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Illustration courtesy of Amanda Weckwerth

Amanda Weckwerth is a member of the OACCPP and a person with lived experience in mental health. She is a graduate of the Community Psychology program at Wilfrid Laurier University in Waterloo Ontario. Currently, her work focuses on a local art gallery where she has conceptualized and working to develop an art-and-health outsider art collective for persons with primarily mild to moderate mental health issues.
President’s Message

"Time to Say Goodbye"

OK, so I know at least some of you have some questions ... like “Why are you leaving?”
Answer: “My term’s up folks”. You’re probably curious as to how I feel: happy, sad, relieved, nostalgic, a bit anxious about how to fill my time, confident of my legacy, etc.?” Answer: “All of the above, but mainly I feel gratitude and a great deal of pride for the work accomplished by the people I worked with: the board, the staff, and the editors of our e-magazines during my tenure. They have been, bar none, the best of the best.”

The current staff, Maryann Istiloglu, Kamil Devonish, and Ruth Taylor have all had an incredibly steep learning curve during my time as President. Their challenges have been substantial, and their work has been very impressive, as has the work of all the board members during my four years as President. The writing and editing standards held by editors Sarah Sheard (and before her, Sandra Lewis) for Psychologica and Dodie Pirie for The Pulse have been remarkably high and continually well received. The space restrictions for this message won’t allow me to fully express my appreciation of each and every board member, and I therefore plan to do so at the AGM. But here I would like to recognize our longest standing board member, Chair of Legislation and Past President, Naseema Siddiqui. Over the years Naseema has worked tirelessly on so many initiatives, most recently representing us during the period in which the College of Registered Psychotherapists of Ontario became established. This was a lobby effort Naseema spearheaded over ten years ago with the formation of the Coalition of Mental Health Professionals. And she deserves special recognition for her contributions to OACCPP in that regard alone. So, yes, as I look back, I am both grateful and proud of all those who supported me, often through very tough times – particularly when I faced some daunting health challenges early on in my tenure.

Other initiatives include producing the many seminars dealing with questions about College regulations, consultations with the Ministry of Health and Long-Term Care, maintaining our fee structure, the amalgamation of two committees: Ethics and Professional Conduct, an abbreviated process for Certification of CRPO members, and the expansion of insurance coverage benefits through both Sun Life and McFarlan Rowlands, to name only a few. I will elaborate on these and other achievements at the AGM when I deliver my report.

But as with any association like ours, there are also tasks to be continued; some of these have started as a seed of an idea; others are in the making. Here they are: We would like to develop a defined career path for mental health care workers and registered psychotherapists. We have begun planning around creating a training and certification program for supervisors and ultimately our hope would be to establish a fully developed registry of clinical supervisors for registered psychotherapists. As a further future project, we would like to pass on to the new board the task of designing an enhanced certification program for mental health specialists, as well. Ultimately all of these initiatives are directed towards increasing opportunities and earning potential for OACCPP's mental health professionals and registered psychotherapists. These are only some of the initiatives I will be passing on to the new President and Board and I will speak to these projects more fully at the AGM in September.

So, as I bid adieu, I want to pass on what the Presidency has taught me. I've learned to make sure I follow my instincts as best I can and not to regret the times I may have fallen short. I've learned to recognize my limits with respect to what is doable, and even permissible. I've learned the power of laughter. And, I've learned to listen more closely. (One would think in our profession, that would be a given, but not always). I wish all of you a wonderful late summer and early fall, and I hope as many of you as possible will come to the conference and AGM. It is especially important to me to thank all of our board members at that time, elaborate on the work done on your behalf in the past four years, and, to thank all of you for your support.

Enough. Adieu!

James Whetstone, MA, RP, Cert(OACCPP)

Psychologica Magazine
Summer | Fall 2016
Editor’s Note
Sarah Sheard, MA, RP, (Cert) OACCPP

I looked up ‘trauma’ to find its original meaning, having become somewhat numb, by the end of editing this issue, to the impact of the word. It’s an ancient Greek medical term meaning “a wound, a hurt, a defeat”. Its verb root means “to rub, twist, pierce” etc. In 1804, the meaning was expanded (according to my online dictionary) to include psychic injuries causing abnormal stress.

Trauma, in other words, has been around for a very long time yet somehow it strikes my ear as a contemporary term. It wasn’t in conversational currency in my childhood. Was it in yours? It’s understood now to refer to everything from catastrophic world events and their impact on whole societies to the most private of violations occurring behind closed doors inside a home, an office — or even within the psyche of a single individual.

While the term ‘PTSD’ in soldiers has replaced ‘shell shock’ used by the military in World War One and its symptoms and treatment better understood today, yet the population of PTSD sufferers continues to grow exponentially. Our world appears filled with ever-more plentiful sources and sufferers of trauma.

It’s timely then, that Trauma is the topic of OACCPP’s Annual Conference in September. When I put out the call for submissions to Psychologica on the subject, I received an instant and sizeable response indicating that many of our members are involved in trauma work. They use a range of approaches and philosophies to help their clients recover and move on.

The articles presented here offer only a small sample of the skilled work being done on trauma’s battlefield by our member clinicians.

Sarah
I spent much of the weekend mom-ing, and it was lovely. My older son and his significant other were home from college and in need of a little mom time. My practice has ebbed to a slow trickle now as I prepare to move and cannot take on any new clients here. I needed a break from the long slog of sorting and packing up a life as I prepared for our move to a new city, so doing the mom thing this weekend was just what the Dr. (in me) ordered.

I shopped and cooked for two hungry college students, talked shop when they wanted to, offered a little counselling regarding their relationship when they asked me to, enjoyed dinner conversation with the 20- somethings, and offered a listening ear to my son’s girlfriend when she spoke about the trauma of childhood and the scars her psyche still carries that offer challenges to their relationship but in truth have little to do with it.

I remember feeling much like this lovely young woman does, and in fact I would say my insecurity and self-doubt lingered far longer into my adult years than hers will. But somewhere along the way I left all that behind.

I wonder where and when — and more importantly — how? I would like to know the formula that brought me to a Healed Place, feeling sturdy, anchored in myself and my gifts and in Knowing Who I Am. It must have been some years ago that I left behind the childhood trauma and the fear of being found wanting that plagued me all of my adolescence and young adulthood. There were hurts I wore as badges; stories I told myself over and over; fears I had when I believed that, because it had been like that in the past, the present or future were bound to be like that too.

What is it that healed the trauma for me, so that I could walk bravely forward into the life I am living now? I want to say it was good psychotherapy, or the fiery kiln of motherhood, or my connection with the angels who help me daily, or my meditation practice, or the help of dear friends, or the final hurrah of clearly confronting someone with whom I needed closure in order to move on past that time in my history. Was it all those things? Did I distil years of therapy into a few nuggets of wisdom that gave me me? Was it the drop-by-drop filling of my spirit with my meditation and angel intuitive practice over 45 years that finally unhooked the trauma from my body-soul, so I could be who I am now every day, instead of once in a blue moon? Did the grit of all these years of parenting wear down all my rough edges so I could feel true and whole in my personal and professional relationships now?

Was it Divine Intervention? I talk to the archangels daily, on behalf of someone else’s need or my own. At what point did I allow them to assist me? These days, as well as my asking for help, there is a resonating reply.

I could not say to my son’s dear one that time would heal those traumas for her, because it was not just the passage of time that healed me.
At this point in my life I look back on all the difficult experiences and yes, even the great and terrible traumas of my past, and bless them for the gifts they have offered me: strength, courage, true friendships, clarity. I have been fired in the kiln of life and all that was unnecessary was burned away. The unfired glaze that was splashed on my surface has been seared into something beautiful within. Superficial things no longer matter to me. I know what does matter: the transcendent moments, the precious tenderness of unexpected joy, awareness of the exquisite beauty of Nature, the raw feeling of soul connection with another.

What I see from this vantage point is that trauma is healed by focusing on what is real and good and life-affirming, here and now. If I am open, life will surprise and delight me in expected and unexpected ways. I need to ask for help when it is required, and then I need to focus on the needs of the situation, in some ways lose myself in the requirements around me or the beauty of the present moment. Sometimes I need to speak my truth, knowing that, as I do, something changes in me, which in turn changes everything. Maybe I just realize that the trauma no longer has the power to hold me back, because life is a river, always flowing, always new.

Being present in each amazing moment in time somehow shifts my vision from what is missing to the tender awareness that all is well and is indeed very well.

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For several years she was chair of the Psychology Dept. at the Canadian College of Naturopathic Medicine in Toronto, worked in Crisis Counselling at Stevenson Memorial Hospital in Alliston, ON and at Scarborough Centenary Hospital.

She has been a writer forever. She has published stories in 6 Chicken Soup for the Soul books. Her newest book, Hope and Miracles, was released in February 2015.

She is a proud mom of two independent, creative and interesting young men.

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Whether trauma is caused by an unexpected death, marriage breakup or violent experience, the route to resilience often involves the same steps, in my experience working with trauma clients.

Experiencing a traumatic situation tends to shake the foundations of our beliefs about ourselves. It can affect the natural development process and leave individuals with feelings of vulnerability and loss. Without timely help, many individuals blame themselves for enduring situations of abuse. The unresolved effects of trauma can result in anxiety, depression and often substance abuse.

