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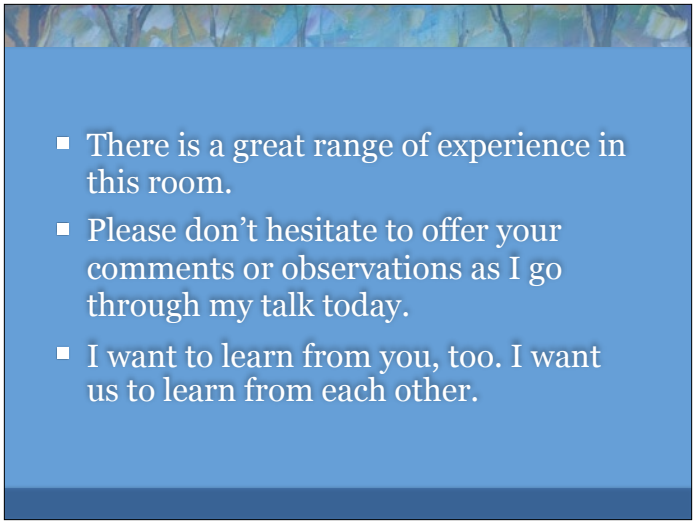

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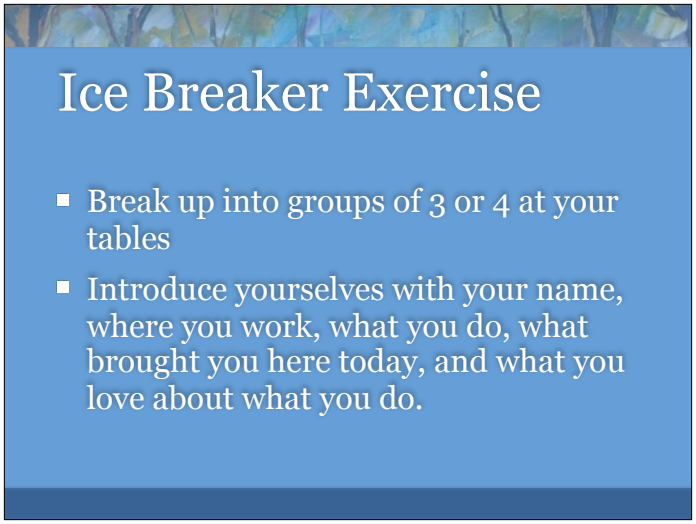
These are my assumptions about you all.



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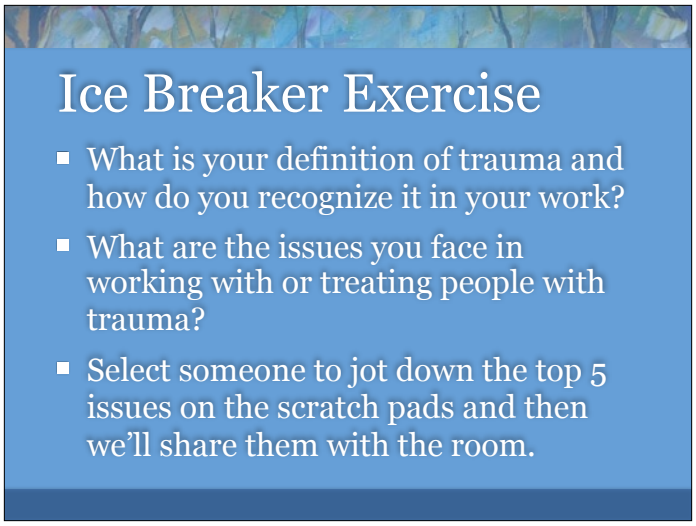
Hi, my name is Dave Ebaugh. I am so excited to be here today and have the opportunity to share with you a new technique that is only 10 years old. It is my hope you will become as excited as I am and in imagining what your work with the people you help could be like. I continue to have wonderful clinical experiences and very satisfied clients, the people I work with.

I am going to be talking about my personal experience and share with you some of the conclusions I've drawn in my work, and from what I've studied about attachment development, how we perceive physical sensation in our bodies, and how chronic stress impairs the way we process those sensations. There is a lot of experience and expertise in the room, and I want to hear from you throughout the presentation. I'll ask to hear some of that collective knowledge periodically, so hold on to your comments, jot them down on the notepads at your table. I'll make sure we all hear from each other.

The first thing I'd like us to do is to get us to know each other and get an idea of the experience in there room. Spend about 3 minutes taking turns. Take notes, afterwards be your notes are passed to the front of the room.



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Continue in your small groups and talk about these two topics.
You'll have about 3 minutes per person, and I'll remind you every 3 minutes. We'll have a total of 15 minutes or so for this conversation.

Remember to respect everyone's confidentiality.

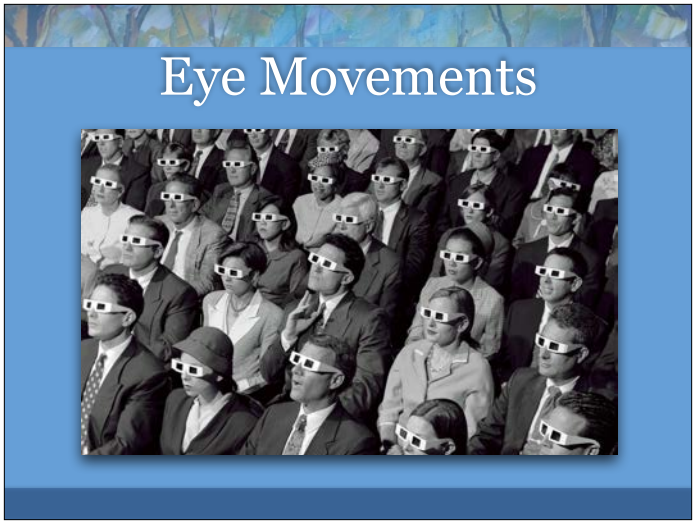
For those of you who are sharing , you

5

In 1847, a physician by the name of Semmelweis, advised that all physicians wash their hands before touching a pregnant women, in order to prevent child bed fever. His research showed that you could reduce the mortality rates from septicemia from 18% down to 2%, simply through washing your hands with chlorinated lyme. His medical colleagues refused to accept that they themselves were responsible for spreading infection. Semmelweis was ridiculed by his peers, and the criticism and back lash broke him down, and he died tragically in an asylum, 2 weeks later, from septicemia, at the age of 47.

What I'm going to talk about today may sound as radical as hand washing sounded to a mid 19th century doctor, and yet it is equally scientific. It is the simple idea that eye movements and imagery can heal a dysregulated nervous system in as little as 90 minutes.

Rebecca Davis. 2015. The Doctor Who Campaigned Hand-Washing and Briefly Saved Lives. National Public Radio. http://www.npr.org/sections/health-shots/2015/01/12/375663920/the-doctor-who-championed-hand-washing-and-saved-women-s-lives



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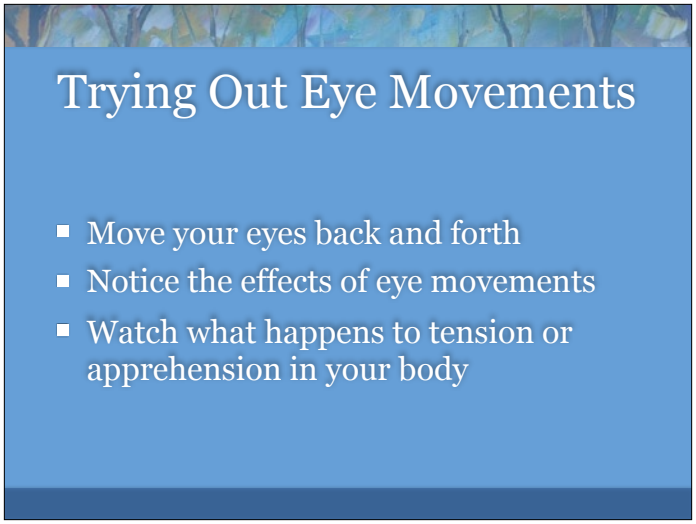
It is my hope, that the use of eye movements and imagery for crisis stabilization, treatment of emotion regulation disorders and general calming, will become as common place as hand washing is today.



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This is a 3 minute experiment.
Participation is voluntary.
You can watch the moving dot, you can look at two points in front of you, you can close your eyes and keep up with the sound of the metronome.

If you're having tension, or apprehension, or tightness in your body, keep your eyes moving and focus on the areas of tension and simply imagine those place relaxing an softening.
If you prefer, you can visualize a pleasant place, or pleasant time of your life.

8

Eye movements
"EMDR Self Administered with 528Hz Harmonics"
Look for "emdr 528" on youtube

Initial guided relaxation and Container exercise
A chance to use your your container as a resource in another experiential exercise later this morning.
The container is part of what's called resourcing in trauma work

Resourcing is common in trauma therapies.
Keep your eyes moving as you imagine creating a container that will be strong enough to hold your difficult thoughts or sensations.
Put those thoughts or sensations in that container, seal it up good, and put it away where it's out of the way, but you can get it again, if you need it.
Put distrust of this process away for now, you can get that distrust later if you want it.

Trying Out Eye Movements

- Move your eyes back and forth
- Notice the effects of eye movements
- Watch what happens to tension or apprehension in your body

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What did you observe?
Did you notice sensations in your body?
Did you notice how you responded to those sensations?
The eye movements help you become more aware of sensation in your body.
Of course I'll talk more about the technique later, but just be aware that the eye movements are used to get people more in touch with their bodies.

Next, let's talk about how we learn to perceive and respond to sensation in our own bodies. Attachment Development.

