

CHRIST-CENTERED VISUALIZATION AND EMDR IN HEALING TRAUMA

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General Principles of Trauma

Trauma is defined by Webster as: “a startling experience which has a lasting effect on mental life; a shock”. It may occur to one personally, or it may be the observation of someone else experiencing a trauma. It overwhelms the senses and ability to cope. This includes many diverse situations, real or imagined, such as natural disasters, physical and emotional attacks, accidents, and losses.

Francine Shapiro, the developer of EMDR, describes trauma in the following manner: “What do we mean by the word *trauma*? Is it ‘traumatic’ to be in a near-fatal car accident? To see a person robbed and beaten? To be locked out of your car in a storm? To find out you need surgery? When psychotherapists talk about trauma, they are generally referring to events that would be upsetting to nearly everyone and that involve a reaction of fear, helplessness, or terror. Unfortunately, many people (and some psychotherapists!) mistakenly believe that events are somehow unimportant if they do not meet this standard. But many events can be disturbing because of their personal significance, such as overhearing a passing remark that you are unattractive, getting a failing grade in school, or having a pet run away. Although in some types of conventional psychotherapy, there may be a struggle to distinguish between the two types of trauma, this separation is irrelevant in EMDR. Because EMDR focuses on personal experience, it downplays what the therapist thinks of the event and, instead, deals directly with how the experience has affected the client. Experiences of all sorts play an important role in our inner life. But for now, let's clarify and distinguish what we can call big "T" trauma-which the psychology community recognizes as a cause of posttraumatic stress disorder (PTSD)-and what in EMDR we refer to as small "t" trauma. Big "T" trauma includes events that a person perceives as life-threatening: combat; crimes such as rape, kidnapping, and assault; and natural disasters such as earthquakes, tornadoes, fires, and floods. These events are so stressful they can overwhelm our ordinary capacity to cope. They result in intense fear, extreme feelings of helplessness, and a crushing loss of control. The symptoms of PTSD span two classes of simultaneous, and diametrically opposed, behaviors. In one type, the traumatized person cannot get away from his trauma: He is forced to relive the original event through intrusive symptoms such as flashbacks, nightmares, panic attacks, and obsessive thoughts. In the other, he can't get near it: He is compelled to insulate himself from reminders of the trauma through avoidance symptoms such as social isolation, emotional numbing, and substance abuse. Trauma victims also have

physiological reactions, such as insomnia, hyper vigilance, and the tendency to be easily startled by any reminder of the event, such as a particular sound or touch. Small "t" trauma, on the other hand, occurs in the innocuous but upsetting experiences that daily life sends our way. It can result in some of the same feelings as big "T" trauma and have far-reaching consequences" (Shapiro & Forrest, pp13-14, 2004).

Some survivors of trauma recover on their own, with no professional intervention. Some block-out the trauma, either fully or partially, then "function," but fail to become all of whom God intended. Many develop posttraumatic stress disorder (PTSD), with the following behavioral symptoms: intense fear, horror, helplessness, flashbacks, disorganized or agitated behavior, numbing or denial of feelings, avoidance of stimuli associated with trauma, nightmares, persistent increased arousal or anxiety, etc. (see Appendix A for a more complete description of PTSD).

The initial reaction to trauma is shock or denial. This is God's provision to those victimized by natural events or by the actions of an evil world, to allow time to cope, think, seek help, etc. Many remember their reaction to a trauma, such as the 9/11 attack, their initial shock and coldness that did not fully comprehend or react to what was occurring. Then as the reality hit, intense feelings of fear, terror and powerlessness began, as well as an obsessive intrigue to review again and again the trauma that has occurred. This is part of our drive for mastery or healing.

In time (minutes, hours or days), anger emerges and seeks a target as the "cause" of the trauma. The desire to fight back to eliminate the powerlessness occurs. If no human target is readily available, God is often blamed, or at least His love is questioned.

Bargaining follows as an attempt to control the uncontrollable. A frequent prayer states, "God if only you will stop or change this, then I will do ____ for you." When the bargaining does not change the reality, depression descends like a very dark oppressive blanket of shame, guilt, and total helplessness, with a quiet desperation. Self-pity, suicidal thoughts, and self-defeating behaviors are typical at this stage. Grieving the loss of what will never be may be a prolonged and extensive process.

Finally, acceptance is critical, and the goal of trauma therapy, with the belief that healing is possible and a good life after trauma will occur, albeit changed.

Physiological Reactions to Trauma

Physical reactions occur, in both our body and our brain. It has been through recent technology and research that scientists can now objectively visualize the effects of

emotional trauma on the brain. Neuropsychological responses occur, that result in right brain over stimulation and minimized left brain functioning. SPECT scans (single-photon emission computed tomography) are three dimensional brain scans, which typically show a diamond patterns of increased activation in specific brain regions for clients with PTSD (Lansing, Amen, Hanks, & Rudy, 2005; Francati, Vermetten, & Bremner, 2007). Areas that are over activated include: right lateral temporal lobe, thalamus (limbic), basal ganglia, and anterior cingulate. It is easy to understand the psychological symptoms of individuals with PTSD because they are linked with the functions of each over-activated brain region, which include visual and audio perceptions, as well as memory.

Extended exposure to trauma creates abnormalities in the hippocampus, which is also in the temporal lobe of the brain, and is associated with motivation and emotion. When trauma occurs, our flight or fight response is activated by a gland in the brain called the amygdala, which modulates feelings, expressions, emotional memory, and recognition of emotions in others. The amygdala is “fired up” when individuals are in threatening situations. Continued over-activation of the amygdala, as in extended or recurrent traumatic events, can result in persistent heightened arousal, anxiety, and hypervigilance as seen in PTSD, even when the threat no longer exists.

Individuals with PTSD often have flashbacks, nightmares and altered sleep cycles, because the thalamus is activated, which is responsible for sensory perception and sleep wake cycles. Each PTSD symptom is linked to an anatomical area of the brain. A bone that has been broken takes time and treatment to heal; the brain is no different. Areas in our brain responsible for movement and learning are also affected by traumatic events. The Basal ganglia is associated with these tasks, as well as executive functioning. Executive functioning involves decision-making, troubleshooting, managing new or difficult situations, and dealing with habits or temptations. When this part of the brain is malfunctioning individuals are disorganized, feel helplessness, and easily surrender to their temptations.

Lastly, the anterior cingulate plays an important part in regulating the heart, lungs, sweat glands, kidneys, digestion, and reproductive organs. This region is also associated with decision-making, emotional response modulation, as well as rational cognitive and emotion functioning. When this area of the brain is over-activated, the trauma creates symptoms seen in PTSD such as emotional numbing, denial, disorganization, and the inability to problem-solve.

Physical reactions occur not only in the brain, but also in the body of individuals with PTSD. Many people experience more cold and flu symptoms when they are stressed. There is a physiological reason why individuals who are stressed are at greater risk for a physical illness. At the time trauma occurs there is a slight increase in the excretion of

cortisol, which is responsible for increasing blood sugar, suppressing the immune system, and digesting fats, proteins, and carbohydrates. As time passes individuals eventually show lower cortisol levels, but an increase in a specific hormone (CRH, corticotrophin-releasing hormone). The change in cortisol and CRH affect systems in the body responsible for maintaining a strong immune system. When these systems fail, individuals are at higher risk of developing more illness, inflammatory responses, and even autoimmune diseases including lupus, chronic fatigue syndrome, diabetes, irritable bowel syndrome, multiple sclerosis, fibromyalgia, and arthritis. Autoimmune diseases often develop or worsen with prolonged stress (Selye, 1976; Glasser, et al 1987). Utilizing EMDR to treat PTSD is essential to both the quality and quantity of an individuals life.