I have found that, particularly after the end of a long-term relationship, it is usual for clients to feel lost, afraid and alone. One client told me that after many years of marriage she had never anticipated being on her own. She felt that her partner had effectively “thrown away” all that they had built over the years. There was a deep sense of loss and betrayal that was hard to get over. Would she ever be able to trust again? Well, my answer to that, drawing from my own experience in the field, is “Yes, you will most likely be able to trust again”.

If I were to offer general advice to anyone struggling with a traumatic experience, here’s what I’d say: one of the first things to do after a shattering experience is to stop and take stock. Finding a calm place is important to see things objectively. Depending on the severity of the trauma, this might include going away for a week to a friend’s home or visiting someone you have not seen in a long time or attending a spiritual retreat. If you have not had a holiday, this may be the perfect time to take one. For others, it may be a trip to the park with a book by your favourite author. Whatever it takes, the need to find a calm place in order to re-evaluate your self-esteem is crucial. The importance of self-esteem, in fact, cannot be overemphasized in recovering from traumatic experiences. Having a loving relationship with yourself, as strange as this may seem, is one of the keys to resilience after trauma. Knowing that you deserve better is another way of putting it. Having the unconditional support and love of your family and friends helps to reinforce our positive emotions, especially after trauma.

Another of the least credited but most effective pillars of resilience is to develop a spiritual base. In my experience, I have found that those who believe and trust in a transcendent spiritual presence, however defined, will find their healing process expedited and appear to fare better in the long run.
The practice of Mindfulness can be especially helpful. If we can see things as they are in that moment without judgement, we can free ourselves and see others in a more objective light. It is easier to move on when we can look at the experience, however negative, as a learning experience. When we find the quiet and peace to meditate, we are able to listen to our inner voices and act with confidence.

The experience of one client I had was informative. Coming out of a disastrous and traumatic relationship, she decided to change her environment and set new goals for herself. This is often referred to as ‘reinvention’. She credits her dog for getting her out on long walks and providing her with unconditional love when this was most needed. She joined a church group, became involved in a Bible Study class and did outreach work with newly arrived immigrants. This work enabled her to compartmentalize lingering feelings of distress and gain some perspective on her own challenges. In other words, during the course of her volunteering, my client could see that there were others much less fortunate than her.

The helping process in which my client became involved through her church was indeed therapeutic. She subsequently began to make friends and felt validated and valued in her work. She could almost feel admiration for herself. This is when she decided to join an exercise program. She was able to have a trainer design a specific regimen that she could follow on her own on a daily basis.

Soon after, my client sought counselling. She has described her decision to do so, ‘self-affirming’. Finding the right fit in a counsellor was crucial to her. She claimed that the counselling experience enabled her to pursue her goals with some very clear objectives.

This client clearly took many of the right steps in overcoming her significant challenges. The process involved self-assessment, reaching out, helping others and making some decisive self-help decisions. This path is not always the same for everyone, of course. Some seek counselling earlier in the process. Others may choose to work things out themselves. When they choose this option, the process can take longer.

Whatever the healing process entails, I would encourage all those suffering from traumatic experiences to reflect on this: whatever route you choose, it is useful to consider that you are not alone. As well, we all learn from our experiences and often feel stronger for having had that experience, however unwanted at the time. When you reach a place where you can see yourself and your challenges in a more positive light, you will know that you are truly on the way to acquiring resilience.

Jennifer Hosten is a Registered Psychotherapist practicing in the Oakville area. Prior to entering the field of Psychotherapy, Jennifer’s varied career has included Broadcasting, the Airlines, winner of the 1970 Miss World contest, Grenada’s High Commissioner to Canada, Program Manager & Policy Analyst with the Federal Government of Canada. She is also a published author and small business owner. Jennifer’s background and experience has instilled in her strength and resilience through adversity, which informs her practice as a Psychotherapist. In this article she shares some important insights.
The Temperament Profile of Trauma

Julie Christiansen, MA, RP

“I used to be different”.
“I want the old me back”.
“This is my new normal”.

These statements from three of my clients are familiar. They have been repeated over and over again in my office by clients of all ages, backgrounds, and walks of life. The common denominator between them all is that they have experienced an acute traumatic event (like a motor vehicle collision), or a prolonged trauma (like workplace bullying, policing, or trauma experienced while in the war theatre). Additionally, my observations of their behaviours and self descriptions post trauma suggest that their traumatic experiences seem to have altered their temperament profiles, a psychological disposition once believed to be unalterable.

Workplace Bullying, Trauma Symptoms, and Temperament Shifts

Victoria (pseudonym) worked over ten years as a nurse and for much of that time she experienced the ill effects of repeated peer-to-peer bullying and harassment. After several sick leaves, filed grievances and failed attempts to change the culture in her workplace, despite receiving several glowing references from doctors and surgeons who worked with her, Victoria was released from her place of employment without a severance package. Victoria’s primary struggle was with depression, low self-esteem, and acute anxiety related to attending her scheduled work shifts, particularly when she was placed on the same team as the nurses who bullied her. She also displayed symptoms of avoidance and had repeated nightmares about her place of employment. Denise (pseudonym) also a nurse, was exceptional at her job but acquired a workplace-related injury that saw her leaving active duty nursing and working in a less physically demanding capacity. In her new role, she experienced harassment and a toxic work environment and was transferred to a new department, where the bullying behaviours only intensified. As her self-esteem plummeted and her mental health declined, Denise also wound up on sick leave due to stress and ended up on LTD (long-term disability). Further assessments
showed that, in addition to depression, Denise displayed symptoms of post-traumatic stress including avoidance, anxiety, and heightened arousal.

Lou-Anne (pseudonym) had a troubled childhood, a tumultuous marriage, and had experienced her share of trauma and loss. In her late 40s she experienced a serious illness that required surgery. The surgery resulted in significant changes to her cognitive functioning, memory, and sleep schedule. It also caused overwhelming fatigue, weight gain and other symptoms difficult for her to manage. While medication mitigated the symptoms somewhat, it did not reduce them entirely. Upon her return to work, Lou-Anne found her employer to be overly critical of every error — and she was indeed making errors due to her cognitive and memory impairments. Lou-Anne was also having trouble staying awake on some shifts due to fatigue. When she asked for shifts that were lighter and would better accommodate her impairments, these requests were denied. Lou-Anne observed other staff members arriving late, sleeping on the job during night shifts and making serious clerical errors.

Lou-Anne also observed that those same staff members were frequently excused and/or promoted, while every misstep of hers was magnified and criticized. Eventually, Lou-Anne’s work-related stress resulting from being micro-managed and criticized was more than she could handle and she went off on her stress leave. She was referred to counselling for anxiety, but additional assessment found Lou-Anne suffering from symptoms of post-traumatic stress disorder and depression as well.

What interested me about these cases (in addition to the clear similarities in their stories) is that each client’s description of her temperament before and after she was traumatized by her experience seemed to suggest a degree of alterability.

Temperament Before and After

Using the Structure of Temperament Questionnaire STQ-77: a self-report assessment tool that rates 77 statements on a four point Likert scale (strongly disagree, disagree, agree, strongly agree) as an assessment tool at intake, I noticed some interesting patterns emerging among these three clients. The STQ measures three aspects of temperament traits: behavioural, energetic, and orientational, giving the assessor insights into not only how one might respond behaviourally to stimuli, but also the tempo or speed at which they would respond, and the things to which they might be most sensitive (sensation or risk, empathy with others, or sensitivity to probabilities). While certain aspects of the clients’ temperaments appeared to reflect their verbal reports of their “before” selves, certain similarities appeared in each temperament profile, suggestive of something else happening.

For example: in each case, scores for sensitivity to sensation or risk-seeking behaviour were low. In the majority of cases, empathy scored very high. In each case, when the client scores were evaluated for areas in which the client might experience distress, two very clear commonalities appeared. Each client showed distress in the area of somatization and phobic anxiety. Of course, there were some differences; some showed increased risk of distress in the areas of interpersonal sensitivity, depression and anxiety, and a small percentage showed distress in paranoid thinking or psychoticism.
There seemed to be enough of a trend though, to cause one to question: does trauma alter one’s temperament profile? Let’s take a look at Lou-Anne’s temperament profile at intake and examine it within the context of what I learned about her through the course of treatment.

Lou-Anne’s temperament profile indicates that she enjoys physical activity (ERM or motor energy) but works at a slow pace, which is reflective of the after-effects of her surgery. She does have some sensitivity to sensation (SS), part of her “before” temperament, but she reports being socially withdrawn and has a fairly low tolerance for large social gatherings (ERS or Social Energy and TMS or Social Tempo); this would be the “after”. She scores very high on the empathy scale (EMP), which she described as a stable trait from “before”. Her self-concept (defined by the STW Manual as self-confidence or the subject’s expectation of success in a given activity) is average to low, and this could be due to the multiple traumas she experienced prior to the workplace bullying, or a result of all of her experiences combined. It could also just be a trait that has remained stable over her lifespan – we cannot be certain. She scores high on the neuroticism scale (NEU), which is second only to her empathy scale scores. The STQ manual defines neuroticism as: the sensitivity of an individual to the probability of failure, the degree of withdrawal from novelty and uncertainty. (Rusalov & Trofimova, 2007).

**Challenging the Presumed Stability of Temperament**

It used to be common belief in the schools of temperament and personality theory that temperament was innate, stable and fairly unchanging throughout adulthood. Recent research has challenged some early assumptions about the constancy of temperament, suggesting a higher degree of plasticity in its expression. For example, a study I completed with Dr. Irina Trofimova (2016) found some people with high scores for hostility, sensation-seeking and impulsivity who may have a tendency to take risks and live an unhealthy lifestyle with drugs, alcohol, and aggression appear to mellow as they age. Youth’s appear to tend to be more neurotic, a finding that has recently been supported by CAMH’s study about mental illness and substance abuse in school-aged pre-teens and teens. Furthermore, our research suggests that neuroticism also tends to decline for most people as they mature through early and middle adulthood. This would suggest that life circumstances and the various stages of development may have some impact on temperament throughout the lifespan.

