psychotraumatology treatment program. It has since been revised to provide important diagnostic information. Part I asks the client to judge for him/herself whether or not they have experienced traumatic events sufficient to meet Criterion A of the DSM-IV for posttraumatic stress disorder. The language of this question is drawn directly from the DSM-IV and, therefore, relieves the therapist of the burden of having to make this evaluation. Part II is simply an inventory of the traumatic events that the client has experienced, over their life span, which meet this criterion. Finally, Part III contains 11 items in which the respondent is asked to rate her/himself on the *recovery or absence* of PTSD symptoms. The items were created by attempting to language the symptoms of the DSM-IV in solution-focused language (distressing intrusive thoughts vs. “*I make it through the day without distressing thoughts of the past.*”) While the validity data on this scale is still being collected and analyzed, preliminary data points toward a score < 50 indicating significant clinical posttraumatic distress while a score of > 75 indicates recovery from or the minimal presence of traumatic sequelae.

Also in the TRS, you will notice that there are two Item #5 (5a. *I feel safe* & 5b. *I am safe*). These items should be averaged to give one score for Item # 5 and then all the scores summed and divided by 10 to give a mean score. This item # 5 provides an excellent opportunity for the clinician to begin to confront cognitive distortions around the issue of safety in early treatment. This will be further discussed in future sessions of this practicum.

Impact of Events Scale (Impact of Events Scale –Revised). The Impact of Events Scale is a 15 item scale which measures the intrusion and avoidance symptoms resultant from a single event. It enjoys high reliability and validity data and is easily scored (See **Trauma Profile**). The Impact of Events – Revised has included arousal symptoms, however, the interpretation of the scores is not available at the time of this writing.

Symptom Check List – 45 (SCL-45). The SCL-45 is a symptom checklist that measures general psychiatric distress (subscales for somatization, depression, anxiety and psychosis). Scores of > 100 reflect severe distress, 80 – 100 moderate distress and < 80 mild distress. One note, scores of greater than 100 on the SCL-45 affect the interpretation of the DES (See Trauma Profile).

Dissociative Experiences Scale (DES). This 28-item scale is used to measure the degree to which a person suffers from dissociative symptoms. To obtain a score on the DES, sum all items and then divide by 28 to arrive at a mean score. Loosely interpreted, the mean score will reflect the percentage of time that the clients experiences dissociative phenomena. Scores of ≥ 20 indicate significant level of dissociation and score ≥ 30 indicate, generally, the presence of one or more “parts” and this individual should be evaluated for Dissociative Identity Disorder using the SCID-D. One caveat in scoring the DES is that the higher the SCL-45 the more this influences the score on the DES. In other words, when the score is > 100 on the SCL-45, the

DES scoring criteria raises 10 points (i.e., instead of scores ≥ 20 indicating significant dissociation the cut-off becomes ≥ 30).

Dissociative Regression Scale (DRS). The DRS was developed by Louis Tinnin, MD at WVU to measure the degree to which the client's intrusive posttraumatic and dissociative symptoms are causing a regression of ego functioning. If a client has a higher DRS score than a DES score and they are both over 20, then this indicates that a regression is present and stabilization must precede trauma resolution work. The further the separation between the DRS and the DES (with the DRS being higher) the greater the degree of regression. Dissociative regression means that the clients has become so overwhelmed with their intrusive and anxiety symptoms that there normal adult ego functioning (i.e., recording of time, managing of tasks, volition, sense of identity) have been compromised. To begin trauma work with these individuals in which they are confronting their trauma memories will only exacerbate their symptoms. We will further explore the phenomenon of dissociative regression and its' treatment later in this course.

Toronto Alexithymia Scale (TAS). Alexithymia means "the inability to language feelings." This condition is prevalent with trauma survivors and the scores of this scale are usually correlative with scores for intrusive symptoms and dissociation. As the client resolves the intrusion symptoms by confronting and metabolizing the trauma memories, these score will normally make a drastic decline as the client regains the capacity to "speak their feelings." A score of > 73 indicate the presence of alexithymia on the TAS.

Symptom Check List. Notice on pages 3-4 of the **Psychotraumatology Evaluation**, there is a Symptom Checklist that allows you to inventory the posttraumatic symptoms that your client is experiencing. This section provides you with the source of this data. This will allow you to make your diagnoses with confidence as well as identify what problems you and the client will want to address in your treatment. We have used the following clusters of symptoms to identify in our report:

- Traumatic experiences
- Intrusive Symptoms
- Avoidance Symptoms
- Arousal Symptoms
- Dissociative Symptoms
- Depressive Symptoms
- Other Symptoms.

Each of these areas are defined in the Symptom Check List portion of The evaluation.

Mental Status Exam. The Psychotraumatology Evaluation provides the clinician with a checklist style template for completing a mini mental status examination. This is a good way to document having explored suicidality/ homicidality as well as substance abuse with your client.

Client Strengths/Resources – This section is as much an intervention as it is evaluation. For this portion of the evaluation the clinician should ask the client to inventory his/her strengths and resources. Do not allow the client to discuss weakness or shortcomings, keep them focused

upon their strengths. When they have exhausted their supply, the clinician may ask, “Do you mind if I add a few others to that list?” From here the clinician can fill in other strengths for which the client is blind that the clinician discovered during the evaluation thus far.

Expectations/Goals from Treatment. The author always asks his clients “*How will you know when you are ready to fire me?*” This is a playful, tongue-in-cheek way to elicit from clients their desired outcomes from therapy. It is important that these goals be languaged in positive terms (i.e., don’t accept “get rid of trauma” or “make it stop” instead ask the client “What would you have if you ‘got rid of the trauma?’”) Make sure that you craft solid, specific goals of which the outcomes are able to measured (.e., “How will you know that you ‘have a life?’”). The goal of establishing goals with the client is for you and the client to align your intentions toward a mutually agreed upon destination. By doing this you will have moved closer the development of a strong therapeutic alliance.

