

ACEP Certification Module 13: Client Trauma Care Skills & Resources for Certified Energy Health Practitioners

Introduction to this Module:

One of the great contributions of Energy Psychology is its use in helping people overcome post-traumatic suffering. The discovery of a method that can rapidly and humanely help relieve this suffering prompted many thousands of people to explore Energy Psychology. Indeed, from the outset, reports that even severe and long-term post-traumatic stress disorder (PTSD) symptoms could be alleviated in a single energy psychology session attracted great interest among mental health professionals, allied practitioners and lay people.

Currently, thousands of people around the world have benefited from CEP treatment. Clinical reports of deeply moving, successful treatments abound, and research studies are now appearing to support these outcomes.

Another significant advantage of CEP is that many methods are easily learned, easily taught, and can be used successfully for self-treatment. This means that virtually every member of the human community will soon have access to these wonderful tools. Much as we live in a time of increased fears of mass trauma, we are blessed to be developing tools for large scale-health.

It would appear on first glance that given the apparent effectiveness of CEP that the treatment of trauma would be relatively straightforward. While this is certainly true some of the time, it is not always so. Peoples' responses to trauma are remarkably varied. Truly, each person reacts in a unique manner. Many PTSD sufferers are ready, willing and able to move out of their pain and re-enter their lives free from their past burdens. But many are not. For some, recovery from even a single, limited, traumatic event is not a simple endeavor.

The purpose of this module is first to provide you with a strong foundation regarding the nature and impact of traumatic reactions, and second to educate you regarding the basics of sound decision-making in trauma treatment using CEP methods. Finally, the information in this section will help you assess your limits regarding the treatment of trauma and thus know who you can help and who you should refer to another more experienced colleague.

Combined on-line and workshop Learning Objectives:

- **Name 3 components of the definition of a trauma**
- **Be able to name the 5 categories of acute trauma symptoms**
- **Identify 3 key symptoms of PTSD**
- **Define 6 categories of trauma (simple, complex, relational, secondary, vicarious, communal)**
- **Identify 8 issues central to understanding PTSD**
- **Be able to name the 4 stages of trauma treatment**
- **Identify 3 key clinical issues in trauma treatment**
- **Identify 2 essential personal issues in trauma treatment**
- **Identify 3 requirements for doing CEP trauma treatment**
- **Identify 4 situations that may make CEP treatment of trauma contraindicated (includes legal issues)**
- **Name 3 trauma conditions that will require referral to a specialist.**

How are the on-line and workshop material related?

As currently designed, the Client Care & Facilitation Skills workshop involves this on-line module and a one day in-vivo workshop. This supplemental trauma module assumes that you already are extremely familiar with the foundations of CEP treatment that were covered in basic CEP on-line and in-vivo course. We will devote no more than two hours of the in-vivo workshop to the topic of trauma treatment. These two hours will be spent highlighting the key issues regarding trauma treatment, and going over clinical examples. Therefore, it is essential that you study this material carefully and **BRING IT WITH YOU** to the in-vivo workshop.

Content Outline:

- I. Trauma: nature, definitions and clinical picture
- II. Treating Trauma: Clinical Considerations
- III. Treating Trauma: Personal Considerations
- IV. Treating Trauma: The CEP approach

Module Credits

The Client Trauma Care Skills & Resources for Certified Energy Health Practitioners module was produced by Larry Stoler, Ph.D., Mary Sise, CSW and Lynn Karjala, Ph.D. and edited by Gregory Nicosia, Ph.D. All information herein is provided by permission of these authors for the express purpose of being utilized in ACEP's Certification Program.

MODULE CONTENT:

I. Trauma: nature, definitions and clinical picture

Background:

Today, we live in a world where the reality of psychological trauma is more openly acknowledged. Moreover, the media informs us--essentially traumatizing us--about many different kinds of traumatic events, including wars, terrorism, murder, rape, plane crashes, and other accidents, as well as natural disasters like tsunamis, hurricanes, earthquakes and fires. Trauma is a topic of serious academic research. There are many trauma clinics around the U.S. And the existence of a professional organization, the International Society for Traumatic Stress Studies, is an indicator of the widespread interest in understanding trauma.

It wasn't always this way. Historically, the link between what we now term post-traumatic reactions and the originating traumatic incident was not always recognized. However, with the increasingly devastating weaponry and savage fighting of WWI, the phenomenon of combat soldiers who were not physically wounded, yet suffered breakdowns and could no longer fight, came to be known as shell shock. Vietnam era soldiers, however, who had similar problems were diagnosed as suffering from PTSD. It is now generally understood that a soldier's PTSD is related to exposure to extreme violence, and that it can occur in someone without a history of previous mental illness.

Given that exposure to combat has been shown to produce PTSD, it would be natural to think that most soldiers involved in combat will have PTSD. Yet, that is not the case. Current research suggests that about 9% of soldiers returning from deployment in Iraq have PTSD. This number is somewhat misleading as the percentage of PTSD increases the more incidents of active combat a soldier experiences. Also, the real extent of PTSD is likely to be considerably greater because PTSD can continue to develop after a soldier leaves the combat zone, and because soldiers under-report their symptoms. Two conclusions emerge from this data: first, many thousands of soldiers will suffer from PTSD as a result of their experience in Iraq, and second, most soldiers are psychologically resilient and are able to adapt even after exposure to terrifying, life threatening circumstances.

This latter observation is true with every traumatic circumstance. Human beings are remarkably resilient. Most people experiencing most traumas will return to normal after a relatively short period of physiological and psychological disruption.

Why this vagueness? Why can't we say with more certainty what kinds of traumatic circumstances will lead to PTSD? The answer to this is that traumatic circumstances differ in significant ways from one another, and every individual and the social context of each trauma is unique. Moreover, in more complex cases, it isn't always easy to know whether, or even if, the client's traumatic history is most responsible for her/his present difficulties.

Defining Trauma: Acute Traumatic Reactions

We now know that when someone directly experiences or witnesses an event that could be life threatening or could lead to serious physical injury that a time-limited reaction referred to as an acute traumatic reaction is common. These reactions also frequently occur among policemen, fire fighters, emergency medical staff, and other first responders, as well as people who are witnesses to traumatic events. They are also seen among people who are related to victims or who hear about the traumatic incident.

The immediate signs of an acute traumatic reaction can be broken down into five categories: physical, emotional, cognitive, interpersonal, and spiritual.

