101 TRAUMA-INFORMED INTERVENTIONS

Activities, Exercises and Assignments to Move the Client and Therapy Forward

by

Linda A. Curran

BCPC, LPC, CCDP, CAC-D

PESI
Publishing
& Media
www.pesipublishing.com

"The Past: Our cradle, not our prison; there is danger as well as appeal in its glamour. The past is for inspiration, not imitation, for continuation, not repetition."

~ Israel Zangwill

"However many holy words you read, however many you speak, what good will they do you if you do not act upon them?"

~ Buddha

Table of Contents

Introduction 1
About the Book 4
Adult Attachment Patterns 5
Family Values 11
Family Sociograms Group 13
Dialogue with Your Child 15
Developing a Nurturing Voice 17
Multisensory Guided Imagery 19
Containment Imagery Script 22
Comfortable Place Script 25
*Repair*enting: Imagery for Disrupted Attachment 28
Imagery for Care and Nurture Script 32
Imagery for Addiction: Longings/Cravings 34
Boundaries 38
Recognizing, Maintaining, and Respecting Boundaries 40
Projection Exercise 56
Transference Exercise 58
Gestalt 59
Gestalt Interventions 60
Psychodrama 67
Role Playing 68
Warm-up Exercises: Sociometry 70
A Message for You 71
Writing Your Own Eulogy 72
Representing Feelings 73
The Best Gift Ever Given/Received 74
Family Sculpting Exercise 75
Guided Imagery for the Substance Abuser 77
The Body 79
Checking In with the Body 80
Body Scan: Awareness of the Felt Sense 83
Drawing Out Emotion—Awareness of the Felt Sense 84

Focusing on Sensations—Awareness of the *Felt Sense* 94
Body Scan Body Map—Awareness of the *Felt Sense* 96
Yoga 99
Yoga 100
Dö-In 109
Dö-In Exercises 110
Qigong 113
Qigong Exercises 114
Body Language 128
Mirroring Exercises 130
Regulating the Dysregulated Autonomic Nervous System 131
Exercises for Activating the PNS 133
Holding Neurovascular Points 137
Acupressure Points 138
Emotional Freedom Technique (EFT) 143
EFT 143
The EFT "Basic Recipe" 144
Meridan Tapping Points 147
Improving Right/Left Hemispheric Communication 148
Using Sound, Music, and Vocalizations to Regulate the Autonomic Nervous System 149
Finding Your Voice: Expanding the Throat 151
Mantra Meditation 152
Kirtan Kriya 154
Shoulder Gripping Chant 156
Discerning Intention 159
Full Awareness 175
Roots Meditation 177
Walking Meditation 180
Mindfulness Eating Exercise 181
Developing Presence Exercise 189
Exploring Dreams 191
Jung's Self Shadow 193
The Shadow Self 194
Me and My Shadow Exercise 196
The Imagined House Exercise 197
Revealing and Liberating the Shadow: *A Waking Dream Technique* 198

Emotions 199
Emotions 200
Exploding Water Balloons: Releasing Anger 204
Fear Fantasy 205
Positive Emotion 207
Exercises from the World of Positive Psychology 209
Three Blessings 210
Taking In the Good 211
Gratitude Letter 212
Stages of Forgiveness 216
Stage One 218
Stage Two 219
Stage Three 220
Stage Four 221
Stage Five 222
Reference / Additional Reading 227

Introduction

In all honesty, I can't say that as a professional entering the mental health field I had not heard of the diagnosis PTSD, or post-traumatic stress disorder. I had. In fact, in graduate school I had heard of it twice: once within a required course on psychopathology and, then again, within a required course on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Sadly, what neither of those courses required of me was that I learn what "T" was, all that "T" encompassed, how pervasive "T" was, both in the general and psychiatric populations, or how "T" appears to be present in almost all psychopathology and in nearly every psychological disorder catalogued in the DSM.