Diagnosis. It is not the purpose of this course to teach the methodology of diagnosis. It is an art that requires much practice to perfect. However, you have all you need to be able to offer the diagnosis of PTSD, provided that the client meets the criteria (described in the Diagnostic Worksheet section of the CAPS). A copy of the DSM-IV will be helpful here. You may find yourself wanting to provide differential and/or secondary diagnoses on Axis I. Some of the more common ones include: Major Depressive Episode, Bipolar affective Disorder, Dissociative Disorder NOS, Substance Abuse/Dependence, Dysthymia. The trauma history should be recorded on Axis IV.

Preliminary Treatment Plan. This section should contain the Criteria for Stabilization, the Criteria for Resolution as well as a comprehensive and circumspective treatment plan complete with projected number of sessions and prognosis.

The Trauma Profile

Instruments

Symptom Check List - 45 (SCL-45)
Toronto Alexithymia Scale (TAS)
Dissociative Experiences Scale (DES)
Dissociative Regression Scale (DRS)
Clinician Administered PTSD Scale (CAPS)
Impact of Events Scale (IES)
Solution-Focused Trauma Recovery Scale (TRS)

Scoring

DES: sum of scores / 28
SCL-45: sum of scores
DRS: sum of scores / 6
TAS: reverse scores on items # 1, 5, 6, 9, 11, 12, 13, 15, 16, 21, 24
sum of scores
IES: column 1 = 0, column 2 = 1, column 3 = 3, column 4 = 5
sum of scores
TRS: sum of scores / 10

Values

TAS: < 62 = no alexithymia
> 73 = alexithymia
< 70 = condition is mild or acute
> 70 condition is chronic or severe

IES: Intrusive items = 1, 4, 5, 6, 10, 11, 14, 15

TRS: Intrusive = 1, 2, 3
Avoidant = 4, 5, 6, 7
Arousal = 8, 9, 10

Diagnostic

SCL-45 < 100; DRS < DES

- DES: 20 - 30 = PTSD
 - DES: 30 - 50 = DDNOS
 - DES: 50+ = DID

DRS < DES

No significant regression
Trauma work permitted

SCL-45 > 100; DRS > DES

- DES: 30 - 40 = PTSD
- DES: 40 - 60 = DDNOS

DRS > DES

Regression present
if DRS > 50 then treat
regression (see anti-

DES: 60+ = DID

regression schedule :ARS)

PSYCHOTRAUMATOLOGY EVALUATION

Clinician: _____

Date: _____

Demographic Information

Name: _____	(Preferred): _____
Address (1): _____	(2) _____
_____	_____
Phone (1): () _____	(2) () _____
FAX: () _____	email: _____
Employment: _____	
Marital Status: _____	Age: _____ DOB: _____
Referred by: _____	

Presenting Problems

Chief Complaint: _____

History (including previous treatment)

Symptoms (progression)

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Trauma History (primary & secondary) - see TRS

Medical History

Current problems: _____

Historical problems: _____

Current Rx: _____

Family History

Physical Illness: _____

Mental Illness (optional): _____

How well did your family manage stress? _____

What did they do to manage stress?: _____

What are the main sources of stress in your life?: _____

What do you do to manage this stress?: _____

How well is it working?: _____

TRAUMA PROFILE

- ____ CAPS-2 (during evaluation session)
- ____ TRS
- ____ IES
- ____ DES
- ____ DRS
- ____ SCL-45
- ____ BDC
- ____ SWLS
- ____ TAS

Symptom Check List

(from Trauma Profile)

Criterion A: Event + reaction (CAPS;TRS)

- _____
- _____
- _____
- _____
- _____

Criterion B: Intrusion (CAPS; IES; SCL-45)

- _____ (B-1) Unwanted memories of the event
_____ (B-2) Unpleasant dreams/nightmares
_____ (B-3) Acted or felt as if [EVENT] was happening again/flashbacks
_____ (B-4) Intense psychological distress with exposure to cues (internal/external)
_____ (B-5) Physiological reactivity with exposure to cues

Criterion C: Avoidance (CAPS; BDI; IES; SCL-45)

- _____ (C-1) Efforts to avoid thoughts, feelings, or conversations associated with the [EVENT]
_____ (C-2) Efforts to avoid activities, places or people that remind of [EVENT]
_____ (C-3) Inability to recall important aspects of the trauma
_____ (C-4) Markedly diminished interest or participation in significant activities
_____ (C-5) Feeling of detachment or estrangement from others
_____ (C-6) Restricted range of affect
_____ (C-7) Sense of foreshortened future

Criterion D: Arousal (CAPS, IES, SCL-45, TRS)

- _____ (D-1) Difficulty falling or staying asleep
_____ (D-2) Irritability or outbursts of anger
_____ (D-3) Difficulty concentrating
_____ (D-4) Hypervigilance
_____ (D-5) Exaggerated startle response

Criterion E: Duration

- _____ More than one month
_____ Delayed onset (> 6 months before symptoms)
_____ Chronic (> 6 months)

Criterion F: Subjective Distress

- _____ Distress present
_____ Area of life
• _____
• _____
• _____
• _____

Dissociative Symptoms (DES; DRS; SCL-45)

- _____ Voices (# 28 on DES; SCL-45)
_____ Loss of time
_____ Amnesia
_____ Depersonalization
_____ Derealization
_____ Identity confusion (“parts”, alters)
_____ Loss of consciousness

Depressive Symptoms (BDI; CAPS; SCL-45)

- _____ Depressed mood
- _____ Anhedonia
- _____ Weight loss/gain (>5%)
- _____ Insomnia/hypersomnia
- _____ Psychomotor agitation/retardation
- _____ Anergia
- _____ Feelings of worthlessness/inappropriate guilt
- _____ Diminished concentration
- _____ Suicidal ideation/recurrent thoughts of death