EMDR Defined

Eye Movement Desensitization and Reprocessing (EMDR) is a successful method for treating trauma. It rapidly and effectively releases anxiety, disturbing emotions, and negative thoughts associated with trauma. "It is a complex and powerful method of psychotherapy that integrates many of the most successful elements of a wide range of therapeutic approaches. In addition, it uses eye movements or other forms of rhythmical stimulation, such as hand taps or tones, in a way that seems to assist the brain's information processing system to proceed at a rapid rate" (Shapiro & Forrest, 2004, p. 4-5). EMDR therapists are trained to focus on potential dangers of unexpected flashbacks or overload. It is a powerful tool that creates connections between current anxiety and childhood or adult trauma, and should be conducted only by trained therapists.

Robin Shapiro describes it in the following manner: "Call it EMDR. Think of it as 'reprocessing therapy'... EMDR's "eye movements" are only one form of bilateral stimulation (BLS), which can be alternating hand taps, hand pulsers, or headsets playing alternating tones or music. 'Desensitization' isn't right either. Think of associative and integrative therapy. Desensitization is exposure to something until your brain gives up responding to it. EMDR connects the 'here and now' parts of your brain to the 'there and then' trauma parts, until your brain says, 'Oh, it's over. I'm okay'. If EMDR's developer, Francine Shapiro, knew 20 years ago what she knows now, she'd call it reprocessing therapy. However, it's called EMDR and we'll stick with that...EMDR includes elements of mindfulness, somatic awareness, exposure, and cognitive therapies" (R. Shapiro 2010, pp.93-94).

"One of the simplest ways of describing EMDR's effect is to say that the target event has remained unprocessed because the immediate bio-chemical responses to the

trauma have left it isolated in neurobiological stasis. When the client tracks a moving finger or attends to hand taps, tones, or even a fixed point on a wall, active information processing is initiated to attend to the present stimulus. If the client is asked to attend simultaneously both to this stimulus and to the traumatic memory, the active information-processing mechanism is linked to and processes the target event as well as the current stimulus. This processing mechanism is physiologically configured to take the information to an adaptive resolution” (F. Shapiro, 2001, p. 323).

EMDR was developed by Francine Shapiro in 1989, when she “noticed that the upsetting emotions accompanying disturbing thoughts disappeared as her eyes moved rapidly back and forth” (Shapiro & Forrest, 2004, p. 270). Researchers performed neuroimaging on patients with PTSD and consistently found structural and functional changes in the brain regions associated with emotions and memory (Gurvits et al. 1996, Bremner, 1999; Hull, 2002; Gilbertson, et al 2002; Francati, et al., 2007). EMDR stimulates cerebellar processing and activates the dorso-lateral and orbito-frontal cortices via the optical region (Bergmann, 2000). This region is responsible for sensory interpretation and involved with memory and emotional processing associated in the hippocampus and amygdala (Carlson, 2007). EMDR permits neutral processing by low frequency stimulation of the brain, thus modifying memories in a safe environment (Rasolkhani-Kalhorn & Harper 2006). After EMDR, brain scans found increased activity in both the anterior cingulate gyrus and the left prefrontal cortex in patients, which is responsible for discriminating between imagined and real fears (Levin, Lazrove, & van der Kolk 1999; Oh & Choi, 2007). Therefore, the objective evidence of brain scans shows the effectiveness of EMDR in reprocessing traumatic events effectively.

Christ-centered visualization

Visualization is defined by Webster as: 1. to recall or form mental images or pictures, 4. to make perceptible to the mind or imagination. Visualization is a therapeutic technique used as a way of fostering healing, and changing perceptions that are destructive distortions and lies. The process of visualizing a traumatic event, combined with EMDR, enables survivors to release fear and anxiety associated with the event. Spiritual truths that are visualized can bring healing and comfort that words alone cannot. For example: visualizing the Lord’s presence as described in Hebrews 13:5–6 (Amplified), can eliminate overwhelming feelings of aloneness and abandonment. “For He (God) himself, has said, I will not in any way fail you, nor give you up, nor leave you without support. I will not, I will not, I will not in any degree leave you helpless, nor forsake, nor let you down, relax my hold on you. Assuredly not!”

Current research evaluating the efficacy of visualization and EMDR

Current research and brain scans help us understand the power and value of visualization versus talk therapy or cognitive behavioral therapy. Visual pictures are processed by the right frontal lobe of the brain, which is where traumatic memories are stored. Visualization has been utilized by coaches for years. According to the bio-informational theory, visualizing used to enhance performance also activates the same brain regions as if it were the actual situation (Lang, 1979; Murphy, et al., 2008). Neuroimaging studies show that similar processes occur in the brain with imagery, and that they are equivalent to interpreting real situations (O'Craven & Kanwisher, 2000). Visualization affects memory encoding and retrieval, thus influencing recall and concreteness (Arbuthnott, et al., 2001). It also activates the fear network, thus allowing individuals to incorporate corrective information to enhance coping.

Two of the research psychiatrists who have focused on trauma and brain functioning, Drs. Bessel Van der Kolk and Daniel Amen, have both demonstrated the efficacy of EMDR combined with visualization, documenting case studies of clients with PTSD who were treated with EMDR, and displayed "marked normalization" of brain activity (Amen, 1988, pp.183). Van der Kolk also conducted neuroimaging after cognitive behavioral therapy without EMDR, and demonstrated its failure to create significant brain activity changes (Van der Kolk 2002).

Personal motivation for using this method

Specializing in trauma for over thirty years has taken me down every road suggested by trauma specialists. The extreme pain of the trauma and subsequent treatment have motivated my prayerfully seeking the Lord's design for how we heal. Unfortunately trial and error has been common, until experiencing the power of EMDR in 1992, combined with Christ-centered visualization. Teaching crisis counseling to doctoral psychology students has increased my awareness of the efficacy of the various methods. Brain scans from the past decade have validated the success of visualization and EMDR to return the traumatized brain back to normal. This has been the most successful method in eliminating the anxiety as well as changing the destructive lies that were believed as a result of the trauma.

Biblical Basis

God, as our creator, knows everything about us: our complete history, present, and future. He knew us before we were even born, and saw every influence upon our life.

He alone totally comprehends our body and neurological functioning, as well as our emotions, our thinking, our actions and reactions. We are fearfully and wonderfully made (Psalm 139:14) and created to heal from most of life's assaults. We will have difficulties in this world (Psalm 34:19, LB), "The good man does not escape all troubles – He has them too. But the Lord helps them in each and every one." We can count on the Lord's presence and assistance in the midst of trouble (Isaiah 43:2, LB), "When you go through deep waters and trouble, I will be with you. When you go through rivers of difficulty, you will not drown! When you walk through the fire of oppression, you will not be burned up – the flames will not consume you."

