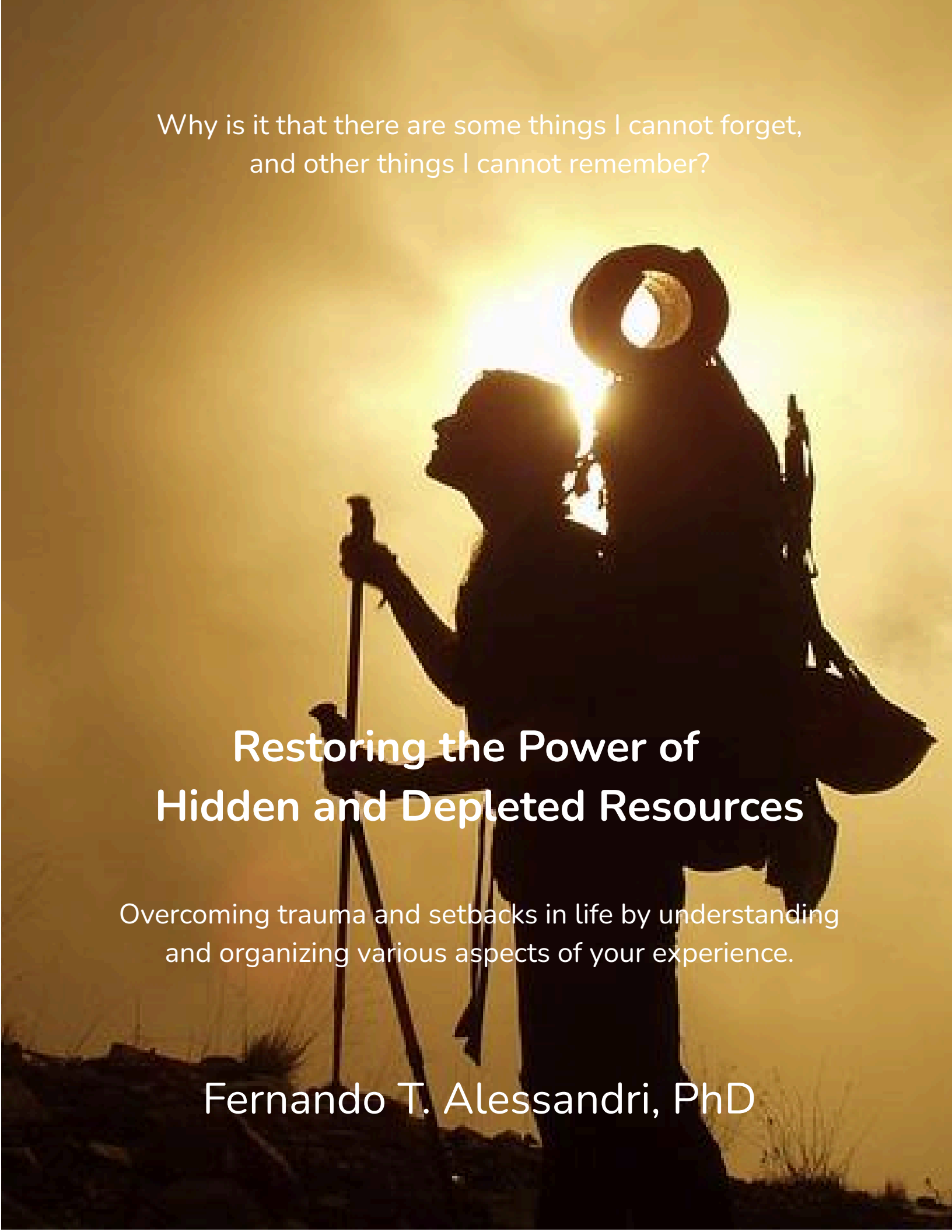


Why is it that there are some things I cannot forget,
and other things I cannot remember?

Restoring the Power of Hidden and Depleted Resources

Overcoming trauma and setbacks in life by understanding
and organizing various aspects of your experience.

Fernando T. Alessandri, PhD

Chapter 1.

A funny thing happened on the way to a dissertation.

During my first practicum experience en route to a doctorate in psychology I was exposed to people involuntarily confined to an inpatient crisis center in rural Mississippi. Some came in the back of police cars, others in ambulances. An occasional one was voluntary. My role was to lead group therapy sessions, and to provide some informal counseling as well as provide general support. By then I had already learned a number of principles of first-, second-, and third-wave behavioral therapies. I could lead mindfulness exercises, expose flaws in logic and thinking, and could explain various brain functions and diagnoses. I was very enthused being there and most patients responded very affirmatively to my efforts.

I quickly realized that many people were quite capable of understanding barriers that were interfering with living normal, self-regulated lives. Only a few cases involved a true break from reality and requiring long-term care. Very soon I recognized three key pillars involved in severe distress. They were substance use, relationship discord, and trauma. Everything else I was encountering seemed to fit as secondary to those: suicidality, job loss, academic failures, and even some of the psychosis I encountered. Later during postdoc I would go on to confirm that many presumed cases of a thought disorder (e.g., schizophrenia) were better treated as posttraumatic stress disorder (PTSD) with psychotic features. (For some strange reason, that is not an actual diagnosis in the DSM 5, but remains a possible modifier of many other conditions such as major depressive disorder and bipolar disorders, “with psychotic features.”)

Another thing I learned during that practicum was that the reason therapists are always asking how an experience makes a person feel is that many people seem to benefit from expressing those words. Yet for other people, especially men, that question can feel quite intimidating. Some people have a very poor vocabulary for physical and emotional sensations or “feelings.” I soon realized I could help people out and make things extremely efficient if I provided word lists for people to choose from. Later I went on to read research studies that added evidence to the value of what they called “granularity” in labeling emotions, using many words with different nuances rather than limiting expression to basic ones. I felt vindicated in the work I had been doing. My word lists were quite successful in getting people – including men and teenagers – to acknowledge, express, and “sit with” painful emotions that needed acknowledgment.

Lest the practicum experience sound entirely positive, I was also horrified by something I saw. Much of the staff seemed to believe the mission of the crisis center was to keep everyone calm and poised. The nurses did not like it when I had patients becoming upset, or crying, or expressing anger. They were quite ready and willing to sedate people. Even among the mental health staff and other trainees, there was a belief that trauma was a “Pandora’s Box,” not to be opened or dealt with. There was a belief that many months or even years were required for trauma, and yet they were well aware that few of the people coming through their doors would ever get such treatment.

It was then that I became a bit subversive. I could not stomach the betrayal to patients and their families. I thought three days was plenty of time, let alone up to 21. I had come to psychology after careers in advertising and film. I had seen people's behaviors and lives changed from exposure to as little as a single print-ad, or a 30-second commercial, and certainly with 2-hour movies. To say we wouldn't have enough time for making sure the inpatient experience would produce a very clear "before" and "after" in the person's life was ludicrous to me. And to say that the variability in length of patient stays was a barrier was the final challenge I needed to develop something that would hit all those targets. These were not people who were going to go home and follow through on a course of regularly scheduled therapy. Their lives were largely chaotic. The opportunity to be seized was now. A flame was lit within me to make their stays a very worthwhile life experience, regardless of how many days or hours were given. It was now or never.

While I agreed it would be ill-advised to launch into "gold-standard" 12-session therapies for PTSD, I began teaching people some of the underlying principles so that they could begin to practice things like *imaginal* and later *in vivo* or real-time exposures to feared memories and sensory cues of those memories (e.g., loud bangs). People accepted my suggestions and reported increasing tolerances for memories that used to frighten them. Education about the mind and body, fight-or-flight, and the autonomic nervous system were all they needed to learn to stay put and get to the other side of those fears. This applied to anxiety and panic as well, with trauma simply offering a convenient focal point around which to teach a number of self-calming and adjustment improvement techniques.

The final piece, or rather a very deep research rabbit hole I entered for the development of my Comprehensive Trauma Organizer was exploring the highly recommended practice of "journaling." Years earlier I had personally been advised to do it in my own therapy experiences, but neither that highly regarded academic psychiatrist nor a renowned private psychologist seemed to know much about how to do it for maximum benefit. Those were still the dark ages of this field, which I hope clears up by about 2075 AD. With the hundreds of people I met at the crisis center it became obvious that there were helpful and unhelpful ways to journal, just as thinking can be very productive and liberating or quite unproductive and confining.

I dove into the research literature around the specific practice of Expressive Writing, developed by James Pennbaker. In the late 1970s and early 1980s he had established a connection between stress and trauma. He was having students write several times about the worst thing they had ever been through, and very often these students showed signs of improved health and academic performance, in contrast to students tasked with writing about neutral topics. By the time I was studying his work, more than three decades of research and three meta-analyses had been amassed. I found great clarity about what seemed to differentiate helpful writing from unhelpful. My goal was then to develop an instrument that would simply prompt the user to do things that would contribute to recovery, and to avoid behaviors that obstructed it.