Other Symptoms

- _____ Somatization (SCL-45)
- _____ Alexithymia (TAS)
- _____ Victim mythology/distorted belief system/Survivor Guilt
- _____ Relational difficulties
(explain: _____)
- _____ Other: _____
- _____ Other: _____
- _____ Other: _____

Mental Status Exam (MSE)

Presentation/appearance: _____

Oriented X1____ X2____ X3____ X4____

Attitude/Behavior: (attention, eye contact, demeanor, outlook, mannerisms) : _____

Mood/affect: _____

Speech: _____

Thought/associations (ego functions: identity, time, volition) _____

Psychotic Features: _____

Suicidal Ideation: (+) _____ (-) _____ Lethality: Plan _____ Means: _____

Homicidal Ideation: (+) _____ (-) _____ Lethality: Plan _____ Means: _____

Substance Abuse: (+) _____ (-) _____ What kind: _____

How much: _____

Other addictions (compulsions/obsessions—e.g., gambling, sex, shopping, etc) : _____

Sleep: _____

Appetite: _____

Memory Functions (long/short term, attention, concentration): _____

Judgment/Insight/Fund of Knowledge: _____

Motivation for treatment: _____

Prognosis: _____

Client Strengths/Resources

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Expectations/Goals from Treatment

Goals:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: (current GAF): _____ (Highest in past year): _____

Preliminary Tx Plan:

- _____
- _____
- _____
- _____
- _____

Clinician _____ Date: _____

Supervisor: _____

Psychotraumatology Evaluation (SAMPLE REPORT)

DATE: 15 December

CLIENT: XXX

IDENTIFYING INFORMATION. The client is a 38 year old married Hispanic female who resides with her family in XXX and was referred to this therapist by XXX, a licensed clinical psychologist in XXX, for assessment and treatment of her posttraumatic symptoms and complications. XXX presents herself, accompanied by her husband (XXX), to this office for assessment and treatment on December 13, 14 and 15.

CHIEF COMPLAINT: The client was referred to this office for intensive outpatient psychotrauma therapy by XXX. She has been receiving treatment from XX during the past few months for her posttraumatic symptoms. Recently, her husband has learned that she has been involved in an extramarital affair with a co-worker and this discovery precipitated a crisis in their relationship that has led to this referral. The client is suffering from extreme ambivalence regarding the decision she must make to either end the affair or separate from her husband and family. The client reports that she is currently unable to make this decision. Both the client and XXX believe that her involvement in the affair and her painful difficulty with the impending decision to have an etiology that stems from earlier traumatic experiences. The client identifies the development of insight and skills necessary to resolve this dilemma as the primary objective of her treatment.

HISTORY: The client was born in XXX in 1961 where she lived for five years before her family moved to XXX where she has lived since that time. She reports that her grandmother was her primary caretaker and that both her parents had little involvement in her development. Her father was an alcoholic and she reports that her mother was both physically and emotionally abusive throughout her development. She states that she was raped three (3) times by an uncle when she was six years old and told no one about these incidents for several years. As she developed into adolescence, the client states that she became very involved in the church to escape the pain and difficulty of her home. At age 16, the client reports that her Sunday school teacher (age 28) became enamored with her and made advances which had strong sexual overtones. The client reports that she began to become progressively involved with this Sunday school teacher until she was, in essence, living with her. She states that she spent increasing amounts of time with this woman who made many demands upon and was kept almost as a "hostage." The client reports that while they never actually "had sex", much of their time together was highly eroticized (petting, caressing, nude massage) while at the same time this woman verbalized a legalistic religious morality. The client reports that this relationship was maintained in this fashion for over five years and ended abruptly when the woman became afraid that she was being investigated for her relationship with the client and feared losing her job at the university where she was an instructor. During the period that the client was involved with this

woman she completed an undergraduate and graduate degree in accounting at this university where she graduated *cum laude*.

Shortly after the dissolution of this relationship, the client met and married her husband, XXX. The client reports that she has and does love her husband intensely. They have three children, ages 14, 10 and 8. Her husband is the pastor of a church at which the client reports to have become very much involved (playing the piano, playing in the church band, church accounting, children's ministry). She is also an executive-level manager in a long-distance communications firm and has successfully maintained this job throughout the course of her marriage. She reports that she managed each of these responsibilities flawlessly for several years, even while she was becoming progressively depleted from her efforts.

In 1989, while pregnant with her second son, the client accidentally hit a pedestrian with her automobile. The victim subsequently died from the wounds suffered in this accident. She was vindicated from culpability for this accident in both civil and criminal courts.

The client reports that 10 months ago she met and eventually became obsessed with a co-worker with whom she has had an ongoing sexual and romantic affair. She states that she is deeply in love with both this co-worker while maintaining strong feelings of love for her husband and family. She has clear awareness of the difficulty this affair is causing her husband, her family and herself. She has tried, on several occasions, to end this affair but has not been able to maintain the separation. She describes this relationship as like an "addiction." Her continued involvement in this affair and her husband's subsequent discovery has caused intense friction for the client in her marriage, her job (where she may be facing disciplinary action for sexual harassment), her family and the congregation of her church. Her continued involvement in this affair, with its seeming self-destructive consequences, is perplexing to the client, her family and her referring therapist. Her desire to arrive at a decision to end her marriage, leave her family, and commit fully to the relationship with her paramour or to terminate this relationship and return to her marriage and family is the primary goal of her treatment.

In addition to this goal, the client reports that she has had several periods during which she "blacks out" with rage. Many of these experiences have happened while disciplining her children, replicating her mother's abuse episodes with her. She states that she wants to develop insights and tools necessary to terminate this behavior so that she never again is harmful towards her children. She also states that she has ongoing intrusive symptoms, in the form of anxiety, nightmares and flashbacks, of the rapes that occurred when she was six years old. She articulates a desire to resolve these symptoms during this week of intensive outpatient therapy.

The client's husband reports, during the interview, that he is very much committed to assisting his wife in resolving her issues and retains hope that she will return to him, her children and their life together.