This method creates a picture of the relevant Biblical truths, beginning with God's love and the presence of the Holy Spirit within those who have received God's forgiveness and salvation. He is the source of the truth that will lead to healing (John 16:13, NASB) ... "the Spirit of truth ... will guide you into all the truth," and (Psalm 32:8, LB), "I will instruct you (says the Lord) and guide you along the best pathway for your life, I will advise you and watch your progress." He has promised to use for good that which man intended for evil. It is truly the traumatized individual who most clearly demonstrates this principle. We are instructed to leave the past behind, but our body and brain prevent that, even for the most determined and persistent Christian. This method allows the return of normal functioning and moving on to the present. Hope for the future is essential, (Jeremiah 29:11, NIV), "For I know the plans I have for you, declares the Lord plans to prosper you and not to harm you, plans to give you a hope and a future" (Psalm 42:11, LB), "Oh my soul, don't be discouraged, don't be upset, expect God to act! For I know that I shall again have plenty of reason to praise Him for all that He will do. He is my help! He is my God!" The Biblical truths of forgiving a perpetrator and self are central tenets. Revenge must be left to the Lord, (Romans 12:17-19, NIV), "Do not repay anyone evil for evil...As far as it depends on you, live at peace with everyone. Do not take revenge ... but leave room for God's wrath, for it is written, 'It is mine to avenge; I will repay,' says the Lord." Seeking the Lord's truth in every step of the healing is demonstrated in the case study.

When using EMDR and Christ-centered visualization there are three important spiritual components for both the client and counselor: 1) pray for truth and wisdom, 2) listen for God's answers, and 3) follow the Lord's healing direction. No one hears God perfectly, so it is important to understand that clients and counselors have their own various thoughts and pictures in combinations with God's wisdom. When the ideas we hear are from God, they will never go against Biblical truth, because God does not contradict himself. Prayer is not a one-time event, and needs to continue throughout the counseling process. A dangerous practice is praying for another's truth, and then informing them about your insights, as if God is speaking through you. For some clients, the information may be false, yet traumatizing if they visualize it as true. For

others, the information may be accurate, but the client is incapable of coping with it at that time.

Visualization is a powerful tool to release anxiety from trauma. It gives peace about truth, and creates hope and direction for the next step of recovery. "I wait patiently for the Lord; he turned to me and heard my cry. He lifted me out of the slimy pit ...he set my feet on a rock and gave me a firm place to stand. He put a new song in my mouth" (Psalms 40: 1-3, NIV). "Those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint" (Isaiah 40:31, NIV). People who picture God as strong, trustworthy, rescuing, and loving, can often shorten their healing period. The road to recovery is unique for each person, with the Lord as the director and counselor for each step of the way.

EMDR poses no spiritual challenges. On the contrary, EMDR can be used by trained therapists, through the power and direction of the Holy Spirit. "The Spirit of the Lord is upon me, because the Lord has anointed me to bring good news to the suffering and afflicted. He has sent me to comfort the broken hearted, to announce liberty to captives, he will give beauty for ashes; joy instead of mourning, praise instead of heaviness" (Isaiah 61: 1-3, LB).

Suggested Uses for this Method

Successfully treating PTSD and trauma

"EMDR is a therapy for the entire spectrum of trauma. With well-attached, affect-tolerant clients, you can often completely clear one-event traumas in a few sessions. What does clearing mean? It means that clients can hold a traumatic event in mind while experiencing no symptoms of PTSD: no negative cognitions, no old, bad sensations, no flashbacks, and later, no bad dreams. Of course, the more pervasive the trauma-years in a war zone or a horrific childhood-the more sessions you need. You can use EMDR to transform the "small t," (F. Shapiro, 2001) relational traumas, and attachment deficits that create so many personality, attachment, and secondary dissociation disorders. And tied with ego state therapies, you can use it to clear the catastrophic attachment and pervasive trauma of tertiary dissociation (Forgash & Copeley, 2008, Paulsen, 2009 as cited in R. Shapiro 2010, p.93).

Treating Other Clinical Symptoms

EMDR can be used for a variety of other symptoms as well as trauma and PTSD. Robin Shapiro includes: "distressing physical sensations, eating disorders, phantom and chronic pain (Wilson & Tinker, 2005), beliefs about the self (Knipe, 2005), anxiety

disorders, and depression (Manfield, 1998) ...familial and cultural introjects, traumatic couples issues, anxiety disorders, some forms of depression, obsessive-compulsive personality disorder, medical trauma, and multiple chemical sensitivities (R. Shapiro, 2005, 2009a, 2009b) ... Children are the best subjects for EMDR. They process more quickly than adults. In the time an adult would be just getting started, a child will say "Done" and mean it. Some modify the protocol for smaller children. I modify it for adolescents. If they don't want to tell me exactly what we're targeting, I don't make them...They may or may not tell me about it later. Some boys like it because they don't have to talk too much when in therapy. Boys often like the technology (pulsers and flashing lights) that go with ... EMDR. Several clinicians have found ways to use stories with embedded EMDR to work with children (Greenwald, 1999; Lovett, 1999; Turner, 2005"; R. Shapiro, 2010, p.97).

Evaluating the truth of memories

EMDR using visualization may be the safest method of evaluating the truth of traumatic memories (McDonald, 1995). Clients retain full consciousness and control at all times, unlike drugs or hypnosis, creating less opportunity for suggestibility by leading questions from the therapist. Guided visualization can create false memories, especially for young children and suggestible clients (McDonald, 1995; Loftus, 2008; Bruck, Ceci, & Kulkofsky, 2010). It is important for counselors to encourage clients to sort out facts from fears and fantasies. Visualizations may be accurate, but they may also be partially false, based on the client's perceptions at the time, rather than the reality of the situation. Visualizations can also reveal fears or fantasies, similar to dreams, thus are not strong enough evidence to convict the accused.

Possible contraindications' for the use of this method

Validating childhood memories that are partially or fully blocked from consciousness

Some have questioned if EMDR and visualization elicit accurate childhood memories. To date, there has not been sufficient research to validate the truth of memories. Because *perceptions* of trauma create the disturbance, information is only as accurate as the individual's discernment. Anxiety can originate from fears, rather than from actual incidents. Therefore memories may be a combination of fears and events, and are not to be taken as literal or accurate without validation. There has been no evidence that EMDR implants false memories. In fact, there is no therapeutic method that is less suggestive, since all of the initial information and the ongoing connections come from the client (McDonald, 1995).

Clients who have overwhelming anxiety, without the time, finances, or support for intensive therapy

EMDR therapists are trained to focus on potential dangers of unexpected flashbacks or overload. It is a powerful tool that creates connections between current anxiety and childhood or adult trauma, and should be conducted only by trained therapists.

Robin Shapiro voices her concern about the importance of taking “so much care with fragile EMDR clients, because this powerful technique often takes minutes to break through decades of emotional defense and dissociation. If you want your most distressed clients to stay alive, intact, and in therapy, you will help them titrate the reexperiencing of affect and cognitions that went with years of horrible abuse. To do that you have to have tools in place and enough therapeutic relationship to call your client out of the morass, or to enter the morass slowly and in control. Don't try to do EMDR without formal training. It's so powerful you can hurt people with it, if you don't know what you're doing” (R. Shapiro, 2010, p.98). Counselors must practice “closing down” the emotions of a trauma if the work is not complete by the end of the session. This is a critical process addressed in the EMDR training.