Physical reactions include:

- cardiovascular strain
- insomnia
- shaking
- crying
- fatigue
- gastro-intestinal upset
- headaches
- reduced immune function
- diminished libido

Emotional reactions include:

- shock
- terror
- guilt
- sadness
- blaming others
- emotional numbing
- sense of helplessness

Cognitive reactions include:

- impaired concentration
- impaired decision-making ability
- memory impairment
- disbelief
- confusion
- nightmares
- decreased self-esteem
- self-blame
- intrusive thoughts/memories
- worry
- disrupted consciousness: e.g., feeling “spacey,” lost, or having tunnel vision
- rarely, psychotic disturbances (delusions, hallucinations)

Interpersonal reactions:

- increased relational conflict
- social withdrawal or avoidance
- problems with intimacy
- alienation
- impaired work/school performance
- mistrust of others

Spiritual reactions:

- anger at God
- disconnection from previous sources of spiritual support
- loss of purpose
- Disturbing and unintegrated spiritual and/or psychic experiences (e.g., encounters with dead relatives, spirit guides or “angels,” direct psychic communication with loved ones)

Many of these reactions result from the “fight” aspect of the fight-or-flight response being in overdrive. Alternatively, when faced with an overwhelming threat, or when the person is prevented from action by the circumstances (like being a hostage), or believes that no effective action is possible, he/she might freeze, or become numb, or in other ways disconnect from the overwhelming reality of the situation. This disconnection can take the form of remaining detached from reality (derealization), or from oneself and one’s body (depersonalization), or other dissociative responses. Dissociation is a means of psychic self defense. When it occurs, dissociation helps a person cope with an overwhelming threat by splitting it into parts, so that, for example, the key traumatic aspect of an experience is forgotten (dissociative amnesia), or the intense emotions of the horrific experience are blocked from awareness. In the days, weeks and months following the trauma, the person may experience vivid, intrusive, memories of the traumatic event (flashbacks). They may lose their appetite, appear depressed, and show little interest in life. Despite the intensity of these acute traumatic reactions and the disruptions they can cause, for most people these reactions will diminish over time, as the individual assimilates the experience. In other words, for most people, the intense--and normal--disruptions following a traumatic experience do not lead to long-term PTSD. Interestingly, there is some evidence in the research suggesting that people whose primary response to the trauma is to freeze and shut down are more likely to develop PTSD in the future.

The focus here has been primarily on the negative and disruptive aspects of acute traumatic reactions. It should also be noted that for some individuals, exposure to trauma deepens or renews their sense of gratitude and hope, and of the potential for goodness and kindness in the world, particularly in the face of strangers’ profound, unsolicited and selfless sacrifice and charity.

When someone has recently experienced a trauma, responses reflecting that the world remains orderly and predictable are extremely helpful. Thus, attending to the person’s physical comfort (clothing or a blanket), providing food, and reassurances that the danger

has passed will all help the person readjust. Of course, CEP interventions can be extremely helpful, as they help restore inner psychic balance along with physical and emotional calm.

One note of caution: Because of the overwhelming intensity of the traumatic reaction, some people will attempt to manage their upset by self-medicating. This may involve using existing prescription drugs inappropriately and/or turning to alcohol or other recreational drugs. Alcohol and drug use must be assessed in every trauma case.

Defining Trauma: Post Traumatic Stress Disorder

If an individual has persistent emotional, physical, cognitive, interpersonal, and spiritual difficulties following a traumatic experience, then that person is thought to be suffering from PTSD. Indeed, speaking of someone as “traumatized” is now part of common speech. In more formal, clinical terms, however, PTSD is a psychiatric disorder. It is listed in the American Psychiatric Association’s *Diagnostic and Statistical Manual, Fourth Edition-TR*. In order to satisfy the criteria for this diagnosis a person must:

- Have experienced or witnessed a traumatic event
- Show persistent fear, helplessness or horror (or for children, disorganized, agitated or regressed behavior)
- Persistently re-experience the traumatic event (e.g., nightmares, flashbacks, be constantly preoccupied with thoughts associated with the event).
- Persistently avoid stimuli associated with the traumatic event and experience numbing of general responsiveness
- Have persistent symptoms of increased arousal (exaggerated “startle” reactions, hyper-vigilance)
- Have symptoms that cause significant disruption in the person’s social, occupational and daily life
- Have symptoms that last for at least one month
- These symptoms are not caused by a medical illness, other mental illness, or substance abuse.

It is clear that there can be considerable overlap between an acute traumatic reaction and formal PTSD. One way to understand the difference is that PTSD represents a “hardening” of the person’s response to the trauma. An acute trauma reaction is by definition transitory. It may take weeks or months, but the direction is towards improved coping and general resolution of the problem. With PTSD, symptoms become increasingly fixed and unchanged. The person’s life becomes increasingly defined by the symptoms.

UNDERSTANDING PTSD: SPECIAL CONCERNS AND CONTROVERSIES

A. It's about meaning

A complete understanding of trauma and PTSD is impossible without acknowledging this central fact: The meaning that each individual gives to the trauma will significantly influence how “traumatized” that person becomes. This was demonstrated in a study done during WWII comparing a group of soldiers who were injured in combat with a matched group of civilians back in the States who suffered injuries of similar seriousness. The civilians all had much higher levels of stress and trauma as a result of their injuries. Why? For the soldiers, their injuries provided a face-saving way to escape the war. On the other hand, the civilians interpreted their injuries in terms of their loss of freedom and disruption of their expectations for a “normal” life.

Someone with PTSD may struggle with the realization that the world is no longer as predictable and orderly as they previously believed. The persistent worry and mistrust this generates is likely to interfere with the ability to return to normal life. Another person's recovery may be hindered because deeper pre-existing negative beliefs were reaffirmed by the trauma. For example, if a person had a preexisting belief that the world isn't a safe place, a trauma is likely to activate and reinforce this belief. This, too, could interfere with a successful adjustment.

It is still true, however, that certain kinds of trauma are more likely to result in post-traumatic stress, and the degree of individual variation regarding the likelihood of becoming traumatized decreases. For example, the massive flooding, destruction and loss of life caused by Hurricane Katrina, combined with the collapse of the social support network (emergency rescue, police, medical personnel, hospitals) will lead to much higher general levels of PTSD than other traumas. Trauma researchers tell us that no individual is completely immune from becoming traumatized. In some situations, such as being involved in prolonged combat, virtually every soldier will emerge traumatized.

B. Developmental issues

Individual differences, then, can make an enormous difference in how someone responds to a trauma. Arguably, the most significant individual difference is age. Children respond differently to trauma than do adults. The elderly also face significant issues.

Children pass through a number of significant developmental stages on the path to becoming competent, independent adults. Generally speaking, the more dependent, and the less developed a child's cognitive, emotional, and social skills, the more traumatized they are likely to be by a traumatic event. Also, children are particularly at risk for trauma as a result of abandonment, neglect and displacement. In addition, children can be easily traumatized by being around adults who are themselves traumatized. Children don't have strong enough independent identities to protect themselves from their surrounding emotional environment. Moreover, it is not developmentally appropriate for

them to be autonomous; they are still profoundly connected with the adults around them. Unremediated early traumatic experience has been linked to many adult adjustment difficulties, including depression, anxiety problems, relationship difficulties, health problems (irritable bowel syndrome and headaches, for example), substance abuse and violence. Early childhood trauma disrupts the normal development of internal self-regulation. In normal development, as the child grows and faces each new developmental challenge, a properly supportive and nurturing external environment supports internal mastery and behavioral growth. It helps the child to internalize control, and learn to be able to self-soothe and not be ruled by his/her internal emotional, physiological and psychological world.