MEDICAL/PSYCHIATRIC: The client reports that she suffers from back pains, chronic fatigue syndrome and fibromyalgia. She has been treated for depression and anxiety for several years by a psychiatrist with Serzone and benzodiazapines. She was recently hospitalized for depression and is being followed by XXX, who has participated in this referral. She reports that she is allergic to Sulfa.

Current Rx:

- Prozac 20 mg/day
- Klonopin 0.5mg BID

XXX symptoms are summarized in the following list:

PROBLEMS:

A. History of trauma:

- Type I trauma of *rape (3x)* by uncle at age six, which she reports to have responded with horror, terror and helplessness.
- Type I trauma of *motor vehicle accident* at age 28 while pregnant during which the victim was killed
- Type II trauma of *severe physical abuse* (contusions and lacerations) ongoing from infancy to age 21 by mother. She also reports ongoing verbal and emotional abuse.
- Type II trauma of *sexual captivity* from ages 16 to 21 by Sunday school teacher.

B. **Intrusive symptoms:** Recurrent images and thoughts of each of the above traumatic experiences (rape most prevalent), nightmares, severe psychological and physiological distress with reminders of the trauma, dissociative flashbacks.

C. **Avoidant symptoms:** Efforts to avoid thinking about the trauma, avoidance of activities which remind her of the rape, diminished interest in participating in significant activities, Alexithymia, significant amnesia for events associated with trauma, feelings of detachment and estrangement from others, restricted range of affect.

D. **Arousal symptoms:** Severe insomnia/sleep disturbances, frequent irritability with dissociative rage experiences, extreme exaggerated startle response, marked increase in anxiety and sadness with reminders of the affair, hypervigilance, physiological reactivity upon exposure to events which symbolize or resemble her abuse experiences.

E. **Depressive Symptoms:** anhedonia, depressed mood most every day, diminished libido, identity disturbance/ distortion, anhedonia, anergia, crying spells, diminished concentration, inappropriate guilt/shame.

F. **Dissociative Symptoms:** Depersonalization, derealization, dissociative flashbacks, retrograde and anterograde amnesia, time loss,

G. **Other Symptoms:** Ego-dystonic involvement with self-destructive relationship, somatization including shakiness and tremors, victim mythology, marital difficulties, extreme performance standards, and self-critical cognitive style.

FINDINGS:

Baseline values:

- **Clinician Administered PTSD Scale (CAPS) = 29** (intrusive - severe) + **40** (avoidance - severe) + **32** (arousal - extreme) = **101 total** (severe clinical). Meets clinical significance for every symptom of PTSD
- **Dissociative Experiences Scale (DES) = 35.4** (significant dissociative phenomena)
- **Dissociate Regression Scale (DRS) = 40** (significant dissociative regression)
- **Symptom Checklist 45 (SCL-45) = 80** (moderate general psychiatric symptoms/somatization)

- **Trauma Recovery Scale (TRS) = 38** (minimal recovery/stabilization from PTSD symptoms)
- **Impact of Events Scale (IES) = 52** (Rape - extreme intrusion & avoidance)
- **TAS = 83** (extreme alexithymia)
- **BDC = 45** (Moderate depression)

INSTRUMENT	Pre-Referral	Baseline	Posttreatment	Follow-up
(CAPS) - Total	NA	101		
(CAPS) - Intrusion	NA	29		
(CAPS) - Avoidance	NA	40		
(CAPS) - Arousal	NA	32		
DES	33	35.4		
DRS	40	40		
SCL-45	89	80		
TRS	25	38		
IES	NA	52		
TAS	80	83		
BCD	NA	45		

Mental Status: XXX is casually dressed, well groomed, of small stature and appears her stated age with a presentation of attentive alertness. She exhibits good eye contact, amiable facial expressions, with a friendly and cooperative demeanor. She is alert and oriented (x4), perceptive and has extremely good verbal communication skills. Her outlook is guarded with significant belief in future difficulties. Her affect is, much of the time, inappropriately bright to content (she is tearful at times) and labile; her mood is anxious and depressed. She has a good attention span and exhibits no episodes of intra-session amnesia for content during assessment. She reports memory disturbances in the form of retrograde and anterograde amnesia, as well as minimal present loss of time. Her speech (English) is pressured but clear and articulate (Spanish is her native language), coherent with a wealth of content and appropriate to content. She denies suicidal ideation but indicates a mild preoccupation with thoughts of death. She denies homicidal ideation or intent. She denies auditory and/or visual hallucinations and delusions. She does, however, report episodes of depersonalization, depersonalization and dissociative flashbacks and rages. She also reports ego-dystonic obsessions/compulsions in the form of continued involvement with her extramarital affair. She reports very mild alcohol usage and denies any further substance abuse. She has a remarkable fund of knowledge and is of extremely high intelligence with good judgment. Her insight is excellent, as is her motivation for treatment. Prognosis is hopeful.

ASSESSMENT:

Diagnosis:

Axis I:	309.81	Posttraumatic Stress Disorder, Chronic, with delayed onset
	296.22	Major Depressive Disorder, Recurrent, moderate
	300.15	Dissociative Disorder NOS
	V61.9	Partner Relational Problem
	V61.21	Physical & Sexual Abuse during Childhood
	313.82	Identity Problem (ego-dystonic homosexuality)

Axis II: 799.9 **Diagnosis Deferred on Axis II**
R/O Borderline Personality Disorder; R/O
Dependent Personality Disorder

Axis III: **Back Pain**
Chronic Fatigue Syndrome
Fybromialgia

Axis IV: **History of Type I & Type II trauma**
Problems with primary support group
(family, significant others, church)
Problems related to social environment
(triangled relationship with significant others)

Axis V: **GAF** (current): **52**; (highest in past year): **85**

Criteria for stabilization:

- Self-reported ability to implement self-regulation strategies which allow client to continue functioning and remain in control immediately following intrusive imagery, thoughts and affect (grounding and containment).
- Self-reported mastery of affective regulation and negative arousal reduction strategies.
- Establish self-reported environmental, interpersonal and intrapersonal safety sufficient to begin trauma resolution phase of treatment.
- Development and practice of daily self-care activities which maintain stability in adult functioning.