Before I highlight those findings I want to acknowledge that the leading therapies for PTSD also foster many of the same helpful behaviors. Yet not every clinician understands those behaviors as targets; they are simply following a proven protocol. As a result, I believe those protocols tend to require more sessions, longer home assignments, and a bit of luck regarding whether some important things are going to come up and be addressed. They also presume patients who can fit into the college-looking mold of reliably attending weekly therapy and completing homework – among a population whose lives are often chaotic or jam-packed with responsibilities. Plus so much of the work is to be completed at home, precisely when a helping hand is needed, and requires confronting things the person has persistently avoided rather than engaged with. That sets someone up for further avoidance and then shame, which is likely a factor in those therapies tending to have fairly substantial frequencies of incompletion (i.e., dropout).

With all of these elements swirling in my head I was shocked and awed to discover in studies and meta-analyses that some expressive writing was yielding results similar to those therapies – from as little as writing three essays of 20-30 minutes each. They also found no significant difference in the positive effects between participants who had spaced the writing apart by a week, a day, or even completed within the same day. This was earthshaking for me. If it proved to be true, it meant that effective protocols could be developed for use in a place like a brief inpatient center. It also suggested expressive writing might be tapping into tremendous internal resources already present within the person. And it implied to me that lack of benefit might be linked with skill deficits and behaviors like avoidance – things that could be overcome with help. Again, these findings suggested that what typically requires 8-12 sessions across 6-12 weeks might be achieved by far less intervention and possibly all within the same day when necessary.

I tested my ideas with a pilot protocol and five participants, under the watchful eye of my university's Institutional Review Board. My goal was to have willing participants visit for a single 2-hour window, though completing confirmatory symptom measures beforehand and again at 2 weeks and a month post-visit. That went very well and so I rolled it out to a full randomized non-inferiority clinical trial. As each participant came in for their 2-hour block they were randomly assigned to either write three 30-minute essays with a traditional paragraph of expressive writing instruction, or to receive a therapist trainee-administered protocol (that has become the workbook contained in this volume). To parallel the conditions as much as possible, each participant was met with individually by either myself or a peer trainee named Lauren Weathers (now PhD), with breaks of 5-10 minutes between each third of the assigned intervention, and with a periodic inquiry asking the participant to self-rate their level of distress every 5-7 minutes.

There were 83 participants, 41-42 people in each condition. Both protocols performed very admirably with PTSD symptoms and moderately with physical health symptoms. My protocol, however, showed a sustained moderate improvement in depression symptoms whereas expressive writing participants saw a much more modest effect for depression at 14 days that was lost over the following two weeks. Regarding factors I believed could be barriers to recovery, my protocol showed significantly greater reductions in thought avoidance, and much better performance on measures of rumination and alexithymia.

Analysis by subgroups showed that both interventions greatly benefitted those who had a trauma and symptoms that would have likely qualified them for PTSD, and both performed admirably with people whose trauma met criteria but whose symptoms had not been as severe. However, among people whose disturbing experience would not have qualified for a PTSD diagnosis, such as a sudden life change of dealing with a chronic illness in the family, mere essay writing showed no significant benefit while those who completed my highly structured protocol showed large, sustained symptom improvements. For depression symptoms, both protocols showed a large reduction for the likely PTSD group, but my protocol showed significantly better reduction among the other two subgroups. A similar result occurred with the measure of thought suppression. These differences suggest something significant had occurred with these interventions, rather than conclude people had simply improved with time.

During my postdoc and with facility permission I went on to modify and use my protocol with Veterans in the inpatient unit of a large academic VA medical center. For those who met a clear PTSD diagnosis it was very effective in a majority of cases. Unfortunately the results can only be taken as tentative since the final sample size was only 11 people. However, I have used this tool many more times in outpatient settings and have seen lives transformed by it. Some cases even turned out to have been misdiagnosed as psychotic, when the true condition being PTSD with psychotic features – which remitted after the intervention. During two administrations of the protocol I had a different supervisor observe and each said they were quite impressed. With one

patient it was less effective and I believe that was because PTSD was quite secondary to significant personality issues and true psychosis. With the other, who had been repeatedly suicidal, it was visibly life-changing and my mentor expressed the belief that, “Maybe we’ve been doing it all wrong!” (speaking of “gold standard” trauma treatments). The majority of cases were like that one. Feel free to request the research articles on the above.

Nearly a decade later and with much more clinical practice since then, I continue to hold that trauma is best treated like a physical surgery, going “all-in” for 2-3 hours, rather than like short weekly visits to a dentist. I also disapprove of extensive preparation for such work as it leads to a lot of unnecessary stress and no-shows; it’s better to offer it when the work can be done immediately. I believe Pennebaker gave his participants little-to-no warning ahead of time and demonstrated the tolerability of such exercises. For participants it can be a major victory to complete something they have assumed is intolerable and unfixable.

Of course, any trauma treatment will likely bring unpleasant memories to the forefront of consciousness, just as having a broken bone set will be very painful that day. There is typically an increase in nightmares the first and maybe second night, but then they typically subside by the third or fourth day. I cannot recall such rapid decline in intrusive thoughts and dreams when administering Cognitive Processing Therapy nor Prolonged Exposure Therapy. Thus I still advocate for starting without delay, and perhaps not offering it when not feasible to administer a significant portion of it.

Chapter 2.

What I learned from more than 30 years of research literature.

From absorbing so much prior research, and then my own, I learned several things about what a person seems to need for trauma recovery. I cannot claim these as absolute knowledge, but I believe the findings and implications explain a great deal. I do not pretend that the following ideas are original to me, they are mostly based on observations from abundant research literature. (I am struggling with when to include credit to others and when to simply explain things; numerous times lay people have asked me to leave out the technical language and citations.)

1. Early expressive writing studies showed that writing itself was not an essential component of the experience. Participants benefited equally whether writing, telling their story to another person, or telling it to a taping machine. There is no need to burden people with writing, grammar, and anything of that sort which might make a person hesitate to do the necessary tasks. In addition, the privacy and lonely burden of trauma is not to be underestimated; benefits are associated with disclosure to others.

2. Emotional expression proved to be very important.

    a. Negative emotions are extremely important to verbalize. Yet some moderation appears to be important. The optimal pattern across three essays is expressing a great deal of negative emotions in the first essay and a moderate number by the third essay. Lack of progress was associated with an extreme number that shows little change across essays, whether initially very large or very small.

    b. Not surprisingly, a prolonged exposure study showed a very similar graph across six sessions in which people who benefitted showed initial high distress that reduces over time. This was in contrast to people who either did not admit distress or who consistently rated their distress as high and unrelenting. The researchers called the distress deniers “low engagers” in the therapy, which is a theme similar to what an expressive writing study referred to as “sugarcoaters” or people who denied adverse effects from their trauma and focused their essays on positives or lessons learned. It seems there is an optimal amount of acknowledging negative emotions even if initially very many, if the person can avoid panic or hopelessness about their occurrence. In other words, they need to be normalized and expected rather than treated as problems in themselves.

    c. Various researchers (including myself) have wondered whether a condition known as *alexithymia* is a potential barrier. Someone who is alexithymic has difficulty putting feelings into words. The results were mixed for this in prior research and my own. Some researchers, after observing a decrease in

alexithymia following expressive writing, pondered whether the assignment and instructions provided a rare opportunity and even permission to discuss emotions that were normally not discussed by people whose high initial alexithymia was potentially due to lack of prior opportunity or justification to safely explore emotions without criticism. Other researchers found that people high in alexithymia benefited less than others, suggesting it can be a barrier.

d. Either way, in my experience at the crisis center I had found that many people could circle numerous emotion words on a page but had had difficulty expressing more than a few prior to being given a list – and this was consistently the case with reticent teenagers at a group home. There was a yearning to be heard and understood, and a list seemed to be a very helpful vehicle for that experience. Thus my protocol has a trauma word list to help achieve a rich expression of varied and sometimes contradictory feelings.

e. In addition, since exposure and habituation (or desensitization) are key strategies for trauma and other anxiety work, the long list of emotions was also designed to prolong a person's exposure to such words and feelings as a path to reducing their intensity and connection. Words on a page are mere symbols, and their power to trigger corresponding emotions reduces with repetition.

f. Four emotions form unique barriers to recovery. They are shame, blame, anger, and guilt. None of the therapies can succeed without addressing these if they are factors in a person's trauma. Existing therapies had some tools, but I dug deep into research on "forgiveness" and found things to incorporate. I have avoided the word forgiveness in the intervention because it has become a word that needs more explaining of what it isn't than to explain what it is. Yet the intensity of anger towards a single person requires noticing and questioning since life tends to involve much greater complexity than we initially recognize.