If the clients’ self-reports (as summarized at the beginning of this article), of their “before” temperaments are to be taken at face value, their responses to perceived prolonged trauma have a profound effect on their temperament frameworks. My observation is that those clients who tested high in empathy displayed that trait prior to the bullying. I would suggest that highly empathetic people are impacted twice by bullying. First, they experience injury when bullying is targeted toward them and receive a second hit when they see others being targeted by the bully. In effect, they experience their own pain and the pain of others more intensely, thereby feeling double the negative effects of a toxic work environment. Most clients though, do not describe their “before” temperament as being highly neurotic. In those rare cases where the client self-identified as having pre-existing unresolved mental health or emotional issues, the areas of distress displayed in the STQ results seem to multiply and intensify as in Lou-Anne’s case below. (It should be noted that the STQ found Lou-Anne to score high in empathy, and low in physical tempo, social endurance, social tempo, and plasticity).
Regardless, the distress areas of somatization and phobic anxiety remain constant. This suggests that neuroticism is more typically a trait of the “after” temperament than the “before”. When I have to worry about what will happen at work tomorrow; with whom I will be working; what they will say and how they may try to get me in trouble, undermine my success at work or malign my reputation, I will, after a time, likely display greater levels of neuroticism as a result. A person who displays high levels of empathy might also begin to worry more about herself as well as those co-workers who are targets of bullying, resulting in higher levels of neuroticism being reported in testing.

My observations reveal that every single client in my practice who has experienced workplace bullying, as well as those who have diagnosed PTSD due to MVA (motor vehicle accidents) or first responder trauma, says things like: “Before, I used to be outgoing. I loved my life. I was more outspoken. I was more adventurous. I was more — .”

My three clients reported, post trauma, having low self-esteem, having feelings of guilt and shame, and a sense that they had “allowed” themselves to be victimized. They also expressed having a sense of weakness of character because of their perceived inability to bounce back from the trauma. They expressed feeling angrier, more irritable than “before” and more socially withdrawn and avoidant of people, places, or things reminding them of work or of the trauma they experienced.

The Questions that Remain

I wish I had been able to know them “before”. Had I known my clients before they experienced trauma, I might have been able to examine fuller self reports that might more conclusively point to the plasticity of temperament following alterations in brain chemistry when clients are exposed to trauma. The test results along with fuller self reports of these three clients’ “former selves” seem to point in that direction, but more research is clearly needed.

We understand how temperament could be seen as a possible predictor of trauma responses. In this article, I have also explored how prolonged trauma, such as workplace bullying/harassment may be a trigger bringing about specific alterations in brain chemistry that result in altered temperament profiles. In that respect, altered temperament can be seen an artifact of trauma.

### Area of Distress | Level of Risk
---|---
Somatization | High
Obsessive Compulsive Symptoms |  
Interpersonal Sensitivity | High
Depression |  
Anxiety |  
Hostility |  
Phobic Anxiety | High
Paranoid Ideation | High
Psychoticism |  

Julie Christiansen is an internationally recognized speaker, Registered Psychotherapist, published author, and an adjunct professor at George Brown College. Branded as “Oprah for the Office” and “The Anger Lady” by her clients, Julie educates and entertains audiences throughout Canada, the United States, and the Caribbean with an energetic, humorous, and insightful style that is all her own. Early in her life, she committed her future to finding and sharing real solutions to stress and anger. After 15 years of working the front lines as a counselor, Julie successfully merged her previous career with her passion for helping people to create radical, positive, lasting change in their lives. Julie holds a Bachelor’s degree in Psychology and a Master’s Degree in Counselling Psychology. She is the author of several books and publications including Anger Solutions: Proven Strategies for Resolving Anger, and When the Last Straw Falls: 30 Ways to Keep Stress from Breaking Your Back. Her research paper on temperament and mental illness was published in the Spring issue of Psychological Reports. Julie lives in St. Catharines with her husband, two children and her toy poodle, Forrest Gump.
If the 20th century was notable for man’s leaving the earth’s surface and entering outer space, there is a good possibility that the 21st century will become known as the century of the brain. Neuroscience research is deepening our knowledge and understanding of who we are in a radical way that is rapidly changing psychiatry and clinical practice.

Neuroscientist Antonio Damasio emphatically states that in the past, much of our approach to understanding human behaviour and emotion was fashioned on what he terms “Descartes’ Error” of separating reason from emotion. In his book, *Descartes’ Error: Emotion, Reason and the Human Brain* Damasio argues that this reductionist, mechanistic world view has dominated man’s thought and action for the past 400 years. In contrast, Spinoza, another philosopher of Descartes’ period, held a radically different world view, one rich with affect as well as linear thought. Damasio’s research brings us to this deeper, fuller expression of our interior world. He points out how limiting Descartes was in processing and behaviour.

Damasio’s research in the 20th philosophy that we have not brain (2003). We are so much exponentially developed embraced with his slogan, “I

In 2014, neurologist Antonio 100 most eminent *Science Humaines* included thinkers in the human His research and conclusions everywhere.

He and other researchers, (functional magnetic and other advances, now are exponentially interfaced can see what the brain does.

One of the most important nervous systems are very closely connected to our fellow mammals’. Our behaviour shares similar primitive drives — the most cogent of which is survival and threat.

Brain scans show that, under threat, we react very much like our four-legged cousins (Levine). The finesse of logic and reasoning flies out the window and gives way to the older subcortical brain structures we share with all mammals.

These structures deal in black and white. It’s safety — or danger. Because our physiology has not changed since we lived in caves, even today, threat is driven by the question: “Is this my dinner or am I its dinner?”

In the media, we are keenly aware of people — both at home and abroad — who experience daily overwhelming crisis and threat, whether from natural disasters like the Fort McMurray wildfire or political and violent disasters too numerous to name. In school and the workplace, bullying and racism still erupt, creating countless, silent victims.
The hidden epidemic of domestic violence and addiction so closely tied to poverty and the upheaval of refugees desperately fleeing for their lives are tragically familiar to us today. All these scenarios isolate, radicalize and lead to traumatized souls.

We cannot reason ourselves out of helplessness, feeling overwhelmed, in severe crisis or under threat. Physiology dominates. These ancient subcortical structures are lightning fast, much faster than the prefrontal cortex and they have only one agenda: not to die. The action defenses to threat seen in all mammals are: flight, fight or freeze.

Many presentations in our patients have an underlying threat response. It lies deep beneath the surface of daily life but shows itself in symptoms and pathological relationships — to self, to others and to the social environment.

Leaders in the field of trauma, such as Peter Levine, Dan Siegel, Bessel van der Kolk, Pat Ogden, Robert Scaer, Ruth Lanius and Paul Frewen, understand that with the threat response, the circuits of higher reasoning are not available. These areas go offline when the alarm system of the amygdala summons the fire brigade.

The brain has more connections than any other system in the universe. The possibilities are practically infinite. The brain will prefer and repeat whatever it deems had succeeded before. Consider our automated motor skills: once we have learned to walk, we no longer have to think about it; we simply walk. Consider rage patterns that repeat over and over in a dysregulated relationship; the firing triggers an automated escalation of behaviour.

And so it is with the threat response. Well-worn neural pathways that have been linked by association to similar threatening experiences now express themselves in the body as symptoms: panic attacks, anxiety, insomnia, gastrointestinal disturbances, headaches, chronic pain, violent outbursts, depression.

The wonderful thing is that if we address these deeper brain structures through bottom-up therapy accessed through our felt senses, temporarily laying aside meaning, then we invite the physiology to be heard in a new way.

External stimuli, in other words, come to us through physiological sensations. This information elicits an emotional response to the activation, after which we attach thought and eventually, behaviour.

When we allow the body to be heard, we can become intimate with the deeper message that has been driving the bus. We learn to be familiar with the texture of our sensations, the arousal and activation of the Sympathetic Nervous System and in therapy, patients are challenged to develop a mindful ‘witness online’.

From tolerating troubling sensations (saying hello to our symptoms), we can move into the affect that is being expressed by them. From a place of stabilization that is felt in the body, it is then possible to pendulate towards these more difficult feelings. We can learn to stay with discomfort in the knowledge that it does not control us; that it is accessible to us through this ‘felt sense’ and is indeed fluid if only we will allow the body to be present and to be heard.
Through somatic resources, new links can be made with the ‘devil memory or event’ and this stimulates the brain to pay attention. (The brain loves novelty. It is hard-wired to notice something different.) Then there can be a change in perception that diminishes the old neural pathway in much the same way Pavlov did with classical conditioning.

When meaning does ‘land’ it does so as a shift in perspective from what before held one hostage with constriction, choked emotion and out of control symptoms. Once the physiology has been down-regulated, there is time to examine the narrative... after the tiger has lost its bite.

Therapy with horses directly addresses this bottom-up processing as narratives and reasons for behaviour hold no meaning to these powerful yet sensitive and supremely sociable animals. Their safety is in belonging to the herd. In relationship, this is all and only what they measure. Clients in distress are felt by the horse directly and energetically. Horses are exceedingly sensitive to states of arousal, fear, anger and threat just as they are to calm, empathy and care. With the horse and human, the endless loop of telling the story gives way to pure sensation and emotion. Here lies the potential for authentic connection and the possibility of new choices and a shift in perspective with altered neural connections that actually change the brain and behaviour patterns.

