"Had I another five hundred years, I could not have created a more perfect public and organizational management psychopathology than Evidenced-Base's (EB's) application to individual, systemic and, particularly, combat-caused psychological trauma. But it only took thirty-five REAL years to create - then fully publish - something better: ETM TRT SHOM. ‘Better’ means that it works ALL the time, making irrelevant application of statistical probabilities pertaining to EB styled attempts to quantify its ideologically compatible, albeit, otherwise constantly - in the kindest of expressions - questionable Nosotropically-focused (that is, behavioral-symptom methodologically structured) clinical and managerial performances.”

Jesse W. Collins II

Welcome to the

“Etiotropic Trauma Management (ETM)
Trauma Resolution Therapy (TRT)
Strategic Human Ontological Management (SHOM)
Professional Training and Certification Program

This is its primary manual.

Since 1979

by

Jesse W. Collins II
Etiotropic Trauma Management (ETM)  
Trauma Resolution Therapy (TRT)  
Professional Training and Certification Manual  

By Jesse W. Collins II
Although anyone is invited to read this book, it is a manual designed to provide text (written) support for clinical and management professionals who are participating in the ETM TRT SHOM Training and Certification (Online) Program. Additional ebooks that support that program include and are entitled:

*ETM Professional Due Diligence for the 1st Secular Cure of PTSD*

*Neurobiology of Psychological Trauma Etiology and It’s Reversal* (now also referenced as “Cure”) with *Etiotropic Trauma Management*

*Guerrilla (or Terrorism or Asymmetric) Warfare’s Pathogenesis and Cure: Assuming the practical application to Combat Trauma of Strategic ETM TRT*

*ETM TRT SHOM Crisis Management*

*The Great Evidenced-Based, Cognitive Behavioral Therapy, Self-Help and Government Merger: Monopolistic Cultural Infusions of Pharmacological & Behavioral Whack-a-Mole; Or, Psychological Trauma — Cope or Cure?!*

Systems – Family applications

*ETM TRT Patient Education Series*
Compiled originally (between 1979-1985) in the employee training and management documentation of ten Licensed or JCAHO facilities and seventeen psychiatric hospital psychological trauma and family chemical dependency treatment centers located in the southwestern portion of the United States of America.

First printing spiral notebook form 1986-1990 as the text for the ETM School presented as an advanced curriculum at the University of Houston Chemical Abuse Counselor’s Course

Second printing (revised) 1990 under the title *The Integrated Trauma Management System: an Etiotropic approach to the treatment and management of psychological trauma and post-traumatic stress*

Third printing (revised) 1994 *The Etiotropic Trauma Management Training and Certification Program Manual;* comb bound paperback 654 pgs

Fourth printing (revised in 2004 and published as the ETM TRT Professional Training and Certification School Manual. Online Course also published by Jesse Collins)

The current online version of this book title is provided here as the fifth printing (revised for the new online school being consolidated and reproduced beginning in 2012)

Published online from Angel Fire, NM 87710

[http://Etiotropic.com](http://Etiotropic.com)

ISBN 0-9768934-0-1

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1979 – 2012

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Simplifying Modality Distinction
(Getting to the point)

The most succinct decision matrix that addresses psychological trauma and post-traumatic stress (PTS) poses two options for their respectively successful, or partially so, remedies. Choose to help people 1) to cope with psychological trauma (a partial remedy), or to 2) cure them of it (a full remedy). Where Nosotropic (symptom-focused Behavioral-based) approaches hallmark the former (as in #1), ETM TRT SHOM represents the latter (as in #2) path.

Hence, for purposes of modality distinction, that decision matrix is reflected iconically as an expression of our motto, slogan, trope and declamation:
Author’s Message
Author’s Thesis and Goals Underpinning ETM Publications

Having done this work for the past three decades-plus, I’m leaving the next generation of dedicated ETM TRT professionals with this missive. Naming it the “Author’s Message,” it is the most important statement to be made about ETM TRT by its author, showing its meaning for and importance to humanity and concluding with clarification of the model’s goals set for it to achieve by the end of the twenty-first Century.

Restating for emphasis, ETM TRT has endurably, completely and Etiotropically resolved the psychological trauma affecting every case to which it was administered in accordance with its application criteria. As ETM TRT’s author celebrating this 30th (plus) anniversary of its initial development (1979-1981), I am stating what I have learned starting with the years just following its inception and continuing thereafter to be true: “Resolution” as I’ve employed it here means that ETM TRT has cured, stills cures, and will continue to cure immemorially people affected by psychological trauma and its more recognizable outcome Post-Traumatic Stress Disorder (PTSD). Moreover and in case you have not understood the full meaning of this statement, no other secular-based body of psychological research and study has ever provided the world since the beginning of humankind’s existence a view or experience of this phenomenon’s equal. Imagine the final removal of the deepest, darkest vacuum of devastation that heretofore has hollowed our hearts and minds of their ontological essence, vacating ordinary existence, joy and pleasure from our lives as they have been taken inexorably over the millennia to their endings, never having known without abuse their life’s wonderments. Albeit not intended as an ideological creation for a utopian person, society or world civilization, due to ETM TRT’s applications so far to some members of our generations, for them there’ll be no more sequestered haunting trauma attended by seemingly perdurable loss-causing shock, horror, unyielding anxiety, hurt, shame, sadness, disillusion and everlasting depression.

Psychological trauma has two other functions different from just being the intrapsychic source of individual, family and community life long misery. These variables make psychological trauma the Gordian knot to be untied if anyone other than me, and I know already that there are a few, intends to end pain and suffering that has been reinventing itself as if an infinite part of man for (at least) the last three to five thousand years.

First, psychological trauma provides an inexhaustible fuel supply for that inveterate relic of the once dark ages of mental health, the “cycle of violence.” Traumatized people sometimes traumatize others, including even their loved ones. In that same vein, traumatized people have also been found to be hindered by the same trauma from defending themselves and their loved ones against recurring like events. Second, psychopaths use trauma, for example, created through the killing of innocent citizens as a time responsive intrapsychically implanted manipulation device that systemically controls their political oppositions’ defensive management activities. That is called
“terrorism.”
Strategic ETM employs its oft referenced to be daedal structural features in conjunction with TRT’s ability to cure trauma affected individuals and systems in order to expunge and then dispose of that system management debilitating fuel that repeatedly re launches the “cycle.” Removing the fuel interrupts the cycle and then ends it.
Thereafter, what also can we expect to succumb to our cause, determinations, and Strategic ETM strengthened capacities? It will be those perpetrators of perpetual calamity and hysteria. That is, strategic uses of ETM will end not just their hegemonic methods, but also the very existences of those people who would commit the heinous and vile deeds the methods require to traumatize their prey. The days where terrorists so adroitly exploit peace and innocence to advance minority interests are coming to an end. Without any equivocation, ETM TRT is the sword that will cut the Gordian knot of otherwise believed to be human nature-inspired thus ever continuing criminal, as in terrorism, violence.
Imagine, then, even more profoundly if you dare, what our world could be like without that cycle of violence and the ability of psycho-socio-pathic offenders to use trauma to control others; although ending that cycle is not suggested or intended to produce a utopian civilization, it is the intent to create one that operates itself without perpetual heinousness constantly attempting to predominate decision making: that is, how we conduct and otherwise manage ourselves. But at least if our thirty years past, current and near future preparations work, that is, establishing global understanding that trauma as a horrific and sometimes self-perpetuating force can be removed from our planet’s populations’ lives, then our next generation of determined ETM TRT professionals can more easily and readily spend their time just finishing the job of actual implementation: extricating the rest of our civilizations out from under trauma’s now obscenely unnecessary multidimensional burden. After achieving the goals of ridding our citizenry of trauma’s effects and then preventing it from being used by criminality and the insane, who knows what else a world without psychological trauma can do?
I intend to train and certify as ETM TRT competent and with my authority to administer the model, only those professionals who can and will ascribe to the referenced goals. And please know and remember: Even if you are not the administrator of ETM’s strategic functions, it is the clinical TRT incremental work done at the individual cure level that can and will make the more grandeur view become reality.
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Bibliography
Preface

This text is a compendium of work produced by Nancy and me over the past at least twenty-five years (actually starting in 1979). Most of it comprised other school texts and patient educational handbooks written between 1981 and 1994, and then again updated in 2004. In 1987 we published a series (19) of pamphlet styled patient educational materials and then compiled them into the text *Trauma Resolution Therapy: a structured psychodynamic approach to the treatment of post traumatic stress*. Starting in 1994, the referenced texts were combined with theory and research and translated into the work *The Integrated Trauma Management System: an Etiotropic approach to the treatment, management and prevention of psychological trauma*. It was converted in 1994 to the Internet to comprise the [Etiotropic Trauma Management Tutorial](http://etiotropic.org). It is published today in the same format at http://etiotropic.org.

In 1995 and 1996 Nancy and I each sustained major depreciations in health that have affected this life’s work. Nancy was found to have, and then was treated for breast cancer. The surgery and radiation were followed a year later by a head-on collision where she sustained brain injury, a malady that still adversely affects her today. In a bizarre oral surgery accident, a suction device used within the walls of the maxillary sinus and upper face to the right eye became entangled in my major Trigeminal facial and cranial nerves, causing me irreparable damage. It rapidly became manifested by chronic pain – now diagnosed as atypical Trigeminal Neuralgia. I’m told that this is a lifetime condition. Medications for unendurable levels of facial and eye pain also took their toll. I’ve experienced subsequently after being gifted a reduction of the original nerve damage pain its lessening to endurable levels. That miracle, as it was felt by me, has allowed me to abandon the use of the medications since 2009. However, their ramifications to various body organs have been substantial and are debilitatingly extant in respiratory, teeth, digestive functionings. The latter as degenerated into chronic diverticulitis, which hemorrhaging requires emergency hospitalizations and fairly long convalescents from time to time.

All influences from that past period retard my professional and social skills dramatically, enough to have placed our trauma management activities on hold for almost two decades. I’m disabled by the injury 100%. All work is now done within the context and limitations of the conditions.
As a part of these years’ convalescence, we combined the Etiotropic Trauma Management Tutorial with the internationally renown computer educational Blackboard professional online academic course creation system and produced the Etiotropic Trauma Management (ETM) Trauma Resolution Therapy (TRT) Online Training Certification School. This book is the textbook for that course/school. As an online school registrant, you can sign on with a student ID and password and take the course. All chapters from the course are now provided in this text, saving you the trouble of printing the material from the Internet. As mentioned earlier, the questions in each quiz are referenced straight from this text. When the answer is shown following the quiz, it also refers the student to the approximate location in the text where the answer is retained with supporting information. Between the interaction of the online curriculum and this textbook, you should receive a very detailed understanding of ETM TRT’s principles and applications. The book and ETM Tutorial will then serve as a reference guide for applying TRT.

**Book (Chapter) Redundancies**

There is much redundancy (the reuse of same passages) in the book. For example, chapters three and four address ETM theory of psychological trauma and its resolution with TRT. When chapter five explains how to implement TRT, same discussions of theory from chapters three and four are reiterated so that the reader does not have to work to correlate the action with the concept of why we are doing it. It is right there, available with the how to facilitate TRT. These chapters are written the same way, that is, with duplication of theory, on the Internet.

**Acknowledgements**

I would like to acknowledge the hard work of Licensed ETM Trainer Craig Carson. Through his efforts, we were able to train and receive feedback from approximately 2000 registrants in the traditional ETM training school, held for 1 full (44 hour) week per program. Many testimonials from that group are listed in the ETM Tutorial. That work has allowed us to complete the fully online school now being offered at [http://etiotropic.com](http://etiotropic.com).

Nancy and I have a special appreciation of Craig. During the height of our illnesses, he personally saw to our health and living arrangements, caring for us as only family would. Without hyperbole, we owe him our lives and
express our caring for him now. None of this book could have been written without Craig’s contributions.
Part One

ETM TRT SHOM Theory and Facilitation
Chapter 1 Section (a): Embedded as a slide presentation into the course (Presentation Title) Etiotropic Trauma Management Training - Certification Program Start Up Manual

Ebook Title CHAPTER ONE

ETM and TRT

ETM has two components: management and clinical. Management triages the clinical application to individuals and systems. For example, management would determine who in a multi-persons affected event would receive the clinical applications where, when and in what order. Such is the reference to 'ETM.' Management is integrated with the clinical component. It provides individual and systemic treatment, delivering two relatively different kinds of applications to the address of near- or long-term trauma. ETM's clinical component is 'TRT.'

Ebook Title CHAPTER TWO

Etiotropic's Meaning

ETM, supported by its clinical component (TRT), identifies and then reverses psychological trauma etiology. It is a medical term that refers to the source of a disease or problem. 'Reversal' means expunge, do away with, remove. Reverse etiology and behavioral symptoms will not manifest. Thus, ETM is curative of psychological trauma from its etiological source to its symptomatic reactions. That chronological treatment order of source to its response accounts for the meaning of 'etiotropic' in Etiotropic Trauma Management.
Trauma etiology is, in ETM parlance, extinction of those psychoneurobiological elements of identity existing before the event occurred that caused the extinction. Etiology is always attended by symptoms. Combining etiology with symptoms results in post traumatic stress disorder (PTSD). ETM is a structured psychodynamic, blended cognitive behavioral, and existentially based model (TRT) for treatment of PTSD. TRT defines and reverses the disorder's etiology, which then brings symptoms to an end.

As emphasized in the preceding sections, ETM focuses on etiology. Virtually all other models initiate treatment with a nosotropic approach. 'Nosotropic' means to focus on symptoms. TRT maintains its focus on etiology, as opposed to symptoms, with a highly structured compendium of integrated therapies. With TRT, both the client and therapist never lose sight of their approach goals and accompanying methods.

After reading the instructions on this page, click here to open the ETM Tutorial in a second window. The title’s individual
components are distributed diagonally from the upper left corner to the bottom right. ‘Etiotropic,’ ‘Trauma,’ ‘Management’ and ‘Tutorial’ form a downward left to right stair step, beginning with ‘Etiotropic’ and ending with ‘Tutorial.’ When you scroll the cursor over each word, a popup abbreviated description appears. Aside from scrolling, you can click on each word. Starting with ‘Etiotropic,’ click on it, read the full definition, and then go to the next word in the sequela, reading each component’s full text before proceeding to the next. Notice that some of the definitions require clicking on multiple elements to acquire the complete description. For example, when you click on ‘Trauma,’ the 2nd window opens and shows 3 additional selections labeled in order as ‘Page 1,’ ‘Page 2’ and Page ‘3.’ A click on each brings up additional information, all of which delineate the various perspectives of ‘trauma.’

Before moving on from the Tutorial front page, lets get a wider view of how the Tutorial is set up. On the right of the page you’ll see gold print that begins with ‘You might skip the rotating Contents . . .’ Click the print and another window opens over the first. It plays a movie that describes the different elements of the Tutorial. Upon completion, close the window. Look at the 5 blue buttons spread across the lower part of the screen. Notice the button on the far left that says ‘ETM Summary.’ Don’t click it for the time being. Instead, close the window by pressing the cursor on the white ‘X’ in the upper right red square. Next, press on the arrow below that points to ‘Chapter Six.’

**Ebook Title CHAPTER SIX**

(Please ignore the reference in this chapter to the movies. They are Java technology based and became, after ten years of use, inoperable. The JAVA reader was changed in the cloud. Repair has been beyond this system’s control.)

This chapter provides the movie contents recommended for your viewing.
After reading (or printing) this page, open the Tutorial home page again. Click the button noted earlier, ‘ETM Summary.’ It will take you to the ETM Summary Movies page. Starting with Overview: What is ETM?, open, follow the instructions, and play it. You will notice that the movie plays continuously (you can’t make it pause). The timing of the presentation of the animations is set for average to low speed. However, when much text is required to be read, the word ‘Next’ presents, stopping the movie’s progress. When done reading that text at the speed necessary or via replication, click ‘Next’ and continue. Close the movie window (lower right button) when done. Or, replay the movie (lower left button).

Go to and click on the next movie, Thinking Etiotropically: Introduction. After watching it, notice that it provides at the end of the movie a menu of the Thinking Etiotropically series. In addition, the word ‘Next’ will be presented adjacent to the movie in the series to follow. Click on the title to open that movie in the same window.

The series’ movies will continue for you to view in the same window until that series is completed. When done, view the last movie, (1) Substrate (Neurobiology) of Trauma Etiology's Psychology: Introduction.

**Ebook Title CHAPTER SEVEN**

**Trauma is Always Resolvable**

Without hyperbole, the ETM / TRT methods are always successful, with the only stipulation being that the administrator conform with application directions. They include following the criterion that precludes application of TRT in certain circumstances. For example, if a counselor tries to apply TRT to an alcohol using or medicated individual, or in another example an individual suffering certain mental illnesses, TRT won’t work. Absent such conditions, when an individual has been affected by
extraordinary trauma, regardless of the severity of the causal event(s), no attending ETM / TRT trained clinician would make a prognosis such as ‘This trauma and loss will take a long time to heal, maybe never.’ Within the ETM clinical environment, there's no place for generalities such as ‘long time’ to ‘heal,’ or maybe the person will get well with good family support. And unlike virtually all competing models, there is no such thing as incurable psychological trauma, or never-ending grief. In each case to which ETM / TRT are properly applied, trauma is always resolvable.

**Ebook Title CHAPTER EIGHT**

Certification Program Curriculum

**Chapter One: ETM TRT Certification Program Start Up**

- Chapter Two: ETM TRT Theory of Psychological Trauma Etiology
- Chapter Three: The Survivor - A Paradoxical System of Control
- Chapter Four: Psychology of Trauma Etiology's Reversal
- Chapter Five: How To Facilitate TRT Phases One Through Five
- Chapter Six: TRT Facilitation and Feedback Guidelines

Chapter Seven: Is now (2012) placed in its separate e book entitled Neurobiology of Psychological Trauma Etiology and Its Reversal with Etiotropic Trauma Management

Chapter Eight: How to Reverse Near Term Psychological Trauma (events which occurred no more than 90 days past)
Chapter Nine: Treating Chemical Dependency's Traumatic Effects with TRT

Chapter Ten: Facilitation of Client Use of Patient Educational Materials

Chapter Eleven: Entry, Assessment, Triage, Multiple Sources of Trauma, Parallel Therapies, Begin TRT

Chapter Twelve: This chapter is now (2012) available in its own ebook and entitled Strategic Application of ETM for Crisis Management

Chapter Thirteen: Evaluating for Trauma's Resolution

Course Bibliography: Supports the Entire Curriculum
Chapter 2 Section (a):
ETM TRT Theory of Psychological Trauma Etiology

Introduction: Theory

Welcome to ETM Theory. Over viewing it, this introduction also discusses theoretical and application differences between ETM and other approaches to psychological trauma treatment, management and prevention.

Traumatic Sequelae

When an extraordinary (and depreciating) event occurs, it causes traumatic sequelae (series of related and causal effects) for pertinent individuals and systems.

The sequelae begin with a reduction or loss to identity - values, beliefs, images and other realities retained within memory. That first change initializes a process called "extinction," which while it is occurring separates identity into non integrated (pre- and post-trauma) elements. This extinction - disintegrated identity forms the traumatic sequelae's "etiology." It is a medical term that describes the "source" or "cause" of a disease or problem.

The trauma's etiology then produces emotional, thought and behavioral changes. They are referred to as "grief." When these changes manifest within certain time frames and under specific conditions (described later in this section and also referenced in the Diagnostic and Statistical Manual for mental health disorders), the emotional, thought / behavioral responses to the etiology are usually characterized as post-traumatic "stress," or post-trauma "symptoms." Fully developed, the traumatic sequelae, that is, the etiological-to-symptomatic effects of the trauma, have been (since 1980) formerly referred to as a "disorder": "Post-Traumatic Stress Disorder."

Neurological change underpins the sequelae's (or disorder's) psychological ones.
Helping Methods: Nosotropic and Etiotropic

Depending on philosophy, helping methods responding to the trauma induced changes may focus on certain elements of the sequelae. For example, if the primary problem of trauma is seen by a helping method to be the emotional pain and different - apparently abnormal - thoughts/behavior, then the method will attempt to correct the thoughts and behavior and to ameliorate the emotion, returning the person or group to normal status. If on the other hand the problem is seen to be the changes to identity sundered by the event, the helping response attempts to restore that identity, or to reconstitute another one in a like manner, but with consideration for the real life changes that depreciated the original identity in the first place. Some helping methods posit that they give equal attention to both ends of the sequelae - the etiology and symptomatology.

Helping methods that define trauma as a problem by focusing on the symptomalogical elements of the sequelae are said to be "nosotropic." Methods that define the problem by focusing upon the beginning (etiology) of the sequelae are called "etiotropic."

Methodological Problems: Behavioral (nosotropic) vs. Psychodynamic (etiotropic)

When applied to trauma-affected individuals, each of these methods has had its problems.

Etiotropic models, often referred to as "psychodynamic," become overwhelmed by an overload of informational processing required to understand the trauma's effects on identity. Moreover, the symptoms cause havoc for the etiology identification - restoration effort. The symptoms can even prevent the etiology's address.

When viewing the traumatic sequelae from the nosotropic perspective, that is, when using behavioral methods to watch for and then appraise symptoms, and with the intent to stop them, some may not appear or otherwise not be apparent for days, months, or even years. And as symptoms do present, they frequently mimic other mental health problems. Delayed attempts then to understand or define the traumatic sequelae can result not only in confusion, but often in no definition at all.
Meanwhile, the etiology can grow, apparently in the unconscious. After long lapses in time, the event may be forgotten partially or entirely by the trauma-affected individual and also forgotten or in other ways minimized by the surrounding system. Lose memory of the event, lose recognition of the initial assault upon identity, lose the ability to detect the trauma etiology.

**Methodological Problems Produce Cultural Management Ones**

Referenced methodological problems (occurring as prospective remedies for psychological trauma) produce sociocultural management incapacitation.

Absent diagnostic certitude, the sequelae becomes speculation and supposition. And when symptomatic behaviors contrast with social norms, consideration of a trauma-fractured identity as a prospective cause of aberrant behaviors can be and often is argued to be an excuse for irresponsible behavior. Taking on an added social dynamic, not only do the individual's symptoms prevent the etiology's address, but so also does the culture. It cannot allow etiology's address to excuse the aberrant and apparently antisocial behavior. The etiology's address is made more difficult, if not prevented outright.

The trauma-affected individual, culture and the helping methods exist within a problems solving dilemma. The etiology can't be identified, much less addressed directly, without invoking the excuse theory. Failure to address the etiology can effect more symptoms, regardless of assiduously and stringently applied behavioral (nosotropic) attempts to quash the antisocial activities.

Conflict between nosotropic- and etiotropic-oriented peoples and methodologies has evolved. The conflicts have a chilling effect on individual and social remedies. It throttles attempts to understand, treat and manage psychological trauma and its sociocultural influences.

An enigma, that is, not knowing what to do, or if so having to engage dramatic battles in order just to be truly helpful, produces professional management and public attitudes of futility -- perceptions that little or nothing can be done. Social management paradigms are then organized on that premise: futility. Because of it, they function reactively instead of proactively.
ETM Differences

Etiotropic Trauma Management (ETM) approaches the traumatic sequelae differently from either the psychodynamic or nosotropic (behavioral) methods. The underpinning of this "difference" is ETM's structure. It allows an unfettered address of trauma's etiology by dividing it into readily addressable increments; segmentation of tasks makes informational processing (referenced as overwhelming without the segmentation) of the damaged identity logical and sequitur.

The "increments" represent the natural steps that identity goes through in order to complete the extinction of those elements of identity altered by the initial traumatic event. Understanding those steps can lead to their facilitation, which when completed reintegrates pre- and post-traumatic identities into a homogenous one, therein ending the presence of trauma etiology. ETM defines and manages clinical facilitation of those extinction steps as they pertain to each person affected by the event.

In addition, ETM's structure holds off any symptomatic attempts to prevent the etiology's address. Axiomatically, remove trauma etiology and mitigate the long-term - most devastating - emotional consequences and end or preempt symptomatic behavior.

In this approach, ready address of trauma etiology would also preempt the cultural dilemma created by the excuse theory. If the etiology is gone, there can be no symptoms to excuse, making that theory moot. Symptoms cannot exist without an etiology. And non trauma-effected aberrant behavior could not be rationalized by previous traumatic events.

Moreover, removal of trauma etiology and ending of symptoms would also end the cultural enigma as a source of futility. The culture would know how and always expect to win against trauma and its symptoms. That expectation would be built into all systemic management paradigms, allowing attitudes to shift toward the use of proactive methods that preempt the sequelae's full development at both individual and systemic levels. ETM assists organizations to identify and remove trauma etiology at those levels.
Chapter 3 Section (a)

The Paradoxical System of Control: The Survivor

The 4 patterns, including the etiology, are defended by a paradoxical system of control; the trauma victim is perpetually and simultaneously attempting to end and continue the trauma's effects. The paradox keeps the etiology from being reversed and at the same time tries to find the means to reverse the etiology. As long as extinction of existential identity is not completed, the paradoxical system of control is needed. It will:

1. produce post-traumatic symptoms
2. function as a consequence of post-traumatic symptoms
3. produce more etiology
4. maintain itself by paradoxically maintaining the etiology: its reversal or ending would end the need for and existence of the paradoxical system of control

This control apparatus is also referenced as the "Survivor."

Control and Operational Identity

So far, ETM theory has considered primarily existential identity's influence by traumatic events; the foundation of psychological control, which also influences an element of identity, has not been explained. This section provides that explanation.

Although psychological control enjoys a relationship to existential identity, control is an active process that emanates from identity's other component. Because it is active or operationally oriented, it is referenced within ETM language as "operational identity."

Operational identity is comprised of action-oriented attributes (inherent capacities to do or experience certain things), interactions between the attributes and existential identity, and interactions between the attributes
themselves. In this definition, these "attributes" are categorized as existing in 2 groups having different orientations; there are rational/cognitive- and experiential-oriented attributes.

Rational/cognitive attributes can include the abilities to:

- establish, discern, accept or discard various values, beliefs, images, and realities,
- think
- learn
- perform tasks
- analyze, interpret and plan events,
- strive to control one's own destiny through the assertion of individual will

Attributes stemming from experientially-oriented brain functionings include abilities to:

- sense
- feel
- be creative
- be spiritual
- empathize, intuit, care
- love, reproduce and manifest sexuality.

Thus, the most distinguishing characteristic between operational identity and existential identity is that operational identity is action-oriented, and existential identity is grounded in basic, developing and, eventually, fixed attitudes.

Following the event, trauma-affected control functions rely increasingly on rational/cognitive oriented attributes during survival and less upon experiential attributes. The latter group of attributes, experiential in their orientation, are also repressed along with the loss and accompanying emotional counterparts comprising the 4 psychological trauma patterns. This unbalanced use of attributes results in a divided operational identity. To compensate for this division the psyche produces a new and overlaying thought system: the Survivor.

The Survivor serves as a connecting element between the conscious use of rational attributes and the repressed aspects of the psychological trauma
patterns and experiential-oriented attributes. Herein lies the crux of the Survivor's psychological formation; its primary goal of protecting the person is underpinned by dual and opposing missions. On the one hand, the Survivor attempts to resolve the trauma (reverse the etiology) retained in the subconscious: end that trauma's effects on the psyche. On the other hand, the Survivor has to prevent this resolution: the reversal of the etiology would result in the end of the Survivor's protective existence. Thus, the Survivor is paradoxical in its orientation and its functioning. That is, the Survivor exists as a thought system engaged in a tug-of-war with itself.

In this theory, the paradoxical system of control, the Survivor, is a cyclical and self-perpetuating phenomenon that controls the person, including his or her perceptions, experiences, and decisionmaking processes to the extent that everything is assimilated in a way that leads to the trauma's resolution, but at the same time prevents that resolution. The paradoxical system also makes no distinction between itself and the person, the psychological management system that existed before the Survivor's formation. As a rule, there can be no realization by the person of this condition's existence until its influences are ended and the person's psychological controls are returned to their pretrauma functioning.

**Survival Responses to Psychological Trauma**

The paradoxical system of control produces thoughts and behaviors; they are manifested as survival responses. Other people, professionals, and various groups refer to these responses as "symptoms" of psychological trauma or symptoms of post-traumatic stress disorder. In some programs, responses are simply called "defenses."

For purposes of consolidation, those responses/defenses are presented here in 9 general categories. Each category is accompanied by an outline of the category's contents.

1. The Survivor is instrumental in saving the Self and others. This action includes:
   - The saving of physical life: one's Self and others
   - Attempting to prevent future trauma-causing events from occurring
   - Providing emotional support, caring, and physical protection
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- Providing courage for standing against intrusion, hostility, and domination
- The maintenance of intellectual integrity: standing for principle and ethics.

2. The Survivor provides for the recollection or reliving of the trauma-causing events, including:
   - Partial recollections
   - Nightmares.
   - Reliving the event with absolute clarity and accompanying emotional experience: reliving is experienced as if the event is a movie being viewed on a screen.
   - Obsessive recollection of the event(s).

3. The Survivor provides for additional signals that tells others that the trauma, to include the memory of the event, contradictions to existential identity, repression of emotional pain and loss, and interruptions to the operational identity that existed prior to the event, although unseen, do exists. Those signals can come in the form of:
   - Startle response
   - Hysteria
   - Hyperarousal
   - Paranoia
   - Self-pity, self-blame, and self-absorption.
   - Cyclical degeneration into inexpressible and unanswerable emotional pain and loss.
   - Depression

4. The Survivor provides for the means of living life without conscious experience or recollection of the event or the internally retained damage resulting from it. Such provisions can include:
   - Complete, near total, loss of memory of the event
   - Rationalization and minimization of the event(s) or circumstances leading to the trauma's occurrence(s)
   - Intellectualization of the circumstances surrounding the event(s) to the extent that the sources of the trauma (for example, "source" can be chemical use, chemical dependency, or physical abuse) are ignored
   - Denial ("denial" in this use refers to suppression followed by an intense effort to not discuss anything related to the experience) of the trauma and the event(s).
5. The Survivor provides for the means of defending with projection the person; the defense is against the reality of the damage to existential and operational identity. Projection can include:
   o Transferring the locus of the unconsciously retained trauma to the thoughts, actions, and motivations of others, and usually not the perpetrator, the actual initiator, of the trauma.
   o Physical/sexual assault
   o Aggrandizement: the acquisition of things or power to the extent that others are harmed
   o Other anti-social activities
   o Homicide.
6. The Survivor defends the person from the realization of the damage to existential and operational identity; the means of the defense is counter projection: the assumption of responsibility for traumatic events not caused by the trauma victim. Such counter projections can include:
   o The feeling of guilt as an emotional response to a traumatic event caused by someone or something else
   o Alignment with and/or protection of the perpetrator of the trauma-causing event(s)
   o Continuing to stay in a recurring trauma-causing situation
   o Compulsive obsession with the perpetrator of the trauma
7. The Survivor provides for strength with which to overcome the trauma and its effects. Such strengths can include:
   o Stoicism
   o Stalwartness
   o Determination, including driven or obsessive determination
   o The achievement of economic/social success and control
8. The Survivor produces an environment through which the internal dynamics of the trauma are accorded adequate time and the appropriate distance from the influences of external forces; these forces can include attempts to help the trauma victim. Some of these responses can be:
   o Withdrawal
   o Isolation
   o Aimlessness
9. The Survivor provides for attempts to end the internal experience of emotional pain and loss. Such provisions can include:
   o Fusion or inextricable pairing with another
   o Increased dependence on other family members or friends
Repeated reliance upon professionals and/or helping groups, including self-helping groups, for assistance

Suicide

Survival Thought and Behavior: A Dichotomous Experience
The manifestation of survival thought and behavior is usually a dichotomous experience. This means that trauma victims present their survival responses in opposites. In pronounced cases of psychological trauma, the variations between survival responses can be extreme. For example:

1. The family member involved with a chemically dependent person routinely will try to prevent future trauma-causing events, additional drug use behaviors, from occurring (survivor characteristic 1.B; from now on the "Survivor characteristic" delineation is dropped in these examples), and at the same time, or shortly thereafter, deny that the previous events have occurred (4.D), or deny that there is a drug problem at all (4.C).
2. Trauma victims proceed through protracted periods of denial (4.D) or loss or near loss of memory (4.A) of the traumatic event; trauma victims also may periodically engage in unending, obsessive, recollection of the experience (2.D).
3. People affected by trauma will withdraw and isolate themselves (8.A, B); these behaviors are then offset by fusion or the expression of a clinging need while looking for support and assistance (9.A, B, C).
5. Periods of obsessive determinism (7.C) are offset by periods of aimlessness (8.C).
6. Periods of success, for example, getting in control (7.D), are offset by the experience of a degenerative cycle of inexpressible and unanswerable emotional pain, confusion, and loss (3.F); the person becomes devoid of control and experiences profound failure.
Chapter 4 Section (a):

Psychology of Trauma Etiology's Reversal

Etiotropic Trauma Management reverses psychological etiology by applying the structured psycho dynamic model TRT (Trauma Resolution Therapy). This chapter explains etiology reversal within the context of TRT's application, but without considering the specifics of how TRT is applied. You may find that explanation (and this chapter's description of theory alongside of its correlate application components) under Clinical/ Long-Term Trauma. I recommend that version over this one, as it makes for fairly lengthy abstract description of etiology reversal theory.

TRT Phase One

The first phase of TRT begins the resolution process with the identification of the trauma-causing event, which is responsible for initiating development of the 4 psychological trauma patterns (About/ Theory/ Psychology of Trauma Etiology) in the first place. During this identification, the client sets aside Survivor-initiated coping philosophies adopted as defenses to the retention of the patterns and instead directly addresses the emotional experience created by the traumatic event.

The combination of the writing, reading, and feedback elements of the therapy strengthen the patient's capacity, and initiate the client's interest, to learn all there is to know about the trauma's effects: the patient gains the means and confidence to continue the resolution process until it is completed. That "completion" includes reversal of the etiology: reconciliation/reconstitution of existential identity that was contradicted by the events described in Phase One.

Etiology-reversal of the first etiology is achieved through application of TRT Phase Two. That reversal is the subject of the next section.
TRT Phase Two:
Overview Etiology One Reversal

TRT resolves psychological trauma by reversing the etiology described in patterns 1 and 3. As indicated in the preceding section, to begin this resolution process, TRT Phase One initiates the resolution effort by identifying the trauma-causing event that created the etiology. This identification then opens the door to the address of the etiology referenced in pattern 1; the reversal is facilitated through the application of Phase Two. Phase Two takes specific steps to reverse the etiology (from now on also referenced as "etiology one") attending this pattern. Those steps include the:

- identification, experience, and expression of the emotional elements of grief cycles accompanying loss resulting from specific contradictions occurring as responses to the event
- identification of the contradicted elements of identity
- identification, experience, and expression of the loss that resulted from the contradictions and that necessitated the grief cycles.
- reconstitution of the damaged identity.
- regaining of control.

Completion of these tasks expunge patterns 1 and 2 from memory, or as explained in the biology section, the identity is reconfigured to its pre trauma existence, but within the context of the current reality. "Reconfiguration" and "expunge" are both functions of learning "what happened" to the psychological management system following, and as a direct consequence of, the effects of the traumatic event.

Phases One and Two also neutralize the paradoxical system of control that defends the trauma; in providing this neutralization, control is regained. The paradox, however, is more suitable for description, the concept is easier to understand, when relating it to the thoughts and behaviors that result from the paradox. We offer this explanation in detail when describing Phase Three's effects on pattern 3, the pattern that retains, in memory, the contradictions to identity caused by the paradox initiated survival thoughts and behaviors (see the next "Phase Three" subsection). Once the explanation of the paradox is more fully provided there, we show how its undoing is also facilitated by Phases One and Two. Consequently, the paradox and the issue of control, although profoundly influenced by Phase Two, are not fully discussed until later.
Parallel Grief Cycles

The reader who has read the previous chapter (About/ Theory/ Psychology of Etiology Reversal) will likely recall that the discussion of parallel grief cycles was postponed because the subject might be more theoretically appropriate when the cycles are seen as a response to the resolution process. I'm going give that explanation here as the cycles relate to the 4 psychological patterns. Then I'll discuss etiology-reversal in detail.

When using the term "grief cycle," it is intended to refer to the repeated and generally sequential occurrence of certain emotions. In the end, all of the emotions, including their experiences, relate to the reconciliation and resolution of 1 or more losses that have a specific relationship to an element of existential identity that has been contradicted by an extraordinary event.

"Grief patterns" would provide the best word choice. However, delineation from the 4 psychological trauma patterns providing the mainstay of the overall ETM theory of psychological trauma and the distinction of the relationship of the grief to the 4 patterns would be made more difficult if "patterns" were used twice.

In the case of psychological trauma, the loss is unexpected. Furthermore, the loss is a consequence of radical, real and sometimes portentous change that demonstrates that the ongoing status of the organism, or some aspect of that status, is in jeopardy.

These losses can be related to the loss of tangible items, for example, a home, loved one, part of the human body, or the body's capacity to function. The loss can also be related to less tangible issues, for example, esteem, worth, and relationship elements like trust, respect, companionship, socialization, an image of what the family is supposed to be, and so forth. If the loss is of tangible items, this kind of loss will also be accompanied by intangible losses. Finally, losses can occur across all dimensions of human psychology to include intrapsychic, interpsychic, and systemic variations of that psychology.

The grief cycle is associated with the loss resolution process to the extent that the individual suffering it is likely to experience, prior to identification of the loss, the emotions of shock, disbelief, confusion, pity, fear, anger, embarrassment, hurt, guilt and sadness. Other losses can produce a re-
experience of the same emotions. Consequently, the term "grief cycle" to which we refer is the progression through the emotions described in the previous sentence, and in a general order depicted in the same, with the final component of the progression being the identification, understanding and acceptance of the particular loss being addressed by the progression. The literature is replete with the recognition of such grief cycles and their relationships to various kinds of losses (see About/Comparison - Contrast and About/Bibliography).

When an individual completes all of TRT's phases, he or she progresses through 3 general grief cycles related to the reversal of the etiologies referenced to exist in pattern 1 (etiology one) and pattern 3 (etiology 2). For purposes of clarification and codification, we title the grief cycles as: (A), (B), and (C).

The grief cycles are related to and comprise elements of the 4 psychological trauma patterns. We distinguish these cycles from the patterns because such delineation clarifies our observations of the trauma resolution process as it occurs, not just in the application of TRT Phase Two, but in all of the TRT phases. Further clarification of these cycles is provided here.

Parallel Grief Cycle: (A)
The first cycle (A) is related to those losses that result from the initial trauma-causing event. However, the cycle is divided into 2 therapeutic experiences: TRT Phase One and TRT Phase Two. That is, when the individual describes a single trauma causing event, he or she initiates grief cycle (A) and completes the first half of that cycle (A). For example, the emotions usually recorded in the Phase One description are of numbness, shock, disbelief, the state of being unreal, pity, fear (including where appropriate horror and terror), and embarrassment.

When the trauma victim completes the application of the Matrix to that same incident, the second half of the emotions representing grief cycle (A) are experienced. They present for observation.

For more detail, when the person is working in TRT Phase Two, the emotions experienced (while being recorded in writing and then shared when the Matrix is read) are generally anger (rage), hurt, depression, guilt, and sadness. When the losses are identified, experienced and expressed in column 4 of the Matrix, this grief cycle (A) is completed. Consequently,
through the use of TRT Phases One and Two, grief cycle (A) is identified, experienced, expressed and then completed for each loss resulting from each initial trauma-causing event. As the reader can probably see, grief cycle A comprises the emotional components to psychological trauma patterns 1 and 2.

Parallel Grief Cycle: (B)
We observed a second grief cycle (B) that is similar to the first, except that the cause of the losses to which the cycle relates are the trauma victim's own behaviors: survival responses (to the initial trauma-causing events) that also contradict values, beliefs, images and realities. This cycle is divided into two groups as cycle A was divided.

In this division, shock, disbelief, the state of being unreal, fear and embarrassment are usually experienced during the first part of the cycle, during the client's use of TRT Phase Three (explained in the referenced section). The emotions comprising the second part of cycle (B) are usually experienced while the trauma victim is completing TRT Phase Four: the identification of contradicted values, beliefs, images and realities and identification, experience, expression and reconciliation of losses resulting from those contradictions. Thus, grief cycle (B) comprises the emotional components of psychological trauma patterns 3 and 4.

Parallel Grief Cycle: (C)
The third grief cycle (C) relates to losses resulting from all the traumas pertaining to the entire experience as a single source of trauma: as the experiences have resulted in a single impact upon the individual's life. For example, when a spouse of a chemical dependent person completes all 5 TRT phases, he or she looks at the entire experience for its total effect. In some cases, this total effect may encompass as little as 6 months, or as much as 35 years, of one's life.

The grief cycle (C) relates to this total effect and is manifested as a parallel grief cycle (C) to the first two cycles (A) and (B). In this regard, the client experiences generalized feeling states in addition to the specific feeling states associated with specific losses. In TRT Phase One, the generalized feeling states (stemming from grief cycle C) are shock, disbelief and horror. While completing TRT Phase Two, the generalized states are shame, anger, and hurt. Phases Three and Four are manifested in cycle (C) by, respectively, guilt, sadness (TRT Phase Three) and profound sadness or deep mourning.
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Parallel Grief Cycles: Summary
To summarize the three grief cycles (A), (B), and (C), cycle (A) is a consequence of the individual's grieving specific losses directly resulting from the initial trauma-causing event(s). This cycle (A) comprises psychological trauma patterns 1 and 2 and is experienced over TRT Phases One and Two. Grief cycle (B) is also a consequence of the trauma victim's grieving specific losses, but losses that result from the trauma victim's own behaviors -- that is, survival responses to the initial trauma-causing event(s). This cycle (B) comprises psychological trauma patterns 3 and 4 and is experienced (divided) over TRT Phases Three and Four. Grief cycle (C) is manifested as a parallel, overlapping, experience to cycles (A) and (B). Cycle (C) is experienced as a general manifestation of grief comprising all four psychological trauma patterns and is experienced evenly over the entire 5 phase Trauma Resolution Therapy process.

Detailing Etiology Reversal:
Resolving the Initial Trauma
The application of the Matrix resolves the initial trauma: reverses etiology (one) directly caused by the event, as opposed to reversing etiology (two) indirectly caused by trauma-induced survival responses (described in chapters 3 and 4). To achieve this resolution, the client transacts 2 parallel and existentially oriented processes: 1) the identification and experience of specific emotions comprising grief cycles (A) and (C) and simultaneous with 2) the intellectual assimilation, reassociation and reconstitution of those values, beliefs, images and realities comprising pre trauma existential identity and that were contradicted by the event(s).

Resolving the Initial Trauma:
First Resolution Component; Emotional Processing of Grief Cycles (A) and (C)
In the first process, that is, while negotiating the passage through the emotional component, the trauma victim proceeds through grief cycles (A) and (C). With regards to cycle (A), by the time clients are working in Phase Two, they have already addressed in Phase One the first elements of that cycle; clients have identified, experienced and expressed shock, disbelief, fear and embarrassment.

However, when clients apply the incidents to Phase Two they re-identify and
re-experience those emotions again, but without the volatility that accompanied their identification and experience in Phase One. The additional emotions recorded in column 2 of the Matrix are usually feelings that continue the person’s progressions through cycle (A); those emotions are often shame, anger, and hurt.

As the person progresses across the form, contradicted values, beliefs, images and realities (column 3) and subsequent losses (column 4) are identified and the rest of grief cycle (A) is negotiated. Guilt and sadness are the predominant emotional experiences reported as that part of the Matrix is completed.

The feedback processes described in Clinical/ TRT Phase One and Two provide for the clients' identifications of the emotions, as well as provide for their experience and expressions. The person identifies the particular emotion and then remains with the experience and without associating it with any particular intellectual thought.

This experiential process continues until the emotion is expressed. The feelings -- experiences eventually dissipate.

Because the client's use of the Phase Two format provides for the inevitable association of these feelings and feeling states to the specific contradictions and losses underpinning their existence, it is not necessary to use analytical cognitive methods during the experiential component of the effort to provide such associations. For example, when someone expresses profound sadness or hurt, it is unnecessary to facilitate the association of those particular feelings to a particular contradicted belief or loss because the structure provides for such association automatically.

A subsequent and central value of the structure is that it allows for the emotions to be experienced to the extent required individually. Phase Two makes guesswork obsolete, which interrogatory activities are shown through facilitation of TRT to divert the person from the full experience. Subsequent stabilization facilitates thorough understanding.

With regards to grief cycle (C), clients notify therapists of this ongoing process when asked to discuss the emotional experiences they are having outside of (following) their TRT sessions. As indicated in the preceding section on grief cycles, the trauma victim usually experiences
embarrassment to the extent that it becomes great shame, and anger to the extent that it becomes rage. These 2 feelings characterize the client's general emotional progressions through Phase Two.

To summarize the emotional process, clients, as a rule, readdress (re-experience) the shock, disbelief, fear and embarrassment already addressed in Phase One, but without the volatility and intensity accompanying initial elements of that Phase. As the client proceeds across the Matrix, he or she will continue negotiating cycle (A), all the while identifying, experiencing and expressing those emotions comprising that cycle until those emotions no longer exist. Outside of the group process the predominant emotional experiences are great shame and rage. These latter and sometimes general characterizations of emotional experience indicate that the individual is progressing through grief cycle (C): the emotional processing related to all the episodes taken as a single life experience.

Resolving the Initial Trauma: Second Resolution Component; Intellectual / Experiential Reconstitution of Existential Identity
The second resolution component provides for the combined intellectual and experientially influenced reconstitution of existential identity. Completion of this component involves completing the last 4 (b, c, d and e) resolution steps described earlier and reviewed here:

- b. identification of the contradicted elements of identity
- c. identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles)
- d. reconstitution of the damaged identity
- e. regaining of control.

Identify the Contradicted Elements of Identity (b) and Identify, Experience and Express Loss (c)
Loss is a paradox. That is, the term "loss" is intended to represent something that no longer exists, but in that non existence there is a psychological (and neurological) reality, and although frequently unknown, this new reality is equal to any other element of the psyche. The identification of this loss is always tied to the successful identification of that which existed prior to the occurrence of the loss: the particular element of existential identity contradicted by the intruding episode.
Therefore, when completing the third and fourth columns of the Matrix, clients first identify the contradicted values, beliefs, images and realities that comprised themselves before the intrusion; second, clients identify the loss that had become a replacement for those values, beliefs, images, and realities which used to exist unfettered, uncompromised, and unchallenged in the psyche. Following the identification of the loss, it is also experienced to the extent that it carries with it its own characterization of feeling. In other words, the loss is both an element of existential identity, that is, a replacement for seemingly non existent values, etc., and a feeling experience in its own right.