3. Positive emotions matter too, but they should not be explored ahead of negative ones.

    a. Pennebaker and other studies showed that people who benefited from expressive writings showed a pattern of a low initial number of positive emotions and a higher number by the third essay.

4. Insight matters, but should not be placed ahead of the acknowledgement of suffering and confusion.
    a. A very interesting study compared two writing conditions. In one, participants were asked to focus on insights and positive outcomes from their disturbing experience. In the other, emphasis was to be placed on negative emotions experienced. Compared to a neutral control group, both conditions showed improvements, but emphasizing positivity seemed to hold back the first group as compared to the benefits seen in the negative emotions group. Thus I frequently speak of avoiding "premature positivity" and equate it to the need in physical medicine of fully cleaning out a wound before putting a bandage over it.
    b. I would also avoid premature challenging of extreme beliefs before assessing negative emotions. Extreme beliefs can be very attention-grabbing but avoid

the risk of getting into arguments about them when negative emotions have not yet been acknowledged and given time to swell and dissipate.

i. Keep in mind that many people grow up with people who invalidate their emotions and try to strongarm and shame them with logic. Compassion and validation of emotions prior to exploring their basis can be far more effective and strengthens rather than severs relationships. Consider an 8-year-old player who gets hurt during a team sport. One coaching style is to say, "Suck it up! Get back in the game! That's just a tiny flesh wound, you little sissy!" Another approach is to unite with the player's pain, "Ouch! That must really hurt! You probably need to sit out the rest of the game! Maybe the rest of the season!" Using the latter technique I have seen kids quickly jump back into the game and they never had to experience feeling criticized, shamed, humiliated, judged, angry, or inner rage.

c. That being said, insight is extremely important. Cognitive behavioral therapies are based on fostering insight, whether prior to, or subsequent to, a change in behavior. Thinking and speech that fail to achieve insight or some sense of progress is called "rumination." Such behavior is associated with worse depression.

d. Many people improve over the course of therapy by what are called "sudden gains," marked by flashes of insight and sharp symptom declines, rather than slow steady linear improvement throughout the therapy. These can occur very early in therapy and tend to boost motivation. After the emotion work, this protocol prompts people to fully explore their thoughts and offers ideas for questioning the validity of depressing and anxiety-provoking thoughts, perceptions, conclusions, expectations, and more. But again, a person must first become able to willingly and patiently engage with negative emotions. The timing is usually organic because moving from negative emotions to identifying negative thoughts has a lot of overlap (e.g., "I felt robbed" is more than a feeling, it includes a cognitive framing or perspective).

5. In my doctoral program I was trained in mindfulness and acceptance-based therapies in addition to change-based therapies. Thus, at the crisis center I found myself emphasizing acceptance of distress to challenge perceptions that it was intolerable. The goal was to reduce what Steven Hayes calls "experiential avoidance" and to increase "psychological flexibility" in lieu of knee-jerk reactivity. This led to teaching people to differentiate between true immediate threats and the much more common experience of "mere" discomfort and fear. By learning to tolerate the unpleasant reactions that come with a false alarm, the brain begins recognizing overreactions – over-expenditures of resources – and tends to reduce reactivity. In contrast, this new learning and calibration do not occur when we prematurely remove ourselves from situations that make us merely uncomfortable; we experience a short-term relief but at the cost of prolonging a pattern of escape and avoidance, which interferes with recovery.

a. In expressive writing, studies that showed negative effects or lack of improvement were marked by various forms of avoidance, whether by neglect of writing itself, or by the aforementioned tendency to emphasize positives and

minimize or deny negatives. In prolonged exposure, the topic of avoidance is discussed extensively as a key barrier to progress. More recently I was very happy to find that some expressive writing researchers have added coaching for emotional acceptance to help people tolerate distress at home between the five sessions of their protocol. Incidentally, I believe the lack of such training helps explain an early "cautionary" expressive writing study in which participants were expected to write their essays at home, without any hand-holding or proctor of any kind. Participants tend to not only avoid but actually suffer a great deal more than necessary with such assignments looming over them. The effort here is to provide exercises for guided or individual work, but with abundant explanation ahead of time to reduce likelihood of procrastination and hand-wringing.

b. In contrast to that, I believe the setting itself can help people with recovery. In Pennebaker's work I believe he simply introduced essay writing with little time to worry about it and further conveyed the safety of it all by simply having people go through it together. Others have simply used the structure of a campus research office plus the implementation of stopwatches and formal instructions which may have conveyed a kind of nonchalance and the familiar tedium of writing in an academic setting. In most expressive writing studies the proctor does not get involved in the content of essays, but they do serve a role of confident companionship and empathic concern for the participant. This accords with research that suggests therapeutic alliance is a major factor in the effectiveness of therapy. That time-limited structure, which is comparable to that of getting a root canal, stands in great contrast to what happens to many people who are asked to do a home assignment – the agonizing around it can be exponentially longer than the time actually required for the work itself. We can save people a great deal of torment if we simply sit closeby and keep time for them, perhaps with periodic check-ins on their well-being. Incidentally, studies performed better when participants were guaranteed that no one would read their essays; the freedom to fully express oneself is important. This does not negate that even more benefit comes from then sharing the trauma with someone.

6. Lastly, I want to speculate about the few expressive writing studies that showed equal (albeit modest) improvements among participants regardless of subgroup, including the neutral control groups. Some studies had so many assessment measures that poked and prodded about physical and emotional feelings, and required disclosure of type of trauma, that I believed the assessment tools themselves were responsible for the symptom improvements. I make the case that their length and specificity provided a badly needed opportunity for disclosure paired with prolonged exposure to unpleasant topics and feelings but which brought some relief to the person. Also the fact that researchers were unknowingly validating the participants as being victims of trauma, thereby reducing avoidance and minimization or denial. I have often wondered if half my role as a therapist is simply to express shock at what is shocking, thus helping a person reconfigure their concept of normality and begin to recognize pathological environments in their past.

Chapter 3.

My essential elements and tasks in helping people recover from trauma and PTSD.

In addition to what I learned from research literature (on expressive writing, prolonged exposure, cognitive processing therapy, acceptance and commitment therapy, dialectical behavior therapy, cognitive behavioral therapy, numerous other therapies, and research on forgiveness), my years of working with trauma, PTSD, and dysfunctional relationships have led me to understand and prioritize the following things in helping people recover. These are all factors to recognize if they occur, and to address, though perhaps not in a linear fashion.

1. After a trauma that resists recovery, the brain lives in a state of feeling overwhelmed and disoriented by sensitivity to perceived new threats and potential losses, and has trouble organizing the experience.
    a. Feeling dominates over clear thinking.
    b. Lower brain regions dominate over conscious intellect.

2. Some people react with disbelief, minimization, and anger in order to stay functioning.
    a. It is as if the person worries that admitting and grieving their losses will make them a weak or bad person, or will cause more loss or hurt, or damage their ability to stay whole and survive. Thus they avoid or suppress what needs to be felt and acknowledged. This pattern of avoidance must be interrupted.
    b. In addition to avoidance of healthy grieving and strong emotions, specific emotions that directly interfere with recovery are guilt, shame, blame, and anger. These must be addressed and resolved, so tools are provided for this as well.

3. To avoid further loss, the person stays desperately vigilant for anything that can threaten their sense of who they are, or what still belongs to them, or their ability to keep themselves functioning.

4. This has the negative effect of further draining their mental and physical resources.
    a. They cannot concentrate.
    b. Their thinking becomes more and more biased toward perceiving everything as a threat, making them “jumpy” or easily startled.
    c. They believe every fear that crosses their mind. They unknowingly equate opinions, guesses, and impressions with actual facts. They become less rational and less requiring of actual evidence or truth.
    d. Their minds turn and turn on questions of “Why?” as if the problem is intellectual and not one of deep emotional pain that must be processed. (A tool is included to help solve this.)
    e. All of the above lead to social and relationship problems, arguments, withdrawal, isolation.

f. With all the above activity, plus nightmares, they cannot sleep very well, which leads to not restoring or rebuilding mental and physical resources.
g. This depletion of resources continues and can lead to psychosis experiences too. Psychosis is simply thinking and behavior that very obviously show a person's confusion between imagination, memory, and current reality.

5. Thus, the main tasks for recovery are the following, and tools are provided to help achieve these.
    a. Organizing the traumatic experience.
    b. Grieving losses and admitting the large number of emotions occurring, rather than blocking or avoiding them.
    c. Restoring logic and rigor to thinking patterns.
        i. Recover the ability to differentiate true threats from false alarms.
        ii. Accept current safety as an opportunity to rest, sleep, and recover internal resources.
        iii. Teach the lower brain to distinguish between what is past, what is present, and what is future.
        iv. Teach the lower brain to distinguish between what is fact versus feelings, impressions, guesses, worries, etc.
    d. Improving social functioning.
        i. Share the trauma, share the grieving process, break the isolation.