Criteria for recovery:

- Client resolves ambivalence regarding decision
- Problems B, C, D, E, F & G resolved
- IES < 25; TRS > 75; CAPS < 30; TAS < 45; SCL-45 < 50; DES < 10
- Resolution of trauma memories AEB no intrusive imagery/thoughts
- Resolution of victim mythology and self-critical cognitive style.

CLIENT STRENGTHS/RESOURCES

- “Loving”
- ”Strongwill”
- “Hard worker”
- “Organized”
- “Good humor”
- Verbal abilities
- Support system (husband & family)
- Financial management
- Extreme intelligence
- Integrity
- Musical abilities
- Strong spiritual/religious beliefs;
- Compassionate
- Financial stability

EXPECTATIONS FROM TREATMENT

1. “To make a decision [husband and family vs. paramour] that brings peace”
2. “To resolve the issues with my mother so that I never again hurt my children or respond to them in a rage”
3. “Removal of some hurt [from past traumatic events]”
4. Resolve the psychological effects of the rapes by uncle at six years old.
5. Resolve “edginess”
6. “Being able to reconnect with and feel a part of my family”

TREATMENT PLAN:

Assessment/Evaluation (4- 6 hours)

- Introduction to treatment/Informed consent
- Structured Clinical Interview
- Psychotraumatology Evaluation
 - Presenting Problem
 - History and Progression of Symptoms
 - Symptom Inventory/Assessment Battery/Baseline Data
 - Clinician Administered Posttraumatic Stress Scale
 - Dissociative Experiences Scale
 - Dissociative Regression Scale
 - Symptom Check List-45
 - Trauma Recovery Scale
 - Toronto Alexithymia Scale
 - Beck Depression Inventory
 - Impact of Events Scale
- Medical History (including current Rx)
- Trauma History
- Family History
- Expectations from Treatment

- Resources Inventory
- Mental Status Exam
- Criteria for Stabilization
- Criteria for Recovery
- Treatment Plan (preliminary)
- Treatment Contract

Safety & Stabilization (2-4 hours)

- If Dissociative Regression present, then Anti-Regression Protocol (6-10 hours)
- If no Dissociative Regression, then continue with below (2-6 hours)
- Flashback Journal
- Grounding & Containment Strategies
- Arousal Reduction/Self-soothing skills
- Expression Strategies
- Continue with this phase until Criteria for Stabilization is achieved

Trauma Resolution – for Type I Trauma (*non-abreactive*) [4 – 8 hours]

- Time-Limited Trauma Therapy/Trauma Recovery Institute Method (Tinnin, 1994, 1998)
 - Video-assisted Verbal Anamnesis (1.5 – 3 hours) – to create trauma narrative
 - Recursive Review (1.5 – 3 hours) – integration and metabolization
 - Non-verbal anamnesis/Trauma Art (2 – 3 hours) – resolution of intrusive imagery
 - Video-dialogue (2 – 4 sessions; 1.5 – 2 hours each) – to resolve peri- and post-traumatic dissociation.
- Eye-Movement Desensitization & Reprocessing (with Resource Installment) (2 – 4 sessions; 1.5 – 2 hours each) – to resolve and restructure posttraumatic cognitive distortions
- Focal and Dynamic Psychotherapy – (1 – 4 sessions; 1.5 hours each) – to resolve traumatic grief, victim mythology, and to facilitate re-engagement.
- Re-evaluation. Upon resolution of intrusive symptoms and significant amelioration of avoidance (depressive) and arousal symptoms, move to Phase IV. If insufficient symptom relief, treatment plan renegotiated with possible inclusion of other trauma resolution strategy (i.e., Traumatic Incident Reduction, Neuro-linguistic Programming/Visual-Kinesthetic Dissociation, Direct Therapeutic Exposure/Cognitive-Behavioral Therapy)

Trauma Resolution – for Type II Trauma (*mild to moderate abreactive*) [3 – 15 hours]

- All above with on-going psychodynamic/hypnotherapeutic psychotherapy (2 – 10 sessions; 1.5 hours each)
- Re-evaluation. Upon resolution of intrusive symptoms and significant amelioration of avoidance (depressive) and arousal symptoms, move to Phase IV. If insufficient symptom relief, treatment plan renegotiated with possible inclusion of other trauma resolution strategy (i.e., Traumatic Incident Reduction, Neuro-linguistic Programming/Visual-Kinesthetic Dissociation, Direct Therapeutic Exposure/Cognitive-Behavioral Therapy)

Reconnection [4-6 hours]

- Video-assisted Mission Statement Exercise (1.5 – 3 hours)
- Conjoint marital therapy (2 hours)
- Focal Psychotherapy (if needed) – Present/future oriented (1-4 sessions; 1.5 hours each)
- Follow-up Planning/Exit Interview/Outcome Data (1.5 – 3 hours)

client

date

J. Eric Gentry, PhD, LMHC
Therapist

date

Tri-Phasic Model

Judith Herman, M.D.

Judith Herman is a psychiatrist in the Boston area. She has worked extensively with Bessel van der Kolk and is the author of two books, *Father Daughter Incest* (1981) and *Trauma and Recovery* (1992), and numerous articles on the enduring effects of chronic trauma. *Trauma and Recovery* is considered a seminal work on the history and treatment of chronic Type II trauma.

Herman conceives trauma recovery to proceed in three stages:

Safety

The central task of recovery is safety. Victims of chronic trauma are betrayed not only by their loved ones but by their own bodies. Their symptoms become sources of triggers that cause re-traumatization. The clinician's primary goal is to help the client regain internal and external control. This is accomplished through careful diagnosis and education. If flashbacks are the chief symptom, the clinician helps the client to learn skills to reduce their frequency and duration. Similarly, if the client is living in an abusive environment, the therapist discusses with her alternatives, including the availability of shelters for battered women and other abuse victims. The overriding goal is to enable the client to make a gradual shift from "unpredictable danger to reliable safety" (p. 155) both in their environments and within themselves. Accomplishing this goal may take as long as nine months.