Attachment Development

- Strange Situation
- Developed by Mary Ainsworth in 1969
- Observe attachment relationships between a caregiver and a child

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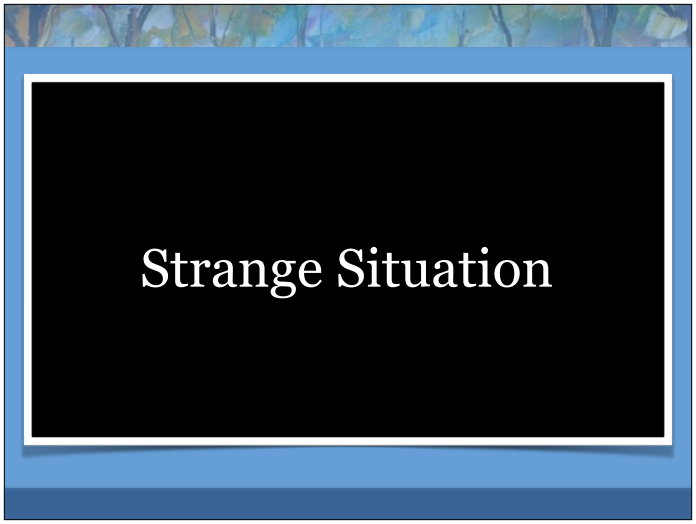
Our attachment experience is a significant foundation in the development of our autonomic nervous system and how we learn to manage distress as it arises in our bodies. Our nervous system has evolved to self-regulate, over time, moving from calm, to arousal, to calm again. Watch how a securely attached baby responds to the strange situation. Watch your own responses too.



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https://youtu.be/s608077NtNI
"Ainsworth Strange Situation"

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Effects on the baby? Effect on you?
Behavior of the caregiver affects the development of the child into an adult.

The baby is experiencing distress. That distress is then soothed when the mother returns. This shows the baby that moments of distress are temporary and then followed by feeling calm and soothed again. It's the natural rhythm of our arousal or fight/flight/freeze response. Sensation is experienced as something that is easily managed and not at all distressing. When that cycle is interrupted, because we can't get away from the stress or find relief, we either learn to ignore the signals from our body, or we become overwhelmed by those same sensations.

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Fight/Flight/Freeze

- Perceived a threat or distress, our amygdala activates our bodies us to fight, run, or freeze
- Activation creates sensations inside our bodies, butterflies, nervousness
- Normal bodily sensations can become experienced as overwhelming, or people learn to ignore or numb out those sensations

When our Fight/Flight/Freeze response is activated our amygdala

Our autonomic nervous system is activated by the amygdala sending adrenaline and cortisol through our bodies, blood rushes to our extremities, preparing us to fight, run, or freeze.
Sensations inside our bodies, butterflies, nervousness. Those very sensations can become activating and triggering in themselves. Normal bodily sensations can become experienced as overwhelming, or people learn to ignore or numb out those sensations.

In my experience, and if anyone knows specifically, and I'd like to hear from you later, attachment styles greatly influence how we respond to those sensations.

At this point I will review with you the three main types of attachment.

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Attachment Styles

- Secure
- Avoidant
- Anxious/Ambivalent (Disorganized)

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https://youtu.be/uSAPfiSw_Ic
"Attachment Theory and its Effects on Adult Relationships"

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An attuned, attentive caregiver responds and we learn that distress passes
An ambivalent or insecure caregiver may respond with more stress and we learn that stress is followed by more stress

In my experience working with people over the course of my career, I've observed that our attachment styles affect how we respond to stress.

Our response to stress is habitualized over time, and the experience of adrenaline and cortisol in our own bodies can be additionally arousing. It becomes an automatic response, like Pavlov's dog.

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It's a conditioned response.
Bacon, bell, saliva.
Bacon, bell, saliva.
Bacon, bell, saliva.
Bell, saliva.
Bell, saliva.
Our responses to emotions, and to sensation in our bodies is learned. It becomes hardwired, automatic, reflexive.

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The physical sensations associated with stress, anxiety, or depression is like an ice cream headache. It's intense, it's uncomfortable, and the it passes.
Only, when you're in it, it doesn't feel like it will pass.
Certainly there are genetic or biological factors that add to the picture, but, as you know, our response to guilt, or shame, powerlessness and vulnerability make those experiences that much worse.

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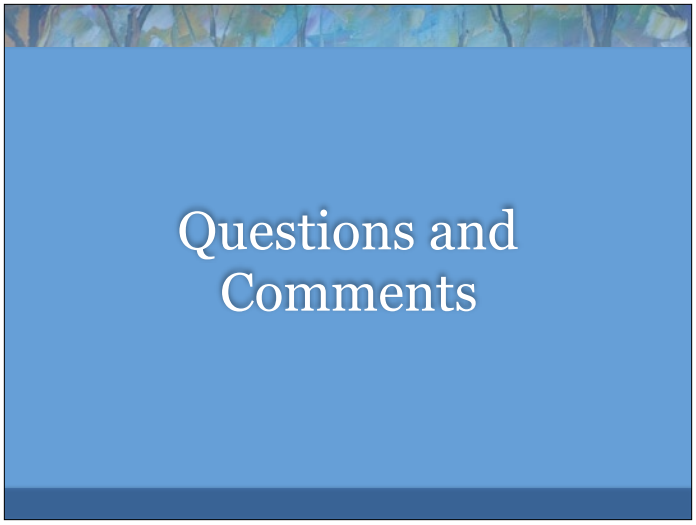
The thoughts we have about the sensations in our body, related to fear, apprehension, anxiety, are also temporary, but our responses to them, uncertainty, self-doubt, fear, anxiety, depression, are habituated.
The negative self talk are always the same.
These aren't responses they are reactions, and they are always the same.
Anger, anxiety, panic, depression, addictive urges, shame, guilt, feeling vulnerable or unseen.



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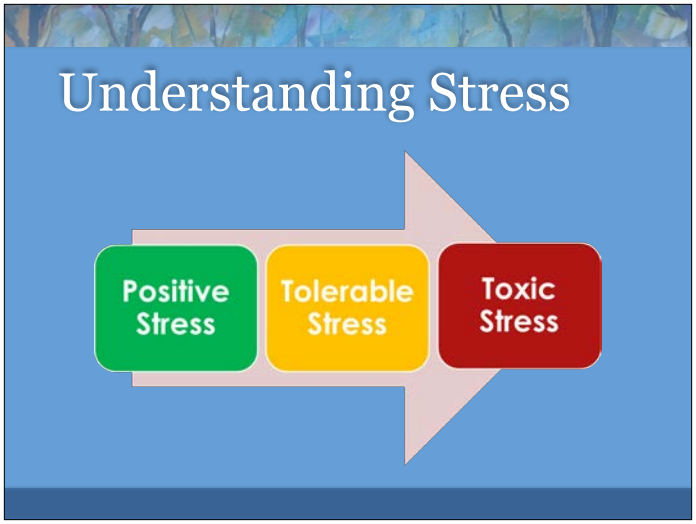

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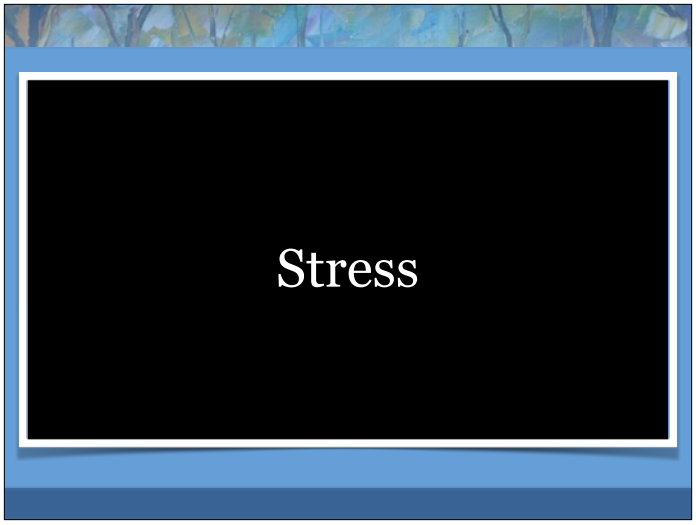
Stress is a neurological experience in the biological organism that is your body. How we perceive stress, and how we can manage stress determines the level of it's toxicity.
The stress of waiting in line for a roller coaster is perceived differently from the stress of expecting a bad review from your boss. One stress is wanted, and the other is unwanted.



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https://youtu.be/-6gon66jF8s
"Regal Roller Coaster Policy Trailer"

As this is starting I want you to be aware of sensation in your body. Then I'd like to encourage you to use eye movements, or bi-lateral tapping to see if you notice any change in sensation.
Finally, use eye movements and your container we created earlier and see if that causes any change in what you're feeling or thinking.