All of the tasks on the following pages are designed to help achieve the above steps. Throughout the exercises, you may have better ideas than the examples we provide.

Definitions and mechanisms

The *DSM-5* defines a traumatic event as exposure to actual or threatened death, serious injury, or sexual violence through direct experience, witnessing the event in person, learning that the event happened to a close friend or family member, or experiencing repeated or extreme exposure to the aftermath of an event, such as in the case of a first responder (American Psychiatric Association, 2013). By the time people reach 18 years of age, 62% have already experienced at least one potentially traumatic event (PTE; McLaughlin et al., 2013), and across the lifespan estimates are as high as 75-90% (American Psychiatric Association, 2013; Kilpatrick et al., 2013; Mills et al., 2011).

However, only 9.4% of people exposed to a traumatic event develop PTSD (Kilpatrick et al., 2013), and researchers have reported strong predictive relationships between mere exposure to potentially traumatic events (PTEs) and greater healthcare utilization (Gawronski, Kim, & Miller, 2014;

Bruce et al., 2001). PTEs are associated with medical conditions such as cardiovascular diseases, diabetes, gastrointestinal disorders, and cancer (Boscarino, 2012; Kendall-Tackett, 2009; Pacella, Hruska, & Delahanty, 2013). In addition, many people experience serious life stressors (SLSs; Gawronski et al., 2014) such as abandonment by a parent, relationship conflicts, or natural deaths that do not meet the DSM-5 definition of traumatic stressor, yet which also drive increased healthcare utilization. Psychiatric difficulties associated with PTEs and SLSs include adjustment disorders, PTSD, anxiety disorders, depression, substance abuse, suicidality, psychiatric hospitalization, personality disorders, psychoses, and psychosocial problems (Bruce, 2001; Nemeroff et al., 2006; Pennebaker & Chung, 2011; van Winkel, van Nierop, Myin-Germeys, & van Os, 2013). While many people demonstrate great resilience to stressors (Southwick & Charney, 2012), broad exposure to PTEs and SLSs, and high healthcare utilization, suggest many others are not adjusting as well as might be thought. More needs to be done to promote recovery from significant stressors, which requires understanding relationships between stressors, functioning, and recovery.

Mechanisms theorized to be involved in the relationship between PTEs, SLSs, and worse health include: 1) heightened sensitivity to reminders of the stressor, leading to 2) large efforts to achieve homeostasis (increasing "allostatic load"), resulting in 3) depletion of physical, cognitive, and emotional resources, and this leading to 4) lowered immunology to toxins, poor decision-making and/or performance, and disruption in occupational and social functioning (D'Andrea, Sharma, Zelechoski, & Spinazzola, 2011; McEwen & Tucker, 2011). More specifically, ongoing heightened sensitivity (i.e., lack of habituation) to acute and chronic stressors leads to frequent surges in blood pressure and cortisol, which lead to neuronal damage and alteration in the limbic, hippocampal, and other neurological systems (D'Andrea et al., 2011; McEwen & Tucker, 2011). Psychologically, the ongoing perception of stressors as overwhelming not only triggers physical depletions but maladaptive coping in the form of substance use, risky impulsive behaviors, and poor performance and conflict in social, academic, and occupational roles, which are exacerbated in contexts of poverty and conflict-laden relationships

(D'Andrea et al., 2011; McEwen & Tucker, 2011). Thus some researchers emphasize the importance of PTSD symptoms (PTSS) rather than a PTSD diagnosis since intrusive disturbing thoughts and memories, hyperarousal, negative mood and cognitions, and maladaptive avoidance behaviors can occur without full PTSD and drive deteriorations in functioning (Pacella et al., 2013).

Comprehensive Trauma Organizer

Structured worksheets to use in helping another person recognize and remove barriers to ***natural recovery*** after trauma and other negative life experiences.

Developed by Fernando Alessandri, PhD

fernando.alessandri.phd@gmail.com

For the research basis please visit
TraumaCPR.org

This version has only minimal instructions or theory and is intended to be administered by a warm human being with or without trauma expertise. Your role is three-fold: 1) Your assuring presence and interest in the person's moment-to-moment well-being can help them schedule this activity and be more willing to approach things they have avoided; 2) You may be able to address questions that arise; and 3) Your distance from the traumatic experiences may help you notice leaps in logic (*non-sequiturs*), imprecisions in thinking, and overreactions that have come to be perceived as normal by the person. If you get stuck please contact the author or another mentor for coaching.

Materials: Print this double-sided from pages 1-20. Box of tissues. 2 pens. Water.

All instructions can be read aloud to the person you are helping, unless in square brackets. [Start here:]

Thank you for your willingness to meet and do this. It takes a lot of courage and I think you're going to learn a lot and be really glad you did this. Do you need anything before we get started, like the bathroom? Water? It's important to not have any distractions. Are you worried about anything, like your car being towed? [Pause, don't forbid handling mundane things that may be necessary over the next 2 hours.] *Feel free to use these tissues. I should have told you to dress like you're going to the gym, we might sweat a little but nothing bad is actually going to happen. Ready?* [Y/N]

I will be logging how much distress you are feeling at the beginning and end of each page [prompts are provided]. *A key thing to learn with repetition is that our physiological ups and downs in reaction to memories, thoughts, and emotions are normal – just as occurs with physical exercise. Over time we get conditioned and the peaks do not even get as high any more.*

The entire protocol is intended to be administered in a single visit of up to 2 hours. Staying on track is part of learning that we can take charge and do productive work instead of wasting time or wringing our hands or "giving in" to disorganization and scatter. Breaks of 5-10 minutes are recommended after Step 4 and Step 7. Thus in three "sittings" we should be able to achieve a whole new understanding of: 1) The normalcy of physical and emotional feelings; 2) How trauma messes with our thinking and perceiving; and 3) How to fully integrate our experiences so we can climb out of some really deep pits and discover some positive directions for our life. Let's do this!

[If completed as self-help, as part of training, or in non-professional use, please initial below.]
By proceeding, I acknowledge that these lessons and exercises are educational and not intended to diagnose, treat, cure, or prevent any diseases. They have not been evaluated by any country's regulatory bodies. Use of this is not a substitute for psychotherapy, medicine, or healthcare. _____*(initial)*

Status Check: *On a scale of 0 to 100 (0=calm, 100=very bothered or distressed), how are you feeling right now?* _____

Step 1: What has kept you from confronting and grieving your negative life experiences?

Please rate the degree to which you believe these statements. (*circle the numbers*)

If I allow myself to admit and mourn my losses, or to think about my worst memories, I am afraid I will…	Not at all (0%)			50/50 (50%)			Fully (100%)
1. Choke or be unable to breathe.	0	1	2	3	4	5	6
2. Not be able to handle it.	0	1	2	3	4	5	6
3. Faint.	0	1	2	3	4	5	6
4. Never stop crying.	0	1	2	3	4	5	6
5. Start yelling.	0	1	2	3	4	5	6
6. Lose control.	0	1	2	3	4	5	6
7. Embarrass myself.	0	1	2	3	4	5	6
8. Have a heart attack.	0	1	2	3	4	5	6
9. Kill or hurt myself.	0	1	2	3	4	5	6
10. Do something violent.	0	1	2	3	4	5	6
11. Go insane.	0	1	2	3	4	5	6
12. Die.	0	1	2	3	4	5	6
TOTAL: Subtotals							

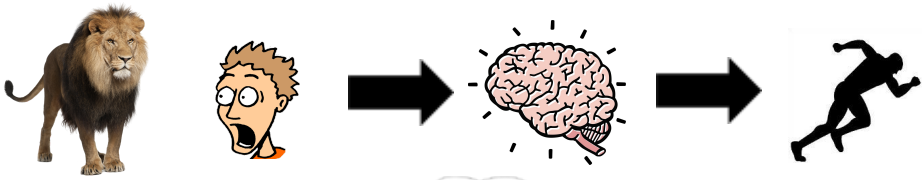
It is logical to avoid contact with things that can *actually* hurt us or cause extreme reactions. What are some ways you currently cope with (or avoid) strong emotions?