Clients who have a pending court testimony

Some have equated EMDR to hypnosis, as an altered state of consciousness, which would be inadmissible in court. However, EEG and brain scan research demonstrates normal brain waves during EMDR, and thus it is admissible in court (Shapiro & Forrest 2004). However, it is often advisable to delay EMDR until court proceedings are completed, because the lack of anxiety and reaction to a trauma may decrease the believability of a testimony.

The process of applying EMDR and visualization in the clinic

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Complete a thorough history and assessment.

SEE THE UNIQUENESS OF EACH PERSON in these areas: their pre-trauma personality/pathology; the age of onset and termination of trauma, developmental issues; frequency and severity of abuse; the personality of perpetrator; the relationship between perpetrator and survivor; the non-trauma history; and their personality and defenses. An important component of early therapy is creating an imaginary “Safe Place,” which is a visual picture of a beautiful garden-like setting, which is for the Lord and the individual only. No one else is allowed to enter. This is extremely important for comfort whenever the feelings become overwhelming. This is also helpful in assessing an individual’s relationship with the Lord in terms of their feelings of trust, closeness,

obedience, and availability. It often reveals feelings that may contradict their theological knowledge. Visualizing the Lord's love and presence at all times is often the rudder that allows survival in the difficult and painful memories.

Pre-plan the therapeutic interventions for this unique individual

Teach self-soothing and self-care. When trauma occurs, many individuals have difficulty eating, sleeping, exercising, and daily functioning. Even when the trauma has occurred years prior, some remain in this overwhelmed state. A guided visualization of caring for a traumatized child often exposes the areas where self-care and self-soothing need to occur. Assessing the client's ego strength and previous method of surviving difficult situations, will reveal the degree and kinds of support that have been successful.

Freezing or numbing is a common reaction to trauma. It seems to be God's method of enabling us to cope with the overwhelming nature of a trauma, until someone arrives to assist us. However, we are not meant to remain in that state. Dissociation occurs when the numbness or splitting from the feelings is not resolved. Trauma survivors who have dissociated describe the trauma from a distance, as if they are watching it occur to someone else. This is especially common for children who do not reveal the trauma, but keep it a secret, often because of threats from the perpetrator. As a client visualizes their "Safe Place" with Jesus, they may be encouraged to prayerfully ask the Lord to reveal to them pictures of the split-off or dissociated parts, such as a hurting, angry, terrified, or controlling child. They may also have split-off adult parts. Understanding these splits, their interrelationships, and their relationship to the Lord, provides a clearer road map to the extent and type of therapy required. "Safety, readiness, and dissociation assessment are mandatory ... the fastest way to find undiagnosed DID (dissociative identity disorder) is to do EMDR without screening" (R. Shapiro, 2010).

It is important to evaluate available methods for release of feelings: (terror, anger, denial, guilt, shame, sadness, grief, helplessness, hopelessness, etc.) Understanding the client's comfort with various feelings often provides a direction for therapy. If a client is unable to access certain feelings, it may be helpful for them to picture themselves with that feeling in the safe place with the Lord.

Plan the method of providing safety during therapy.

Develop a support system, with family or friends, who are informed about the possible needs during therapy. Visualizing and feeling the Lord's continual presence provides the core support whenever possible. If abuse has occurred from a father or father-figure, this may be difficult or impossible. Creating a bond between the client and therapist is also essential. Introducing and experiencing both visualization and EMDR, enable the client to give informed consent, as well as to have clear expectations.

Assess the advantages of hospitalization, day-treatment, and weekly sessions. Trauma therapy is often emotional “surgery,” and minimal functioning may be the result during the intense portion of the therapy. Because of this, the McDonald Therapy Center has developed an Intensive day treatment program, which is often the easiest method for a client to deal with trauma. Hospitals rarely deal with trauma because of the current requirements by most insurance that only permits stabilization, followed by out-patient therapy. Weekly therapy becomes overwhelmingly painful for many clients, when the pain isn’t resolved, and they must remain in the pain until the next session. Having tried all of the options, the day-treatment has been the most successful and least traumatic for clients. It is described in Appendix B

Understand memory and how memories fit into psychotherapy

There are three stages or components of memory: perception, storage, and retrieval. Memories can be accurate or distorted in each stage of memory. Dr. Elizabeth Loftus has done extensive work in this area, and can provide a thorough understand of our memory and eye-witness reports. As a client visualizes their trauma, they need to ask the Lord to reveal truth and distortions.

We never have a guarantee that all memories are accurate. Misperceptions occur frequently, but are nevertheless the cause of the trauma, and must be dealt with accordingly. Memories may not be factual information, but expressions of fears or feelings. The intensity of a feeling does not necessarily indicate the true content of the memory, nor do symptoms always denote the specific trauma.

Decrease PTSD symptoms through EMDR and visualization

Trauma treatment without EMDR is like surgery without the anesthetic. All of the feelings associated with a trauma are reactivated during therapy, but are quickly reduced through EMDR.

“The beginning of trauma processing ... includes selecting the picture that represents the target, identifying the negative cognition, developing a positive cognition, rating the validity of cognition, naming the emotion, estimating the subjective units of disturbance, and identifying body sensations. The brilliant beginning of trauma processing brings together the image, cognitions, emotions, and body sensations. Daniel Siegel (2003), when asked why EMDR works, said that the bilateral stimulation begins in phase 3, by starting with the image and hopping from left-brain cognitions to right-brain emotions to left-brain measuring while holding the emotion, to right-brain body-mapping. ... desensitization, includes reprocessing the memory using BLS (bilateral stimulation) in sets of varying length, depending on the client's response, until the trauma is completely cleared... BLS seems to stimulate the integrative capacity of the brain. Some think that

the dual attention-clients remembering and feeling while paying attention to the here-and-now stimulation-is part of why it works. Others think that the bilaterality stimulates the connection across the corpus callosum. Robert Stickgold 2010, a sleep researcher, thinks that BLS stimulates a REM-like state that helps process the undigested trauma” (R. Shapiro, 2010, p.95).

As of 2004, approximately 20,000 psychotherapists have been EMDR trained, and over one million individuals have been helped (Shapiro & Forrest 2004) Shapiro found 84% to 90% of the client’s trauma associated with rape, natural disasters, loss of a child, catastrophic illness, or other trauma have recovered from PTSD in three sessions. Other psychological methods addressing trauma achieved 55% success rate in seven to fifteen sessions (Shapiro & Forrest 2004). EMDR therapists are trained to focus on potential dangers of unexpected flashbacks or overload. It is a powerful tool that creates connections between current anxiety and childhood or adult trauma, and should be conducted only by trained therapists.

As the client visualizes the Lord’s presence with them during the trauma, usually the overwhelming aloneness dissipates. It will be essential to isolate and work on only one trauma at a time, until anxiety is resolved. This may require EMDR for each separate aspect of the trauma. Visualize Jesus as the Comforter during the trauma, but do not attempt to change reality. Spiritual truths that are visualized often bring healing and comfort that words alone cannot. For example: visualizing the Lord’s presence as described in Hebrews 13:5b – 6 (Amplified), can eliminate overwhelming feelings of aloneness and abandonment. As a client pictures the truth and reality of God’s presence, it replaces the pictures of the trauma.