One of the most serious consequences of early trauma stems from the betrayal of trust that occurs when a child realizes that the adult or adults on whom she/he must depend are, in fact, dangerous and unsafe. This kind of trauma, being blocked from the experience of trusting and relying on others, has the potential to distort every other important relationship, including the relationship with one's body, the relationship with other people, and the relationship with the world. It can become the foundation for depression, anxiety, self-hatred, shame, generalized negativity and more.

It is important to consider carefully the life stage of every trauma client in order to better understand what the trauma means to that specific person at this particular time of his/her life.

C. The far-reaching effects of trauma

We have been describing the effects of exposure to trauma on an individual in order to highlight the patterns of both acute responses and more serious PTSD. The effects of trauma, however, can be profoundly disruptive to an individual and to the people around him/her. Here are a number of ways to understand the broad impact of trauma.

If an adult without a previous trauma history and who also does not have any prior serious emotional or adjustment difficulties experiences an intense trauma, this can be considered a simple, uncomplicated trauma. But as you are learning, things are seldom "simple" with trauma.

Whenever an individual who has experienced prior trauma, either as an adult or during childhood, and/or has a prior history of significant emotional or adjustment problems, this can be considered complex trauma.

We usually recognize the initial traumatizing effects of exposure to a severe traumatic event. What sometimes is overlooked, unfortunately, is the very impact of living as a traumatized person--experiencing unwanted frightening memories and nightmares, being hyper-vigilant, and being afraid to engage in a normal full life. These symptoms are considered forms of secondary traumatization, since the disruptions that result are the direct result of having to live with primary trauma symptoms.

When an individual experiences a trauma, many of the people who are close intimate relations—spouse, children, family members, close friends, and even neighbors—are often traumatized as well. This is a form of vicarious traumatization.

People who are living with or who are engaged in helping traumatized individuals (for example, family members, therapists, firefighters, emergency first responders) suffer another form of vicarious traumatization. You are probably included in this list! This is particularly true if you are treating many trauma victims, and even more so if you work with a number of traumatized people from the same event (like treating 9/11 survivors). These activities put you at risk for vicarious traumatization; sometimes referred to as compassion fatigue.

The effects of trauma are, in a sense, communicable. People experiencing vicarious traumatization can have the same symptoms as the original trauma survivor.

A traumatized person often has difficulty in interpersonal relationships as a result of the traumatic experience. But certain kinds of traumas are more likely to lead to on-going relational problems. These are traumas that happen directly as a result of other people's actions. These are relational traumas. Rape, one-on-one violence, kidnapping, and childhood sexual abuse are all examples of relational traumas. Childhood physical or sexual abuse, or neglect, and any abuse of a child by an adult in a position of authority and trust (religious leaders, teachers, coaches) should be thought of as a relational trauma. Relational traumas often have the potential to lead to a lasting disruption in the individual's ability to form trusting, loving and intimate relationships.

Many such events can traumatize not only those immediately affected but also because of their scope or nature, can traumatize a wider social network. Obvious examples of this are terrorist attacks, like that on 9/11, or the Madrid train bombings. But also included in this category are traumas that affect a smaller community, such as a car accident in which popular high school students are killed or severely injured. These traumas can be termed communal trauma.

In order to obtain a complete and more nuanced understanding of the nature of the traumatic experience your client is having, it is important that you take into consideration all of these dimensions of trauma. Practitioners who do this will be better able to help their clients identify relevant treatment goals and recognize when treatment is complete.

D. Social Support

Another individual difference is the resilience and adaptability of the trauma survivor's social support network. Put simply, the stronger the person's family, friends, and community support network, the less likely it is that the person will develop PTSD. Resilience among the community of people who respond to help a traumatized individual is an often overlooked aspect of healing from trauma. The fact is that many of these people have also been traumatized by the event. In strong and resilient social support

networks, people comfort and reassure each other; they seek additional information and resources; their capacities expand to meet the need. The opposite is true in stressed and inadequate networks. Instead of growth, there is contraction, isolation and fragmentation. Dysfunctional coping behaviors such as denial, anger, impatience, avoidance, blaming, and seeking premature closure are common. Also, in these networks, there can be an increase in violence and substance abuse. As a person who is in a position to help people heal from trauma, it is important to evaluate the functioning and capacity of your client's social support network.

E. Pre-existing Coping

Trauma doesn't occur in a vacuum. Every person's ability to manage trauma is based, in part, on his/her coping abilities developed as a result of facing other difficulties. If a person grew up in a positive, loving home, has overcome some significant personal challenges and has a supportive social support network, there is far less likelihood that that person will develop severe PTSD. However, if the person had significant adjustment problems before this trauma occurred, these difficulties will impair his/her ability to make a complete recovery.

Of course, if the person has experienced previous trauma, this will likely have a profound impact on how he/she responds to the current trauma. In general, the complex issues involved in the treatment of individuals who have experienced multiple traumas will be beyond the scope of most EHP practitioners.

F. Pre-existing mental health problems

Trauma research indicates that many PTSD sufferers have pre-existing mental health problems. This means that, before this particular trauma, these individuals had experienced depression, anxiety problems, or other mental illnesses. Such a history would most likely complicate the treatment of these individuals. As part of the treatment process, it is important to find out whether your client has ever been hospitalized for a mental disturbance, has a history of head injury, has ever made a suicide attempt or seriously considered suicide, has had episodes of severe depression or anxiety, has had problems controlling anger, or has had problems with substance abuse. If you discover or suspect that your client has a history of mental, emotional, or adjustment problems, a referral to a licensed mental health professional should be considered.

G. Trauma and memory

As detailed above, trauma produces disturbances in cognition. Memory disturbances are among the most beguiling and controversial problems in the trauma spectrum. In general terms, trauma survivors can experience one or both of the following diametrically opposite memory problems. The first, exemplified by intrusive memories, flashbacks and night terrors, is the problem of being unable to forget the trauma. In normal life, a distressing experience may temporarily disrupt the flow of everyday life, but it relatively quickly recedes, and is integrated into the person's life story. It does not command much

conscious or even unconscious attention. Traumatic memories, on the other hand, are much different. Indeed, referring to them as memories is in many ways inaccurate, since what is recalled is much more than a memory. Unlike normal memories, traumatic memories don't change over time. A traumatic moment can rush into consciousness (as in a flashback), triggered by a stimulus in everyday life that is unconsciously linked to the trauma (the way a car backfiring can lead a soldier with PTSD to seek cover because he/she thinks it was a gunshot). Once the "memory" is triggered, the trauma survivor then is propelled back into the traumatic event, reliving the event as it occurred—seeing the same events that transpired and having the same somatic and emotional reactions. In severe PTSD, a trauma survivor can experience an intense dissociative episode following a trauma trigger. When this happens, the person has a split in consciousness, sometimes losing touch with the present reality (the dissociative response) and is completely immersed in a private internal re-experiencing of the trauma scene.