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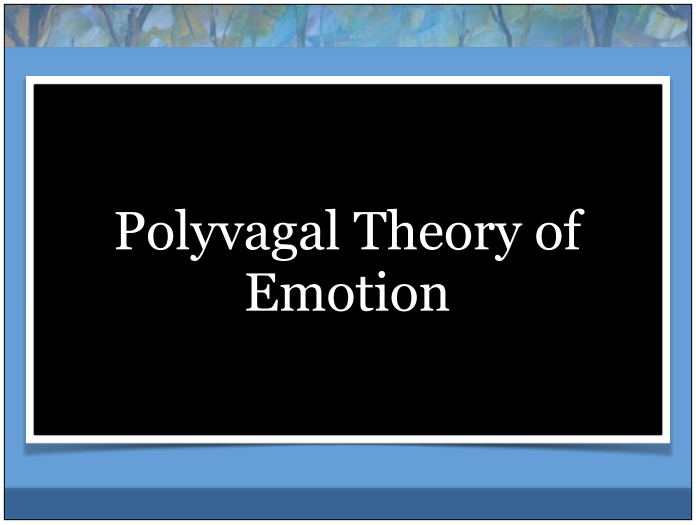
Did you feel it anywhere in your body?
Did anybody try eye movements or bilateral tapping?
Did it make a difference?
Imagine if you couldn't feel internal physical sensation.
Imaging if internal sensation was so overwhelming you just couldn't control it. That's what it's like with a traumatized nervous system.
This a very important piece because traumatized people can't control sensation in their body.
But first let's take a look at how we are wired to regulate emotion. Peter Levine talks about Steven Porge's polyvagal theory of emotion



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Polyvagal Theory of emotion
Steven Porges explained by Peter Levine

Fight or flight, or shut down (freeze)
Silent, withdrawn, avoidant
The sensation of gastro-intestinal distress becomes associated with loss of control and greater distress
It's through body sensation that we are able to move through shut down, into arousal (fight or flight), and return to social engagement
SE (somatic experiencing) therapist, and any body-oriented therapy, will help the client move through these states and back to relaxation.
Eye movements facilitate relaxation and body awareness very well.
Using imagery and metaphor, you can have people experiment with exploring that sensation. With traumatized nervous systems, you have to do that very carefully so it does not overwhelm the body or reactivate the trauma.

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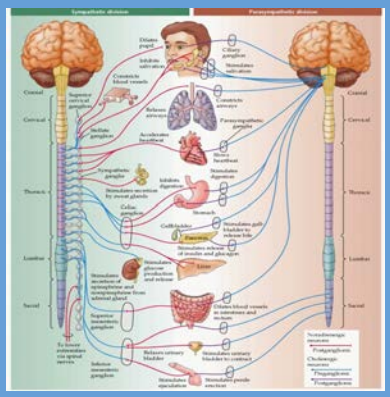
Sympathetic and Parasympathetic Nervous Systems

Threat memory involves the entire body (the body keeps the score):

- Immediate reactions to threat
- Long-term effects



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What to Understand

- It's an instinctive survival response to a perceived danger
- It is a hyper-arousal of the nervous system which temporarily creates a chemically altered state of consciousness
- It creates a loss of connection to parts of ourselves

Necessary things to understand about trauma

Initially, perceived dangers are real dangers, they are from the past and they are perceived as though they are happening in the present.

Loss of connection - think about it, under when we are experiencing trauma, we can't get away from the perceived danger, we are cut off from others, and even cut off from awareness of our own feelings.

Our psyche seeks release or discharge but if we do not complete the biological pattern, we will seek release through recreation of circumstances which create more trauma.

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What to Understand

- It is potential energy; but excessively charged energy
- Our body holds it in
- We instinctually seek to release it

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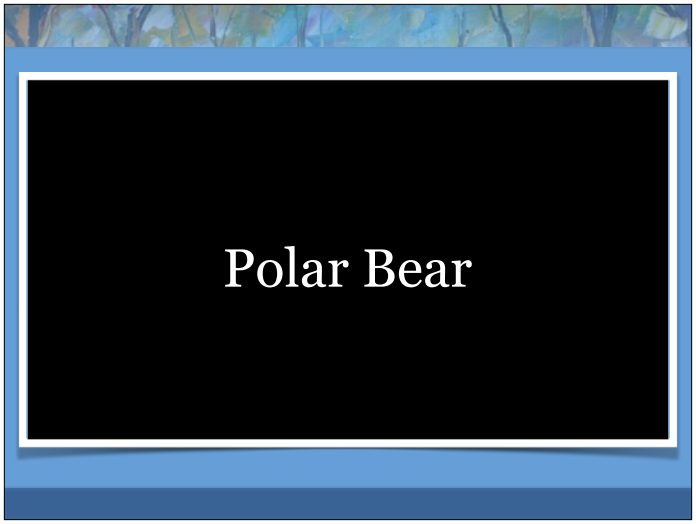
What to Understand

- Psychological and Cognitive Symptoms set in later because the natural functioning of the nervous system is compromised
- Unresolved trauma eventually effects our physical health too

This hyper-aroused energy must be discharged from the body, or it will remain bound up inside and continue to create unrest for the mind



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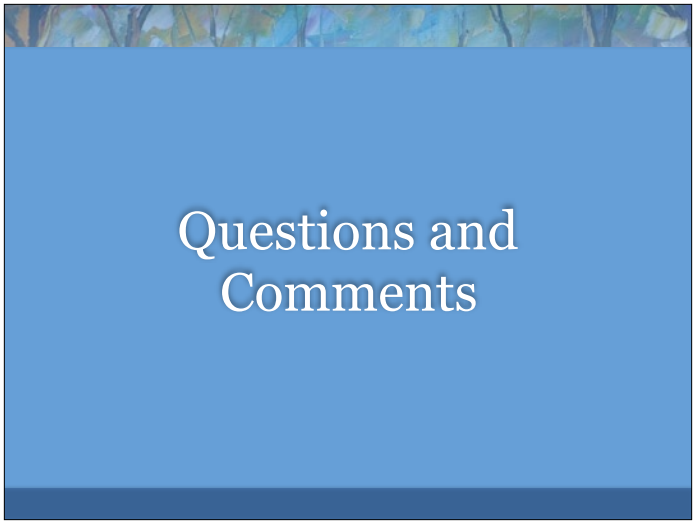
"Nature's Lessons in Healing Trauma: An Introduction to Somatic Experiencing® (SE™)"
https://youtu.be/nmJDkzDMllc

National Geographic Film clip of how a polar bear biologically completes the natural cycle of a traumatic experience and returns to equilibrium



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Instinctual Trauma Resolution

versus

Perpetual Fight or Flight

or Freeze Response

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Two sources of Trauma

- Shock Trauma or Single Incident Trauma
- Developmental Trauma or Complex Trauma

Shock Trauma

Occurs when we experience overwhelming event(s) which we perceive as life-threatening at any time in our life.

Developmental Trauma

Occurs from on-going childhood abuse(s) such as neglect, cruelty, inadequate nurturing or guidance at critical developmental periods while growing up.

As clinicians we need to recognize the effect of trauma on physiology and help people regain awareness and control over their physiological responses. People with traumatized nervous systems become overwhelmed and simply don't know how to manage their sensations.

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Trauma and Toxic Stress

- Childhood experiences shape our reactions to sensations in our body
- We engage in fight, flight, or freezing when we are overwhelmed
- Freezing is numbing, emotionally withdrawing, numbing through substances, activities, over achieving

Freezing is numbing, emotionally withdrawing
Numbing through substances, activities, over achieving
Secure attachment makes us more resilient in the face of stress.
Here are some experiences involving extreme or prolonged stress that can shape those habitual reactions.

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ACE Study

- Research on the prevalence and consequences of adverse childhood experiences
- Between 1995 and 1997 CDC and Kaiser Permanente study and long-term follow up for health outcomes
- Over 17,000 Kaiser Permanente patient volunteers

In the 1980s, the dropout rate of participants at Kaiser Permanente's obesity clinic in San Diego, California, was about 50%; despite all of the dropouts successfully losing weight under the program. Vincent Felitti, head of Kaiser Permanente's Department of Preventive Medicine in San Diego, conducted interviews with people who had left the program, and discovered that a majority of 286 people he interviewed had experienced childhood sexual abuse. The interview findings suggested to Felitti that weight gain might be a coping mechanism for depression, anxiety, and fear.
https://en.wikipedia.org/wiki/Adverse_Childhood_Experiences_Study

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The 10 ACEs Measured

- Physical, sexual and verbal abuse
- Physical and emotional neglect
- Witnessing a mother being abused
- Losing a parent to separation, divorce or other reason
- A family member who is:
  - depressed or diagnosed with other mental illness;
  - addicted to alcohol or another substance;
  - in prison

Trauma may be triggered by many factors including: childhood abuse or neglect, interpersonal violence (IPV), sexual assault (SA), natural disasters, illness, sudden death, oppression, accidents, and historical trauma that has occurred in the community (Substance Abuse and Mental Health Administration, 2014). Trauma before the age of eighteen is estimated to be experienced by 63% of the population in the United States (Felitti, et al., 1998). Twenty-two percent of adult women in the U.S. and 4% of men have been sexually assaulted (Elliot, Mok, & Briere; 2004). One in five U.S. women report being physically assaulted by an intimate partner (Tjaden & Thoennes; 2000). In the elderly U.S. population, 6% reported being significantly abused in the past 30 days (Kellogg, 2005). Finally, 10-20% of US men report combat exposure (Wilson & Keane; 2004).

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Other Childhood Trauma

- Witnessing a sibling being abused
- Witnessing violence outside the home
- Witnessing a father being abused by a mother
- Being bullied by a classmate or teacher

ACE Scores

- 1/3 of adults have an ACE score of 0
- ACE score of 0 show few, if any, risk factors for disease

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The majority of adults with an ACE score of 0 have few, if any, risk factors for diseases that are common causes of death in the US.

About ACEs

- Surprisingly common, nearly two-thirds (64%) of adults have at least one
- If you have one, there's an 87% chance that you have two or more
- One study found that individuals with an ACE score of four or more had significantly higher rates of the following mental and physical health problems

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It's one point for each item on the ACEs inventory

Higher ACES score (0-10 items) is a greater predictor of later impaired social functioning, decreased well-being, health risks, disease, and death

In the study, eleven percent reported having been emotionally abused as a child, 30.1% reported physical abuse, and 19.9% sexual abuse. In addition, 23.5% reported being exposed to family alcohol abuse, 18.8% were exposed to mental illness, 12.5% witnessed their mothers being battered, and 4.9% re- ported family drug abuse.