The root of all trauma is threat and lack of safety. Danger is perceived everywhere — both without and within. The horse is a quiet, gentle lifeline, connected to the client through patterns of movement and the absolutely essential element of physical touch. A horse offers a warm breathing body that needs to feel safe — just as we do.

Laurene Winkler is a Somatic Experiencing Practitioner and has assisted at trauma trainings throughout North America. She works as a somatic trauma counsellor and Neurofeedback provider. During the summer months she partners with her small herd of horses to help clients renegotiate trauma and relationship challenges at her farm, DawningVista in Stirling Ontario. On September 23, she will be presenting at Trauma Approaches to Change and Recovery, the OACCPP Annual conference. Her topic is ‘Horses for the Health of It! Powerful in Movement, Powerful in Healing’.
Childhood Trauma, Addictions and Affect Management

Lora Bradford, MA, RP

Approximately 98% of the clients I saw coming in and out of addiction services reported having experienced childhood abuse and neglect. These clients were all in a residential addictions program for homeless men between the ages of 19 and 65, who had been struggling with substance use for a number of years. The main form of childhood abuse reported was sexual abuse by a male perpetrator before age 10. Predominant substances of choice for this population were alcohol and cocaine. The average number of attempted individual recoveries for this client group was 7 with 17 being the highest and 5 being the lowest. The majority of clients was at some point involved with the criminal-justice system and reported multiple re-traumatizing experiences in adulthood such as witnessing or being involved in violent acts. All of the clients reported interpersonal problems. Notably, the gender of the childhood aggressor was usually the gender with whom clients experienced most difficulties interacting.

This, to me, is clear proof of the debilitating effects of childhood abuse and neglect on the individual’s development and adult functioning and it calls for more integration of addictions and trauma work, with emphases on affect management. As we know, abuse and neglect affect a child’s early assumptions about the world, self and others, which manifest later in the individual’s overall belief system. These abuse-related cognitive assumptions become central to organizing the individual’s thinking and behaviour patterns. For example, the abuse-related assumption of a sexually abused boy might be: ‘older men are dangerous and are going to take advantage of me’. This thought pattern can trigger emotional reactions similar to the ones experienced during the time of abuse in later interactions with older men. The emotional arousal may lead to overly aggressive, submissive or avoidant behavioral reactions, which are not relevant to the current situation.

These cognitive schemes relate to the traumatized individual’s constant perceptions of threat, hostility and hypervigilance. Memories of traumatic experiences and flashbacks can be triggered in a number of ways.
Recognizing triggers and the structures these activate — distorted thinking and conditioned emotional reactions of fear, shame, anxiety etc. — allows the individual to employ skills in regulating emotion and in challenging cognitive beliefs. Since abuse takes place during childhood, the development of affect regulation capacities in many survivors of childhood maltreatment is interrupted; thus, they present with difficulties in affect regulation and low frustration tolerance in adulthood. When such skills are unavailable to the individual experiencing post-traumatic activation from explicit trauma triggers (places, dates of events, narratives etc.) he or she is compelled to find other ways to regulate the emotional flooding, pain and cognitive discomfort. Most difficult for the individual to recognize and deal with are the implicit sensory triggers (smell, touch, facial features, physical gestures etc.) as these can unexpectedly activate conditioned emotional reactions and cognitive distortions and bring to the individual intense, unexplained and frightening discomfort. The trauma survivor who experiences post-traumatic hyper-arousal symptoms, yet lacks affect-regulation skills accesses whatever tension-reducing and avoidance strategies are available to him in an effort to cope. As the individual’s need exceeds his cognitive and affective competencies, the survivor of childhood abuse often resorts to the numbing effects of drugs and alcohol, self-injuries, physical and verbal aggression, suicidal gestures and the largely unconscious retreat into dissociative episodes.

Men suffering from post-traumatic stress were found more likely than women to self-medicate. Since these maladaptive behaviours "succeed" at reducing the individual’s tension and emotional pain, they become the trauma survivor's "preferred" self-regulation and avoidance coping strategies. As such, they are most frequently accessed at the earliest sign of hyper-arousal or discomfort. The over-accessing of these avoidance strategies (i.e. substance use) inhibits the development of adaptive emotional capacities and, over time, obstructs the individual’s ability to function in relationships.

The over-reliance on substances to avoid hyper-arousal symptoms leads to substance abuse and dependence. Thus, when in recovery, the trauma survivor can expect the resurfacing of the very symptoms he was medicating with drugs and alcohol. In this case, the intolerable emotional pain and fear as well as insufficient affect regulation skills counteract the individual’s motivation for change and put him at risk of relapse. In order to sustain recovery, it is important to address the interconnectedness of trauma symptoms and substance use, and improve affect regulation skills.

From a relapse prevention point of view, it is helpful for abuse survivors to first identify trauma related triggers and note how these provoke cravings for drugs or alcohol. The ensuing challenge for them is then to learn affect management skills such as grounding techniques, identifying and labeling emotions, targeting and disputing thoughts related to negative emotions, cognitive reappraisal, behaviour modulation, present awareness and, finally, acceptance. All these strategies could be helpful in preventing relapses and sustaining recovery from drugs and alcohol in trauma survivors.
Lora Bradford is the founder of Lakeridge Counselling & Consulting Services, providing online counselling to youth, adults and seniors in Ontario and across Canada, including consultations on Settlement Issues and Transitioning to a New Environment, to third party agencies. www.lakeridgecounselling.ca Lora is a compassionate counsellor experienced with evidence-based psychosocial interventions for youth and adults struggling with post-traumatic stress, substance abuse and mental health issues. As a counsellor she has supported clients from diverse populations in various ways - from alleviating everyday stress and anxiety to managing mood, behavior and personality disorders.

She is trained in the use of Motivational Interviewing, Adlerian Psychotherapy, Rational-Emotive Behaviour Therapy, Cognitive-Behavioural Therapy, Logotherapy, Trauma-Informed Therapy, Solution-Focused therapy.

She is competent in the areas of conflict resolution and crisis intervention.

In order to meet the clients' individual needs, she uses an integrative approach, drawing from therapeutic models such as Cognitive-Behavioural Therapy (CBT), Psychodynamic Therapies, Transactional Analyses, Dialectical Behavioural Therapy, Motivational Interviewing, First and Second Stage Trauma Treatment Methods.
Where is Home? A Story of Trauma and Dislocation

Andrew Nussey, MDiv, RP

My deep-seated attachment-based trauma first came to a head several years ago with the sudden dissolution of a significant relationship. For the first time in my life I became personally acquainted with grief and its attendant ugliness.

At the time, I knew nothing about “attachment styles” or “selfobject needs”. All I knew was the hopelessness, the disorientation, and the sense of utter isolation I sharply felt—in a single word: pain. All of a sudden I had no reference point for my own self: I was disoriented as if the very rug of my life had been pulled away from under my feet, as if my soul were dislocated not only from my body but from the Universe itself. Here I emphasize the dis part of the words above because etymologically dis means “to split,” and so I wish to make clear the connection between trauma and being “split off” from the centre of my Being (dislocation).

While it is true that I experienced deep anguish, looking back, I see my painful experience as a merciful and much-needed earthquake of love that jolted me awake, beginning for me a process of intentional gradual awakening. This has indeed been a spiritual journey. I read the words of St. Paul in the Bible about waking out of sleep and I recognize myself (see Romans 13:11). Thanks to angels in my midst, I have been guided and encouraged to make connections in my life where they had not previously been made. At this time, I began seriously to see a spiritual director with regularity. I saw a therapist for the first time, too—and I saw her a lot. With no small effort by others, I found a family doctor willing to take me on even though he wasn't officially accepting new patients. I solidified healthy relationships with a diversity of wise and caring people. For the first time, I had a network of caring support. I was not alone. True, I had never been alone—but now I was coming to see and know this for myself.

A few years later, with the sudden dissolution of yet another significant relationship, I became quickly reacquainted with trauma and dislocation. I had thought I had finished with such dire hardships! (Silly me!) I had more waking up to do, and thus phase two of my new life kicked into high gear. A friend who had herself experienced grief not long before, introduced me to the concept of Mindfulness. I meditated. I prayed. I began reading books and actually finishing them—a lot of them. I saw for the first time that the tree outside my window was clothed with vibrant colour. The world became alive.

Supported by the guidance of a diversity of people and angels, I took a giant
leap of faith. I attended an interview in support of an application for acceptance at the Toronto Centre for Pastoral Counselling Education, a program of the Toronto School of Theology at the University of Toronto. I sold my house and my possessions—and what I did not sell I gave away—and moved into a bedroom in Toronto.

That autumn, my eyes began to open wider and wider. I could recognize myself in what I was studying and in what I was doing. It all began to come together and make sense. I knew I was not alone.

Connection. For me, that is the key to it all and the reason for being, itself. I believe we are made for connection in relationships — and life-giving relationships at that. The common wisdom is that we should primarily invest ourselves in experiences and not in things. How true. To me, this speaks to the importance of a relational approach to psychotherapy. It took dramatic disconnection for me to realize connection, and perhaps this has been true for others as well.