The second kind of memory disturbance is traumatic amnesia. In this instance, important details about the traumatic event cannot be recalled or identified. An example of traumatic amnesia is the phenomenon of "body memories." Here, as above, the trauma survivor experiences an unexpected flashback characterized by an intense physiological fear reaction (shaking, crying, involuntary movements and/or vocalizations) linked to a prior traumatic event. However, despite the intense somatic reaction, these individuals cannot recall why they are so frightened. That is, they can't describe the originating trauma. Indeed, they may have no idea that their reaction is linked to a previous traumatic event. An example of a body memory is when a rape victim whose attacker attempted to kill her by choking her cannot tolerate having anything touch her neck. She won't wear necklaces and she won't allow her boyfriend to touch her neck. In a true body memory, this person won't realize that the intense reaction she is having in her life (that is, experiencing sudden fear and not being able to catch her breath when her boyfriend puts his arm around her) is directly linked to her rape experience.

Much is now known about the underlying psycho-physiology of traumatic memories. What is important here is that the traumatic memories are stored in the amygdala, a part of the limbic system of the brain. It is the limbic system that governs our automatic reactions in life or death situations (you don't have time to think through a "proper" response when your life is threatened). Under conditions of extreme threat, processing of a threatening event never reaches higher brain centers like the frontal lobes and, therefore, they are never integrated into the individual's personal narrative. This explains why there is amnesia for these memories. Having never been processed and integrated into higher consciousness, they can't be accessed through the customary conscious search strategies. More importantly, from a clinical perspective, is that since they cannot be accessed, the emotional intensity of the trauma cannot be resolved by talking it out. This is one of the great advantages of energy psychology. CEP trauma treatment can resolve these intense memories, apparently calming the limbic system, without the need to talk about them.

Another important and controversial aspect of traumatic memory is the phenomenon of recovered memory or delayed recall of traumatic events. Recovered memories are those

involving past traumatic events that are recalled long after (sometimes many years after) the traumatic event occurred. There is ample evidence that delayed recall of traumatic events is a valid phenomenon. Most often, the traumatic event being recalled is an incident (or incidents) of childhood sexual abuse. As a consequence of the growing numbers of adults recalling incidents of childhood sexual abuse and then accusing their parents of abusing them, a political movement developed whose purpose was to defend the parents who claimed they were falsely accused. This movement was based on the claim that such delayed memories were confabulated. Thus, the “false memory syndrome” was born, spawning the heated scientific, clinical, legal and social debate that followed. This is an enormously complex issue which, for our purposes, can be summarized in this way:

- a. Sexual and physical abuse of children is quite widespread. For example, a conservative estimate is that in the US, 250,000 children are sexually abused each year (van der Kolk, McFarlane, and Weisaeth, p. 38).
- b. Some children do have traumatic amnesia for their abuse. Such amnesia is facilitated by family dynamics ruled by secrecy, fear of punishment, shame and guilt.
- c. Adults can have delayed recall of childhood traumatic experiences.
- d. On the other hand, memory for traumatic events is not perfect, particularly in children given their age-specific cognitive capacities and the fact that trauma is often coded in fragments through sensory pathways and not in a logical narrative form. (Note: Even memories of non-traumatic childhood events are seldom perfectly recalled.)
- e. Many other factors regarding the clinical significance of an adult client recalling childhood trauma need to be considered in order to understand the meaning of this for any specific person. Some factors to consider include the presence of relationship conflicts, child custody disputes, other present-day violence or intimidation, other legal proceedings, and the presence of co-existing psychiatric disorders.
- f. For these reasons, practitioners should never use uncovering techniques whose purpose is to discover previously undisclosed incidents of trauma. This includes using ideomotor techniques or muscle checking for these purposes.
- g. For EHPs, at the very least, it is recommended that you seek consultation with an expert in the evaluation and treatment of trauma and abuse if you are treating a client dealing with a recovered memory. It would probably be prudent to refer such clients to mental health professionals qualified to treat these clients.

H. Energy Psychology and trauma

Our understanding of the nature of traumatic reactions has been growing tremendously over the past 20 years. Significant advances have been made in the understanding of the underlying physiology of trauma leading to the development of new and effective medications. Learning based psychotherapies (e.g., exposure therapy, cognitive-behavioral therapy) have also been proven effective.

As noted at the beginning of this section, CEP trauma treatment has helped thousands of people overcome PTSD symptoms. Even though CEP is still considered unconventional by mainstream practitioners and we are lacking a complete understanding of how it

works, CEP remains the most promising trauma therapy available. Therapists using CEP approaches have helped people overcome virtually every kind of trauma. Treatment is typically shorter, less retraumatizing, and the results more profound than with other available therapies. Trauma relief specialists have singled out CEP as being uniquely helpful to victims of war and natural disasters. Moreover, CEP is effective across cultures. Well trained lay people can be effective healers in their communities (and you will by virtue of this certification be a leader in this group). You can use CEP methods to treat your own traumatic reactions and to help protect you from vicarious traumatization.

You are part of the vanguard of this healing movement. When you complete this course, you will have gained skills to effectively treat many kinds of trauma. You will be able to recognize those individuals who need more sophisticated treatment and make appropriate referrals. Finally, by treating your own distress, you will strengthen your healing presence and continue to be a beacon of light to those you help.

II. Treating Trauma: Clinical Considerations

A. OVERVIEW

In this and the next section, key factors in how to be a good trauma therapist will be reviewed. The aim is to help you know the main components of effective trauma therapy. In good trauma treatment as in all good therapy, the therapist has to simultaneously process many different levels of information. The task is like being an air traffic controller. You absolutely have to know what is occurring on the ground and with the planes about to take off or land. But you also have to track the planes in the immediate vicinity of the airport, as well as those farther off in the distance. And you have to monitor broader considerations, like the weather, that can affect the performance of the whole system. Finally, you have to keep yourself clear and centered so that you can do all of this without “crashing” yourself.

In this section, we will cover some important clinical and structural components involved in doing trauma treatment. In the next section, we will cover important personal considerations—and ways to keep yourself from “crashing.”

B. SHOULD I DO TRAUMA WORK WITH THIS CLIENT?

Every time you meet a new client, you have to formulate a plan of treatment that will address that client’s problems. In doing so, you will use all the skills presented in earlier sections of this module and in the certification program as a whole. The actual treatment offered will be the result of a collaborative effort between you and this client. And treatment can begin only after the client gives his/her informed consent.