The goal is the release of feelings, without overwhelming the client. This involves visualizing Jesus with each of the feeling parts, and His acceptance and direction for healing. It is important to visualize Jesus cleansing the shame and guilt, which is so frequently a debilitating result of trauma, especially abuse in any form. Journaling of feelings, including writing a letter that will not be sent to the perpetrator is usually helpful. Encourage appropriate expression of anger, moving from helplessness and victimization. Utilize EMDR and visualization for any anxiety regarding the expression of feelings, identifying the cause of the fear. This may be related to a previous trauma, when a client was abused or threatened for expressing a specific feeling, such as anger or sadness.

Allow the necessary time for the grieving and healing process, picturing the Lord as our Shepherd walking through the valley with us. Find the necessary steps for integration,

visualizing each split and the healing the Lord intends for this part. Fill the emptiness left when trauma is removed. Christian music and novels or tapes, as well as fellowship are very helpful.

Identify the cognitive distortions, replacing them with Biblical truth. This is a more extended process, as one pictures the Lord renewing the mind, with specific Bible verses contradicting the lies that resulted from the trauma. Retell the trauma story, and the “meaning” it has in the present. EMDR and visualization are also used during this phase of therapy: Robin Shapiro describes “installing the positive cognition: “While holding the memory in mind, the client is able to completely endorse the positive cognition; for example, ‘It’s over.’ ‘I’m safe now.’ ‘I’m blameless.’ ‘I’m lovable.’ At this point, the client no longer feels the trauma inside and usually can endorse the original positive cognition while thinking of the traumatic event’ (R. Shapiro, 2010, P.95). See Appendix C for a sample.

Fear and anxiety resulting from trauma is often held in our body, either at the place where the trauma occurred, if it was physical, or wherever tension is held. A mental scanning of one’s body searches for any area of discomfort or pain, continuing to use EMDR and visualizing the Lord’s healing of that particular area.

Most clients need to resolve the question of “Where was God when this happened?” and their bitterness at his “failure to intervene or stop the trauma. This must be the client’s resolution in line with their theology, not the counselor’s. *The Shack* is an excellent narrative revealing the many spiritual concerns occurring after a trauma, and the visual pictures as the writer seeks resolution.

Arriving at forgiveness and “letting go” of the trauma is often a challenge. Many clients need to grasp that “forgiveness” does not necessarily include reconciliation. It does require giving up one’s right to revenge, and giving that revenge to the Lord. “It is mine to revenge, I will repay, says the Lord” (Romans 12:19 NIV). Restoring the relationship with a perpetrator of abuse should only occur with repentance, time, and safety.

Moving on to wholeness is the goal. Robin Shapiro describes the last two stages as closure and reevaluation: “Closure, includes homework to monitor changes, expectations, and, if needed, bringing the client to a state of emotional equilibrium. Clients who are working on huge or repeated trauma may need to be brought back to their safe places or use containers to get back to themselves. If the trauma isn’t completely cleared, flashbacks of old or even newer material may pop up between sessions.” Finally, there is the stage of “reevaluation, which includes checking in at the

next session to see if the client requires new processing for the previous target or associated behavior. Because EMDR wakes up material that's associated with the original trauma, your client may come to the next session with a new, but related target (R. Shapiro, 2010, pp.95-96).

Risk openness and trusting again (of God, self, others, and circumstances). It is time to ask the Lord to give new dreams. Visualize Jesus with play, laughter, new dreams and goals, and all the fruits of the Spirit today.

Case Study

Melissa is a wife and mother of three, who also worked part-time as a nurse. She was referred to the Intensive Day Treatment program by her therapist in another state, due to PTSD, reoccurring depression, and anxiety. Her therapist had already completed a thorough history, which included childhood physical and sexual abuse, a severe accident in which her mother was killed and she was severely injured, and a second car accident as an adult, in which she was helpless to save the life of her child, despite her training as a nurse. Extensive grief work had occurred, except for any feelings of anger. Melissa was active in her church, with a strong and close relationship with the Lord, although she often questioned His willingness to protect her or her children. She had two close friends with whom she could share anything, with permission to call them anytime, day or night, during her time here. Her husband was less available emotionally, generally overwhelmed and irritated at her depression and the subsequent added demands of the family, which he had assumed. Her parents were distant, although happy to come and care for the children when Melissa came for the intensive therapy. Melissa was motivated, with strong ego strength, and desperate to move past all of this in order to function in the present. Several psychotropic drugs had been tried, with only mild success. Anti-anxiety drugs were currently used as needed.

In the initial stage of the intensive therapy, Melissa created her imaginary "Safe Place," a beautiful island with tropical trees and plants and waterfalls. She visualized "Jesus" there (her term for the Lord which felt safest). She was troubled as she pictured Him as distant and unavailable. As she connected this picture to the relationship with her mother, father, and husband, she began to find Jesus more "approachable." As she prayerfully asked the Lord to reveal to her any splits that exist, she described several: a terrified five year old, a playful happy four year old, and a very angry unknown child hiding in a cave. There were also adult splits: a competent professional nurse, a helpless frightened adult, and a negative protective mom. Only the playful child could feel trust and run to Jesus.

Self-care was discussed, and Melissa committed to leave all family and work problems behind, using this time for self-care and recovery. She quickly adapted to the use of tactile probes for the EMDR, and agreed to the projected process as presented.

The trauma therapy began with her visualizing the Lord and asking Him where to begin. The picture of her car accident in which her mother died first came to mind. As she focused on it, she was asked to rate the degree of anxiety on a 0 to 10 scale, and immediately said 10+, showing visible signs of terror. Her belief was that she was helpless and they all would die. The EMDR and visualization of the accident, with Jesus there beside her, continued for several sessions, until the anxiety was gone and she could say, "I'm alive and I'm not helpless." Melissa remained at the McDonald Therapy Center all day long. In between the double sessions, she journaled, drew, listened to Christian music, and sobbed intensely. She also exercised by walking at the beach. She repeatedly retold the story, with every detail, both in therapy, and over the phone, with her two friends.

She made excellent progress, except for the missing anger. She returned to her "Safe Place" and asked Jesus where the anger was hidden, despite her reluctance to do this. A picture of her at age four emerged, when she was very angry and was beaten by her father and told, "You haven't felt anything yet. Throw another fit and I'll kill you!!" That was the last time Melissa was ever angry. EMDR and Christ-centered visualization then focused on this trauma, again rated "10" and the belief, "If I get angry I'll die." After several sessions, the terror and anxiety were gone, and Melissa was able to believe that appropriate anger is helpful and necessary. With encouragement and modeling, she was able to use our "anger room," which included a punching bag, releasing the intense anger towards her dad, as well as towards the driver who hit and killed her mom. Later she pictured the adult Melissa holding this precious four year old, telling her she is lovable, and the adult will teach her to handle her anger, and that she will love her even when she is angry.

A similar process occurred with the incidents when Melissa was sexually abused as a child." Details of the sexual abuse were targeted with the EMDR. The expression of anger came relatively easily, but the shame and feelings of being "dirty" persisted. She especially struggled with the knowledge that parts of the abuse had been enjoyable on most of the occasions, and thus it felt like it was "her fault." Through EMDR and picturing Jesus cleanse the sexually abused little girl, both inside and outside, she began picturing this child now dressed in white, made "as white as snow." Again, she retold the story several times in therapy as well as to her two friends at home. She also needed to understand and process her promiscuity as a teen and young adult, receiving the Lord's forgiveness for her poor choices.