Mysticism—seeing and experiencing reality with non-dual eyes; discerning with one's being the hidden unity and equanimity of what is, has been for me a window into an enchanted world previously untapped by my soul. Previously, I had blindly and unknowingly let my ego run rampant. With non-dual eyes, however, I perceive with increasingly clarity a hitherto hidden unity beyond the now-naive and unsatisfying distinctions of black and white, good and bad. Now when my ego (my "little self") gets the best of me, I can more clearly see what it's up to and more quickly return to a centre within me that is more whole and real. I have found home within, and where my soul is centred there it is united with the Great Spirit which is the very breath of my life. In this vein, I would like to end with words much wiser than my own, those of St. Augustine of Hippo from his Confessions:

"Belatedly I loved thee, O Beauty so ancient and so new, belatedly I loved thee. For see, thou wast within and I was without, and I sought thee out there. Unlovely, I rushed heedlessly among the lovely things thou hast made. Thou wast with me, but I was not with thee. These things kept me far from thee; even though they were not at all unless they were in thee. Thou didst call and cry aloud, and didst force open my deafness. Thou didst gleam and shine, and didst chase away my blindness. Thou didst breathe fragrant odours and I drew in my breath; and now I pant for thee. I tasted, and now I hunger and thirst. Thou didst touch me, and I burned for thy peace ... There is One within me who is more myself than my self."

Andrew Nussey is a Therapist and Pastoral Counsellor in private practice. Specializing in person-centred relational psychotherapy and informed by various psychotherapeutic modalities, Mr. Nussey provides therapeutic services to both couples and individuals. In addition, Mr. Nussey counsels indigenous youth and their families who have concerns related to mental health and addictions.

compasscompanioning.ca
Working with Attachment Trauma

Lori Gill, MA, RP

Therapists understand the critical role that attachment, attunement, and quality attention play in everyone’s earliest years. These interactions lay the foundation for brain and nervous system development with 5/6th of our brain growth in the first year relying on attachment interactions, such as being held, rocked, sung to, mutual gaze interactions, and having someone attune to and validate our feelings and meet our needs. Research continues to support the impact of early life experiences on our future relationships and the fact that we are born primed for connection and attachment. At the Attachment and Trauma Treatment Centre for Healing (ATTCH) we truly believe that parents do the best they can with what they know, largely based upon what they themselves experienced, growing up. Gently and non-judgmentally educating people about attachment can be incredibly validating and therapeutic. Teaching them about the brain; what we require for optimal development and what we know of the impact not occur, can help better understand experiences impacted continue to influence.

Many people criticize from one unhealthy This can gently be attachment understand that need, not a want or a relationships directly impact infants’ developing nervous systems, thereby helping children learn to self-regulate, grow and develop optimally, and experience confidence in themselves and their abilities. A secure attachment relationship promotes optimal development of the right brain, affect regulation, and adaptive mental health. Conversely, when an infant experiences extremes of stimulation and arousal of varying intensities (high with abuse, low with neglect) the infant’s emotional needs tend not to be effectively met, resulting in alterations to the biochemistry of the developing brain, particularly in the areas responsible for regulation of emotions and coping with later life stressors.

As a result, caregiver-induced trauma is considered to be more impactful than any other stressor. When primary caregivers are the source of safety and security, this results in regulation. When they are the source of perceived danger, dysregulation occurs. When dysregulation persists, without the learned experience of regulation, children with affect dysregulation will grow into youths and adults who seek out whatever helps them feel better (alcohol, drugs, sex, gambling, cutting etc.). Although their efforts to self-regulate are well-intended, these false refuges unfortunately serve only to provide temporary relief, are often followed by feelings of shame and guilt.

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and do not truly address the underlying issue. Clinicians can help those they work with through education, bearing witness to their clients’ experiences, and helping them to validate what this felt like for them and what they needed to have happen. As a result, clients form new meanings of their experiences, which then promote integration between their emotional and bodily felt experiences, and their thoughts and cognitions.

Helping clients reconnect with their emotional experiences in a titrated and structured manner is a powerful component of healing attachment trauma. Once this has occurred, they can consider what they need, not from a place of blaming those who were not able to meet their needs, but rather from a place of validation and acknowledgement of these unmet human needs. We have a remarkable capacity to offer ourselves the very thing we often seek so desperately from others: love, acceptance, kindness etc. I often use art to help people share their experiences, identify their needs, and offer themselves what they need at the time.

It has been my experience that attachment trauma is one of the most pervasive forms of trauma. We are born primed for connection with our caregivers. When this does not occur, we lack a safe base from which to explore the world and this shapes how we view ourselves and the world around us. When our own parents could not love us, this can create a pretty devastating and entrenched negative self-concept. As people come to understand that not all parents know how important attachment, love, nurture, and attunement are to a child's developing brain and body and that often their parents did the best they could with what they knew, clients are able to depersonalize their experiences a bit and look at it more so from the view of human behaviour and neuroscience. This helps shift some of the shame and self-blame an individual may have been carrying for years, allowing for reconstruction of perceptions and greater compassion for themselves and their experience.

To do this however, clinicians need to have a thorough understanding of trauma and attachment, including how to safely guide clients in reducing the impact of their trauma experiences, forming meaning, and regulating their emotions in a healthy manner. At ATTCH we offer a trauma and attachment certification program that helps clinicians and professionals in various positions learn how to do just this. It is our goal to help educate others to become
trauma-informed and help professionals deliver trauma-specific services in accordance with best practice approaches. What is exciting is that we now understand how powerful therapeutic presence is for promoting healing within the attachment structures of the brain through the brain-body connection that occurs between therapist and client. When the therapist is able to remain attuned, fully present at a right-brain to right-brain level, and hold space for their clients through their calm presence, it makes it possible for clients to wade through the atrocities of their lives in a manner both meaningful and therapeutic to them.

In addition to being therapeutic for the client, this is also important for the therapist and plays a role in preventing compassion fatigue. Present and embodied therapists also notice when they are activated by a session and are better able to tend to their own needs.

Trauma-informed work involves providing non-judgmental and compassionate support to those who have often survived unfathomable trauma. Humans have remarkable resolve and when people are vulnerable enough to reach out for help we need to do our best to help them become more attuned, embodied, authentic, and empowered — all the while keeping in mind the importance of self-care and self-nurturance for ourselves as helpers. This includes externalizing that which is not ours and consciously reflecting on the wonderful gift that we as helpers can be to those we support. We make a difference and the work we do is meaningful.

Lori Gill, B.A., M.A. is the founder and lead trauma therapist of the Attachment and Trauma Treatment Centre for Healing (ATTCH). She is a Registered Psychotherapist, Certified Trauma Specialist (CTS), Consultant Supervisor, and Trainer, for the National Institute for Trauma and Loss in Children (TLC) and a former Psychology Professor. Lori maintains membership with the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists (OACCPP) and has over 16 years of clinical experience working with children, youth, and adults. Lori has held various professional positions working with addictions, mental health, child welfare, access to services, school counselling, and eating disorders.
Every therapist knows only too well that helping a client resolve a trauma can be a challenging and delicate process, demanding skill, discernment, patience and focus in order to bring about real change and healing. Since its inception in the 1990s, EMDR (Eye Movement Desensitization Reprocessing) treatment has become one of the top evidence-based treatment modalities for both 'large T' and 'small t' trauma. Despite a rocky beginning in which scientific studies criticized it and many therapists questioned its true capacity to create meaningful change, EMDR is now used worldwide as a trauma resolution therapy, its efficacy well demonstrated by evidence.

Training in EMDR is highly structured. Each step of the protocol is undertaken with precision and attention; the stages follow one another in a comprehensive sequential pattern, never skipping over something nor proceeding until the client has shown demonstrable movement in his or her emotional processing. It would be accurate to describe the process as painstaking. When undertaken with care, every step in the protocol creates a thread of experiences emanating from the client's mind to reveal that previously buried trauma is being accessed. When the therapist navigates this process carefully, the client can begin to re-experience the unfinished trauma. According to the early literature on EMDR, buried traumas exist due to the 'unexperienced experience' which seeks completion in order to be released from the emotional centers in the right hemisphere of the brain.

I undertook the basic training certification in EMDR in 2011. Later, I completed a course in Advanced EMDR in 2013 which focused on Complex PTSD-DDNOS-DID (Post-traumatic Stress Disorder/Dissociative Disorder Not Otherwise Specified/Dissociative Identity Disorder). I have been using this treatment modality with increasing frequency over the past five years to great success and I now find it to be an exceptional tool for most of my psychotherapy clients. I would go so far as to suggest that, as a mechanism for accessing and resolving historical trauma, EMDR is unrivalled.

What does a typical session of EMDR look like? Before commencing with EMDR treatment, a comprehensive Attachment and Trauma History is taken to ascertain the client's suitability for treatment. That done, a typical session of EMDR involves choosing a particular event on which to focus in order to bring the trauma to the surface for processing, invoking
bilateral stimulation of the hemispheres by using side-to-side eye movements. (Other bilateral options include tapping and generating sounds in an alternating pattern.) Using her hand, the therapist asks the client to follow from left to right for several repetitions at various speeds. This eye movement creates an opportunity for the brain to release stored trauma, allowing the client to experience the full effect of emotions possibly aborted prematurely at the time the trauma took place. It unlocks and releases information stored in the nervous system, allowing the neural network to heal. There is great variation with each client but this back-and-forth hand movement, followed by the client’s eyes, might occur 20 or 30 times in one session.