- _____
- _____
- _____

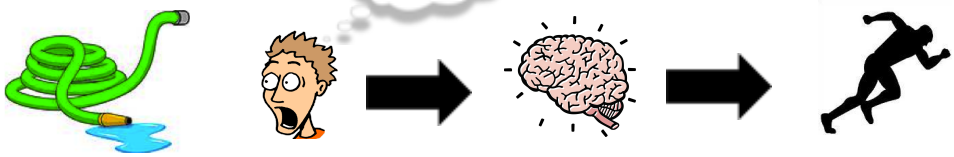
Through these exercises we hope to demonstrate that many fears are exaggerated, and many of the unhealthy things we do to avoid our feelings can be replaced by healthy acknowledgement of the many things we are going through, even if they make us sweat a little… as occurs with exercise too. Your body will learn to calm down if you give it a chance to process experiences.

Step 2: Understanding our autonomic nervous system. Why do our bodies react so much?

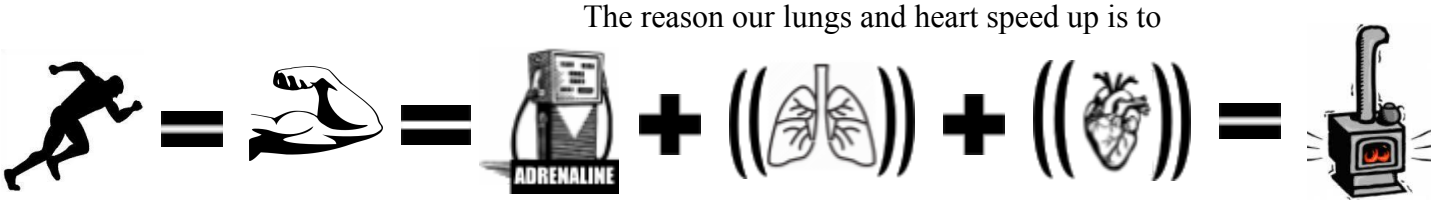
Imagine walking in the woods alone, unarmed, and you encounter a hungry lion. Your lower (puppy) "autonomic" brain immediately sends out orders for your survival, to run, fight or freeze.



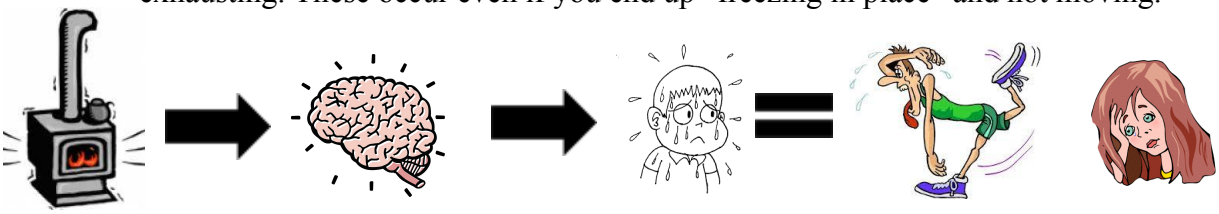
Many times our reactions  are based on false alarms.



The reason our lungs and heart speed up is to



quickly deliver adrenaline and oxygen to our muscles, which burn it up. The whole process is exhausting. These occur even if you end up "freezing in place" and not moving.



This cycle is often unnecessary. There are many **false alarms**. There are also problems that are not emergencies, for which we need our calm intellect, not muscles.

Our higher brain needs to *re-train* our lower brain to stop running at the first sign of threat. Things like memories, dreams, reminders of traumatic experiences, and even complex problems about our future, *are not immediately dangerous* and therefore should not be responded to with adrenaline and muscle. Nor should we "numb"our feelings with alcohol, drugs, or other types of avoidance. Instead we need to clarify the error and *allow* memories and reminders to come and go. If they stir up our autonomic system, so what? Let it all adjust. There is no danger in recalling a very upsetting experience, nor in planning solutions that require our intellect. Trust your body to adjust the same way you accept sweating and discomfort during exercise or learning anything new. Are these ideas clear? (Y/N]

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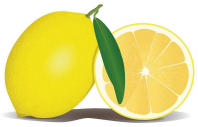
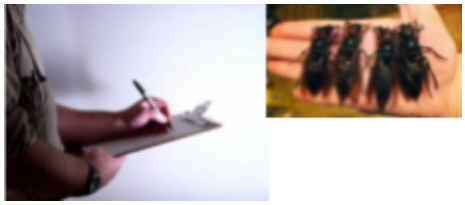
Step 3. Practicing Awareness and Reprogramming our Responses



Exercise 1: Close your eyes and vividly *imagine* you're holding a lemon. A big, ripe, juicy lemon. Bring it to your nose, smell it, and take such a big bite that the juice runs down your chin. Let me know when you feel your mouth water. [Pause] If your mouth salivated in response to *imagining* tasting a lemon, then you experienced the interplay of your *thoughts* and autonomic responses. Yet if you repeat that 5 more times your brain will probably stop ordering saliva. Your brain will slowly learn that just because you are thinking about a lemon does not mean that a real one will appear.

Exercise 2: Take a deep breath and relax... Drop your shoulders... Drop them more if they will go… Even more this time, really let your arms and shoulders relax... Did you get more relaxed with each request? We often don't realize how much *tension* we're holding, even when we're *trying* to relax. Our lower "autonomic" brain areas are working all the time to keep us upright and balanced. They do not wait for conscious orders like "keep breathing" or "keep my heart beating." Yet conscious orders can break through and command slower breathing or more relaxation.



Imagine you could earn a lot of money by counting legs and antennae on disgusting insects. At first you might be really uncomfortable and jumpy, especially every time they moved. But eventually your willingness to examine them would result in your body calming down and getting used to them. It may not feel like your traumatic losses and memories could ever become less physical but they can if we give them a chance to be explored and made peace with.

TIPS FOR REDUCING AGITATION WHEN REMINDED OF TRAUMA BUT NOT ACTUALLY IN IMMEDIATE DANGER:

1. Stop! Repeat, "*Yes I am uncomfortable, but I am not in danger.*"
2. Breathe deeply. Notice your body's needs and tensions.
3. Drink cold water.
4. Stretch your neck, jaw muscles, shoulders. Rub your eyes.
5. Look around, name and touch objects to feel the safety of the present.
6. Walk around but then resume this trauma recovery work. Avoidance leaves the reactions strong.

By doing these things, your body will adjust and learn to be less reactive to the same reminders later.

Once again, notice that the physical reactions we are talking about occur with physical exercise as well. It would be odd and unhealthy to go running and to try not to sweat or to keep your heart and breathing from going faster. The more often you practice these, the less reactive your body will be. It is all just *conditioning* that occurs.

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Step 4. Emotion Triggers

In this step you will identify, allow, and *ride out* feelings associated with your disturbing event. These words may feel overwhelming at first, but feelings are not actually dangerous. *Naming* them helps *bring them down to size*. Eventually your autonomic brain will *catch up* and realize that intense physical reactions are not needed. Your lower brain will start to realize a memory is like a movie; you are not really "back there"; you are here, in this room, and your brain needs to sit around with reminders to start recognizing that they are not the same as real dangers. Any questions? [Y/N]

This will not work if you deny feelings, turn them off, or distract yourself from feeling them. Will you try to allow them to arise, take deep breaths, and ride them out? [Y/N]

When you are ready, allow yourself to visualize the most disturbing event you have ever experienced. Allow it to *feel as if* it's all happening *right now*. Let your heart beat faster if it wants to. Don't hold back tears, etc. Use tissues if necessary. Skip words that are unfamiliar or don't apply to you.

Think in the present tense: ***"As I see it happening I am feeling…"*** (Circle words even if only slightly)

Startled
Surprised
Shocked
Disbelieving
Confused
Ambushed
Isolated
Abandoned
Alone
Forgotten
Sold
Hated
Robbed
Cheated
Deprived
Disgusted
Deceived
Brainwashed
Betrayed
Manipulated
Coerced
Exploited
Naked
Exposed
Vulnerable
Defenseless
Unprepared
Unsafe
Weak
Tiny
Powerless

Violated
Castrated
Disrespected
Helpless
Insignificant
Miserable
Devastated
Broken
Off Balance
Ruined
Lost
Cursed
Imprisoned
Mutilated
Charred
Crippled
Choked
Damaged
Handicapped
Unfixable
Hopeless
Despairing
Futureless
Doomed
Defeated
Defective
Flawed
Useless
Freakish
Fake
Pretending

Grotesque
Abnormal
Burdened
Stressed
Reckless
Blind
Dumb
Ignorant
Foolish
Idiotic
Stupid
Gullible
Pathetic
Absurd
Ridiculous
Humiliated
Mocked
Embarrassed
Belittled
Scolded
Accused
Judged
Condemned
Misunderstood
Frustrated
Annoyed
Angry
Furious
Hateful
Resentful
Distrusting

Tired
Cold
Empty
Numb
Distant
Detached
Lifeless
Dead
Adrift
Meaningless
Unloved
Unlovable
Rejected
Neglected
Overlooked
Friendless
Unvalued
Unsupported
Unheard
Unvalidated
Silenced
Worthless
Disposable
Dirty
Filthy
Polluted
Cheap
Ashamed
Blameworthy
Regretful
Guilty

Battered
Abused
Bullied
Attacked
Hurt
Bruised
Heartbroken
Sad
Unlucky
Pessimistic
Discouraged
Crushed
Depressed
Bitter
Cynical
Faithless
Fed Up
Tormented
Troubled
Unclear
Uneasy
Uncomfortable
Exhausted
Challenged
Overwhelmed
Avoidant
Intimidated
Jumpy
Fearful
Scared
Shaky

Sickly
Queasy
Anxious
Nauseated
Sweaty
Tense
Terrified
Cowardly
Spineless
Stuck
Trapped
Paralyzed
Conflicted
Oppressed
Overworked
Punished

Others:

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Add up the number of words circled. _____ What was it like to identify so many words? [Provide validation] *So many of the most painful human emotions! Most of us would rather break a leg than go through that!* Sometimes we think we should have recovered by now, but this number of words shows how heavy our burden truly has been. A good next step is to use these words out loud, or write sentences about why we chose each one. "*I was shocked because…"* [Have them explain some of their choices.] You should do more with these words at home, writing about them or talking into your phone.