Trauma victims negotiate this experience by stating that it is occurring, and then as occurs in other experiential processing, the client remains with the experience of the loss until it no longer is manifested: the loss is dissipated. This "remaining with the feeling of loss" is a profoundly sad experience. Moreover, the experience of loss is also antithetical to control, which experience requires its own description.

"Antithesis of control" is manifested by some as "nothingness" and a "dark, deep and bottomless void." The passage through this experience of "nothingness" and "bottomless void" proves to be the ending of it.

Some clients also report that prior to using TRT they had routinely entered (that is, felt as if they were entering some form of passage) these experiences of "nothingness" and "voids without ending" and become frightened by the prospects that they would never exit these passages. However, in TRT, the structure, to include the written component completed prior to its reading and the group's continued and consistent feedback to have been demonstrated (in Clinical/ TRT Phase One) to accompany the person to any level of internal introspection and emotional pain, replaces this fear of not exiting the dark passages.

The structure assures the individual that the venture through such passages are a matter-of-fact therapeutic process. Assisted excursions into previously unknown areas, which, based on the experience of the first TRT phase, undoubtedly result in a positive outcome. Patients and facilitators learn to trust the structure implicitly.

As the passages through "nothingness" and "the void" are negotiated to the
extent required individually, the vacuums previously comprising these passages are dissipated. Moreover, the "nothingness" and "void" are replaced with the trauma victim's reconstitution of those values, beliefs, images and realities that had existed prior to the trauma's occurrence, and which had been contradicted to the extent that the "nothingness" and "void" had been created in the first place.

Importantly, when values, etc., are "reconstituted," they are maintained in the existential identity depending on the ontology of the individual; the retention is not a function of the values of those administering the therapeutic process. This ability to select elements of existential identity that are now pertinent to the individual ontology, or to discard other values, beliefs, images and realities no longer pertinent to that ontology, represent a manifestation of the trauma victim's reestablishment of control: the regaining of free will, the ability to choose.

Etiology one is reversed.

After discussing the trauma-induced paradoxical thought system that encumbers control, the next section describes the referenced process through which TRT reestablishes control.

TRT Phase Three

Paradox and Survival Response Create Problems for Etiology Reversal
We should remind the reader that at the third phase of TRT, although the etiology (one) caused by the initial traumatic event has been reversed by the application of Phases One and Two (patterns 1 and 2 no longer exist), the etiology caused by the action of survival response, the contradiction of existential identity, has not. Therefore, sufficient etiology remains to continue some paradoxical influence during the application of Phase Three. If this influence is not addressed, it can and will effect the opposite outcome desired: the paradoxical influence can and will prevent the reversal of the etiology (two) attending pattern 3. Where this section overviews this problem, a fuller description of it is provided in About/ Comparison - Contrast/ Neurobiology.

Phase Three identifies survival responses. The identification leads to Phase Four's reversal of the etiology. However, if the paradox is inadvertently
strengthened during the Phase Three process of identification of survival responses, then the etiology will not be reversed.

This "strengthening" occurs when, following Phase Three's identification of the responses, the paradoxical control system initiates and manages ongoing and usually *repeated attempts to change* the behaviors. If these attempts are allowed, they will divert attention from the remaining resolution process. The attempts to change behavior in mid stream (Phase Three is halfway through the entire resolution process) will alter the direction of the therapy such that its goals of identifying and reversing the second etiology no longer exist. The new goals would become identification and reduction of the trauma's symptoms (survival responses).

Symptom-reduction activities engage completely different brain functions from those that provide for the experience of grief (see About/ Theory/ Neurobiology/ Etiology/ Etiology Reversal, and About/ Comparison - Contrast/ Psychology and Biology) and emphasizing symptom-reduction over existentially-based functions at this time can not only end the resolution process altogether, but failure to use the proper amount of existentialism to complete the grief functions can and will strengthen etiology in the long-run, making matters worse (the person can lose trust that the condition can be overcome).

This "paradoxical-strengthening" must and can be avoided. Recommendations are provided in the facilitation section of Clinical/ Long-Term Trauma/ TRT Phase Three (following the descriptions of how to write and read Phase Three).

Phase Three Initiates Etiology Two's Reversal (Etiology Two attends Pattern 3) Clients progress through Phase Three accordingly.

First, Phase three provides cognitive connection between survival responses to etiology resulting from the initial traumatic event. One continuous system of logic tracts the fact of the occurrence of the event (Phase One - Pattern 1), to the event's effects (Phase Two - patterns 1 and 2), to trauma victim thought and behavior (Phase 3 - pattern 3).

Second, Phase Three initiates the passage through grief cycle B. The person identifies, experiences, and expresses the first emotional components of that
pattern. Those emotions include shock, disbelief, and fear.

Third, grief cycle C is continued. The client identifies, experiences and expresses profound sadness. This sadness is related to the entirety of the trauma's effects. The person sees survival thought and behavior both as damaging and as a consequence of damage resulting from the original identity.

Fourth, Phase Three recapacitates operational identity: returns control. As indicated at the beginning of this chapter, however, this return of control occurs first during applications of Phases One and Two.

Because the paradox’s effects on control were not described in earlier sections addressing etiology reveral in TRT Phases One and Two, the description of the return of control was delayed until the paradox was explained in this section. Consequently, before continuing with the description of the influence of Phase Three on control processes, I'll take time out here to discuss Phase One's and Phase Two's influences on the same.

Regaining Control: Phases One and Two
The first vestages of control begin to occur while the trauma victim is progressing through TRT Phase One. Behavioral manifestations of this appearance include the ability to remain in therapy, recall and relate a story previously not recallable or describable, and not be controlled by wide emotional swings or outburst, including hysteria, hyperarousal and other symptoms of trauma that prevent people from addressing it.

I emphasize "appearance of control" because these controls are in large part provided by the TRT structure. The trauma victim is drawn through the experience by the logic and the dictates of the controlled writing, controlled reading, and controlled feedback.

In Phase Two, this appearance (of returning control) becomes real. It is located in the client's psychological management system as opposed to the therapy.

For additional detail, as the trauma victim progresses through the reading of the Matrix, the person completes grief cycle (A) for a portion (usually half) of the total number of trauma-causing incidents applied as rows to the
Matrix, the person identifies contradictions to existential identity and then identifies, experiences and expresses loss directly resulting from those contradictions, the person begins to effect his or her choice over the reconstitution of the reestablishment/reconstitution of existential identity. Simultaneous with the initiation of this newly reconstituting management (control) process, the person also begins, outside of the TRT process (usually in parallel "here and now," couples, or family groups) to demonstrate the ability to interact between experiential and rational/cognitive oriented attributes to the extent that the person can modulate feelings with intellectual processes.

These feelings can be 1) related to the traumatic event(s), 2) emerging in response to interaction with other trauma victims who are addressing their traumatic episodes, or 3) occurring as a response to discussions about issues separate from the trauma resolution process (or as indicated in parallel clinical processes). Moreover, projections onto perpetrators, that is, upside-down perceptions of the locus of responsibility for the trauma-causing events (where the client assumes responsibility for the perpetrator's acts) are also ended. And, trauma victims assert, where applicable (prospective exposure to additional trauma-causing events: the TRT participant is a spouse of an actively-using chemically dependent person), that the trauma-causing events will be concluded. Behaviors described in codependency treatment literature as enabling behaviors cease.

Further indications of control being regained include perpetrator confrontation where appropriate (safe). Such confrontations usually occur when spouses intervene on chemically dependent people who are still using.

In such cases, the spouse (TRT participant) usually demands both an end to the use and participation in an abstinent oriented helping process as a condition for further interaction (a continuing relationship). If these two conditions are not met, and with conviction of commitment, the trauma victim likely sets out on a new life path that does not include the perpetrator (still actively using chemically dependent person). (If you believe this to be harsh, please read the "Codependency" examples in Clinical/Long-Term Trauma/TRT Phases One - Five.

Regaining Control: Phase Three
Phase Three continues the return of control. This return is demonstrated by increased interaction between rational-cognitive and experiential oriented
attributes and between all attributes and the existential identity.

Examples include the growing capacity to modulate between intellectual and emotional experience and to choose the most beneficial life direction. This choice is based on individual needs and interests forming out of the newly reconstituting existential identity. "Growing" means that these changes occur on a continuum in concert with the progress initiated in Phase One, strengthened in Two, and continued in Phase Three.

**Responsibility**

In TRT sessions, and in contrast to other forms of therapy, trauma's resolution is primarily a management (therapist) as opposed to individual (patient) responsibility. In TRT, responsibility is not conveyed by projecting it didactically; for example, the slogan "People" or "You," meaning the patient, "ought to be accountable and responsible," is replaced with an alternative slogans: "I am responsible to this patient," and "I am responsible for the success of the therapy that I deliver." TRT does meet this responsibility; it is accountable to the patient. It does reverse psychological trauma's etiology.

In addition, on observing the facilitation of the patient's identification of survival responses that function contrary to the individual's (and the culture's) best interests, some clinicians may ask why the therapy does not shift its focus to one that attempts to change that apparently (from some views) irresponsible behavior, in the process incorporating the standard psychotherapy application where the teaching that assumption of personal responsibility for individual behavior is the mainstay, or primary goal, of the clinical process.

The complete answer to this important question is long and complex, and considered again in other parts of the book including the neurobiology chapters in About/ Theory and Comparison - Contrast, and in the Clinical and Strategic segments of the book. I can say here, however, that where I assume that many people no doubt would benefit from such teachings, trying to enforce controls over trauma-induced behavior can strengthen the paradox described in this chapter and in the process produce the opposite outcome desired.

A strengthened paradoxical system of control will almost always, or
eventually, produce apparent aberant or irresponsible behaviors: ones that function not only countervailant to the individual's interest, but also as antithetical to universal cultural standards.

Given that this hypothesis may be correct, responsibility-teaching methods would be destined, when applied to trauma victims, to become part-in-parcel the new problem. They could lock the etiology into place by strengthening the paradox against the trauma's resolution, cyclically and continuously producing apparent irresponsible behaviors and regardless of the assiduity with which the behavioral control methods were applied.

Moreover, because TRT does not engage in judging behavior, it functions apolitically. And because this functioning stands in contrast to the responsibility-teaching paradigm (the nosotropic approach) where helping is occurring politically, that is, the culture is attempting to conform individual behavior to cultural standards, conflict between the models can arise. **Strategic** sheds some light on how this conflict is reconciled through application of ETM.

**Biology of Resolution and Control**

The reader will remember that these chapters are presented from the psychological paradigm. About/ Theory/ Neurobiology/ Etiology and Reversal, supported by About/ Comparison - Contrast/ Biology, present the biological perspective of resolution and control, a perspective that is grounded in molecular terms as opposed to behavioral. Those chapters explain, among other things, the great value of emotional pain to neuronal molecular change, the structural and functional substrate of resolution and control.

The next section describes the rest of the trauma resolution process. It regards reconstitution of existential identity contradicted by survival responses.

**TRT Phase Four:**
**Reversing the Last of the Etiology**
**(Etiology Two, Attending Pattern 3)**

Phase Four reverses the etiology attending pattern 3, but does so by first completing the address of pattern 4. Phase Four's etiology-reversal process is
identical to the one facilitated by Phase Two (reversal of etiology attending pattern 1), except that the Phase Four effort connects the identification, experience and expression of the loss in pattern 4 and the reversal of the etiology in pattern 3 to the initial trauma. The negotiation of the different grief cycles addressed by Phase Four constitute the additional principal exception, that is, primary difference between Phases Two and Four. This section explains Phase Four's address of patterns 3 and 4, the etiology-reversal process, and the demise of the paradoxical system of control.

Phase Four Facilitates the Emotional Reconciliation Component of the Etiology Reversal Process
Phase Four assists the client to negotiate and complete grief cycle B, the emotional responses to the contradictions resulting from the survival thoughts and behaviors, and grief cycle C, the emotional response to the sum of the impact of the episodes taken as a whole. Excepting the experience in the summary, completion of these grief cycles produces the culmination of the emotional experience; it is hallmarked by sadness and mourning.

Phase Four Facilitates the Contradiction - Reconciliation Component of the Etiology Reversal Process
The client identifies survival response-induced contradictions to values, beliefs, images and realities. To make this identification, pretrauma existential identity must also be identified in order to show the contradictions.

Identification of the contradictions leads to identification of loss resulting from the contradictions. Like the loss addressed in pattern 2, this loss in pattern 4 is, once identified, also experienced and expressed as an emotion.

Phase Four Facilitates the Restoration -of- Control Component of the Etiology Reversal Process
The operational identity formerly divided by the repressed emotion (grief cycles B and C) and the unreconciled loss is reintegrated with the emotion/loss reconciliation; the rational-cognitive and experiential processing attributes now can and do work together to effect control over the psychological management system. The paradoxical system of control has lost its influence and the system no longer exists. The same examples of regained control provided in chapter 3 are applicable in Phase Four, but they are now experienced and demonstrated with a consistency, congruity and certitude not prevalent in the earlier components of the therapy. Moreover, regained control produces the ability to, and does, restore values, beliefs,
images and realities previously contradicted, damaged, by the traumatic event. The person says, "These values and beliefs were me." "They were taken from me -- I was taken from me." "Now, they are mine again. I've got them back. And I've got me back!"

Existential identity affected by the event has now been reconstituted -- etiology two has been reversed. The 4 psychological trauma patterns have been expunged.

Phase Four Facilitates Reconstitution of Existential Identity Within the Current Reality
Etiology reversal provides additional control capacities that include the ability to reconstitute existential identity within the context of the current reality; the person *automatically* evaluates whether the pretrauma values, beliefs, images and realities that have been restored by the etiology reversal process fit today's person. For example, the trauma may have occurred during childhood: the values, beliefs, images and realities contradicted were those of a child.

Once the etiology resulting from those contradictions (trauma) has been reversed, as it has by the application of the 4 TRT phases, the childhood beliefs, etc., may no longer be applicable to the adult. In contrast, some values do not change with adulthood. Through the restoration of an integrated, or reintegrating, operational identity, the person then automatically chooses those elements of identity most important to today's individual: values that fit the ontology of the individual. "Automatically" infers that no additional therapeutic assistance is required to make these evaluations and choices.

**The Trauma is Resolved**

Completion of Phase Four completes the trauma resolution process. Both etiologies, one attending pattern 1 and the other attending pattern 3, have been reversed. Existential and operational identities are restored.

**Phase Five:**

**Concluding and Reviewing TRT**

In TRT Phase Five, the last TRT Phase (for this source of trauma), the client looks back on the resolution process, summarizing the process. This summary is a sad, joyous, and concluding experience. During the review, the
client reports learning, that is, clients will report that they know and understand:

1. Who they were before the traumas occurred
2. Exactly what happened to them because of the events
3. The difference between what they had to do to survive and who they were/are (as people)
4. Who they are now that the traumas have been resolved

These learning experiences then provide the basic criteria for determining if resolution has occurred. "Measuring Trauma Resolution" presents specific guidelines for making this determination.

The person exits TRT for this source of trauma. If another source of trauma exists, the patient will likely discontinue therapy for a while, months or even a year or two. The client will, as a rule, then elect to apply TRT to the other source of trauma.
Chapter 5 Section (a):

How To Facilitate TRT Phases One Through Five

Introduction: TRT

ETM's clinical component is Trauma Resolution Therapy (TRT). It has two primary structures. The first, sometimes called the "TRT Short Form," reverses near-term trauma etiology. The second TRT structure is called the "TRT Long Form" because it reverses long-term trauma etiology.

You will recall from reading previous ETM theory sections that if trauma is not addressed early, that the traumatic sequelae can develop into 4 psychological trauma patterns. They are maintained by a paradoxical system of management control.

As a part of the sequelae's (pattern's) formation, the attendant defensive (paradox) structure will assist the individual to undo the trauma's effects. The same defensive psychological element will also work to maintain those effects indefinitely. Trauma-affected people can exist for long periods in a seemingly never-ending tug-of-war with themselves.

To end this sequelae, TRT's long form, which is comprised of 5 TRT Phases, neutralizes the paradox. TRT then finds and reverses all trauma etiology stemming from the traumatic event or series of events.

This section (referring to ETM Clinical Treatment: Long-Term Trauma Etiology Reversal), shows how to apply TRT’s 5 phases to a single source of trauma.

Entry

Before recommending TRT to a particular client, an assessment, evaluation, and treatment-planning process is conducted (described in "Clinical/ Entry"). If the client has been affected by different kinds of trauma, that entry will help both client and TRT counselor (from now on called "therapist") to determine which trauma is to be addressed first, second, and so forth. ETM
Clinical/ Multiple Sources and Training/ Cases; Examples provide examples of entry management.

The instructions provided in this chapter assume that the:

- etiotropic approach is compatible with the therapist's philosophy of therapy and that individual is certified as a TRT counselor (the therapist has successfully completed the ETM Professional Training School and has elected ETM/TRT certification).
- initial trust-building stages attending traditional therapeutic process have been completed.
- client is appropriate for TRT and vice versa.
- client elects the therapy (informed choice).
- therapy is going to address at this time only one kind of trauma, but possibly occurring through many episodes of a like kind.

Theory Review

ETM/TRT theory is reviewed here for your convenience. The review supports the description of each of the first four of the five TRT phases.

In this theory, traumatic events create (for a trauma-affected individual) a psychological sequelae (a series of interrelated causal effects). In the near term, the sequelae establishes extinction of identity. It disintegrates identity until the extinction process is completed. While extinction is ongoing, survival responses are required. Sometimes, they cause additional extinction of identity.

The referenced sequelae is viewed within ETM theory as occurring or otherwise establishing for the affected individual 4 psychological trauma patterns. When you get to the resolution of the trauma with TRT a little later, you'll see why it is valuable to view the sequelae in this manner. It lends itself to TRT's structured approach, which you will also see segments the sequelae's address by considering each of the patterns, in order of their formation and one at a time.

Before overviewing the application of that structure, here is more information about the proposed composition of each pattern and the psychological apparatus that protects them all. Patterns 1 and 3 provide the locus of the trauma's dual etiologies. The 4 psychological trauma patterns and the etiologies include:
1. The experience of the event contradicts the pre-trauma values, beliefs, images and realities; these contradictions form etiology one.
2. The loss from the contradictions and associated emotional outcomes are maintained in memory, conscious or otherwise.
3. The maintenance of the emotional elements resulting from the contradictions creates the need for survival protective measures -- thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional memory retention; in the process of that dissociation, additional contradictions occur to existential identity; the additional contradictions provide the locus of etiology two.
4. The dissociative activity, the contradictions resulting from survival responses, produce additional experiences of loss and emotion that are also maintained in memory.

The contradicted values, beliefs, images and realities described in "1" and "3" represent the dual etiology of psychological trauma; etiology one is formed in pattern 1 and etiology two is formed in pattern 3. Although the losses described in patterns 2 and 4 are inextricably linked to the contradictions reflected, respectively, in patterns 1 and 3, for purposes of simplification of description, the losses are not at this time included in the locus of the etiology; the losses' relationship to etiology is explained in detail in the About ETM/ Theory/ Neurobiology and Comparison / Contrast/ Neurobiology chapters that address the neurobiology of psychological trauma.

The 4 patterns, including the etiology, are defended by a paradoxical system of control where the trauma victim is perpetually and simultaneously attempting to end and continue the trauma's effects; the paradox keeps the etiology from being reversed and at the same time tries to find the means to reverse the etiology. TRT neutralizes the paradoxical defense structure and then addresses each psychological trauma pattern, one pattern at a time and until the trauma, its etiology, and its effects have been expunged from the reality system. Ending of the patterns' retentions in memory through reversal of the etiology ends the paradox; pre trauma psychological management control is restored.

**TRT has 5 Phases**
To reverse the etiology and remove the patterns from memory so that the psychological trauma no longer exists, the elements of existential identity contradicted by the traumatic event and then additionally contradicted by the dissociative survival response to the event must be identified and reconstituted. Identification and reconstitution of existential identity is achieved through a series of steps, called Trauma Resolution Therapy (TRT) Phases.

There are 5 TRT Phases. Each addresses a particular segment of the long term traumatic sequelae. The first 4 Phases also correlate to the 4 psychological trauma patterns. The last TRT Phase (5) serves as summary and conclusion of the resolution, and the clinical process.

### Four Psychological Trauma Patterns and TRT's Structured Approach to Resolution

<table>
<thead>
<tr>
<th>Pattern One</th>
<th>TRT Phase One</th>
</tr>
</thead>
<tbody>
<tr>
<td>The experience of the event contradicts pre-trauma values, beliefs, images and realities.</td>
<td>Begins the identification of the contradictions by assisting the patient to first describe the experience created by the event.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern Two</th>
<th>TRT Phase Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following the event contradictions, the related loss and associated emotional responses/outcomes are maintained in memory. Sometimes (often), the most painful aspects of these retentions are suppressed into memory so that during survival a person can still function.</td>
<td>Helps the patient to identify and reconcile the contradictions to (intrusions upon) identity. He or she may also restore that identity by completing Phase Two.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern Three</th>
<th>TRT Phase Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maintenance of the emotional elements resulting from the contradictions creates the need for survival protective measures: thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional memory retention; in the process of that dissociation, some protective behaviors function contrary to identity, creating additional contradictions for it.</td>
<td>Makes it easier for the patient to identify and to understand how the trauma influenced thought and behavior while trying to survive.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern Four</th>
<th>TRT Phase Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>The contradictions to identity (caused by dissociative - aberrant behavior and other activity) produce additional experiences of loss and emotion; they are maintained in memory.</td>
<td>Helps the patient to identify and reconcile contradictions to identity created during survival. Phase Four also assists restoration of identity caused by the trauma. Excepting the summary of the resolution process provided in TRT Phase Five, this fourth TRT phase completes the</td>
</tr>
</tbody>
</table>
TRT Phase Five

Phase Five summarizes the four phase resolution process and concludes TRT. The summary reviews the patient’s understandings of:

1. Who she or he was before the traumatic event occurred.
2. What happened to him or her because of the event.
3. The differences between who the patient was and what he or she had to do to survive.
4. Who the patient is now that the trauma is resolved.

Phase Five’s conclusion facilitates the patient’s exit from TRT.

Multiple Sources

There are many sections in the About and Clinical sections that discuss TRT’s application to multiple sources of trauma. For quick review, when more than one source of trauma exists, all 5 phases of TRT are applied to one source at a time and until the etiology comprising that source is reversed. Following the formula for addressing multiple sources, TRT’s 5 phases are then applied to any additional sources, but always one source at a time. Clients usually exit therapy for a while, however, between the address of the sources.
Chapter 5 Section (b):
How To Facilitate TRT Phases One Through Five

TRT Phase One

This chapter:

- Shows how to apply TRT during the entry level of the trauma's address.
- Explains the written, oral, feedbacking, and facilitative components of Phase One.
- Provides observations of patient responses to the use of Phase One.
- Overviews pertinent (Phase One) elements of the TRT theory of resolution.

Identification and reconstitution of existential identity is achieved through a series of steps, called TRT Phases, that begin with the identification of the trauma-causing event itself; this initial identification, step, is referred to as TRT Phase One.

Phase One event-identification has two parts: writing and reading. Usually, the writing is accomplished outside of the therapeutic session. In difficult cases, the writing occurs in conjunction with the therapist's assistance. The writing is also supported by the TRT Educational Program (the ETM Patient Educational Information side of this web site); it provides instructions to the client that describe how to do TRT. The reading component occurs in accordance with special procedures that will be discussed shortly. Generally, a client reads the prepared homework assignment to either the therapist or group of TRT participants, or to both (first to the therapist individually and then to the group; the reading to the group is facilitated by the therapist).

The TRT Written Component: Phase One

A single traumatic event is recorded in the Phase One format. There are 6 elements to this form. They instruct and encourage the client to:
1. address the perpetrator of the trauma directly by using second person language "You." This language is usually applied where the trauma occurred through a relationship, for example, in a marriage or child-to-parent relationship. Other person language can be used in different situations; for example, a natural catastrophe may be referenced in the third person, "It." A crime or combat incident may, respectively, also refer to the perpetrator or particular oppositional combatant (the enemy or criminal) in the third person ("he," "she," or "they").
2. identify the specific time, date, and place the incident (trauma-causing event) occurred.
3. use the past tense for verbs.
4. describe the facts of the event. When chemical use is an issue, as it is when the event is perpetrated by a drunk or other drug-influenced person, the facts of the description should include a reference to the use, including a description of the use itself if possible.
5. describe the client's emotional experience of the event.
6. not use rhetoric or philosophy in the description.

Phase One Written Example: Rape

The following is a fictional example of the use of the Phase One writing form by an adult woman; the example describes an earlier-occurring (during childhood) physical assault (rape) by an alcoholic father. To remind the reader, "fictional" means that we not only created this traumatic event to meet training needs, but that we went to considerable lengths to not incorporate any individual's actual experience. This is true for all the fictional examples used in this book and in our training schools. Moreover, our assumption is that the reader is likely to have had some experience in addressing traumatic episodes; consequently, this or other examples, albeit painful to read, are expected and hoped to not be unduly shocking or disarming. If you do not have such experience, this and the other examples will be difficult to read as they are explicit descriptions of not only the resolution process, but of the psychological trauma-causing events, themselves; these kinds of events are routinely experienced while conducting TRT. The idea that the event is fiction, that it did not actually happen, may make it easier to concentrate on the method as opposed to the story. If you find this example too difficult to read, or you cannot proceed with surety, then we recommend discontinuing this program until additional training allows you to continue more comfortably.
We lived in the country. I was 11 years old. I don't remember what time of year it was. You were drunk. Your speech was slurred and you seemed agitated. Mother was gone and you made me undress. I felt afraid and nauseous. I knew what was going to happen. You had done this before. You held me down on the floor. I was naked. It was cold. Then you began to have intercourse with me. It hurt so much that I didn't think I could breathe. I was bleeding badly when you stopped. At first, I couldn't move. Then, I gradually stood up. I still couldn't walk. I felt dazed and numb. I could see the blood coming out of me. I knew I was torn and hurt. I began to move slowly. I was thinking I was going to get blood on the floor and everyone would know. I made it into the bathroom. I knew I had to stop myself from bleeding. At the same time I began crying and thought that I might die. I felt terrified. I also was disoriented and numb.

The hallway floor was made of wood and I heard you coming back. You tried to open the door. When you discovered that it was locked, you broke it open. I was sitting naked on the side of the tub. I fell into it as you ran at me. You were yelling at me for having locked the door. I screamed that I was sorry. Blood was all over the floor, the tub, and me. You grabbed me by the hair and pulled me out of the tub hitting me and cursing me for bleeding on everything. Then you held my head over the toilet. You pushed my head into the water until I couldn't breathe. I believed that I was going to drown and that my life was over. You grabbed me by my hair and jerked my head out of the toilet. You screamed that if I didn't clean this mess up and keep what we were doing to ourselves, that you would drown me. You left and I laid on the tile floor. I stopped bleeding. I don't know how. I felt numb and physically hurt.

Some incidents require the therapist's assistance to write, as this fictional childhood rape episode being described by an adult would no doubt mandate. Such special assistance is provided in individual sessions; the therapist listens to the oral (non writing) description and then helps the client to record it, one word at a time, until a full sentence and then paragraph have been constructed. Catharsis accompanies such writing efforts. A back-and-forth process of telling the story, writing, and crying ensues. The same principles that guide group members in giving feedback (described in a later section) are applied by the therapist in this private session to assist the individual to translate the entire episode into the Phase One format. You will learn later that these principles emphasize respect for individual progressions -- pressure to accomplish a therapeutic task is never allowed, much less
required, in any segment of TRT. The task, however, of converting the painful experience into the TRT structure, does add a sense of, and actual, security to the initial descriptive process; the patient's and therapist's concentrations on the form, itself, strengthens the patient's ability to tell the story. In addition to the experience's being cathartic, it should also be slow going, sometimes taking more than one individual session to translate an episode into the Phase One format.

Through the use of the educational materials (ETM Patient Educational Information), most incidents of trauma presented by most clients can be translated into the Phase One format at home. In addition to the application of individual sessions, use normal telephone contact (patient-to-therapist) to assuage beginning and moderately difficult-to-get-started-writing processes.

**Reading**

After translating the recollection of the event to the Phase One format, the client reads the incident to the group (assuming the therapist also uses the group model). Special guidelines described under "Giving Feedback" and "Facilitation" manage the reading experience. If the incident has been particularly difficult to write, then it should be read first in an individual session, sometimes in multiple individual sessions, until the client says that he or she is ready to read it to the group. The episode should then be shared with the group members, who provide feedback via the methods described in the pertinent section. You will learn more about the reading element of Phase One in these upcoming sections.

**Translating Many Traumatic Episodes**

One kind of traumatic process can produce many traumatic episodes. For example life with a chemically dependent person produces many bizarre experiences. Depending on the number of years in the relationship, the following numbers of events can be expected.

<table>
<thead>
<tr>
<th>Years</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>11 - 14</td>
</tr>
<tr>
<td>7</td>
<td>18 - 23</td>
</tr>
<tr>
<td>14</td>
<td>35 - 42</td>
</tr>
<tr>
<td>24</td>
<td>87 - 107</td>
</tr>
<tr>
<td>33</td>
<td>131 - 150</td>
</tr>
</tbody>
</table>

Etiotropic Trauma Management Trauma Resolution Therapy
Training – Certification Program
In marriages where the non chemically dependent spouse enters the relationship at the beginning of the chemical dependency, the incidents begin with simple public embarrassment experiences and end, in some cases, with violent episodes, including, but not necessarily limited to, physical/sexual assault, suicide and/or homicide attempts. Where the non chemically dependent spouse enters the relationship later in the chemical dependency’s development, or a child is born or entered into the relationship as a consequence of a second or third marriage, the incidents often begin with more radically contradicting episodes -- again, sometimes of a violent nature. The kinds of incidents and the general percentages of their occurrence (in each presentment) attendant in chemical dependency affected relationships include:

<table>
<thead>
<tr>
<th>Kinds of Incidents</th>
<th>Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public embarrassment</td>
<td>92%</td>
</tr>
<tr>
<td>Arrest (DWI and Public Intoxication)</td>
<td>77%</td>
</tr>
<tr>
<td>Automobile wrecks</td>
<td>57%</td>
</tr>
<tr>
<td>Automobile wrecks (injury/death)</td>
<td>15%</td>
</tr>
<tr>
<td>Mental abuse</td>
<td>94%</td>
</tr>
<tr>
<td>Sexual assault/abuse (battering)</td>
<td>20%</td>
</tr>
<tr>
<td>Theft of employer's assets</td>
<td>42%</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>12%</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>43%</td>
</tr>
</tbody>
</table>

Combat also provides multiple episodes stemming from the same kind of trauma. In the example presented later, the total combat episodes equalled 65 incidents. Five of those episodes are presented in this book and in the accompanying professional training program.

Sometimes, an apparent single incident can be described as several incidents in one. An example will be provided in the combat example section.

The process of writing and reading multiple traumatic episodes resulting from the same kind or source of trauma actually involves several sequential steps taken within the overall writing and reading process. We describe these sequences after explaining how to give feedback during and following a Phase One reading.

Giving Feedback in TRT Phase One: Guidelines

Because the reader is invited, and in fact lead by the written guidelines instructing the person how to proceed through the letter writing
psychodrama, to lessen his or her defenses, it is inappropriate to make such an invitation without ensuring that the responders are apprised that the reader's vulnerability is by direction -- a part of the logic of the therapy. Therefore, the responses to that reading must be equally directed to interact with the reader at a similar level of vulnerability. In that regard, the feedback to the reader must be provided with an equal degree of risk-taking by the listener and immediately rather than waiting until the group naturally lowers its defenses (for example, by establishing group trust over long periods and through many sessions as occurs in the application of client centered therapy) to match the lowering of those by the reader as such defense reduction is occurring through the use of the written form. Thus, the following six guidelines for providing feedback are incorporated into the reading/responding process as a supportive component of the psychodrama. Compliance with these guidelines is a condition of participation in TRT.

1. Do Not use abstractions as diversions.

"Do not use abstractions as diversions" means to refrain from the use of expressions that shift the focus of therapy from the trauma victim's emotional experience associated with the event. This "shifting" that is to be prevented includes the use of expressions of philosophy or rhetoric. For example, when a trauma victim reads a battering incident, listeners are instructed (through a review of the guidelines prior to the person's entry into the process) to not respond to the event with a particular philosophy about marriage, relationship abuse, or personal responsibility.

2. Do not give advice.

Absent the pre-entry instructions for giving feedback, some participants respond to readings of traumatic episodes by giving advice. For example, some people familiar with self-help methods advise the reader, among other things, to attend more self-help meetings. Some people just like to give advice, even if they have no self-help experience. Regardless of from where the advice comes, it must be prevented/stopped. Specifically, the listeners are prevented by this guideline from telling people to go to more self-help meetings, to stand up to the perpetrator, get a job, protect the children, or to choose another relationship or life-style and so forth. There is a time outside of the TRT process to help individuals who are in dangerous
 situations and require advice. The period immediately following a TRT Phase One reading is not one of those times. Also, the TRT counselor selects this advice-giving time; the group does not assume this responsibility. To assuage a group's concerns, the counselor may, following the completion of the client's reading, inform the group that the necessary action is being taken.

3. Reflect feeling, not opinion.

When giving a feeling response to a patient's reading, these feelings are described as simple expressions of emotion, for example, fear, terror, horror, anger, embarrassment, shame, sadness, hurt, guilt, shock, panic, disbelief, or numbness. Importantly, expressions such as feel "like" and feel "that" are considered in this theory and therapy as expressions of opinion, and should be restated without the "like" or "that."

For example, as a response to a physical assault episode, it is common for a group member to respond to the reader and the episode by stating that the listener feels that people who commit such heinous crimes should be prosecuted and punished. That may be a point of view well taken in a different arena, for example, in a legislative or other political process. However, immediately following the reading of the incident, the reader should hear, according to this TRT guideline for giving feedback, what the listener feels. The usual feeling responses to such episodes include fear, horror, anger, rage, and hurt for the beaten, stabbed or shot individual -- the person reading the description.

4. Reflect supportive perception.

"Supportive perception" means that the listener shares how he or she saw the reader during the reading, or immediately thereafter, or how the prospective respondent sees the reader now (as the feedback response is being offered) and without critical, intervening, or especially to include attacking commentary. Examples of supportive perception include expressions like: "When you were reading, you covered your arms and rocked back in forth in your chair." "You looked shocked and hurt."
5. Use empathy instead of identification.

Empathy is the process through which the individual experiences the emotional elements of the reader's traumatic experience and then shares that experience with the reader. Identification is the process through which the reader's emotional pain stimulates a recollection of emotional pain stemming from a past event experienced by the listener. Through the identification method, the listener then shares that event and pain with the reader. The reader should endeavor to use his or her empathic capacities and save the process of sharing the identified experience until an appropriate time. Such times are usually available in the next session and are facilitated by the therapist (see the next section "Facilitating TRT Phase One").

6. Make simple, but special, connections.

"Make simple, but special, connections" refers to the making of eye contact during the feedback process, a periodic touch on the shoulder or back of a reader, and a verbal expression that the reader has heard the feedback. More discussion of these "connections" is provided in the facilitation section. Details for giving feedback in TRT are provided in an instructional aid (individual pamphlet) in the TRT Educational Program. The aid/pamphlet is entitled "Giving Feedback in TRT". See "ETM Patient Educational Information."

Facilitating TRT Phase One

Facilitate TRT Phase One by assisting the client(s) to follow the directions for the use of the Phase One writing and reading format to, respectively, translate and share the traumatic incident(s). Also, facilitate Phase One by following guidelines for giving feedback during the reading process and by assisting clients to do the same. There are some additional, but general facilitation instructions. They are provided here.

Caring vs. Structure

The first priority of the therapy is to care for the client. As you will see later when learning the other TRT phases, this caring is highly focused on the specific effects that the traumatic event has had on the pre-trauma psychology and neurology.
The goal is singular -- reverse the etiology of the trauma comprising and underpinning those effects. The "highly focused" part of the caring occurs because client, therapist, and group, together, use the structure to achieve the etiology-reversal goal.

For some facilitators, however, the use of the structure inadvertently becomes the priority of the therapy. For example, the facilitator may attempt to speed-up the writing and reading process. If this happens, it's likely that the facilitator's priorities have shifted -- the structure is becoming ascendant over the caring element of the therapy.

Never let this happen; the structure itself or its use should never become elevated to a status other than for what it is intended -- a support of the application of caring, which is the principal value of the therapy and the unequivocal priority. If the term "caring" is not clearly understood as it is referenced here, it should become more defined as you proceed through this book. If not, it will be demonstrated in the experiential component of the accompanying professional training program.

**Stop the Projection of Stoicism During Feedback**

The reading of a traumatic incident can evoke an interruptive response from a group member whereby stoicism defends the listener; that person then projects this philosophy onto other people in the group (readers) in order to strengthen the defense. The interruption occurs when the responder encourages the reader to be stoic like the person introducing the defensive philosophy. For example, responders who use stoicism as the philosophical defense will encourage, even admonish, readers to "stop feeling sorry for themselves," "get off the pity-pot," "be strong," "focus on their own behaviors," and "to make something of their lives by becoming responsible."

Stop the use of this particular philosophy while in TRT by educating the people that attempt to apply it. If possible, provide the educational instruction prior to an individual's participation in the group and elicit an agreement as a condition for participation in the therapy to not project this value onto other people while the session is being conducted. The use of this philosophy outside of the clinical proceedings has no bearing on that process (it doesn't matter if participants are stoic outside of the sessions), but failure to comply with the philosophy's disuse during the application of TRT should
result in referral to another clinical environment where the philosophy is tolerated.

**Stop the Use of Psychotherapy During Feedback**

"Psychotherapy" has many meanings and myriad applications, some of them contradicting. All of them should be precluded as responses to a reading during TRT -- TRT is not psychotherapy. Generally and according to the literature (see About ETM/ Bibliography), the purposes of the psychodynamic forms of psychotherapy when applied to psychological trauma are twofold: address the inner effects of the trauma and correlate those effects to symptom identification so that the symptoms may be stopped.

In contrast, the goal of TRT is singular, reverse the etiology. Stopping symptoms is not the goal, nor is symptom reduction built into the methodology as the reduction effort is built into the application of psychotherapy.

An example of group members' attempts to employ psychotherapy as a response to a reading is demonstrated through a responder's use of interrogatories following the reading; "interrogatories" are questions intended to help the reader to understand the meaning of the trauma or to see the relationship of the incident to the development of his or her current behaviors, disease (psychological), or interactions with others.

Some questions are actually masks for behavioral forms of psychotherapy, for example, advice-giving processes -- "Did the reader go to many Al Anon meetings?" As you will learn when reading Phases 2 - 4, these interrogatories are not only unnecessary, but they divert the reader from achieving the goal of this therapy -- reversal of the etiology.

Do not let this (diversion) happen. Stop it when it occurs in group and then conduct educational processes parallel to the session(s) that explain this therapy's (TRT's) goal and methods used to achieve it. See the cases provided in "Training" for recommendations related to ethics and tact.

**Use Empathy First; Identification Second**

A last and most frequently used survival coping mechanism involves the use of the process through which the listener identifies with the reader and the
event. This identification especially happens when the listener still has not completed the resolution process for him or her self (or the listener has not been accorded parallel cognitive education).

Inevitably, such people use their response to another's description of a traumatic episode to divert the focus of the therapy away from the reader and toward the listener through the listener's identification with the episode, and then the sharing of that which had been identified with the group. For example, a reader might describe a combat episode as a trauma-causing event. A listener who has engaged in combat, but in a different war, will attempt to share this similar experience with the reader as soon as the reading is over.

Although in some instances the person providing the comparable story intends to help the reader by letting him or her know that he or she is not the only person so affected, the only person who has been involved in difficult experiences during war, the use of the identification feedback method shifts the focus from the reader's emotional experience to the telling of the comparable story. We see this method as a means through which the group or individuals within the group divert the therapeutic focus from the trauma and its effects. It is critically important that you prevent this diversionary process from occurring, least all the work that went into the writing and reading for the trauma victim will have been for naught.

**Multiple Episodes: Same Source of Trauma**

One source of trauma, like combat experienced during one military campaign, or life with a violent drug addict, can produce a myriad of traumatic episodes. One to three incidents from this source of trauma should be described in the written Phase One format and then shared with the therapist or group. Thereafter, all the episodes will present one after another until the entire source (all incidents comprising the source) has been described.

**Forgotten, Suppressed, or Repressed Memories**

Some incidents will be less clearly recollected than others. Clarification will be restored through the writing and reading process. Some events are even forgotten, suppressed, or repressed (see the section entitled "Special Situations"). As a rule, these memories too will be recalled through the application and patient use of the writing and reading process.
There is an argument ongoing at the time of this writing over the validity or accuracy of repressed memories retrieved either through therapy or via some other process. Apparently, the new idea is that once something is forgotten, later remembrance of it is not credible.

Moreover, complaints abound over the use of hypnosis and drugs in the memory retrieval process, with some of the complaints being directed toward the veracity of the people employing the methods. And recently, some practitioners are calling for therapists to verify, apparently through investigative means, the veracity of patients. This is a long and controversial subject, some of which is covered in other parts of this section, like "Adult Children" and the biology of memory and forgetting discussed in the About ETM, and in the bibliographical (About ETM/ Comparison - Contrast); biology chapters only explain the neurobiological foundations of memory (the biology chapters do not address the controversy, itself). The subject is not, however, considered in this book as a primary issue for discussion, and the veracity of therapists is not considered at all.

We can make several general statements in this section and chapter about forgotten memories for the purpose of relating this subject to the application of TRT Phase One. First, 99.9% of all episodes considered through the use of TRT have been consciously recalled prior to entry into the therapy. Truly forgotten memories are a statistical rarity when compared to those that are remembered. Second, TRT does not use hypnosis or drugs, although these methods may be perfectly valid approaches. Third, nosotropic models appraise symptoms and guess that repressed trauma is the etiology. TRT is an etiotropic model -- symptom appraisal is not part of the assessment process or the therapy, so guesswork about repressed trauma-causing events is also unnecessary. Fourth, all of the episodes involving forgetting, or apparent suppression or repression that I witnessed were, with the exception of a few sexual abuse events, directly related to severely violent episodes, and all of these blanked-out experiences were recalled through the Phase One writing and reading activity without having to search for their existences. Moreover, most people described the "forgetting" part of the process in hindsight (after the descriptions were conveyed in the sessions) as having simultaneously been remembered and not remembered. Fifth, almost every event recalled through the Phase One process was validated through the parallel systemic methods described in the "Clinic/ Family and About ETM/ Development/ Family sections.
This does not mean that we believe or recommend that TRT counselors should pursue validation of every previously forgotten episode (unless legal/licensing standards require such validation). In fact, we believe, in contrast to investigative psychiatrists' and psychologists' beliefs, that such activities are not the purview of the therapeutic relationship.

**Pace**

Facilitate the trauma victim's sharing of the episodes within the periods that are required to meet individual needs. Each person progresses, that is writes and reads descriptions of trauma-causing events, at his or her individual pace, except for those special situations described in the next subsection. No one is pushed or encouraged to write and read faster than is appropriate individually. Some participants might take 3 to 6 weeks to begin, but after individual assistance (described earlier), progress at a rate similar to the other group members. Eventually, all participants vie for group time, even to the extent that they reserve time in a future session.

Most participants continue in the process until all the trauma-causing incidents have been addressed, but with stipulations described under "Completing Therapy."

**Special Situations**

Four situations arise during the course of Phase One's facilitation that require special handling. First, participants stop writing and reading for long periods, 4 to 8 weeks, after already having shared several or numerous incidents. Second, some group members will at some time begin to read very rapidly, trying to "get it all over with as soon as possible." Third, a member while accelerating the reading to a rapid pace, will skip a particular event by only partially describing something that seems intensely impacting. Fourth, reader's leave out an incident altogether. Through parallel individual sessions and a thorough knowledge of the client, the therapist should know, relatively speaking, the contents of all lists preceding and during readings. If you do not know when an incident is not being read, the participant will probably inform you through some means, for example, during or after group, by phone, or in an individual session.

In all four of these situations, one or a series of trauma-causing incidents require special attention in individual sessions -- the trauma related in those incidents tends toward being of the variety that has more intensely impacted
the individual than has other incidents. Such varieties usually include (not always) sexual/physical assault or a traumatic event where there was much loss of blood by someone, other carnage, or death.

After the incident(s) is read and discussed in the individual session, the episode should then be shared in the group with the group's understanding that they are going to hear something that requires additional attention. Thus, before such readings, the group members each tell the reader how he or she has been seen by the group member from the time they had become group participants together.

When the reader is thoroughly integrated/connected with all the group, the particularly heinous trauma-causing event(s) is shared. It is important to note that the only interference with a participant's pace is the slowing-down of those who begin to read rapidly to "get it all out." "Slowing-down" means that you should stop such readings, inform the person of the rapidity of the reading, your difficulty in remaining connected to him or her, and then facilitate the group's integration with the reader before continuing.

Stop Ineffective Readings

Other therapies routinely apply the "telling-of-the-tale" (Kopp) modality for addressing psychological trauma -- the traumatic event is described as a part of the life story. The experience is accompanied by flooding of memories with the emotion and experience of the event. This recollection of the experience and getting "it" (a reference to the pain associated with an event) "out," terms that are used in some self-help and even media processes, comprise the goal of the therapy -- "getting the pain out" becomes the end of the process.

Where this may be a valuable approach, some people who have used it, say in self-help groups and before entering TRT, will bring the attendant concept to the TRT process, which is a mistake that requires correction. The facilitator can assume that this approach is prospectively being used when the reader reflects (1) no recognition of the effect of the story on the group members and (2) showmanship, a term that is not intended to derogate such readers but to reflect that this approach is not having the desired effect. In this two-part process, the reader, usually as a consequence of having learned the other methods' use of the oral event description, is actually telling the story in isolation with him or her self.
If you are able to determine that this kind of reading is occurring, stop it. Then, facilitate the readers *integration* with the group members so that he or she reads the description with an awareness of its prospective effects on the respondents.

If you have doubts about the reader's prospective isolation while reading the Phase One description, use the integration method with this person until the individual learns the difference between this description in TRT and in other processes. "Integration" of the reader with the group is explained in the next section.

**Integration**

"Integration" is facilitated as an exchange of experience between 2 people, the reader and the responder(s); the intended outcome is the ending of the isolation that results from and cyclically perpetuates the retention of the 4 psychological trauma patterns described in this theory. This integration is facilitated through the use of strategic therapy (instruction and direction) in TRT.