As I developed my skill with this form of treatment I witnessed its potential, seeing the profound effect it exerted upon the un-experienced trauma as it was unearthed from its hiding place and exposed to the light of day where processing could finally happen. In working with this treatment, one observes the extraordinary capacity of the brain to hide information from itself, apparently for protection, concealing information via the flight/flight/ freeze response from the one who experiences the trauma. It is as if the emotional response to the trauma must be controlled at all costs; the brain ‘will have none of it’ and creates a neural black hole into which this incomplete emotional response is swallowed up - locked in never-never land. There it remains, frozen in time yet endlessly giving off the energy of its presence like the ripple effect of a stone skipping across the water. Emanating throughout the client’s life in myriad ways, it makes its presence known by the not-so-silent screams of addictions, mood and personality disorders deriving from early childhood trauma, as well as other signs of arrested emotional processing. The emotions connected to unprocessed trauma are not usually available to the client’s awareness but the intra-psychic pressure generated by the unfinished processing cycle pushes the individual towards those all-too common defenses in order to keep it at bay. The disconnect remains buried: out of sight yet never out of mind. The power of this unfinished event carries itself across a lifespan, giving rise to repetitive symptoms demanding suppression through dysfunctional behaviours.

My experience over time using this modality has allowed me to discern subtle changes in the client’s processing system during the session. There will often be subtle but extraordinary evidence displayed by the client that, although barely discernible, shows trauma starting to arise into consciousness, allowing itself to be felt, processed and released. I observe slight changes in skin coloration, body shifts or subtle movements that would otherwise seem irrelevant; movement behind the eyes seemingly independent of those germane to the treatment process. It’s as if there is a second level of eye movement going on behind the left-right repetitions of the protocol. It is extremely subtle and barely observable to the naked eye but remarkable once I see it happening. I have come to know this subtle background eye movement or barely detectible ‘humming’ that happens as a sign that a shift is occurring in the client’s emotional processing of the target being worked on in that moment. It is astounding to observe the profound workings, normally hidden from view, of the mind. I can actually follow the laser-like auger of the modality as it pierces the defenses of the emotional body and releases the client from the stranglehold of the buried trauma.

There is an additional component required for success in using this treatment — the therapist herself. Exceptional success comes once the therapist has developed a high degree of sensitivity to these subtle nuances the client reveals during treatment. If the therapist doesn’t tune into these signs, he or she won’t be able to seize the moment
when change is beginning to occur and the potential of that change can be lost to the client. It happens so quickly it can easily be missed. EMDR will pull traumatic effects to the surface by way of the eye movement or other bi-lateral stimulation during the treatment, but the extent to which the therapist is keenly attuned to the signs being revealed on the meta-level of the client’s mind determines how proficiently the therapy works on a given trauma in a given moment, thereby having an impact on the overall success of the treatment.

The therapist is not incidental to the efficacy of this treatment. If we believe in the importance of what we are seeing and pay attention to the minutiae we can transform the exceptional capacity of this treatment for, dare I say, miraculous outcomes. When we move from being skilled and proficient in EMDR to becoming highly precise in our attunement to its subtleties, we can elevate this treatment into an art form.

I have had the privilege to witness much healing and resolution of trauma with EMDR. The process often leaves me in awe, aware of the enormity of what I am participating in with my clients. EMDR demands that we believe in the capacity for change in human beings, trust in the truth of its sound premise and are willing to ‘bushwhack’ through consciousness for the sake of the client. In addition to these necessary components as a therapist, I believe EMDR requires an unwavering belief in the ability of the human mind to create health, wholeness and a peaceful emotional life. Most importantly, we know the mind has a wisdom all its own that will guide us in its effort to heal itself. I stand firm in believing these things, for myself and for all the clients with whom I have worked.

Brenda Whiteman, RSW
May 20, 2016

Brenda Whiteman practises psychotherapy, is a counsellor and registered social worker in private practice in Peterborough, Ontario. Her background includes primary health-care settings, children’s mental health agencies, public and private educational milieux as well as writing for newspapers and professional journals in the field of mental health. She is currently writing a book on child-rearing and personality development.
Psychotherapy After the Motor Vehicle Collision:

Some Freely Expressed Observations
Maryna Svitaseva, PhD, RP

Looking around, we see different kinds of people: young and old, men and women, wearing pants, skirts and so on. Typically we don’t think about yet another possible classification: people who’ve never had vehicle accidents and people who have. In fact, only those in that second group know how radically life can be changed by even a minor motor vehicle collision.

Pain is one of the consequences — often severe pain in muscles and joints. It doesn’t allow sleep; it interferes with every single minute of the person’s life; it causes low mood and it often brings about social withdrawal. The reasons for that pain may not be visible. Hence, relatives and friends may have real difficulties understanding the suffering their dear one is experiencing. Even a minor car accident can seriously affect a person’s connections with others.

In addition to the physical injury, the behavioural and emotional consequences from the motor vehicle accident may be extensive. Many drivers say their driving changes. They lose confidence, refuse to drive on highways, prefer not to change lanes if possible, have spates of anxiety when passing the place where the accident happened, obsessively check their mirrors and so on. Some people refuse to drive at all (at least temporarily). Often, together with anxiety and general tension, come symptoms of depression: lack of energy, loss of interest, avoidance of sex, irritability, poor sleep (not only due to pain), etc.

Hypothetically, the worse the accident, the more significant the psychological impact may be. However, I’m daring to say that this is a myth. Providing people who’ve suffered a motor vehicle collision with psychotherapy at the rehabilitation clinic, I’ve noticed no clear correlation between the severity of the accident and the severity of the mental and emotional consequences. Some people develop serious depression symptoms after their cars are hit in a parking lot or at a red light where no high speed is involved. I talk to other people with totally different experiences. In the latter case, they almost “flipped the car onto its roof” (due to somebody else’s faulty driving); felt seriously stressed; then “shook it off” saying “things happen”, and then they moved forward. Motorcyclists, for instance, rarely quit riding their motorcycles even if they’ve barely survived a collision.

You may say that individual traits determine the reaction. I would agree. Similarly, some cognitive stereotypes and introjections actively ‘participate’ in
the processing of the motor vehicle accident experience. Some clients really struggle to accept the experience of an accident if they believe that “nothing wrong will happen to me if I do everything right” or “everything is up to me”. These beliefs don’t work — at least not when driving. It is clearly dangerous not to factor in the attitudes and mistakes of other drivers.

There is one more observation I would like to share. When the psychotherapeutic relationship achieves a stage of real trust, the client becomes able to explore the emotional content of that moment when the collision occurred. People say, “it happened so fast,” but together we try to stretch the memory’s imagery, like decelerating a movie. Then, more details emerge. Typically, the drivers, passengers or pedestrians who develop depressive symptoms following a car accident identify that moment of feeling “in danger for their life” as accompanied by the thoughts “I’m gonna die right now”, or “that’s it”.

My question “Have you survived?” causes the clients a perplexity I cannot compare with anything else. As a Gestalt therapist it is easy for me to imagine the general psychotherapeutic strategies I might apply, starting with work on awareness that the client’s death “has not come yet, and you are alive”. I emphasise “here-and-now functioning” and mindfulness procedures in relation to the current client’s life as my main therapeutic interventions. It may seem strange, but when working with the depression and the anxiety caused by car accidents, I ask clients about their interpersonal communication, their daily routines, parenting issues, bosses’ caprices, etc. It all helps.

There is another kind of scenario: when the psychological consequences of the motor vehicle collision less obviously connect to pre-existing issues. I don’t mean pre-existing conditions. I mean where the stress caused by the collision actualizes unresolved issues that took place long before the accident. Surprisingly, work on these “pre-accident” difficulties can often be worthwhile. I don’t have to be attached to the “car accident topic” in order to provide clients with the help they need in dealing with their unfortunate collision on the road. I like to repeat: “The better you understand yourself, your feelings, reactions and relationships, the better you will drive”.

Maryna Svitasheva, Ph.D., is a registered psychotherapist in two rehabilitation clinics in Toronto and in private practice. She has been providing psychotherapy for diverse groups of clientele since 1997 after she was graduated from the Moscow Institute of Gestalt and Psychodrama and made her Doctoral dissertation “Functional direction of the Psychological Defence in Ontogenesis”. Maryna’s professional experience includes using a number of different therapeutic methods (CBT, Psychodrama, Art Therapy, Family therapy), teaching psychotherapy and general psychology. Meanwhile she represents herself mainly as a Gestalt therapist.
To define and understand the practice of meditation, can be there a better explanation than what Bhagavad Gita, the ancient Hindu Scripture, has to offer? It describes the process and benefits of the meditation technique as follows:

Shutting off the senses from what is outward, fixing the gaze at the root of the eye-brows, checking the breath-stream in and out going within the nostrils, holding the senses, holding the intellect, thrusting fear aside, thrusting aside anger and putting off desire. The Bhagavad Gita further says, truly, that the human being who can practise the above consistently, is made free forever. (https://en.wikipedia.org/wiki/Jangama_dhyana)

It is quite another topic for discussion as to what becoming free truly means. While there is a lot of material in circulation, simply put, meditation is nothing but focusing one's attention intently on an object such as one's breathing or a candle flame or other environmental element. There are different approaches, including the currently very popular Vipassana Meditation, supposed to have been practiced by Gautama Buddha himself.

To my mind, meditation involves directing or thought process — if not the focus of attention that all other one's consciousness like a monkey is a much world. Just as a monkey so does the mind keep to another. Such obviously does not come form of psychological repression at times, circumstances.

systematic practice of ability to keep the mind

With the regular and meditation, the practitioner's focused on one object does improve significantly over a period of time and the benefits such as: clear thinking on issues, the ability to concentrate better, sustained motivation to carry out tasks, maintenance of equanimity, self-control and keeping one's emotions in check etc. are all clearly felt.