Let's take a break. (5-10 min).
Status Check upon Return: *On a scale of 0 to 100, how are you feeling right now?* _____

Step 5. Catching Unhelpful Questions and Thoughts

Often we ask *why* something happened, or we make *negative predictions* about our future, or we are disturbed about *who is responsible*, including God. Circle and write in thoughts that have bothered you since your most disturbing event. Don't hold back any emotions that arise. Let them ride themselves out.

- *(Maybe) I should have* _____.
- *If only* _____.
- *Why* _____*?*
- *I can't believe* _____.
- *Where was* _____ *when this was happening?*
- *How could* _____*?*
- *I'm so* _____.
- *I'll always be* _____.
- *I feel like such a(n)* _____.
- _____ *being punished.*
- *It was my fault. I deserved it. I'm just a(n)* _____.
- *Now I'll never* _____.
- *This will keep me from* _____.
- *No one* _____ *can understand what I've been through.*
- *I don't deserve to* _____.

Step 6. Addressing Anger, Blame, Shame, Guilt

This section is about anger, blame, shame and guilt. These emotions can contribute to keeping disturbing events present and powerful in our lives. Anger is a special emotion in that it does not necessarily lessen by "venting". Many unskillful approaches to *thinking* about anger or trying to *make sense* of it can actually make it grow, and the same may be true for shame, blame, and guilt. This may be due to thinking in overly simplistic terms (e.g., *jerk, murderer, stupid*…) when reality is often much more complex.

Who do you blame for what occurred? _____ How fully? _____ (100%?)

If you had a friend in your shoes, would you blame them as much as you blame yourself? (Y/N)

Discuss the different treatment of yourself and a friend.

_____

_____

Do intentions matter, or only the outcome? If a driver runs over a child, does it make a difference whether it was due to: 1) the traffic lights being broken and both sides saw a green light, 2) the driver backed out without ever looking, 3) the driver checked twice but then the child came out of nowhere, and 4) a driver went on a rampage to intentionally kill pedestrians. Discuss.

If a person FEELS sad, guilty, and responsible does it necessarily mean they ARE all those things?

Imagine you are driving a car and another car slams into you and then races off. Perhaps you are hurt and need medical attention. You might feel anger towards that driver, not only at first but every time you recall the incident. However, imagine later you found out that the other driver was bleeding to death and racing to the hospital. This new piece of information might lessen your anger, even though the harm to you and your car was real and undeserved. Recognizing that we *might not have all the information* can help us *accept* what occurred.
If your anger is toward yourself, imagine you were the bleeding driver. You might have trouble accepting that you did a hit-and-run, while others would understand that you cannot be BOTH bleeding to death and still function at a normal level.
Reflecting on your disturbing event, could any of the following have kept individuals from acting as fully functioning healthy adults? (*Circle "they" or "I" as appropriate.*)

- ☐ It happened so fast, there was no time to think.
- ☐ I did not want to be mean, judgmental, or not give someone a chance.
- ☐ I saw myself as desperate, damaged, lucky to have someone rather than be alone.
- ☐ Too much was going on. Focus was scattered.
- ☐ Sleep had been off for days. Running on fumes.
- ☐ There were pressures coming from all sides.
- ☐ Being really young or inexperienced.
- ☐ There was abuse that went untreated so the cycle repeated itself.

- ☐ Issues from childhood or other situations went underestimated and unaddressed.
- ☐ There was an addiction involved.
- ☐ It was a dangerous place or even a war zone.
- ☐ There was too much fear to know what to do.
- ☐ Information was wrong or missing, or someone was deceiving.
- ☐ There was a perpetrator, it was not some random thing.
- ☐ There was coercion or overpowering, not genuine free consent.
- ☐ There was no known track record or reason to expect that kind of behavior.
- ☐ Coping skills were lacking for such an intense situation.
- ☐ People in charge were either too lax or else lacking enough resources.
- ☐ While something may be clear now, it was not clear then.
- ☐ People needed professional help but were not open or accessing it at the time.
- ☐ In retrospect, with all the factors and vulnerabilities that were going on, something like that was bound to happen. It's sadly not that surprising after all.

Do any of the above help you be less shocked about human flaws, errors, and wrongdoing? (Y/N)

_____

_____

Step 7. Getting Unstuck and Moving from, "*Why?*" to "*I dislike…*"

As we have seen, trauma leaves many of us asking questions like, "*Why me? How could…? What will I do now?*" Or we keep saying, "*I cannot believe it.*" What are some questions or statements like these that repeat over and over in your mind?

_____

_____

The problem with these questions and statements is that they fool the brain into an endless *counterproductive* cycle, which is draining and prolongs our suffering – for decades!

We can bring these anger-provoking loops to rest by actually answering them and then shifting focus toward productive activity. One very productive activity is to ***label the feelings and sit with them***.

Examples of answering our rhetoricals:

1: *Why me? Why did this have to happen?* → *"Why NOT me? These things do happen, it's always unfortunate, but there's no reason it shouldn't happen to me or someone in my family. It's not really about "why" but about not liking it, I wish it had not happened, it makes me feel really sad.*"

2: *Are you kidding me? I can't believe it!* → "*Unfortunately, no one is kidding me. This really happened. The problem is not an issue of belief. It's that I was not ready for this, it's devastating, life is going to be different, this is very sudden and sad.*"

3. *Why didn't I scream?* → Red flags are a special category. Sometimes we missed them but more often we realize we saw them and did not act on them. This is usually because earlier in life we learned to not trust our own intelligence, or to not confront people. Consider your own history and why you might have talked yourself out of taking red flags more seriously.

Answer at least 1 unanswered question or statement that lives in your mind. More than one is better.

Step 8. Evaluating the Fairness of Other Negative Thoughts

What is your worst or most disturbing thought or conclusion about what your disturbing experience(s) mean(s) about you, your future, or the world? For example, "Because this thing has happened, now I will never have a normal life."

My worst conclusion:

How strongly do you believe it? (0-100%) _____

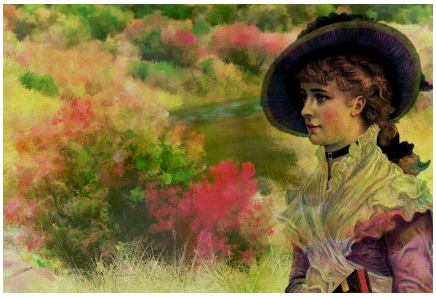
Name 3-4 feelings that come with it, and how strongly: _____
(E.g., Sad, 90%; anger 80%; hopeless 90%.)

If you had a lawyer arguing for this conclusion in court, what would they say is evidence that supports it? ("Your Honor, my client now will never… *because*…")

It is important to cross-examine our ideas, conclusions, and perceptions. What would an opposing lawyer say about the evidence for your conclusion? (E.g., "It was only 3 times out of 30" or, "They didn't have the necessary skills back then but that doesn't mean they can't learn them now.")

Human beings tend to be a bit fast and loose with language. Often there is no harm in it, but other times problems are created or made worse by inexact words. Consider a surgeon asking for a "thing" and getting aggravated when each wrong "thing" is handed to her, especially if the patient is bleeding profusely. Accurate labeling matters.

Discuss differences between the words in bold below, using the artwork as a reference (Source: Open license on Pixabay.com).