The final incident involved the car accident when Melissa lay trapped in her car, helplessly watching her daughter scream and shortly die from the injuries, and helplessly begging the Lord to save them. The added layers of guilt and helplessness and responsibility as the driver of the car, made this the most challenging and lengthy incident for Melissa to process. The most difficult cognitions to change were, "It's all my fault" and "God didn't care." For the first time she admitted she was on the phone talking, thus somewhat preoccupied, and believed she may have been able to prevent the accident otherwise. She acknowledged the change that had occurred with her marriage following this accident, and vowing to never tell her husband. The terror of his discovering this truth was an additional feared trauma, a target for EMDR and visualization. Through days of prayerful search for direction, she eventually told her husband over the phone, at a time when he was meeting with their pastor, who already knew the information, and agreed to help him process this. Melissa sought forgiveness from the Lord, picturing His love and forgiveness. With great difficulty, she finally chose to forgive herself (see Appendix C for an example of changing the lies to Biblical truths).

Integration of the child parts occurred quite easily, after the treatment of the trauma and the Lord's healing and cleansing. They could then become part of the adult, after reassurances that the playfulness and the ability to be angry when necessary would not be lost. The integration of the adult parts became more complicated, with numerous issues arising, but was eventually complete.

It is now two years later, Melissa continued in weekly therapy in her home state for several months, reporting that the anxiety did not return. She chose to share the information about the physical and sexual abuse with her parents, and reports it was a neutral experience, as they listened, but did not give much response. She and her husband sought marriage counseling from their pastor. They both report dramatic changes. Melissa is no longer depressed, nor is she suffering any of the symptoms of PTSD. They are beginning to dream and plan for new projects. Hope has returned

References

- American Psychiatric Association; *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.
- Arbuthnott, K. D., Arbuthnott, D. W., & Rossiter, L. (2001). Guided imagery and memory: Implications for psychotherapists. *Journal of Counseling Psychology*, 48(2), 123-132.
- Bergmann, U. (2000). Further thought on the neurobiology of EMDR: The role of the cerebellum in accelerated information processing. *Traumatology*, 6, 175-200.
- Bremner, J. (1999). Does stress damage the brain? *Biological Psychiatry*, 45(7), 797-805.
- Bruck, M., Ceci, S., Kulkofsky, S., Klemfuss, Z., & Sweeney, C. (2008). Children's testimony. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor, A. Thapar (Eds.), *Rutter's child and adolescent psychiatry (5th ed.)* (pp. 81-94). Wiley-Blackwell.
- Carlson, N. R. (2007). *Physiology of behavior* (9th ed.). Boston: Pearson Allyn & Bacon.
- Francati, V. V., Vermetten, E. E., & Bremner, J. D. (2007). Functional neuroimaging studies in posttraumatic stress disorder: review of current methods and findings. *Depression & Anxiety (1091-4269)*, 24(3), 202-218.
- Gilbertson, M. W., Shenton, M. E., Ciszewski, A., Kasai, K., Lasko, N. B., Orr, S. P., & Pitman, R. K. (2002). Smaller hippocampal volume predicts pathologic vulnerability to psychological trauma. *Nature Neuroscience*, 5(11), 1242.
- Glaser, R., Rice, J., Sheridan, J., Fertel, R., Stout, J., Speicher, C., et al. (1987). Stress-related immune suppression: Health implications. *Brain, Behavior, and Immunity*, 1, 7-20.
- Gurvits, T. V., Shenton, M. E., Hokama, H., & Ohta, H. (1996). Magnetic resonance imaging study of hippocampal volume in chronic, combat-related posttraumatic stress disorder. *Biological Psychiatry*, 40(11), 1091-1099.
- Hull, A. M. (2002). Neuroimaging findings in post-traumatic stress. *British Journal of Psychiatry*, 181(2), 102-110.
- Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, 16, 495-512.

- Lansing, K., Amen, D. G., Hanks, C., & Rudy, L. (2005). High-resolution brain SPECT imaging and eye movement desensitization and reprocessing in police officers with PTSD. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 17(4), 526-532.
- Levin, P., Lazrove, S., & van der Kolk, B. (1999). What psychological testing and neuroimaging tell us about the treatment of posttraumatic stress disorder by Eye Movement Desensitization and Reprocessing. *Journal of Anxiety Disorders*, 13(1-2), 159-172.
- Loftus, E., Doyle, J.M., & Dysert, J. (2008). Charlottesville, Va: Law Publishing.
- McDonald, A. N. (1995). *Repressed memories: can you trust them?* Grand Rapids, Mich.: Fleming H. Revell.
- Merriam-Webster's dictionary and thesaurus*. (2007). Springfield, Mass.: Merriam-Webster.
- Murphy, S., Nordin, S. M., & Cumming, J. (2008). Imagery in sport, exercise and dance. In T. Horn (Ed.), *Advances in sport and exercise psychology* (3rd ed.), pp. 297–324. Champagne, IL: Human Kinetics.
- O'Craven, K. M., & Kanwisher, N. N. (2000). Mental Imagery of Faces and Placed Activates Corresponding Stimulus-Specific Brain Regions. *Journal of Cognitive Neuroscience*, 12(6), 1023.
- Oh, D., & Choi, J. (2007). Changes in the regional cerebral perfusion after eye movement desensitization and reprocessing: A SPECT study of two cases. *Journal of EMDR Practice and Research*, 1(1), 24-30.
- Rasolkhani-Kalhorn, T., & Harper, M. L. (2006). EMDR and Low Frequency Stimulation of the Brain. *Traumatology*, 12(1), 9-24. Taylor, K. N. (19831971).
- Shapiro, F., (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, protocols and procedures* (2nd ed.). New York: Guilford.
- Shapiro, F., & Forrest, M. S. (2004). *EMDR: the breakthrough therapy for overcoming anxiety, stress, and trauma*. 4-8, 270-271. New York, NY: BasicBooks.
- Shapiro, R, (2010), *The trauma Treatment Handbook*, 93-100, New York, N.Y.: W.W. Norton & Company.
- Selye, H. (1976). *The stress of life*. New York: McGraw-Hill.

Taylor, K. N. (1971). *The living Bible, paraphrased* . Wheaton, Ill.: Tyndale House; distributed by Doubleday [New York.

The amplified Bible (Old Testaments and New Testament). (1987). Grand Rapids, Mich.: Zondervan Bible Publishers.

The living Bible, paraphrased (Red letter ed.). Wheaton, Ill.: Tyndale House.

The life Application Bible (New International Version ed.). (1991). Grand Rapids, Mich.: Zondervan.

Van der Kolk, B. A. (2002). Posttraumatic Therapy in the Age of Neuroscience. *Psychoanalytic Dialogues*, 12(3), 381.

Yehuda, R. (2001). "Are glucocorticoids responsible for putative hippocampal damage in PTSD? How and when to decide." *Hippocampus* 11: 85-90.

Appendix A

Posttraumatic Stress Disorder (DSM IV.. 309.81)

309.81 Posttraumatic Stress Disorder

Diagnostic Features

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent

distressing dreams during which the event can be replayed or otherwise represented (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situations, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outbursts of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3).

Specifiers

The following specifiers may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

Acute. This specifier should be used when the duration of symptoms is less than 3 months.

Chronic. This specifier should be used when the symptoms last 3 months or longer.