Now that you are well familiar with the different kinds of symptoms and reactions a traumatized individual may display, three essential questions need to be answered in order to formulate a trauma treatment plan.

The **first** question has to do with determining whether you and this client can form a good therapeutic alliance. In short, “Can we work together?”

The **second** question itself has two parts. First: Is trauma the main issue for this client? And second: Is a traumatic experience (recent or in the past) a significant factor in understanding the client’s current distress?

The **third** question is: Even if trauma is a main issue, is it *the* primary focus of the treatment?

Let’s examine these questions in the following three scenarios:

Scenario #1:

You are working with an adult female who tells you she has trouble even telling you about a recent trauma. When she begins to talk, she starts shaking and crying. You learn that she is a single mother and that her six year old son was killed by a drunk driver as she and her son were crossing a busy street. Miraculously, she was unhurt when the car knocked her down. However, her son died after being dragged behind the car for some distance. Eventually, you learn that she hasn’t been able to sleep well and that when she can fall asleep she has nightmares. She has had trouble concentrating. She has missed several days of work, and has not been socializing as much as she used to before the trauma. The trauma occurred four months ago.

In this scenario, this woman is experiencing a normal, and expected traumatic reaction to her son’s death. You are able to answer the critical three questions without difficulty.

Regarding question one, you observe that even though this client is very upset, and breaks down while talking with you, she responds to your questions, seems to be comforted by your presence and support, and cooperates with you to make a plan of treatment by stating her goals for treatment.

The second question is also straightforward. There is no doubt that trauma is the main issue here.

The answer to the third question is also clear. The trauma is the primary issue for the treatment. You decide that this is so even after learning that, prior to her son’s death, this woman was having major problems at work, and that her boss had warned her that unless her performance improved that she might be fired.

Scenario #2:

Your adult client and her 15-year-old daughter were in a music store at a strip mall when a car driven by an elderly man drove through the store’s front window hurling a number of shoppers to the ground, including this woman and her daughter. The driver of the car, who was unconscious and bleeding from a head injury was taken away in an ambulance. Your client was briefly knocked unconscious and was also taken to the hospital, but was

released after several hours of observation. Her daughter was picked up by her aunt and taken home, but your client didn't know that until much later. Your client was erroneously told in the ER that several teenagers in the store had been seriously injured and that her daughter was one of them. When you meet the client, her symptoms are exactly like the mother in scenario #1, except that she has been suffering from intense guilt and her nightmares involve seeing images of the man being taken away. Her daughter had some adjustment problems immediately after the trauma, but now seems to be doing all right. But there are differences in her history and life circumstances. You also learn that her father, the beloved patriarch of the family, with whom she is very close, was recently diagnosed with pancreatic cancer and told he has only a few months to live. She has been groomed to be the CEO of the family business that her father started and now has to suddenly assume those responsibilities. You also learn that she was in a major car accident when she was 17 in which one of her close friends, a passenger in the car, was severely injured, but eventually recovered. They had both been drinking.

In this scenario, the issues are much more complex. The "air traffic controller" in you is on heightened alert because along with the recent trauma, there are several other worrisome issues to be taken into account.

Regarding question #1: You find that this client comes to you and emotionally collapses during your session, but rallies and pulls herself together with your support. You both agree on the goals for treatment. You learn that she is beginning to not take care of herself as she used to and has been drinking 1-2 glasses of wine every night. She says she finds coming to her session with you helpful.

Regarding question #2: The trauma from this strange accident is certainly a major issue for this client. This, plus her father's terminal illness and her previous car accident, are significant additional traumas. Addressing these traumas will definitely be a major focus for the treatment.

Regarding question #3: This frightening and traumatic accident at the store will need to be addressed, but most likely it will not be the initial focus of your treatment. Instead, it will be important to help her become more emotionally stable, stop drinking, focus on her father's illness and make a plan to deal with the transitions at work. After this is done, you will be able to work on the store-related trauma.

Scenario #3:

You are working with an adult male client in his late 30's. He tells you that he is very unhappy at work. He has seniority in his job and has managed the layout of the magazine he works for, but his new supervisor is micromanaging his work. He is currently living with friends because his girlfriend kicked him out after their last fight. He tells you that his girlfriend is a severe asthmatic and can't work. He was recently a witness to a drive-by shooting in this new neighborhood. In addition, you learn that his father sexually abused him for five years when the client was 7-12 years old. On one occasion, when his father was drinking, he threatened to kill the client by holding a gun to his head. The

client has had multiple relationships before this marriage, with both men and women. He says he uses marijuana daily to relax, but also to help him be creative.

Regarding question #1: You find that when the client talks to you, he often regresses and speaks in a quiet voice. Although he mentioned that he had been abused as a child, he couldn't tell you the whole story. At one point, while attempting to tell you about it, he stopped talking altogether curled up in the corner of the office and softly cried to himself. It is hard for you to piece together a coherent story about his life because he only gives you one part at a time, then suddenly changes the topic to talk about something else, or dissociates. He gives you the impression that while he is looking for help, he is very suspicious about your motives.

Ok, granted we are making the case very clear here. This is a client with whom you do not have a solid therapeutic alliance. You cannot do any focused trauma work with this client until he is better grounded and your relationship together is on more solid ground.

Regarding question #2: Trauma both past and present is a significant issue to be sure. You are immediately thinking about the relational trauma with which this man is dealing.

Regarding question #3: As noted with #1, you are not going to start the therapy by addressing the most recent traumas, witness the shooting and being kicked out of his home because the therapeutic alliance is not strong enough to do this. With such clients, you can conceptualize the entire treatment as being trauma related. Your primary focus is to establish trust and rapport with this client, and this is itself a direct remedy for the relational trauma he experienced in his childhood.

C. WHAT ARE THE COMPONENTS OF TRAUMA TREATMENT?

By now you have noticed that there are many issues to be considered before beginning any treatment of a trauma client. This remains true whether you are using CEP methods or any other trauma treatment approach.

What follows is a brief overview of the main components of good trauma treatment.

Assuming that you are working with a traumatized client, there are four stages of treatment that you should keep in mind as you plan your treatment. These four stages are:

- Evaluation
- Stabilization and Containment
- Trauma Processing and Resolution
- Reconnection and Integration

The **Evaluation** stage:

We have covered the physical, emotional, cognitive, inter-personal, and spiritual disturbances commonly seen in traumatized people. Aside from the specific evaluation of trauma, you'll definitely be using the interviewing skills reviewed in the earlier sections of this module to establish rapport and engage the client in the treatment.

It is also essential to keep in mind when you are working with a traumatized individual, that the therapy begins with your first contact with that person and continues until you both decide the treatment is over. This means that you should be attentive to all the contextual factors that signal to the client that it is safe to be with, and to work with, you. For example, be sure that you are on time for the appointment, and that you dress in a respectful and socially appropriate manner. Also, keep in mind that you may be the first person that this client has ever told about the trauma. Your sensitivity and your ability to create a relational space within which the client will feel safe enough to open up to his/her feelings and reactions associated with the trauma are critical.