As a rule, when feedback is provided, the reader tends to listen to the group member's responses without acknowledging them. The reader is usually in such a state of shock during these times, that he or she needs assistance in recognizing such responses.

At these times, you should facilitate the reader's acknowledgement of the feedback by reminding him or her to look directly at the respondent, to make eye contact, and to acknowledge the comment by saying "Thank you." This acknowledgement should be facilitated following each group member's feedback response.

Regardless of the simplicity of the expression, the connections made as a result of the directed effort, and especially to occur at times when the individual is progressing through passages of shock, horror, and terror, provides for extraordinary stability, that is, internal strengthening of the reader so that he or she can complete such passages. In this therapy, the reader is considered to be well integrated with the group when he or she understands that the traumatic event being read not only has affected him or her, but is now also affecting those with whom he or she is now sharing the experience.
Integration is also used when a reader has just completed, or is still in the process of sharing of the trauma-causing event, and the reader is in state of shock, feels numb, following the reading of a particular event; the reader cannot process his or her feelings because the numbness can't even be identified. Group members can also be shocked to the extent that they can't say anything -- the event is too heinous.

To facilitate integration during such times, stop the reading and ask each member to express in one word what he or she is predominantly feeling. The feelings usually expressed during this process include shock, horror, terror, and rage.

Once expressed, the reader is then usually capable of identifying one predominant feeling, which often is either shock, numbness, or horror. This singular expression by all group members is one of the most frequently used facilitative processes in undoing the retardant effects that heinous experiences have on interactive efforts to remove trauma victims from their isolated conditions.

Integration is also facilitated through touch, but there can be some problems with this method if it is not used carefully -- restrictions (other than the obvious ethical issues that are not the subject of this book) are required. Touch should be limited during application of TRT to the placement of a hand lightly on the reader's shoulder during especially cathartic moments, say following a reading of an event that is very difficult (painful) to describe. The slight touch lets the reader know during the depth of the grieving experience, and when eye and voice contact are impossible because of the catharsis, that he or she is not alone.

Do not allow one or more group members to leave their seats and hug the person during this catharsis. Such hugs, otherwise representative of well-intentioned and meaningful displays of caring, will divert the reader from the most profound experience; the physical contact can have the opposite (adverse) effect, almost as if the group is hugging away the pain. Although this activity is common in other therapies, it must not occur during TRT.

You will see in later chapters that the catharsis is not the "all" of the trauma resolution process, but only the beginning, and that it must not be interrupted if the optimum progression through the entire process is desired.

**Observations of the Effects of TRT Phase One**
"About ETM" describes TRT’s development; this story includes reports of client progress at each phase of TRT. That prospective progress is reprinted here for your convenience. As a rule, clients report that Phase One assists them to:

1. recall events previously forgotten; they were only partially remembered.
2. share stories previously not sharable -- they were too emotionally painful to discuss or no one had previously been interested in listening to them.
3. identify emotional pain previously unidentifiable.
4. experience that pain to a degree that was appropriate for him or her, and not have that experience interrupted by internal blocking processes, or interfered with by outside influences (other people admonishing the reader to adapt various philosophies as a response to the emotion or the event).
5. begin to regain a semblance of Self previously known, but lost following the occurrence(s) of the trauma-causing event(s).

In addition to the client’s self-reports of their experiences of the therapy (TRT Phase One), our observations showed that clients tend to:

6. pass through emotional and intellectual blocks that previously prevented direct address of the trauma.
7. continue the process relentlessly (with previously noted exceptions).
8. pursue a steady and consistent, albeit cyclical, state of catharsis until the entry level aspect of the resolution effort is completed.
9. negotiate passages through the experiences of shock, horror and terror, but with the confidence to complete such passages and remain psychologically intact.

**Completing Phase One**

TRT participants will not as a rule withdraw from the clinical process after completing TRT Phase One. They will, however, leave the therapy during this phase if certain conditions prevail. This section describes these conditions and discusses the factors influencing decisions to abandon or complete the therapy.
People who are using parallel pharmacological methods will not complete TRT Phase One. Other drug users, social or otherwise, will also not complete the process. There are rules for addressing the drug use issue; see About ETM/ Drug use.

Excluding the drug using population, if the educational materials are not applied, 50% of participants, usually those who are simultaneously attending self-help -and some religion-based programs and who are simultaneously involved/living with a using drug addict, including violent ones, will withdraw from therapy during the application of TRT Phase One. These people believe that TRT is interfering with their other psychological methods (these methods are no doubt very helpful to these people and the methods should not be interfered with; see Training/ Cases for directions and examples). The drop-out rate for this population will decrease to 25% if the pamphlet form of the educational materials is applied as recommended. The pamphlets help people to understand the different goals of the various helping processes.

If the slide presentation rendition of the TRT Educational Program is provided as recommended, there will be, as a rule, no drop-out. Again, Training/ Cases describes, through the consideration of cases, the ethical issues related to TRT participants' simultaneous attendance in other helping processes.

Withdrawals occur for several reasons.

First, the therapy is competing with nosotropic models that propose new life experiences by learning new coping methods; the learning involves the control or changing of symptoms. When compared to the etiotropically-based (non symptom-focused) method, the nosotropically-based (symptom reduction, control, change) method seems, on the surface, to be more active, positive, and purposeful.

Second, emotional pain is difficult to address, especially when it is a consequence of old traumatic events. The pain makes people, at first, to not want to do the therapy.

Third, any therapy that progresses toward reversal of the etiology will inevitably undermine the use of defenses, which paradoxically are needed until the etiology is reversed -- creating dissonance.
Fourth, some people need defenses like denial and so forth to protect them from continuing trauma-causing events that are being perpetrated by abusers (usually actively using drug addicts). The therapeutic path that leads to etiology-reversal restricts the availability of the denial defense, making the situation, either the therapy or the abuse, seem intolerable.

Generally, the use of the structure, the educational program, reliance upon focused-caring that is provided by the therapist and group, and the natural integrative process that results from the ability to honestly address emotional pain simultaneously with clarification and understanding of the effects of the event(s), usually lead to a choice to reverse the etiology despite the ideological competition, pain, the paradox, and prospective coercion that is likely to be applied by a perpetrator.

There are specific counters to client rationales for abandoning the TRT treatment process.

First, the etiotropic approach provides clear and attractive alternatives to the competing nosotropic (symptom control and reduction) counterpart. Symptom focused models are trying to change behavior which attempts, themselves, suggest that the symptoms are the responsibility of the affected individual as opposed to the trauma-causing event's being responsible. In contrast, TRT blames the event rather than the person.

Second, attempts to change symptoms/behaviors require the application of teaching methods that are designed to establish for the client a new existential identity (values, beliefs, images and realities), as if the original identity is not adequate. The etiology-reversal through existential - identity - reconstitution method provided by TRT says that the old identity is adequate -- it just has to be distinguished from the trauma's effects. When the teaching-new-coping methods is used, the risk inherent in the method is that the person doing the teaching does not know what he or she is doing (the leader's identity is confused), which is sometimes the case and a condition that is impossible for the client to defend against, despite credentialling processes -- leaders sometimes fail followers despite social encouragements to remain flawless. In TRT, the reconstitution process does not rely on any one person's (the facilitator's) identity or leadership capacities.

Third, when emotional pain is addressed with the support of the structure, clients learn that this pain is an acceptable aspect of themselves and one that
will no longer threaten them -- patients regain control through experience, expression, and dissolution of emotional pain. The belief eventually adopted is that the person can overcome any emotionally challenging experience, which belief adds to the desire to seek out answers related to the effects that the trauma has had on the internal dynamics of personal psychology.

Fourth, the structure holds the paradoxical condition in check, allowing defenses to also be placed in check or temporarily stored, while the etiology is being reversed: that is, while the trauma-damaged identity is being reconstituted.

Fifth and last, the structure provides the client with a safe environment where the previously necessary denial can be temporarily or partially set aside so that the effects of the abuse can be evaluated by the client absent the coercion attending intimidating and dangerous behavior.

Resolution Theory: Phase One

The first phase of TRT begins the resolution process with the identification of the trauma-causing event, which is responsible for initiating development of the 4 psychological trauma patterns in the first place. During this identification, the client sets aside coping philosophies adopted as defenses to the retention of the patterns and instead directly addresses the emotional experience created by the traumatic event.

The combination of the writing, reading, and feedback elements of the therapy strengthen the patient's capacity, and initiate the client's interest, to learn all there is to know about the trauma's effects. The patient gains the means and confidence to continue the resolution process until it is completed. That "completion" includes reversal of the etiology = reconciliation/reconstitution of existential identity that was contradicted by the events described in Phase One. Etiology-reversal of the first etiology (referenced in ETM Theory sections) is achieved through application of TRT Phase Two and is the subject of the next chapter.
TRT Phase One: Examples

Battered Spouse, Combat, Violent Crime Trauma
Continued through all TRT 5 Phases

Examples of the Phase One written component show the various applications of Phase One to different sources of trauma:

1. combat
2. a stabbing and murder occurring during commission of a criminal act (referenced as "violent crime trauma").
3. a spouse's experience of life with a violent chemically dependent person (also referenced as "codependency trauma").

Five Phase One episodes are taken from each of the first two kinds of trauma causing experiences. The violent crime incident is comprised of a single episode. The Phase One episodes are listed as they would be recorded in the client's Phase One journal. These incidents provide the basis for the continuation of the application of all the TRT Phases Two - Five.
Chapter 5 Section (c):

Example (A1): Codependency Trauma -- Five descriptions taken from TRT Phase One (to be applied to TRT Phase Two in the next section)

The following 5 descriptions depict the application of Phase One to trauma resulting from a spousal relationship with a chemically dependent person. The incidents include examples of Phase One applications to trauma caused by domestic violence. TRT training program utilizes a total of 12 of these descriptions. They begin with the spouse's entry into the alcoholic relationship and end a hypothetical 25 years later as the spouse enters treatment. In an actual case like this the spouse would write and read approximately 95 incidents. Because it would be cumbersome to include 95, or for that matter, 12, incidents, and then apply them to the Matrix, as well as to the rest of the TRT phases, we've selected 5 from that list to serve as an abbreviated example of the correct application. Additional Phase One incidents are provided in the Phase Two Examples (addendum to the next section "Phase 2.". The first 5 descriptions follow.

(1) You didn't drink for six months after the first accident. We were supposed to go to a wedding. I expected you at 5. You didn't get home until 6:30PM and then you were very drunk. We started for the church. You went up on the freeway. I was terrified because you were driving too fast. The car in front swerved to avoid us as you tried to go around it. I screamed at you to stop. Then we hit the guard rail and started spinning across the traffic. I thought that we were going to be smashed and killed. The car rolled backward onto the grass and then slid down the hill. I could not believe that we were alive. You started laughing that we hadn't been hurt. You said you used to race cars and that saved us from the reckless drivers on the freeway. You never raced cars. I got out of the car and walked home. I felt stunned. I packed my bag when I got home, but I couldn't leave.

(2) It was 8 years ago. I'm not sure about the time of the year. I was wakened by a noise that sounded like water or rain. I could see you in the dark standing at the end of the bed. I turned the light on and you were nude; you were urinating on the end of the bed. I could not believe what I was seeing. I felt stunned. I jumped up and tried to stop you. You hit me and knocked me to the floor. Then you continued peeing. I felt it falling on my feet. I crawled to the corner and lay there. I felt terrified. I was afraid to move. You tried to
have sex with me. I was repulsed. I hated you. You stopped. I felt shame and humiliation. I was so angry that I wanted to see you die.

(3) The next incident happened a year later. It was a Friday night and you were supposed to be home by 5:30 PM; we were going to dinner with friends. You didn't come home until 11:00 PM. I was angry and hurt. Then I saw lipstick on your neck. I felt betrayed; I felt rage. I yelled at you; I called you a liar when you said you were with business associates. I accused you of being with another woman. You stopped walking across the living room; then you turned and hit me in the face with your fist. I was knocked to the floor; you stood astride my shoulders, pummeling me. I tried to fight back and kicked at your groin. A blow to my face made me lose partial consciousness. You grabbed me by the hair and dragged me down the hall; part of my hair was being pulled out. I started trying to fight again. You slammed me onto the bed and pushed my arm up behind my back. You pulled my head back at the same time; my head and my arm were touching. I heard and at the same time felt my arm break at the elbow. You took my scissors and slashed my back. The pain was unbearable at first. Then I felt nothing. I seemed to be out of my body watching you go berserk. I believed that I was dying - dead. I was more than numb; I felt and was nothing.

(4) It was almost seven years ago. I awoke at midnight. You were not in bed. I looked for you in the living room, bathrooms, and garage. I walked by the girls' room and opened the door to check on them. The light from our room shined partially on Lori's bed. You were in your undershorts kneeling next to her bed. Her nightgown was up and your hand was on her ribs. Lori was staring at the ceiling as if petrified. Then she looked at me. You looked into the light and your eyes were glazed over -- you were so drunk. I closed the door quickly and stood against the wall. I didn't know whether to scream, kill you, or what to do. I went to my room and sat in the corner wondering where the gun was. I didn't know if I was going to shoot you or me. Then you walked out into the hall and into the living room. I sat there for hours not being able to believe what was happening. In the morning you acted as if nothing had happened. I felt numb, unreal, nauseous, and terrified. I felt horror.

(5) You were very drunk. It was just before New Years 4 months ago. You turned your back to me and then swung and hit me in the face. I felt my tooth give way and a white flash go through my brain. The back of my head hit the wall as I landed against the couch. Then you kneeled on my chest and
I couldn't breathe. You grabbed my hair and beat my head against the wall. I was losing consciousness when you hit me again with your fist in my face. I felt my nose break. My teeth seemed to be caving in. You started strangling me and I passed out. I awoke and a neighbor was outside standing on the sidewalk yelling at you to stop because he had called the police. I reached up to my face. I had to breathe through my mouth because air wouldn't come through my nose. My hand found something on my chin. When I held it up, I saw that it was my tooth. I was in shock. I held my tooth in the palm of my hand in case I needed it later. Then while you were still on the sidewalk, I crawled to the pantry closet where I hid under the shelves with the knife in my hand. The next thing I heard was a man who identified himself as a policeman. When I came out, he called an ambulance and I was taken to the hospital. I felt shock, horror and fear for my life throughout the experience. I also kept thinking that I was dying -- that this time I would die.

Example (B1): Combat Trauma -- Five descriptions taken from TRT Phase One (to be applied to TRT Phase Two in the next section)

The following 5 descriptions are taken from the role plays used in the ETM Professional Training School. We draw your attention to example 4. It is actually several episodes couched as one. Incident 4 demonstrates how one continuous exposure to trauma occurring over several days can be recorded into the Phase One format. We have included this otherwise lengthy description because it shows how such experiences are accorded special handling when applied to Phase Two (demonstrated in in the next section).

(1) We were down south on an operation. I think the month was January; but it was hot. I was on a mission that brought a reconnaissance team in that had been out for five days. I was talking to a fellow from the team who I had not seen since boot camp. We were making a peanut butter and jelly sandwich when the sergeant across from me ejected the magazine from a captured Luger. He pointed the gun down and squeezed the trigger. The gun was not clear and he shot another man, who was standing next to me, in the groin. The wounded man began screaming and fell into a cactus plant; he was yelling and cursing. A corpsman was there before I could move. He tried to stop the bleeding. I helped to hold the wounded man down and keep him from rolling in the thorns and sand. When we got his pants down, someone was yelling that his penis had been partially severed. Blood covered his groin and was pouring onto the sand. The corpsman was saying something about a femur artery. It would not stop bleeding. The corpsman tied his belt
around the bleeding man's upper thigh in an attempt to make a tourniquet; someone was yelling to stop the blood flow. The tourniquet was not very effective. In a few minutes the wounded man stopped yelling, then talking or crying; he just lay there.

The sergeant was yelling at everyone and slamming the gun to the ground again and again. He seemed to have gone insane. I think the man who was shot died. I don't know for sure because they carried him to a helicopter which then took him to the Repose. The pilot told me later that he thought the man was dead when they got him to the hospital ship. I looked down. Blood was on my shirt, belt, and trousers. I ate the sandwich that I had made. All that I remember is that I felt numb. Everything seemed unreal.

(2) I was on an operation. I think it was early in the year. I remember it wasn't raining constantly anymore and it was getting hotter. We were in a place with a lot of sand. Machinegun fire was coming over the hill and through our position. Everyone ran and jumped into holes, or got behind whatever cover was available. One fellow about thirty feet away sat up on his knees and was yelling about how the fire was coming at us without any visibility from the enemy gunner. He was shouting that the gunner must be about 800 yards away given the trajectory. The fellow was hit in the chest and head. The way he was hit, he must have been dead instantly. Another man was shot in the chest while sitting on top of an Amtrac. He was dead. We carried them to helicopters. I tried not to look at the man shot in the head. The bullet entered where his eye used to be. I also couldn't keep from seeing that the back of his head was gone. One minute he was alive and carrying on. Then he was dead. I felt numb. It seemed unreal.

(3) I went with an officer who was the head of our group to a staff meeting in the same operation that I read about last week. On our way back it was just getting dark and automatic weapon fire was coming over the hill again. The man kept walking through it. I walked up higher on the hill and parallel to him so that he would be shielded and not killed. I could hear the incoming as it went past us. The whole time I was walking in the open I kept expecting the next bullet to hit me in the right side of my head and then I wouldn't have a left side anymore. I also kept seeing the fellow who had been shot in the eye. I had to force myself to keep walking. I wanted to lay down and hide. I felt fear. I was scared.
(4) In March, the NVA (North Vietnamese Army personnel) shot down a helicopter that was extracting a recon team. We carried a company (of Marines) into the area. About 20 helicopters carried the first part of the company. We circled the enemy unit. I heard the pilot say over the intercom that four helicopters were down. We landed and picked up one of the crews. I felt fear and vulnerable. We were exposed and I thought we were very open; while we were in the air, we were easy to shoot. I was shaking so badly that I couldn’t talk to tell others where the fire (NVA automatic weapons firing) was coming from. I was embarrassed. Shooting the 60 (M60 machinegun) gave me courage. Until then, I wasn't sure that I could function; I kept telling myself that I could do my job when it got bad. The North Vietnamese were there in battalion strength. We loaded and landed a battalion to match theirs. The flights took us most of the day. We carried people and ammunition to several zones in the area. During a strike in the morning, and then again in the afternoon, I always thought the jets that were coming down over us were going to hit us. I remember that they were going so fast and diving so low, and sometimes even beneath us, that I wondered how they missed smashing into the ground. They were shooting. We were shooting. Everyone on the ground was shooting too. Once the battalion was completely in, the Vietnamese showed a division. When we went back in, they came out of caves and tunnels. They were shooting at us with automatic and antiaircraft weapons. We kept flying up and down the hills, then turning back around and going back through the zone. I shot at flashes of fire. We were going up and down so fast and so low to the ground that I became airsick. I started throwing up. I tried to shoot NVA, but they kept coming up behind and sometimes inside of our perimeters and positions. I was scared that I would shoot the wrong people. I also felt embarrassed and ashamed that I had thrown up.

On the second day of the operation I flew port gunner on three missions. On the first mission, we stayed aloft and overhead while another helicopter went in and picked up four wounded Marines. When they lifted off, we went in and picked up seven more. Three of the men were wounded in either the chest, arms, neck, or head. When they got on board, I felt detached; I just looked at them, and then looked away when I could. The other four men were carried on board by their buddies. Two Marines had fragmentation wounds in the chest. A third had lost the lower part of his leg. The fourth man had been shot in the leg twice. The bone was broken and sticking out of the bandage. The man was screaming. Then he stopped. Most of the wounded lay on the floor, except for one guy who sat against the side of the
helicopter. I was afraid we were carrying too many people and that we couldn't get up, off the ground. We started taking fire and we left. No one was hit. We flew back to the base. On the way the tourniquet came off the man's partial leg and it started bleeding again; I tied the tourniquet back on. The corpsman was on the other 34 (helicopter) and I didn't know what I was doing. Neither could I believe that I was looking at the end of where this man's leg was supposed to be. I kept telling myself to do the job that was expected of me. I stopped the bleeding. My biggest fear was that I wasn't trained well enough to help this person properly. Everybody was in shock including me.

On the next flight, we went in and the other helicopter stayed up. This time, the corpsman rode with us. We took four people; all of them were wounded in the upper portion of their body. The corpsman told me how to keep pressure on wounds to stop the flow of blood. I never worked in the medical field before this and I couldn't remember what boot camp had taught me about wounds. My fear for myself, though, was not as great any more; I began to be more concerned for the other people than just myself and my inabilities. I felt desperate to be better at what I was doing.

On the third mission we dropped ammunition at another spot first and then went into a landing zone to pick up wounded. We had yellow smoke and the zone was supposed to be secured. The clearing was very small. A hill with heavy foliage went straight up from the clearing's perimeter. As we were loading three Marines, we began taking fire from about 3/4 the way up the hill. NVA were shooting down on us and through the floor. The plane was damaged and wouldn't get up, so we unloaded the wounded back to their defensive positions. Two of the wounded men were hit again; one in the hip and the other in the wrist. The man shot in the hip was knocked down hard. The other man's hand dangled and the blood pumped out. Someone grabbed him and then laid down next to him and held the wrist to stop the blood. The crew chief fired up the hill the whole time. Our copilot was hit in the neck and chest. The crew chief took him down and was trying to stop the bleeding. I felt terrified. I fired on the position up the hill with the chief's gun until the chase bird landed. There were explosions on the hill, I think from rockets fired from a jet; maybe they came from artillery. This time I saw the jet and it hit the hill again. The jet was so close I thought the rockets were going to hit us. The incoming stopped. We loaded the wounded lieutenant, pilot, crew chief, and the three wounded men. I didn't think we could get off the ground. The pilot and crew chief fought to save the
lieutenant's life. He was alive at C Med. I was exhausted and can remember no feelings except that after the rockets had hit the position, I was afraid that I was going to cry. They told me the lieutenant was sent to Da Nang.

The North Vietnamese disappeared the next morning. I was told that in the two days they killed 206 of us, mostly grunts, and that we had killed over 2000 of them. I was glad that I was alive. I was glad the others were alive too. I also remember being grateful to the person who was flying that plane; I never met him. I cannot describe my feelings for the dead Marines. I just felt sad for them; my feelings are beyond description. I felt stunned and numb. I think this numbness lasted for several days. I remember that when I walked or got around other people, I felt detached and sometimes as if I were operating in slow motion. I began to feel separate from everything. I don't know for sure, but when I went back to the base, I think that those people looked at me differently too. Even though I was with other people for these days, I began to feel different and alone.

(5) This was the operation up north. I was sleeping on a cot in a tent set up for us to rest. The operation was over and we were supposed to go back to the base the next day. At 3:00 in the morning, an explosion went off and I was going, I think blown, through the air and across the tent, landing in the mud; we were in a partially drained rice paddy. A burst of light accompanied the explosion; but when I landed it was dark and I couldn't see anything. I thought I was dead or dying. I thought my body was gone; I couldn't feel anything. When I realized I was alive, my thought was that I couldn't find my rifle. I knew I would be dead if I didn't get it. At first I was too scared to move. I felt terror and horror; the feelings paralyzed me, making me immobile. I talked to myself silently and made my fingers dig into the mud so that I could pull myself through it. I had to find my rifle. There were many explosions and much shooting. Then they were shooting down on us. A flare went off and I saw another man next to me. He was a lieutenant. He was new. He had pushed his head down into the mud and water and was only 6 inches from my face. Then, with the aid of the light from a flare, I saw my rifle in the mud and crawled to where it lay. When I got it into my hands, I wasn't paralyzed any more. There were no holes that I could get into, so I crawled to the front of the tent so that I could kill anyone trying to run through it. There were lots of figures running very fast through the dark. I started to, but did not shoot; I could hear some yelling -- the people screaming were ours. One man was running along the top of the dike; I almost shot him, but then the light from the tracers and flashes and other
explosions showed that he wore a flak jacket and helmet. He ran right into the middle of tracers, stood their for a second, and began yelling orders: *Kill them goddammit.* This thing lasted about thirty minutes, before it became quiet. The men on the line, about 10 yards away, killed them all. Apparently, a platoon had tried to run through our line, to overrun and take our position.

The dead bodies in the morning looked like manikins. I can't remember how many VC there were. They were shot many times. The impact of the bullets tore their bodies apart. We left them on the ground throughout the early morning hours until they were removed by a group of villagers. The villagers tied the dead mens’ hands together at one end of a pole. Their feet were then tied to the other end. Two men hoisted each end of a pole onto their shoulders and then carried the bodies away, the dead Vietnameses’ heads being partially blown away and dangling, hanging upside down like animals shot in a hunt.

I discovered that the Vietnamese had crawled to our perimeter, about 10 yards away, and had laid a grenade next to a Marine who was asleep. The grenade had gone off at the same time with the others. This one blew half the man's waist, shoulders, and a portion of his head from his body. Another man was shot, I was told, in the chest, stomach and side of his head -- I didn't see him. A third Marine was shot in the center and top of his head. Another man and I carried the corporal's body to the helicopter. On the way, part of his body fell out of the poncho. We stopped and didn't know what to do. Then I looked down into his brain and I couldn't talk. I sat on my knees and stared at him. I remember feeling fuzzy, as if my mind was swimming. I asked myself what happened to God when people lost the part of themselves that allowed them to think of such things.

When I returned from the helicopter, no one talked about what had happened. At least they weren't talking to me. The entire experience seemed unreal and I do not know what words could describe what it was like. I felt stunned and dazed. When I looked back at where I crawled during the attack, I saw unexploded NVA grenades laying in the mud around the area where I had been. It was unbelievable to me that the other men were killed, that these grenades had not gone off, and that I, or that lieutenant, or anyone else, was alive. I felt numb and stunned by the attack, concussion, and the deaths.

We went to a memorial service for the dead Marines on Sunday.
Etiotropic Trauma Management Trauma Resolution Therapy
Training – Certification Program

Example (C1): Violent Crime Trauma — One description taken from TRT Phase One (to be applied to TRT Phase Two)

This example is intended to portray what we have come to understand is one of the most difficult traumas to address — trauma resulting from physical and sexual assault, and combined with a death of a loved one. As in combat trauma, a single description can actually be a complex assortment of multiple traumatic experiences. We reiterate that the example is fiction.

Five years ago, May 12, we were returning from the play. I got out of the car when we stopped in the driveway. My husband, Gary, then drove into the garage where I heard him park the car. I walked up to the back door, but stopped before going in because the door was open. I remember feeling surprised; I knew that earlier I had closed and locked it. It took a moment for me to realize that something was wrong. I put my hand on the door knob, but then felt very frightened. I turned quickly and started back to get Gary. I was afraid that someone was in the house. When I walked into the garage, something hit me on the side of the head and I fell into the bicycles. My mouth hit one of the bars and the pain was sharp; it hurt so badly that I was afraid my teeth were broken. Then someone was kneeling on my back grabbing my hair and pulling my head back. The spokes and pedals were cutting into my chest and I was afraid that my back was breaking. I tried to scream, but my throat was pulled too tightly. I couldn't get any noise to come out. He began to hit the right side of my head with his fist. The first blow struck my ear. Another landed next to my right eye. He kept hitting me. Then, I knew the blows were still happening, but I couldn't feel them.

People seemed to be fighting on the floor; they were right next to me. Then it stopped. I was losing consciousness again. Someone said, "Take her into the house." I felt myself being lifted by my upper body and head. An arm closed around my neck and I lost my breath. All the while, I was being partially carried and partly dragged on the ground. I lost consciousness and then regained it; I was on the kitchen floor. You were yelling at me to tell you something, but I could barely hear. Then, you began kicking me in the side. I tried to stay on my stomach but the force of the blows threw me against the cabinets. You kicked me in my stomach. Then you kicked me in the chest and groin. I lost all air from my lungs. I began to pass out; I thought I was dying.

"I woke up. Something was tearing at my rectum. I felt pressure and pain. My insides felt like they were being torn out and pushed apart. I felt
inhuman; I thought I was not a person. I thought I was on my way to death. I heard two very loud explosions and then a third. Someone shouted at you. You stopped what you were doing to me and went outside. I tried to get away, but my body wouldn't move. I tried to scream, but couldn't; no sound came out. You walked back in and over to the counter that was next to where I lay. You jerked the drawers out and threw them and their contents onto me and the floor. I knew that you were going to kill me. A small knife fell next to my face and I grabbed the handle and pulled it under my chest while you were tearing the counter drawers apart. I knew that you had found the butcher knives. You took one and walked over to me, stood for a moment and then knelt and turned me over. I stabbed at your groin. My arm moved slowly and seemed to have no force at all. You fell back screaming and then recoiled and sunk the knife into my neck. You stabbed me again in the chest and stomach.

I knew I was dying and I felt or saw nothing else until I realized I was being put into an ambulance. I lost consciousness again and then remember people talking to me; they were telling me to try to live and that they were helping me. When I awoke again I was being cared for in a hospital room. No one would tell me about Gary. Later, a nurse and a doctor told me that my husband had been killed. They said he was shot 3 times. I felt separate from them and everything. I began to cry and to scream, but the sounds were gurgling in my throat. They gave me a sedative and I slept.

When I awoke, they continued to give me sedatives. They said that my injuries required time and that I couldn't move. The entire experience was like being in a dream. I wanted to wake up and find out that it had not happened and that my husband was still there, waiting for me.
Chapter 5 Section (d):
How To Facilitate TRT Phases One Through Five

TRT Phase Two (The Matrix)

This chapter:

1. Describes TRT Phase Two's application: writing, reading and facilitation.
2. Provides examples for the application of TRT Phase Two.
3. Discusses the effects of TRT Phase Two on the resolution process (reverses etiology one).
4. Continues the explanation of the TRT theory of psychological trauma and its resolution.

Theory Review

Reviewing from the About ETM/ Theory, psychological trauma exists in memory in 4 patterns. They are:

1. The experience of the event contradicts the pre-trauma values, beliefs, images and realities (existential identity).
2. The loss from the contradictions and associated emotional outcomes are retained in memory (meaning in this use maintained in memory: conscious or otherwise).
3. The repression of the emotional elements resulting from the contradictions creates the need for survival protective measures -- thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional repression and in the process of that dissociation further contradict the existential identity.
4. The dissociative activity, survival responses, produce additional experiences of loss and emotion that are also retained in memory.

The contradicted values, beliefs, images and realities described in "1" and "3" represent the etiology of psychological trauma. The 4 patterns, including the etiology, are defended by a paradoxical system of control; the trauma
victim is perpetually and simultaneously attempting to end and continue the trauma's effects.

**TRT Phase Two: Introduction**

TRT resolves psychological trauma by reversing the etiology described in patterns 1 and 3. To begin this resolution process, TRT Phase One initiates the resolution effort by identifying the trauma-causing event that created the etiology. This identification then opens the door to the address of the etiology referenced in pattern 1, which is facilitated through the application of Phase Two. Phase Two takes specific steps to reverse the etiology (from now on also referenced as "etiology one") attending this pattern. Those steps include the:

- (a) identification, experience, and expression of the emotional elements of grief cycles accompanying loss resulting from specific contradictions.
- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions and that necessitated the grief cycles.
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Completion of these tasks "expunge" patterns 1 and 2 from memory, or as explained in the biology section, the identity is "reconfigured" to its pretrauma existence, but within the context of the current reality. "Reconfiguration" and "expunge" are both functions of learning "what happened" to the psychological management system following, and as a direct consequence of, the effects of the traumatic event. Phases One and Two also neutralize the paradoxical system of control that defends the trauma; in providing this neutralization, control is regained.

The paradox, however, is more suitable for description, the concept is easier to understand, when relating it to the thoughts and behaviors that result from the paradox. We offer this explanation in detail when describing Phase Three's effects on pattern 3, the pattern that retains, in memory, the contradictions to identity caused by the paradox initiated survival thoughts and behaviors (see TRT Phase Three).

Once the explanation of the paradox is more fully provided in that chapter, we show how its undoing is also facilitated by Phases One and Two.
Consequently, the paradox and the issue of control, although profoundly influenced by Phase Two, are not fully discussed until later (Phase Three).

The first part of this chapter explains Phase Two's application. The rest of the chapter explains how TRT Phase Two reverses the etiology comprising pattern 1 and in the process removes the influences of both patterns 1 and 2 on the psychological management system of the trauma victim.

**TRT Phase Two Application**

Phase Two, like Phase One, is also comprised of 2 elements: writing and reading. This section describes the written component first, then gives examples of the written application, and concludes with explanations of how to read and facilitate the phase.

**TRT Phase Two: Written Component (The Matrix)**

If you review the literature (About ETM/ Bibliography), you will find that psychodynamic approaches to psychological trauma are seen as unwieldy because the amount of trauma-induced change affecting the psychological management system is enormous. Hence, trying to assimilate and integrate this large amount of information creates an overwhelming task -- information overload occurs and terminates the assimilation/integrative effort; in the process, psychodynamic models are made to seem less efficacious and consequently less reliable (according to the literature). Phase Two eases this informational processing task-- makes it simple; in the process of that simplification, the psychodynamic method is made extremely effective and very reliable, but with the added feature that the structure inherent in the Matrix creates that new capacity and subsequent certitude, confidence in the structure's dependability.

The simplicity is derived from Phase Two's form, which is a Matrix comprised of 5 columns and a number of rows equal to the number of incidents described in Phase One -- each incident from that phase is applied horizontally to the form. The incident then makes up the row which is retranslated in the context of the 5 columns. An example of the form is shown in figure 1. The numbers in the left column (1) of the example are correlated to the number denoting the incident described in Phase One.

The first column contains a summary of the trauma-causing event(s) the patient shared in Phase One. The second column is a reiteration, redescription, and summary of the emotions experienced when first writing
Phase One and also experienced again currently when filling in this form. The third column is a simple description of the values, beliefs, images and realities contradicted by the event. The fourth column provides for identification and depiction of losses directly resulting from the contradicted values, beliefs, images and realities recorded in column 3. Column 5 denotes thought/behavioral responses occurring at the time of the event and shortly thereafter.

Approximately 5 incidents taken from Phase One are usually applied to a single sheet of paper (8 1/2 by 11 inches and placed horizontally on the page). Thus, if a person had recorded 50 trauma causing episodes in Phase One, Phase Two’s format would yield approximately 10 pages of Phase Two output, each page consisting approximately of the 5 columns and 5 rows (a single incident per row) of data.

Clients should apply 3 incidents to the Matrix and then bring them to a group or individual session for review by the therapist. This "review" will be discussed later under facilitation. For now, once the client is assured of having the right idea, the rest of the incidents are applied to the Phase Two format.

The following is a sample form of:

### TRT Phase Two (The Matrix)

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
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<tbody>
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The Matrix will extend each column depending on the number of incidents applied from Phase One. For example, 5 incidents will use at least 5 rows.
TRT Phase Two Written Component: Examples

The examples from chapter 1, "Examples" section are continued in this chapter and section. The examples presented here depict the application of Phase Two to trauma resulting from life with a drug addicted and violent spouse, and to trauma resulting from combat and violent crime.

Example (A2): Codependency Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

This example, as different from the combat and violent crime examples, represents the standard application of trauma-causing experiences to Phase Two. "Standard" means that the trauma-causing experiences occur, and thus are recorded in Phase One, and are then applied to Phase Two, as single, clearly delineated from each other, incidents.

The first incident in this list of 5 descriptions is applied horizontally to the 5 column Phase Two form (the Matrix). It is important to keep the summary in column 1 brief. The instructions for the second column provide for a copying into that column/row of the emotions recorded in the Phase One description, and then a placement of a summary of additional emotions; they were identified as either occurring at the time of the event or being felt for the first time while applying the particular Phase One description to the Matrix. The rest of the columns are self explanatory.

### Codependency Trauma TRT Phase Two Matrix: Example

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Near accident on the freeway while he was driving drunk</td>
<td>Stunned - Shock, fear, terror, horror, embarrassment, anger, hurt, shame</td>
<td>My values were that my husband should drive safely. He should not drive drunk -- threaten my life or anyone else’s.</td>
<td>I lost self-esteem and self-worth. I lost respect for my husband and trust in him and his driving. I lost a sense of security and safety. I lost a role model for a husband and father who could be depended upon to</td>
<td>I packed my bags and planned to leave. Then I stayed. Then I pretended it did not happen.</td>
</tr>
<tr>
<td>2. He urinated on the bed. He hit me and wanted to have sex with me</td>
<td>Shock, stunned, disoriented, repulsed, disgust, revulsion, hurt, anger and rage</td>
<td>I believed my husband should urinate in the toilet - - not pee on the bed or me. He should not hit me. He should not try to force me to have sex, especially after trying to hurt me. He should not be so drunk that he loses control -- his mind</td>
<td>I lost self-esteem and self-worth. I lost trust in his judgment, his sanity, and him as a person. I lost respect for him as a regular human being and a husband. I also lost a sense of cleanliness, humanness, safety, security, and my own sanity</td>
<td>I planned to kill him. I thought of myself as an animal. I washed the bed. Then I forgot that it happened</td>
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</tr>
<tr>
<td>3. He broke my arm and slashed me with scissors</td>
<td>Shock, panic, stunned, anger, hurt, horror, shame, physical pain, and terror</td>
<td>My values were that my husband should be faithful. He should not have sex with other women. I believed that he should care about me and not hurt me. He should not hit me., pull my hair., break my arm or cut me and make me bleed. My blood should remain in my body and not run all over the bed and floor</td>
<td>I lost the belief that my life would continue. I lost my belief that I was human. I almost lost my life. I lost trust in my marriage. I lost more respect for my husband. I lost any sense of safety and security -- the experience of being protected</td>
<td>I ignored it and later apologized to him for starting the argument that caused the beating and near death experience. I forgot that it happened. I started having affairs.</td>
</tr>
<tr>
<td>4 He was sexually molesting our daughter</td>
<td>I was petrified and shocked. I felt anger., rage., disbelief., and horror.</td>
<td>I believed my husband should not fondle my child. My values were that my child's father should care about her and protect her -- not hurt her or try to have sex with her. The children should be safe and not threatened.</td>
<td>I lost a husband and father of our children as a role model. I lost my own sanity</td>
<td>I ran and hid. I wanted to kill him. I planned how to kill him. The next day., I denied that it happened. I didn't talk to him about it. I did not talk to Lori about it. I started thinking that she was bringing it about.</td>
</tr>
<tr>
<td>5 This was the New Years incident where he beat me badly and I was hospitalized</td>
<td>I felt terror., horror, panic, shame, shock., disbelief., disorientation., hurt., guilt, anger, and rage. I felt physical hurt and pain.</td>
<td>My reality was that my tooth was supposed to be in my mouth, not in my hand. I was not supposed to be bleeding. I was supposed to be able to breathe through my nose. My image was</td>
<td>I lost self-esteem and self-worth. I lost trust and respect for my husband. I lost the belief that I would continue to live. I lost any sense of safety, security, reality, and sanity. I lost all concept of the person</td>
<td>I began to believe that I was not human any longer. I was less than an animal. I wanted to kill him or escape</td>
</tr>
</tbody>
</table>
that I was a regular person -- not a disfigured individual. My husband was supposed to protect me -- not kill me

that I used to be. I lost my tooth,, my appearance, and image as a woman. I lost my femininity -- my being

Example (B2): Combat Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

There are three purposes underlying our use of the combat examples. They are explained here before showing the examples; but with the preface that (ETM Strategic/ Crisis Management and Managers) addresses the same subject in detail.

First, combat personnel are crisis managers. Crisis managers are affected differently from all other trauma victims; crisis managers are comprised of two kinds of existential identity -- personal and professional. The trauma that they experience usually occurs as an interruption to personal identity, and even though there is no intrusion or contradiction to those values, beliefs, images and realities comprising professional identity.

For example, death and personal injury are expected aspects of the job function; thus, professional training provides a set of values, beliefs, images and realities that can accommodate those aspects of the job. When extraordinary events occur, the internal psychic damage is to the personal identity, and frequently unbeknownst to conscious psychology. Consequently, when applying into Phase Two trauma experienced by crisis managers, we ask that they record (emphasize in their deliberations) into column three contradictions to personal identity. Therefore, when you read this Matrix (example of a combat application), you may be saying to yourself, "This is combat; where is the person's professional self?" The answer is that it does exist, but it is not emphasized, at least in this phase of TRT.

Second, combat provides the means of describing how exposure to much carnage affects the reality system. In this example we emphasized those effects as they are a part of the professional address of some kinds of psychological trauma.
Third, in some instances an incident (4) is lengthy and complex -- there are many traumatic episodes occurring within the incident. This example shows how to apply such complex experiences to Phase Two.

The TRT Phase One combat incidents are applied to the TRT Phase Two "Matrix."

TRT Phase Two (The Matrix) Example: Combat Trauma

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
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<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 This was the accident where the man was shot in the groin</td>
<td>Numb and unreal. Shock, horror, anger, and sadness</td>
<td>My values were that people would not be hurt, much less mutilated or killed. I believed the sergeant should have been more careful and cleared the gun properly. Reality -- the man's blood was supposed to be in his body. Not on me and in the sand. His penis was not supposed to be injured</td>
<td>I lost a sense of safety and security. I lost my belief in how life should go on uninterrupted. I lost respect and trust in other people. I lost my belief in my partners -- despite the problems with the enemy, my own buddies might kill me by accident. I lost a member of the group</td>
<td>I continued eating my sandwich. I asked myself if there were anything wrong with me because I was eating with blood on my hands, arms, and clothes. I became paranoid and relied only on myself. I watched everyone so that they didn't accidently shoot me or anyone else. I constantly stayed on guard</td>
</tr>
<tr>
<td>2 One man was shot in the eye. Another in the chest. Incoming over the hill</td>
<td>Numb and unreal. Disbelief, shock, horror, hurt, and sadness</td>
<td>Even though this was war, a part of me believed people shouldn't kill each other. Reality: The man should not have been killed. His eye should have been intact. The back of his head should have been together. The other man's chest and back should not have</td>
<td>I lost a sense of safety and security. I lost the belief in the continuity of life. I lost the belief in the meaning of life. I lost the belief that living or dying was anything but a random event. I began to lose my belief that there was a God</td>
<td>I dug deeper the holes that I used for cover and sleeping. I withdrew from others. I didn't talk about it with anyone; it was just part of my job -- combat and war. I blamed the men who were killed for not</td>
</tr>
</tbody>
</table>

2-a-103
<table>
<thead>
<tr>
<th>3 Walking during incoming</th>
<th>Fear. Relief when it was over</th>
<th>I believed we should have taken cover</th>
<th>I lost safety and security. I kept doing my job</th>
<th>I also began to believe that I was going to be killed regardless of how hard I tried to do the job right. I began to wonder why I was alive and others were dead. I kept remembering the one man who was shot in the eye and I didn't want to be killed that way. I tried to put it out of my mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a This was the first day of a 2 day operation. I got airsick</td>
<td>Excitement, much fear, embarrass-ment and shame</td>
<td>I believed I wasn't supposed to throw up while I was needed. I should have been more dependable</td>
<td>I lost self-esteem, self-worth, and self-respect. I also lost safety, security and control.</td>
<td>My responses were that I did my job despite my fear and throwing up. I thought again that life or death was a random event; there was no meaning to life. There was no credibility to the concept of destiny</td>
</tr>
<tr>
<td>4b Same operation. We picked up wounded</td>
<td>Fear, shock and horror. Concern for the men and desperation to save them</td>
<td>I believed people shouldn't try to kill people who were wounded. Reality: the man's hand was supposed to be attached totally to his arm. His blood was not supposed to be pumping out of his body. People should not be disfigured or have their bodies mutilated</td>
<td>I lost understanding about life. I lost my belief in the continuity of body functions. I lost my belief in the continuity of life. I lost any sense of importance as an individual or sense of meaning to life</td>
<td>I did my job. I stopped the man's leg from bleeding. I began to think how glad I was that I had not lost my leg or hand. I began to wonder at times when I looked at my leg and hand why they were still there and others no longer had theirs.</td>
</tr>
<tr>
<td>4c The</td>
<td>Terror. Intensely scared,</td>
<td>My beliefs were that</td>
<td>I lost a sense of</td>
<td>I tried to stay</td>
</tr>
</tbody>
</table>

Etiotropic Trauma Management Trauma Resolution Therapy Training – Certification Program
<table>
<thead>
<tr>
<th>Copilot was wounded</th>
<th>Concerned for him. Anger and rage. Relief and glad for the air support. Glad when the lieutenant lived</th>
<th>People I knew should not be shot. I believed, even though I was trained differently, that people should not kill each other. I believed our helicopter could get us out of there.</th>
<th>Safety or control over whether I lived or died</th>
<th>Alive and kill NVA. I helped with the wounded and the lieutenant. I told no one. I tried harder at being very good at my job. A part of me withdrew from others. I couldn't and didn't talk to anyone about the experience.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5a Up North. Several Marines and enemy were killed. I was almost killed</td>
<td>Stunned, dazed, and terrified. Rage at the enemy. Hurt from my near death from the explosion</td>
<td>I had believed that I was safer than I really was. I was supposed to be able to control whether I lived or died.</td>
<td>I lost self-esteem, self-worth, and me. I lost belief in the continuity of any life. I lost belief in the purpose of life. I lost belief in the prospect of my life going forward.</td>
<td>I walked around dazed. I tried to be tough and show that I could do my job and that I was unaffected. I tried to understand carnage. I decided that dead is dead and life is life. I tried to not care as much about people in general.</td>
</tr>
<tr>
<td>5b Same incident. I observed carnage.</td>
<td>Unreal. I felt dazed, sick, sad, nauseous, and separate. I felt sadness and loss for the man I carried because he was another human being and he was dead</td>
<td>Reality: People's bodies were supposed to be intact -- not torn apart, mutilated, or disfigured. People deserved to be treated as humans when dead. I believed that anyone who had children, like the man who I carried, should not be killed. He should have gone home alive to his children.</td>
<td>I lost myself, safety, those men, the belief in the sanctity of life and belief that there was any meaning to life</td>
<td>I didn't talk to anyone about it, except the Chaplain. He said he did not understand it either. I wanted the dead man's children and wife to be OK. I could not understand why he was dead when so many needed him and no one needed me; and I was alive.</td>
</tr>
</tbody>
</table>
Example (C2): Violent Crime Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

This example shows how to apply to Phase Two several traumatic experiences occurring as consequences of a single event. One event has resulted in five related experiences of psychological trauma.