With Delayed Onset. This specifier indicates that at least 6 months have passed between the traumatic event and the onset of the symptoms.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Post-traumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. Auditory hallucinations and paranoid ideation can be present in some severe and chronic cases. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

Posttraumatic Stress Disorder is associated with increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia, and Bipolar Disorder. These disorders can either precede, follow, or emerge concurrently with the onset of Posttraumatic Stress Disorder.

Associated laboratory findings. Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

Associated physical examination findings and general medical conditions. Physical injuries may occur as a direct consequence of the trauma. In addition, chronic Posttraumatic Stress Disorder may be associated with increased rates of somatic complaints and, possibly, general medical conditions.

Specific Culture and Age Features

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation"-that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

Prevalence

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder of approximately 8% of the adult population in the United States. Information is not currently available with regard to the general population prevalence in other countries. Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Course

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, a person's reaction to a trauma initially meets criteria for Acute Stress Disorder (see p. 469) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma. In some cases, the course is characterized by a waxing and waning of symptoms. Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development

of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Familial Pattern

There is evidence of a heritable component to the transmission of Posttraumatic Stress Disorder. Furthermore, a history of depression in first-degree relatives has been related to an increased vulnerability to developing Posttraumatic Stress Disorder.

Differential Diagnosis

In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder**, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., a Mood Disorder or another Anxiety Disorder). Moreover, if the symptom response pattern to the extreme stressor meets criteria for **another mental disorder** (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

Acute Stress Disorder is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1 month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder.

In **Obsessive-Compulsive Disorder**, there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features, a delirium, Substance-Induced Disorders, and Psychotic Disorders Due to a General Medical Condition**.

Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person 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

(2) the person's response involved intense fear, helplessness or horror. **Note:** In children this 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 on 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 on 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 1 month.

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

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Appendix B

OUTPATIENT INTENSIVE THERAPY PROGRAM

BENEFITS OF OUTPATIENT INTENSIVE PSYCHOTHERAPY: Patients who have experienced trauma or have backgrounds of abuse (physical, sexual, emotional), often find it difficult to access their buried pain within the context of a once a week, 45 or 50 minute therapy session. The patient's innate emotional defense mechanism will not allow the retrieval or processing of such painful feelings. This can rarely occur in the traditional therapy setting because of the necessary boundaries associated with the responsibilities of adult life. Consequently, many patients suffering from current trauma or abusive backgrounds spend years in traditional weekly therapy with very little progress, often resulting in feeling stuck and frustrated.

In the past, the only other alternative has been psychiatric hospitalization. Unfortunately, the philosophy of the majority of psychiatric hospitals has been to keep a patient "under control", which usually means medication and restraints whenever the patient's pain becomes apparent. This is appropriate if the patient is psychotic, suicidal, or self-destructive. However, many patients are *not* mentally ill, nor are they suicidal or destructive. These persons have *emotional* damage and do not require 24 hour-a-day supervision in a hospital setting. Yet these patients often have histories of multiple hospitalizations and still are far from being emotionally healthy.

Both of the above situations are very costly to the insurance company and cause lengthy periods of emotional pain for the patient - often without positive results.

We offer an alternative to persons who are stable enough not to require 24-hour supervision: Outpatient Intensive Therapy, where the patient is allowed to release their memories and pain in a safe environment. Therapeutic approaches used include grief and trauma therapy, art therapy and cognitive education. Our program is based on over twenty-five years of experience in this field.

THERAPEUTIC APPROACHES: Outpatient Intensive Therapy consists of four 45-50 minute sessions per day, or two 75-80 minute sessions per day, five days per week, for an average of one to three weeks. During this time the patient will have a private location and peaceful surrounding in order, to establish a safe place to begin appropriate work on their presenting problems. The intensive schedule of the program encourages the following:

- ~ Rapid progress in marriage, family, or personal difficulties
- ~ The breakthrough of defense mechanisms that have kept issues unresolved or memories blocked from recall. This can rarely occur in the traditional therapy setting because of the necessary boundaries associated with the responsibilities of adult life.
- ~ The expression of feelings associated with memories. This involves work with grief in a safe and secure environment, where a client may cry as long as necessary or release suppressed terror, anger, guilt, shame and pain.
- ~ The identification of self-destructive thinking.
- ~ The integration of truth and skills into a client's life, e.g. learning to perceive oneself and others in a healthy perspective, developing coping skills which allow a client to live a productive life.

The majority of patients stay in a nearby hotel where amenities such as a heated swimming pool, spa and workout rooms along with nearby parks, allow a variety of activities and environments in which to process their therapy sessions. (Choice of lodging is optional and not included in cost of therapy.) Having the patient away from home and temporarily removed from the demands of career and family enables them to stay focused on therapy issues. Patients are also encouraged to journal daily and are given additional homework that occupies a portion of their "between session" time.

REFERRALS/FOLLOW UP: The patient may currently be in treatment with a primary therapist. Consultation with this therapist would be made to determine if intensive therapy is suitable for the patient at this point in their therapeutic treatment. In addition, it is important that the patient coming from out of the area has access to a local therapist for follow-up after their intensive work. If they're in the San Diego area, follow-up can continue through this clinic. This type of intensive outpatient therapy has proven to be not only very effective in terms of *accelerated healing* for the patient, but also is *far less costly* than hospitalization or long-term once per week treatment. Outpatient Intensive Therapy shortens the overall time of treatment, thereby maximizing the benefits to both the patient and the insurance company.

Appendix C
Melissa's Cognitive Distortions and Biblical Truths

<u>Lies Believed</u>	<u>What God Says</u>
"I'm bad."	I am the righteousness of God in Christ (see Phil. 3:9).
	"Blessed are the pure in heart"(Matt. 5:8).
	I am being conformed to the image of God's Son (see Rom. 8:29).
"It's not OK to cry"	"Those who sow in tears will reap with songs of joy" (Ps. 126:5 NIV).
	"Jesus wept" (John 11:35).
"It's not OK to feel."	The Word of God is a discerner of the thoughts and intents of the heart (see Heb. 4:12).
	Jesus was filled with compassion (see Matt. 9:36 NIV; 14:14; Mark 1:41; 6:34).
	"Blessed are those who mourn" (Matt. 5:4 NIV).
"I must be quiet."	"Speak the truth to each other" (Zech. 8:16 NIV).
	Speak the truth in love (see Eph. 4:25).
	"I pour out my soul" (Ps. 42:4 NIV).
"This isn't happening."	By constant use of the Word I can learn to discern good from evil (see Heb. 5:14 NIV).
"I'm a loser."	"We are more than conquerors through Him who loved us" (Rom. 8:37 NIV).
	God always causes us to triumph in Christ (see 2 Cor. 2:14).
"It's unacceptable to be me."	I am accepted in the beloved (see Eph. 1:6).
	I am God's workmanship (see Eph. 2:10).
"I'm fat and ugly."	"I am fearfully and wonderfully made" (Ps. 139:14 NIV).
"I'm weak."	His strength is made perfect in weakness (see 2 Cor. 12:9).
	In quietness and trust is my strength (see Isa. 30: 15).
"I'm useless."	"For it is God who works in you to will and to act according to his good purpose" (Phil. 2:13 NIV).
	"I can do everything through him who gives me strength" (Phil. 4:13 NIV).
	"I am the vine, you are the branches. He who abides in Me, and I in him, bears much fruit" (John 15:5 NKJV).
"I'm an emotional cripple."	I have the mind of Christ (see 1 Cor. 2:16).
"I'm too vulnerable to succeed."	I have the full armor of God (see Eph. 6:11-18).
	No weapon forged against me will prevail (see Isa. 54:17)
"No place is safe."	"He is my refuge and my fortress." (Ps. 91:2 NIV)
	I can dwell in the secret place of the Most High (see Ps. 91:1)
"I'm all alone and abandoned."	"He (God) Himself has said, nor give you up nor leave you without support. I will not, I will not, I will not in any degree leave you helpless, nor forsake nor let you down, relax my hold on you—assuredly not!"