- **Hard Fact** - E.g., *The shape is a rectangle.*
- **Guess / Prediction** - *She is in danger.*
- **Opinion / Preference** - *There is too much vegetation.*
- **Habit / Impression** - *This has to be British.*
- **Feeling** - *Her situation makes me nervous.*

Next, re-read your worst conclusion and circle the bullets of the categories your thought belongs in.

• Hard Fact • Guess / Prediction • Opinion / Preference • Habit / Impression • Feeling

Next, is the thought fair and balanced? Is it SELECTIVE about what information is included? Does it LEAVE OUT important factors or circumstances like those considered on an earlier list?

_____

Does the thought or conclusion make only negative or extreme assumptions about people, the future, all people, or the world? (E.g., *All men are creeps*.)

_____

Does the thought or conclusion ignore the person's strengths, knowledge, experience (e.g., How much they have already been able to endure)? Often anxiety fails to "keep score" of how often it is wrong.

_____

How strongly do they still believe their original thought? (0-100%) _____

Have them rewrite their thought or conclusion in a more balanced way. (Write one that a judge would believe with less difficulty.)

_____

_____

How much do they believe the new thought (0-100%). _____

Rerate the strength of the feelings named earlier: _____
(E.g., Sad, 70%; anger 60%; hopeless 60%.)

Discuss / Reflect. _____

_____

Step 9. Isolation & Lack of Voice

Disturbing events can make us feel very isolated. Yet it's important to be heard. If you have not told anyone else about this important aspect of your life, how would you go about doing so? (1) Who would it be? (2) Would you do it one-on-one or in a group? (3) In what setting: over coffee, taking a walk, etc? (4) How could you start so that they would first have to agree to only offer helpful listening and support instead of unwanted advice, judgment, blame?

_____

_____

_____

Step 10. Evaluating the Fairness of Another Negative Thought

What is another disturbing thought or conclusion about what your disturbing experience(s) mean(s) about you, your future, or the world? *A depressing, anxiety-provoking, or other negative thought:*

_____

_____

How strongly do you believe it? (0-100%) _____

Name 3-4 feelings that come with it, and how strongly: _____
(E.g., Sad, 90%; anger 80%; hopeless 90%.)

If you had a lawyer arguing for this conclusion in court, what would they say is evidence that supports it? ("Your Honor, my client now will never… *because*…")

_____

_____

Status Check: *On a scale of 0 to 100 (0=calm, 100=very bothered or distressed), how are you feeling right now?* _____

It is important to cross-examine our ideas, conclusions, and perceptions. What would an opposing lawyer say about the evidence for your conclusion? (E.g., "It was only 3 times out of 30" or, "They didn't have the necessary skills back then but that doesn't mean they can't learn them now.")

_____

_____

Circle the bullets of the categories below that your thought belongs in.

• Hard Fact • Guess / Prediction • Opinion / Preference • Habit / Impression • Feeling

Is the thought fair and balanced? Is it SELECTIVE about what information is included? Does it LEAVE OUT important factors or circumstances like those considered on an earlier list?

_____

Does the thought or conclusion make only negative or extreme assumptions about people, the future, all people, or the world? (E.g., *All men are creeps*.)

_____

Does the thought or conclusion ignore the person's strengths, knowledge, experience (e.g., How much they have already been able to endure)? Often anxiety fails to "keep score" of how often it is wrong.

_____

How strongly do they still believe their original thought? (0-100%) _____

Have them rewrite their thought or conclusion in a more balanced way. (Write one that a judge would believe with less difficulty.)

_____

_____

How much do they believe the new thought (0-100%). _____

Rerate the strength of the feelings named earlier: _____
(E.g., Sad, 70%; anger 60%; hopeless 60%.) Discuss.

On a scale of 0 to 100, what was your highest level of distress on this page? _____

Step 11. Evaluating the Fairness of Another Negative Thought

What is another *depressing, anxiety-provoking, or other negative thought:*

_____

How strongly do you believe it? (0-100%) _____

Name 3-4 feelings that come with it, and how strongly: _____
(E.g., Sad, 90%; anger 80%; hopeless 90%.)

If you had a lawyer arguing for this conclusion in court, what would they say is evidence that supports it? ("Your Honor, my client now will never… *because*…")

_____

_____

It is important to cross-examine our ideas, conclusions, and perceptions. What would an opposing lawyer say about the evidence for your conclusion? (E.g., "It was only 3 times out of 30" or, "They didn't have the necessary skills back then but that doesn't mean they can't learn them now.")

_____

_____

Circle the bullets of the categories below that your thought belongs in.

• Hard Fact • Guess / Prediction • Opinion / Preference • Habit / Impression • Feeling

Is the thought fair and balanced? Is it SELECTIVE about what information is included? Does it LEAVE OUT important factors or circumstances like those considered on an earlier list?

_____

Does the thought or conclusion make only negative or extreme assumptions about people, the future, all people, or the world? (E.g., *All men are creeps*.)

_____

Does the thought or conclusion ignore the person's strengths, knowledge, experience (e.g., How much they have already been able to endure)? Often anxiety fails to "keep score" of how often it is wrong.

_____

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How strongly do they still believe their original thought? (0-100%) _____

Have them rewrite their thought or conclusion in a more balanced way. (Write one that a judge would believe with less difficulty.)

_____

_____

How much do they believe the new thought (0-100%). _____

Rerate the strength of the feelings named earlier: _____
(E.g., Sad, 70%; anger 60%; hopeless 60%.) Discuss.

Let's take a break. (5-10 min).
Status Check upon Return: *On a scale of 0 to 100, how are you feeling right now?* _____

Step 12. Anniversaries and Sensory Reminders

If your trauma is in the distant past, there are probably anniversaries and physical or sensory reminders that still disturb you. This exercise is about *undermining* the power of reminders. Living by avoiding them keeps you vulnerable to them. Plus, trying to avoid all reminders can really limit your life. Instead, looking *directly at* reminders while letting your reactions exhaust themselves, can dilute their power. For example, imagine there was a *red car* involved in your trauma and now red cars trigger your fear response and you try to avoid seeing any. That very avoidance might be keeping the *association* strong between red cars and your disturbing memory. Instead, if you spend a week looking for red cars and letting your reactions occur then you might weaken the power of red cars to disturb you.

Recalling sensory details about your experience can be uncomfortable. Remember to let any feelings ride themselves out. ***List any current reminders. Try to put yourself in the memory and write <u>every sensory detail</u> you can notice in terms of:***

1. <u>Alarming Sounds</u> _____
2. <u>Alarming Smells</u> _____
3. <u>Alarming Touches</u> _____
4. <u>Alarming Tastes</u> _____
5. <u>Alarming Sights</u> _____
6. <u>Distressing Anniversaries</u> _____

If you want to undermine the power of the above, practice "sitting with" them often. Start with the words and your imagination. Then use YouTube videos or the help of others to make things more vivid.

This is not encouragement to put yourself in actual danger but to provoke "false alarms" and adjustment to them. This is like retraining a dog that survived a house fire to now tolerate enjoyable campfires again. You would begin with photos, videos, and eventually have a friend strike a match at 100 meters. You would calm your dog, then have your friend repeat it at 90 meters, while you assure your dog. And eventually the dog will recognize that the present fire is not indicative of a new tragic fire.

Step 13. Visualizing Recovery

Sometimes we think the rest of our life will be just as painful or as difficult as it is now. It can help to envision future adaptation and recovery. ***When I am 80 or 90 years old, I believe I will (still)...***

	No (0)	Not Sure (1)	Yes (2)	N/A (0)
1. Not believe or accept what occurred.				
2. Be unable to concentrate or think about other things.				
3. React strongly to every reminder of it.				
4. Have trouble sleeping because of it.				
5. Have frequent negative dreams or daytime memories about it.				
6. Not trust more than 1 or 2 people.				
7. Avoid places or activities they used to enjoy.				
8. Rely on substances to calm themselves down.				
9. Seek distractions to avoid sad memories.				
Subtotals				
TOTAL				

Add up each column and then a total score using a score of 1 for any "Not Sure" and 2 for "Yes." This total score is out of a possible 18. Any scores above zero suggest the person cannot envision fully moving on, which can be a barrier in working towards it. They likely need additional personal or professional help in processing their experiences, though perhaps the remaining exercises will help.

Step 14. Emerging from the Experience

It can help to let your mind and body acknowledge current feelings in contrast to when the event occurred.. Identify emotions **<u>you are feeling right now about the event(s)</u>**, and allow yourself to fully experience them. Consider each word slowly and don't hold back any bodily reactions.