**TRT Phase Two Matrix Example: Violent Crime Trauma**

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<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
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<tr>
<td>1 I was attacked and beaten in the garage</td>
<td>Shock, panic, stunned, disbelief, terror, hurt and horror</td>
<td>I believed that I was a human being who hadn't hurt anyone and that I should not be hurt. I should not be hit in the head and ear. I believed in the sanctity of my body and life</td>
<td>I lost any sense of control over my own life</td>
<td>I tried to protect myself. Then I had no me with which to respond. I wondered for a moment where my husband was and what was happening to him. A part of me separated from the reality of what was happening.</td>
</tr>
<tr>
<td>2 The attacker dragged me into the kitchen. I was beaten again</td>
<td>I was in shock and becoming more disoriented as I went in and out of consciousness. I was numb, stunned and feeling physical pain to my head, arms, back, neck, ribs, and stomach. I felt horror, hurt, terror, and futility</td>
<td>My values were that I should be treated with care and respect by other people. I should not be treated as inhuman. No one should strangle me, drag me like an animal, kick or beat me</td>
<td>I lost self-esteem, self-worth, trust in any thing, safety, security, and control over my life. I lost hope that I would live. I lost the ability to breathe and think clearly. I lost belief in the continuity of my life</td>
<td>I fought back at first. Then I seemed to be gone. Nothing was left with which to fight.</td>
</tr>
<tr>
<td>3 He sodomized me</td>
<td>I felt horror, shame, shock and disorientation. Physical pain and numbness. Anger, I believed that this was inhuman. No one should treat anyone like this. I believed it was evil and vileness</td>
<td>I lost more esteem, worth, sense of female value and human existence. I lost the feeling of sanctity and</td>
<td>My response was to hope that it would be over soon and that I wouldn't be killed. I began</td>
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</tr>
<tr>
<td>4</td>
<td>I was stabbed</td>
<td>I felt my life leaving me</td>
<td>My belief was that my life was supposed to go on -- to continue</td>
<td>I lost myself as I thought my life was over</td>
</tr>
<tr>
<td>5</td>
<td>My husband was killed</td>
<td>I felt disbelief, hurt, deep sadness, and profound emptiness</td>
<td>I believed my husband was supposed to be alive -- to have stayed with me. No one had the right to take him from me. No one should have hurt my husband, much less shot him three times and killed him. I loved my husband -- he was part of me. He should not have been gone</td>
<td>I lost my husband. I lost my belief in any meaning to life. I lost a part of myself. I lost his companionship. I lost his love for me. I lost me</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>rage, and hurt</td>
<td>at its utmost. Something like this occurring to me was not in my mind as being possible. It could not occur</td>
<td>privacy of my body</td>
<td>to think that if I was nice to him he wouldn't kill me</td>
</tr>
</tbody>
</table>

**TRT Phase Two Reading Component**

When sharing the Matrix, begin with the first row, and read across the page from column one to column five. This reading may follow the explicitly written words or the writing may serve as notes from which the client relates the information. Depending on the amount of information applied to the Matrix, it will be shared in one session or over multiple meetings. The next section, "Facilitating Phase Two," provides additional information about the process of reading the Matrix.

**Facilitating TRT Phase Two**

This section explains how to facilitate the writing, reading, and feedbacking components of Phase Two.
Facilitating the Phase Two Written Component

Getting the written component of Phase Two correct in the first place makes the reading component and the rest of the TRT process, Phases Three, Four and Five, proceed smoothly. Two problems usually interfere with this correct application; they are explained in the next two paragraphs.

While filling in column 1, some trauma victim's attempt to detail the event; the event is supposed to only be summarized. If event detailing happens, transition to the process through which the effects of the event are identified and addressed, the process through which the etiology is reversed, will not occur -- the etiology will not be reversed.

To correct the error (detailing in column one), remind the person that only a brief summary (several words) is needed. If the client still details the event(s), ask that person to return to Phase One and reread these particular events in their entirety and until the story no longer requires telling in the detailed form.

If that person so chooses, he or she may even elect to add more information to the first Phase One re descriptions; after they have been reread, assist the person to return to the Matrix and to summarize the event(s) in the first column. Do not proceed with Phase Two until the client can summarize the events in column one.

While filling in column 5, clients tend to either generalize responses or skip the column all together; sometimes they ascribe nothing to the column. Facilitation of the writing of the Matrix for such people requires your close scrutiny -- ensure that column 5 is fully completed. If this careful attention is not given, or the recommendations for filling in column 5 are not followed, the client will find him or her self incapable of continuing with the therapy in Phases Three and Four, which incapability requires a return to the Matrix and rewriting and rereading of it; this is not just an unhappy thought, but a time consuming and prospectively (and needlessly) expensive project.

Do not let this failure to complete column 5 happen; it most probably will happen if you do not focus on every patient's application of that column. Even though the educational materials for patients (referenced in appendix B) mitigate this problem and lower the risk of its occurrence, despite the pamphlets' uses some patients will still tend to not complete column 5 properly.
You will also see, as you proceed in this book and then later apply TRT to your clients, that a failure by the client to comply with the instructions for completing column 5 is a clinical issue related to the means through which the trauma is defended in memory. That is, the paradoxical system of control prevents removal of itself or lowering of the protective defenses; column 5 and, as you will see later in Phase Three, it directly address these removal prevention efforts and the defenses.

This problem can be solved through conscientiousness. Make sure column 5 is completed fully and properly during the writing phase.

**Facilitating the Phase Two Reading Component**

During the reading of the Matrix, the client, group, and therapist are presented with 2 views of the traumas' effects. The first portrays each traumatic incident's individual effects upon the trauma victim. The second view demonstrates the whole of the traumas' effects, as if they are a painting of the traumas' influences on the psychodynamic canvas of the client's person.

If only one or a few rows are read at a time, the first picture emerges -- individual effects. If all the incidents are read in one session, the latter is emphasized. The therapist strikes a balance during the reading that reflects elements of both. This balance is negotiated, facilitated, at the therapist's discretion.

If TRT is read in a group, the optimum facilitation of each session occurs when the group hears from people who are reading from different phases; for example, a group may hear 1 Phase One series of, say 3 incidents, and 1 Phase Two reading of 4 episodes' applications to the Matrix. Obviously, there are numerous other combinations of prospective readings. Because Phase Two's reading can be a lengthy process, the number of incidents (applied to the Matrix) read should be considered in the context of other group members' reading needs. Generally, short Matrixes, like the violent crime example presented in this chapter, are read in a single session; group time should be planned accordingly.

Long matrixes, as depicted in the other examples, are usually read at the rate of 3 to 5 incidents per session; groups rarely listen to more than 8 Matrix applications in a single session. Additional guidelines are provided under "Facilitating Feedback."
Facilitating Feedback

The feedback guidelines and processes for reading TRT Phase Two are the same as those for reading Phase One (see Phase One). At the counselor's discretion, feedback may be given at any time, but is best facilitated every 3 rows or after every extraordinarily difficult to read row of effects. If the group is involved in a marathon experience, that is, the group has decided to meet for an entire day, then the number of incidents read, as they are applied to the Matrix, may be increased, but depending on the total of the individual and group needs, as those needs are appraised by the therapist.

Facilitation of Phase Two readings will progress very smoothly if the educational aids (written to clients) are used. The aids ensure everyone understands the goal, method, limitations, and process.

**Phase Two Reverses Etiology (Pattern 1)**

Phase Two reverses etiology one. This resolution occurs when the therapist facilitates the client's accomplishment of a series of interrelated tasks. Those tasks include the:

- (a) identification, experience and expression of the emotional elements of the grief cycles attending loss resulting from specific contradictions occurring as responses to the event (Phase One initiated the client's progressions through those grief cycles -- explanation follows).
- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles).
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Before explaining etiology-reversal, some description of grief cycles and their relationship to the 4 psychological patterns is necessary.

**Parallel Grief Cycles**

When we use the term "grief cycle," we intend it to refer to the repeated and generally sequential occurrence of certain emotions; in the end, all of the emotions, including their experiences, relate to the reconciliation and resolution of 1 or more losses that have a specific relationship to an element
of existential identity that has been contradicted by an extraordinary event. (Grief patterns" would provide the best word choice; however, delineation from the 4 psychological trauma patterns providing the mainstay of our overall theory of psychological trauma and the distinction of the relationship of the grief to the 4 patterns would be made more difficult if "patterns" were used twice).

In the case of psychological trauma, the loss is unexpected. Furthermore, the loss is a consequence of radical and portentous change that demonstrates that the ongoing status of the organism, or some aspect of that status, is in jeopardy.

These losses can be related to the loss of tangible items, for example, a home, loved one, part of the human body, or the body's capacity to function. The loss can also be related to less tangible issues, for example, esteem, worth, and relationship elements like trust, respect, companionship, socialization, an image of what the family is supposed to be, and so forth. If the loss is of tangible items, this kind of loss will also be accompanied by intangible losses. Finally, losses can occur across all dimensions of human psychology to include intrapsychic, interpsychic, and systemic variations of that psychology. The grief cycle is associated with the loss resolution process to the extent that the individual suffering it is likely to experience, prior to identification of the loss, the emotions of shock, disbelief, confusion, pity, fear, anger, embarrassment, hurt, guilt and sadness.

Other losses can produce a re-experience of the same emotions. Consequently, the term "grief cycle" to which we refer is the progression through the emotions described in the previous sentence, and in a general order depicted in the same, with the final component of the progression being the identification, understanding and acceptance of the particular loss being addressed by the progression. The literature is replete with the recognition of such grief cycles and their relationships to various kinds of losses (see About ETM/Comparison - Contrast).

When an individual completes all of TRT's phases, he or she progresses through 3 general grief cycles related to the reversal of the etiologies referenced to exist in pattern 1 (etiology one) and pattern 3 (etiology 2). For purposes of clarification and codification, we title the grief cycles as: (A), (B), and (C). The grief cycles are related to and comprise elements of the 4 psychological trauma patterns. We distinguish these cycles from the patterns
because such delineation clarifies our observations of the trauma resolution process as it occurs, not just in the application of TRT Phase Two, but all of the TRT phases. Further clarification of these cycles is provided here.

**Parallel Grief Cycle: (A)**

The first cycle (A) is related to those losses that result from the initial trauma-causing event. However, the cycle is divided into 2 therapeutic experiences -- TRT Phase One and TRT Phase Two.

That is, when the individual describes a single trauma causing event, he or she initiates grief cycle (A) and completes the first half of that cycle (A). For example, the emotions usually recorded in the Phase One description are of numbness, shock, disbelief, the state of being unreal, pity, fear (including where appropriate horror and terror), and embarrassment.

When the trauma victim completes the application of the Matrix to that same incident, the second half of the emotions representing grief cycle (A) are experienced, they present for observation. When the person is working in TRT Phase Two, the emotions experienced (while being recorded in writing and then shared when the Matrix is read) are generally anger (rage), hurt, depression, guilt, and sadness.

When the losses are identified, experienced and expressed in column 4 of the Matrix, this grief cycle (A) is completed. Consequently, through the use of TRT Phases One and Two, grief cycle (A) is identified, experienced, expressed and then completed for each loss resulting from each initial trauma-causing event.

As the reader can probably see, grief cycle A comprises the emotional components to psychological trauma patterns 1 and 2.

**Parallel Grief Cycle: (B)**

We observed a second grief cycle (B) that is similar to the first, except that the cause of the losses to which the cycle relates are the trauma victim's own behaviors -- survival responses (to the initial trauma-causing events) that also contradict values, beliefs, images and realities. This cycle is divided into two groups as cycle A was divided.
In this division, shock, disbelief, the state of being unreal, fear and embarrassment are usually experienced during the first part of the cycle -- during the client's use of TRT Phase Three (explained in the next chapter). The emotions comprising the second part of cycle (B) are usually experienced while the trauma victim is completing TRT Phase Four (explained in chapter 4) -- the identification of contradicted values, beliefs, images and realities and identification, experience, expression and reconciliation of losses resulting from those contradictions. Thus, grief cycle (B) comprises the emotional components of psychological trauma patterns 3 and 4.

**Parallel Grief Cycle: (C)**

The third grief cycle (C) relates to losses resulting from all the traumas pertaining to the entire experience as a single source of trauma -- as the experiences have resulted in a single impact upon the individual's life. For example, when a spouse of a chemical dependent person completes all 5 TRT phases, he or she looks at the entire experience for its total effect.

In some cases, this total effect may encompass as little as 6 months, or as much as 35 years, of one's life. The grief cycle (C) relates to this total effect and is manifested as a parallel grief cycle (C) to the first two cycles (A) and (B). In this regard, the client experiences generalized feeling states in addition to the specific feeling states associated with specific losses.

In TRT Phase One, the generalized feeling states (stemming from grief cycle C) are shock, disbelief and horror. While completing TRT Phase Two, the generalized states are shame, anger, and hurt. Phases Three and Four are manifested in cycle (C) by, respectively, guilt, sadness (TRT Phase Three) and profound sadness or deep mourning (TRT Phase Four). Grief cycle (C) is a component of all 4 psychological trauma patterns.

**Parallel Grief Cycles: Summary**

To summarize the three grief cycles (A), (B), and (C), cycle (A) is a consequence of the individual's grieving specific losses directly resulting from the initial trauma-causing event(s). This cycle (A) comprises psychological trauma patterns 1 and 2 and is experienced over TRT Phases One and Two. Grief cycle (B) is also a consequence of the trauma victim's grieving specific losses, but losses that result from the trauma victim's own behaviors -- that is, survival responses to the initial trauma-causing event(s).
This cycle (B) comprises psychological trauma patterns 3 and 4 and is experienced (divided) over TRT Phases Three and Four. Grief cycle (C) is manifested as a parallel, overlapping, experience to cycles (A) and (B). Cycle (C) is experienced as a general manifestation of grief comprising all four psychological trauma patterns and is experienced evenly over the entire 5 phase Trauma Resolution Therapy process.

**Etiology Reversal: Resolving the Initial Trauma**

The application of the Matrix resolves the initial trauma -- reverses etiology (one) directly caused by the event, as opposed to reversing etiology (two) indirectly caused by trauma-induced survival responses (described in chapters 3 and 4). To achieve this resolution, the client transacts 2 parallel and existentially oriented processes: 1) the identification and experience of specific emotions comprising grief cycles (A) and (C) and simultaneous with 2) the intellectual assimilation, association and reconstitution of those values, beliefs, images and realities comprising pretrauma existential identity and that were contradicted by the event(s).

**Resolving the Initial Trauma: First Resolution Component -- Emotional Processing of Grief Cycles (A) and (C)**

In the first process, that is, while negotiating the passage through the emotional component, the trauma victim proceeds through grief cycles (A) and (C). With regards to cycle (A), by the time clients are working in Phase Two, they have already addressed in Phase One the first elements of that cycle; clients have identified, experienced and expressed shock, disbelief, fear and embarrassment. However, when clients apply the incidents to Phase Two they re-identify and re-experience those emotions again, but without the volatility that accompanied their identification and experience in Phase One. The additional emotions recorded in column 2 of the Matrix are usually feelings that continue the person's progressions through cycle (A); those emotions are often shame, anger, and hurt. As the person progresses across the form, contradicted values, beliefs, images and realities (column 3) and subsequent losses (column 4) are identified and the rest of grief cycle (A) is negotiated -- guilt and sadness are the predominant emotional experiences reported as that part of the Matrix is completed.

The feedback processes described in "Phase One" and in this chapter provide for the clients' identifications of the emotions, as well as provide for their experience and expressions. The person identifies the particular emotion and
then remains with the experience and without associating it with any particular intellectual thought. This experiential process continues until the emotion is expressed; the feelings, experiences, eventually dissipate.

Because the client's use of the Phase Two format provides for the inevitable association of these feelings and feeling states to the specific contradictions and losses underpinning their existence, it is not necessary to use analytical cognitive methods during the experiential component of the effort to provide such associations. For example, when someone expresses profound sadness or hurt, it is unnecessary to facilitate the association of those particular feelings to a particular contradicted belief or loss because the structure provides for such association automatically. A subsequent and central value of the structure is that it allows for the emotions to be experienced to the extent required individually. Phase Two makes guesswork obsolete, which interrogatory activities are shown through facilitation of TRT to divert the person from the full experience. Subsequent stabilization facilitates thorough understanding.

With regards to grief cycle (C), clients notify therapists of this ongoing process when asked to discuss the emotional experiences they are having outside of (following) their TRT sessions. As indicated in the preceding section on grief cycles, the trauma victim usually experiences embarrassment to the extent that it becomes great shame, and anger to the extent that it becomes rage. These 2 feelings characterize the client's general emotional progressions through Phase Two.

To summarize the emotional process, clients, as a rule, readdress (reexperience) the shock, disbelief, fear and embarrassment already addressed in Phase One, but without the volatility and intensity accompanying initial elements of that Phase. As the client proceeds across the Matrix, he or she will continue negotiating cycle (A), all the while identifying, experiencing and expressing those emotions comprising that cycle until those emotions no longer exist. Outside of the group process the predominant emotional experiences are great shame and rage. These latter and sometimes general characterizations of emotional experience indicate that the individual is progressing through grief cycle (C) -- the emotional processing related to all the episodes taken as a single life experience.
Resolving the Initial Trauma: Second Resolution Component -- Intellectual/Experiential Reconstitution of Existential Identity

The second resolution component provides for the combined intellectual and experientially influenced reconstitution of existential identity. Completion of this component involves completing the last 4 (b, c, d and e) resolution steps described on page 53 and reviewed here:

- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles).
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Identify the Contradicted Elements of Identity (b) and Identify, Experience and Express Loss (c)

Loss is a paradox. That is, the term "loss" is intended to represent something that no longer exists, but in that non existence there is a psychological (and neurological; see About ETM/ Theory/ Neurobiological Trauma Etiology) reality, and although frequently unknown, this new reality is equal to any other element of the psyche. The identification of this loss is always tied to the successful identification of that which existed prior to the occurrence of the loss -- the particular element of existential identity contradicted by the intruding episode. Therefore, when completing the third and fourth columns of the Matrix, clients first identify the contradicted values, beliefs, images and realities that comprised themselves before the intrusion; second, clients identify the loss that had become a replacement for those values, beliefs, images, and realities which used to exist unfettered, uncompromised, and unchallenged in the psyche.

Following the identification of the loss, it is also experienced to the extent that it carries with it its own characterization of feeling. In other words, the loss is both an element of existential identity, that is, a replacement for seemingly non existent values, etc., and a feeling experience in its own right.

Trauma victims negotiate this experience by stating that it is occurring, and then as occurs in other experiential processings, the client remains with the feeling of the loss until it no longer is manifested: the loss is dissipated. This "remaining with the feeling of loss" is a profoundly sad occurrence. Moreover, the experience of loss is also antithetical to control, which
requires its own description. "Antithesis of control" is manifested by some as "nothingness" and a "dark, deep and bottomless void."

The passage through this experience of "nothingness" and "bottomless void" proves to be the ending of it. Some clients also report that prior to using TRT they had routinely entered (that is, felt as if they were entering some form of passage) these experiences of "nothingness" and "voids without ending" and become frightened by the prospects that they would never exit these passages. However, in TRT, the structure, to include the written component completed prior to its reading and the group's continued and consistent feedback to have been demonstrated (in Phase One) to accompany the person to any level of internal introspection and emotional pain, replaces this fear of not exiting the dark passages. The structure assures the individual that the venture through such passages are a matter-of-fact therapeutic process -- assisted excursions into previously unknown areas, which, based on the experience of the first TRT phase, undoubtedly result in a positive outcome.

Patients and facilitators learn to trust the structure implicitly. As the passages through "nothingness" and "the void" are negotiated to the extent required individually, the vacuums previously comprising these passages are dissipated. Moreover, the "nothingness" and "void" are replaced with the trauma victim's *reconstitution* of those values, beliefs, images and realities that had existed prior to the trauma's occurrence, and which had been contradicted to the extent that the "nothingness" and "void" had been created in the first place.

Importantly, when values, etc., are "reconstituted," they are maintained in the existential identity depending on the ontology of the individual; the retention is not a function of the values of those administering the therapeutic process. This ability to select elements of existential identity that are now pertinent to the individual ontology, or to discard other values, beliefs, images and realities no longer pertinent to that ontology, represent a manifestation of the trauma victim's reestablishment of control -- the regaining of free will, the ability to choose. Etiology one is reversed.

The next chapter (3) describes this reestablishment process after discussing the trauma-induced paradoxical thought system that encumbered control in the first place.

*Bottom of Form*
Chapter 5 Section (d):

How To Facilitate TRT Phases One Through Five

TRT Phase Two (The Matrix)

This chapter:

5. Describes TRT Phase Two's application: writing, reading and facilitation.
6. Provides examples for the application of TRT Phase Two.
7. Discusses the effects of TRT Phase Two on the resolution process (reverses etiology one).
8. Continues the explanation of the TRT theory of psychological trauma and its resolution.

Theory Review

Reviewing from the About ETM/ Theory, psychological trauma exists in memory in 4 patterns. They are:

5. The experience of the event contradicts the pre-trauma values, beliefs, images and realities (existential identity).
6. The loss from the contradictions and associated emotional outcomes are retained in memory (meaning in this use maintained in memory: conscious or otherwise).
7. The repression of the emotional elements resulting from the contradictions creates the need for survival protective measures -- thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional repression and in the process of that dissociation further contradict the existential identity.
8. The dissociative activity, survival responses, produce additional experiences of loss and emotion that are also retained in memory.

The contradicted values, beliefs, images and realities described in "1" and "3" represent the etiology of psychological trauma. The 4 patterns, including the etiology, are defended by a paradoxical system of control; the trauma
victim is perpetually and simultaneously attempting to end and continue the trauma's effects.

**TRT Phase Two: Introduction**

TRT resolves psychological trauma by reversing the etiology described in patterns 1 and 3. To begin this resolution process, TRT Phase One initiates the resolution effort by identifying the trauma-causing event that created the etiology. This identification then opens the door to the address of the etiology referenced in pattern 1, which is facilitated through the application of Phase Two. Phase Two takes specific steps to reverse the etiology (from now on also referenced as "etiology one") attending this pattern. Those steps include the:

- (a) identification, experience, and expression of the emotional elements of grief cycles accompanying loss resulting from specific contradictions.
- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions and that necessitated the grief cycles.
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Completion of these tasks "expunge" patterns 1 and 2 from memory, or as explained in the biology section, the identity is "reconfigured" to its pretrauma existence, but within the context of the current reality. "Reconfiguration" and "expunge" are both functions of learning "what happened" to the psychological management system following, and as a direct consequence of, the effects of the traumatic event. Phases One and Two also neutralize the paradoxical system of control that defends the trauma; in providing this neutralization, control is regained.

The paradox, however, is more suitable for description, the concept is easier to understand, when relating it to the thoughts and behaviors that result from the paradox. We offer this explanation in detail when describing Phase Three's effects on pattern 3, the pattern that retains, in memory, the contradictions to identity caused by the paradox initiated survival thoughts and behaviors (see TRT Phase Three).

Once the explanation of the paradox is more fully provided in that chapter, we show how its undoing is also facilitated by Phases One and Two.
Consequently, the paradox and the issue of control, although profoundly influenced by Phase Two, are not fully discussed until later (Phase Three).

The first part of this chapter explains Phase Two's application. The rest of the chapter explains how TRT Phase Two reverses the etiology comprising pattern 1 and in the process removes the influences of both patterns 1 and 2 on the psychological management system of the trauma victim.

**TRT Phase Two Application**

Phase Two, like Phase One, is also comprised of 2 elements: writing and reading. This section describes the written component first, then gives examples of the written application, and concludes with explanations of how to read and facilitate the phase.

**TRT Phase Two: Written Component (The Matrix)**

If you review the literature (About ETM/ Bibliography), you will find that psychodynamic approaches to psychological trauma are seen as unwieldy because the amount of trauma-induced change affecting the psychological management system is enormous. Hence, trying to assimilate and integrate this large amount of information creates an overwhelming task -- information overload occurs and terminates the assimilation/integrative effort; in the process, psychodynamic models are made to seem less efficacious and consequently less reliable (according to the literature). Phase Two eases this informational processing task-- makes it simple; in the process of that simplification, the psychodynamic method is made extremely effective and very reliable, but with the added feature that the structure inherent in the Matrix creates that new capacity and subsequent certitude, confidence in the structure's dependability.

The simplicity is derived from Phase Two's form, which is a Matrix comprised of 5 columns and a number of rows equal to the number of incidents described in Phase One -- each incident from that phase is applied horizontally to the form. The incident then makes up the row which is retranslated in the context of the 5 columns. An example of the form is shown in figure 1. The numbers in the left column (1) of the example are correlated to the number denoting the incident described in Phase One.

The first column contains a summary of the trauma-causing event(s) the patient shared in Phase One. The second column is a reiteration, redescription, and summary of the emotions experienced when first writing
Phase One and also experienced again currently when filling in this form. The third column is a simple description of the values, beliefs, images and realities contradicted by the event. The fourth column provides for identification and depiction of losses directly resulting from the contradicted values, beliefs, images and realities recorded in column 3. Column 5 denotes thought/behavioral responses occurring at the time of the event and shortly thereafter.

Approximately 5 incidents taken from Phase One are usually applied to a single sheet of paper (8 1/2 by 11 inches and placed horizontally on the page). Thus, if a person had recorded 50 trauma causing episodes in Phase One, Phase Two’s format would yield approximately 10 pages of Phase Two output, each page consisting approximately of the 5 columns and 5 rows (a single incident per row) of data.

Clients should apply 3 incidents to the Matrix and then bring them to a group or individual session for review by the therapist. This "review" will be discussed later under facilitation. For now, once the client is assured of having the right idea, the rest of the incidents are applied to the Phase Two format.

The following is a sample form of:

**TRT Phase Two (The Matrix)**

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

The Matrix will extend each column depending on the number of incidents applied from Phase One. For example, 5 incidents will use at least 5 rows.
TRT Phase Two Written Component: Examples

The examples from chapter 1, "Examples" section are continued in this chapter and section. The examples presented here depict the application of Phase Two to trauma resulting from life with a drug addicted and violent spouse, and to trauma resulting from combat and violent crime.

**Example (A2): Codependency Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two**

This example, as different from the combat and violent crime examples, represents the standard application of trauma-causing experiences to Phase Two. "Standard" means that the trauma-causing experiences occur, and thus are recorded in Phase One, and are then applied to Phase Two, as single, clearly delineated from each other, incidents.

The first incident in this list of 5 descriptions is applied horizontally to the 5 column Phase Two form (the Matrix). It is important to keep the summary in column 1 brief. The instructions for the second column provide for a copying into that column/row of the emotions recorded in the Phase One description, and then a placement of a summary of additional emotions; they were identified as either occurring at the time of the event or being felt for the first time while applying the particular Phase One description to the Matrix. The rest of the columns are self explanatory.

**Codependency Trauma TRT Phase Two Matrix: Example**

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Near accident on the freeway while he was driving drunk</td>
<td>Stunned - Shock, fear, horror, embarrassment, anger, hurt, shame</td>
<td>My values were that my husband should drive safely. He should not drive drunk -- threaten my life or anyone else's.</td>
<td>I lost self-esteem and self-worth. I lost respect for my husband and trust in him and his driving. I lost a sense of security and safety. I lost a role model for a husband and father who could be depended upon to</td>
<td>I packed my bags and planned to leave. Then I stayed. Then I pretended it did not happen.</td>
</tr>
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<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td><strong>2. He urinated on the bed. He hit me and wanted to have sex with me</strong></td>
<td><strong>Shock, stunned, disoriented, repulsed, disgust, revulsion, hurt, anger and rage</strong></td>
<td><strong>I believed my husband should urinate in the toilet -- not pee on the bed or me. He should not hit me. He should not try to force me to have sex, especially after trying to hurt me. He should not be so drunk that he loses control -- his mind</strong></td>
<td><strong>I lost self-esteem and self-worth. I lost trust in his judgment, his sanity, and him as a person. I lost respect for him as a regular human being and a husband. I also lost a sense of cleanliness, humanness, safety, security, and my own sanity</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3. He broke my arm and slashed me with scissors</strong></td>
<td><strong>Shock, panic, stunned, anger, hurt, horror, shame, physical pain, and terror</strong></td>
<td><strong>My values were that my husband should be faithful. He should not have sex with other women. I believed that he should care about me and not hurt me. He should not hit me, pull my hair, break my arm or cut me and make me bleed. My blood should remain in my body and not run all over the bed and floor</strong></td>
<td><strong>I lost the belief that my life would continue. I lost my belief that I was human. I almost lost my life. I lost trust in my marriage. I lost more respect for my husband. I lost any sense of safety and security -- the experience of being protected</strong></td>
<td></td>
</tr>
<tr>
<td><strong>4. He was sexually molesting our daughter</strong></td>
<td><strong>I was petrified and shocked. I felt anger, rage, disbelief, and horror.</strong></td>
<td><strong>I believed my husband should not fondle my child. My values were that my child's father should care about her and protect her -- not hurt her or try to have sex with her. The children should be safe and not threatened.</strong></td>
<td><strong>I lost a husband and father of our children as a role model. I lost my own sanity</strong></td>
<td></td>
</tr>
<tr>
<td><strong>5. This was the New Years incident where he beat me badly and I was hospitalized</strong></td>
<td><strong>I felt terror, horror, panic, shame, shock, disbelief, disorientation, hurt, guilt, anger, and rage. I felt physical hurt and pain.</strong></td>
<td><strong>My reality was that my tooth was supposed to be in my mouth, not in my hand. I was not supposed to be bleeding. I was supposed to be able to breathe through my nose. My image was</strong></td>
<td><strong>I lost self-esteem and self-worth. I lost trust and respect for my husband. I lost the belief that I would continue to live. I lost any sense of safety, security, reality, and sanity. I lost all concept of the person</strong></td>
<td></td>
</tr>
</tbody>
</table>

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**Etiotropic Trauma Management Trauma Resolution Therapy Training – Certification Program**

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Example (B2): Combat Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

There are three purposes underlying our use of the combat examples. They are explained here before showing the examples; but with the preface that (ETM Strategic/ Crisis Management and Managers) addresses the same subject in detail.

First, combat personnel are crisis managers. Crisis managers are affected differently from all other trauma victims; crisis managers are comprised of two kinds of existential identity -- personal and professional. The trauma they experience usually occurs as an interruption to personal identity, and even though there is no intrusion or contradiction to those values, beliefs, images and realities comprising professional identity. For example, death and personal injury are expected aspects of the job function; thus, professional training provides a set of values, beliefs, images and realities that can accommodate those aspects of the job. When extraordinary events occur, the internal psychic damage is to the personal identity, and frequently unbeknownst to conscious psychology. Consequently, when applying into Phase Two trauma experienced by crisis managers, we ask that they record (emphasize in their deliberations) into column three contradictions to personal identity. Therefore, when you read this Matrix (example of a combat application), you may be saying to yourself, "This is combat; where is the person's professional self?" The answer is that it does exist, but it is not emphasized, at least in this phase of TRT.

Second, combat provides the means of describing how exposure to much carnage affects the reality system. In this example we emphasized those effects as they are a part of the professional address of some kinds of psychological trauma.
Third, in some instances an incident (4) is lengthy and complex -- there are many traumatic episodes occurring within the incident. This example shows how to apply such complex experiences to Phase Two.

The TRT Phase One combat incidents are applied to the TRT Phase Two "Matrix."

### TRT Phase Two (The Matrix) Example: Combat Trauma

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 This was the accident where the man was shot in the groin</td>
<td>Numb and unreal. Shock, horror, anger, and sadness</td>
<td>My values were that people would not be hurt, much less mutilated or killed. I believed the sergeant should have been more careful and cleared the gun properly. Reality -- the man's blood was supposed to be in his body. Not on me and in the sand. His penis was not supposed to be injured</td>
<td>I lost a sense of safety and security. I lost my belief in how life should go on uninterrupted. I lost respect and trust in other people. I lost my belief in my partners -- despite the problems with the enemy, my own buddies might kill me by accident. I lost a member of the group</td>
<td>I continued eating my sandwich. I asked myself if there were anything wrong with me because I was eating with blood on my hands, arms, and clothes. I became paranoid and relied only on myself. I watched everyone so that they didn't accidently shoot me or anyone else. I constantly stayed on guard</td>
</tr>
<tr>
<td>2 One man was shot in the eye. Another in the chest. Incoming over the hill</td>
<td>Numb and unreal. Disbelief, shock, horror, hurt, and sadness</td>
<td>Even though this was war, a part of me believed people shouldn't kill each other. Reality: The man should not have been killed. His eye should have been intact. The back of his head should have been together. The other man's chest and back should not have</td>
<td>I lost a sense of safety and security. I lost the belief in the continuity of life. I lost the belief in the meaning of life. I lost the belief that living or dying was anything but a random event. I began to lose my belief that there was a God</td>
<td>I dug deeper the holes that I used for cover and sleeping. I withdrew from others. I didn't talk about it with anyone; it was just part of my job -- combat and war. I blamed the men who were killed for not</td>
</tr>
<tr>
<td>3 Walking during incoming</td>
<td>Fear. Relief when it was over</td>
<td>I believed we should have taken cover</td>
<td>I lost safety and security. I kept doing my job</td>
<td>I also began to believe that I was going to be killed regardless of how hard I tried to do the job right. I began to wonder why I was alive and others were dead. I kept remembering the one man who was shot in the eye and I didn't want to be killed that way. I tried to put it out of my mind</td>
</tr>
</tbody>
</table>

| 4a This was the first day of a 2 day operation. I got airsick | Excitement, much fear, embarass-ment and shame | I believed I wasn't supposed to throw up while I was needed. I should have been more dependable | I lost self-esteem, self-worth, and self-respect. I also lost safety, security and control. | My responses were that I did my job despite my fear and throwing up. I thought again that life or death was a random event; there was no meaning to life. There was no credibility to the concept of destiny |

| 4b Same operation. We picked up wounded | Fear, shock and horror. Concern for the men and desperation to save them | I believed people shouldn't try to kill people who were wounded. Reality: the man's hand was supposed to be attached totally to his arm. His blood was not supposed to be pumping out of his body. People should not be disfigured or have their bodies mutilated | I lost understanding about life. I lost my belief in the continuity of body functions. I lost my belief in the continuity of life. I lost any sense of importance as an individual or sense of meaning to life | I did my job. I stopped the man's leg from bleeding. I began to think how glad I was that I had not lost my leg or hand. I began to wonder at times when I looked at my leg and hand why they were still there and others no longer had theirs. |

| 4c The | Terror. Intensely scared, | My beliefs were that | I lost a sense of | I tried to stay |
A copilot was wounded concerned for him. Anger and rage. Relief and glad for the air support. Glad when the lieutenant lived.

People I knew should not be shot. I believed, even though I was trained differently, that people should not kill each other. I believed our helicopter could get us out of there.

Safety or control over whether I lived or died. Alive and kill NVA. I helped with the wounded and the lieutenant. I told no one. I tried harder at being very good at my job. A part of me withdrew from others. I couldn't and didn't talk to anyone about the experience.

5a Up North. Several Marines and enemy were killed. I was almost killed.

Stunned, dazed, and terrified. Rage at the enemy. Hurt from my near death from the explosion.

I had believed that I was safer than I really was. I was supposed to be able to control whether I lived or died.


I walked around dazed. I tried to be tough and show that I could do my job and that I was unaffected. I tried to understand carnage. I decided that dead is dead and life is life. I tried to not care as much about people in general.

5b Same incident. I observed carnage.

Unreal. I felt dazed, sick, sad, nauseous, and separate. I felt sadness and loss for the man I carried because he was another human being and he was dead.

Reality: People's bodies were supposed to be intact -- not torn apart, mutilated, or disfigured. People deserved to be treated as humans when dead. I believed that anyone who had children, like the man who I carried, should not be killed. He should have gone home alive to his children.

I lost myself, safety, those men, the belief in the sanctity of life and belief that there was any meaning to life.

I didn't talk to anyone about it, except the Chaplain. He said he did not understand it either. I wanted the dead man's children and wife to be OK. I could not understand why he was dead when so many needed him and no one needed me; and I was alive.
Example (C2): Violent Crime Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

This example shows how to apply to Phase Two several traumatic experiences occurring as consequences of a single event. One event has resulted in five related experiences of psychological trauma.

**TRT Phase Two Matrix Example: Violent Crime Trauma**

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 I was attacked and beaten in the garage</td>
<td>Shock, panic, stunned, disbelief, terror, hurt and horror</td>
<td>I believed that I was a human being who hadn't hurt anyone and that I should not be hurt. I should not be hit in the head and ear. I believed in the sanctity of my body and life</td>
<td>I lost any sense of control over my own life</td>
<td>I tried to protect myself. Then I had no me with which to respond. I wondered for a moment where my husband was and what was happening to him. A part of me separated from the reality of what was happening.</td>
</tr>
<tr>
<td>2 The attacker dragged me into the kitchen. I was beaten again</td>
<td>I was in shock and becoming more disoriented. I was numb, stunned and feeling physical pain to my head, arms, back, neck, ribs, and stomach. I felt horror, hurt, terror, and futility</td>
<td>My values were that I should be treated with care and respect by other people. I should not be treated as inhuman. No one should strangle me, drag me like an animal, kick or beat me</td>
<td>I lost self-esteem, self-worth, trust in any thing, safety, security, and control over my life. I lost hope that I would live. I lost the ability to breathe and think clearly. I lost belief in the continuity of my life</td>
<td>I fought back at first. Then I seemed to be gone. Nothing was left with which to fight.</td>
</tr>
<tr>
<td>3 He sodomized me</td>
<td>I felt horror, shame, shock and disorientation. Physical pain and numbness. Anger, I believed that this was inhuman. No one should treat anyone like this. I believed it was evil and vileness</td>
<td>I lost more esteem, worth, sense of female value and human existence. I lost the feeling of sanctity and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2-a-128
rage, and hurt  

at its utmost. Something like this occurring to me was not in my mind as being possible. It could not occur  

privacy of my body  

to think that if I was nice to him he wouldn't kill me  

4  
I was stabbed  

I felt my life leaving me  

My belief was that my life was supposed to go on -- to continue  

I lost myself as I thought my life was over  

I fought back at first. Then I seemed to be gone. Nothing was left with which to fight.  

5  
My husband was killed  

I felt disbelief, hurt, deep sadness, and profound emptiness  

I believed my husband was supposed to be alive -- to have stayed with me. No one had the right to take him from me. No one should have hurt my husband., much less shot him three times and killed him. I loved my husband -- he was part of me. He should not have been gone  

I lost my husband. I lost my belief in any meaning to life. I lost a part of myself. I lost his companionship. I lost his love for me. I lost me  

I withdrew from everyone. I dreamed that Gary had come back to me. When I was with my second husband,, I imagined he was Gary. I became paranoid,, boarded up windows and doors. I would not go out or to the garage. I bought a gun and thought the killers were coming back. I thought I was going insane.
Facilitating the Phase Two Written Component

Getting the written component of Phase Two correct in the first place makes the reading component and the rest of the TRT process, Phases Three, Four and Five, proceed smoothly. Two problems usually interfere with this correct application; they are explained in the next two paragraphs.

While filling in column 1, some trauma victim's attempt to detail the event; the event is supposed to only be summarized. If event detailing happens, transition to the process through which the effects of the event are identified and addressed, the process through which the etiology is reversed, will not occur -- the etiology will not be reversed.

To correct the error (detailing in column one), remind the person that only a brief summary (several words) is needed. If the client still details the event(s), ask that person to return to Phase One and reread these particular events in their entirety and until the story no longer requires telling in the detailed form.

If that person so chooses, he or she may even elect to add more information to the first Phase One re descriptions; after they have been reread, assist the person to return to the Matrix and to summarize the event(s) in the first column. Do not proceed with Phase Two until the client can summarize the events in column one.

While filling in column 5, clients tend to either generalize responses or skip the column all together; sometimes they ascribe nothing to the column. Facilitation of the writing of the Matrix for such people requires your close scrutiny -- ensure that column 5 is fully completed. If this careful attention is not given, or the recommendations for filling in column 5 are not followed, the client will find him or her self incapable of continuing with the therapy in Phases Three and Four, which incapability requires a return to the Matrix and rewriting and rereading of it; this is not just an unhappy thought, but a time consuming and prospectively (and needlessly) expensive project.

Do not let this failure to complete column 5 happen; it most probably will happen if you do not focus on every patient's application of that column. Even though the educational materials for patients (referenced in appendix B) mitigate this problem and lower the risk of its occurrence, despite the pamphlets' uses some patients will still tend to not complete column 5 properly.
You will also see, as you proceed in this book and then later apply TRT to your clients, that a failure by the client to comply with the instructions for completing column 5 is a clinical issue related to the means through which the trauma is defended in memory. That is, the paradoxical system of control prevents removal of itself or lowering of the protective defenses; column 5 and, as you will see later in Phase Three, it directly address these removal prevention efforts and the defenses.

This problem can be solved through conscientiousness. Make sure column 5 is completed fully and properly during the writing phase.

**Facilitating the Phase Two Reading Component**

During the reading of the Matrix, the client, group, and therapist are presented with 2 views of the traumas' effects. The first portrays each traumatic incident's individual effects upon the trauma victim. The second view demonstrates the whole of the traumas' effects, as if they are a painting of the traumas' influences on the psychodynamic canvas of the client's person.

If only one or a few rows are read at a time, the first picture emerges -- individual effects. If all the incidents are read in one session, the latter is emphasized. The therapist strikes a balance during the reading that reflects elements of both. This balance is negotiated, facilitated, at the therapist's discretion.

If TRT is read in a group, the optimum facilitation of each session occurs when the group hears from people who are reading from different phases; for example, a group may hear 1 Phase One series of, say 3 incidents, and 1 Phase Two reading of 4 episodes' applications to the Matrix. Obviously, there are numerous other combinations of prospective readings. Because Phase Two's reading can be a lengthy process, the number of incidents (applied to the Matrix) read should be considered in the context of other group members' reading needs. Generally, short Matrixes, like the violent crime example presented in this chapter, are read in a single session; group time should be planned accordingly.

Long matrixes, as depicted in the other examples, are usually read at the rate of 3 to 5 incidents per session; groups rarely listen to more than 8 Matrix applications in a single session. Additional guidelines are provided under "Facilitating Feedback."
Facilitating Feedback

The feedback guidelines and processes for reading TRT Phase Two are the same as those for reading Phase One (see Phase One). At the counselor's discretion, feedback may be given at any time, but is best facilitated every 3 rows or after every extraordinarily difficult to read row of effects. If the group is involved in a marathon experience, that is, the group has decided to meet for an entire day, then the number of incidents read, as they are applied to the Matrix, may be increased, but depending on the total of the individual and group needs, as those needs are appraised by the therapist.

Facilitation of Phase Two readings will progress very smoothly if the educational aids (written to clients) are used. The aids ensure everyone understands the goal, method, limitations, and process.

Phase Two Reverses Etiology (Pattern 1)

Phase Two reverses etiology one. This resolution occurs when the therapist facilitates the client's accomplishment of a series of interrelated tasks. Those tasks include the:

- (a) identification, experience and expression of the emotional elements of the grief cycles attending loss resulting from specific contradictions occurring as responses to the event (Phase One initiated the client's progressions through those grief cycles -- explanation follows).
- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles).
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Before explaining etiology-reversal, some description of grief cycles and their relationship to the 4 psychological patterns is necessary.

Parallel Grief Cycles

When we use the term "grief cycle," we intend it to refer to the repeated and generally sequential occurrence of certain emotions; in the end, all of the emotions, including their experiences, relate to the reconciliation and resolution of 1 or more losses that have a specific relationship to an element.
of existential identity that has been contradicted by an extraordinary event. (Grief patterns" would provide the best word choice; however, delineation from the 4 psychological trauma patterns providing the mainstay of our overall theory of psychological trauma and the distinction of the relationship of the grief to the 4 patterns would be made more difficult if "patterns" were used twice).

In the case of psychological trauma, the loss is unexpected. Furthermore, the loss is a consequence of radical and portentous change that demonstrates that the ongoing status of the organism, or some aspect of that status, is in jeopardy.

These losses can be related to the loss of tangible items, for example, a home, loved one, part of the human body, or the body's capacity to function. The loss can also be related to less tangible issues, for example, esteem, worth, and relationship elements like trust, respect, companionship, socialization, an image of what the family is supposed to be, and so forth. If the loss is of tangible items, this kind of loss will also be accompanied by intangible losses. Finally, losses can occur across all dimensions of human psychology to include intrapsychic, interpsychic, and systemic variations of that psychology. The grief cycle is associated with the loss resolution process to the extent that the individual suffering it is likely to experience, prior to identification of the loss, the emotions of shock, disbelief, confusion, pity, fear, anger, embarrassment, hurt, guilt and sadness.

Other losses can produce a re-experience of the same emotions. Consequently, the term "grief cycle" to which we refer is the progression through the emotions described in the previous sentence, and in a general order depicted in the same, with the final component of the progression being the identification, understanding and acceptance of the particular loss being addressed by the progression. The literature is replete with the recognition of such grief cycles and their relationships to various kinds of losses (see About ETM/ Comparison - Contrast).

When an individual completes all of TRT's phases, he or she progresses through 3 general grief cycles related to the reversal of the etiologies referenced to exist in pattern 1 (etiology one) and pattern 3 (etiology 2). For purposes of clarification and codification, we title the grief cycles as: (A), (B), and (C). The grief cycles are related to and comprise elements of the 4 psychological trauma patterns. We distinguish these cycles from the patterns
because such delineation clarifies our observations of the trauma resolution process as it occurs, not just in the application of TRT Phase Two, but all of the TRT phases. Further clarification of these cycles is provided here.

**Parallel Grief Cycle: (A)**

The first cycle (A) is related to those losses that result from the initial trauma-causing event. However, the cycle is divided into 2 therapeutic experiences -- TRT Phase One and TRT Phase Two.

That is, when the individual describes a single trauma causing event, he or she initiates grief cycle (A) and completes the first half of that cycle (A). For example, the emotions usually recorded in the Phase One description are of numbness, shock, disbelief, the state of being unreal, pity, fear (including where appropriate horror and terror), and embarrassment.

When the trauma victim completes the application of the Matrix to that same incident, the second half of the emotions representing grief cycle (A) are experienced, they present for observation. When the person is working in TRT Phase Two, the emotions experienced (while being recorded in writing and then shared when the Matrix is read) are generally anger (rage), hurt, depression, guilt, and sadness.

When the losses are identified, experienced and expressed in column 4 of the Matrix, this grief cycle (A) is completed. Consequently, through the use of TRT Phases One and Two, grief cycle (A) is identified, experienced, expressed and then completed for each loss resulting from each initial trauma-causing event.