Mourning and Remembrance

In the second phase of recovery the client reconstructs her story in minute detail. Because of the nature of traumatic memories, this process is rarely linear. Bits and pieces of the story emerge and can be told. The objective is to create a space in which the client can relive and begin to make sense of the devastating experiences that have shaped her life. The clinician's role is "bear witness" to the client's experiences, and help her find the fortitude to heal.

A number of brief treatments can be used to enable the client to describe traumatic events. These include EMDR, time-limited trauma therapy, and traumatic incident reduction. When the client is not able to process the events verbally, art and music therapy are useful.

Reconnection

The final stage of recovery involves redefining oneself in the context of meaningful relationships. Trauma survivors gain closure on their experiences when they are able to see the things that happened *to them* with the knowledge that these events do not determine who *they are*. Trauma survivors are liberated by the conviction that, regardless what else happens to them, they always have *themselves*. Most survivors also are sustained by an abiding faith in a higher power that they believe delivered them from oppressive terror. In many instances survivors find a "mission" through which they can continue to heal and to grow. They often end up helping others with similar histories of abuse and neglect. Successful resolution of the effects of trauma is a powerful testament to the indomitability of the human spirit.

For the purposes of this course, we will focus our attention upon the first two of these three phases with a concentrated effort toward helping participants develop adequate safety with and for their clients.

I. Safety

In 1996, while completing a fellowship in psychotraumatology at West Virginia University in Morgantown, WV, I wrote an article on developing and maintaining safety with trauma survivors which was later published as a chapter in *Death and Trauma* (Figley, 1997). In this chapter, which provides a protocol for assessing and developing stabilization, I attempt to define and operationalize the concept of “safety” into three levels, relative to the treatment of trauma survivors. These three levels of safety are as follows:

- I. **Resolution of impending environmental (ambient, interpersonal and intrapersonal) physical danger;**
 - i. Removal from “war zone” (e.g., domestic violence, combat, abuse)
 - ii. Behavioral interventions to provide maximum safety;
 - iii. Address and resolve self-harm.
- II. **Amelioration of self-destructive thoughts & behaviors** (i.e., suicidal/homicidal ideation/behavior, eating disorders, persecutory alters/ego-states, addictions, trauma-bonding, risk-taking behaviors, isolation)
- III. **Restructuring victim mythology into a proactive survivor identity** by development and habituation of life-affirming self-care skills (i.e., daily routines, relaxation skills, grounding/containment skills, assertiveness, secure provision of basic needs, self-parenting)

One of the most difficult questions that a clinician must answer for him/herself is: *What is the adequate level of safety/stability necessary to transition to Phase II (Trauma Resolution) of treatment?* We are taught from the first days of our clinical training to “above all do no harm (*primum non nocere*),” which makes it logical to assume that the more safety and stability that we, as clinicians, can affect in the lives of our clients, the better for their treatment – right? The answer to this question is a double-edged sword. For example, early in my career as a trauma therapist I spent many therapy hours working with clients to establish safety and stability that, when I now look back, I see clearly that it was my own anxiety about approaching the traumatic material. And, upon further inspection, I can see how *my anxiety* actually escalated the crises of my clients. It is a commonly held hypothesis among trauma therapists that the most important ingredient to effective establishment of stabilization and even treatment outcomes is the confidence and competence of the clinician. This has been the reason for the sequencing of material for this course. It you will remember the first section of T-105, it deals with self-of-the-therapist issues and the maintenance of a non-anxious presence. This non-anxious presence along with an unwavering optimism for the client’s prognosis is probably the most powerful intervention that you can provide toward the development of stabilization for your clients. Secondly, you will find that destabilization and the lack of safety is very often behaviors and thoughts of the client in response to the bombardment of intrusive symptoms (nightmares, flashbacks, psychological and physiological reactivity) in their lives. A protracted period of

attempting to over-develop safety for these clients is not helpful – what is needed is an approach which develops the minimum (“good enough”) level of safety and stabilization and then addresses and resolves the intrusive symptoms by narratizing the traumatic experience. This is often counter-intuitive and almost always anxiety producing for the clinician. However, the client will be much better equipped to change his/her self-destructive patterns (e.g., addictions, eating disorders, abusive relationships) with the intrusive symptoms resolved, having much more of their faculties available for intervention on their own behalf.

So again, what is the minimal standard of safety necessary to begin Phase II of treatment? While this question has not even been addressed in the literature, much less resolved, I will propose the following criteria:

1. **Level One [Resolution if impending environmental (ambient, interpersonal and intrapersonal) physical danger]** of safety, discussed above, must be achieved. Traumatic memories will not resolve if the client is in **active** danger and the clinician must use cognitive and especially behavioral treatments to assist the client in removing him/herself from harm’s way. (Note: see “Am Safe vs. Feel Safe” discussion below)
2. **Ability to distinguish between “Am Safe” and “Feel Safe.”** Many trauma survivors feel as if danger lurks around every corner, every next minute. In fact, the symptom cluster of “Arousal” is mostly about this phenomenon. It is important for the clinician to confront this distortion and help the client to distinguish, objectively, between “outside danger” and “inside danger.” Outside danger, or a “real” environmental threat, must be met with behavioral interventions designed to help the survivor remove or protect her/himself from this danger. Inside danger, or the fear resultant from intrusive symptoms of past traumatic experiences, must be met with interventions designed to lower arousal and develop awareness and insight into the source (memory) of the fear.
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:
 - a. **3-2-1** Sensory grounding technique
 - b. Visualization of a “safe-place”
 - c. Progressive relaxation (and/or other anxiety-reduction skills)
 - d. Development of self-soothing discipline (e.g., working out, music, art, gardening, etc)
 - e. Containment strategy(ies)
 - f. Expression Strategy (ies)
4. **Ability to demonstrate self-rescue.** It is useful to ask the client to begin to narrate his/her traumatic experience(s) and when s/he begins to experience intensifying affect the clinician should challenge him/her 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 him/herself from overwhelming traumatic memories. It also is 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 s/he 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. **Contract with client to address traumatic material.** The final important ingredient of the Safety Phase of treatment is negotiating the contract with the client to move forward to Phase II (Trauma Resolution) with the client. 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 (i.e., *“I have watched you develop some very good skills to keep yourself safe and stable in the face of these horrible memories. Judging from how well you have done this, I expect the same kind of success as we begin to work toward resolving these traumatic memories. What do you need before we begin to resolve these memories?”*).