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Life-long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Diabetes
- Fetal death
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Liver disease
- Lung cancer
- Obesity
- Skeletal fractures
- Work problems—including absenteeism, productivity & on-the-job injury

- These are the health conditions proven by research to have a dose-response relationship to ACEs. This list is a little flexible. As the researchers have continued to follow the original 17,000, new health connections have emerged.
- People who experience more ACEs ***are more likely to suffer multiple health outcomes from the list, an average of 4.5 conditions for people with the highest ACE score compared to 1.5 for people with no ACEs*** .
- The costs of accumulation—for individuals, business, and society as a whole are quite stunning, giving us important reasons beyond our own humanity and compassion to reduce this kind of pile up.

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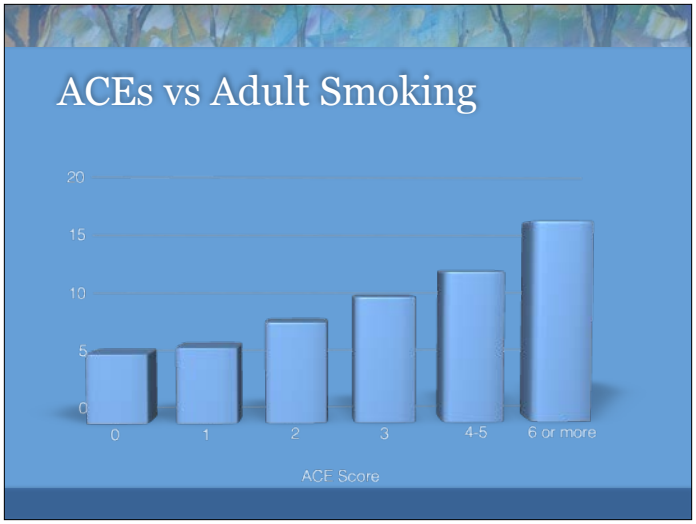
Life-long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Depression, anxiety & other mental illness
- Self-regulation & anger management problems
- Suicide attempts
- Multiple divorces
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization

Trauma is very common. In my experience, ACEs affect individuals relative to their attachment styles, where insecurely or ambivalently attached individuals are less familiar with trusting their emotions.
And what are emotions after all, if not a series of sensations and thoughts triggered by normally occurring sensations in the body.
If we don't trust our feelings and the normally occurring sensations in our body what else about ourselves don't we trust, and why don't we trust all of our selves, all of our experience?
I trust this table, this chair, yet I don't trust other information my senses are giving me?
My stomach is tensing up. My thoughts are starting to race. I'm becoming more stressed as I'm aware of stress welling up in my body. And then I'm overwhelmed.
Ongoing and unrelenting distress is extreme stress.
As Bessel van der Kolk attempted to advocate for the last round of DSM, disorders of extreme stress (DOSNES).
This is what we are treating, plain and simple.
Any thoughts?

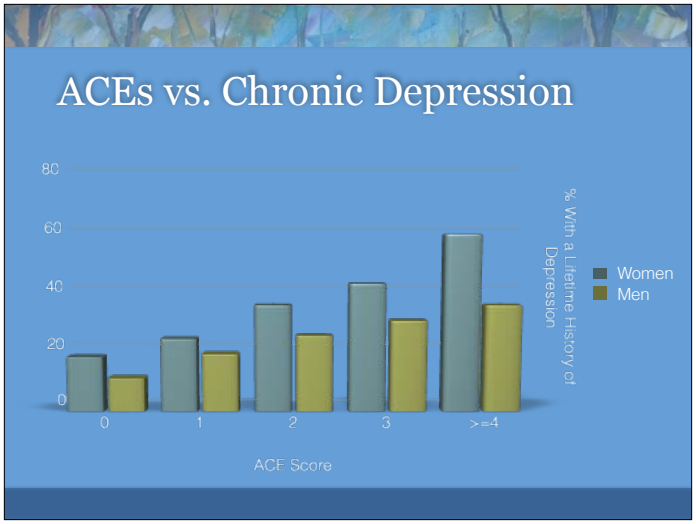
Developmental Trauma Disorder A new, rational diagnosis for children with complex trauma histories. Bessel A. van der Kolk, MD
http://traumaticstressinstitute.org/wp-content/files_mf/1276541701VanderKolkDvptTraumaDis.pdf


ACEs vs Adult Smoking
20
15
10
5
0
0
1
2
3
4-5
6 or more
ACE Score

41

ACEs vs Adult Alcoholism
18
13.5
9
4.5
0
% Alcoholic
0
1
2
3
>=4
ACE Score

42



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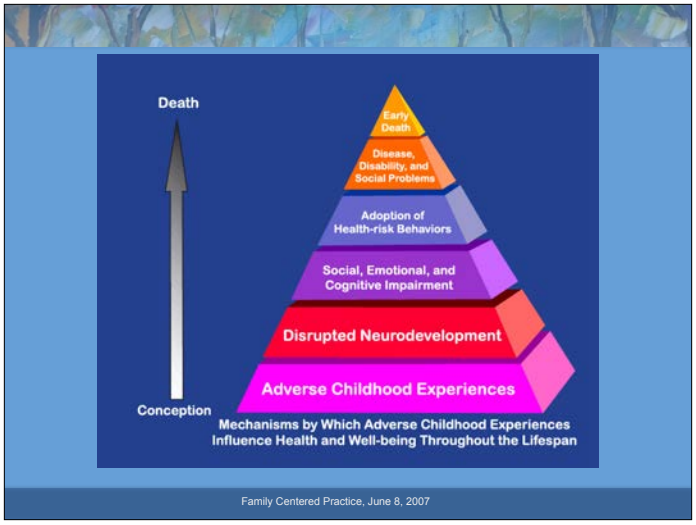

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So what we are doing in trauma focused treatment is remediating the adverse childhood experiences at the base of the pyramid

The learned responses have to be unlearned

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Questions and Comments

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What is trauma?

Bessel van der Kolk, MD

https://youtu.be/6vwNX0Qo1IA
Bessel van der Kolk Explains What Trauma Is

Trauma informed therapy greatly been enhanced by the brilliant and innovative work of Bessel van der Kolk, he is one of the people who's appropriately defined trauma and he's said it so well. He's also developed the criteria for his proposed diagnosis of Developmental Trauma Disorder

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- Trauma overwhelms the central nervous system and changes the way you remember and react.
- Disorganized attachment, living in an environment where nobody sees you and helps you deal with the realities of life.
- Not being seen or protected will increase the chances of having multiple traumatic incidences.

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Developmental Trauma Disorder

A. Exposure
- Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (eg, abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death).
- Subjective experience (eg, rage, betrayal, fear, resignation, defeat, shame).

B. Triggered pattern of repeated dysregulation in response to trauma cues

Dysregulation (high or low) in presence of cues. Changes persist and do not return to baseline; not reduced in intensity by conscious awareness.
- Affective
- Somatic (eg, physiological, motoric, medical)
- Behavioral (eg, re-enactment, cutting)
- Cognitive (eg, thinking that it is happening again, confusion, dissociation, depersonalization).
- Relational (eg, clinging, oppositional, distrustful, compliant).
- Self-attribution (eg, self-hate, blame).

Chronic trauma interferes with neurobiological development and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole.

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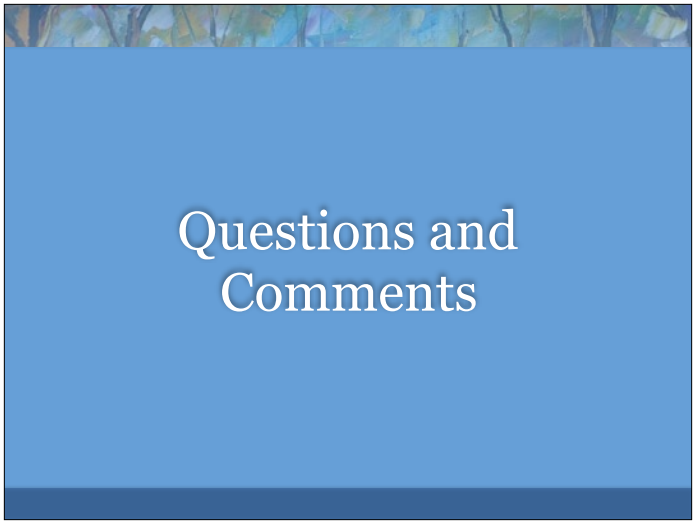
Posttraumatic stress disorder (PTSD) is not the most common psychiatric diagnosis in children with histories of chronic trauma. For example, in one study of 364 abused children, the most common diagnoses in order of frequency were separation anxiety disorder, oppositional defiant disorder, phobic disorders, PTSD, and ADHD. Numerous studies of traumatized children find problems with unmodulated aggression and impulse control, attentional and dissociative problems, and difficulty negotiating relationships with caregivers, peers, and, later in life, intimate partners.



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De-conditioning Pavlov's Dog
Maybe even curing Little Albert of his conditioned rabbit fear.

The Little Albert Experiment was a study conducted back in 1920 by famed psychologist, "the father of behaviorism", John B. Watson. It essentially involved conditioning a baby, identified only as "Albert. B" to experience fear at the sight of anything fluffy.