In addition, it is important that you remain sensitive to the enormous psychological risk your client is taking by telling you about the trauma. Most traumatized clients feel shame, embarrassment, or guilt associated either with the trauma itself or their behavior at the time the trauma occurred and afterwards. They may believe, because of the nightmares and intrusive memories of the trauma, that they are “crazy” and that you will affirm this. Many traumatized clients, particularly those who have been sexually abused, were told that they themselves or someone they love would be hurt, disgraced or even killed if they ever told anyone about what happened.

Even though this sharing is occurring during part of your evaluation of the client, your response at these moments can be extremely therapeutic. When you provide a name for the client's experience (i.e., by letting them know that the upset and disturbances they are experiencing are normal reactions to trauma and that they are *not* “crazy”), or educate them about the range of thoughts, feelings and somatic reactions common to traumatized people, you help to validate their inner reality. This validation, which is in itself a powerful source of healing, forms the foundation for a healing relationship.

Certainly, one of the key benefits of using CEP to treat trauma is that when done properly it does not retraumatize the client. So, too, it is crucial that you become proficient at helping clients describe traumatic experiences in a way that will not retraumatize them.

In the evaluation stage of a trauma client you want to determine:

1. Is the client well connected to him/herself?
 - a. Can the client provide a rational, logical explanation of the problem?
 - b. Is the client able to manage his/her own emotions with appropriate support?
 - c. If the client dissociates, does he/she stay connected to the current surrounding?
 - d. Is the client currently using drugs or alcohol?

- e. Is the client in touch with reality? Is the client hallucinating? Does the client have delusions, or other gross distortions of reality?
- 2. Is the client able to connect well with you?
 - a. Does your interest, concern and support help bring some measure of calm to the client?
 - b. Do you feel empathy and concern towards this client?
 - c. Can you and the client form a partnership regarding the goals of your work together?
- 3. Is the client in a stable social environment?
 - a. Consider intimate relationships (spouse, partner, immediate family)
 - b. Consider work
 - i. Is the client in a stable job environment?
 - ii. Does the client find work satisfying?
 - iii. Can the client concentrate at work?
 - iv. Is the client missing work because of trauma-related symptoms?
 - c. Does the client get support from a religious or spiritual community?
- 4. Are there are any significant medical problems?
 - a. History of head injury?
 - b. Headaches?
 - c. Physical pain?
 - d. Past/current illnesses and injuries?
 - e. Medications?
 - f. Sleep problems?
 - g. Appetite problems? Gained or lost weight?
 - h. Sexual problems?

Note: Every client you see should have an up-to-date medical evaluation.

- 5. Past mental health or substance abuse history?
 - a. History of suicide attempts?
 - b. Psychiatric hospitalization?
 - c. History of eating disorders?
 - d. History of cutting themselves?
 - e. Drug or substance abuse history?

The **Stabilization and Containment** phase:

The whole emphasis of trauma treatment is to create an environment that helps the traumatized person regain a sense of control, restore trust and faith, and be able to freely pursue his/her life's purpose. Treatment must at all times be empowering. The practitioner must be mindful that the pace of treatment does not overwhelm the client and honors the client's capacity for change and integration.

To a greater or lesser degree, traumatic experience shatters the client's sense of safety and trust that the world is orderly and predictable. The establishment of safety and trust are therefore necessary prerequisites for doing any deep trauma resolution work (including doing CEP trauma clearing). Attention to the issues of stabilization and

containment will ensure that the client feels sufficiently safe, trusts the therapist and the therapeutic setting, and can manage the emotional and personal reactions that treatment might raise.

Here are several examples of situations where stabilization and containment are needed:

1. The client is easily overwhelmed by any mention of the trauma, becomes flooded with emotion and upset, and is not easily calmed down.
2. The client is dealing with an intense trauma, and his/her life situation (e.g., home life, financial crises, on-going physical dangers) is unstable or unsafe. Embarking on trauma work would very likely lead to further destabilization.
3. You suspect that the client has a significant trauma history but the client hasn't admitted this yet. In the meantime, you know that the client is engaging in impulsive and potentially dangerous sexual behavior.

There are those clients who have more developed internal emotional controls and also have strong social support networks. With such clients, even when they become very distressed after sharing details of the trauma, they become calmer and more centered with your help and support. In these situations, you will be able to move into the next stages of the treatment.

For other clients, such as the ones in the scenario #2 and #3 above, considerable effort will need to be spent on stabilization and containment. There is a group of seriously traumatized clients who may need years of treatment at this stage. It may never become safe enough to do much trauma processing. There are many therapeutic strategies that can help these clients, but these strategies are beyond the scope of this training. Certified Energy Health Practitioners should refer these kinds of clients to licensed mental health practitioners who are experts in trauma treatment.

The Trauma Processing and Resolution phase:

At this point in doing trauma work, you and the client agree to work directly on reducing or eliminating the trauma symptoms. As someone trained in using CEP, this is the primary time to bring CEP into the treatment.

When you are treating trauma using CEP, there are two steps to follow:

1. You use CEP to help the client reach a state of calmness and centeredness such that recalling the details of the trauma no longer triggers intense emotional reactions. The trauma will become part of the client's history and life story and will no longer intrude into the present moment. Talking about or thinking about the trauma will have no specific emotional charge. It will just be like telling a story from the past.
2. You help the client integrate this change and establish goals for the future in light of the newly emerged freedom from the trauma.

One of the profound advantages of treating trauma with CEP is that you can have the goal of helping the client attain complete freedom from the effects of the trauma. It is

important, therefore, while conducting CEP trauma treatment that you continually assess the client for indicators of trauma symptoms. To do this, encourage the client to take note of any distress in his/her physical, emotional, cognitive (beliefs), inter-personal, and spiritual experience.

The **Reconnection and Integration** stage:

The final stage of trauma treatment involves helping the client to live life as a person no longer plagued by trauma symptoms. This is, after all, the aim of the journey that you embarked on with this client. It is a goal captured by the title of Reynolds Price's extraordinary memoir about his battle with life threatening spinal cancer called, A Whole New Life. Price writes that as a result of his illness he had to grieve the person he had been and reinvent himself anew. So it is with every traumatized person. The discovery of and rebirth into a new life is the goal of the reconnection and integration stage. Depending on the severity of the trauma, this could involve the significant reworking of all the major aspects of the client's life and all his/her important relationships. Here, too, CEP work can be of enormous benefit. It can help strengthen hope and resolve while removing blocks (limiting beliefs, distressing emotions) that could sidetrack this movement.