In your Psychotraumatology Evaluation with your client, you developed some objective criteria for stabilization (see previous section). It is important to review these criteria before moving forward. It is a good idea to administer another set of assessment instruments (e.g., TRS, DES, DRS, SCL-45, IES) and discuss the results with the client. 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 these shortcomings to insure that there is no danger in moving ahead with treatment. Some “red flags” which should alert the clinician that movement forward may be premature are as follows:

- **TRS < 50**
- **SCL-45 > 100**
- **DRS > DES** (with both scores > 20 and the difference between > 10)

If any of these scores are present then it could indicate that (a) the client needs more work toward the development of stabilization skills and/or (b) the client is experiencing a dissociative regression.

Managing Dissociative Regression

(adapted from Tinnin, 1995)

What is dissociative regression? This phenomenon has been described by Tinnin (1995) as the condition that ensues when the ego (or left brain) is constantly being bombarded and overwhelmed by intrusive symptoms (i.e., flashbacks, affect, abreactions, pain). Autonomous executive ego functions, such as time, volition, identity and affect regulation begin to deteriorate, or regress.

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

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

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

Prohibitions

- No alcohol or sedatives or stimulants
- No rumination
- No naps

Stimulus Barrier

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

Reduce Ambiguity

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

Auxiliary Ego Function

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

Support Autonomous Ego Functions

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

Grounding and Containment Skills

- For use with addictive reenactments and flashbacks.

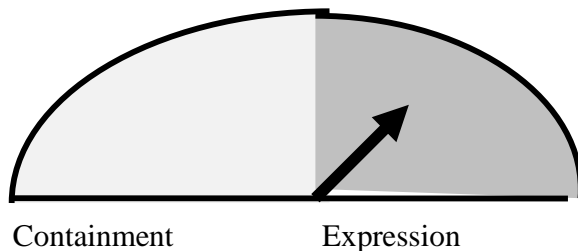
How long will this take? If the client is cooperative with the treatment tasks described above, most dissociative regressions abate within two - three weeks. If it continues longer, consult psychiatrist/hospital.

Grounding & Containment

- I. Overview of Safety
 - A. Inside or Outside
 1. Safety Reconnaissance
 - a. Tx Planning
 2. “Am safe” vs. “feel safe”
 - B. A word about “Balanced Living/Systems Management”
- II. Inside/Intrapersonal Management of Traumatic Stress
 - A. Triggers
 1. What are “triggers”
 2. Three Phases
 - a. (1)Environmental Stimuli
 - b. (2) Emergent Memory + Arousal
 - c. (3) Emotional Aftermath
 - B. Grounding (*in vivo* ASAP)
 1. 3-2-1 Sensory Grounding
 2. Relaxation Strategies
 - a. Progressive
 - b. Autogenics
 - c. Biofeedback
 - d. Diaphragmatic (Belly) Breathing
 - e. Tubes-in-legs Breathing
 - f. Stress Inoculation (Michenbaum, 1989)
 3. Postural Grounding
 4. Transitional Object
 5. NLP Anchoring Techniques
 6. Internal Safe Place
 7. Mindfulness
 8. Affirmations/Slogans (AA/NA)
 9. Eye Movement
 - a. For acute dissociative flashbacks
 10. Sensory Experiences (food, drink, smells, bath, ice)
 11. Rubber Band
 12. Grounding Tape
 13. Post-It Notes
 14. Spiral Technique
 15. Light Steam
 16. Journaling
 17. Visualization
 - a. Stop Sign
 - b. “What appears to be a cave is, in truth, a tunnel”
 18. Reading aloud
 19. Serenity Prayer

C. Containment

1. Of What?
 - a. Triggers/Flashbacks
 - b. Suicidal Ideation/Behavior
 - c. SIB
 - d. Switching
 - e. Intense Emotions
 - f. Alters (word of caution)
2. Internal Vault/Box
3. "What do you want that you are afraid that you won't get?"
4. Internal Safe Place (with safe objects for sleep)
5. Dissociative Table Technique (Fraser, 1992)
6. Art Therapy with triggers
7. Cigar Box/Envelope w/ staples
8. Titration: metaphors (Slow Leak - Kluft)
9. Transference/Projective Identification ("Who am I right now...how do I want to hurt you?")
10. Rituals (Sleep)
11. Containment/Expression Tachometer



D. Expression

1. Timed/metered affect modulation
2. Sounds/primal scream (automobile)
3. Anxiety to Anger
4. Tearing Paper
5. Video-dialogue
6. Red Marker
7. Ice

The Clearness Committee:

An Alternative Method for Group Clinical Supervision

“Each of us has an inner teacher, a voice of truth, that offers the guidance and power we need to deal with problems”

- Parker Palmer

The Courage To Teach

The Clearness Committee is drawn from Palmer’s (1997) book who discovered it from the Quakers. The Quakers used this technique to help members of their congregation solve their own problems because they had no clerical leaders. This material has been adapted for use in clinical supervision with a strong argument towards believing that it is the development of the “self-of-the-therapist” that is more important than the mastery of technique.

Below are the directions, rules and anecdotes for the implementation of the Clearness Committee in a group clinical supervisory setting.