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Unwiring Trauma

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Memory Reconsolidation

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Reconsolidation and Eye Movements

- Better understanding of how memories are retrieved and re-stored
- We tend to remember how we last remembered
- Window of opportunity when memories are fragile
- Eye movements and imagery can be used to generate new memories
- Drugs are not needed to dampen anxiety symptoms

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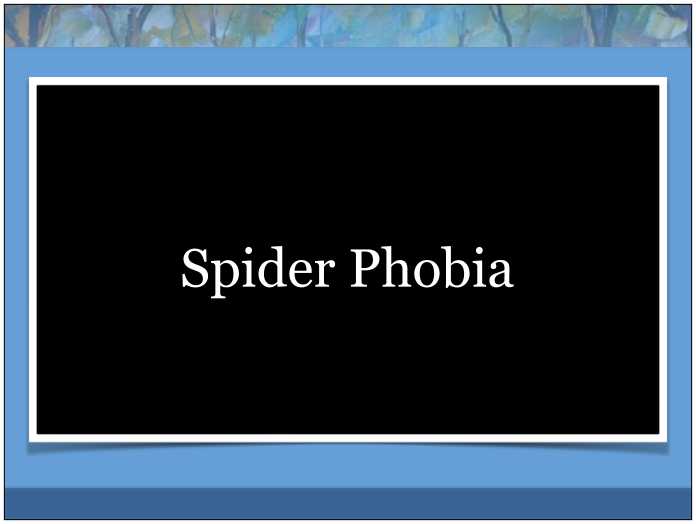
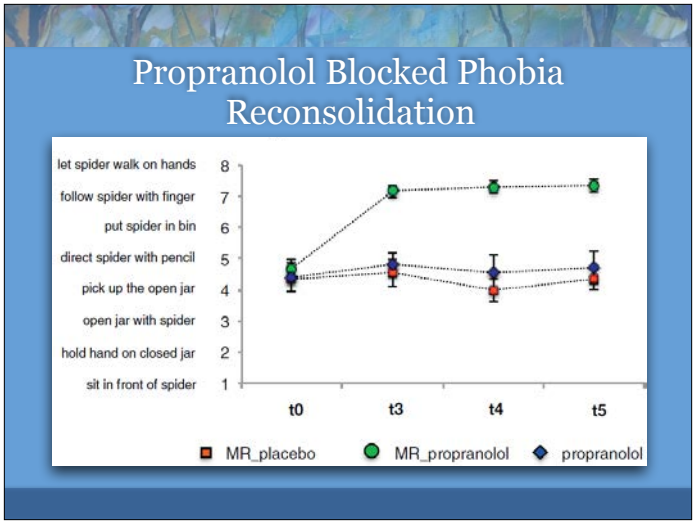
The following is an example of extinguishing a spider phobia through memory reconsolidation

Warning: You will see a large, hairy spider
No spiders or human subjects were harmed.



57

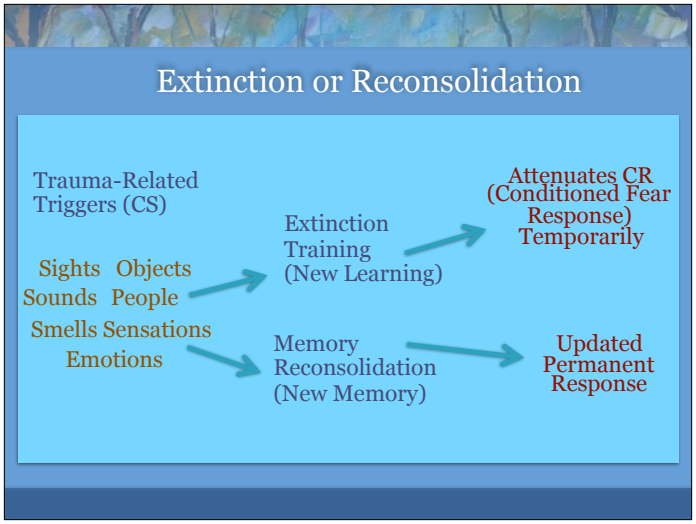
Practical application of reconsolidation



58

Behavioral approach toward the baby tarantula at pretreatment, post treatment, and 3 month and 1 year follow up for three experimental groups

Soeter M, Kindt M. Biol Psych 2015



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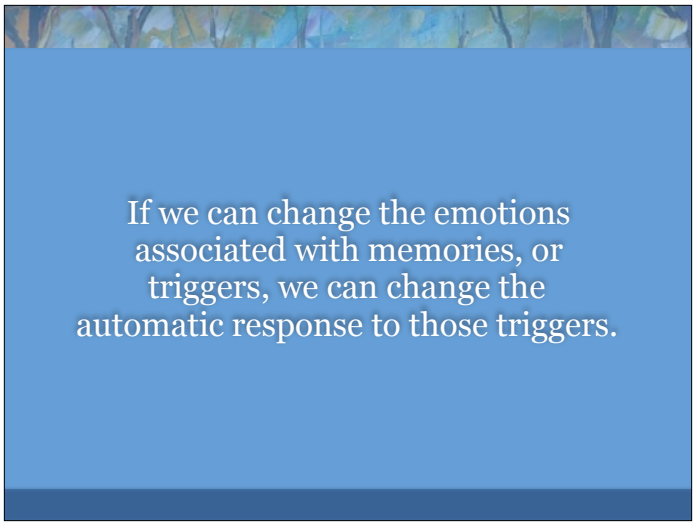
Trauma-focused therapies rely primarily on extinction learning rather than reconsolidation

Extinction training (from longer or multiple CS exposure) involves new learning (mediated by NMDA glutamate systems)
Incremental learning, erodes over time or with new context.
Permanent extinction (reconsolidation) reinforced when:
Threat memory activated briefly prior to extinction training
Training is paired with novel non-threatening stimulus

LeDoux- (Monfils, et al, Science 2009, Dunsmoor, et al Biol Psychiatry 2015)



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We've seen through the process of attachment and the development of the nervous system that certain reactions become habituated or conditioned.
We now know we can change those responses by changing the fear memory associated with the memory or trigger.
Triggers can be memories, physical sensation, visual or auditory cues.

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Question and Comments

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Overview of ART and Comparison to Other Trauma-Focused Treatments

Slides courtesy IS-ART Conference, Orlando FL 2016

Lisseth Thomas, Ph.D and Willeta Wilson LMFT
Co-Occurring Partial Hospital Program (COOPH)
Fort Belvoir Community Hospital
"Utilization of ART with Addiction Disorders in a Co-Occurring Program"

Charles W. Hoge, M.D. Colonel, U.S. Army (Ret.),
Walter Reed National Military Medical Center, Walter Reed Army Research Institute
"Use of ART in Relation to Other Trauma-Focused Treatments"

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Overview of ART and Comparison to Other Trauma-Focused Treatments

Slides courtesy IS-ART Conference, Orlando FL 2016

Kevin E. Kip, Ph.D.
Distinguished Health Professor University of South Florida, Tampa, FL
"Updated Review of the Empirical Research Base of ART"

Terry Nowakowski, L.C.S.W., ACHE and Vickie B. Alston, LCSW, DCSW Behavioral Health Services, The Connection, Middletown, CT
"ART as an Intervention to Co-Occuring Disordered Individuals"

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Accelerated Resolution Therapy

Practical application of reconsolidation
Veterans Alternative video

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Accelerated Resolution Therapy

- ART was developed in 2008 by Laney Rosenzweig, LMFT
- First used to successfully to treat Obsessive-Compulsive Disorder (OCD) in a one-hour session
- Treatment protocols that are directive, standardized and easy to apply to different conditions

ART was developed in 2008 by Laney Rosenzweig, LMFT. As a mental health clinician, Laney was trained and proficient in multiple treatment modalities, including EMDR. She quickly appreciated the therapeutic value of eye movements but also recognized the need to modify how they are used and integrated with other techniques. She created treatment protocols that are directive, standardized and easy to apply to different conditions. The genesis of ART involved integrating elements from different therapies in a unique and more effective way.

She first used her ART technique successfully to treat a client with Obsessive-Compulsive Disorder (OCD) during a one-hour session. Since then, the procedure has been refined to help individuals overcome issues related to Post Traumatic Stress Disorder, physical and sexual abuse, depression, eating disorders, fibromyalgia, chronic pain, and many phobias.

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Basis Components of ART

- Imaginal Exposure (IE)
- Imagery Rescripting (IR)
- Use of Eye Movements
- Directive – not free associative

Kip, 2016

Imaginal Exposure (IE): Recall (verbally or non-verbally) details of the traumatic event (scene), while focusing attention on physiological sensations, thoughts, and emotions.

Imagery Rescripting (IR): Imagine changing (replacing) the traumatic scene (imagery/sensory components) from negative to positive (like the “director” of a movie).

Use of Eye Movements: Participant follows therapists’ hand back and forth moving their eyes from left to right, with bilateral eye movements performed – used in both the IE and IR components.

Directive – not free associative

Foa EB, Dancu CV, Hembree EA, Jaycox LH, Meadows EA, Street GP. A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. Journal of Consulting and Clinical Psychology 1999;67:194-200.
Foa EB, Rothbaum BO, Riggs DS, Murdock TB. Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling. Journal of Consulting and Clinical Psychology 1991; 59:715-723
Hackmann A. Imagery rescripting in posttraumatic stress disorder. Cognitive and Behavioral Practice 2011; 18:424-432.
Purves D, Augustine GJ, Fitzpatrick D, et al. Neuroscience. 2nd ed. Sunderland: Sinauer Associates; 450 2001.

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Core Components of Trauma-Focused Psychotherapies

- Narration - oral, written, visualized
- Cognitive restructuring
- In-vivo / in-vitro exposure (systematic desensitization).
- Relaxation / stress management / stress inoculation
- Diaphragmatic breathing, SUD scales, mindfulness, progressive muscle relaxation, eye-movements

Hoge, 2016

Narration. Desensitization/extinction to trauma account through narrative or imaginal exposure (oral, written, visualized)

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Other Evidence-Based Therapies

Cognitive Processing Therapy (CPT)	**Prolonged Exposure Therapy (PE)**	**Eye Movement Desensitization Reprocessing (EMDR)**
12 sessions (60-90 minutes) w/outside skills practice	10 sessions (~90 minutes each) with homework assignments	8 to 12 weekly 90-minute sessions
Dropout rates up to 29%	Dropout rates up to 50%	Dropout rates up to 36%
Non-response rates 4-48%	Non-response rates 20-67%	Non-response rates between 7-92%

Kip, 2016

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Other Evidence-Based Therapies

Among veterans who begin treatment for PTSD with psychotherapy or medication (Hoge, 2011):

"A high percentage of veterans drop out."