As the reader can probably see, grief cycle A comprises the emotional components to psychological trauma patterns 1 and 2.

**Parallel Grief Cycle: (B)**

We observed a second grief cycle (B) that is similar to the first, except that the cause of the losses to which the cycle relates are the trauma victim's own behaviors -- survival responses (to the initial trauma-causing events) that also contradict values, beliefs, images and realities. This cycle is divided into two groups as cycle A was divided.
In this division, shock, disbelief, the state of being unreal, fear and embarrassment are usually experienced during the first part of the cycle -- during the client's use of TRT Phase Three (explained in the next chapter). The emotions comprising the second part of cycle (B) are usually experienced while the trauma victim is completing TRT Phase Four (explained in chapter 4) -- the identification of contradicted values, beliefs, images and realities and identification, experience, expression and reconciliation of losses resulting from those contradictions. Thus, grief cycle (B) comprises the emotional components of psychological trauma patterns 3 and 4.

**Parallel Grief Cycle: (C)**

The third grief cycle (C) relates to losses resulting from all the traumas pertaining to the entire experience as a single source of trauma -- as the experiences have resulted in a single impact upon the individual's life. For example, when a spouse of a chemical dependent person completes all 5 TRT phases, he or she looks at the entire experience for its total effect.

In some cases, this total effect may encompass as little as 6 months, or as much as 35 years, of one's life. The grief cycle (C) relates to this total effect and is manifested as a parallel grief cycle (C) to the first two cycles (A) and (B). In this regard, the client experiences generalized feeling states in addition to the specific feeling states associated with specific losses.

In TRT Phase One, the generalized feeling states (stemming from grief cycle C) are shock, disbelief and horror. While completing TRT Phase Two, the generalized states are shame, anger, and hurt. Phases Three and Four are manifested in cycle (C) by, respectively, guilt, sadness (TRT Phase Three) and profound sadness or deep mourning (TRT Phase Four). Grief cycle (C) is a component of all 4 psychological trauma patterns.

**Parallel Grief Cycles: Summary**

To summarize the three grief cycles (A), (B), and (C), cycle (A) is a consequence of the individual's grieving specific losses directly resulting from the initial trauma-causing event(s). This cycle (A) comprises psychological trauma patterns 1 and 2 and is experienced over TRT Phases One and Two. Grief cycle (B) is also a consequence of the trauma victim's grieving specific losses, but losses that result from the trauma victim's own behaviors -- that is, survival responses to the initial trauma-causing event(s).
This cycle (B) comprises psychological trauma patterns 3 and 4 and is experienced (divided) over TRT Phases Three and Four. Grief cycle (C) is manifested as a parallel, overlapping, experience to cycles (A) and (B). Cycle (C) is experienced as a general manifestation of grief comprising all four psychological trauma patterns and is experienced evenly over the entire 5 phase Trauma Resolution Therapy process.

**Etiology Reversal: Resolving the Initial Trauma**

The application of the Matrix resolves the initial trauma -- reverses etiology (one) directly caused by the event, as opposed to reversing etiology (two) indirectly caused by trauma-induced survival responses (described in chapters 3 and 4). To achieve this resolution, the client transacts 2 parallel and existentially oriented processes: 1) the identification and experience of specific emotions comprising grief cycles (A) and (C) and simultaneous with 2) the intellectual assimilation, association and reconstitution of those values, beliefs, images and realities comprising pretrauma existential identity and that were contradicted by the event(s).

**Resolving the Initial Trauma: First Resolution Component -- Emotional Processing of Grief Cycles (A) and (C)**

In the first process, that is, while negotiating the passage through the emotional component, the trauma victim proceeds through grief cycles (A) and (C). With regards to cycle (A), by the time clients are working in Phase Two, they have already addressed in Phase One the first elements of that cycle; clients have identified, experienced and expressed shock, disbelief, fear and embarrassment. However, when clients apply the incidents to Phase Two they re identify and re experience those emotions again, but without the volatility that accompanied their identification and experience in Phase One. The additional emotions recorded in column 2 of the Matrix are usually feelings that continue the person's progressions through cycle (A); those emotions are often shame, anger, and hurt. As the person progresses across the form, contradicted values, beliefs, images and realities (column 3) and subsequent losses (column 4) are identified and the rest of grief cycle (A) is negotiated -- guilt and sadness are the predominant emotional experiences reported as that part of the Matrix is completed.

The feedback processes described in "Phase One" and in this chapter provide for the clients' identifications of the emotions, as well as provide for their experience and expressions. The person identifies the particular emotion and
then remains with the experience and without associating it with any particular intellectual thought. This experiential process continues until the emotion is expressed; the feelings, experiences, eventually dissipate.

Because the client's use of the Phase Two format provides for the inevitable association of these feelings and feeling states to the specific contradictions and losses underpinning their existence, it is not necessary to use analytical cognitive methods during the experiential component of the effort to provide such associations. For example, when someone expresses profound sadness or hurt, it is unnecessary to facilitate the association of those particular feelings to a particular contradicted belief or loss because the structure provides for such association automatically. A subsequent and central value of the structure is that it allows for the emotions to be experienced to the extent required individually. Phase Two makes guesswork obsolete, which interrogatory activities are shown through facilitation of TRT to divert the person from the full experience. Subsequent stabilization facilitates thorough understanding.

With regards to grief cycle (C), clients notify therapists of this ongoing process when asked to discuss the emotional experiences they are having outside of (following) their TRT sessions. As indicated in the preceding section on grief cycles, the trauma victim usually experiences embarrassment to the extent that it becomes great shame, and anger to the extent that it becomes rage. These 2 feelings characterize the client's general emotional progressions through Phase Two.

To summarize the emotional process, clients, as a rule, readdress (reexperience) the shock, disbelief, fear and embarrassment already addressed in Phase One, but without the volatility and intensity accompanying initial elements of that Phase. As the client proceeds across the Matrix, he or she will continue negotiating cycle (A), all the while identifying, experiencing and expressing those emotions comprising that cycle until those emotions no longer exist. Outside of the group process the predominant emotional experiences are great shame and rage. These latter and sometimes general characterizations of emotional experience indicate that the individual is progressing through grief cycle (C) -- the emotional processing related to all the episodes taken as a single life experience.
Resolving the Initial Trauma: Second Resolution Component -- Intellectual/Experiential Reconstitution of Existential Identity

The second resolution component provides for the combined intellectual and experientially influenced reconstitution of existential identity. Completion of this component involves completing the last 4 (b, c, d and e) resolution steps described on page 53 and reviewed here:

- (b) identification of the contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles).
- (d) reconstitution of the damaged identity.
- (e) regaining of control.

Identify the Contradicted Elements of Identity (b) and Identify, Experience and Express Loss (c)

Loss is a paradox. That is, the term "loss" is intended to represent something that no longer exists, but in that non existence there is a psychological (and neurological; see About ETM/ Theory/ Neurobiological Trauma Etiology) reality, and although frequently unknown, this new reality is equal to any other element of the psyche. The identification of this loss is always tied to the successful identification of that which existed prior to the occurrence of the loss -- the particular element of existential identity contradicted by the intruding episode. Therefore, when completing the third and fourth columns of the Matrix, clients first identify the contradicted values, beliefs, images and realities that comprised themselves before the intrusion; second, clients identify the loss that had become a replacement for those values, beliefs, images, and realities which used to exist unfettered, uncompromised, and unchallenged in the psyche.

Following the identification of the loss, it is also experienced to the extent that it carries with it its own characterization of feeling. In other words, the loss is both an element of existential identity, that is, a replacement for seemingly non existent values, etc., and a feeling experience in its own right.

Trauma victims negotiate this experience by stating that it is occurring, and then as occurs in other experiential processings, the client remains with the feeling of the loss until it no longer is manifested: the loss is dissipated. This "remaining with the feeling of loss" is a profoundly sad occurrence. Moreover, the experience of loss is also antithetical to control, which
requires its own description. "Antithesis of control" is manifested by some as "nothingness" and a "dark, deep and bottomless void."

The passage through this experience of "nothingness" and "bottomless void" proves to be the ending of it. Some clients also report that prior to using TRT they had routinely entered (that is, felt as if they were entering some form of passage) these experiences of "nothingness" and "voids without ending" and become frightened by the prospects that they would never exit these passages. However, in TRT, the structure, to include the written component completed prior to its reading and the group's continued and consistent feedback to have been demonstrated (in Phase One) to accompany the person to any level of internal introspection and emotional pain, replaces this fear of not exiting the dark passages. The structure assures the individual that the venture through such passages are a matter-of-fact therapeutic process -- assisted excursions into previously unknown areas, which, based on the experience of the first TRT phase, undoubtedly result in a positive outcome.

Patients and facilitators learn to trust the structure implicitly. As the passages through "nothingness" and "the void" are negotiated to the extent required individually, the vacuums previously comprising these passages are dissipated. Moreover, the "nothingness" and "void" are replaced with the trauma victim's reconstitution of those values, beliefs, images and realities that had existed prior to the trauma's occurrence, and which had been contradicted to the extent that the "nothingness" and "void" had been created in the first place.

Importantly, when values, etc., are "reconstituted," they are maintained in the existential identity depending on the ontology of the individual; the retention is not a function of the values of those administering the therapeutic process. This ability to select elements of existential identity that are now pertinent to the individual ontology, or to discard other values, beliefs, images and realities no longer pertinent to that ontology, represent a manifestation of the trauma victim's reestablishment of control -- the regaining of free will, the ability to choose. Etiology one is reversed.

The next chapter (3) describes this reestablishment process after discussing the trauma-induced paradoXical thought system that encumbered control in the first place.
## TRT Phase Two (The Matrix) Example: Combat Trauma

<table>
<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
<th>Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities</th>
<th>Thoughts and Behaviors Occurring as Survival Responses to the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> This was the accident where the man was shot in the groin</td>
<td>Numb and unreal. Shock, horror, anger, and sadness</td>
<td>My values were that people would not be hurt, much less mutilated or killed. I believed the sergeant should have been more careful and cleared the gun properly. Reality -- the man’s blood was supposed to be in his body. Not on me and in the sand. His penis was not supposed to be injured</td>
<td>I lost a sense of safety and security. I lost my belief in how life should go on uninterrupted. I lost respect and trust in other people. I lost my belief in my partners -- despite the problems with the enemy, my own buddies might kill me by accident. I lost a member of the group</td>
<td>I continued eating my sandwich. I asked myself if there were anything wrong with me because I was eating with blood on my hands, arms, and clothes. I became paranoid and relied only on myself. I watched everyone so that they didn't accidentally shoot me or anyone else. I constantly stayed on guard</td>
</tr>
<tr>
<td><strong>2</strong> One man was shot in the eye. Another in the chest. Incoming over the hill</td>
<td>Numb and unreal. Disbelief, shock, horror, hurt, and sadness</td>
<td>Even though this was war, a part of me believed people shouldn't kill each other. Reality: The man should not have been killed. His eye should have been intact. The back of his head should have been together. The other man's chest and back should not have been torn apart. He should have been alive</td>
<td>I lost a sense of safety and security. I lost the belief in the continuity of life. I lost the belief in the meaning of life. I lost the belief that living or dying was anything but a random event. I began to lose my belief that there was a God</td>
<td>I dug deeper the holes that I used for cover and sleeping. I withdrew from others. I didn't talk about it with anyone; it was just part of my job -- combat and war. I blamed the men who were killed for not being careful enough.</td>
</tr>
<tr>
<td><strong>3</strong> Walking during incoming</td>
<td>Fear. Relief when it was over</td>
<td>I believed we should have taken cover</td>
<td>I lost safety and security. I kept doing my job</td>
<td>I also began to believe that I was going to be killed regardless of how hard I tried to do the job right. I began to wonder why I was alive and others were dead.</td>
</tr>
<tr>
<td>4a This was the first day of a 2 day operation. I got airsick</td>
<td>Excitement, much fear, embarrassment and shame</td>
<td>I believed I wasn’t supposed to throw up while I was needed. I should have been more dependable</td>
<td>I lost self-esteem, self-worth, and self-respect. I also lost safety, security and control.</td>
<td>kept remembering the one man who was shot in the eye and I didn’t want to be killed that way. I tried to put it out of my mind</td>
</tr>
<tr>
<td>4b Same operation. We picked up wounded</td>
<td>Fear, shock and horror. Concern for the men and desperation to save them</td>
<td>I believed people shouldn’t try to kill people who were wounded. Reality: the man’s hand was supposed to be attached totally to his arm. His blood was not supposed to be pumping out of his body. People should not be disfigured or have their bodies mutilated</td>
<td>I lost understanding about life. I lost my belief in the continuity of body functions. I lost my belief in the continuity of life. I lost any sense of importance as an individual or sense of meaning to life</td>
<td>My responses were that I did my job despite my fear and throwing up. I thought again that life or death was a random event; there was no meaning to life. There was no credibility to the concept of destiny</td>
</tr>
<tr>
<td>4c The copilot was wounded</td>
<td>Terror. Intensely scared, concerned for him. Anger and rage. Relief and glad for the air support. Glad when the lieutenant lived</td>
<td>My beliefs were that people I knew should not be shot. I believed, even though I was trained differently, that people should not kill each other. I believed our helicopter could get us out of there.</td>
<td>I lost a sense of safety or control over whether I lived or died</td>
<td>I tried to stay alive and kill NVA. I helped with the wounded and the lieutenant. I told no one. I tried harder at being very good at my job. A part of me withdrew from others. I couldn’t and didn’t talk to anyone about the experience.</td>
</tr>
<tr>
<td>5a Up North. Several Marines and</td>
<td>Stunned, dazed, and terrified. Rage at the enemy. Hurt</td>
<td>I had believed that I was safer than I really was. I was supposed to be able to control</td>
<td>I lost self-esteem, self-worth, and me. I lost belief in the continuity of any</td>
<td>I walked around dazed. I tried to be tough and show that I could do my job and</td>
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</tbody>
</table>
enemy were killed. I was almost killed
from my near death from the explosion
whether I lived or died.
life. I lost belief in the purpose of life. I lost belief in the prospect of my life going forward.
that I was unaffected. I tried to understand carnage. I decided that dead is dead and life is life. I tried to not care as much about people in general.

5b Same incident. I observed carnage.
Unreal. I felt dazed, sick, sad, nauseous, and separate. I felt sadness and loss for the man I carried because he was another human being and he was dead
Reality: People's bodies were supposed to be intact -- not torn apart, mutilated, or disfigured. People deserved to be treated as humans when dead. I believed that anyone who had children, like the man who I carried, should not be killed. He should have gone home alive to his children.
I lost myself, safety, those men, the belief in the sanctity of life and belief that there was any meaning to life
I didn't talk to anyone about it, except the Chaplain. He said he did not understand it either. I wanted the dead man's children and wife to be OK. I could not understand why he was dead when so many needed him and no one needed me; and I was alive.

TRT Phase Two Matrix Example: Violent Crime Trauma

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<thead>
<tr>
<th>Summary of the Trauma-Causing Event</th>
<th>Summary of Feelings/Emotional States</th>
<th>Values, Beliefs, Images and Realities Contradicted by the Episode</th>
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</tr>
</thead>
<tbody>
<tr>
<td>I was attacked and beaten in the garage</td>
<td>Shock, panic, stunned, disbelief, terror, hurt and horror</td>
<td>I believed that I was a human being who hadn't hurt anyone and that I should not be hurt. I should not be hit in the head and ear. I believed in the sanctity of my body and life</td>
<td>I lost any sense of control over my own life</td>
<td>I tried to protect myself. Then I had no me with which to respond. I wondered for a moment where my husband was and what was happening to him. A part of me separated from the reality of what was happening.</td>
</tr>
<tr>
<td>2</td>
<td>The attacker dragged me into the kitchen. I was beaten again</td>
<td></td>
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<td>----------------------------------------------------------</td>
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<td></td>
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<tr>
<td></td>
<td>I was in shock and becoming more disoriented as I went in and out of consciousness. I was numb, stunned and feeling physical pain to my head, arms, back, neck, ribs, and stomach. I felt horror, hurt, terror, and futility</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>My values were that I should be treated with care and respect by other people. I should not be treated as inhuman. No one should strangle me, drag me like an animal, kick or beat me</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>I lost self-esteem, self-worth, trust in any thing, safety, security, and control over my life. I lost hope that I would live. I lost the ability to breathe and think clearly. I lost belief in the continuity of my life</td>
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<td></td>
<td>I fought back at first. Then I seemed to be gone. Nothing was left with which to fight.</td>
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<tr>
<th>3</th>
<th>He sodomized me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I felt horror, shame, shock and disorientation. Physical pain and numbness. Anger, rage, and hurt</td>
</tr>
<tr>
<td></td>
<td>I believed that this was inhuman. No one should treat anyone like this. I believed it was evil and vileness at its utmost. Something like this occurring to me was not in my mind as being possible. It could not occur</td>
</tr>
<tr>
<td></td>
<td>I lost more esteem, worth, sense of female value and human existence. I lost the feeling of sanctity and privacy of my body</td>
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<tr>
<td></td>
<td>My response was to hope that it would be over soon and that I wouldn't be killed. I began to think that if I was nice to him he wouldn't kill me</td>
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<tr>
<th>4</th>
<th>I was stabbed</th>
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<tr>
<td></td>
<td>I felt my life leaving me</td>
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<td></td>
<td>My belief was that my life was supposed to go on -- to continue</td>
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<td></td>
<td>I lost myself as I thought my life was over</td>
</tr>
<tr>
<td></td>
<td>I fought back at first. Then I seemed to be gone. Nothing was left with which to fight.</td>
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<th>5</th>
<th>My husband was killed</th>
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<tr>
<td></td>
<td>I felt disbelief, hurt, deep sadness, and profound emptiness</td>
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<td>I believed my husband was supposed to be alive -- to have stayed with me. No one had the right to take him from me. No one should have hurt my husband, much less shot him three times and killed him. I loved my husband -- he was part of me. He should not have been gone</td>
</tr>
<tr>
<td></td>
<td>I lost my husband. I lost my belief in any meaning to life. I lost a part of myself. I lost his companionship. I lost his love for me. I lost me</td>
</tr>
<tr>
<td></td>
<td>I withdrew from everyone. I dreamed that Gary had come back to me. When I was with my second husband, I imagined he was Gary. I became paranoid, boarded up windows and doors. I would not go out or to the garage. I bought a gun and thought the killers were coming back. I thought I was going insane.</td>
</tr>
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TRT Phase Two: "The Matrix"

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<tr>
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Chapter 5 Section (i):

How To Facilitate TRT Phases One Through Five

TRT Phase Three

This chapter:

1. Reviews theory and the effects of Phases One and Two
2. Describes the paradoxical system of control
3. Explains survival responses and their dichotomous presentation
4. Shows how to apply TRT Phase Three -- writing, reading and facilitation
5. Discusses client progress related to Phase Three

Theory Review

Psychological trauma is retained in memory in 4 patterns; patterns 1 and 3 provide the locus of the trauma's dual etiologies. The 4 psychological trauma patterns and the etiologies include:

1. The experience of the event contradicts the pre-trauma values, beliefs, images and realities; these contradictions form etiology one.
2. The loss from the contradictions and associated emotional outcomes are maintained in memory: conscious or otherwise.
3. The maintenance of the emotional elements resulting from the contradictions creates the need for survival protective measures -- thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional memory retention; in the process of that dissociation, additional contradictions occur to existential identity; the additional contradictions provide the locus of etiology two.
4. The dissociative activity, the contradictions resulting from survival responses, produce additional experiences of loss and emotion which are also maintained in memory.

The contradicted values, beliefs, images and realities described in "1" and "3" represent the dual etiology of psychological trauma; etiology one is formed in pattern 1 and etiology two is formed in pattern 3. Although the losses described in patterns 2 and 4 are inextricably linked to the contradictions
reflected, respectively, in patterns 1 and 3, for purposes of simplification of description, the losses are not at this time included in the locus of the etiology; the losses' relationship to etiology is explained in detail in the chapters (About ETM/ Theory/ Neurobiology) that address the neurobiology of psychological trauma.

The 4 patterns, including the etiology, are defended by a paradoxical system of control where the trauma victim is perpetually and simultaneously attempting to end and continue the trauma's effects; the paradox keeps the etiology from being reversed and at the same time tries to find the means to reverse the etiology. TRT neutralizes the paradoxical defense structure and then addresses each psychological trauma pattern, one pattern at a time and until the trauma, its etiology, and its effects have been expunged from the reality system. Ending of the patterns' retentions in memory through reversal of the etiology ends the paradox; pretrauma psychological management control is restored.

Phase One initiates the patterns' address by identifying the trauma-causing event (in pattern 1) and the client's emotional experience of it. Phase Two completes the address of pattern 1 and then begins and completes the address of pattern 2. These Phase Two addresses of patterns 1 and 2 occur in 5 steps; Phase Two's facilitation of the:

- (a) identification, experience and expression of the emotional elements of grief cycles accompanying loss resulting from specific contradictions.
- (b) identification of the contradicted elements of identity.
- (c) identification, experience and expression of the loss that resulted from the contradictions and that necessitated the grief cycles.
- (d) reconciliation of the contradictions and reconstitution of the identity through choice.
- (e) the person regains control.

Completing these steps culminates in the reversal of the pattern 1 etiology -- event- inscribed (into memory) contradictions to values, beliefs, images and realities; the contradictions are identified and reconciled, and then reconstituted where individually appropriate. Phases One and Two also effect the client's return of control, but this return was not described in previous chapters because the loss of control to the trauma-induced and trauma-defending paradoxical condition had not yet been explained. That
condition and the return of control by Phases One, Two and Three are explained in this chapter.

**TRT Phase Three: Introduction**

TRT Phase Three's purpose is similar to Phase One; that purpose is to identify the events that establish etiology (etiology two in pattern 3), with the noted exception that the events contradicting existential identity are the client's own thoughts and behaviors. Phase Three identifies these events comprising pattern 3; the identification initiates the etiology-reversal process to be completed later in Phase Four.

Before explaining how Phase Three accomplishes this task, identification of additional trauma-causing events and initiation of the etiology reversal process to be completed in Phase Four, and before describing how to apply Phase Three, this chapter overviews the theory of the paradoxical system of control that has prevented etiology-reversal; thereafter, the chapter provides for the description of that defensive system's thought/behavioral manifestations as psychological trauma symptoms, otherwise referenced in this work as survival responses.

**The Paradoxical System of Control -- The Survivor**

The 4 psychological trauma patterns produce a protective and remedial activity. This activity divides the trauma victim's control functions into processes having both similar and opposing goals, functionings, and effects; a management dichotomy is created. Because paradox characterizes this new system, we entitled it "the paradoxical system of psychological control"; we also call it the "Survivor." Once created, the Survivor is self-sustaining. This section explains.

So far, in the first two chapters, we have talked only of existential identity and its influence by traumatic events; we have not explained the foundation of psychological control. Although control is related to existential identity, which relationship will be explained, control is an active process that emanates from another aspect of identity; we have entitled this additional aspect "operational identity."

Operational identity is comprised of action-oriented attributes (inherent capacities to do or experience certain things), interactions between the attributes and existential identity, and interactions between the attributes
themselves. In this definition, these "attributes" are categorized as existing in 2 groups having different orientations; there are rational/cognitive- and experiential-oriented attributes. Rational/cognitive attributes can include the abilities to:

1. manage, that is, establish, discern, accept or discard various values, beliefs, images, and realities
2. think
3. learn
4. perform tasks
5. analyze, interpret and plan events, and
6. strive to control one's own destiny through the assertion of individual will.

Attributes stemming from experientially-oriented brain functionings include the abilities to:

7. sense
8. feel
9. be creative
10. be spiritual
11. empathize, intuit, care
12. love, reproduce and manifest sexuality.

Thus, the most distinguishing characteristic between operational identity and existential identity is that operational identity is action-oriented where existential identity is grounded in basic, developing and, eventually, fixed attitudes.

Following the event, trauma-affected control functions rely increasingly on rational/cognitive oriented attributes during survival and less upon experiential attributes. The latter group of attributes, experiential in their orientation, are also repressed along with the loss and accompanying emotional counterparts comprising the 4 psychological trauma patterns. This unbalanced use of attributes results in a divided operational identity. To compensate for this division the psyche produces a new and overlaying thought system -- the Survivor.

The Survivor serves as a connecting element between the conscious use of rational attributes and the repressed aspects of the psychological trauma patterns and experiential-oriented attributes. Herein lies the crux of the
Survivor's psychological formation; its primary goal of protecting the person is underpinned by dual and opposing missions. On the one hand, the Survivor attempts to resolve the trauma (reverse the etiology) retained in the subconscious -- end that trauma's effects on the psyche. On the other hand, the Survivor has to prevent this resolution -- the reversal of the etiology would result in the end of the Survivor's protective existence. Thus, the Survivor is paradoxical in its orientation and its functioning. That is, the Survivor exists as a thought system engaged in a tug-of-war with itself.

In this theory, the paradoxical system of control, the Survivor, is a cyclical and self-perpetuating phenomenon that controls the person, including his or her perceptions, experiences, and decision making processes to the extent that everything is assimilated in a way that leads to the trauma's resolution, but at the same time prevents that resolution. The paradoxical system also makes no distinction between itself and the person, the psychological management system that existed before the Survivor's formation. As a rule, there can be no realization by the person of this condition's existence until its influences are ended and the person's psychological controls are returned to their pretrauma functioning.

**Survival Responses to Psychological Trauma**

The paradoxical system of control produces thoughts and behaviors; they are manifested as survival responses. Other people, professionals, and groups refer to these responses as "symptoms" of psychological trauma or symptoms of post-traumatic stress disorder. In some programs, responses are simply called "defenses."

TRT Phase Three delineates survival responses, which also can encompass, at any time during the Survivor's existence, numerous and varied activities. For purposes of consolidation, those activities are presented here in 9 general categories. Each category is accompanied by an outline of the category's contents.

1. The Survivor is instrumental in saving the Self and others. This action includes:
   - A. The saving of physical life -- one's Self and others.
   - B. Attempting to prevent future trauma-causing events from occurring.
   - C. Providing emotional support, caring, and physical protection.
2. The Survivor provides for the recollection or reliving of the trauma-causing events, including:
   - A. Partial recollections.
   - B. Nightmares.
   - C. Reliving the event with absolute clarity and accompanying emotional experience -- reliving is experienced as if the event is a movie being viewed on a screen.
   - D. Obsessive recollection of the event(s).

3. The Survivor provides for additional signals that tells others that the trauma, to include the memory of the event, contradictions to existential identity, repression of emotional pain and loss, and interruptions to the operational identity that existed prior to the event, although unseen, do exists. Those signals can come in the form of:
   - A. Startle response.
   - B. Hysteria.
   - C. Hyperarousal.
   - D. Paranoia
   - E. Self-pity, self-blame, and self-absorption.
   - F. Cyclical degeneration into inexpressible and unanswerable emotional pain and loss.
   - G. Depression.

4. The Survivor provides for the means of living life without conscious experience or recollection of the event or the internally retained damage resulting from it. Such provisions can include:
   - A. Complete, near total, loss of memory of the event.
   - B. Rationalization and minimization of the event(s) or circumstances leading to the trauma's occurrence(s).
   - C. Intellectualization of the circumstances surrounding the event(s) to the extent that the sources of the trauma (for example, "source" can be chemical use, chemical dependency, or physical abuse) are ignored.
   - D. Denial ("denial" in this use refers to suppression followed by an intense effort to not discuss anything related to the experience) of the trauma and the event(s).
5. The Survivor provides for the means of defending with projection the person; the defense is against the reality of the damage to existential and operational identity. Projection can include:
   - A. Transferring the locus of the unconsciously retained trauma to the thoughts, actions, and motivations of others, and usually not the perpetrator, the actual initiator, of the trauma
   - B. Physical/sexual assault
   - C. Aggrandizement -- the acquisition of things or power to the extent that others are harmed
   - D. Other anti-social activities
   - E. Homicide

6. The Survivor defends the person from the realization of the damage to existential and operational identity; the means of the defense is counter projection -- the assumption of responsibility for traumatic events not caused by the trauma victim. Such counter projections can include:
   - A. The feeling of guilt as an emotional response to a traumatic event caused by someone or something else
   - B. Alignment with and/or protection of the perpetrator of the trauma-causing event(s)
   - C. Continuing to stay in a recurring trauma-causing situation
   - D. Compulsive obsession with the perpetrator of the trauma

7. The Survivor provides for strength with which to overcome the trauma and its effects. Such strengths can include:
   - A. Stoicism
   - B. Stalwartness
   - C. Determination, including driven or obsessive determination
   - D. The achievement of economic/social success and control.

8. The Survivor produces an environment through which the internal dynamics of the trauma are accorded adequate time and the appropriate distance from the influences of external forces; these forces can include attempts to help the trauma victim. Some of these responses can be:
   - A. Withdrawal
   - B. Isolation
   - C. Aimlessness

9. The Survivor provides for attempts to end the internal experience of emotional pain and loss. Such provisions can include:
   - A. Fusion or inextricable pairing with another.
   - B. Increased dependence on other family members or friends.
- C. Repeated reliance upon professionals and/or helping groups, including self-helping groups, for assistance.
- D. Suicide.

**Survival Thought and Behavior: A Dichotomous Experience**

The manifestation of survival thought and behavior is usually a dichotomous experience. This means that trauma victim's present their survival responses in opposites. In pronounced cases of psychological trauma, the variations between survival responses can be extreme. For example:

- The family member involved with a chemically dependent person routinely will try to prevent future trauma-causing events, additional drug use behaviors, from occurring (survivor characteristic 1.B; from now on the "survivor characteristic" delineation is dropped in these examples), and at the same time, or shortly thereafter, deny that the previous events have occurred (4.D), or deny that there is a drug problem at all (4.C).
- Trauma victims proceed through protracted periods of denial (4.D) or loss or near loss of memory (4.A) of the traumatic event; trauma victims also may periodically engage in unending, obsessive, recollection of the experience (2.D).
- People affected by trauma will withdraw and isolate themselves (8.A, B); these behaviors are then offset by fusion or the expression of a clinging need while looking for support and assistance (9.A, B, C).
- Periods of obsessive determinism (7.C) are offset by periods of aimlessness (8.C).
- Periods of success, for example, getting in control (7.D), are offset by the experience of a degenerative cycle of inexpressible and unanswerable emotional pain, confusion, and loss (3.F); the person becomes devoid of control and experiences profound failure.

**Paradox and Survival Response Create Problems for Etiology Reversal**

We should remind the reader that at this third phase of the therapeutic process, although the etiology (one) caused by the initial traumatic event has
been reversed by the application of Phases One and Two (patterns 1 and 2 no longer exist), the etiology caused by the action of survival response, the contradiction of existential identity, has not. Therefore, sufficient etiology remains to continue some paradoxical influence during the application of Phase Three; if this influence is not addressed, it can and will effect the opposite outcome desired -- the paradoxical influence can and will prevent the reversal of the etiology (two) attending pattern 3. Where this section overviews this problem, a fuller description of it is provided in the section "About ETM/ Development/ Individual TRT."

Phase Three identifies survival responses; the identification leads to Phase Four's reversal of the etiology. However, if the paradox is inadvertently strengthened during the Phase Three process of identification of survival responses, then the etiology will not be reversed. This "strengthening" occurs when, following Phase Three's identification of the responses, the paradoxical control system initiates and manages ongoing and usually repeated attempts to change the behaviors. If these attempts are allowed, they will divert attention from the remaining resolution process; the attempts to change behavior in mid stream (Phase Three is halfway through the entire resolution process) will alter the direction of the therapy such that its goals of identifying and reversing the second etiology no longer exist, the new goals become identification and reduction of the trauma's symptoms (survival responses).

Symptom-reduction activities engage completely different brain functions from those that provide for the experience of grief (see About ETM/ Development/ Neurobiology, and Comparison - Contrast) and emphasizing symptom-reduction over existentially-based functions at this time can not only end the resolution process altogether, but failure to use the proper amount of existentialism to complete the grief functions can and will strengthen etiology in the long-run, making matters worse (the person can lose trust that the condition can be overcome). This "paradoxical-strengthening" must and can be avoided. Recommendations are provided in the facilitation section of this chapter (following the descriptions of how to write and read Phase Three).
TRT Phase Three Application

This section explains how to write, read, and facilitate Phase Three. Codependency trauma provides the example. Combat and violent crime trauma examples are continued in the addendum.

Writing Phase Three

To complete the written component of TRT Phase Three the client needs only to copy onto a sheet (or several sheets) of paper the survival responses listed in column 5 of TRT Phase Two. We have 2 recommendations for this copying; if followed, they make it easier to complete TRT Phase Four. First, each survival response should be separated from the others; where each row in the Phase Two Matrix may list several survival responses, list them in this Phase Three as individual responses. Second, the survival responses should be listed along the left margin of the page, leaving approximately 2 inches of space in the margin on the parallel and right side of the page.

Later, in Phase Four, the client can use this format as a worksheet for consolidating like survival responses into categories (see Phase Four). In addition to these two recommendations, the client may also elect another option for completing TRT Phase Three: the client can, after completing the detailing of the specifically recalled instances relating to individual traumatic incidents, delineate recollections of survival responses relating to all the incidents taken as a whole.

For example, a spouse of a chemically dependent person, after having listed all the survival responses from column 5 from the Phase Two Matrix, might realize that he or she had not provided the children in the family with the parenting originally intended. The spouse had become preoccupied with combating the alcoholism.

TRT Phase Three Written Examples

The following examples are continued from Phases One and Two.

TRT Phase Three Application Example (A3):
Battered Spouse - Codependency Trauma
This section provides an example of TRT Phase Three's application to Trauma. It is a continuation of the battered spouse-codependency examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5, TRT Phase Two (Matrix), and apply in the TRT Phase Three format. The one exemplified here. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

**TRT Phase Three: Battered Spouse - Codependency**

I laughed at his drunkenness.
I made light of it.
I played like it was funny.
I apologized to my friends.
I attempted to cover up for the drunk behavior.
I made excuses to them about why the man I was marrying drank so much.
I began to withdraw.
I played like it wasn't happening.
I quit talking about what was happening.
I began to pretend that he loved me and the children, even when he was out drinking.
I packed my bags and wanted to leave.
I stayed.
Instead of leaving I began to pretend it wasn't happening.
I tried to take care him when he was passed out.
Then I left him there and tried to detach.
I tried to carry him out of the yard.
Then I covered him up.
I went along with his ignoring that it had happened.
I ignored the beating.
I apologized to him for causing it.
I forgot the battering experience happened.
I started having affairs.
I began to believe there was no such thing as hope.
I wanted to get away.
I wanted him to die.
I helped him select another car as if he had never run into a bus.
I lived as if it had never happened.
I confronted him about urinating in the closet.
I then began to question myself.
Cleaned the clothes in the closet.
I lied to the people at the cleaners about my coat.
I promised I would leave but I stayed.
On the second day I forgot that it had happened.
I began to be a part of what I was beginning to believe was an animal experience.
I began to take control of our family's life.
I borrowed money and ran the finances.
I assumed the responsibilities of raising the children alone.
I continued to lie to everyone about where he was.
I yelled at him later.
I cleaned up my husband's urine.
I cleaned up his vomit repeatedly.
I continued to stay in the marriage against my judgment.
I increased the frequency of extramarital sexual encounters.
I began to see sex with my husband as a repulsive and degrading experience.
I played like he wasn't in trouble with the law.
I asked the stranger to leave and played like my husband hadn't brought him into the house.
I wanted to kill my husband.
I planned how to kill him when I realized he was having sex with Lori.
I denied the following day that it had happened at all.
I covered up his nudity in front of the children.
I took care of him.
I played like it hadn't happened.
I wanted to kill him or escape after the beating New Years.
I began to believe I was no longer human.
Generally:
I acted differently than I ever believed I would act.
I didn't place my children first in my life.
The alcoholism was first.
Sometimes I reacted verbally and physically towards the children rather than my husband.
I seemed to have become another person throughout the experience.
I became obsessed with controlling him.
I lived in degradation like I never thought that I would. Top of Form

**TRT Phase Three Application Example (B3): Combat Trauma**

This section provides an example of TRT Phase Three's application to Trauma. It is a continuation of the combat examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5 of the TRT Phase Two (Matrix) and apply to this page using the TRT Phase Three format. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

**TRT Phase Three: Combat**

I became extremely paranoid and afraid of everyone.
I believed I might be killed even by accident.
I watched everyone so that they wouldn't shoot me.
I constantly stayed on guard. I dug deeper holes.
I withdrew from others.
I didn't talk about the deaths.
I believed intensely that it was just part of the job.
I blamed the men who were killed.
I kept doing my job even though I could have been killed.
I talked only with the chaplain. Then stopped talking with him.
I learned to be tough and act as if the damage was no big deal.
I began to believe I was above it all.
I quit caring about people.
I withdrew from everyone and didn't talk with anyone about what was really happening to me. I quit believing in God and decided life had no meaning.
I hated the NVN and wanted to kill them.
  • I began to play like I was invincible and reflected to everyone that I was very strong and afraid of nothing.
I did my job in spite of throwing up and in spite of my fear.
I believed more intensely that life was a random event and
that God did not exist.
I believed there was no reality to concepts of destiny or future.
I decided God was a fabrication to protect other people against
the reality of what I was experiencing.
I did my job and decided life would only be a short term experience.
I tried my best to kill the NVA.
I helped the wounded as it was the only thing
I could do other than kill the NVA.
I became more intense at doing my job so that I could stay alive.
I began to believe that war and killing were natural.
I took pride in my ability to keep others alive.
I ignored the hurt.
I became obsessed with doing my job properly and
hoped that would keep me alive.
I was amazed that my body still functioned and at times
I could not believe that it was even still there.
I believed nothing mattered.
I wondered what my brain blown apart and laying on the
ground would look like.
I thought I was going insane.
I began to show no courage and acted like a coward.
I wondered if my own stomach would be opened up and left in the dirt.
I began to hate my friends (at home).
I began to hate my Country that before I loved the
same as God and my family.
I withdrew from all people because I believed I was
not like any of them and that something was wrong with me.
I began to see myself as less than an animal.
I cried alone.
The way I changed was that:
At first, I remember being afraid to drive through an intersection
at home, -- I wondered where automatic weapons would
be placed for an ambush.
In my first relationship with a woman, although a part of me loved her,
I had to leave as I didn't know how to make a long-term commitment.
I no longer knew what long-term meant and had no concept of being
able to live an extended future.
I tried to avoid anything that resembled permanence.
Something always seemed to be missing for me and
I felt constantly different.
I started wondering what normal people looked like and why I was such a crazy person as to have put myself into the conflict. I started thinking, with the help of others that I had not served because I cared about my Country, but because there was something wrong with me and I loved violence. I began to believe I must be a distorted and evil person inside. I felt like a pin ball bouncing around between partial relationships and different geographical places.
I had a yearning to go back to Vietnam and retake the area in which I had fought and others had died. My greatest regret was that Ho Chi Men died before I could kill him. I withdrew from anyone who looked my age. The only people with whom I felt the slightest identification were the older generation that had fought through World War II. I isolated myself further from the society and poured myself into my job whatever it was. Later, my ability to do my job began to fall apart as I found myself being stuck.
Even though I sought help for relationship problems in my first marriage, I could not do the things the other couples seemed to be doing. Real caring and love were no longer in my vocabulary and impossible to either give or receive. I became a devout atheist -- all the while I felt that something was deeply wrong. The most hurting thing that I did was decide that I would never fight for my country again, even if it was dying.

TRT Phase Three Application Example (C3):
Violent Crime Trauma

This section provides an example of TRT Phase Three's application to Trauma II is a continuation of the violent crime examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5 of the TRT Phase Two (Matrix) and apply to this page using the TRT Phase Three format. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.
TRT Phase Three: Violent Crime Trauma

I tried to protect myself from the blows to my head.
I began to separate myself from the reality of the experience.
I struggled for my existence.
I separated myself from the beating further.
I tried to breathe and stay alive.
I hoped that it would be over soon and that I wouldn't be killed.
I began to think that if I was nice to him that he wouldn't kill me.
At that moment I felt myself change and become something other than what I used to be.
I fought back against being stabbed.
I did not believe my husband was gone.
I withdrew further.
I began to dream and hallucinate that my husband was coming back.
I compared my current husband to Gary.
When I made love to my second husband, I played like it was Gary.
I became paranoid and boarded up windows.
I never went to the garage.
I bought a gun and repeatedly sat in the kitchen until the sun came up, hoping the killers would return -- I would kill them.
I began to have extramarital sexual involvements even though I loved my husband.
I thought I was going insane.

Reading Phase Three

Read TRT Phase Three in one setting. Such readings require approximately 20 minutes of group time.

Facilitating Phase Three

Generally, facilitation of Phase Three involves the use of the same guidelines provided in chapters 1 and 2, except that there are, as a rule, considerably fewer interruptions (for giving group feedback) of the reading. Another guideline for successfully completing Phase Three is described here; the guideline provides for the address of the paradox's influences on resolution efforts (described under a previous heading entitled "Paradox and Survival Response Create Problems for Etiology-Reversal").
Neutralize the Paradox's Influences on Etiology-Reversal Efforts

The paradox's influence must be neutralized so that following identification of the survival responses, the Survivor does not shift the therapy into a symptom-reduction mode (see previous heading entitled "Paradox and Survival Response Create Problems for Etiology-Reversal"). "Neutralization" occurs in 4 steps.

First, inform clients through education (see ETM Patient Educational Information) that TRT is different from therapies that attempt to change behaviors. The locus of the difference can be found in the goals. For example, the TRT program does not attempt to make people be responsible, recover from disease, abandon family traits handed down over multiple generations, change behavior, become better employees, have stronger careers, marriages, or otherwise become successful citizens. TRT theory posits that reversal of the trauma-induced etiology automatically provides for such behavioral achievements. However, if some people still require or desire advice about how to live life following the etiology's reversal, the therapist can give such assistance at that later time. Such assistance is not likely to be required following the application of TRT.

Second, remove from the therapeutic nomenclature, clinical terms, that engage and then support the paradoxical condition. For example referring to survival responses as "indications of disease" or "behavioral disorder," "maladaptive behaviors," "character defects," or the use of any term that vilifies survival responses or otherwise characterizes them as something that has to be changed because of their repugnance (dislike), is not constructive. Such terminologies and references should be struck from the therapeutic lingo. In TRT, survival responses are considered natural and logical responses to the trauma despite the fact that they frequently contradict existential identity. In this logic, the problem is the etiology, not the survival response.

In addition, the "striking-jargon" policy should be maintained in parallel therapies. For example, when couples are attempting to reconcile interactional conflict in a parallel (to TRT) marital therapy group (see Clinical/Family), they might use (during an argument) the expression, "Those are your survival responses talking."
Stop this kind of interpretation by advising the person or persons using this interpretive approach to describe the specific behaviors causing the concern and to drop their characterization as "survival responses." If allowed to stand, "survival responses" will become a bad thing, which perception carries into the TRT group and has the effect of strengthening the paradox; this "strengthening" reinforces the etiology and, ironically, the "bad things."

Third, provide ethical interpretations of parallel therapies, including self-help activities. Do not let other helping philosophies control or influence the facilitation of TRT. Chapter 15 demonstrates through case analysis the ethical means for providing these interpretations.

Fourth, ask clients before beginning Phase Three to identify and evaluate the survival responses only for the purpose of helping the person to eventually identify (in TRT Phase Four) the elements of existential identity damaged by the responses. If the client shows a strong desire anyway (despite your request) to use the Phase Three list (of survival thoughts and behaviors) to change the responses, that is, the client wants to commingle therapies, then ask that person to refrain from such commingling by postponing attempts to make such changes until the entire TRT process, all five phases of TRT, has been completed. Then, the client can return to the cognitive-behavioral/analytical-interpretive methods if they are so inclined, or even follow advice provided by other helping processes. Neither of these outcomes is likely, however, once both etiologies (etiology one in pattern one and etiology two in pattern three) are reversed -- the trauma is resolved.

Again, see chapter 15. It provides hypothetical cases that exemplify how to implement these 4 recommendations.

**Phase Three Initiates Etiology Two's Reversal (Etiology Two attends Pattern 3)**

Clients progress through Phase Three accordingly.

1. Phase three provides cognitive connection between survival responses to etiology resulting from the initial traumatic event -- one continuous system of logic tracts the fact of the occurrence of the event (Phase One - Pattern 1), to the event's effects (Phase Two - patterns 1 and 2), to trauma victim thought and behavior (Phase 3 - pattern 3).
2. Phase Three initiates the passage through grief cycle B -- the person identifies, experiences, and expresses the first emotional components
of that pattern (see Phase Two); those emotions include shock, disbelief, and fear.

3. Grief cycle C (also see Phase Two) is continued -- the client identifies, experiences and expresses profound sadness. This sadness is related to the entirety of the trauma's effects; the person sees survival thought and behavior both as damaging and as a consequence of damage resulting from the original identity.

4. Phase Three recapacitates operational identity -- returns control. As indicated at the beginning of this chapter, however, this return of control occurs first during applications of Phases One and Two.

Because the paradox's effects on control were not described in correlate Phases (1 and 2) to those phases, the description of the return of control was delayed until the paradox was explained in this chapter. Consequently, before continuing with the description of the influence of Phase Three on control processes, we take time out here to discuss Phase One's and Phase Two's influences on the same.

**Regaining Control: Phases One and Two**

The first vestiges of control begin to occur while the trauma victim is progressing through TRT Phase One. Behavioral manifestations of this appearance include the ability to remain in therapy, recall and relate a story previously not recallable or describable, and not be controlled by wide emotional swings or outburst, including hysteria, hyperarousal and other symptoms of trauma that prevent people from addressing it.

We emphasize "appearance of control" because these controls are in large part provided by the TRT structure -- the trauma victim is drawn through the experience by the logic and the dictates of the controlled writing, controlled reading, and controlled feedback. In Phase Two, this appearance becomes real -- focused in the client's psychological management system as opposed to the therapy. That is, as the trauma victim progresses through the reading of the Matrix, the person completes grief cycle (A) for a portion (usually half) of the total number of trauma-causing incidents applied as rows to the Matrix, the person identifies contradictions to existential identity and then identifies, experiences and expresses loss directly resulting from those contradictions, the person begins to effect his or her choice over the reconstitution of the reestablishment/reconstitution of existential identity.
Simultaneous with the initiation of this newly reconstituting management (control) process, the person also begins, outside of the TRT process (usually in parallel "here and now," couples, or family groups -- see Clinical/Family and About ETM/Development/Family TRT), to demonstrate the ability to interact between experiential and rational/cognitive oriented attributes to the extent that the person can modulate feelings with intellectual processes.