For expert practitioners of meditation, the experience is believed to be somewhat like consciousness transcending the material plane and reaching beyond into what I am inclined to define as the spiritual sphere. It is claimed by the Yogis that, at that level of practice, consciousness essentially bypasses the intellectual and cognitive states and enters the spiritual state. A realization of enlightened awareness of the universe and of one's own place in it becomes possible in that condition, supposedly.

Swami Vivekananda took the world by storm, expounding Hindu religious precepts to the Western world with his electrifying speech at the 1893 World Parliament of Religion in Chicago. He became identified as a ‘Messenger of Indian Wisdom to the Western World.' He could meditate nonstop for days together without food or water, it is said. The power of the mind he was believed to have developed was such that he could finish reading a 1000-page book within a few hours and answer questions about any page with clear precision.
For a novice practitioner, it is enough to understand that even at elementary levels of practice, meditation can be quite beneficial in helping maintain inner peace and tranquility in one's day-to-day existence. Meditation, even for a short duration every day, helps the practitioner maintain mental equilibrium and induces a positive stream of thoughts and motivation, providing mental energy for whatever one sets out to accomplish.

Professional trainers and behavioral coaches oftentimes advise their clients to take deep breaths during stressful moments. The idea is that taking a deep breath helps to relax the client, steady the mind and encourage rational and cool thinking. This clearly corroborates with the stated positive spinoffs of the meditative process, which also begins with streamlining one's breath and encouraging smooth exhalations and inhalations. The notion that meditation has to involve a rigorous systematic practice is misplaced. In fact, starting off meditation with such an expectation upon oneself may only compound one's stress.

It is interesting to note that group meditation has been successfully introduced as an experiment into some jails in India, helping to cool the highly volatile prison environment and bring about peace and tranquility in the prison population.

In a different context, observing the practice of worship in various religions, I cannot help wondering if this not a meditative process, though the stated purpose may be different, say, paying obeisance to a superior power and inculcating a humble attitude in the worshipper. But the insistence that the focus has to be on God in a religious setting perhaps has a more substantial hidden purpose which could be to help calm the mind of the worshipper and help bring about conditions conducive to universal peace.

Tailoring the meditative process to suit psychotherapy's objectives could indeed be a tricky exercise and possibly detrimental to the client's interests if not handled properly. It is absolutely imperative that the counselor's assessment of the client's suitability and capacity to absorb the principles of meditation and practice be very accurate. The challenge I see in suggesting meditative techniques to the client is that it is a solitary process whereas counseling is a two-way process. While the principles and methods of meditation can be shared with the client, the client has to try it out himself without external support. How comfortable might he or she be, practicing it, and how might it impact the client, aggravating pre-existing difficulties, if meditation is not practised under supervision?

In sum, meditation may prove beneficial for many clients, including those suffering from PTSD or other forms of trauma, but it would be prudent to fully assess the possible range of responses, and any inherent risks, for all clients ...

Shankar Swaminathan is a Mental Health Professional with India Rainbow Community Services of Peel, Mississauga since 2008 counseling and supporting clients with Mental Health Issues. Shankar has also been in part time private practice extending counseling support to clients on Marriage, Family and Employment related issues besides Mental Health through his website speakurmindcounseling.com. Earlier, in India over two decades, Shankar has been actively associated with the non-profit organization, Nandini Voice for the Deprived in the city of Chennai, serving the cause of the disabled, economically and socially disadvantaged and clients with Mental Health Issues. He was also the editor of the monthly journal promoted by the non-profit organization championing various social issues and causes besides representing the organization in various forums including mass and visual media making presentations on important issues from time to time.
One day walking along the beach, I came across a tiny bird's nest. Wispy and somewhat fragile, the nest appeared to have been placed with great care and respect on a bench. It was as if someone had meant for the nest to be seen – perhaps even seen by me. As icy raindrops began falling, I left the little nest behind and continued briskly onwards along the path. When I circled back towards home I noticed the little nest had not been claimed. I gently placed it underneath the bench, hoping to protect it from the downpour. Clearly the nest and I had made a connection.

Later that day when I was back in my studio, the little nest resurfaced in my thoughts and would not let me go. I drove back to see if it had survived the rains or had been claimed. It was still there: soggy, tired, worn and in the process of fragmentation.

I cradled the nest in a protective paper cocoon, took it back to my studio, set it carefully on a shelf to dry and made a home for it. For weeks I imagined and played with all the possible ways to artistically transform this once very soggy and still broken nest through art processes such as assemblage, painted gold, preservation in wax. However, I sensed that the little nest just wanted “to be.”

Allowed the space to become itself once again, the nest seemed encouraged to grow stronger. Its various twiggy parts dried and became nestlike again. I felt privileged to witness this process of reintegration from a fragmented assemblage of soggy twigs into the strong and whole little nest it once was. Simply looking at this newly reconfigured nest (made by an expert nest-maker) inspired in me the possibilities for new directions in my own work.

As an Art Psychotherapist I frequently witness a similar transformation of my clients' experiences of trauma during our therapy sessions. Many traumatized clients find it difficult to express what they feel. But many are able to use various forms of the expressive arts as vehicles to externalize unthinkable, unformulated and
preverbal experiences of trauma, allowing them to go to places deep inside themselves where they often have no language or words to express what they feel. When clients are allowed the space to start where they are, to go at their own pace in order to feel safe and grounded, they are more able to use their own creative process to transform traumatic experience into their own narrative weaving words together into a nest of meaning.

Susan Leopold MA, MPS, MSW, is a Registered Psychotherapist, an award-winning illustrator, visual artist and educator, who became interested in the therapeutic benefit of expressive and creative therapies for diverse populations. She is particularly interested in working with complex trauma. Leopold completed her MA at UCSF, her Masters Degree at Pratt Institute (M.P.S.) and her MSW in Clinical Social Work at Smith College. She has over six years of clinical training including: Catholic Family Services Toronto, York University Personal Counselling Services, Toronto General Hospital (UHN) and the Hincks Dellcrest Centre for Childrens Mental Health. She has extensive direct experience and training working with diverse clients (age, culture, race, gender, sexual identity) facing many personal life challenges, and providing services to individual adults, children, youth and their families. At Hinks Dellcrest, she provided creative/expressive and play therapy to children and adolescents in residential treatment, gained broad knowledge of community resources for children and youth. In addition, her Hincks Dellcrest experience included collaborative work with Trauma team, treatment services, Assessment, Individual Art and Play therapy, Family therapy and Group work with parents, children and adolescents. She maintains a private art therapy studio in Toronto, where she works relationally with clients, using a variety of creative approaches such as: creative arts therapy, play therapy, sand and other expressive arts therapies.
Almost all of us have developed tools to handle trauma because it is almost inescapable during a lifetime. Traumatic experiences resonate differently with each individual because we create our own perceptions of events. For example, in one family, the loss of a loved one can create pain, suffering and depression, whereas in another it may give peace to know the loved one is at rest. Perceptions of events, duration of exposure and frequency are very important factors to consider when assessing the severity and treatment of traumatic exposure. If a client has been physically or sexually abused for months as opposed to suffering an isolated incidence, this will significantly impact perception of events. Often, trauma experienced by one person can leave a mark on the entire family. Someone who has experienced a sudden jolt of trauma may appear to go from a fun-loving, caring and funny extrovert, to a sad, angry and displeased introvert. A spouse, parents, siblings or close friends may then feel the subsequent impact through a change in their loved one’s behaviour.

Trauma is one of my areas of specialization and I usually start with a full assessment when someone requires treatment. I use the Trauma Symptom Inventory (TSI-2A) which “assesses a wide range of potentially complex symptomatology, from PTSD, dissociation and somatization to insecure attachment styles, impaired self-capacities and dysfunctional behaviours. Trauma can impact someone in a variety of ways, so having an accurate assessment helps when formulating a treatment plan. This assessment also tests for measures of suicidal ideation, that I believe to be imperative when working with trauma survivors. One measure that often shows elevation from the TSI-2A is the category of Tension Reduction Behaviour (TRB). I find this an important area of focus because most people tend to develop their own coping techniques following a traumatic event and in so doing often make poor choices. Some people experience very low levels of dopamine and serotonin shortly after their traumatic experience. To compensate for this, they may end up gambling in a casino for hours or turn to drug use. Each person has different forms of TRB which I thoroughly explore and help to readjust if necessary.

The diagram below explains the process of trauma from start to finish. The initial stages may include shock, denial, anger and frustration, fear, depression, health issues, repression of feelings, anhedonia etc. The diagram suggests some of the possible symptoms associated with trauma. Following these reactive negative events, we see a peak of depressive symptoms. This is where we begin to shift perspective and start to re-balance. This process may occur from intense therapeutic
intervention or a shift in awareness after the ‘trauma dust has settled.’ Once this occurs, a period of resiliency begins where we build ourselves back up through a transition of tolerance, forgiveness, humour, mindfulness, increased empathy, increased self-regulation etc. and finally achieve a phase called sublimation. Ideally, each person reaches this phase following a traumatic event. This is where our focus shifts towards ways in which we can use our experience of this traumatic event and turn it into something positive (raising awareness, participating in charity fundraisers, public speaking, helping others, and so on). The timespan for this transition, from start to finish, can cover two years or more.