"Rate of recovery of 60% to 80% among treatment completers declines to about 40% when non-completers are taken into account."

Kip, 2016

Interventions for War-Related Posttraumatic Stress Disorder Meeting Veterans Where They Are Charles W. Hoge, MD JAMA, August 3 2011 – Vol 306, No 5

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Question and Comments

ART and Co-Occuring Disorders

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Co-Occurring Partial Hospital Program (COOPH)

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Mission

Provide intensive multi-disciplinary individualized treatment for active duty service members. (Duration: 4-6 weeks)

Trauma Recovery Track
This track is for those service members with post traumatic stress or any other trauma issues and substance use disorders (SUD).

Substance Use Disorder Track
This track is for Service members with substance use disorders and mood disorders (anxiety, Panic, Depression).

Intensive Psychiatric Outpatient Track
This track is for Service members with severe Axis I disorders and no substance use disorders.

Modalities

- Cognitive Behavioral Therapy (CBT)
- Cognitive Processing Therapy (CPT)
- Accelarated Resolution Therapy (ART)
- Prolonged Exposure (PE)
- Graphic Narrative
- Relapse Prevention/ Maintenance Approaches
- Seeking Safety
- Eye Movement Desensitization and Reprocessing (EMDR)
- Acceptance and Commitment Therapy (ACT)
- Motivational Interviewing (MI)

Multi-Disciplinary Components

Individual Therapy – Medication Management – Group Therapy – Yoga, iRest, Nidra – Spirituality – Art & Writing Therapy – Recreational Therapy & Community Reintegration

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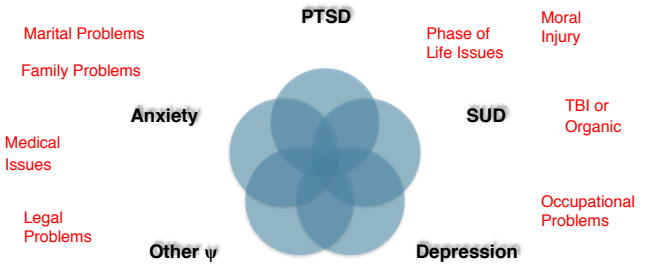
COOPH Overview

Common Co-Occurring Disorders



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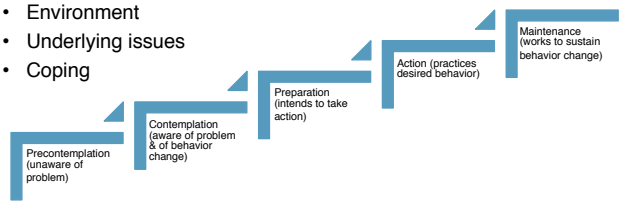
Clinical Considerations

- Readiness (Stages of Change)
- Safety
- Stability
- Environment
- Underlying issues
- Coping



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ART SUD Interventions

- Typical Day
- Little Liar
- Cravings Work
- "Alcohol Story"
- Target Trigger Times
- Metaphors

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ART SUD Intervention

- What is your Alcohol Story? Looking back on your life, what alcohol related scenes/images have really impacted you?
- TTT: seeing themselves successfully working their program
- Metaphors
- Cravings

Cravings Work

- Benefits to Assessing Cravings
  - Severity of SUD
  - Select Tx Approach
  - Monitor Changes
- "Urge" and "craving": broad range of thoughts, physical sensations, or emotions that tempt individual to drink, even though there is a desire not to. Urges to drink are short-lived, predictable, and controllable..
- **External triggers**: people, places, things, or times of day that offer drinking opportunities or remind you of drinking..
- **Internal triggers:** internal events such as fleeting thought, a positive emotion such as excitement, a negative emotion such as frustration, or a physical sensation such as a headache, tension, or nervousness.
- Not possible to avoid ALL triggers.

  Need for strategies.
  - Challenge the thought that drives the urge. Stop it, analyze the error in it, and replace it.
  - Identify the feeling associated with his craving and the degree of the intensity utilizing the ARTOMETER.
  - Patient given the short-form of the ACQ-SF-R prior to the intervention.
  - Using the ***ART*** modality the goal was to replace the negative addictive behaviors, change the preoccupation of unhealthy thoughts with a positive behavior.

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There has been an increased interest from researchers and clinicians regarding cravings.

The assessment of craving can have numerous clinical benefits, such as helping the clinician to evaluate the severity of a patient's alcohol dependence, to select appropriate treatment approaches, and to monitor changes throughout a patient's treatment.

As one's approach to drinking changes, it's customary and common to have urges or a craving for alcohol. The words "urge" and "craving" refer to a broad range of thoughts, physical sensations, or emotions that tempt individual to drink, even though there is a desire not to. Fortunately, urges to drink are short-lived, predictable, and controllable.

An urge to drink can be set off by external triggers in the environment and internal ones within yourself.

External triggers are people, places, things, or times of day that offer drinking opportunities or remind you of drinking..

Internal triggers can be puzzling because the urge to drink just seems to "pop up." The urge may have been set off by a fleeting thought, a positive emotion such as excitement, a negative emotion such as frustration, or a physical sensation such as a headache, tension, or nervousness.

It's not possible to avoid all high-risk situations or to block internal triggers, so you'll need a range of strategies to handle urges to drink.

One such strategy is to Challenge the thought that drives the urge. Stop it, analyze the error in it, and replace it.

Patient was asked to Identify the feeling associated with his craving and the degree of the intensity utilizing the ARTOMETER. Patient was then given the short-form of the ACQ-SF-R prior to the intervention. Using the ***ART*** modality the goal was to replace the negative addictive behaviors, change the preoccupation of unhealthy thoughts with a positive behavior.

Cravings Assessment

ALCOHOL CRAVING QUESTIONNAIRE-SHORT FORM-REVISED (ACQ-SF-R)

INSTRUCTIONS: Please indicate how much you agree or disagree with each of the following statements by placing a single checkmark (like this: _X_) along each line between STRONGLY DISAGREE and STRONGLY AGREE. Your checkmark should be placed closer to one end or the other indicate the strength of your disagreement/agreement. We are interested in how you are thinking or feeling right now as you are filling out this questionnaire. Please complete every item.

RIGHT NOW

1. If I had some alcohol, I would probably drink it.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
2. I miss drinking.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
3. I am not making any plans to drink.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
4. I could not stop myself from drinking if I had some alcohol here.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
5. I want to drink so bad I can almost taste it.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
6. I would feel less irritable if I used alcohol now.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
7. If I used alcohol, I would feel less tense.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
8. Drinking would not be very satisfying.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
9. I would feel less restless if I drank alcohol.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
10. If I were using alcohol, I would feel less nervous.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
11. It would be easy to pass up the chance to use alcohol.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE
12. Drinking would put me in a better mood.
STRONGLY DISAGREE___:___:___:___:___:___:___STRONGLY AGREE

ALCOHOL CRAVING QUESTIONNAIRE-SHORT FORM-REVISED (ACQ-SF-R)

SCORING KEY

CONTENT VALIDITY AND RELIABILITY: The Alcohol Craving Questionnaire-Short Form (ACQ-SF-R; Singleton, 1997) contains 12-items from the 47-item Alcohol Craving Questionnaire (ACQ-NOW) developed to assess craving for alcohol among alcohol users in the current context (right now). Items were derived from the initial validation study (Singleton et al., 1995) of the ACQ-NOW administered to 219 subjects who had used alcohol at least once in the last 30 days. The ACQ-SF-R contains 12 items strongly correlated with the four subscales and total ACQ (Singleton, 2000; Tiffany et al., 2000). Factor naming is consistent with the ACQ-NOW (Drobes et al., 1999; Potgieter et al., 1999; Singleton et al., 1998). The following item sets provide subscales that approximate each factor. Each item has seven response options (0 = strongly disagree, 1 = disagree, 2 = slightly disagree, 3 = neutral, 4 = slightly agree, 5 = agree, 6 = strongly agree). To perform the operation (6 – reverse-keyed item raw score = raw score) for reverse-keyed items (marked with an *). Then sum the raw scores for each factor and divide by three (3) to yield a factor-based score. A general craving index may be derived by summing all items (total ACQ score) and dividing by 12 (the number of items with significant loadings).