These feelings can be

1. related to the traumatic event(s),
2. emerging in response to interaction with other trauma victims who are addressing their traumatic episodes, or
3. occurring as a response to discussions about issues separate from the trauma resolution process (or as indicated in parallel clinical processes).

Projections onto perpetrators, that is, upside-down perceptions of the locus of responsibility for the trauma-causing events (where the client assumes responsibility for the perpetrator's acts) are also ended. Moreover, trauma victims assert, where applicable (prospective exposure to additional trauma-causing events -- the TRT participant is a spouse of an actively-using chemically dependent person), that the trauma-causing events will be concluded; they are concluded. Behaviors described in codependency treatment literature as enabling behaviors cease.

Further indications of control being regained include perpetrator confrontation where appropriate (safe). Such confrontations usually occur when spouses intervene on chemically dependent people who are still using.

The spouse (TRT participant) usually demands both an end to the use and participation in an abstinence oriented helping process as a condition for further interaction (a continuing relationship). If these two conditions are not met, and with conviction of commitment, the trauma victim likely sets out on a new life path that does not include the perpetrator (still actively using chemically dependent person).

Regaining Control: Phase Three

Phase Three continues the return of control. This return is demonstrated by increased interaction between rational-cognitive and experiential oriented
attributes and between all attributes and the existential identity. Examples include the growing capacity to modulate between intellectual and emotional experience and to choose the most beneficial life direction; this choice that is based on individual needs and interests forming out of the newly reconstituting existential identity. "Growing" means that these changes occur on a continuum in concert with the progress initiated in Phase One, strengthened in Two, and continued in Phase Three.

**Responsibility**

In TRT sessions, and in contrast to other forms of therapy, trauma's resolution is primarily a management (therapist) as opposed to individual (patient) responsibility. In TRT, responsibility is not conveyed by projecting it didactically; for example, the slogan "People" or "You," meaning the patient, "ought to be accountable and responsible," is replaced with alternative concepts: "I am responsible to this patient," and "I am responsible for the success of the therapy that I deliver." TRT does meet this responsibility; it is accountable to the patient -- it does reverse psychological trauma's etiology.

In addition, on observing the facilitation of the patient's identification of survival responses that function contrary to the individual's (and the culture's) best interests, some clinicians may ask why the therapy does not shift its focus to one that attempts to change that apparently (from some views) irresponsible behavior, in the process incorporating the standard psychotherapy application where the teaching that assumption of personal responsibility for individual behavior is the mainstay, or primary goal, of the clinical process. The complete answer to this important question is long and complex, and considered again in other parts of the site including the following sections About ETM/ Theory, Comparison - Contrast, Development, and Strategic -- the criminal violence prevention segment of the book.

I can say here, however, that where we assume that many people no doubt would benefit from such teachings, trying to enforce controls over trauma-induced behavior can strengthen the paradox described in this chapter and in the process produce the opposite outcome desired. A strengthened paradoxical system of control will almost always, or eventually, produce apparent aberrant or irresponsible behaviors -- ones that function not only
countervailant to the individual's interest, but also as antithetical to universal cultural standards.

Given that this hypothesis may be correct, responsibility-teaching methods would be destined, when applied to trauma victims, to become part-in-parcel the new problem. They could lock the etiology into place by strengthening the paradox against the trauma's resolution, cyclically and continuously producing apparent irresponsible behaviors and regardless of the assiduity with which the behavioral control methods were applied.

Moreover, because TRT does not engage in judging behavior, it functions apolitically. And because this functioning stands in contrast to the responsibility-teaching paradigm (the nosotropic approach) where helping is occurring politically -- the culture is attempting to conform individual behavior to cultural standards, conflict between the models can arise.

This entire web site, and especially the Strategic section, is intended overcome the referenced dilemma imposed by application of nosotropic methods to psychological trauma and its consequences. In this section, let it be understood only that the patient is not to be made by the therapeutic process responsible for the otherwise cultural management shortfalls. At the same time, however, the client needs to know that although survival responses are accounted for in TRT as direct consequences of the initial traumatic event's effects on neurobiology, that the culture may not see it that way. Outside of TRT, the client has an obligation to comply with some standards of behavior, regardless of the various causal theories.

The ETM Strategic section sheds considerable light on how these conflicts are reconciled through application of Etiotropic Trauma Management.

**Biology of Resolution and Control**

The reader will remember that these chapters are presented from the psychological paradigm. About ETM/ Theory/ Neurobiology, supported by About ETM/ Comparison - Contrast/ Neurobiology and Multiple Sources, present the biological perspective of resolution and control, a perspective that is grounded in molecular terms as opposed to behavioral. Those chapters and the supporting appendix explain, among other things, the great value of emotional pain to neuronal molecular change, the structural and functional substrate of resolution and control. The next chapter (TRT Phase
Four) describes the rest of the trauma resolution process -- reconstitution of existential identity contradicted by survival responses.
TRT Phase Three Application Example (A3):
Battered Spouse - Codependency Trauma

This section provides an example of TRT Phase Three's application to Trauma. It is a continuation of the battered spouse - codependency examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5, TRT Phase Two (Matrix), and apply in the TRT Phase Three format. The one exemplified here. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

TRT Phase Three: Battered Spouse - Codependency

I laughed at his drunkenness.
I made light of it.
I played like it was funny.
I apologized to my friends.
I attempted to cover up for the drunk behavior.
I made excuses to them about why the man I was marrying drank so much.
I began to withdraw.
I played like it wasn't happening.
I quit talking about what was happening.
I began to pretend that he loved me and the children, even when he was out drinking.
I packed my bags and wanted to leave.
I stayed.
Instead of leaving I began to pretend it wasn't happening.
I tried to take care him when he was passed out.
Then I left him there and tried to detach.
I tried to carry him out of the yard.
Then I covered him up.
I went along with his ignoring that it had happened.
I ignored the beating.
I apologized to him for causing it.
I forgot the battering experience happened.
I started having affairs.
I began to believe there was no such thing as hope.
I wanted to get away.
I wanted him to die.
I helped him select another car as if he had never run into a bus.
I lived as if it had never happened.
I confronted him about urinating in the closet.
I then began to question myself.
Cleaned the clothes in the closet.
I lied to the people at the cleaners about my coat.  
I promised I would leave but I stayed.  
On the second day I forgot that it had happened.  
I began to be a part of what I was beginning to believe was an animal experience.  
I began to take control of our family's life.  
I borrowed money and ran the finances.  
I assumed the responsibilities of raising the children alone.  
I continued to lie to everyone about where he was.  
I yelled at him later.  
I cleaned up my husband's urine.  
I cleaned up his vomit repeatedly.  
I continued to stay in the marriage against my judgment.  
I increased the frequency of extramarital sexual encounters.  
I began to see sex with my husband as a repulsive and degrading experience.  
I played like he wasn't in trouble with the law.  
I asked the stranger to leave and played like my husband hadn't brought him into the house.  
I wanted to kill my husband.  
I planned how to kill him when I realized he was having sex with Lori.  
I denied the following day that it had happened at all.  
I covered up his nudity in front of the children.  
I took care of him.  
I played like it hadn't happened.  
I wanted to kill him or escape after the beating New Years.  
I began to believe I was no longer human.  
Generally:  
I acted differently than I ever believed I would act.  
I didn't place my children first in my life.  
The alcoholism was first.  
Sometimes I reacted verbally and physically towards the children rather than my husband.  
I seemed to have become another person throughout the experience.  
I became obsessed with controlling him.  
I lived in degradation like I never thought that I would.
TRT Phase Three Application Example (B3):
Combat Trauma

This section provides an example of TRT Phase Three’s application to Trauma It is a continuation of the combat examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5 of the TRT Phase Two (Matrix) and apply to this page using the TRT Phase Three format. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

TRT Phase Three: Combat

I became extremely paranoid and afraid of everyone.
I believed I might be killed even by accident.
I watched everyone so that they wouldn't shoot me.
I constantly stayed on guard. I dug deeper holes.
I withdrew from others.
I didn't talk about the deaths.
I believed intensely that it was just part of the job.
I blamed the men who were killed.
I kept doing my job even though I could have been killed.
I talked only with the chaplain. Then stopped talking with him.
I learned to be tough and act as if the damage was no big deal.
I began to believe I was above it all.
I quit caring about people.
I withdrew from everyone and didn't talk with anyone about what was really happening to me. I quit believing in God and decided life had no meaning.
I hated the NVN and wanted to kill them.
• I began to play like I was invincible and reflected to everyone that I was very strong and afraid of nothing.
I did my job in spite of throwing up and in spite of my fear.
I believed more intensely that life was a random event and that God did not exist.
I believed there was no reality to concepts of destiny or future.
I decided God was a fabrication to protect other people against the reality of what I was experiencing.
I did my job and decided life would only be a short term experience.
I tried my best to kill the NVA.
I helped the wounded as it was the only thing I could do other than kill the NVA.
I became more intense at doing my job so that I could stay alive.
I began to believe that war and killing were natural.
I took pride in my ability to keep others alive.
I ignored the hurt.
I became obsessed with doing my job properly and hoped that would keep me alive. I was amazed that my body still functioned and at times I could not believe that it was even still there. I believed nothing mattered. I wondered what my brain blown apart and laying on the ground would look like. I thought I was going insane. I began to show no courage and acted like a coward. I wondered if my own stomach would be opened up and left in the dirt. I began to hate my friends (at home). I began to hate my Country that before I loved the same as God and my family. I withdrew from all people because I believed I was not like any of them and that something was wrong with me. I began to see myself as less than an animal. I cried alone.

The way I changed was that:
At first, I remember being afraid to drive through an intersection at home, -- I wondered where automatic weapons would be placed for an ambush.
In my first relationship with a woman, although a part of me loved her, I had to leave as I didn't know how to make a long-term commitment.
I no longer knew what long-term meant and had no concept of being able to live an extended future.
I tried to avoid anything that resembled permanence. Something always seemed to be missing for me and I felt constantly different.
I started wondering what normal people looked like and why I was such a crazy person as to have put myself into the conflict.
I started thinking, with the help of others that I had not served because I cared about my Country, but because there was something wrong with me and I loved violence.
I began to believe I must be a distorted and evil person inside.
I felt like a pin ball bouncing around between partial relationships and different geographical places.
I had a yearning to go back to Vietnam and retake the area in which I had fought and others had died.
My greatest regret was that Ho Chi Men died before I could kill him.
I withdrew from anyone who looked my age.
The only people with whom I felt the slightest identification were the older generation that had fought through World War II.
I isolated myself further from the society and poured myself into my job whatever it was.
Later, my ability to do my job began to fall apart as I found myself being stuck.
Even though I sought help for relationship problems in my first marriage, I could not do the things the other couples seemed to be doing. Real caring and love were no longer in my vocabulary and impossible to either give or receive. I became a devout atheist -- all the while I felt that something was deeply wrong. The most hurting thing that I did was decide that I would never fight for my country again, even if it was dying.
This section provides an example of TRT Phase Three’s application to Trauma It is a continuation of the violent crime examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5 of the TRT Phase Two (Matrix) and apply to this page using the TRT Phase Three format. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

**TRT Phase Three: Violent Crime Trauma**

- I tried to protect myself from the blows to my head.
- I began to separate myself from the reality of the experience.
- I struggled for my existence.
- I separated myself from the beating further.
- I tried to breathe and stay alive.
- I hoped that it would be over soon and that I wouldn't be killed.
- I began to think that if I was nice to him that he wouldn't kill me.
- At that moment I felt myself change and become something other than what I used to be.
- I fought back against being stabbed.
- I did not believe my husband was gone.
- I withdrew further.
- I began to dream and hallucinate that my husband was coming back.
- I compared my current husband to Gary.
- When I made love to my second husband, I played like it was Gary.
- I became paranoid and boarded up windows.
- I never went to the garage.
- I bought a gun and repeatedly sat in the kitchen until the sun came up, hoping the killers would return -- I would kill them.
- I began to have extramarital sexual involvements even though I loved my husband.
- I thought I was going insane.
Chapter 5 Section (m):

How To Facilitate TRT Phases One Through Five

TRT Phase Four

This chapter:

1. Reviews theory and the preceding TRT Phases' resolution effects.
2. Reiterates the goal of Phase Four and the steps to achieving it.
3. Describes Phase Four's application: writing, reading and facilitation.
4. Explains Phase Four's effects on the 4 psychological trauma patterns.

Reviewing Theory and TRT Application To Date

Psychological trauma is retained in memory in 4 patterns; patterns 1 and 3 provide the locus of the trauma's dual etiologies. The 4 psychological trauma patterns and the etiologies include:

1. The experience of the event contradicts the pre-trauma values, beliefs, images and realities; these contradictions form etiology one.
2. The loss from the contradictions and associated emotional outcomes are maintained in memory, conscious or otherwise.
3. The maintenance of the emotional elements resulting from the contradictions creates the need for survival protective measures -- thoughts and behaviors that serve to dissociate the person from the reality of both the contradictions and the emotional memory retention; in the process of that dissociation, additional contradictions occur to existential identity and the additional contradictions provide the locus of etiology two.
4. The dissociative activity, the contradictions resulting from survival responses, produce additional experiences of loss and emotion that are also maintained in memory.

The contradicted values, beliefs, images and realities described in "1" and "3" represent the dual etiology of psychological trauma. Etiology one is formed in pattern 1 and etiology two is formed in pattern 3.
The 4 patterns, including the etiology, are defended by a paradoxical system of control. The trauma victim is perpetually and simultaneously attempting to end and continue the trauma's effects. The paradox keeps the etiology from being reversed and at the same time tries to find the means to reverse the etiology.

**Pattern/Paradox Address by TRT's First 3 Phases**

When the client reaches Phase 4, the referenced patterns have been addressed accordingly:

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Addressed by Phases One and Two (Phase Two reverses the etiology attending this pattern)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pattern One</td>
<td>Addressed by Phase Two</td>
</tr>
<tr>
<td>Pattern Two</td>
<td>Addressed by Phase Three (the path to resolution is initiated, but the second etiology remains)</td>
</tr>
<tr>
<td>Paradox</td>
<td>Addressed by all 3 Phases; they have reduced the paradox's influences and the client is regaining control in direct proportion to the reduction</td>
</tr>
</tbody>
</table>

**TRT Phase Four: Introduction**

Phase Four completes, with the exception of the summary provided in Phase Five, the resolution process for the particular source of trauma being addressed. Resolution is achieved by reversing the etiology (two) attending pattern 3. Like Phase Two’s resolution of the first etiology, Phase Four’s resolution of the second etiology also occurs in several and similar steps. They are:

- (a) identification, experience and expression of the emotional elements of the grief cycles attending loss resulting from specific (survival response-induced) contradictions.
- (b) identification of the (response-induced) contradicted elements of identity.
- (c) identification, experience, and expression of the loss that resulted from the contradictions (loss that necessitated the grief cycles).
• (d) reconstitution of the remaining damaged identity.
• (e) regaining of control.

**TRT Phase Four Application**

To complete Phase Four, assist your client(s) to:

1. Complete a preparatory worksheet that categorizes survival responses identified in Phase Three.
2. Apply the categories delineated on the worksheet to the primary Phase Four form, a 3 column Matrix.
3. Read the Phase Four Matrix to you and the group (where the group method is used).

**The TRT Phase Four Worksheet**

The first column of the Phase Four worksheet consolidates the individual responses into like groups to create a much smaller listing of various categories of responses. Consolidation is achieved by starting at the top of the worksheet and progressing down the list, placing the responses, depending on their characteristics, into similar categories by assigning numbers in sequence. Each expression that represents a new or different category of response is given a new number. To demonstrate this process, we use the codependency trauma example. The first 6 survival responses listed in Phase Three were:

"I laughed at his drunkenness."
"I made light of it."
"I played like it was funny."
"I apologized to my friends."
"I attempted to cover up for the drunk behavior."
"I made excuses to them about why the man I was marrying drank so much."

To begin the categorization process, the evaluation is conducted by appraising each response as it is related to the others. In that regard, the first response obviously would be new and so far not duplicated. Consequently, we would place the number (1) in the margin to the right.

"I laughed at his drunkenness." (1)

The second sentence is almost the same as the first; we would give it a (1) also.

"I made light of it." (1)
The third expression, however, is at least partially new -- "playing like" or "pretending"; thus, we give it the first different number "2."

"I played like it was funny." (2)
The fourth listing also represents a new and different kind of response -- an apology for something the spouse did not do; thus, this response is distinguished as the third category.

"I apologized to my friends." (3)
The fifth response is also relatively new -- covering up for the drunk behavior. We assign it the number "4" representing the fourth category of response.

"I attempted to cover up for the drunk behavior." (4)
The next response is not entirely new. It describes the use of excuses, which is new, but which closely parallels her apology described in (3). Depending on the client's and TRT Counselor's views, the client can create a new category ("excuse"), or the client can place this response in the apology category already described as (3). Either way will be effective in the continuing TRT process. For purposes of demonstration, we will consider the "excuses" as parallel to the "apologies" and so will place the number that identifies the apology response (3) next to the excuse response.

"I made excuses to them about why the man I was marrying drank so much." (3)

It does not matter that a client's or counselor's interpretations of these survival response likenesses are different. The object of the process is that both the client and TRT Counselor work together to find their own indications of similarities and categorize the client's survival responses listed in Phase Three into categories that are satisfactory to that client. The completed Phase four Worksheet for this example of codependency trauma is provided below.

**Example (A4 Worksheet): Codependency Trauma -- Delineate Survival Responses from Phase Three by Category**

<table>
<thead>
<tr>
<th>Survival Responses</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I laughed at his drunkenness.</td>
<td>(1)</td>
</tr>
<tr>
<td>I made light of it.</td>
<td>(1)</td>
</tr>
<tr>
<td>I played like it was funny.</td>
<td>(2)</td>
</tr>
<tr>
<td>I apologized to my friends.</td>
<td>(3)</td>
</tr>
<tr>
<td>I attempted to cover up for the drunk behavior.</td>
<td>(4)</td>
</tr>
<tr>
<td>I made excuses to them about why the man I</td>
<td></td>
</tr>
</tbody>
</table>
was marrying drank so much.  
I began to withdraw.  
I played like it wasn't happening.  
I quit talking about what was happening.  
I began to pretend that he loved me and the children, even when he was out drinking.  
I packed my bags and wanted to leave, but I stayed.  
Instead of leaving I began to pretend it wasn't happening.  
I tried to take care him when he was passed out.  
Then I left him there and tried to detach.  
I tried to carry him out of the yard.  
Then I covered him up.  
I went along with his ignoring that it had happened.  
I ignored the beating.  
I apologized to him for causing it.  
I forgot the battering experience happened.  
I started having affairs.  
I began to believe there was no such thing as hope.  
I wanted to get away.  
I wanted him to die.  
I helped him select another car as if he had never run into a bus.  
I lived as if it had never happened (forgot rather than pretended).  
I confronted him about urinating in the closet.  
I then began to question myself.  
Cleaned the clothes in the closet.  
I lied to the people at the cleaners about my coat.  
I promised I would leave but I stayed.  
On the second day I forgot that it had happened.  
I began to be a part of what I was beginning to believe was an animal experience.  
I began to take control of our family's life.  
I borrowed money and ran the finances.  
I assumed the responsibilities of raising the children alone.  
I continued to lie to everyone about where he was.  
I yelled at him later.  
I cleaned up my husband's urine.  
I cleaned up his vomit repeatedly.  
I continued to stay in the marriage against my judgment.
I increased the frequency of extramarital sexual encounters. (9)
I began to see sex with my husband as a repulsive and degrading experience. (12)
I played like he wasn't in trouble with the law. (2)
I asked the stranger to leave and played like my husband hadn't brought him into the house. (2)
I wanted to kill my husband. (11)
I planned how to kill him when I realized he was having sex with Lori. (11)
I denied the following day that it had happened at all. (2)
I covered up his nudity in front of the children. (7)
I took care of him. (7)
I played like it hadn't happened. (2)
I wanted to kill him or escape after the beating New Years. (11)
I began to believe I was no longer human. (15)
Generally:
I acted differently than I ever believed I would act. (17)
I didn't place my children first in my life. (18)
The alcoholism was first. (18)
Sometimes I reacted verbally and physically towards the children rather than my husband. (19)
I seemed to have become another person throughout the experience. (17)
I became obsessed with controlling him. (18)
I lived in degradation as I never believed that I would live. (15)

**Apply the Worksheet Data to the Primary Phase Four Form (A 3 Column Matrix)**

The information in the worksheet is applied to the primary Phase Four form, which is a 3 column matrix (figure 1). The columns provide for:

1. A listing of the categories of survival response.
2. A description of values, beliefs, images and realities contradicted by the responses.
3. The delineation of loss resulting from the contradictions.
Figure 1. TRT Phase Four (also called "The Second Matrix")

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summarize each category into a few words; use only one word if possible. Place one category summary per row in the first (left) column. The client then evaluates the effects of those categories on existential identity. The client cites the response and ask him or her self how that response contradicted pertinent values, beliefs, images and realities. After all the contradictions resulting from a particular category of survival response are identified, the person then asks the question, "What did I lose as a result of these contradictions?" Facilitate placement of the identified losses into the third column and in the same row where the attendant contradictions have been recorded.

In some instances, a survival response does not contradict existential identity. For example, in a struggle for one's life, the survival response may include defending one’s self, which in and of itself, is not a contradiction. People believe they are supposed to defend themselves from harm. However, that defense may result in the harm of another person, which may be a contradiction to another element of existential identity. To account for this prospect, the person records in writing when he or she believes a response is not contradictory; it is OK for the same response to be recorded from another perspective when it is contradictory.

The categories of survival response delineated in the Phase Four sample worksheet (representing codependency trauma) are applied to the Phase Four Matrix below. Examples of contradictions and losses are also recorded in that same demonstration.

**Apply the Codependency (A4) Worksheet Data to the Primary Phase Four Form (2\textsuperscript{nd} Matrix)**

2-a-180
## Example (A4): TRT Phase Four
**Codependency Trauma (The Second Matrix)**

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I minimized what happened to me.</td>
<td>I would like to have been able to see and relate more clearly to what was going on.</td>
<td>I lost touch with the reality of how serious the situation was</td>
</tr>
<tr>
<td>I covered up for him and protected him.</td>
<td>I believed people shouldn't have to lie to help someone else. My husband should not have been like a child or invalid to me -- I was supposed to be his wife, not guard and protector</td>
<td>My losses were self-esteem,, self-worth,, and self-respect. I lost trust and respect for my husband.</td>
</tr>
<tr>
<td>I withdrew.</td>
<td>I believed I should be involved with people, including my husband, my friends and family.</td>
<td>I lost companionship, friendships, people to remind me of what reality was, love, caring and intimacy with others.</td>
</tr>
<tr>
<td>I played like the drinking and abuse were not happening.</td>
<td>I believed a person and woman shouldn't take abuse from anyone. My denial of it was giving my consent.</td>
<td>I lost self-esteem, self-worth, and self-respect. I lost a sense of reality as I got further out of touch with the truth of what was happening</td>
</tr>
<tr>
<td>I quit talking about what was happening.</td>
<td>I didn't believe I should collude with him. My not talking was collusion through omission. I should have said what I thought.</td>
<td>I lost self-esteem and self-worth. I also lost the opportunity to attain other people's views. I lost touch with the truth. I pretended he loved me and the children.</td>
</tr>
<tr>
<td>I pretended he loved me and the children.</td>
<td>I should have had a husband who loved me and a father to my children who loved them. I shouldn't have had to fantasize the existence of this love and caring.</td>
<td>I lost my understanding of love and caring. I lost my husband as a role model and as a father to the children. I lost the reality of caring spouse -- the person with whom I expected to share my life and my children's lives.</td>
</tr>
<tr>
<td>I planned to leave but stayed.</td>
<td>My belief was that a valuable person would not stay in this kind of situation.</td>
<td>I lost self-respect and self-esteem. I lost the sense that I had control over my life.</td>
</tr>
<tr>
<td>Took care of him when he was drunk or after he had been drunk.</td>
<td>I believed my husband should take care of himself. I should not keep helping him to get drunk. I should not be his nurse or mother.</td>
<td>I lost respect for him. I lost separateness from him.</td>
</tr>
<tr>
<td>I detached from him</td>
<td>I believed that I should be able to talk</td>
<td>I lost further contact and connection</td>
</tr>
<tr>
<td>behavior.</td>
<td>frankly and honestly with my husband.</td>
<td>with myself. I lost connection with my own feelings as I consciously withdrew from his actions.</td>
</tr>
<tr>
<td>I apologized to him for the beating and then forgot that he had hurt me.</td>
<td>I should not have apologized for his behavior and his hurting of me. He should have apologized to me.</td>
<td>I lost self-esteem, self-worth, and any further understanding of who I was as a person. I lost my identity over to him. I began to see my husband as sexually repulsive.</td>
</tr>
<tr>
<td>I once valued our sexual relationship.</td>
<td>I wanted to have a sexual and loving relationship with my husband.</td>
<td>I lost my sexuality, femininity, closeness, companionship, and understanding of what was happening.</td>
</tr>
<tr>
<td>I began to have affairs.</td>
<td>I believed in honesty and fidelity in marriage.</td>
<td>I lost self-respect, self-esteem and self-worth. (The affairs were not just contradictions. Sometimes I felt that I was getting my worth back.)</td>
</tr>
<tr>
<td>I wanted him to die. I wanted to kill him.</td>
<td>I believed that I should love my husband. That I should not want him or anyone to die. I should never want to kill anyone, much less my husband.</td>
<td>I lost control. I lost self-worth and self-respect. I lost trust in myself. I believed I was going insane.</td>
</tr>
<tr>
<td>I was confused.</td>
<td>I valued my ability to be strong, clear and know what I was doing.</td>
<td>I was losing myself.</td>
</tr>
<tr>
<td>I lied.</td>
<td>I believed in telling the truth and being honest.</td>
<td>I lost myself and my basic belief in myself.</td>
</tr>
<tr>
<td>I began to think of myself as an animal.</td>
<td>I believed I should live like a human being.</td>
<td>I lost my worth as a person and my identity as a human being -- much less a woman.</td>
</tr>
<tr>
<td>I took control of the family.</td>
<td>On the one hand, this was not a contradiction because someone needed to take responsibility for the family. On the other hand, I was assuming my husband's responsibilities which he should have performed. We should have at least been sharing responsibilities.</td>
<td>I lost the ability to depend on him for his part in the relationship. I lost the freedom to do my duties as necessary.</td>
</tr>
<tr>
<td>I began to lose control.</td>
<td>I believed in maintaining a calm approach to life.</td>
<td>I lost peace.</td>
</tr>
<tr>
<td>While obsessed with the alcoholism, I abandoned my children.</td>
<td>Of all the values and expectations about myself, I believed that I was and should be a good mother.</td>
<td>I lost the opportunity with my children to be the kind of mother that I had wanted and had expected of myself to be.</td>
</tr>
<tr>
<td>I became another person.</td>
<td>I should have remained who I was before the alcoholic relationship.</td>
<td>I lost me.</td>
</tr>
</tbody>
</table>
Reading and Facilitating the Phase Four (Matrix)

Unlike the reading of the first Phase Two Matrix where between 4 to 8 incidents' applications to the 5 column form are read in a particular session, the reading of the Phase Four Matrix is always completed in one session and usually takes about 1 hour. The reader may stop periodically during the reading to receive feedback from the group. That processing is facilitated under the feedbacking guidelines described in chapters 1, 2 and 3 for giving feedback in, respectively, TRT Phases One, Two, and Three.

Phase Four Reverses the Last of the Etiology (Etiology Two, Attending Pattern 3)

Phase Four reverses the etiology attending pattern 3, but does so by first completing the address of pattern 4. Phase Four's etiology-reversal process is identical to the one facilitated by Phase Two (reversal of etiology attending pattern 1), except that the Phase Four effort connects the identification, experience and expression of the loss in pattern 4 and the reversal of the etiology in pattern 3 to the initial trauma. The negotiation of the different grief cycles addressed by Phase Four constitute the additional principal exception, that is, primary difference between Phases Two and Four. This section explains Phase Four's address of patterns 3 and 4, the etiology-reversal process, and the demise of the paradoxical system of control.

Phase Four Facilitates the Emotional Reconciliation Component of the Etiology Reversal Process

Phase Four assists the client to negotiate and complete grief cycle B, the emotional responses to the contradictions resulting from the survival thoughts and behaviors, and grief cycle C, the emotional response to the sum of the impact of the episodes taken as a whole. Excepting the experience in the summary, completion of these grief cycles produces the culmination of the emotional experience; it is hallmarked by sadness and mourning.
Phase Four Facilitates
the Contradiction-Reconciliation

Component of the Etiology Reversal Process The client identifies survival response-induced contradictions to values, beliefs, images and realities. To make this identification, pretrauma existential identity must also be identified in order to show the contradictions. Identification of the contradictions leads to identification of loss resulting from the contradictions. Like the loss addressed in pattern 2, this loss in pattern 4 is, once identified, also experienced and expressed as an emotion.

Phase Four Facilitates
the Restoration-of-Control

Component of the Etiology Reversal Process The operational identity formerly divided by the repressed emotion (grief cycles B and C) and the unreconciled loss is reintegrated with the emotion/loss reconciliation; the rational-cognitive and experiential processing attributes now can and do work together to effect control over the psychological management system. The paradoxical system of control has lost its influence and the system no longer exists. The same examples of regained control provided in chapter 3 are applicable in Phase Four, but they are now experienced and demonstrated with a consistency, congruity and certitude not prevalent in the earlier components of the therapy. Moreover, regained control produces the ability to, and does, restore values, beliefs, images and realities previously contradicted, damaged, by the traumatic event. The person says, "These values and beliefs were me." They were taken from me -- I was taken from me." "Now, they are mine again. I've got them back. And I've got me back!" Existential identity affected by the event has now been reconstituted -- etiology two has been reversed; the 4 patterns have been expunged.

Phase Four Facilitates Reconstitution of
Existential Identity Within the Current Reality

Etiology reversal provides additional control capacities that include the ability to reconstitute existential identity within the context of the current reality; the person automatically evaluates whether the pretrauma values, beliefs, images and realities that have been restored by the etiology reversal process fit today's person. For example, the trauma may have occurred during childhood -- the values, beliefs, images and realities contradicted
were those of a child. Once the etiology resulting from those contradictions (trauma) has been reversed, as it has by the application of the 4 TRT phases, the childhood beliefs, etc., may no longer be applicable to the adult. In contrast, some values do not change with adulthood. Through the restoration of an integrated, or reintegrating, operational identity, the person then automatically chooses those elements of identity most important to today's individual -- values that fit the ontology of the individual. "Automatically" infers that no additional therapeutic assistance is required to make these evaluations and choices.

The Trauma is Resolved

Completion of Phase Four completes the trauma resolution process -- both etiologies, one attending pattern 1 and the other attending pattern 3, have been reversed. Existential and operational identities are restored. In the next chapter (5), the client looks back on the resolution process, summarizing the experience. This summary is a sad, joyous, and concluding process. For this source of trauma, the client exits TRT.

Phase Four Worksheet and 2nd Matrix Examples
For Combat and Violent Crime Trauma

TRT Phase Four Application Example (B4):
Combat Trauma

This section provides an example of TRT Phase Four's application to trauma. This example continues the combat examples presented in TRT Phases One, Two and Three.

TRT Phase Four Worksheet Example: Combat Trauma --
Delineate Survival Responses from Phase Three by Category

<table>
<thead>
<tr>
<th>Survival Responses</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I became extremely paranoid and afraid of everyone.</td>
<td>(1)</td>
</tr>
<tr>
<td>I believed I might be killed even by accident.</td>
<td>(2)</td>
</tr>
<tr>
<td>I watched everyone so that they wouldn't shoot me.</td>
<td>(1)</td>
</tr>
<tr>
<td>I constantly stayed on guard.</td>
<td>(1)</td>
</tr>
<tr>
<td>I dug deeper holes.</td>
<td>(1)</td>
</tr>
<tr>
<td>I withdrew from others.</td>
<td>(3)</td>
</tr>
<tr>
<td>I didn't talk about the deaths.</td>
<td>(4)</td>
</tr>
<tr>
<td>I believed intensely that it was just part of the job.</td>
<td>(5)</td>
</tr>
</tbody>
</table>
I blamed the men who were killed. (6)
I kept doing my job even though I could have been killed. (5)
I talked only with the chaplain. Then stopped talking with him. (3)(4)
I learned to be tough and act as if the damage was no big deal. (7)
I began to believe I was above it all. (7)
I quit caring about people. (8)
I withdrew from everyone and didn't talk with anyone about what was really happening to me. (3)(4)
I quit believing in God and decided life had no meaning. (9)
I hated the NVN and wanted to kill them. (5)(7)
I began to play like I was invincible and reflected to everyone that I was very strong and afraid of nothing. (7)
I did my job in spite of throwing up and in spite of my fear. (5)
I believed more intensely that life was a random event and that God did not exist. (9)
I believed there was no reality to concepts of destiny or future. (9)
I decided God was a fabrication to protect other people against the reality of what I was experiencing. (9)
I did my job and decided life would only be a short term experience. (5)
I tried my best to kill the NVA. (5)(7)
I began to believe that war and killing were natural. (5)
I helped the wounded as it was the only thing I could do other than kill the NVN. (5)
I took pride in my ability to keep others alive. (5)
I ignored the hurt. (7)
I became obsessed with doing my job properly and hoped that would keep me alive. (5)
I was amazed that my body still functioned and at times I could not believe that it was even still there. (10)
I believed nothing mattered. (9)
I wondered what my brain blown apart and laying on the ground would look like. (10)
I thought I was going insane. (10)
I began to show no courage and acted like a coward. (11)
I wondered if my own stomach would be opened up and left in the dirt. (10)
I began to hate my friends who were at home. (12)(3)
I began to hate my Country that before I loved the same as God and my family. (12)(3)
I withdrew from all people because I believed I was not like any of them and that something was wrong with me. (3)(10)
I began to see myself as less than an
animal. (13)
I cried alone. (3)
The way I changed was that:
At first, I remember being afraid to drive through an intersection
at home, -- I wondered where automatic weapons would
be placed for an ambush. (1)
In my first relationship with a woman, although a part of me loved her,
I had to leave as I didn't know how to make a long-term
commitment. (3)
I no longer knew what long-term meant and had no concept of being
able to live an extended
future. (1)(2)
I tried to avoid anything that resembled
permanence. (3)
Something always seemed to be missing for me and
I felt constantly
different. (10)
I started wondering what normal people looked like and
why I was such a crazy person as to have put myself into the
conflict. (10)(14)
I started thinking, with the help of others that I had not
served because I cared about my Country, but because there was
something wrong with me and I loved
violence. (10)(14)
I began to believe I must be a distorted and evil person
inside. (10)(14)
I felt like a pin ball bouncing around between partial relationships
and different geographical
places. (3)
I had a yearning to go back to Vietnam and retake the area in
which I had fought and others had
died. (5)(7)
My greatest regret was that Ho Chi Men died before I could kill
him. (7)
I withdrew from anyone who looked my
age. (3)
The only people with whom I felt the slightest identification were the
older generation that had fought through World War
II. (8)
I isolated myself further from the society and poured myself
into my job whatever it
was. (3)(5)
Later, my ability to do my job began to fall apart
as I found myself being
stuck. (3)(5)
Even though I sought help for relationship problems in my first marriage,
I could not do the things the other couples seemed to be doing. (3) Real caring and love were no longer in my vocabulary and impossible to either give or receive. (8) I became a devout atheist all the while I felt that something was deeply wrong. (9)(10) The most hurting thing that I did was decide that I would never fight for my country again, even if it was dying. (12)

**TRT Phase Four (The Second Matrix) Example (B4): Combat Trauma**

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I became paranoid.</td>
<td>In my life prior to this experience, I was not afraid. I didn't believe that I should act so distrusting of everything and everyone around me.</td>
<td>My losses were of social involvement and openness. I also lost trust in my own perceptions of myself and others.</td>
</tr>
<tr>
<td>I believed I might be killed even by accident. I constantly stayed on guard.</td>
<td>I believed that people should not always be so defended or have to be so worried. I thought that in some place I should be safe.</td>
<td>I lost freedom to live. I also lost the experience of peace, quiet, and security in my life. I lost the belief that I could live without almost being killed.</td>
</tr>
<tr>
<td>I became isolated as I withdrew from others.</td>
<td>Before, I enjoyed relationships with my friends. I believed in being a part of others lives and they being a part of mine.</td>
<td>My losses were of esteem, self-worth, trust in myself, and a wider and more open view of life.</td>
</tr>
<tr>
<td>I didn't talk about what was really happening to me.</td>
<td>My values were that I liked to discuss whatever was important to me.</td>
<td>I lost companionship, the ability to express myself and confidence in me as a person.</td>
</tr>
<tr>
<td>I became obsessed with doing my job properly. This kept me alive at first.</td>
<td>My values were that I should complete my responsibilities well. But I also did not believe that I should do my work to the exclusion of the rest of my life.</td>
<td>I lost the ability to do other things such as socializing, reading, studying and enjoying the fun aspects of life. I lost my perspective of my own limits and an understanding of the reality of my capacity to achieve certain kinds of goals. I lost myself through that obsessive attempt to accomplish things that were outside of me. I actually was always working to cover over what I</td>
</tr>
</tbody>
</table>
I began to blame other people. I acted tough and as if I were invincible.

My values were that others shouldn't be hurt -- that I shouldn't hurt them. I was a regular and normal human being.

I lost a realistic image of myself and human qualities of humility and the ability to be humble.

I quit caring about people.

My values were that I should care for others.

I lost the ability to give and receive love.

I quit believing in God and decided life had no meaning.

My values and beliefs before this experience were that God cared about my life and others' lives.

I lost my love for one of the most important relationships in my life. I lost trust in any concept of spirituality.

I confused my physical body functions and components with those of others who were being mutilated.

I previously accepted those physical aspects of people as always functional and saw my own physical self as remaining intact.

I lost sanity; separateness from the carnage. I became over-run -whelmed with the prospects of my own destruction.

I gave up my country.

From the time I was a child three things made up the most important aspects of my life: my family, God and America. I believed that I should defend her with my life.

I lost my country.

I began to think of myself as lower than an animal.

At one time I believed I had value as a human being.

I lost self-esteem, self-worth, self-respect, the ability to relate, the ability to care, the ability to be a person, and the ability to be me.

I began to act like a coward.

I believed I should have courage.

I lost self-esteem, worth and respect. I lost me because I thought my courage was all that I had.

I blamed myself.

I shouldn't have been hurt further.

I lost self-respect and my reality.

---

**TRT Phase Four Application Example (C4): Violent Crime Trauma**

This section provides an example of TRT Phase Four's application to trauma. This example continues the violent crime example presented in TRT Phases One, Two and Three.

**TRT Phase Four Worksheet Example: Violent Crime Trauma -- Delineate Survival Responses from Phase Three by Category**
Etiotropic Trauma Management

Trauma Resolution Therapy

Training – Certification Program

Survival Responses

<table>
<thead>
<tr>
<th>Number</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I tried to protect myself from the blows to my head.</td>
<td>(1)</td>
</tr>
<tr>
<td>I began to separate myself from the reality of the experience.</td>
<td>(2)</td>
</tr>
<tr>
<td>I struggled for my existence.</td>
<td>(1)</td>
</tr>
<tr>
<td>I separated myself from the beating further.</td>
<td>(2)</td>
</tr>
<tr>
<td>I tried to breathe and stay alive.</td>
<td>(1)</td>
</tr>
<tr>
<td>I hoped that it would be over soon and that I wouldn't be killed.</td>
<td>(1)</td>
</tr>
<tr>
<td>I began to think that if I was nice to him that he wouldn't kill me.</td>
<td>(1)(2)</td>
</tr>
<tr>
<td>At that moment I felt myself change and become something other than what I used to be.</td>
<td>(2)</td>
</tr>
<tr>
<td>I fought back against being stabbed.</td>
<td>(1)</td>
</tr>
<tr>
<td>I withdrew further.</td>
<td>(3)</td>
</tr>
<tr>
<td>I began to dream and hallucinate that my husband was coming back.</td>
<td>(4)</td>
</tr>
<tr>
<td>I did not believe my husband was gone.</td>
<td>(5)</td>
</tr>
<tr>
<td>I compared my current husband to Gary.</td>
<td>(6)</td>
</tr>
<tr>
<td>When I made love to my second husband, I played like it was Gary.</td>
<td>(6)</td>
</tr>
<tr>
<td>I became paranoid and boarded up windows.</td>
<td>(7)</td>
</tr>
<tr>
<td>I never went to the garage.</td>
<td>(7)</td>
</tr>
<tr>
<td>I bought a gun and repeatedly sat in the kitchen until the sun came up, hoping the killers would return -- I would kill them.</td>
<td>(7)(8)</td>
</tr>
<tr>
<td>I began to have extramarital sexual involvements even though I loved my husband.</td>
<td>(9)</td>
</tr>
<tr>
<td>I thought I was going insane.</td>
<td>(10)</td>
</tr>
</tbody>
</table>

TRT Phase Four (The Second Matrix)

Example (C4): Violent Crime Trauma

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>My immediate response to the incident was to try to stay alive.</td>
<td>None of these behaviors contradicted my values or my beliefs about how I should conduct myself. However, I never had an image of myself having to fight for my existence while someone was trying to kill me.</td>
<td>I lost my image of a peaceful and regular existence.</td>
</tr>
</tbody>
</table>

I separated myself from the experience -- including thinking of being nice to the person to try to save myself. | Saving myself did not contradict my values. Thinking that I should be nice to the person raping me did contradict my values, even though it was necessary at the time. My values before the attack had been that I should never cooperate with anyone. | At that moment, I felt a part of me disappear and become lost. It was that part of me that controlled my own life. It was my strength of will that was taken from me. I lost self-esteem, self-worth, self-respect, human dignity and the belief that I was unique or |
<table>
<thead>
<tr>
<th></th>
<th>who would hurt me like that.</th>
<th>something special.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I withdrew further.</td>
<td>Originally I believed in living an integrated and balanced life with other people. I cared about my relationships. I believed in reaching out and letting others care about me.</td>
<td>I lost socialization; relationships with my closest friends. I lost the ability to relate, companionship, and a wider perspective of myself.</td>
</tr>
<tr>
<td>I denied that my husband was gone.</td>
<td>I originally believed in facing life.</td>
<td>I lost credibility with myself and an understanding of what was real. I lost the opportunity to say goodbye to him.</td>
</tr>
<tr>
<td>I repeatedly had dreams where my husband had returned.</td>
<td>A part of me wanted to live in reality.</td>
<td>I lost reality and a portion of my sanity.</td>
</tr>
<tr>
<td>I compared my current husband to Gary. When we made love I played like he was Gary.</td>
<td>I valued this new relationship and loved my husband. I believed that I should be with this husband. I wanted to be with him.</td>
<td>.I lost intimacy, sexual companionship and sexual intimacy, and trust in myself. I lost respect for myself and the ability to love my husband.</td>
</tr>
<tr>
<td>I became paranoid.</td>
<td>My beliefs prior to the assault were that I should live openly. I believed that I should not distrust everyone and everything.</td>
<td>I lost my own freedom to come and go without trying to control every aspect of my life.</td>
</tr>
<tr>
<td>I bought a gun and fantasized killing the attackers.</td>
<td>Originally, I did not believe in either guns or hurting other people.</td>
<td>I lost my perspective of what I used to be. I lost respect for myself as well as peace within me as the contradictions continued.</td>
</tr>
<tr>
<td>I started having sexual encounters with other men.</td>
<td>I believed in keeping my agreements with my husband. I believed in fidelity and an honest relationship with my husband.</td>
<td>I lost self-esteem, self-worth, self-respect, the ability to be honest with my husband, my perception of myself as an honest person, and the belief in my sanity.</td>
</tr>
<tr>
<td>I believed I was going insane.</td>
<td>I valued stability and control.</td>
<td>I lost control of my life.</td>
</tr>
</tbody>
</table>
TRT Phase Four Worksheet and (Second Matrix) Example:
Battered Spouse - Codependency Trauma

Example (A4 Worksheet): Codependency Trauma -- Delineate
Survival Responses from Phase Three by Category

<table>
<thead>
<tr>
<th>Survival Responses</th>
<th>Category Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>I laughed at his drunkenness.</td>
<td>(1)</td>
</tr>
<tr>
<td>I made light of it.</td>
<td>(1)</td>
</tr>
<tr>
<td>I played like it was funny.</td>
<td>(2)</td>
</tr>
<tr>
<td>I apologized to my friends.</td>
<td>(3)</td>
</tr>
<tr>
<td>I attempted to cover up for the drunk behavior.</td>
<td>(4)</td>
</tr>
<tr>
<td>I made excuses to them about why the man I was marrying drank so much.</td>
<td>(3)</td>
</tr>
<tr>
<td>I began to withdraw.</td>
<td>(5)</td>
</tr>
<tr>
<td>I played like it wasn't happening.</td>
<td>(2)</td>
</tr>
<tr>
<td>I quit talking about what was happening.</td>
<td>(5)</td>
</tr>
<tr>
<td>I began to pretended that he loved me and the children, even when he was out drinking.</td>
<td>(2)</td>
</tr>
<tr>
<td>I packed my bags and wanted to leave, but I stayed.</td>
<td>(6)</td>
</tr>
<tr>
<td>Instead of leaving I began to pretend it wasn't happening.</td>
<td>(2)</td>
</tr>
<tr>
<td>I tried to take care him when he was passed out.</td>
<td>(7)</td>
</tr>
<tr>
<td>Then I left him there and tried to detach.</td>
<td>(6)</td>
</tr>
<tr>
<td>I tried to carry him out of the yard.</td>
<td>(7)</td>
</tr>
<tr>
<td>Then I covered him up.</td>
<td>(7)</td>
</tr>
<tr>
<td>I went along with his ignoring that it had happened.</td>
<td>(2)</td>
</tr>
<tr>
<td>I ignored the beating.</td>
<td>(2)</td>
</tr>
<tr>
<td>I apologized to him for causing it.</td>
<td>(3)</td>
</tr>
<tr>
<td>I forgot the battering experience happened.</td>
<td>(8)</td>
</tr>
<tr>
<td>I started having affairs.</td>
<td>(9)</td>
</tr>
<tr>
<td>I began to believe there was no such thing as hope.</td>
<td>(10)</td>
</tr>
<tr>
<td>I wanted to get away.</td>
<td>(6)</td>
</tr>
<tr>
<td>I wanted him to die.</td>
<td>(11)</td>
</tr>
<tr>
<td>I helped him select another car as if he had never run into a bus.</td>
<td>(7)</td>
</tr>
<tr>
<td>I lived as if it had never happened (forgot rather than pretended).</td>
<td>(8)</td>
</tr>
<tr>
<td>I confronted him about urinating in the closet.</td>
<td>(12)</td>
</tr>
<tr>
<td>I then began to question myself.</td>
<td>(13)</td>
</tr>
<tr>
<td>Cleaned the clothes in the closet.</td>
<td>(7)</td>
</tr>
<tr>
<td>I lied to the people at the cleaners about my coat.</td>
<td>(14)</td>
</tr>
<tr>
<td>I promised I would leave but I stayed.</td>
<td>(6)</td>
</tr>
<tr>
<td>On the second day I forgot that it had happened.</td>
<td>(8)</td>
</tr>
<tr>
<td>I began to be a part of what I was beginning to believe was an animal experience.</td>
<td>(15)</td>
</tr>
<tr>
<td>I began to take control of our family's life.</td>
<td>(7)</td>
</tr>
</tbody>
</table>
I borrowed money and ran the finances. (7)
I assumed the responsibilities of raising the children alone. (7)
I continued to lie to everyone about where he was. (14)
I yelled at him later. (12)
I cleaned up my husband's urine. (7)
I cleaned up his vomit repeatedly. (7)
I continued to stay in the marriage against my judgment. (6)
I increased the frequency of extramarital sexual encounters. (9)
I began to see sex with my husband as a repulsive and degrading experience. (12)
I played like he wasn't in trouble with the law. (2)
I asked the stranger to leave and played like my husband hadn't brought him into the house. (2)
I wanted to kill my husband. (11)
I planned how to kill him when I realized he was having sex with Lori. (11)
I denied the following day that it had happened at all. (2)
I covered up his nudity in front of the children. (7)
I took care of him. (7)
I played like it hadn't happened. (2)
I wanted to kill him or escape after the beating New Years. (11)
I began to believe I was no longer human. (15)
Generally:
I acted differently than I ever believed I would act. (17)
I didn't place my children first in my life. (18)
The alcoholism was first. (18)
Sometimes I reacted verbally and physically towards the children rather than my husband. (19)
I seemed to have become another person throughout the experience. (17)
I became obsessed with controlling him. (18)
I lived in degradation as I never believed that I would live. (15)