Breaking down any human experience into stages is at best a training tool, to help you become a more sensitive participant in an enormously complex phenomenon. In the case of more straightforward, single incident traumas, it is possible to move through these four stages in a single session, or in a few sessions. If, as introduced earlier, you allow yourself to be led by the client and remain free from the arrogance of being too sure that you always know best, you are likely to recognize when the pace is too fast or for that matter, too slow. Still, your inner "air traffic controller" can stay alert for any signs of potential trouble, and you can adjust the pace or direction of treatment as needed.

D. TOUCH

The issue of touch deserves special attention in the context of trauma treatment. In a healing relationship, physical touch can have many meanings. It can be an instrument of profound healing and a source of comfort, but it can also be intimidating, intrusive, controlling, sexual, and even illegal. Depending on the cultural context it can be necessary and expected, or prohibited.

Is there an occasion when touching your client is clinically indicated and appropriate? Is doing energy checking appropriate?

There are no absolute answers to these and other questions. For the purposes of this training, the goal is to encourage you to bring your full awareness to the issues of touch in the context of trauma treatment. Certain considerations are obvious. A male therapist working with a female client should be extremely careful about using touch. To begin with, simply being in a closed room with a man may cause many female clients to be on high alert. A physical gesture intended to be comforting may be regarded as an outright

intrusion and violation, or viewed as a precursor to other more overtly sexual demands. By the same token, male therapists need to be careful about female clients who initiate touch. For example, women who were sexually abused as children often learned to operate in a relational world that was highly sexualized. By using touch in this way, a female client may be repeating her dysfunctional family dynamics in which women were socialized to take care of men at the expense of their own needs. The therapist may misread this client's gesture as a sign of growing trust and closeness and in so doing miss the opportunity to help the client stay focused on her pain and her needs.

These examples are offered to convey a sense of the complexity of the issues here. The same or similar problems exist with female therapists and their male clients, with male therapists and their gay male clients, with adult therapists and teenage clients, and so on.

And from the theoretical framework of energy psychology, the issue of touch goes beyond the physical. Our energy field and our client's energy field are intertwined. When you feel empathy towards your client, you are touching him/her with your heart energy. Establishing and maintaining healthy energetic boundaries with others is also a key component of trauma treatment.

The important principles to remember with regards to the use of touch in trauma treatment are these:

1. Every action you take while treating a traumatized client must empower the client.
2. Observe the maxim: Do no harm.
3. Engage the client with you and make collective decisions about whether certain kinds of touch can be used.
4. Consult with a colleague when in doubt.

The issue of touch is more fully covered in the ethics section of this module and in the main ethics module.

E. DISSOCIATION

Dissociation as a psychic self-defense strategy was introduced at the beginning of this trauma module. You will observe dissociative symptoms in many of your traumatized clients, but most of the time these clients will be able to maintain their connection to you and the present moment. In other words, the dissociative symptoms constitute several types of reactions characterizing a particular client's trauma response.

However, for some clients the dissociative response becomes the problem even more than the originating trauma or traumas. In these cases, the dissociation has come to be the client's main way of dealing with a world he/she views as threatening. You should seek consultation if you suspect that you are working with a client like this. The treatment of dissociative clients is outside the technical scope of most CEHPs.

F. ALTERED STATES OF CONSCIOUSNESS

The extreme state of psychic distress caused by the trauma can sometimes be a catalyst for the client to experience an altered state of consciousness. If you sensitively inquire about their experience in the time period before, during, and after the trauma, traumatized clients will often disclose extraordinary experiences. They may tell you about encounters with angels, or floating above their bodies, or about being in the light and then deciding to return to life. Some post-traumatic symptoms are due to the fact that these experiences remain unintegrated. You have the opportunity to be immensely helpful to your clients if you incorporate asking about these experiences into your work.

G. MEDICATION

There are situations in which CEP treatment and all other treatments you may know to offer a traumatized client do not lead to meaningful improvement in the client's symptoms. If a client's condition does not improve but instead continues to reflect overwhelming anxiety or depression, or if the client is suicidal, is not getting restorative sleep, or in general is unable to manage his/her intense internal emotional states, a referral should be made to a psychiatrist for a medication evaluation.

III. Treating Trauma: Personal Considerations

Treating traumatized clients is *not* for everybody. Learning what kinds of clients you are best suited to work with is an important part of your personal development as a Certified EHP.

Working with traumatized people requires more integrity, better boundaries and more self-awareness than working with many other types of clients.

Here are two basic questions to keep in mind, if you are going to work with traumatized clients:

1. Do I have the skills required to treat this person?
2. Am I emotionally available to do this work?

1. Do I have the skills required to do this work?

This is the easier of the two questions to answer, but it requires that you be able to put the client's needs ahead of your own desire to help. As an ACEP Certified Energy Health Practitioner, you will have a potent set of tools and you will be able to help many people recover from trauma. But as we've reviewed above, many traumatized individuals have complex problems that require a level of treatment sophistication that is beyond an C.EHP competence level. The responsible attitude then is to pledge yourself to continuously educate yourself about trauma and its treatment, and to develop a

consultation and referral network so that you can be sure that clients who are beyond your skill level get the appropriate help.

2. Am I emotionally available to do this work?

Although it may seem above question to begin by asking yourself why you want to devote yourself to working with others who are suffering, it is important that you do just that. Healing work begins with healing yourself. So we must start by being sure that we are motivated primarily out of a desire to ease pain and suffering and not in order to get some primary gain ourselves. In the trauma field, many wonderful therapists have themselves been trauma victims and because they have done their own healing they have that special ability to convey to the client their grasp of the inside experience of both trauma and healing. But there are also many therapists who have been trauma victims, but have not sufficiently healed themselves. These therapists are unable to fully acknowledge the uniqueness of their clients' pain. They see too much of their own situation in the lives of their clients. They work too hard to "rescue" their clients rather than empower them. Acting in the role of "rescuer" keeps the practitioner from having to look at himself or herself.

The challenge in doing trauma work is this: You desire to be empathically connected to a client who is dealing with a life-threatening event or events that have shattered his/her sense of wholeness. In the process of becoming closer to the client, you inevitably experience the intensity of the trauma. Practitioners who are not centered and clear and have not attended to their own healing put themselves at greater risk for vicarious trauma. For the treatment to succeed, you have to be able to hold both the client's terror and pain, and cope with your own horror, desire to escape, or denial of the trauma. Your ability to be with the client in the center of his/her pain and fear serves as a model of healing. It shows that it is possible to experience the trauma and not be destroyed by it. When you remain in the center of the storm, the client can feel that it is safe to trust you.

Remember: You should be sufficiently emotionally available to remain true to the goal of empowering the client.

Doing this requires an on-going commitment to keep your own "inner house" clean in order to be an effective trauma therapist. Good "inner house cleaning" methods include having a daily meditation or spiritual development practice, using CEP methods regularly for self-healing, doing qigong or yoga regularly, pursuing psychotherapy yourself, exercising regularly, or having an on-going consultant relationship with someone with whom you can discuss the issues that doing trauma work raises. It also helps to be part of a consultation or study group.