Startled
Surprised
Shocked
Disbelieving
Confused
Ambushed
Isolated
Abandoned
Alone
Forgotten
Sold
Hated
Robbed
Cheated
Deprived
Disgusted
Deceived
Brainwashed
Betrayed
Manipulated
Coerced
Exploited
Naked
Exposed
Vulnerable
Defenseless
Unprepared
Unsafe
Weak

Tiny
Powerless
Violated
Castrated
Disrespected
Helpless
Insignificant
Miserable
Devastated
Broken
Off Balance
Ruined
Lost
Cursed
Imprisoned
Mutilated
Charred
Crippled
Choked
Damaged
Handicapped
Unfixable
Hopeless
Despairing
Futureless
Doomed
Defeated
Defective
Flawed

Useless
Freakish
Fake
Pretending
Grotesque
Abnormal
Burdened
Stressed
Reckless
Blind
Dumb
Ignorant
Foolish
Idiotic
Stupid
Gullible
Pathetic
Absurd
Ridiculous
Humiliated
Mocked
Embarrassed
Belittled
Scolded
Accused
Judged
Condemned
Misunderstood
Frustrated

Annoyed
Angry
Furious
Hateful
Resentful
Distrusting
Tired
Cold
Empty
Numb
Distant
Detached
Lifeless
Dead
Adrift
Meaningless
Unloved
Unlovable
Rejected
Neglected
Overlooked
Friendless
Unvalued
Unsupported
Unheard
Unvalidated
Silenced
Worthless
Disposable

Dirty
Filthy
Polluted
Cheap
Ashamed
Blameworthy
Regretful
Guilty
Battered
Abused
Bullied
Attacked
Hurt
Bruised
Heartbroken
Sad
Unlucky
Pessimistic
Discouraged
Crushed
Depressed
Bitter
Cynical
Faithless
Fed Up
Tormented
Troubled
Unclear
Uneasy

Uncomfortable
Exhausted
Challenged
Overwhelmed
Avoidant
Intimidated
Jumpy
Fearful
Scared
Shaky
Sickly
Queasy
Anxious
Nauseated
Sweaty
Tense
Terrified
Cowardly
Spineless
Stuck
Trapped
Paralyzed
Conflicted
Oppressed
Overworked
Punished

Others:

Count the number of words circled _____ What was the prior number? _____ Discuss insights and the change in number, if there was one.

_____

_____

_____

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Step 15. Recognizing Our Strength or Resilience

Trauma and anxiety often leave us feeling like we are barely surviving, powerless toward additional threats, and that we are empty and numb inside, no longer "truly alive." This is because we are exhausted and always focused on the next "blind corner" or situation we cannot see or predict. However, anxiety fails to keep a good record and we have to do this more consciously. We need to recognize that our fear continues to warn us about danger but it does not correct itself after every wrong prediction. We need to consciously say to our fear, "*Stop driving me crazy! You are wrong more often than you are right. I have survived so much! You have predicted utter destruction for the past 300 days but here I am, still alive and doing things*."

See if any positive emotions apply to you. **Say, "*On the positive side, when I think about my traumatic or disturbing experience, at this point I am also feeling…***

Encouraged
Recovering
Processing
Liberated
Absolved
Renewed
Clear
Coherent
Harmonious
Closure
Authentic
Complete
Clean
Beautiful
Cured
Balanced
Free
Human
Normal
Lovely
Compassionate
Generous
Forgiving
Likable
Merciful
Competent
Intelligent
Educated
Able
Confident
Surviving
Conquering

Connected
Accompanied
Acknowledged
Recognized
Appreciated
Belonging
Reconciled
Reconnected
Supported
Loved
Lovable
Loving
Optimistic
Hopeful
Cheerful
Calm
Capable
Accepting
Operational
Present
Interested
Knowledgeable
Relaxed
Released
Relieved
Motivated
Determined
Committed
Focused
Brave
Fearless
Accomplished

Achieving
Fruitful
Devoted
Enduring
Firm
Tenacious
Effective
Dependable
Fulfilled
Prepared
Insightful
Aware
Enlightened
Inspired
Sharpened
Purposeful
Put Together
Spirited
Strong
Fortunate
Blessed
Grateful
Joyful
Honored
Touched
Proud
Celebratory
Enthusiastic
Excited
Humbled
Happy
Praising

Noble
Hardened
Persistent
Purified
Experienced
Mature
Wise
Ready
Believing
Considerate
Caring
Cherishing
Comfortable
Comforted
Protected
Treasured
Immunized
Resilient
Rugged
Seasoned
Recharged
Reassured
Rebounding
Passionate
Rebuilding
Successful
Sturdy
Hardworking
Stable
Fixable
Exceptional
Superior

Extraordinary
Courageous
Dignified
Energetic
Faithful
Familiar
Flexible
Flourishing
Forthright
Radiant
Serene
Transformed
Transcendent
Triumphant
Tranquil
Upright
Rested
Safe
Sane
Satisfied
Secure
Whole
In Control
Undisturbed
Adventurous
Amused
Amazed
Fun
Limitless
Useful
Productive
Resourceful

Healed
Open
Patient
Nostalgic
Nurturing
Undefeated
Thoughtful
Peaceful
Penitent
Profound
Realistic
Vindicated
Understood
Validated
Respectable
Significant
Vibrant
Victorious
Redeemed
Reflective
Refreshed
Regenerated
Rejoicing
Upbeat
Valiant
Warm
Whimsical
Youthful

Count and reflect on the number of positive words you chose _____. Use some in sentences.

Step 16. Putting it All Together

Now it's time to put it all together into a coherent story. Include details of what happened, who was involved or missing, how old you were, what you heard, saw, smelled, tasted, and felt. Also what you were thinking at each moment, and bodily reactions and emotions you were having. Include things from the previous pages that help tell the complete story. Tell it like a movie, as if it's happening right now. Start with what you were doing and feeling before the event(s) interrupted that day, and how those thoughts, feelings, and activities changed because of it. Don't just tell the external facts; try to describe all that went through your mind. At the end, include things you have learned, and recent changes regarding thoughts about what this event means for your life. Do not worry about grammar or even full sentences; key words are enough.

(Continue on as many pages as necessary to tell your story. ***You can also type or voice record it.***)

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Step 16. Final Steps and Recap

Please rate the degree to which you believe these occurred. (*circle the numbers*)

When I let my worst losses and memories play in my head, I…	Not at all (0%)			50/50 (50%)			Fully (100 %)
1. Choked/was unable to breathe.	0	1	2	3	4	5	6
2. Was not able to handle it.	0	1	2	3	4	5	6
3. Fainted.	0	1	2	3	4	5	6
4. Was not able to stop crying.	0	1	2	3	4	5	6
5. Started yelling.	0	1	2	3	4	5	6
6. Lost control.	0	1	2	3	4	5	6
7. Embarrassed myself.	0	1	2	3	4	5	6
8. Had a heart attack.	0	1	2	3	4	5	6
9. Killed or hurt myself.	0	1	2	3	4	5	6
10. Did something violent.	0	1	2	3	4	5	6
11. Went insane.	0	1	2	3	4	5	6
12. Died.	0	1	2	3	4	5	6
TOTAL: Subotals							

Compare these outcomes to your initial expectations. Discuss any changes in your view of yourself.

_____

_____

Jot down any negative thoughts that could use more work in the future.

_____

_____

_____

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RECAP: Keep This Page Where You Can See It Often

Throughout these exercises you learned principles related to trauma recovery.

1. You learned that intense feelings such as fear or sadness are not permanent; they arise quickly and then slowly taper down if we allow them to be present (not avoid or numb out).

2. By "staying present" during trauma memories, anniversaries, and sensory cues that trigger strong reactions, and allowing emotions and physical reactions to rise and fall, we "reprogram" our brain to stop treating such things as indicators of new threats. They are about the past, not present or future.

3. Reducing our physical reactions to reminders and memories, and moving on with our life, does not mean that what happened is somehow "OK" or that we do not care. Grieving is an appropriate way to honor a significant loss; it's the opposite of minimizing or denying. Mourning only becomes depression if we allow constant re-thinking of what could have been different, as if we can still change what occurred. It's important to accept and grieve the reality of what happened.

4. After a trauma our thoughts are often negatively biased towards anxiety, depression, shame, and condemnation. Such thoughts need to be *identified* and *cross-examined*. We also benefit from accepting past shortcomings in ourselves and others. Decisions will always be less-than-perfect under numerous pressures, lack of sleep, and limited information. Life is complicated and it is not fair to oversimplify complex factors and situations.

5. You have learned to examine specific memories, feelings, and sensory cues carefully, and you have put the whole experience together into more of a coherent, logical story. What are some things you are now more hopeful about?

   _____

   _____

   _____

6. When strong feelings come again your past habits may lead you to want to avoid them. Even prescription medications, work, and intense exercise can be used for avoidance and thus prolong poor adjustment and suffering. What have you learned that you can do to cope instead?

   _____

   _____

   _____

Thank you for giving this instrument a chance. I truly hope it was helpful! – Fernando Alessandri

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