Questions Asked During Live Webinar Broadcast on 03/12/2015

Do you have experience with EMDR and if so, what is your assessment of its efficacy?

A: So glad that a listener raised the issue of EMDR! It should have had an honorable mention in the Webinar. Experts in the field value this evidence based practice. Last year at the Ivory Garden Conference in Seattle, I heard both Sandra Paulsen and Colin Ross give this practice two thumbs up! There is a growing body of literature about its efficacy. It makes logical sense that it *could* work given what we know about the neuropsychology of PTSD. I have not had the opportunity to get this training but certainly would recommend it. The more tools we can have in our kit – the better! Note: There are contraindications and these should be carefully considered.

I didn't understand how we can see the PTSD in the body? Please explain further.

A: This is a great question! I could write a book about this subject and still have more to comment on. I'll try to summarize: PTSD and other trauma related disorders have a visceral presence and expression in the body, as do other types of mental illness. For instance, hyper arousal, exaggerated startle response and hyper vigilance are fairly easy to observe. These are very physical responses to trauma. Over and above those simple diagnostic markers though, we understand that traumatic memory is stored in the body for many years. Simply put, traumatic memory is not just in the brain structures. It can lay dormant, have intermittent 'flare ups' or provide constant 'trouble' for the survivor. This traumatic memory can unfold in multiple ways – through medical illness such as IBS, seizures, chronic pain, ulcers, muscle pain, headaches (cf: ACE and COLEVA research which gives us a solid understanding of PTSD and its incorporation into the body), in the stillness and surrender of the Freeze response (referred to as the Opioid Wash in the Webinar), via eating disorder and self-harming behaviors.

Is there such a term as "Generational Trauma"?

A: You may have noted that the Webinar contained numerous euphemisms such as the term you are asking about above. I must be transparent about the fact that I have created and used some of these terms in my role as a clinical supervisor, field instructor and some-time freelance writer. They may or may not be reflected in the literature. The term generational trauma is symbolic language that I use to describe what I have gathered in my anecdotal evidence over two decades. The term refers to the transmission of trauma through generations. This occurs through a variety of means including epigenetics, learned behaviors which transform to parenting style/coping skills/conflict management, and the inherited risk to subsequent generations (left-overs) for traumatic injury through mechanisms of poverty, etc .

How do we tell a dissociate disorder from substance abuse blackouts?

A: With great difficulty! What a pertinent question. I hope to be able to provide training specifically on this topic in 2016, so stay tuned! Let's be clear that dissociative episodes can occur when a client is sober *or* intoxicated. They may be apparent to the client, fully under their control, co-conscious or unconscious. This makes it even more difficult to delineate. In oversimplified terms, an alcoholic or drug-induced blackout seems to be all encompassing – and by that I mean the client will recall no information during the blackout period. They may or may not be 'passed out'. A dissociative 'blackout' is more fluid – meaning the client may float in and out of the state with normal functioning just prior (even during) and afterward. Also the dissociative blackout may be patchy. I think all experts agree it is impossible to measure this with absolute certainty. The DES clues us in to the nature of these amnesic like states and helps us look for specific symptoms of dissociative disorder(s). There is often a pattern with dissociation, in terms of what triggers it, and how the client expresses their dissociation to the outside world. It looks a little different in each client. One gentleman I worked with recently, actually thought he was having latent alcohol blackouts, but as we started working

through his trauma he realized this 'blackout' state was in fact a dissociative state. He began to piece together his own dissociative tendencies. We used time lines, chain analysis type investigation and **education** about derealization and depresonalization. Never underestimate the intuitive knowledge of the client once they have a framework or labels to figure this out. I discussed the pace of Trauma Informed Care and this is one of the reasons we have to slow down to make these diagnoses – it takes time to get to know our clients well enough to assess exactly what's going on. It also takes time to educate them about the possibilities of origins of their symptoms. My experience is this has to be repeated many times so naturally the dissociative symptom may take time to discover. Even though the following sounds so simple – a powerful intervention is to normalize the dissociative episode by describing how ALL people dissociate (think of an example the client can relate to) and then have the client write down when this happens to them.

When you listen to constant trauma stories, don't you get vicariously traumatized frequently?

A: Clinicians who deal with this issue frequently, and *don't* 'burn out', or have compassion fatigue or become cynical must have good resilience and ego strength. I spent some time in the Webinar urging clinicians to examine their own 'story' about their motivations for Trauma Informed Care. Such self-knowledge/perspective makes us alert to any potential triggers, projection or counter transference. From my own viewpoint, I do not experience vicarious traumatization from clients. Like all clinicians, I am troubled by some cases, and may even dream about them, or experience other fleeting thoughts, but this dissipates quickly. I am fortunate to have available - Supervisors and a great team of colleagues. We rely on each other and keep each other in check. When my clinical 'antennae' are out – I do experience the mirrored neuron phenomena. But I have learned to retreat those antennae and shift to the different roles I have in life. Sandra Paulsen explains this poetically. Anything you can read by Sandra will be helpful. The most stressful experiences for me over the years, relate to maneuvering within and obstacles within the systems we work or interface with as we carry on our duties. As I reflect on my most stressful times over the years, I usually realize that it is a system enforced issue I struggled with, rather than a particular client. Practicing trauma informed care and evidence based practices, means we rarely get traumatized by our clients. Good self-care involves moving that stress that we receive from clients and systems through the body with activity and exercise, connection to positive renewing activities, and tending to nutrition on a daily basis. We must find a balance between an upbeat and light footed approach to life vs a deep respect for the recovery of our clients. Making sure our sessions are not detail based is also a requirement. There may be times when we are the only safe 'receptacle' for that detail content. Overall, clients should not be focused on spewing traumatic content – we need to guide them to work in their discrepancies and symptoms.

Would using mindfulness help focus a schizophrenic client?

A: I am cautious to rule out any particular approach just based on a diagnosis. I have done zero meta-analysis of the research so I will answer from my own clinical experience with clients. Clients may benefit from a variety of approaches as their recovery unfolds. For instance, in working with Schizophrenic clients, it is a general rule to avoid symbolic reflections. Often their thinking (due to negative symptoms) is so concrete that symbolism can evoke and worsen magical thinking and paranoia. Obviously, there are some clients with this diagnosis who are not so concrete and can certainly understand nuance. In the same way, mindfulness should be applied with clinical judgment. Mindfulness means different things to different clinicians, too. For some people it just means noticing – and it can mean noticing things in the external world. This could be a helpful reality check for any client. For some though, mindfulness is tied to more introspective processes such as meditation. In general, psychosis is not helped by encouraging the client to think about their thinking or body sensations.

You stated: "60-70% of clients w/ PTSD hear voices." Can you tell me the source for that information?

A: Thank you. A note to myself to cite the origin of statistics! Apologies this was not done in the first place.

Experts in the field, including myself, recognize that AH are a common experience among survivors. Brock Chisholm, PhD has a short video clip on this subject:
http://www.mentalhealthcare.org.uk/view_all_videos/dr_brock_chisholm_video_2

The number I cited refers to Complex PTSD that is more chronic and severe in its clinical course. Various studies indicate that 60 – 70 % is a fair and conservative estimate for that more chronic/severe sample. This is certainly true in my practice experience. A Columbia University study with over 5, 000 as a sample size found 52% of respondents with range of severity PTSD experienced 'positive symptoms' such as voices. For listeners interested in reading more on this topic I would recommend reading research by Kilcommons, A.M. & Mornson, A. P. (2005), Saren, J. et al (2005). Tull, PhD also has information on his website.