This illustration highlights the impact of a traumatic event and our emotional responses from beginning to end:
The body and mind are extremely resilient by nature and we are almost never faced with more than we can handle. Ultimately, traumatic events, difficult as they may be, tend to shift our awareness and broaden our perspectives. As the saying goes ‘the greater your storm, the brighter your rainbow.’ Although trauma may be painful in every way and seem impossible to get through, we can somehow manage to end up on the other side of it all, in better condition than when we began.

*Sasha Campbell has a Masters Degree in Counselling Psychology and is currently under supervision working towards the requirements of a Psychological Associate. She operates her own practice in Etobicoke and downtown Toronto. For more information on Allegro Counselling visit www.allegrocounselling.com*

*Illustration courtesy of Amanda Weckwerth*
Traumatic Incident Reduction (TIR) is a client-centered approach that I like because it is usually very effective in a short amount of time. It allows me to get out of the way so the client can find her own solutions — often ones I could not possibly have thought of. They work for the client because they are her own.

TIR, when applied correctly, diminishes or eliminates the negative impact of traumatic events for most people, making it an excellent choice for treatment of trauma. It is a time-efficient, one-on-one method in which the client repeatedly recalls a traumatic memory under the guidance of a trained practitioner in a safe, secure situation with no distractions.

The person who delivers TIR is called a facilitator and the person receiving TIR services, the viewer. The facilitator is highly trained to provide a safe environment and ask the specific guiding questions germane to this method. She helps the viewer through the procedure by keeping the structure of the session intact and giving the viewer a clear task to do at all times. By finding and repeatedly viewing a painful incident, the viewer comes to see it in different ways and in much more detail. Ultimately, the viewer experiences a change in feelings and attitudes and often has some new insight that relieves him of the heavy burden he has been carrying. The result of well-delivered TIR sessions is that the viewer feels empowered and can face his life with renewed confidence.

TIR offers techniques to fit specific situations. Unblocking, for instance, is used to address challenging people, things or situations. It consists of a set of carefully worded questions that are put to the viewer repeatedly. Each question is asked repeatedly until the viewer has no more answers. This is done for a list of 20 questions, or until an end point is reached when the viewer brightens up, and reports a new feeling, insight, decision, or plan.

Jane was the victim of a sexual assault, and it left her experiencing difficulty with relationships, particularly with males. She came to me for help regarding her relationship with her boyfriend. As we went through the questions, I heard a litany of negative things about him, so expected her to reach the decision that he wasn’t the right person for her. However, she suddenly brightened up and said she realized that what she was saying was all negative while there were, in fact, many wonderful, positive things about him that she could choose to focus on instead. She realized that the negatives were things that many couples needed to work out together, and she went off happily to work things out with him.

The repetition of questions allows clients to go deeper than the usual “social script” they typically employ to remain insulated from their emotions.

It is important to prepare the client well before beginning TIR sessions so the client knows what to expect. In unblocking, the process can feel weird at first, so I give the
client a trial run to help clarify the tasks of viewer and facilitator. The subject chosen for a trial run might be “driving to work”. The facilitator might then ask the viewer, “Concerning driving to work, is there anything that has been suppressed?”

The viewer would respond with whatever came to mind, and when she indicated that she was finished, the facilitator would acknowledge the response with words such as “Thank you” or “OK” and then repeat the exact same question: “Concerning driving to work….” This would continue until the viewer indicated that she was finished with that question. The facilitator would move on to the next question: “Concerning driving to work, is there anything that has been invalidated?”

The repetition of the question, and the complete lack of response from the facilitator other than to listen carefully and acknowledge the response, gives the viewer time to really be with the questions and her answers until she arrives at her own insights or decisions. In the case above, Jane came to realize she was focusing on the negative aspects of her relationship with her boyfriend. Those aspects were not really serious and she could return to focusing on the positive aspects of him and their relationship and, like most couples, work on making it better.

If a viewer asks the facilitator for an opinion about the situation or what the viewer has said, the facilitator turns it back to the viewer with a comment such as, “I think it is more important what you think about it.” Thus, there is no discussion, only careful attention to what the viewer is seeing, thinking, feeling or saying.

I was working with a woman who had endured years of sexual, physical, and emotional abuse during her childhood. We had done some sessions of unblocking as well as some traditional TIR about specific events. She kept putting off addressing her mother, fearing that it would be too hard. In TIR, we only address items the viewer is interested in addressing at the time. The day finally came when she arrived telling me it was time. She was clear that she had been putting it off, but knew she had to face it. As we began, she was amazed that it was not very hard at all. Through many of the sessions we had already had together, she had already gotten rid of most of the “charge” about her mother, so it was easy to clean up remaining issues. Our total time together was 12 hours.

Central to TIR is the concept of Charge which refers to emotions linked to traumatizing incidents or persons. When we experience physical or emotional pain, we can either experience it fully and deal with it or try to block its impact. Humans have many ingenious ways of suppressing feelings in order to get on with life.

Unresolved and unexamined past negative events take up energy, keeping part of ourselves anchored in the past; energy that could otherwise be spent living life fully in the present. When that happens, any event that reminds us of the original trauma, whether consciously or subconsciously, can trigger the same feelings.

(With respect to a war veteran suffering from PTSD, fried chicken might remind him of Aunt Millie who makes great fried chicken. Aunt Millie may have been at the May 24th fireworks display which reminded the vet of being in a war zone where bombs landed near him. This memory, in turn, triggered a flashback of the bombing experience, followed by a panic attack. Now, the smell of fried chicken induces the same panic reaction (but not the flashback). Yet the vet has no idea why (as the fried chicken, symbolically, is one removed from the primary or root trigger). TIR can take the client back through the web of associated events until the origin is found and the emotional charge removed. After
that, the original memory becomes just that: a memory, but not one that will trigger a panic attack. All subsequent triggers linked to that original event are also de-triggered.

TIR is used to address known events in the viewer’s life suspected of being the source of negative feelings. This includes viewers who have suffered trauma, significant loss, serious illness, or a life event holding them back from living fully. That known event may or may not be the actual root of the problem, so the facilitator needs to address one event at a time until the root is uncovered and the charge removed.

TIR also addresses those unwanted feelings, emotions, sensations, attitudes, or pains when clients are unaware of their source. For example, a client who experiences panic attacks when forced to remain in a small space for a period of time, such as an airplane, would be asked to describe the way it feels to him, and then find a time when he had that feeling. Once the incident has been identified, the viewer is directed to find the time when that incident began, and the time it ended, and describe what was going on when the incident began. The viewer is then directed to go through the incident silently, viewing it from start to finish. Then he is asked to tell the facilitator what happened. Each time the viewer finishes describing what happened, the facilitator acknowledges the response then directs the viewer to go to the start of the incident again, view it silently, and tell what happened. This process continues to an end point where the viewer indicates he has reached a decision, feels better, or sees things in a more positive way.

Sometimes the facilitator will need to ask or direct the viewer to find earlier or similar incidents until the original trigger is found and the charge removed. One client frequently experienced panic attacks even lying in bed, thinking about being in an airplane, and the triggering incident was discovered through TIR to be a childhood incident in a cave.

It is not uncommon for viewers to go through feelings of great sadness, panic, or distress as they relive their traumatic experiences but once they have fully confronted the incident, the charge is gone, and with it, the associated negative feelings.

In my personal practice, I have used TIR with clients who have dyslexia, ADHD, and autism — clients who are not always good subjects for traditional, reflection-based therapies. TIR is solidly based on the foundational work of Sigmund Freud and Carl Rogers. It was developed in the 1980s by Dr. Frank Gerbody. TIR forms part of the broad subject of applied metapsychology. Training to become a certified TIR Facilitator is readily available in Ontario near Barrie. TIR Facilitators are certified by Applied Metapsychology International. Contact Margaret Nelson, TIR and LSR Senior Trainer at www.margaretnelson.on.ca

For more information, go to www.tir.org

Cathy Dodge Smith has 50 years of experience in special education and psychology. She is the owner and Director of ADD, Dyslexia & Autism Associates Inc. in Oakville. During her career, Cathy has worked as a teacher at elementary school, community college, and university. She has a master’s degree in vocational guidance with a specialty in learning disabilities, and a doctorate in human development and applied psychology. For five years she was the Chair of Services for Students with Special Needs and the Deaf Education Centre at George Brown College in Toronto. She is a registered psychotherapist, practicing Traumatic Incident Reduction therapy. Cathy’s many books and published articles have been praised by parents, professionals, and dyslexic adults. Her work as a volunteer includes many positions, including as president of the Learning Disabilities Associations of Quebec and Canada, and on the selection committee of the Canada Volunteer Award Program (after she was a recipient of that award as well as the Canada 125 Award).
On a Lighter Note...

Allan Hirsh, MA, RP, Cert(OACCPP)

Allan Hirsh has a Bachelor of Science Degree from McGill University and a Master of Arts Degree from the University of Saskatchewan. He is a registered member of the College of Registered Psychotherapists of Ontario. He has been in private practice in the North Bay area for over 30 years.
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Dr Fennell is a Founding Fellow of the Oxford Cognitive Therapy Centre, established in the early 1990s. More recently, with Professor Williams, she designed and co-directed the Oxford MSc in Mindfulness-Based Cognitive Therapy. She has led workshops for more than 30 years, not only in the UK but in many other countries all over the world. Her workshops bring together theory, research and practice. They are always well-targeted, evidence-based, practical and delivered with her characteristic warmth and sharp wit.

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