Apply the Worksheet Data to the Primary Phase Four Form (A 3 Column Matrix)

Example (A4): TRT Phase Four Codependency Trauma (The Second Matrix)

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I minimized what</td>
<td>I would like to have been able to see and</td>
<td>I lost touch with the reality of how</td>
</tr>
</tbody>
</table>

2-a-193
<table>
<thead>
<tr>
<th>happened to me.</th>
<th>relate more clearly to what was going on.</th>
<th>serious the situation was</th>
</tr>
</thead>
<tbody>
<tr>
<td>I covered up for him and protected him.</td>
<td>I believed people shouldn't have to lie to help someone else. My husband should not have been like a child or invalid to me -- I was supposed to be his wife, not guard and protector.</td>
<td>My losses were self-esteem, self-worth, and self-respect. I lost trust and respect for my husband.</td>
</tr>
<tr>
<td>I withdrew.</td>
<td>I believed I should be involved with people, including my husband, my friends and family.</td>
<td>I lost companionship, friendships, people to remind me of what reality was, love, caring and intimacy with others.</td>
</tr>
<tr>
<td>I played like the drinking and abuse were not happening.</td>
<td>I believed a person and woman shouldn't take abuse from anyone. My denial of it was giving my consent.</td>
<td>I lost self-esteem, self-worth, and self-respect. I lost a sense of reality as I got further out of touch with the truth of what was happening.</td>
</tr>
<tr>
<td>I quit talking about what was happening.</td>
<td>I didn't believe I should collude with him. My not talking was collusion through omission. I should have said what I thought.</td>
<td>I lost self-esteem and self-worth. I also lost the opportunity to attain other people's views. I lost touch with the truth. I pretended he loved me and the children.</td>
</tr>
<tr>
<td>I pretended he loved me and the children.</td>
<td>I should have had a husband who loved me and a father to my children who loved them. I shouldn't have had to fantasize the existence of this love and caring.</td>
<td>I lost my understanding of love and caring. I lost my husband as a role model and as a father to the children. I lost the reality of caring spouse -- the person with whom I expected to share my life and my children's lives.</td>
</tr>
<tr>
<td>I planned to leave but stayed.</td>
<td>My belief was that a valuable person would not stay in this kind of situation.</td>
<td>I lost self-respect and self-esteem. I lost the sense that I had control over my life.</td>
</tr>
<tr>
<td>Took care of him when he was drunk or after he had been drunk.</td>
<td>I believed my husband should take care of himself. I should not keep helping him to get drunk. I should not be his nurse or mother.</td>
<td>I lost respect for him. I lost separateness from him.</td>
</tr>
<tr>
<td>I detached from his behavior.</td>
<td>I believed that I should be able to talk frankly and honestly with my husband.</td>
<td>I lost further contact and connection with myself. I lost connection with my own feelings as I consciously withdrew from his actions.</td>
</tr>
<tr>
<td>I apologized to him for the beating and then forgot that he had hurt me.</td>
<td>I should not have apologized for his behavior and his hurting of me. He should have apologized to me.</td>
<td>I lost self-esteem, self-worth, and any further understanding of who I was as a person. I lost my identity over to him. I began to see my husband as sexually repulsive.</td>
</tr>
<tr>
<td>I once valued our</td>
<td>I wanted to have a sexual and loving</td>
<td>I lost my sexuality, femininity,</td>
</tr>
<tr>
<td>sexual relationship.</td>
<td>relationship with my husband.</td>
<td>closeness, companionship, and understanding of what was happening.</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>I began to have affairs.</td>
<td>I believed in honesty and fidelity in marriage.</td>
<td>I lost self-respect, self-esteem and self-worth. (The affairs were not just contradictions. Sometimes I felt that I was getting my worth back.)</td>
</tr>
<tr>
<td>I wanted him to die. I wanted to kill him.</td>
<td>I believed that I should love my husband. That I should not want him or anyone to die. I should never want to kill anyone, much less my husband.</td>
<td>I lost control. I lost self-worth and self-respect. I lost trust in myself. I believed I was going insane.</td>
</tr>
<tr>
<td>I was confused.</td>
<td>I valued my ability to be strong, clear and know what I was doing.</td>
<td>I was losing myself.</td>
</tr>
<tr>
<td>I lied.</td>
<td>I believed in telling the truth and being honest.</td>
<td>I lost myself and my basic belief in myself.</td>
</tr>
<tr>
<td>I began to think of myself as an animal.</td>
<td>I believed I should live like a human being.</td>
<td>I lost my worth as a person and my identity as a human being -- much less a woman.</td>
</tr>
<tr>
<td>I took control of the family.</td>
<td>On the one hand, this was not a contradiction because someone needed to take responsibility for the family. On the other hand, I was assuming my husband's responsibilities which he should have performed. We should have at least been sharing responsibilities.</td>
<td>I lost the ability to depend on him for his part in the relationship. I lost the freedom to do my duties as necessary.</td>
</tr>
<tr>
<td>I began to lose control.</td>
<td>I believed in maintaining a calm approach to life.</td>
<td>I lost peace.</td>
</tr>
<tr>
<td>While obsessed with the alcoholism, I abandoned my children.</td>
<td>Of all the values and expectations about myself, I believed that I was and should be a good mother.</td>
<td>I lost the opportunity with my children to be the kind of mother that I had wanted and had expected of myself to be.</td>
</tr>
<tr>
<td>I became another person.</td>
<td>I should have remained who I was before the alcoholic relationship.</td>
<td>I lost me.</td>
</tr>
<tr>
<td>I lived in degradation.</td>
<td>I should have lived a decent life. I should never have participated in such a degrading experience.</td>
<td>I lost my pride, my esteem, my worth, my understanding of who I was and my life.</td>
</tr>
<tr>
<td>I didn't protect my children.</td>
<td>A mother's first duty is to keep her children from harm.</td>
<td>I lost all sense of motherhood, myself, and reality</td>
</tr>
</tbody>
</table>
TRT Phase Four Application Example (B4):
Combat Trauma

This section provides an example of TRT Phase Four's application to trauma. This example continues the combat examples presented in TRT Phases One, Two and Three.

**TRT Phase Four Worksheet Example: Combat Trauma -- Delineate Survival Responses from Phase Three by Category**

<table>
<thead>
<tr>
<th>Survival Responses</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td></td>
</tr>
<tr>
<td>I became extremely paranoid and afraid of everyone.</td>
<td>(1)</td>
</tr>
<tr>
<td>I believed I might be killed even by accident.</td>
<td>(2)</td>
</tr>
<tr>
<td>I watched everyone so that they wouldn't shoot me.</td>
<td>(1)</td>
</tr>
<tr>
<td>I constantly stayed on guard.</td>
<td>(1)</td>
</tr>
<tr>
<td>I dug deeper holes.</td>
<td>(1)</td>
</tr>
<tr>
<td>I withdrew from others.</td>
<td>(3)</td>
</tr>
<tr>
<td>I didn't talk about the deaths.</td>
<td>(4)</td>
</tr>
<tr>
<td>I believed intensely that it was just part of the job.</td>
<td>(5)</td>
</tr>
<tr>
<td>I blamed the men who were killed.</td>
<td>(6)</td>
</tr>
<tr>
<td>I kept doing my job even though I could have been killed.</td>
<td>(5)</td>
</tr>
<tr>
<td>I talked only with the chaplain. Then stopped talking with him.</td>
<td>(3)(4)</td>
</tr>
<tr>
<td>I learned to be tough and act as if the damage was no big deal.</td>
<td>(7)</td>
</tr>
<tr>
<td>I began to believe I was above it all.</td>
<td>(7)</td>
</tr>
<tr>
<td>I quit caring about people.</td>
<td>(8)</td>
</tr>
<tr>
<td>I withdrew from everyone and didn't talk with anyone about what was really happening to me.</td>
<td>(3)(4)</td>
</tr>
<tr>
<td>I quit believing in God and decided life had no meaning</td>
<td>(9)</td>
</tr>
<tr>
<td>I hated the NVN and wanted to kill them.</td>
<td>(5)(7)</td>
</tr>
<tr>
<td>I began to play like I was invincible and reflected to everyone that I was very strong and afraid of nothing</td>
<td>(7)</td>
</tr>
<tr>
<td>I did my job in spite of throwing up and in spite of my fear.</td>
<td>(5)</td>
</tr>
<tr>
<td>I believed more intensely that life was a random event and that God did not exist.</td>
<td>(9)</td>
</tr>
<tr>
<td>I believed there was no reality to concepts of destiny or future.</td>
<td>(9)</td>
</tr>
<tr>
<td>I decided God was a fabrication to protect other people against the reality of what I was experiencing.</td>
<td>(9)</td>
</tr>
<tr>
<td>I did my job and decided life would only be a short term experience.</td>
<td>(5)</td>
</tr>
<tr>
<td>I tried my best to kill the NVA.</td>
<td>(5)(7)</td>
</tr>
<tr>
<td>I became more intense at doing my job so that I could stay alive.</td>
<td>(5)</td>
</tr>
<tr>
<td>I began to believe that war and killing were natural.</td>
<td>(5)</td>
</tr>
<tr>
<td>I helped the wounded as it was the only thing I could do other than kill the NVA.</td>
<td>(5)</td>
</tr>
<tr>
<td>I took pride in my ability to keep others alive.</td>
<td>(5)</td>
</tr>
<tr>
<td>I ignored the hurt.</td>
<td>(7)</td>
</tr>
</tbody>
</table>
I became obsessed with doing my job properly and hoped that would keep me alive. (5)
I was amazed that my body still functioned and at times I could not believe that it was even still there. (10)
I believed nothing mattered. (9)
I wondered what my brain blown apart and laying on the ground would look like. (10)
I thought I was going insane. (10)
I began to show no courage and acted like a coward. (11)
I wondered if my own stomach would be opened up and left in the dirt. (10)
I began to hate my friends who were at home. (12)(3)
I began to hate my Country that before I loved the same as God and my family. (12)(3)
I withdrew from all people because I believed I was not like any of them and that something was wrong with me. (3)(10)
I began to see myself as less than an animal. (13)
I cried alone. (3)
The way I changed was that:
At first, I remember being afraid to drive through an intersection at home, -- I wondered where automatic weapons would be placed for an ambush. (1)
In my first relationship with a woman, although a part of me loved her, I had to leave as I didn't know how to make a long-term commitment. (3)
I no longer knew what long-term meant and had no concept of being able to live an extended future. (1)(2)
I tried to avoid anything that resembled permanence. (3)
Something always seemed to be missing for me and I felt constantly different. (10)
I started wondering what normal people looked like and why I was such a crazy person as to have put myself into the conflict. (10)(14)
I started thinking, with the help of others that I had not served because I cared about my Country, but because there was something wrong with me and I loved violence. (10)(14)
I began to believe I must be a distorted and evil person inside. (10)(14)
I felt like a pin ball bouncing around between partial relationships and different geographical places. (3)

I had a yearning to go back to Vietnam and retake the area in which I had fought and others had died. (5)(7)

My greatest regret was that Ho Chi Men died before I could kill him. (7)

I withdrew from anyone who looked my age. (3)

The only people with whom I felt the slightest identification were the older generation that had fought through World War II. (8)

I isolated myself further from the society and poured myself into my job whatever it was. (3)(5)

Later, my ability to do my job began to fall apart as I found myself being stuck. (3)(5)

Even though I sought help for relationship problems in my first marriage, I could not do the things the other couples seemed to be doing. (3)

Real caring and love were no longer in my vocabulary and impossible to either give or receive. (8)

I became a devout atheist all the while I felt that something was deeply wrong. (9)(10)

The most hurting thing that I did was decide that I would never fight for my country again, even if it was dying. (12)

TRT Phase Four (The Second Matrix) Example (B4): Combat Trauma

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I became paranoid.</td>
<td>In my life prior to this experience, I was not afraid. I didn't believe that I should act so distrusting of everything and everyone around me.</td>
<td>My losses were of social involvement and openness. I also lost trust in my own perceptions of myself and others.</td>
</tr>
<tr>
<td>I believed I might be killed even by accident. I constantly stayed on guard.</td>
<td>I believed that people should not always be so defended or have to be so worried. I thought that in some place I should be safe.</td>
<td>I lost freedom to live. I also lost the experience of peace, quiet, and security in my life. I lost the belief that I could live without almost being killed.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>I became isolated as I withdrew from others.</td>
<td>Before, I enjoyed relationships with my friends. I believed in being a part of others lives and they being a part of mine.</td>
<td>My losses were of esteem, self-worth, trust in myself, and a wider and more open view of life.</td>
</tr>
<tr>
<td>I didn't talk about what was really happening to me.</td>
<td>My values were that I liked to discuss whatever was important to me.</td>
<td>I lost companionship, the ability to express myself and confidence in me as a person.</td>
</tr>
<tr>
<td>I became obsessed with doing my job properly. This kept me alive at first.</td>
<td>My values were that I should complete my responsibilities well. But I also did not believe that I should do my work to the exclusion of the rest of my life.</td>
<td>I lost the ability to do other things such as socializing, reading, studying and enjoying the fun aspects of life. I lost my perspective of my own limits and an understanding of the reality of my capacity to achieve certain kinds of goals. I lost myself through that obsessive attempt to accomplish things that were outside of me. I actually was always working to cover over what I did not know was inside.</td>
</tr>
<tr>
<td>I began to blame other people. I acted tough and as if I were invincible.</td>
<td>My values were that others shouldn't be hurt -- that I shouldn't hurt them. I was a regular and normal human being.</td>
<td>I lost a realistic image of myself and human qualities of humility and the ability to be humble.</td>
</tr>
<tr>
<td>I quit caring about people.</td>
<td>My values were that I should care for others.</td>
<td>I lost the ability to give and receive love.</td>
</tr>
<tr>
<td>I quit believing in God and decided life had no meaning.</td>
<td>My values and beliefs before this experience were that God cared about my life and others' lives.</td>
<td>I lost my love for one of the most important relationships in my life. I lost trust in any concept of spirituality.</td>
</tr>
<tr>
<td>I confused my physical body functions and components with those of others who were being mutilated.</td>
<td>I previously accepted those physical aspects of people as always functional and saw my own physical self as remaining intact.</td>
<td>I lost sanity; separateness from the carnage. I became over-run -whelmed with the prospects of my own destruction.</td>
</tr>
<tr>
<td>I gave up my country.</td>
<td>From the time I was a child three things made up the most important aspects of my life: my family, God and America. I believed that I should defend her with my life.</td>
<td>I lost my country.</td>
</tr>
</tbody>
</table>
I began to think of myself as lower than an animal.  | At one time I believed I had value as a human being.  | I lost self-esteem, self-worth, self-respect, the ability to relate, the ability to care, the ability to be a person, and the ability to be me.  
---|---|---
I began to act like a coward.  | I believed I should have courage.  | I lost self-esteem, worth and respect. I lost me because I thought my courage was all that I had.  
---|---|---
I blamed myself.  | I shouldn't have been hurt further.  | I lost self-respect and my reality.  
---|---|---
TRT Phase Four Application Example (C4):
Violent Crime Trauma

This section provides an example of TRT Phase Four's application to trauma. This example continues the violent crime example presented in TRT Phases One, Two and Three.

TRT Phase Four Worksheet Example: Violent Crime Trauma --
Delineate Survival Responses from Phase Three by Category

<table>
<thead>
<tr>
<th>Survival Responses</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>I tried to protect myself from the blows to my head.</td>
<td>(1)</td>
</tr>
<tr>
<td>I began to separate myself from the reality of the experience.</td>
<td>(2)</td>
</tr>
<tr>
<td>I struggled for my existence.</td>
<td>(1)</td>
</tr>
<tr>
<td>I separated myself from the beating further.</td>
<td>(2)</td>
</tr>
<tr>
<td>I tried to breathe and stay alive.</td>
<td>(1)</td>
</tr>
<tr>
<td>I hoped that it would be over soon and that I wouldn't be killed.</td>
<td>(1)</td>
</tr>
<tr>
<td>I began to think that if I was nice to him that he wouldn't kill me.</td>
<td>(1)(2)</td>
</tr>
<tr>
<td>At that moment I felt myself change and become something other than what I used to be.</td>
<td>(2)</td>
</tr>
<tr>
<td>I fought back against being stabbed.</td>
<td>(1)</td>
</tr>
<tr>
<td>I withdrew further.</td>
<td>(3)</td>
</tr>
<tr>
<td>I began to dream and hallucinate that my husband was coming back.</td>
<td>(4)</td>
</tr>
<tr>
<td>I did not believe my husband was gone.</td>
<td>(5)</td>
</tr>
<tr>
<td>I compared my current husband to Gary.</td>
<td>(6)</td>
</tr>
<tr>
<td>When I made love to my second husband, I played like it was Gary.</td>
<td>(6)</td>
</tr>
<tr>
<td>I became paranoid and boarded up windows.</td>
<td>(7)</td>
</tr>
<tr>
<td>I never went to the garage.</td>
<td>(7)</td>
</tr>
<tr>
<td>I bought a gun and repeatedly sat in the kitchen until the sun came up, hoping the killers would return -- I would kill them.</td>
<td>(7)(8)</td>
</tr>
<tr>
<td>I began to have extramarital sexual involvements even though I loved my husband.</td>
<td>(9)</td>
</tr>
<tr>
<td>I thought I was going insane.</td>
<td>(10)</td>
</tr>
</tbody>
</table>

TRT Phase Four (The Second Matrix)
Example (C4): Violent Crime Trauma

<table>
<thead>
<tr>
<th>Consolidated Description of Survival Responses</th>
<th>Contradicted Values, Belief, Images and Realities</th>
<th>Losses Resulting from the Contradictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>My immediate response to the incident was to</td>
<td>None of these behaviors contradicted my values or my beliefs about how I</td>
<td>I lost my image of a peaceful and regular existence.</td>
</tr>
<tr>
<td>Event Description</td>
<td>Change in Beliefs / Values</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Try to stay alive.</td>
<td>Should conduct myself. However, I never had an image of myself having to fight for my existence while someone was trying to kill me.</td>
<td></td>
</tr>
<tr>
<td>I separated myself from the experience -- including thinking of being nice to the person to try to save myself.</td>
<td>Saving myself did not contradict my values. Thinking that I should be nice to the person raping me did contradict my values, even though it was necessary at the time. My values before the attack had been that I should never cooperate with anyone who would hurt me like that.</td>
<td></td>
</tr>
<tr>
<td>At that moment, I felt a part of me disappear and become lost. It was that part of me that controlled my own life. It was my strength of will that was taken from me. I lost self-esteem, self-worth, self-respect, human dignity and the belief that I was unique or something special.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I withdrew further.</td>
<td>Originally I believed in living an integrated and balanced life with other people. I cared about my relationships. I believed in reaching out and letting others care about me.</td>
<td></td>
</tr>
<tr>
<td>I lost socialization; relationships with my closest friends. I lost the ability to relate, companionship, and a wider perspective of myself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I denied that my husband was gone.</td>
<td>I originally believed in facing life.</td>
<td></td>
</tr>
<tr>
<td>I lost credibility with myself and an understanding of what was real. I lost the opportunity to say goodbye to him.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I repeatedly had dreams where my husband had returned.</td>
<td>A part of me wanted to live in reality.</td>
<td></td>
</tr>
<tr>
<td>I lost reality and a portion of my sanity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I compared my current husband to Gary. When we made love I played like he was Gary.</td>
<td>I valued this new relationship and loved my husband. I believed that I should be with this husband. I wanted to be with him.</td>
<td></td>
</tr>
<tr>
<td>I lost intimacy, sexual companionship and sexual intimacy, and trust in myself. I lost respect for myself and the ability to love my husband.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I became paranoid.</td>
<td>My beliefs prior to the assault were that I should live openly. I believed that I should not distrust everyone and everything.</td>
<td></td>
</tr>
<tr>
<td>I lost my own freedom to come and go without trying to control every aspect of my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I bought a gun and fantasized killing the attackers.</td>
<td>Originally, I did not believe in either guns or hurting other people.</td>
<td></td>
</tr>
<tr>
<td>I lost my perspective of what I used to be. I lost respect for myself as well as peace within me as the contradictions continued.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I started having sexual encounters with other men.</td>
<td>I believed in keeping my agreements with my husband. I believed in fidelity and an honest relationship with my husband.</td>
<td></td>
</tr>
<tr>
<td>I lost self-esteem, self-worth, self-respect, the ability to be honest with my husband, my perception of myself as an honest person, and the belief in my sanity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believed I was going insane.</td>
<td>I valued stability and control.</td>
<td></td>
</tr>
<tr>
<td>I lost control of my life.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 5 Section (q):
How To Facilitate TRT Phases One Through Five

TRT Phase Five

This chapter:

2. Demonstrates Phase Five's application.
3. Reports observations of effects of Phase Five on client progress.
4. Summarizes the full 5 phase TRT process.

Introduction: TRT Phase Five

Phases 1 thru 4 resolve the trauma resulting from a particular source. Phase Five summarizes the resolution experience and provides for the therapeutic exit.

TRT Phase Five: Application

Two summaries, "A" and "B," comprise Phase Five. "A" summarizes the losses identified, experienced, and expressed in Phases Two and Four into 3 stratifications: different dimensions of being and interaction. These stratification delineations show how the trauma affected individual, relationship and multiple relationship (usually family) processes. Summary "B" overviews the learning aspects of the resolution process.

Application of TRT Phase Five (A)

Writing

The client uses the form provided by the combat example in this subsection. The purpose of the form is to summarize the patterns of psychological trauma, emphasizing the losses as they occurred over intrapsychic, interactional and systemic stratifications.
This process is fairly simple. Copy from Phases Two and Four the losses, without duplication, into their respective format.

Losses directly resulting from contradictions created by the initial trauma-causing event are placed in three columns at the top half of the form. Losses resulting from contradictions created by survival response are placed in the lower half of the page.

The only judgment, that is, evaluation process, involves the delineation of the losses into the 3 stratifications: intrapsychic (pertaining to individual experience only), interpsychic or interactional (pertaining to a particular relationship) and systemic (pertaining to a combination of relationships, usually referring to a family). An example of how to complete the written component of TRT Phase Five (A) is provided below.

**Example (B5a): Combat Trauma TRT Phase Five (A)**

My combat experience contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of</td>
<td>Losses of</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Trust of others</td>
<td>Love of my country</td>
</tr>
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<td>A meaning to life</td>
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</tr>
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<td></td>
<td>my part within my</td>
</tr>
<tr>
<td>Continuity of</td>
<td></td>
<td>country</td>
</tr>
<tr>
<td>life</td>
<td></td>
<td>My country</td>
</tr>
<tr>
<td>Continuity of</td>
<td></td>
<td>Hope for the Nation</td>
</tr>
<tr>
<td>body functions -</td>
<td></td>
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<tr>
<td>Physical reality</td>
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<tr>
<td>My own and separate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>identity from those</td>
<td></td>
<td></td>
</tr>
<tr>
<td>who were killed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope for myself</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Trust in Myself</td>
<td>Openness</td>
<td>Socialization</td>
</tr>
<tr>
<td>Peace</td>
<td>Trust in my</td>
<td>A wider view of life</td>
</tr>
<tr>
<td>Quiet</td>
<td>perspective of</td>
<td>Confidence in my- self with</td>
</tr>
<tr>
<td>Security</td>
<td>others</td>
<td>others</td>
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<td>fun with others</td>
</tr>
<tr>
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<td>being killed</td>
<td>Relationship with</td>
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<td>The ability to love</td>
<td>with my country</td>
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<tr>
<td>of myself</td>
<td>Trust in any concept of spirituality</td>
<td></td>
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<tr>
<td>Humility</td>
<td>Separateness from the carnage</td>
<td></td>
</tr>
<tr>
<td>Sanity</td>
<td>The abilities to relate, care and be</td>
<td></td>
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</tbody>
</table>

**Reading and Facilitating TRT Phase Five (A)**

When the written component is completed, the client notifies the TRT Counselor accordingly and a specific time is arranged to share the written exercise with group members. The reading process is completed in 20 to 30 minutes. Feedbacking guidelines remain the same; but few interruptions occur.

**Application of TRT Phase Five (B)**

**Writing**
TRT Phase Five (B) is an exercise in creative writing for the group participants, including the person completing Five (B). Each individual, including the exiting participant, is asked to prepare a written description of the person who is the focus of the exercise. At least 24 hours notice is required to provide for this creative endeavor. Most people are accorded 1 to 2 weeks notice before a Phase 5(B) is to occur.

The 5(B) writing has a special purpose; describe the individual who existed before the trauma occurred and who has been with the group throughout the experience. This writing becomes a representation of the writer's view of the ontology of the individual.

To provide this description, many people use poetry, selected prose from creative literature, or even song.

**Reading and Facilitating TRT Phase Five (B)**

No one (group member) misses a TRT Phase Five (B) reading. It is a fun, meaningful, joyous, and culminating event. The group member's decide who reads first. Then they each share their descriptions with the individual. The letters never include confrontational interpretations of personality characteristics. Each person's writing is usually acknowledged by the participant with a hug. When the group members have completed sharing their perceptions of the person, the portrait is provided by that individual. Feedback processes are spontaneous and caring and love for the person lead the day. Everybody loves TRT Phase Five (B).

An example of Five (B) is provided in this section. This is the completion of the combat example. The reader will notice that the name "Ray" has been applied to the character. "Ray" is the name given to the example when it is used for role play purposes in the ETM School.

**Example (B5b): Combat Trauma**

Dear Ray,
I have shared with you much of your experience in Vietnam. I saw you living in hurt and not knowing that it was still happening to you. What I came to realize most about you was that the things you said that you decided that you hated, your country and your God, you truly loved all along. I also discovered that when you tried to stop other people from feeling their hurt by telling them how to protect themselves, you were not only trying to
prevent your own pain from being discovered, but also caring about them. I also know that you have cared about me. So probably the most valuable trait that I have come to love about you is that you do care, not just about yourself, but about the things that you believe in and people with whom you become involved. I want you to know that because you are like you are, you've helped me to re-establish my faith in my own ability to care about others. I am glad that I have known you and I love you.

A group member

Dear Ray,
When you began TRT, you really made it rough on me. But even during that fairly difficult beginning, I felt from you something that made me like you. I liked your strength and your energy. I admired the way that you embraced the things that you believed in, even when your beliefs were interrupting what I and the others were trying to do. I liked the way you also tried to help the men who were hurt in Vietnam. It showed me that even though you were terrified you cared enough about others to risk your life. Another part of your caring was reflected in the way you risked becoming involved with all of us. That willingness of yours to reach out to others is probably what I like most of all about you. I care about you and am extremely appreciative of having been able to know you.

A group member

Dear Ray,
I admire your courage most of all. I think the way you survived by being alone in your pain for so many years, when no one could hear or understand it, is an example of the same kind of strength you displayed in the war in which you fought. I know that you used that strength to fight the feelings of self pity that came from your grief. I realize that you had no choice but to rely upon that strength because no one knew how to share your pain with you. Even though that part of you who provided the ability to survive didn't always help you as you needed, I think the job that it did do was a job well done. I admire you for your strength in being able to resolve something that to me was terrifying and horrible. I also appreciate the caring that you gave to me and the rest of the people in this country.

I love you.
A group member

Dear Ray,
I love you. For me to write this to you is very difficult, because what keeps coming through my fingertips is what I would like to say to the other guys who were there too. I'm sorry you were hurt. I'm not really sad just because the experience of fighting was difficult for you. I'm sad because there was no way for you to have been cared for once you had returned. I'm sad too that you had to rely just upon yourself when you returned and that you had so little strength to draw from. But that brings up one of the strengths that I admire about you. I think that you have lots of courage. The way that you tried to help your buddies even when you thought you might die is one example of that courage. Another is the way that you fought and gave everything that you had to your job when you didn't think you had anymore. I'm also proud of you just because you went to Vietnam. I think the way you tried to survive when you returned was exactly what you needed to do at the time. It wasn't your place to give yourself your own appreciation and respect for what you did. And it wasn't your responsibility to have to defend what you were being asked and told to do. Through your own internal strengths you still did those things anyway.

I admire you because, not only did you have the courage to fight each battle, but you also stood alone and without support for years after you had returned. Most of all what I like about you, is the way that you cared about your country and those things that you thought were most valuable to your people.

I care about you and I love you. Thanks for letting me know you.

A group member and Vietnam veteran

To myself,
What I saw about myself was that before the trauma occurred, I believed in things. I believed that love was important. I thought there was meaning to life and that human beings were valuable. I believed in God, the concept of basic individual human rights, and what we as a group of people were doing.

When I fought I thought that we had said that what we were fighting was the antithesis of those beliefs. I thought as a group we had decided that these
values were being severely threatened and that it was better to defend our way of existence while defense was still possible.

I also loved the children who lived in the village where I stayed. I liked those Vietnamese too who shared my interest in individual freedom. I cared about them because we were all saying that we wanted the same thing. They cared enough about it to risk dying for it and so did I.

Those are the things that I cared about. They were lost, not because of the trauma or its affects upon me, but because when I returned, no one cared. I started losing myself after that, but I kept fighting to see if I could get that me back from somewhere. I remember saying once that I would never again fight to defend this country, its values, or its ideals. I said that even if it meant its destruction and the death of its own citizens on its own soil, that I would never care about the people or this country again, and even if it meant the loss of my own freedom. I remember also that just after saying those things, that I felt as if I had been divided into two people. My saying those things hurt so badly that I immediately knew that I could not continue to live like that. I knew somewhere inside of me that I would care again and that I would do what my country needed me to do, or else I would break apart -- die.

I don't think I have a lot of courage. I mostly think I'm a person who feels strongly about what he believes in. And I like that about myself. I think the way I withdrew and protected myself and all the other things I did after the trauma were now pretty natural and probably what many people would do in the same situation. I appreciate this group and all that it has given to me. So I think maybe I've begun to learn how to love again. So I love all of you. I also think TRT is a miracle, and I appreciate you counselors, for thinking it up and then talking me into getting involved in it.

In that I'm at the end of TRT, I'm going to leave soon; however, I'm going to stay until next month so that I can help Sharon with her 5th Phase. I'm going to start my goodbyes to you now. Thank you again for listening to me and caring about me.

I love you all,

Ray
The descriptions of the TRT Combat examples depicting how to apply TRT Phases One through Five to combat episodes have been provided to the ETM School and to this book, now this web site, in memory of

Raymond C. Nora; USMC Private First Class
Killed in Action; Vietnam; May 18, 1968
and
William J. Goodsell; Major USMC
Killed in Action; Vietnam; June 16, 1966

Concluding TRT

At the end of TRT, clients will look back on the resolution process and report learning, that is, they will report that they know and understand:

1. Who they were before the traumas occurred.
2. Exactly what happened to them because of the events.
3. The difference between what they had to do to survive and who they were/are (as people).
4. Who they are now that the traumas have been resolved.

These learning experiences then provide the basic criteria for determining if resolution has occurred.

About ETM/ Theory/ Measuring Trauma Resolution presents specific guidelines for making this determination. The person exits TRT for this source of trauma. If another source of trauma exists, the patient will likely discontinue therapy for a while, months or even a year or two; the client will, as a rule, then elect to apply TRT to the other source of trauma.

TRT Phase Five A (No Phase B) Examples

TRT Phase Five Example:
Battered Spouse - Codependency Trauma

TRT Phase Five (A)
The codependency and battering experiences contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of</td>
<td>Losses of</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Trust in my husband</td>
<td>Husband as a father</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Respect for my husband</td>
<td>and protector of the family,</td>
</tr>
<tr>
<td>Self-respect</td>
<td>Role model for a husband and being loved</td>
<td>children and me</td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td>Family pride</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The experience of being human</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our automobiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My sexual attractiveness and I almost lost my life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survival responses that contradicted my values and beliefs resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of Reality</td>
<td>Losses of Companionship</td>
<td>Losses of Pride and myself as</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Socialization</td>
<td>a role model -- wife and mother</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Marriage</td>
<td></td>
</tr>
<tr>
<td>Being in touch</td>
<td>My children</td>
<td>Motherhood</td>
</tr>
<tr>
<td>with the truth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My understanding of love and caring</td>
<td></td>
<td>Closeness to anyone</td>
</tr>
<tr>
<td>Control over my and my children's lives</td>
<td></td>
<td>Understanding of me to other people</td>
</tr>
<tr>
<td>Separateness from my</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TRT Phase Five Example: Violent Crime Trauma

Violent Crime Trauma TRT Phase Five (A)

The assault / rape of me and murder of husband contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of Self-esteem</td>
<td>Losses of My husband</td>
<td>Losses of My husband</td>
</tr>
<tr>
<td>Self-worth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my person was inviolable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ability to breathe and think clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my life would continue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of female value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanctity and privacy of my body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Survival responses that contradicted my values and beliefs resulted in:

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<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of Socialization</td>
<td>Losses of Myself as a wife</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Socialization</td>
<td></td>
</tr>
<tr>
<td>Self-worth</td>
<td>Friendships</td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td>Trust in myself</td>
<td></td>
</tr>
<tr>
<td>Human dignity</td>
<td>Companionship</td>
<td></td>
</tr>
<tr>
<td>My will</td>
<td>The ability to be</td>
<td></td>
</tr>
<tr>
<td>The belief that I was</td>
<td>honest with my husband</td>
<td></td>
</tr>
<tr>
<td>something special</td>
<td>A wider view of</td>
<td></td>
</tr>
<tr>
<td>My sanity</td>
<td>myself</td>
<td></td>
</tr>
<tr>
<td>Reality</td>
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<td></td>
</tr>
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<td>Freedom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An accurate perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of who I used to be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of my life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Chapter 5 Section (q):
How To Facilitate TRT Phases One Through Five

TRT Phase Five

This chapter:

5. Gives directions for applying Phase Five.
6. Demonstrates Phase Five's application.
7. Reports observations of effects of Phase Five on client progress.
8. Summarizes the full 5 phase TRT process.

Introduction: TRT Phase Five

Phases 1 thru 4 resolve the trauma resulting from a particular source. Phase Five summarizes the resolution experience and provides for the therapeutic exit.

TRT Phase Five: Application

Two summaries, "A" and "B," comprise Phase Five. "A" summarizes the losses identified, experienced, and expressed in Phases Two and Four into 3 stratifications: different dimensions of being and interaction. These stratification delineations show how the trauma affected individual, relationship and multiple relationship (usually family) processes. Summary "B" overviews the learning aspects of the resolution process.

Application of TRT Phase Five (A)

Writing

The client uses the form provided by the combat example in this subsection. The purpose of the form is to summarize the patterns of psychological trauma, emphasizing the losses as they occurred over intrapsychic, interactional and systemic stratifications.
This process is fairly simple. Copy from Phases Two and Four the losses, without duplication, into their respective format.

Losses directly resulting from contradictions created by the initial trauma-causing event are placed in three columns at the top half of the form. Losses resulting from contradictions created by survival response are placed in the lower half of the page.

The only judgment, that is, evaluation process, involves the delineation of the losses into the 3 stratifications: intrapsychic (pertaining to individual experience only), interpsychic or interactional (pertaining to a particular relationship) and systemic (pertaining to a combination of relationships, usually referring to a family). An example of how to complete the written component of TRT Phase Five (A) is provided below.

**Example (B5a): Combat Trauma TRT Phase Five (A)**

My combat experience contradicted my personal values and beliefs and resulted in:

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<td>my part within my</td>
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<tr>
<td>Continuity of life</td>
<td></td>
<td>country</td>
</tr>
<tr>
<td>Continuity of body functions - Physical reality</td>
<td></td>
<td>My country</td>
</tr>
<tr>
<td>My own and separate identity from those who were killed</td>
<td></td>
<td>Hope for the Nation</td>
</tr>
<tr>
<td>Hope for myself</td>
<td></td>
<td></td>
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</tbody>
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2-a-215
Survival responses that contradicted my values and beliefs resulted in:

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<td>Quiet</td>
<td>others</td>
<td>Confidence in my- self with</td>
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<td>The ability to have</td>
</tr>
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<td>Self-worth</td>
<td>free from fear of</td>
<td>fun with others</td>
</tr>
<tr>
<td>Myself</td>
<td>being killed</td>
<td>Relationship with</td>
</tr>
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<td>An understanding</td>
<td>Companionship</td>
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<td>of my limits and</td>
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</tr>
<tr>
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<td>of spirituality</td>
<td></td>
</tr>
<tr>
<td>of myself</td>
<td>Separateness from</td>
<td></td>
</tr>
<tr>
<td>Humility</td>
<td>the carnage</td>
<td></td>
</tr>
<tr>
<td>Sanity</td>
<td>The abilities to</td>
<td></td>
</tr>
<tr>
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<tr>
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<td>care and be</td>
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To provide this description, many people use poetry, selected prose from creative literature, or even song.

**Reading and Facilitating TRT Phase Five (B)**

No one (group member) misses a TRT Phase Five (B) reading. It is a fun, meaningful, joyous, and culminating event. The group member's decide who reads first. Then they each share their descriptions with the individual. The letters never include confrontational interpretations of personality characteristics. Each person's writing is usually acknowledged by the participant with a hug. When the group members have completed sharing their perceptions of the person, the portrait is provided by that individual. Feedback processes are spontaneous and caring and love for the person lead the day. Everybody loves TRT Phase Five (B).

An example of Five (B) is provided in this section. This is the completion of the combat example. The reader will notice that the name "Ray" has been applied to the character. "Ray" is the name given to the example when it is used for role play purposes in the ETM School.

**Example (B5b): Combat Trauma**

Dear Ray,

I have shared with you much of your experience in Vietnam. I saw you living in hurt and not knowing that it was still happening to you. What I came to realize most about you was that the things you said that you decided that you hated, your country and your God, you truly loved all along. I also discovered that when you tried to stop other people from feeling their hurt by telling them how to protect themselves, you were not only trying to
prevent your own pain from being discovered, but also caring about them. I also know that you have cared about me. So probably the most valuable trait that I have come to love about you is that you do care, not just about yourself, but about the things that you believe in and people with whom you become involved. I want you to know that because you are like you are, you've helped me to re-establish my faith in my own ability to care about others. I am glad that I have known you and I love you.

A group member

Dear Ray,
When you began TRT, you really made it rough on me. But even during that fairly difficult beginning, I felt from you something that made me like you. I liked your strength and your energy. I admired the way that you embraced the things that you believed in, even when your beliefs were interrupting what I and the others were trying to do. I liked the way you also tried to help the men who were hurt in Vietnam. It showed me that even though you were terrified you cared enough about others to risk your life. Another part of your caring was reflected in the way you risked becoming involved with all of us. That willingness of yours to reach out to others is probably what I like most of all about you. I care about you and am extremely appreciative of having been able to know you.

A group member

Dear Ray,
I admire your courage most of all. I think the way you survived by being alone in your pain for so many years, when no one could hear or understand it, is an example of the same kind of strength you displayed in the war in which you fought. I know that you used that strength to fight the feelings of self pity that came from your grief. I realize that you had no choice but to rely upon that strength because no one knew how to share your pain with you. Even though that part of you who provided the ability to survive didn't always help you as you needed, I think the job that it did do was a job well done. I admire you for your strength in being able to resolve something that to me was terrifying and horrible. I also appreciate the caring that you gave to me and the rest of the people in this country.

I love you.
A group member

Dear Ray,
I love you. For me to write this to you is very difficult, because what keeps coming through my fingertips is what I would like to say to the other guys who were there too. I'm sorry you were hurt. I'm not really sad just because the experience of fighting was difficult for you. I'm sad because there was no way for you to have been cared for once you had returned. I'm sad too that you had to rely just upon yourself when you returned and that you had so little strength to draw from. But that brings up one of the strengths that I admire about you. I think that you have lots of courage. The way that you tried to help your buddies even when you thought you might die is one example of that courage. Another is the way that you fought and gave everything that you had to your job when you didn't think you had anymore. I'm also proud of you just because you went to Vietnam. I think the way you tried to survive when you returned was exactly what you needed to do at the time. It wasn't your place to give yourself your own appreciation and respect for what you did. And it wasn't your responsibility to have to defend what you were being asked and told to do. Through your own internal strengths you still did those things anyway.

I admire you because, not only did you have the courage to fight each battle, but you also stood alone and without support for years after you had returned. Most of all what I like about you, is the way that you cared about your country and those things that you thought were most valuable to your people.

I care about you and I love you. Thanks for letting me know you.

A group member and Vietnam veteran

To myself,
What I saw about myself was that before the trauma occurred, I believed in things. I believed that love was important. I thought there was meaning to life and that human beings were valuable. I believed in God, the concept of basic individual human rights, and what we as a group of people were doing.

When I fought I thought that we had said that what we were fighting was the antithesis of those beliefs. I thought as a group we had decided that these
values were being severely threatened and that it was better to defend our way of existence while defense was still possible.

I also loved the children who lived in the village where I stayed. I liked those Vietnamese too who shared my interest in individual freedom. I cared about them because we were all saying that we wanted the same thing. They cared enough about it to risk dying for it and so did I.

Those are the things that I cared about. They were lost, not because of the trauma or its affects upon me, but because when I returned, no one cared. I started losing myself after that, but I kept fighting to see if I could get that me back from somewhere. I remember saying once that I would never again fight to defend this country, its values, or its ideals. I said that even if it meant its destruction and the death of its own citizens on its own soil, that I would never care about the people or this country again, and even if it meant the loss of my own freedom. I remember also that just after saying those things, that I felt as if I had been divided into two people. My saying those things hurt so badly that I immediately knew that I could not continue to live like that. I knew somewhere inside of me that I would care again and that I would do what my country needed me to do, or else I would break apart -- die.

I don't think I have a lot of courage. I mostly think I'm a person who feels strongly about what he believes in. And I like that about myself. I think the way I withdrew and protected myself and all the other things I did after the trauma were now pretty natural and probably what many people would do in the same situation. I appreciate this group and all that it has given to me. So I think maybe I've begun to learn how to love again. So I love all of you. I also think TRT is a miracle, and I appreciate you counselors, for thinking it up and then talking me into getting involved in it.

In that I'm at the end of TRT, I'm going to leave soon; however, I'm going to stay until next month so that I can help Sharon with her 5th Phase. I'm going to start my goodbyes to you now. Thank you again for listening to me and caring about me.

I love you all,

Ray
The descriptions of the TRT Combat examples depicting how to apply TRT Phases One through Five to combat episodes have been provided to the ETM School and to this book, now this web site, in memory of

Raymond C. Nora; USMC Private First Class  
Killed in Action; Vietnam; May 18, 1968  
and

William J. Goodsell; Major USMC  
Killed in Action; Vietnam; June 16, 1966

**Concluding TRT**

At the end of TRT, clients will look back on the resolution process and report learning, that is, they will report that they know and understand:

5. Who they were before the traumas occurred.
6. Exactly what happened to them because of the events.
7. The difference between what they had to do to survive and who they were/are (as people).
8. Who they are now that the traumas have been resolved.

These learning experiences then provide the basic criteria for determining if resolution has occurred.

About ETM/ Theory/ **Measuring Trauma Resolution** presents specific guidelines for making this determination. The person exits TRT for this source of trauma. If another source of trauma exists, the patient will likely discontinue therapy for a while, months or even a year or two; the client will, as a rule, then elect to apply TRT to the other source of trauma.