FACTOR 1
Compulsivity (COMP), urges and desires in anticipation of loss of control over drinking - 3 ITEMS
ITEM NUMBER (Factor loading): 4 (.46), 5 (.63), 6 (.51)
RELIABILITY a: .79

FACTOR 2
Expectancy (XPCT), urges and desires to drink in anticipation of the positive benefits of drinking - 3 ITEMS
ITEM NUMBER (Factor loading): 1 (.44), 2 (.37), 12 (.43)
RELIABILITY: .77

FACTOR 3
Purposefulness (PURP), urges and desires coupled with intent and planning to drink - 3 ITEMS
ITEM NUMBER (Factor loading): 3* (.57), 8* (.69), 11* (.69)
RELIABILITY: .77 24

FACTOR 4
Emotionality (EMOT), urges and desires to drink in anticipation of relief from withdrawal/negative affect - 3 ITEMS
ITEM NUMBER (Factor loading): 7 (.41), 9 (.47), 10 (.45)
RELIABILITY: .86
a Reliability value is estimated standardized alpha coefficient

(Singleton, E.G., Tiffany, S.T. & Henningfield, J.E., 2000)

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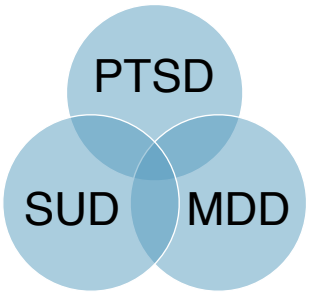
Case Example

- 42 y/o, Caucasian, divorced male, USAR with 17 yrs TIS
- 2 combat deployments
- 26 yrs heavy alcohol use
- 2 hospitalizations for SI
- Occupational & home (health, behavioral & legal) Stressors
- Multiple traumatic events



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Potential ART Scenes

- **Little Liar/Supportive Self protocol (1)**
- **Early Childhood Memory related to "I'm not good enough" and "I'm bad" core beliefs (2)**
- **Lack of confidence and challenging negative core beliefs (3)**
- Drinking at bar as a teenager
- **Ex-wife sabotaging sobriety (4)**
- Returning from deployment to empty house
- **Index Civilian Trauma (5)**
- Child asking him to stop drinking
- Typical Day protocol
- **Index Combat Trauma (6)**

Note
- SM was dealing with combat traumas concurrently in group therapy
- SM had low ego strength/negative core beliefs about self that required attention through scene matching and metaphorical work
- SM actively engaged in SUD group and became AA leader
- SM cravings increased when stressors increased even on Naltrexone. Cravings ART work done throughout time at COOPH.

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The Connection, Inc.

- The Connection Inc. is a non-profit agency that was formed in 1972 as a community response to the devastation being wrought on families and communities from the problems of abuse, dependency, addiction, crime, poverty and neglect.
- We believe that what was relevant in 1972 is even more so today; with an opioid crisis that is both state and national in scope and a society that suffers from both mental health and substance use disorders.

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Who we serve…

- The Connection is about a $50M, statewide agency that serves approximately 6,000 people.
- Our organization has three areas of expertise:
  - Criminal Justice
  - Behavioral Health
  - Supportive Housing
- Most of the clients we serve are living in poverty, have complex trauma, and suffer from Mental Illness and have a Substance Use Disorder

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Alex

- Alex came into one of our Clinic's looking for more Benzodiazepine's.
- Our APRN checked the State of CT Prescription Monitoring and Reporting System (CPMRS) website which shows how many prescriptions have been rendered to date for specific clients.
- Alex had been benzo shopping with prescriptions at multiple pharmacies.
- Toxicology results showed high levels of opioid's, cocaine, and benzodiazepine's.
- The APRN made the decision not to refill Alex's script.

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Something about Alex:

- Alex was a West Point cadet and had graduated with honors.
- Upon graduation, he had been sent to the Middle East and served a couple of tours in Iraq and Afghanistan.
- When Alex returned, he was diagnosed with PTSD and spiraled out of control.
- By the time we met Alex, he had been hospitalized several times, attempted suicide, and now was dually diagnosed with both MH and SA.

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Alex's reaction…

- When the APRN did not fill Alex's script – Alex paced back and forth in the waiting room for three hours.
- Alex was hyper-aroused, sweating, and clearly escalating out of control.
- Staff tried on numerous occasions to calm him down.
- We eventually told him the police would need to be called for the safety of himself and others.
- We needed a solution – let's try ART!

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Trained ART therapist…

- We had one therapist trained in ART at this counseling center.
- I asked him if he would consider doing ART on Alex to see if it might calm him down.
- The therapist agreed and rescheduled other clients.
- I asked Alex if he would be willing to try this intervention – he was reluctant but willing.
- When the session began – Alex rated his level of anxiety, anger and frustration at a 10+.

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Results…

- After the session ended – Alex walked out of the office and appeared calm and able to focus.
- I asked Alex if he felt the intervention was effective – he looked a bit confused but indicated that he felt more relaxed.
- Alex left the Clinic voluntarily and did not return that day.
- The therapist reported at the end of the session – Alex's score went to below a 4.

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Significance…

- The challenge in treating high, risk complex clients is finding solutions that work quickly and reduce symptoms.
- ART provided this client with a way in which to control his urges, follow directions and not have to be carted off by the police and hospitalized.
- Alex still is a client and still suffers from a co-occurring disorder but now realizes that he can control his impulses.

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Healthcare's dilemma:

- How do we treat a chronic, high risk population and achieve positive results?
- Social Determinants of Health (SDOH) are what drive healthcare costs up and result in poor outcomes.
- Community providers have to be innovative and identify interventions that can reduce symptoms quickly.
- Once the intervention works – the client and his/her family can begin to focus on those aspects of their life that need to be addressed (e.g., housing, transportation, employment, etc.).

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Core Phases of an ART Session

I. Imaginal exposure (desensitization/extinction) through visualization of traumatic scene/problem at least twice with processing of sensations.

II. Rescripting (Director, VIR). Has precedent in Imagery Rehearsal Therapy (CBT-I), Suicide CBT,1 and supported by animal and human experiments.2

III. Reinforcement techniques (ie., transfer, outprocessing snapshots, reinforcement of VIR)

IV. In-vitro exposure (target-trigger times).

V. Closing (bridge, bonfire)

Hoge, 2016

1. Rudd, et. al. Am J Psychiatry 2014; Krakow, et. al. JAMA 2001
2. Dunsmoor JE, et al (LeDoux JE) Biol Psychiatry 2015

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ART Brief Demo

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ART and EMDR

- Desensitization and in-vitro exposure accomplished through visualization.
- Eye movements/BLS facilitate processing
- Abreaction is pathway to healing
- Both attend to body sensations and elicit relaxation responses
- Mechanism of recovery presumably is same
- Both can achieve rapid results in some cases
- Both are being used for a variety of problems
- Inherent cautions/risks are the same
- Both are proprietary, training is relatively costly

Hoge, 2016

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ART versus EMDR

EMDR: More free-associative (AIP model)

- Bring up the picture and those ____negative words, and notice where you're feeling that in your body. Follow my finger. (Fast EMs ~35 Sec)
- Take a breath. Let it go.
- What are you noticing now? or (What comes up?)
- Go with that (notice that) and follow my finger (Fast EMs)
- Take a breath. Let it go. What are you noticing now?

Hoge, 2016

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ART versus EMDR

ART: More body-focused

- Start the scene and follow my hand (40 EMs)
- Take a deep breath. Forget the scene
- Check your body from head to toe. What sensations do you have right now?
- Notice that and follow my hand (40 EMs)
- Take a deep breath… Has anything moved or changed?

Hoge, 2016

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Empirical Base
ART Civilian Study

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Empirical Base of ART – Civilian Study

Demographics and Presenting Characteristics.

Characteristic	All (n = 80)	Male (n = 18)	Female (n = 62)
Age in years (mean ± SD)	40.0 ± 10.2	41.9 ± 11.8	40.6 ± 9.8
Race (%)			
Black or African American	7.5	0.0	9.7
White	88.8	94.4	87.1
Other	3.7	5.6	3.2
Hispanic (%)	28.6	5.6	35.6
PCL-C score (mean ± SD)	54.5 ± 13.0	57.3 ± 14.3	53.7 ± 12.6
Less than 40 (%)	13.8	11.1	14.5
40 to 60 (%)	47.5	38.9	50.0
More than 60 (%)	38.8	50.0	35.5
Traumatic memories still impacting life (%)			
1 to 2	19.0	23.57	17.7
3 to 4	31.6	35.3	30.6
5 or more	49.4	41.2	51.6
Previous tx for PTSD/other MH condition (%)	67.9	50.0	73.3
Time lived with traumatic memory(ies) (%)			
Less than 1 year	6.3	5.6	6.5
1 to 6 years	13.8	22.2	11.3
7 years or more	80.0	72.2	82.3

PDSQ: PCL-C: PTSD Checklist, Civilian Version; MH: Mental Health.

Kip, 2016

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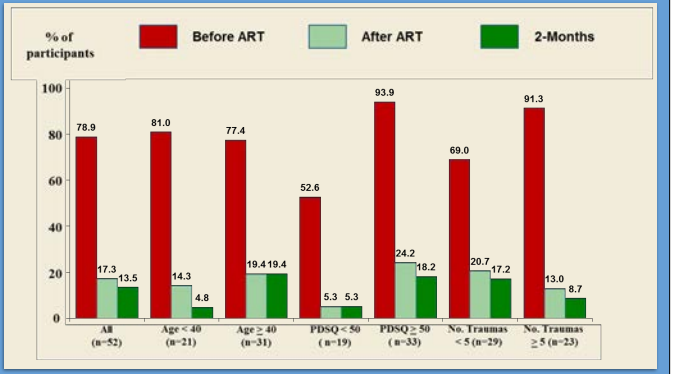
Empirical Base of ART – Civilian Study

Mean of 3.7 Treatment Sessions



Percentage of participants with PCL-C scores ≥ 44 (PTSD) among subgroups at baseline, post-treatment, and 2-month follow-up

Kip, 2016

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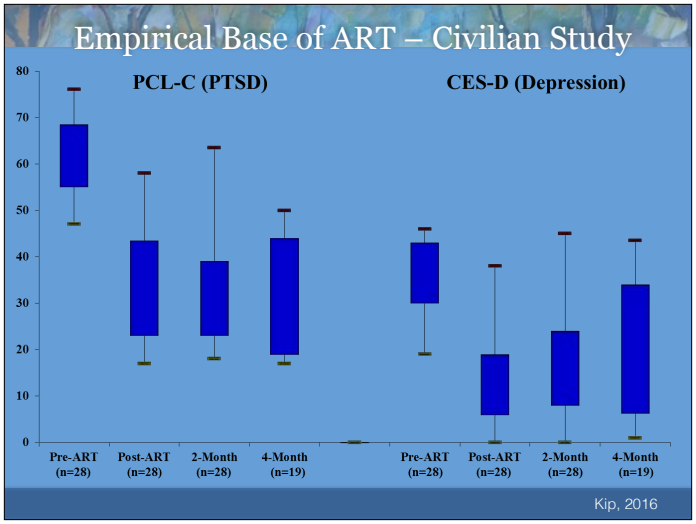
Empirical Base of ART – Civilian Study