Sometimes therapists forget (this is a kind way of referring to self-neglect that may arise out of a distorted sense of service to others) that they need to eat well, exercise, get enough sleep, and develop healthy relationships with others. The discernment and centeredness you gain through your inner work will make you a more effective healer and help you be at peace with your limits.

IV. Treating Trauma: The CEP Approach

In this section, we will briefly highlight some of the key considerations involved in using CEP to treat trauma.

We will address the following issues:

1. When is it appropriate to use CEP methods in trauma treatment?
2. What is unique about the CEP approach to trauma treatment?
3. What special considerations are there for treating trauma with CEP?
4. What contra-indications or limits are there for treating trauma with CEP?

This will not be a presentation about how to do CEP treatment as this material was covered in previous modules and in the basic Certification workshop.

The issues raised in this section will be covered in more depth in the in-vivo workshop.

When is it appropriate to use CEP methods in trauma treatment?

CEP approaches can be used at every stage of trauma treatment, though, as we just reviewed, it may not always be appropriate to do so. Also, you are well aware by now of the importance of obtaining informed consent before beginning any treatment.

It is appropriate to use CEP,

- ✓ when your relationship with the client is strong enough to support this work, and you have a clear contract with the client to use this approach.
- ✓ when you are clear about the goals for introducing CEP, and can explain to the client why this is the best treatment choice at that moment.
- ✓ when you have the necessary skill to address this kind of trauma or this particular individual's trauma reactions.

Here is an example of an appropriate use of CEP at an unusual time: In your initial meeting, you might introduce a CEP method to help calm down an overwhelmed, upset trauma client. Even in this first encounter, if you have made a strong empathic connection with the client, and you can explain the reason for introducing CEP, it can be a powerful and effective intervention. As a result of this timely application of CEP, the client may have his/her first experience of regaining control in the face of escalating traumatic reactions. You can demonstrate to the client that you are serious about promoting empowerment. You will quickly distinguish yourself as someone who can be truly helpful. And you are far more likely to learn more about the client's story than you would have had you not introduced CEP.

As most practitioners know, CEP is the treatment of choice when you and the client decide that it is time to treat core traumatic reactions. Once introduced, you can use CEP anytime intense emotions, physical discomfort, or limiting beliefs block treatment. CEP work is also invaluable after the main traumatic symptoms have been alleviated. You can use CEP to help remove limiting beliefs and fears that arise as the client pursues his/her goals for the future.

What is unique about the CEP approach to trauma treatment?

The unique claim of CEP is that trauma reactions, including PTSD, are due to a primary energetic disruption of the client's energy system. These energetic disturbances profoundly disrupt the client's attempts to be himself/herself in the world. Because CEP treatment is thought to correct core energetic disruptions, the goals of treatment are more extensive than in other treatments. CEP treatment aims to completely alleviate the traumatic symptoms. When a client experiences complete remission of symptoms (including somatic, emotional and cognitive distress), he/she also experiences a new expression of himself/herself in the world. This may be the first chance that this client has ever had to be himself/herself free from the fears that heretofore have been so limiting.

It is vital that you understand the implications of working at this level. Clients enter treatment often with qualified hopes that you will offer some relief. What CEP offers and frequently delivers is profound, transformational change. Clients are given the opportunity to be who they really are in the world. Treatment of a traumatized client is not complete until you explore with each client what they want their life to be like if they were truly free from past limitations. The mutual agreement to work on building the life he/she really wants defines the broad range of goals for treatment.

Several characteristics of CEP trauma treatment are worth keeping in mind:

- ✓ CEP treatment is gentle and humane, that is, it doesn't retraumatize the client. By carefully pacing your work, and using CEP treatment to keep the client from being overwhelmed by trauma reactions, you can help the client quickly regain control and resolve significant components of the trauma.
- ✓ CEP trauma treatment can almost always be accomplished without prolonged, painful abreactions. Working on the energetic level anchors the client and reconnects him/her to core strengths, thus rebuilding the client from the inside out.
- ✓ Because CEP works on the human energy field, treatment simultaneously addresses the somatic, emotional and cognitive components of trauma reactions.
- ✓ CEP methods are effective self-help treatments. This again empowers the client, and helps him/her gain more comfort with using an energy-based approach.

What special considerations are there for using CEP to treat trauma?

If you wish to practice CEP trauma treatment at its highest level, and remain true to the goal of promoting client empowerment, it is important to keep the following five related issues in mind:

1. The traumatized individual is dealing with grief and loss. As CEP practitioners, we realize that we can help people overcome their fears and move beyond the trauma. However, our client may not yet be ready to do this. It is important, therefore, to listen carefully to the client in order to understand the meaning of letting go of the trauma symptoms from his/her perspective. Doing this will help you identify the client's fears and self-imposed limiting beliefs. Sometimes the limitations are more about clients' fears that others won't be able to cope with the change. Your attentiveness to these issues will help you know when it is the right time to offer CEP work.
2. There is great diversity regarding how well clients can integrate the changes initiated by CEP treatment. This includes the depth, extent and pace of change. In your previous certification training, the difficulty clients have coping with change at this level was referred to as disorientation fears. In trauma treatment, the new stance in life that CEP offers can be very unsettling. Again, paying close attention to signs of this disorientation can lead you to identify important issues needing further work.
3. Trauma work is based on trust and safety. A positive treatment relationship develops from this foundation. Some CEP practitioners are focused on what this work can do and too quickly introduce CEP. These practitioners also apply CEP too broadly without obtaining the client's permission. These decisions break the "empower the client" principle we keep emphasizing. Moreover, these actions pose an added risk to trauma clients. Because traumatized individuals have often been coerced or felt helpless to stop the trauma from occurring, even an excellent treatment introduced in this way can be retraumatizing.
4. There are many special issues raised when a traumatized client is involved in a lawsuit related to the trauma. There are confidentiality concerns (you may be deposed to support the client's claim that the trauma caused him emotional harm). CEP treatment can be expected to diminish the intensity of trauma related memories, and this might have an adverse effect on the case. Also, traumatized clients who may be appropriately seeking damages (e.g., a client who was a passenger on a commercial airliner that crashed) will likely experience considerable ambivalence towards their treatment. These are complex cases that will be better served by licensed mental health professionals who have experience with trauma and the law.
5. Complex cases, like those portrayed in scenario #2 and #3, including clients where dissociation is a significant issue, and clients who have additional mental

health problems (depression, substance abuse problems, severe family problems), are best treated by licensed mental health professionals with experience dealing with these kinds of problems.

Summary

The information presented in this trauma module gives you a brief, but comprehensive overview of trauma and its treatment. This training will help you understand and better empathize with what the traumatized client is experiencing. In addition, on the personal level, you will be better prepared to do trauma work. With this preparation, you will be able to bring relief to untold numbers of people.

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