Perhaps you are thinking that somehow this makes sense. Way back then, the DSM was new; people knew very little about trauma; and modern brain imaging techniques—CT, FMRI, PET, and SPECT—were all still the stuff of science fiction. How could I have possibly been well-informed on a subject for which there was so little information? I was a product of my time. Right? Wrong. The iteration of the DSM that my class studied, DSM IV-TR, was published in 2000 and, in addition to earlier writings of Freud, Ferenczi, Kardiner, and Janet, a considerable amount of information regarding trauma had been gleaned and made available in *this century*. The following are a few of the highlights and trauma resources from the last two decades that most certainly would have proved helpful had I been pointed to them:

- In 1992, *Trauma and Recovery: The Aftermath of Violence—from Domestic Abuse to Political Terror* was published. Judith Lewis Herman, its author, wrote:

  > The responses to trauma are best understood as a spectrum of conditions rather than as a single disorder. They range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple post-traumatic stress disorder, to the complex syndrome of prolonged, repeated trauma.
  >
  > In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others. The current formulation of post-traumatic stress disorder fails to capture either the protean symptomatic manifestations of prolonged, repeated trauma or the profound deformations of personality that occur in captivity. The syndrome that follows upon prolonged repeated trauma needs its own name. I propose to call it "complex post-traumatic stress disorder." (p. 119)

- In 1994, Bessel van der Kolk's seminal paper, "The Body Keeps the Score: Memory & the Evolving Psychobiology of Post-Traumatic Stress," was published in the *Harvard Review of Psychiatry*
- In 1996, Bessel van der Kolk's first book, *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, presents theory and research of trauma's lasting effects on an individual's biology, conceptions of the world, and psychological

functioning; the neurobiological processes underlying PTSD symptomatology, traumatic memories, and dissociation; and the core components of effective clinical interventions.

- In 1997, Peter Levine's first book, *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences,* presents a new and hopeful vision of trauma. Levine wrote:

> Trauma is perhaps the most avoided, ignored, belittled, denied, misunderstood, and untreated cause of human suffering. Although it is the source of tremendous distress and dysfunction, it is not an ailment or a disease, but the byproduct of an instinctively instigated, altered state of consciousness. We enter this altered state—let us call it "survival mode"—when we perceive that our lives are being threatened. If we are overwhelmed by the threat and are unable to successfully defend ourselves, we can become stuck in survival mode. This highly aroused state is designed solely to enable short-term defensive actions; but left untreated over time, it begins to form the symptoms of trauma. These symptoms can invade every aspect of our lives. Trauma is a basic rupture—loss of connection—to ourselves, our families, and the world. The loss, although enormous, is difficult to appreciate because it happens gradually. We adjust to these slight changes, sometimes without taking notice of them at all. Contrary to the view of psychiatric medicine—that trauma is basically untreatable and only marginally controllable by drugs—when treated thoroughly healing can lead not only to symptom reduction, but long-term transformation. (p. 23)

Unfortunately and unnecessarily, I, like so many others, entered the field without those resources. I was equipped only with a diploma, a solemn desire to help and a set of freshly honed cognitive behavioral therapy (CBT) skills that I had perfected in role-playing sessions with my fellow graduate students. It would take a month or two of working with actual clients before I noticed that, unlike my classmates, who were quite taken with my ability to explain a *thought record* in a practice session, my clients. . . .not so much. Nor should they have been, because they were getting no help from me.

It was about the same time that I began to truly grasp the degree, acuity, and severity of trauma—both acute and developmental—that each one of my clients had not only endured, but continued to endure and embody in the present. Back then, the one thing that I knew with certainty was that because I lacked the knowledge, information, and resources to be of any assistance to these people, they were screwed. Again. But this time they were not alone; we both felt *trapped,* we both felt *helpless,* and we both felt *overwhelmed.*

At that point, one of two things usually happens. Either we blame the client or we blame ourselves. The first gives rise to a terrible therapist; the second, a soon-to-be burned out, a.k.a. *former,* therapist. Okay, maybe it's not quite that simple or predictable. For me, what came was a galvanizing realization that each of my clients—stronger, more courageous versions of myself—were sitting across from me, looking at and to me, wordlessly insisting that I become a better person and a better therapist. I complied because each one so obviously deserved a better person and a better therapist than I was. Years later I discovered that somebody had anonymously put words to what I had only vaguely known:

> *They are survivors. If you don't have respect for their strength, you can't be of any help. It's a privilege that they let you in—there's no reason they should trust you, none. You can't know their*

> *terror. It's your worst nightmare come true, a nightmare from which you can never awaken. It's unrelenting. There has been no safety: no one, no time, nothing—all was tainted. Hope was obliterated time and time again. That they are in our office is in itself a supreme act of valor.*

Last year, I had the great fortune and honor of interviewing many of the icons in field of traumatic stress, including Dr. Bessel van der Kolk. His impassioned plea to psychotherapists was incredibly moving and bears repeating: "What I'd like to say is that good trauma work is like very fine neurosurgery. It is extremely skilled work. And good intentions and warm feelings do not substitute for really becoming very good at what you do."