Self-Report Changes in Symptoms Before and After Treatment with ART

		Pre-Treatment Versus 2-Month Follow-Up				
Symptom Measure	**N**	**Pre[a]**	**2-Mo.[a]**	**Diff[ab]**	**ES**	**P**
PTSD Checklist (PCL-C)	52	54.1 (12.2)	29.5 (12.0)	24.5 (12.2)	2.01	<0.0001
Brief Symptom Inventory	52	30.1 (14.2)	9.6 (11.9)	20.5 (13.3)	1.54	<0.0001
CES-D (Depression)	51	29.0 (10.7)	13.3 (12.1)	15.5 (11.0)	1.41	<0.0001
Pittsburgh Sleep Quality	47	9.8 (4.6)	6.2 (4.2)	3.6 (4.0)	0.89	<0.0001
Trauma Related Growth						
Global Guilt	52	4.6 (2.4)	1.9 (2.0)	2.7 (2.8)	0.98	<0.0001
Distress	52	18.7 (4.0)	8.0 (5.9)	10.7 (5.6)	1.89	<0.0001
Guilt Cognition	52	44.3 (18.3)	24.4 (14.9)	19.9 (19.2)	1.04	<0.0001
Self-Compassion Scale	52	67.2 (16.8)	82.0 (21.1)	14.8 (17.8)	0.83	<0.0001
Alcohol Use (AUDIT)	52	3.0 (3.3)	1.8 (2.1)	1.2 (2.2)	0.50	0.0008

[a]Presented as mean (standard deviation). [b]All mean differences are coded with positive numbers reflecting improvements in symptoms. ES: effect size.

Kip, 2016



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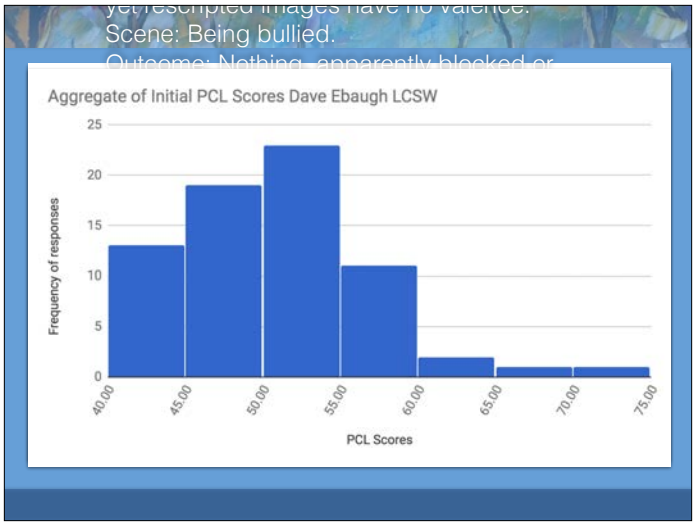

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Initial PCL Scores Private Counseling Practice

High score is 71
Saw him in one session

Cl is 28 yo male, here with his girlfriend, at his request. He is here for treatment for his anxiety. He is preoccupied with negative thoughts. He winds up with panic attacks and he'll be accusatory of his girlfriend, but he can't prevent himself from asking questions, feels very compulsive.

ART assessment review
He was sexually abused by a neighbor over several instances. He can't remember the age and he can remember some of the episodes. He had to keep it secret, "didn't want to share it with people", maybe in grade school. The son of a former neighbor, an older kid age 13 or 14. Cl was bullied frequently.

ART
Focusing on panic, insecurity, anxiety.

Feeling calm second time through.

Looking to activate sensation, reports calm, yet rescripted images have no valence.
Scene: Being bullied.
Outcome: Nothing, apparently blocked or detached (cl agrees)
Metaphor: Lowering shields.
Outcome: Tightness in chest

Outcome: Cl completed protocol, reported feeling generally positive.

Plan: Cl to monitor reactivity and sensitivity, schedule follow up appointment as needed.

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Self-Compassion Assessment Scores

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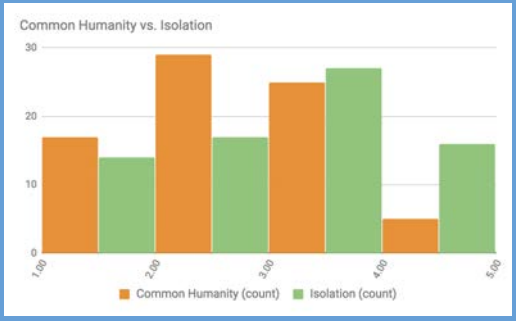
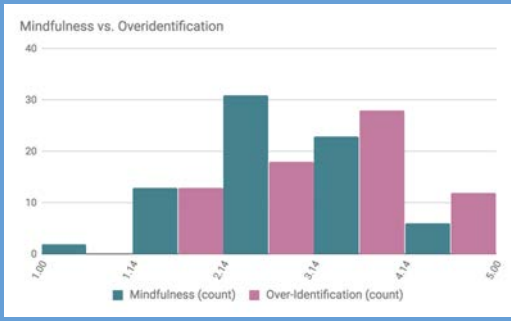
Self-Compassion Assessment Scores



Self-Compassion Assessment Scores



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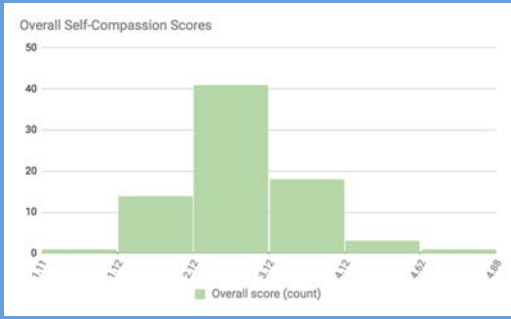
Self-Compassion Assessment Scores



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My Own ART Clinical Experience

- Occasional rapid, dramatic, and sustained cure for PTSD, anxiety, panic attack (1-3 sessions)
- Durability of changes persists, people don't come back for follow up, typically
- ART is incorporated into longer term treatment plans (along with other modalities) for patients with complex trauma histories (10-20+ sessions)

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My Own ART Clinical Experience

- Marked and lasting benefits for some clients
- Less consistent results for others
- Useful tool for addressing specific problems (1 or more sessions)
- Very satisfying for both patient and provider
- Long-term benefits are less clear
- Drop-outs appear low, but do occur

ART is Effective in Treating

- Obsessive Compulsive Disorder
- Phobias
- Depression
- Anxiety
- Symptoms of ADHD
- Substance Abuse and Dependence
- Co-dependency
- Test or Performance Anxiety
- Regulating Anger and other Emotions

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Potential Advantages of ART

Offers another option for trauma-focused therapy that is primarily body-focused.

Highly procedural. Relatively easy to learn.

Satisfying technique to apply (for both patient and provider)

Hoge, 2016

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Potential Advantages of ART

Patient does not have to recount trauma

Other potential advantages (further empirical support needed):

- More effective and lasting reconsolidation of trauma memories?
- Better long-term outcomes.
- Fewer treatment sessions needed?
- Lower drop-outs?

Hoge, 2016

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ART is not suitable for all clients

Cautions especially for:

Severe complex trauma (e.g. childhood physical/ sexual abuse, dissociative disorders)

Risk of severe abreaction

Risk of ongoing processing b/w sessions

Risk of unraveling defenses

Resourcing and social supports important

Hoge, 2016

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ART is not suitable for all clients

Physical conditions that may pose risks during processing:

h/o cardiac / cerebrovascular disease

Seizure disorder

Pregnancy

Ocular disorders or pain during EMs

Legal processes

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Additional Clinical Considerations

A thorough biopsychosocial (and safety) assessment is essential.

Understand rationale/mechanism of each technique.

Documentation of informed consent and treatment options is recommended.

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Additional Clinical Considerations

Although ART encompasses core principals of EB treatments, there has only been one clinical trial.

Thus, ART cannot be considered a standard-of-care EB treatment at this time, despite SAMHSA determination.

If ART is accepted as an EMDR derivative, the extensive EMDR literature can probably be used to support it.

Close f/u is important, preferably with validated outcome measures (e.g. PCL, PHQ-9, GAD-7).

Hoge, 2016

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Minimum Clinician Requirements

Licensed to practice independently

Experience treating PTSD and working with patients with complex trauma

Comfort with abreactions / high emotions

Experience administering one or more established A-level EB TF-psychotherapies

e.g., PE, CPT, EMDR, NET, TF-CBT

Training. Understand rationale behind each technique, and how to address problems that arise.

Hoge, 2016

ART Basic Training in Portland
Accelerated Resolution Therapy is a powerful new SAMHSA endorsed, evidenced-based treatment that resolves trauma in as little as a single session. ART has been implemented on Army bases around the world, and it is being adopted in clinical settings world-wide. Clinicians in the Portland area can now experience the remarkable benefits of this breakthrough therapy for themselves.
You can learn this life-changing technique in just 3 days at the first ever Basic ART Training in the Pacific Northwest.
When: November 3-5, 2017
Where: Portland, OR
For full details and to register visit
www.traumafocusedtherapy.com/training