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Eye Movement Desensitization and Reprocessing (EMDR) is a successful method for treating trauma. It rapidly and effectively releases anxiety, disturbing emotions, and negative thoughts associated with trauma. “It is a complex and powerful method of psychotherapy that integrates many of the most successful elements of a wide range of therapeutic approaches. In addition, it uses eye movements or other forms of rhythmical stimulation, such as hand taps or tones, in a way that seems to assist the brain’s information processing system to proceed at a rapid rate” (Shapiro Forrest, 2004, p. 4-5). EMDR therapists are trained to focus on potential dangers of unexpected flashbacks or overload. It is a powerful tool that creates connections between current anxiety and childhood or adult trauma, and should be conducted only by trained therapists.

EMDR was developed by Francine Shapiro in 1989, when she “noticed that the upsetting emotions accompanying disturbing thoughts disappeared as her eyes moved rapidly back and forth” (Shapiro & Forrest, 2004, p. 270). Researchers performed neuroimaging on patients with PTSD and consistently found structural and functional changes in the brain regions associated with emotions and memory (Gurvits et al. 1996, Bremner, 1999; Hull, 2002; Gilbertson, et al 2002; Francati, et al., 2007). EMDR stimulates cerebellar processing and activates the dorso-lateral and orbito-frontal cortices via the optical region (Bergmann, 2000). This region is responsible for sensory interpretation and involved with memory and emotional processing associated in the hippocampus and amygdala (Carlson, 2007). EMDR permits neutral processing by low frequency stimulation of the brain, thus modifying memories in a safe environment (Rasolkhani-Kalhorn & Harper 2006). After EMDR, brain scans found increased activity in both the anterior cingulate gyrus and the left prefrontal cortex in patients, which is responsible for discriminating between imagined and real fears (Levin, Lazrove, & van der Kolk 1999; Oh & Choi, 2007). Therefore, the objective evidence of brain scans shows the effectiveness of EMDR in reprocessing traumatic events effectively.

Two of the research psychiatrists who have focused on trauma and brain functioning, Drs. Bessel Van der Kolk and Daniel Amen, have both demonstrated the efficacy of EMDR, documenting case studies of clients with PTSD who were treated with EMDR, and displayed “marked normalization” of brain activity (Amen, 1988, pp.183). Van der Kolk also conducted neuroimaging after cognitive behavioral therapy without EMDR, and demonstrated its failure to create significant brain activity changes (Van der Kolk 2002).

Some have questioned if EMDR elicits accurate childhood memories. To date, there has not been sufficient research to validate the truth of memories. Because perceptions of trauma create the disturbance, information is only as accurate as the individual’s discernment. Anxiety can originate from fears, rather than from actual incidents. Therefore memories may be a combination of fears and events, and are not to be taken as literal or accurate without validation. There has been no evidence that EMDR implants false memories. In fact, there is no therapeutic

method that is less suggestive, since all of the initial information and the ongoing connections come from the client (McDonald, 1995). Some have equated EMDR to hypnosis, as an altered state of consciousness, which would be inadmissible in court. However, EEG and brain scan research demonstrates normal brain waves during EMDR, and thus it is admissible in court (Shapiro & Forrest 2004). However, it is often advisable to delay EMDR until court proceedings are completed, because the lack of anxiety and reaction to a trauma may decrease the believability of a testimony.

As of 2004, approximately 20,000 psychotherapists have been EMDR trained, and over one million individuals have been helped (Shapiro & Forrest 2004). Shapiro found 84% to 90% of the client's trauma associated with rape, natural disasters, loss of a child, catastrophic illness, or other trauma have recovered from PTSD in three sessions. Other psychological methods addressing trauma achieved 55% success rate in seven to fifteen sessions (Shapiro & Forrest 2004).

EMDR poses no spiritual challenges. On the contrary, EMDR can be used by trained therapists, through the power and direction of the Holy Spirit. "The Spirit of the Lord is upon me, because the Lord has anointed me to bring good news to the suffering and afflicted. He has sent me to comfort the broken hearted, to announce liberty to captives, he will give beauty for ashes; joy instead of mourning, praise instead of heaviness" Isaiah 61: 1-3 (Living Bible).

References

- Bergmann, U. (2000). Further thought on the neurobiology of EMDR: The role of the cerebellum in accelerated information processing. *Traumatology*, 6, 175-200.
- Bremner, J. (1999). Does stress damage the brain? *Biological Psychiatry*, 45(7), 797-805.
- Carlson, N. R. (2007). *Physiology of behavior* (9th ed.). Boston: Pearson Allyn & Bacon.
- Francati, V. V., Vermetten, E. E., & Bremner, J. D. (2007). Functional neuroimaging studies in posttraumatic stress disorder: review of current methods and findings. *Depression & Anxiety* (1091-4269), 24(3), 202-218.
- Gilbertson, M. W., Shenton, M. E., Ciszewski, A., Kasai, K., Lasko, N. B., Orr, S. P., & Pitman, R. K. (2002). Smaller hippocampal volume predicts pathologic vulnerability to psychological trauma. *Nature Neuroscience*, 5(11), 1242.
- Gurvits, T. V., Shenton, M. E., Hokama, H., & Ohta, H. (1996). Magnetic resonance imaging study of hippocampal volume in chronic, combat-related posttraumatic stress disorder. *Biological Psychiatry*, 40(11), 1091-1099.

- Hull, A. M. (2002). Neuroimaging findings in post-traumatic stress. *British Journal of Psychiatry*, 181(2), 102-110.
- Levin, P., Lazrove, S., & van der Kolk, B. (1999). What psychological testing and neuroimaging tell us about the treatment of posttraumatic stress disorder by Eye Movement Desensitization and Reprocessing. *Journal of Anxiety Disorders*, 13(1-2), 159-172.
- McDonald, A. N. (1995). *Repressed memories: can you trust them?* Grand Rapids, Mich.: Fleming H. Revell.
- Oh, D., & Choi, J. (2007). Changes in the regional cerebral perfusion after eye movement desensitization and reprocessing: A SPECT study of two cases. *Journal of EMDR Practice and Research*, 1(1), 24-30.
- Rasolkhani-Kalhorn, T., & Harper, M. L. (2006). EMDR and Low Frequency Stimulation of the Brain. *Traumatology*, 12(1), 9-24. Taylor, K. N. (1983/1971). *The living Bible, paraphrased* (Red letter ed.). Wheaton, Ill.: Tyndale House.
- Shapiro, F., & Forrest, M. S. (2004). *EMDR: the breakthrough therapy for overcoming anxiety, stress, and trauma*. 4-8, 270-271. New York, NY: BasicBooks.
- Van der Kolk, B. A. (2002). Posttraumatic Therapy in the Age of Neuroscience. *Psychoanalytic Dialogues*, 12(3), 381.