It is my hope that this book serves not only as a concrete collection of trauma-informed interventions, but as an inspiration for you to continue "becoming very good at what you do."

Adult Attachment Patterns

To capture a broad-stroke depiction of attachment, Mary Main and her colleagues developed a semistructured interview about childhood attachment relationships and the meaning the individual ***currently gives to those past relational experiences***. The individuals account is examined for material that is explicitly expressed by the individual and for material that appears out of the interviewee's awareness (e.g., apparent incoherence and inconsistencies of dialogue) with the aim of assessing the unconscious elements of the attachment relationship.

Scoring is based upon:

(a) descriptions of childhood experiences

(b) language used in the interview

(c) ability to give an integrated, believable account of experiences and their meaning

The language and conversation style used is considered to reflect the state of mind of the interviewee with respect to attachment. The Adult Attachment Inventory (AAI) is then scored from the transcript using scales that characterize childhood experience with each parent as loving, rejecting, neglecting, involving, or pressuring. Other scales assess conversational style, overall coherence of transcript and of thought, idealization, active anger, fear of loss, metacognitive monitoring, and passivity of speech. Scale scores are then used to assign the adult to one of three major classifications:

1. ***Secure/autonomous***: Individuals classified as secure/autonomous describe varied childhood experiences, maintain a balanced view of early relationships, value attachment relationships, and view attachment-related experiences as influential in their development.
2. ***Insecure/dismissing***: Adults are classified as insecure on the basis of incoherence, i.e., they have failed to assess and integrate the meaning of those experiential memories. Adults classified as insecure-dismissing deny or devalue the impact of early attachment relationships, have difficulty with recall of specific events, often idealize experiences, and usually describe an early history of rejection.
3. ***Insecure/preoccupied***: Adults are classified as insecure on the basis of incoherence, i.e., they have failed to assess and integrate the meaning of those experiential memories. Adults classified as insecure-preoccupied display confusion about past experiences, and current relationships with parents are marked by active anger or passivity.
4. ***Unresolved***: Individuals may be classified as unresolved in addition to a major classification. These adults report attachment-related traumas of loss and/or abuse that have not been resolved. The unresolved classification is given precedence over the major classification and is considered an insecure classification.
5. ***"Cannot Classify"***: This category is assigned when scale scores reflect elements rarely seen together in an interview (e.g., high idealization of one parent and high active anger at the other). Such interviews are highly incoherent and insecure.

Adult Attachment Patterns

Individual or Group

~adapted from Dan Siegel's AAI-inspired questions from *Mindsight,* 2010

SO WHAT?

Why should anyone care about a research instrument? Well, in addition to its utility for the research community, this particular instrument is highly applicable to adults traumatized as children in clinical settings as well. The coded and interpreted interview is predictive of the adult's attachment style to his/her own children. However, in clinical settings it is multipurpose even without its official coding or interpretation.

1. Describe your early family situation: where you were born, where you lived, whether you moved around much, what your caregivers did at various times for a living.

____

____

____

____

____

2. Describe your relationship with your parents as a young child. Begin as far back as you can remember.

____

____

____

____

____

3. Please choose five adjectives or words that reflect *your relationship with your mother/caregiver* starting from as far back as you can remember in early childhood—as early as you can go, but say, age 5 to 12 is fine.

Mother (or Primary Caregiver):

a. __________ b. __________ c. __________

d. __________ e. __________

4. Think of an example for each word to illustrate a memory or experience that supports the word.

a. _______________

b. _______________

c. ______________________________

d. ______________________________

e. ______________________________

5. Please choose five adjectives or words that reflect ***your relationship with your father/caregiver*** starting from as far back as you can remember in early childhood—as early as you can go, but say, age 5 to 12 is fine.

Father (or Other Caregiver):

a. __________ b. __________ c. __________

d. __________ e. __________

6. Think of an example for each word to illustrate a memory or experience that supports the word.

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

e. ______________________________

7. Which parent/caregiver did you feel closer to, and why?

____

____

____

____

____

____

8. As a child, when you got upset, what would you do?

____

____

____

____

____

____