1. The focus clinician seeking supervision or presenting the case writes up his/her case and send this document to the member prior to the meeting. The write up should contain three foci:
 - a. ***Statement of the problem*** - In this first area the clinician will want to focus upon the problems that s/he is having with the case – NOT CLIENT PROBLEMS. This can range from transference/ countertransference issues to questioning appropriate interventions to secondary traumatization issues to issues of truth vs. illusion in treatment.
 - b. ***Relevant background*** – In this area, the clinician will want to discuss previous experiences, both professional and personal, where this issue has become figural and caused distress for him.
 - c. ***Sought after outcomes*** – The clinician should identify as clearly as possible the goals for which she is striving. She should be able to “paint a picture” of how she would like for the situation to resolve.
2. The meeting begins with the facilitator calling for a time of centering silence and inviting the focus clinician to break the silence, when ready, with a brief summary of the issue at hand. Then the committee members may speak—but everything they say is governed one rule, a simple rule and yet one most people find difficult and demanding: *members are forbidden to speak to the focus clinician in any way except to ask honest, open questions*. This mean absolutely no advice, reflections, suggestions, or interpretations. It means no “Why don’t you...?” It means no “There’s a book/therapist/exercise/training that would help you a lot.” Nothing is allowed except *real* questions, honest and open questions, questions that will help the focus person remove the blocks to his or her inner truth without becoming burdened by the personal agendas of the committee members. I may think that I know the answers to your problems, and on rare occasions I may be right. But *my* answer is of absolutely no value to you. The only answer that counts is the one that arises from your own inner truth. The discipline of the Clearness Committee is

to give you greater access to that truth—and to keep the rest of us from defiling or trying to define it.

3. What is an honest, open question? It is important to reflect on this, since we are so skilled at asking questions that are advice or analysis in disguise: “Have you ever thought that it might be your mother’s fault?” The best single mark of an honest, open question is that the questioner could not possibly anticipate the answer to it: “did you ever feel like this before?” There are other guidelines for good questioning. Ask questions aimed at helping the focus person rather than satisfying your own curiosity. Ask questions that are brief and to the point rather than larding them background considerations and rationale—which make the question into a speech. Ask questions that go to the person as well as the problem—for example, questions about feelings as well as about facts. Trust your intuition in asking questions, even if your instinct seems off the wall: “What color is your problem, and what color will it be when it is resolved.”
4. Normally, the focus person responds to the questions as they are asked, in the presence of the group, and those responses generate more, and deeper, questions. Though the responses should be full, they should not be terribly long—resist the temptation to tell your life story in response to every question! It is important that there be time for more and more questions and responses, thus deepening the process for everyone. The more a focus person is willing to answer aloud, the more material the person—and the committee—will have to work with. But this should never happen at the expense of the focus person’s need to protect vulnerable feelings or maintain privacy. It is vital that the focal person assume total power to set the limits of the process. SO everyone must understand that *the focus person at all times has the right not to answer a question*. The unanswered question is not necessarily lost—indeed, it may be the question that is so important that it keeps working on the focus person long after the committee has ended.
5. The Clearness Committee must not become a grilling or cross-examination. The pace of the questioning is crucial—it should be relaxed, gentle and humane. A machine-volley of questions makes reflection impossible and leaves the focus person attacked rather than evoked. Do not be afraid of silence in the group—trust and treasure it. If silence falls, it does not mean that nothing is happening or that the process has broken down. It may well mean that the most important thing of all is happening: new insights are emerging from within people, from their deepest source of guidance.
6. From the beginning to the end of the Clearness Committee, it is important that everyone work hard to remain *totally attentive* to the focal person and his or her needs. This means suspending the normal rules of social gathering—no chitchat, no responding to other people’s questions or the focal person’s answers, no joking to break the tension, no noisy and nervous laughter. We are simply to surround the focus person with quiet, loving space, resisting even the temptation to comfort or reassure or encourage this person, but simply being present with our attention, our questions and our care. If a committee member damages this ambiance with advice, leading questions, or rapid-fire inquisition, other members (including the focus person) should remind the offender of the rules—and the offender is not at liberty to mount a defense or argue the point. The Clearness Committee is for the sake of the focus person, and the rest of us need to tell our egos to recede.
7. The Clearness Committee should run for the full time allotted for each focal person. Don’t end early fearing that the group has “run out of questions”—patient waiting will be

rewarded with deeper questions than have yet been asked. About ten minutes before the end of the meeting, the facilitator should ask the focus person if s/he wants to suspend the “questions only” rule and invite members to mirror back what they have heard the focus person saying. If the focus person says no, the questions continue, but if s/he says yes, mirroring can begin with more questions. Mirroring does not provide an excuse to give advice or “fix” the person—that sort of invasiveness is still prohibited. Mirroring simply means reflecting the focus person’s own language—and body language—to see if s/he recognized the image. With each mirroring the focus person should have the opportunity to say, “Yes, that’s me” or “No, that’s not.” In the final five minutes, the facilitator should invite the participants to celebrate and affirm the focus person and his/her strengths. This is an important time, since the focus person has just spent a long time being vulnerable. And there is much to celebrate, for in the course of the Clearness Committee, people reveal gifts and graces that characterize human beings at their deepest and best.

8. Remember, the Clearness Committee is not intended to “fix” the focus person, so there should be no sense of letdown if the focus person does not have his or her problem “solved” when the process ends. *A good clearness process does not end*—it keeps working in the focus person long after the meeting is over. The rest of us need simply to keep holding that person in the light, trusting the wisdom of his or her inner teacher.
9. The processing of the Clearness Committee is indigenous to the meeting and members should not confront the focus person once the meeting is over. What is said in the Clearness Committee stays in the Clearness Committee.
10. In the rare instance where there are ethical and/or legal issues, the Clearness Committee will continue working with the focus person and it will become the responsibility of the facilitator to discuss this issue with the focus person immediately following the meeting.