**TRT Phase Five A (No Phase B) Examples**

**TRT Phase Five Example:**  
Battered Spouse - Codependency Trauma

**TRT Phase Five (A)**
The codependency and battering experiences contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual Losses of</th>
<th>Relationship Losses of</th>
<th>Family Losses of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>Trust in my husband</td>
<td>Husband as a father</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Respect for my husband</td>
<td>and protector of the family,</td>
</tr>
<tr>
<td>Self-respect</td>
<td>Role model for a husband</td>
<td>children and me</td>
</tr>
<tr>
<td>Security</td>
<td>and being loved</td>
<td>Family pride</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Love</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of being human</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our automobiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My sexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attractiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and I almost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lost my life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survival responses that contradicted my values and beliefs resulted in:

<table>
<thead>
<tr>
<th>Individual Losses of</th>
<th>Relationship Losses of</th>
<th>Family Losses of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reality</td>
<td>Companionship</td>
<td>Pride and myself as</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Socialization</td>
<td>a role model --</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Marriage</td>
<td>wife and mother</td>
</tr>
<tr>
<td>Being in touch</td>
<td>My children</td>
<td></td>
</tr>
<tr>
<td>with the truth</td>
<td>Motherhood</td>
<td></td>
</tr>
<tr>
<td>My understanding</td>
<td>Closeness to anyone</td>
<td></td>
</tr>
<tr>
<td>of love and caring</td>
<td>Understanding of me</td>
<td></td>
</tr>
<tr>
<td>Control over my</td>
<td>to other people</td>
<td></td>
</tr>
<tr>
<td>and my children's</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separateness from my</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
husband
Separateness from
myself
Sexuality
Femininity
Identity as a
human being
Me

TRT Phase Five Example:
Violent Crime Trauma

Violent Crime Trauma TRT Phase Five (A)

The assault / rape of me and murder of husband contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of</td>
<td>Losses of</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>My husband</td>
<td>My husband</td>
</tr>
<tr>
<td>Self-worth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my person was inviolable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ability to breathe and think clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my life would continue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of female value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanctity and privacy of my body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Survival responses that contradicted my values and beliefs resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of Self-esteem</td>
<td>Losses of Socialization</td>
<td>Losses of Myself as a wife</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Friendships</td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td>Trust in myself</td>
<td></td>
</tr>
<tr>
<td>Human dignity</td>
<td>Companionship</td>
<td></td>
</tr>
<tr>
<td>My will</td>
<td>The ability to be</td>
<td></td>
</tr>
<tr>
<td>The belief that I was unique or something special</td>
<td>honest with my husband</td>
<td></td>
</tr>
<tr>
<td>My sanity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reality</td>
<td>A wider view of myself</td>
<td></td>
</tr>
<tr>
<td>Freedom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An accurate perspective of who I used to be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of my life</td>
<td></td>
<td></td>
</tr>
</tbody>
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TRT Phase Five Example:
Battered Spouse - Codependency Trauma

TRT Phase Five (A)

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<tr>
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<td>Role model for a husband</td>
<td>children and me</td>
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<tr>
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<td>and being loved</td>
<td>Family pride</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
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Survival responses that contradicted my values and beliefs resulted in:

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<th>Relationship Losses of</th>
<th>Family Losses of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reality</td>
<td>Companionship</td>
<td>Pride and myself as</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Socialization</td>
<td>a role model –</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Marriage</td>
<td>wife and mother</td>
</tr>
<tr>
<td>Being in touch</td>
<td>My children</td>
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<td>with the truth</td>
<td>Motherhood</td>
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<td>My understanding</td>
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<tr>
<td>of love and caring</td>
<td>Understanding of me</td>
<td></td>
</tr>
<tr>
<td>Control over my</td>
<td>to other people</td>
<td></td>
</tr>
<tr>
<td>and my children's</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separateness from my</td>
<td></td>
<td></td>
</tr>
<tr>
<td>husband</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separateness from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexuality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femininity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identity as a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>human being</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
An example of TRT Phase 5(B) is provided for combat trauma under the named example heading (click on the "Combat" button when you return to the main window).
Example (B5a): Combat Trauma TRT Phase Five (A)

My combat experience contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of</td>
<td>Losses of</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Trust of others</td>
<td>Love of my country</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Respect of friends</td>
<td>The Nation</td>
</tr>
<tr>
<td>Self-respect</td>
<td>Belief in God</td>
<td>my country as a role model</td>
</tr>
<tr>
<td>A meaning to life</td>
<td>Trust in God</td>
<td>Understanding of</td>
</tr>
<tr>
<td>Security</td>
<td>Love of God</td>
<td>my part within my country</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td>My country</td>
</tr>
<tr>
<td>Continuity of life</td>
<td></td>
<td>Hope for the Nation.</td>
</tr>
<tr>
<td>Continuity of body functions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical reality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My own and separate identity from those who were killed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope for myself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survival responses that contradicted my values and beliefs resulted in:

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losses of</td>
<td>Losses of</td>
<td>Losses of</td>
</tr>
<tr>
<td>Trust in Myself</td>
<td>Openness</td>
<td>Socialization</td>
</tr>
<tr>
<td>Peace</td>
<td>Trust in my</td>
<td>A wider view of life</td>
</tr>
<tr>
<td>Quiet</td>
<td>perspective of others</td>
<td>Confidence in my-self with others</td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td>The ability to have</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Freedom to live</td>
<td>fun with others</td>
</tr>
<tr>
<td>Self-worth</td>
<td>free from fear of</td>
<td>Relationship with</td>
</tr>
<tr>
<td>Myself</td>
<td>being killed</td>
<td>my wife and the other family</td>
</tr>
<tr>
<td>An understanding of my limits and capacity to achieve certain goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A realistic image of myself</td>
<td>The ability to love</td>
<td></td>
</tr>
<tr>
<td>Humility</td>
<td></td>
<td>members</td>
</tr>
<tr>
<td>Sanity</td>
<td>Separateness from the carnage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>My relationship with my country</td>
</tr>
</tbody>
</table>

2-a-227
Example (B5b): Combat Trauma

Dear Ray,

I have shared with you much of your experience in Vietnam. I saw you living in hurt and not knowing that it was still happening to you. What I came to realize most about you was that the things you said that you decided that you hated, your country and your God, you truly loved all along. I also discovered that when you tried to stop other people from feeling their hurt by telling them how to protect themselves, you were not only trying to prevent your own pain from being discovered, but also caring about them. I also know that you have cared about me. So probably the most valuable trait that I have come to love about you is that you do care, not just about yourself, but about the things that you believe in and people with whom you become involved. I want you to know that because you are like you are, you've helped me to re-establish my faith in my own ability to care about others. I am glad that I have known you and I love you.

A group member

Dear Ray,

When you began TRT, you really made it rough on me. But even during that fairly difficult beginning, I felt from you something that made me like you. I liked your strength and your energy. I admired the way that you embraced the things that you believed in, even when your beliefs were interrupting what I and the others were trying to do. I liked the way you also tried to help the men who were hurt in Vietnam. It showed me that even though you were terrified you cared enough about others to risk your life. Another part of your caring was reflected in the way you risked becoming involved with all of us. That willingness of yours to reach out to others is probably what I like most of all about you. I care about you and am extremely appreciative of having been able to know you.

A group member

Dear Ray,

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I love you.

A group member
Dear Ray,
I love you. For me to write this to you is very difficult, because what keeps coming through my fingertips is what I would like to say to the other guys who were there too. I'm sorry you were hurt. I'm not really sad just because the experience of fighting was difficult for you. I'm sad because there was no way for you to have been cared for once you had returned. I'm sad too that you had to rely just upon yourself when you returned and that you had so little strength to draw from. But that brings up one of the strengths that I admire about you. I think that you have lots of courage. The way that you tried to help your buddies even when you thought you might die is one example of that courage. Another is the way that you fought and gave everything that you had to your job when you didn't think you had anymore. I'm also proud of you just because you went to Vietnam. I think the way you tried to survive when you returned was exactly what you needed to do at the time. It wasn't your place to give yourself your own appreciation and respect for what you did. And it wasn't your responsibility to have to defend what you were being asked and told to do. Through your own internal strengths you still did those things anyway.

I admire you because, not only did you have the courage to fight each battle, but you also stood alone and without support for years after you had returned. Most of all what I like about you, is the way that you cared about your country and those things that you thought were most valuable to your people.

I care about you and I love you. Thanks for letting me know you.

A group member and Vietnam veteran

To myself,
What I saw about myself was that before the trauma occurred, I believed in things. I believed that love was important. I thought there was meaning to life and that human beings were valuable. I believed in God, the concept of basic individual human rights, and what we as a group of people were doing.

When I fought I thought that we had said that what we were fighting was the antithesis of those beliefs. I thought as a group we had decided that these values were being severely threatened and that it was better to defend our way of existence while defense was still possible.

I also loved the children who lived in the village where I stayed. I liked those Vietnamese too who shared my interest in individual freedom. I cared about them because we were all saying that we wanted the same thing. They cared enough about it to risk dying for it and so did I.

Those are the things that I cared about. They were lost, not because of the trauma or its affects upon me, but because when I returned, no one cared. I started losing myself after that, but I kept fighting to see if I could get that me back from somewhere. I remember saying once that I would never again fight to defend this country, its values, or its ideals.
I said that even if it meant its destruction and the death of its own citizens on its own soil, that I would never care about the people or this country again, and even if it meant the loss of my own freedom. I remember also that just after saying those things, that I felt as if I had been divided into two people. My saying those things hurt so badly that I immediately knew that I could not continue to live like that. I knew somewhere inside of me that I would care again and that I would do what my country needed me to do, or else I would break apart -- die.

I don't think I have a lot of courage. I mostly think I'm a person who feels strongly about what he believes in. And I like that about myself. I think the way I withdrew and protected myself and all the other things I did after the trauma were now pretty natural and probably what many people would do in the same situation. I appreciate this group and all that it has given to me. So I think maybe I've begun to learn how to love again. So I love all of you. I also think TRT is a miracle, and I appreciate you counselors, for thinking it up and then talking me into getting involved in it.

In that I'm at the end of TRT, I'm going to leave soon; however, I'm going to stay until next month so that I can help Sharon with her 5th Phase. I'm going to start my goodbyes to you now. Thank you again for listening to me and caring about me.

I love you all,

Ray

The descriptions of the TRT Combat examples depicting how to apply TRT Phases One through Five to combat episodes have been provided to the ETM School and to this book, now this web site, in memory of

Raymond C. Nora; USMC Private First Class
Killed in Action; Vietnam; May 18, 1968
and
William J. Goodsell; Major USMC
Killed in Action; Vietnam; June 16, 1966

Concluding TRT

At the end of TRT, clients will look back on the resolution process and report learning, that is, they will report that they know and understand:

1. Who they were before the traumas occurred.
2. Exactly what happened to them because of the events.
3. The difference between what they had to do to survive and who they were/are (as people).
4. Who they are now that the traumas have been resolved.
These learning experiences then provide the basic criteria for determining if resolution has occurred.

About ETM/ Theory/ Measuring Trauma Resolution presents specific guidelines for making this determination. The person exits TRT for this source of trauma. If another source of trauma exists, the patient will likely discontinue therapy for a while, months or even a year or two; the client will, as a rule, then elect to apply TRT to the other source of trauma.
Example (B5a): Violent Crime Trauma TRT Phase Five (A)

The assault/rape of me and murder of husband contradicted my personal values and beliefs and resulted in:

<table>
<thead>
<tr>
<th>Individual Losses of</th>
<th>Relationship Losses of</th>
<th>Family Losses of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>My husband</td>
<td>My husband</td>
</tr>
<tr>
<td>Self-worth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my person was inviolable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ability to breathe and think clearly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The belief that my life would continue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sense of female value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sanctity and privacy of my body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Survival responses that contradicted my values and beliefs resulted in:

<table>
<thead>
<tr>
<th>Individual Losses of</th>
<th>Relationship Losses of</th>
<th>Family Losses of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>Socialization</td>
<td>Myself as a wife</td>
</tr>
<tr>
<td>Self-worth</td>
<td>Friendships</td>
<td></td>
</tr>
<tr>
<td>Self-respect</td>
<td>Trust in myself</td>
<td></td>
</tr>
<tr>
<td>Human dignity</td>
<td>Companionship</td>
<td></td>
</tr>
<tr>
<td>My will</td>
<td>The ability to be</td>
<td></td>
</tr>
<tr>
<td>The belief that I was unique or something special</td>
<td>honest with my husband</td>
<td></td>
</tr>
<tr>
<td>My sanity</td>
<td>A wider view of</td>
<td></td>
</tr>
<tr>
<td>Reality</td>
<td>myself</td>
<td></td>
</tr>
<tr>
<td>Freedom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>An accurate perspective of who</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I used to be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control of my life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An example of TRT Phase 5(B) is provided for combat trauma under the named example heading (click on the "Combat" button when you return to the main window).
Chapter 6 Section (a):

TRT Facilitation and Feedback Guidelines

(For Reversal of Near-term Trauma Etiology referenced below as “Steps A – F,” see Chapter Eight)

Introduction

ETM Facilitation Guidelines for reversal of near-term trauma etiology are similar to those used for reversing long-term trauma via the structured psycho dynamic model "Trauma Resolution Therapy." Incorporate these guidelines into the process through which you facilitate steps A-F (again, see Chapter 8, Lesson 2) used for reversing near-term trauma.

Noting the use and importance of this structured approach, unlike unstructured psycho dynamic models such as grief resolution and Client Centered Therapies, the ETM etiology reversal process invites a trauma affected individual to lessen the use of thought paradigms that defend the etiology. Because of this invitation, which comes in the form of steps A-F, the interactive responses by facilitators or group members are necessarily guided through a similar lessening of the use of defenses against their experiences of the trauma-imposed etiology. If these guidelines were not used, then it is most likely that the defended group member or facilitator responses will not lessen at the same pace as that enjoyed by the person proceeding through steps A-F, and such an imbalance would prevent the etiology's reversal and likely hurt the trauma victim further.

If facilitating etiology reversal with group process, use patient educational materials to explain the purpose of the structured psychodynamic approach. Its use by following the facilitation / response guidelines provided below (and reframed for lay understandings in the patient education materials) is a condition of participation in the clinical process. If the materials are not available, then summarize these methods and controls for group members before they enter the process, eliciting their agreement to comply with the procedures for the purpose of expediting the reversal process for all participating trauma-affected individuals.
Parallel ETM Facilitation Guidelines

(1) Caring and the use of the ETM structure
The most important element of the ETM (etiology reversal) procedure is caring; the ETM structure is the second most important element. A balance between these variables results in the use of the structure to assist you, the client, and any group participants to focus otherwise natural caring capacities upon the crux of the trauma's damage to identity. Do not allow this balance to be altered so that implementation of the structure supersedes the application of caring for the client progressing through the etiology reversal process. (more refers to additional information provided in the glossary at the end of this chapter)

(2) Empathize first; identify second
Use empathy, as opposed to identification, during application of steps A-F. Do not respond with identification until after the steps have been completed. (more)

(3) When reflecting (or eliciting) feelings, ensure that they do not become opinions
Feelings are often difficult to identify because they are covered over or otherwise diverted from identification by opinion. It tends to mask as feeling through expressions such as "feel like" and "feel that." Drop the "like" and "that" and reflect what remains in simple language. Feelings are usually identified, experienced and expressed as "shock," "fear" (terror), "horror," "anger," "sadness," etc.

(4) Once initiated (steps A-F), preclude etiology reversal interruption by nosotropic-based coping (symptom focused) modalities and philosophies. They usually include:

- stoicism (more)
- cognitive-behavioral, including positive thinking and other Rational Emotive Therapies (RET), styled methods (more)
- psychotherapy (more)
- projection; (in this example) presumptions that guesses and theories are reality (more)
- advice-giving (including that necessary for self-protection) (more)
- any application that switches the reversal focus to the memory of another (historic) traumatic event (more)
Pre-etiology reversal client education that explains the etiology reversal goal and ETM method for achieving it is the best means of preventing interruptions. A well trained (in ETM language) facilitator is the second best defense against interruptions.

(5) Follow a pace for etiology reversal that meets the client's needs
   Use the integration procedures (next in #6) to facilitate especially difficult to describe episodes (more)

(6) Integrate the client (with yourself and the group) before, and if necessary, during, and then after the reversal process.
   Apply the following ETM client integration procedures more or less assiduously depending on the delineation of the etiology as, respectively, a consequence of "directly" ("first direct"), second direct, or indirectly affected by the event.

Moreover, the heinousness and physical trauma associated with an event will also determine the need for application of the following client ETM integration procedures a - e.

- share/reflect feeling (more)
- give perceptual feedback (more)
- direct client acknowledgement of group or facilitator response (more)
- during responses, ensure that eye contact is made between client and responders (more)
- touch the client on the arm or shoulder at extraordinarily painful (cathartic) times, but with noted restrictions (more)

**ETM Glossary: ETM Language / Meanings**
*(and some ETM Theory/Philosophy)*

Caring
   In this (ETM) usage, caring means to lend One's Self to, including the temporary conscious merging/sharing of your identity with, the trauma victim during his or her identification and reconciliation of the traumatic event's effects upon the assaulted identity.

Structure
ETM "structure" is comprised of all of the etiology reversal protocols for both short and long term trauma, to include the Parallel ETM Facilitation Guidelines. The protocols and guidelines provide the crux of the mechanism that facilitates identity merger (and subsequent separation) to the degree required to reverse the trauma etiology.

If the structure is properly administered, it will automatically facilitate all identities to work together to complete reversal of the trauma etiology and then to return to normal (non clinical) functionings; that is, the identities will automatically separate after the procedure is completed.

Caution! When the facilitator's attempts to follow the structure are administered to the degree that the focus on structure is emphasized to the extent that caring is minimized, the etiology reversal process will become bureaucratic, and in the process lose its value; the etiology will not be reversed. The first 3 days of ETM training provide the professional experience/skills with which to use the structure to focus caring where it is most needed, and without concern for the prospective bureaucratic effect.

Empathy

Empathy is the process through which one feels, shares, or otherwise understands another's experience. When empathizing during etiology reversal, the responder reflects those feelings and other experiences to the person providing the original description; the focus of the sharing/feeling remains upon the first person's passage through reconciliation of his or her experience of the traumatic event causing the damage being addressed.

Identification

Identification is the method through which the sharing of one event initiates recollections of the listener's past traumatic experiences; they, then, are recounted as the primary response to the description of that original traumatic event.

Identification has value in that it lets a trauma victim know that he or she is not the only person to have been affected by trauma, and that because of the listener's (identifier's) past experiences, then that person may have some special capacity with which to understand the originally affected person's trauma and its effects.

Empathy or Identification; a matter of timing
Applying empathy to the wound (trauma etiology) during the reversal process facilitates it: identification of contradictions to existential identity, identification, experience and expression of related emotions, and reconciliation of loss resulting from the contradictions. The focus remains on the person reversing the etiology. Empathy works akin to a sponge absorbing the deepest elements of damage as it is identified, experienced and expressed. Although identification can have positive results, say, either before or following the administration of steps A-F, the application of the identification method during the etiology reversal process will shift the focus of the clinical experience to the listener's trauma and away from the first person's reversal efforts, and at precisely the wrong time: while the person needs empathy from those listening to, sharing, and otherwise participating in the reversal effort.

Do not use the identification method during application of steps A-F of the etiology reversal process!

Prevent etiology reversal interruption by nosotropic-based thought / methodological paradigms

Nosotropic

Meaning symptom (and in the case of psychological trauma to infer thought/behavioral), as opposed to etiology (that is, causal), focused.

Stoicism

Stoicism provides a primary survival psychological and sometimes believed to be instinctive response to trauma. It is necessary to be very strong at various times while responding to a traumatic event. And that being strong can include suppression and eventually even repression of emotional responses to the trauma; they can incapacitate an individual who is otherwise required to take protective action.

During the etiology reversal process, different strengths are required, and they are augmented with others. That is, identifying the specifics of an event's damage requires some fortitude. Contradictions to identity almost always evoke the experience of incapacitation - the condition of which the conscious Stoic is most afraid: if it surrenders to the emotional processing that accompanies etiology reversal, there may be no defenses remaining with which to protect one's Self.
The caring and structure used by ETM facilitate a gradual lowering of the requirement of the be-strong thought paradigm, stoicism, but only while the person is participating in the safe (ETM clinical) environment. The use of stoicism outside of that environment may still be necessary. Moreover, once the etiology is reversed, the client will usually find that capacity for strength with which to face the realities of the life consequences of the event has been substantially increased.

Consequently, through pre- etiology reversal client education, facilitate the disuse of that application of stoicism that precludes the direct address of emotions, but only while steps A-F are being administered. Thereafter, clients will retain a different, and considerably broader, definition of strength, and become more facile and otherwise adept at employing most effectively (outside the clinical environment) stoicism philosophy and methodology. Cognitive-behavioral, including positive thinking and other Rational Emotive Therapy (RET) oriented/styled methods

Meaning methods that provide cognitive interpretation of trauma's thought/behavioral responses to their etiology, and then, in the uses of positive thinking or RET, teach the affected person how to rethink or adopt other views that frame the traumatic event and its consequences into a more favorable perspective.

For example, the death of a student's friend during an automobile accident which involved the surviving student might be reframed with positive thought to focus that student's perceptions primarily on the more favorable concept and fact that the student did not die as did his or her friend. Additional philosophies, sometimes couched in the forms of sayings or slogans, then support the more favorable view; a few examples might include "Life is for the living"; "We have to go on"; "there is a reason for the tragedy" (the other's death and not the survivor's), etc.

When the positive adaptations become established as primary thought/defensive paradigm, they present a serious obstacle to etiology reversal if they are used during the application of steps A-F. That use must be set aside until the reversal application has been completed.

Because these trauma adaptations are very popular, that is, well ensconced
within sociocultural norms/mores, and the adaptations serve a constructive purpose of restoring an ongoing attitude about the process of life, they must be addressed equally with deference and straightforwardness. In that regard, acknowledge the positive thinking methods' value, usually before the etiology reversal process has begun, and explain through patient education that they will, however, interfere with etiology reversal if used during its administration. Certainly, never tell trauma victims how to think, positive or otherwise, especially while they are engaged in the etiology reversal process.

ETM theory: stop the use of the adaptations during the reversal application and the etiology's reversal will not only end the trauma's symptoms, but also the need for the adaptations.

ETM philosophy: taking positive action, like assisting a trauma victim to reverse the trauma's etiology, is a more valuable response to trauma than telling trauma-affected people how to think. Reverse the etiology, and they will do their own thinking, forming attitudes that are conducive to their identities.

Psychotherapy

Having broad and many interpretations; but in this context, referring to the use of clinical interaction to discover the meaning of the trauma to client, and primarily for the purpose of reducing post traumatic symptoms.

Where psychotherapy's approach to the trauma's meaning can be generalized, complex and require extensive time, ETM's etiology reversal procedure is specific about the etiology's locus and its remedy; simplicity is the norm and time requirements are miniscule when compared to that demanded by psychotherapy. ETM is not psychotherapy.

Moreover, non-structured psychodynamic-based psychotherapies are shown in the literature to become overwhelmed by information overload when attempting to ascertain the meaning of the trauma: discover the trauma's damage to the internal functionings of the psyche. Because of the "information overload" (Scrignar, 1988), trauma victims may be prevented from achieving the goals of the clinical process.

ETM's structure on the other hand, whether applied to near- or long-term trauma resolution (etiology reversal), is reported to assimilate the otherwise
thought to be unmanageable amount of information related to intrapsychic
damage, allowing the client to achieve the goal: etiology reversal.

The differences between the structured ETM and psychotherapy models and
the need, purposes and value of distinction are thoroughly addressed in
the ETM Training School and in the associated literature; the differences' address are assumed to present too great an issue for further discourse by this review.

Summarizing, psychotherapy's goals and methods are sufficiently different
to, if used in conjunction with ETM steps A-F, alter the outcome expected
from the ETM etiology reversal application. Save psychotherapy for another
clinical setting. Do not mix it with steps A-F!

Projection
In this usage, meaning to see One's own Self, needs, or interests in
another.

If the people surrounding a trauma victim project onto that person their
needs, interests, or their own identities, the trauma-affected person will not
be able to identify his or her own values, beliefs, images, and realities
contradicted by the event. Etiology reversal will not occur.

Projections can occur through the uses of guesswork about and the
application of theory of an individual's thoughts and feelings.

Although this modality has recently enjoyed much popularity, don't do it or
allow it when applying ETM's etiology reversal procedures (steps A-F).

Advice-giving
Meaning to tell clients how to think or act in their best interests, what
to do to protect themselves from further harm, or how to proceed
through their experience of a tragedy.

Clearly, the referenced advice is not only at times necessary, but a
responsibility of the clinician; he or she must inform the client of
prospectively dangerous situations and high risk behaviors. During the
etiology's reversal, however, such advice will alter the reversal process and
prospectively end all together the client's opportunity to reconcile the event's contradictions to identity.
Moreover, some people who are proceeding with the client through the reversal experience may attempt to block that experience, especially when it becomes very painful, by telling the client what to think or do. And some people just do not know what else to do when called upon to help, other than to give advice.

Only give needed advice, protective or otherwise, before or after application of steps A-F.

Models that switch (or allow the changing of) the reversal focus to the memory of another (historic) traumatic event

In his treatment of war veterans affected by trauma, Freud hypothesized that the trauma's failed reconciliation in adult life occurred because of childhood or earlier and still unresolved traumatic experiences. He used an analytical modality to reconcile the two trauma's; resolution of the first would lead to eventual resolution of the second. Subsequently, considerable debate over the relationship of multiple life traumas and their effects on the psyche followed in the 1950's and, in fact, continues today.

ETM literature and the professional training School address this debate and provide specific protocols for the reversal of multiple traumatic etiologies. They are different from Freud's in that both the short- and long-term applications of the ETM structure to the trauma provide for the address and reconciliation of the trauma's separately, and in an order that considers first the trauma requiring the greatest attention, usually the later occurring trauma. You can find ETM's theory and formula for the address of more than one trauma under the title's "Multiple Sources of Trauma."

Reviewing your training, you may recall that when reversing etiology from near-term trauma, that the emotional pain and memory of the historic trauma will likely present. Following the ETM protocols referenced under "Multiple Sources of Trauma," listen to the presenting experience with empathy, assure the person that this additional experience will be addressed as thoroughly as the current traumatic event is being addressed. Then, with the client's agreement, return to the position within steps A-F where the memory of the earlier trauma was evoked.

In a few circumstances, that return to the near-term trauma resolution effort
will not be possible or advised; see "Multiple Sources of Trauma" in ETM literature and training for descriptions of how to respond to the various issues that can present when in an individual is affected by more than one extraordinary life (traumatic) event. (Eventually, ETM methods for addressing multiple sources of trauma will be placed on this information system.)

Follow a pace for etiology reversal that fits the client's needs
The client sets the pace for etiology reversal. You do, however, expedite it by removing intellectual obstacles (such as interference by nosotropically-based applications), and by providing empathy and other methods of caring for that person. Generally, the less interference (provided by following these guidelines) and the more attention provided, the more readily the etiology will be addressed/reversed by the client.

Integrate the client (with yourself and the group) before, and if necessary, during, and then after the reversal process

Remember, this is a review and, as a rule, not intended to supplant professional training. The ETM trained professional will recall and non ETM trained professionals are advised that the ETM Training Program demonstrates, with over 100 traumatic examples, the practical and appropriate applications of the following guidelines. The demonstrations provide considerable (for 4 days) experience/practice for the application of the following procedures to both near- and long-term trauma, and with usages of both the written and oral (only) TRT (Trauma Resolution Therapy) forms. Some or all of the procedures may be applied per the ETM trained clinician's discretion (appraisal of client need).

1. share/reflect feeling
   a. following guideline "3" (explaining the method for identifying and sharing feeling as opposed to opinion), reflect your and the group's feelings; depending on the client's need, use this method before, during, and following a description.
   b. when groups are employed, have each group member reflect a single feeling to the client.
   c. example; a client is about to describe an especially heinous event, and the client was physically traumatized in the event. The client returns to (or enters) the state of psychological shock; it is manifested by his or her experiences of numbness, disbelief, and possibly the inability to express him or her self
further. Preempt or stop the description for a moment and reflect your (and the group's) feelings to that person before he or she proceeds with the description. Follow feelings reflection with "c" and "d" from below. Use the same approach if during the description the client presents similarly (shock, horror, or another potentially incapacitating experience).

2. give perceptual feedback
   o before, during or after a reading, tell the client how he or she appears (appeared) to you
   o when using groups, go around the group and facilitate each member to provide his or her view of the client
   o at no time can reflections of perceptual feedback be confrontational (intended to criticize or change behavior) and should never include guesses about the client's internal thought processes
   o but the perceptual feedback can include a combination of a description of the behavior, a reflection of what the client "seemed" to be experiencing emotionally, and the feedback person's feelings
   o example: the client, a student, just used the written description method to recount a rape; she remained blunted in affect; you and the group members, usually after having completed "a," tell her how she looked to each of you while providing the description. Providing with much care and sensitivity:

   "You held your arms while reading; you rocked back and forth as you talked; you seemed to be hurting very much. At least, I know that I felt a lot of hurt (or felt "horror," "rage," etc.) for you while you described what happened to you. I still feel it"

   direct client acknowledgement of group or facilitator response
   o following your (or the group's) reflection of feeling or perceptual feedback to a client, ensure that the client acknowledges each reflection
   o a simple "thank you" will make the connection
   while responses are being given to the client, ask the client to look at the person making the comments (facilitate eye contact during the interactions);

-o clients will often look downward or away from responder(s) after having described the event during responses
-o eye contact facilitates the connection necessary to merge identities during reconstitution of the client's damaged one
-touch the client on the arm or shoulder at extraordinarily painful (cathartic) times, but with noted restrictions
-o use touch on the shoulder or arm when during or following a description a client is crying to the extent that he or she cannot see the others' (your) responses; eye contact will not suffice as an integrator because the catharsis precludes the connection (temporarily interrupts vision)
-o the light touch lets the client know, as did the eye contact and verbal responses, that he or she is not alone while in this pain
-o do not use hugs during the catharsis; stop people from running over to the person who is crying and hugging him or her; such attempts to help can interfere with the client's capability to experience the pain fully, which experience will lead to the etiology's reversal
-o save hugs until after steps A-F, the etiology reversal process has been completed (at the end of the group session); they do, then, have considerable value and no interruptive effects
Introduction: Immediate and Intermediate Protocols

ETM Fast Help consists of 11 protocols that provide immediate (emergency) and intermediate (first 90 day) management and clinical responses to a traumatic event. One through six address the immediate emergency response to the event; those protocols are administered during the first day. Protocols 7 - 11 assist the INTERMEDIATE response; it usually is administered from day 2 and continuing for approximately 90 days after the event. You are currently in the "Intermediate" Fast Help section. Return to the Fast Help main menu (by clicking on the green ball in the upper right corner of the heading) to access the immediate (emergency) ETMN Fast Help protocols.

In addition to the immediate and intermediate ETM Fast Help applications, this section (from the Fast Help main menu) also provides links to corresponding ETM Patient Education sections (they support Fast Help's address of nearer-term trauma) and ETM Strategic (it supports organizational development and management process intended to remove the effects of psychological trauma on systemic functioning). Find these supportive sections by clicking on the green ball in the upper right corner (in the heading).

Etiology Reversal Scheduling

1. Immediately following the event (within 2 - 5 days), plan and schedule etiology reversal appointments for:
   - 1st directly affected (event participants)
   - 2nd directly affected
   - Indirectly affected

2. When making the appointments
   - remind the participant of the appointment purpose - follow-up to the traumatic event
   - schedule adequate time for pre-session patient/client education (see below, Etiology reversal Ethics: Client Education”)

3. For scheduling reversal sessions, use the following guidelines

Scheduling Etiology Reversal: Guidelines

With the exception of people involved in convalescence from physical trauma (see below), etiology reversal processes should, as a rule, begin no earlier than one week (earliest = 3 days for indirectly affected) following the event; beginnings periods should not exceed 90 days post-event. Reminding the ETM professional (and referring to the reversal protocol "10b"), once initiated, reversal proceeds at a pace determined by the client. Consequently, the period to reversal completion may exceed 90 days, depending on individual needs.

Directly Affected (1st Direct)
Schedule etiology reversal to begin no earlier than 3 days, and usually no earlier than one week following the event. Significantly, do not begin etiology reversal within 1-3 days of the event. Otherwise, the reversal process will actually function as counseling for shock, the first stage of grief counseling. Even at 3 days to 1 week delay, most of such a session will continue to be engaged in providing the first stage of grief resolution. Where needed, provide that grief/shock counseling response as often as necessary immediately following the event, but do remember to distinguish the clinical functions: etiology reversal from grief counseling.

When an individual is also affected by physical trauma, provide interim discussion-based, feelings-sharing clinical processes between the event and the time etiology reversal is initiated. But only initiate that reversal when the physical convalescence is completed. Then schedule etiology reversal for the physical intrusion and any difficult medical treatments/consequences; follow with a schedule for etiology reversal for the psychological effects of the event. If the waiting periods for the etiologies' reversals exceed 90 days, apply the written Trauma Resolution Therapy (TRT) form for the address of long-term trauma. And as indicated earlier, that written form is very helpful when reversing etiology resulting from heinous events/experience.

Second Directly Affected (2nd direct)
Subject to the appropriateness for the client, schedule etiology reversal to begin at between 1 - 3 weeks. Provide interim (between the event and the etiology reversal period) discussion-based and feelings-sharing counseling for grief resolution where believed to be valuable.

Indirectly Affected (Indirect)
Schedule etiology reversal to occur optimally at between 2 to 4 weeks. Grief/shock counseling may not be as valuable to this group as the to first two.

Pre-Etiology Reversal

Ethics
Before reversing the etiology, explain the clinical procedure, its purpose, and intended benefit (see "Education" below); ensure that the client is accorded the opportunity of making an informed choice about any clinical process.

Where etiology reversal can have both individual (humanitarian/medical/psychological) and systemic (strategic organizational management) benefits (see etiology reversal theory), always reverse etiology for the benefit of the individual first, the system second; should dual interests compete, subordinate the system's interests to the individual's medical/psychological interests/needs.

Elicit proper parental or other authorization for the application of any clinical procedure.

Maintain respectful regard for different helping processes; integrate any ETM assistance with other modalities, including both secular and non secular ones; see Parallel ETM Facilitation Guidelines under (10b) Etiology Reversal.
Follow the ethical code of conduct governing the ETM professional's licensing or other governing body/agency

**Confidentiality**

1. Maintain confidentiality of privileged information acquired during clinical settings
2. Break confidentiality upon threat of violence: when life is threatened or personal damage is probable/possible
3. Follow confidentiality requirements of the ETM professional's licensing authority

**Patient Assessment and Education**

1. Explain that trauma resolution (clinically referenced in this document as etiology reversal):
   - is intended to end some of the incapacitating effects of the psychological trauma resulting from the event
   - may assist in loss/grief resolution
   - may strengthen the individual to proceed less encumbered by the trauma's effects
2. Where the client/patient is interested, overview ETM theory of trauma etiology and its reversal
3. Where possible, make ETM client/patient education materials available so that the client is properly informed of the goals and methods of the procedure
4. Use the ETM near-term trauma assessment form to screen for appropriateness of application of the etiology reversal procedure
   - identify additional sources of trauma; explain that etiology reversal of near-term trauma may evoke recollections of past traumas, but the procedure is not intended to resolve or reconcile those experiences, albeit, through client choice, they may be reversed through referral to additional ETM clinical processes
   - identify the client's usages of any competing methodologies; provide non competitive (non persuasive) interpretation of etiology reversal's prospective conflicts with the competing paradigms
   - when the assessment demonstrates etiology reversal is likely to conflict with the client's otherwise established methods/philosophies for coping with the event, withdraw recommendation of the ETM near-term etiology reversal procedure and either apply the compatible modality or make an appropriate referral (to a professional who subscribes to and otherwise practices with that method)

**Drug Use**

**Alcohol**
In follow-up conversations with event participants, ask them to refrain from social or other alcohol consumption until the interim etiology reversal procedure has been completed; emphasizing neurobiological trauma issues, explain why (see

Pharmacological Psychological Trauma Treatment Methods

1. Generally, do not attempt etiology reversal with and while a client is using psychoactive substances
2. And, because application of pharmacological psychological trauma treatment methods by non ETM trained professionals will likely interfere with etiology reversal procedures, study the issues under ETM Theory and attempt to reconcile professional differences so that attending conflicts are not imposed on the already traumatized client

Pre-reversal Clinical Functions

1. Follow professional clinical standards
2. Ensure that
   o the clinical relationship has been properly initiated and established:
     ▪ know what happened to this person (see the etiology identification form)
     ▪ know the relationship of the client to the event (see the etiology identification form)
     ▪ care about the person
     ▪ acquire and honor client trust
     ▪ accord client control by assuring that goals, purposes and parameters of the clinical processes are understood (see previous "9 Ethics, Confidentiality, Education")
   o additional issues reflected in the assessment are discussed (reviewed and disposition considered)
   o the client and you have the capacity to discuss the event (more)
   o you've timed/planned the address of convoluted traumatic sequelae that are consequences of:
     ▪ physical trauma
     ▪ loss of life (usually a close relationship)
3. Proceed to (11) Identification and Reversal of Trauma Etiology

Planning Etiology Reversal for Convoluted Sequelae Resulting from Physical Trauma

1. When a client has been physically traumatized, direct the etiology reversal process to unravel the otherwise combining of two sequelae, the etiology related to physical trauma and the etiology resulting from the occurrence of the event
2. Usually, reverse the physical trauma psychological etiology first, and then in a separate (following) session(s), reverse the etiology related to the event's occurrence
3. Example: a teacher is wounded during a gang-related shooting
   - First: identify and reverse the psychological etiology that results from the physical intrusion to the body and subsequent medical care
   - In the following session, or after adequate processing of the first etiology reversal process is completed (possibly two sessions or when the client is ready - see parallel guidelines), identify and reverse the etiology stemming from the event's occurrence: that someone would attack the teacher, threaten and attempt to, and then harm that person, especially in an environment otherwise intended to be secure and focused on providing education, etc.

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**Planning etiology reversal for Convoluted Sequelae Resulting from Loss of Life**
(someone who formed an element of a close relationship)

1. When a client has been affected by a traumatic event that also results in the loss of life of a loved one (or other close relationship), direct the etiology reversal process to unravel the otherwise combining of two sequelae, the etiology related to the event, itself, and the etiology resulting from the loss of the life
2. Opposite from the physical trauma address referenced in the preceding protocol, reverse (usually) the event etiology first, and then in a separate (following) session(s) reverse the etiology related to the loss of life
3. Note: the (loss of life) etiology will necessarily present during address of the event-related etiology reversal process; use patience and traditional (existentially-based) clinical skills combined with ETM skills (use of structure simultaneous with existential modality applications) acquired from ETM training (and overviewed under "Parallel Guidelines") to facilitate both processes, but with the goal to eventually reverse the event-related etiology

Example:
A student witnesses the loss of her best friend's life during an accident; it is an extraordinary event in and of itself; before this etiology has been identified and reversed, you should be prepared for the student to enter the etiology reversal process related to the loss of her best friend's life; the preparation should accord you and the student the opportunity of completing reversal of the etiology stemming primarily from the accident

In the following session, or after adequate processing of the first etiology reversal process is completed (possibly two sessions or when the client is ready - see parallel guidelines), begin identification and reversal of the etiology stemming from the loss of the friend's life; this process may take multiple sessions that last over weeks-months, and following the etiology reversal session, the extended process should follow traditional
psychodynamic forms of grief counseling, but without the confusion attending unresolved trauma: the etiology has been reversed

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**Capacity to Discuss the Event**

Generally, the client's capacity to discuss or even initiate discussion of the event is reliant, not just upon client intrapsychic capability to identify and reconcile the event's influences on existential identity, but also, and in no small part, upon the modality used by the helper to facilitate discussion of the event and experience, as well as upon the clinician's confidence/skill to address profoundly affecting traumatic events and to work therapeutically/experientially at intensely painful thresholds of human existence and interaction. If you are ETM trained, then you will know how to use the ETM structure to facilitate discussion and then reversal of the etiology for virtually any event and with practically any client.

If not ETM trained, then your decision to proceed with severely affected trauma victims is based on other (usually nosotropic, including non structured psychodynamic-based) clinical experiences, professional trainings, and studies of the literature.

If lacking confidence, experience, training, study, etc. to assist such (severely) trauma affected people, get professional supervision before and during provision of the assistance, or get ETM trained if time allows, or refer the client to someone who can provide the necessary care. If you have further questions on this matter, call (713) 797-8340 and leave a message; an ETM professional will contact you.

**Identify and Reverse Trauma Etiology**

In addition to selecting and then following specific procedures "A" through "F" below, see and use **Parallel ETM Facilitation Guidelines: Etiology Reversal of Near-term Trauma**

1. **Step A.** Facilitate event description
2. **Step B.** Facilitate "first" emotional processing (feelings identification, experience, expression)
3. **Step C.** Facilitate identification and expression of event-contradicting values, beliefs, images, and realities (from now on called "existential identity")
4. **Step D.** Facilitate identification of specific losses resulting from contradictions to existential identity
5. **Step E.** Facilitate "second" emotional processing (feelings identification, experience, expression)
6. **Step F.** Reflect your (or group's) perception of client value

**Conclude Etiology Reversal**

1. Schedule and conduct follow-up sessions as appropriate
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2. Also where appropriate, make proper referral (to address additional traumatic sequelae or other issues)
3. Prepare clinical discharge summary

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**Etiology Reversal: Step A. Facilitate Event Description**

1. Discuss the circumstances leading up to the event
2. Facilitate the client's overviewing the event; if necessary (the client doesn't overview the event easily), use the information from the etiology identification/grading form to assist the review

   (note: while assisting in the review, use the information from the form to generally orient the conversation; do not use it to fill in trauma-causing facts as their recollections and descriptions by the client are fundamental elements of the etiology reversal process)

3. In planning to address the specifics of the event and at your discretion, apply the oral-only or combination written/oral form for describing the event; use the following and general guidelines for making this decision:
   - the more heinous or catastrophic the event, the greater the tendency to use the written form
   - the more fragile the client appears in response to the event, the greater the need of the written method

4. Returning to the discussion of the event, facilitate the client's description of his or her experience of the specifics of the traumatic elements of the event; the client describes:
   - date, day of the week, and time (if not already established in the review)
   - place
   - what happened
   - specifics (details) of the most traumatic aspects of the event
   - note: referring to your training and the parallel guidelines,
     - use your clinical (existentially-based) skills to share any emotional pain (crying) expressed during these descriptions; "sharing" infers listening and otherwise letting the client know that he or she is not alone (see Parallel Facilitation Guidelines)
     - remember that the next step in the etiology reversal process assists the client to focus upon (that is, identify specific emotions and then to experience and express them as they present) this emotional experience
     - if possible, that is, unless your clinical expertise and ETM training directs otherwise, do not accelerate the clinical process to identification of feelings until the facts of the event have been related; once the emotion is shared, then return to the description until it is completed; then, proceed to the etiology reversal process'
next step "B." Facilitate "first" emotional processing (feelings identification, experience, expression)

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**Etiology Reversal: Step B. Facilitate "First" Emotional Processing (feelings identification, experience, expression)**

1. Review for the client (and for yourself see parallel guidelines) ETM language for (definition of) feelings
2. Facilitate existentially the client's identification, experience, and expression of feelings
   - if the client education program has not already provided an overview of this procedure, preview (or review where necessary) for the client the existential method; very briefly, relate the vase analogy (provided with graphics in your ETM training program)
     1. a vase full of liquid also contains large air pockets that move in circular motion from the vase's bottom-to-top and then cyclically back to the bottom-to-top of the vase
        - as each feeling nears the top, it can be more readily identified, experienced, and shared
        - usually, the feelings will come in patterns, that is, their presentations follow an order, and even when they are identified, experienced and the experience shared with the facilitator, the feelings tend to return to the cycle for re-identification, -experience and -expression, and often in the same or similar order
        - within the overall cycle, the feelings usually present twice, but more or less depending on the individual
        - concentrate on identifying, experiencing and expressing (sharing the identification and experience with the facilitator) one feeling at a time
     2. begin the procedure
        - follow the general facilitation procedures under parallel guidelines
        - follow closely each feelings identification, experience and expression
        - the feelings or feeling states usually present accordingly
          - shock
          - fear
          - fill in later
        - they will likely present a second time and in the same order, and/or until no further identification, experience and expression are required
3. Proceed to step C, identification of existential identity (values, beliefs, images and other realities) contradicted by the event
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Etiology Reversal: Step C. Facilitate Identification and Expression of Event-contradiction of Existential Identity

1. Ask the question, "How did the event contradict your values, beliefs, images, or other realities?"; note: in lieu of "event," state what actually happened; for example, ask how the "accident," "shooting," "attack," or "death" contradicted (or otherwise function the opposite from) what the client valued, believed, viewed, or any other moral expectation held at the time of the event
2. If the client has difficulty answering this question, reframe it into a series of more simplified questions; for example, and pertaining to the time just prior to the event, ask
   - "What did you value just before the "accident," "shooting," "attack," or "death"?
   - "What did you believe in that was disrupted by the "accident," "shooting," "attack," or "death"?
   - "What view of the (event) situation, related people, or image of yourself did you hold just before the event occurred?
   - "What other reality was contradicted by the event?"
3. The client will likely respond with equally simple (but no less profound) answers; if a shooting of a friend provided the basis of the contradictions, sample answers for the first or all of the questions in (1), (2) a, b, c, or d might include:
   - "I valued safety, my friend's life, security, our friendship"
   - "I believed people should care about others; not threaten, or harm them, much less shooting them, and taking my friends life from me (us)"
   - "I thought we were going to be friends forever"; "I imagined our life going on together; (note: usually presenting images of specific planned involvements like sports, music, drama, dating, etc.)"
4. Note: if the client cannot answer any of these questions, then ask him or her to take them home and work on them in writing; give the client a Phase Two form from Trauma Resolution Therapy's five phase address of long-term trauma (see your educational materials or go to for quick review); ask the client to fill in only the first 4 columns, leaving column 5 blank; when returning to the next session, ask the client to read the first 3 columns
5. After contradictions to existential identity have been identified and described (shared), proceed to the next step D.

Etiology Reversal: Step D. Identification of Losses Resulting from Contradictions to Existential Identity

1. Ask "what did you lose as a consequence of these contradictions/changes that you've just described?"
2. Facilitate identifications of loss resulting from noted descriptions of specific contradictions to identity
   o you might assist the client in reviewing each contradiction identified earlier;
   o following each contradiction review, ask for the correlate loss(es)
3. When losses resulting from reviewed contradictions are identified, the exercise is not complex, but ordinarily simple as the losses are often just a restatement (cognitive identification) that the value, etc. was intruded upon, altered, taken from the person, or in some other way interfered with
4. Expect redundancy: losses repeat for various contradictions
5. Correlating specific losses to specific contradictions is the most important element of the entire etiology reversal exercise; the losses identified by themselves will have little benefit for the etiology reversal process: it will not occur if the contradiction-to-loss linkages are not cognitively established
6. Continuing the example used under "C", a girl loses her friend during a shooting, contradicted:
   o values of
     1. safety and security consequently result in losses of the sense and actuality of living safe and secure
     2. the friendship impose relationship losses of companionship, trust, continuity, the relationship, itself
     3. the friend's life usually results in additional relationship losses of love, caring, sharing; also in intrapsychic losses of self-esteem, worth, and because of the natural tendency to project aspects of one's self onto another during close relationships, a loss of the girl, herself (usually the last loss to be identified), and usually identified as a loss of a part of "me."
   o beliefs that
     1. people should care about others results in losses of trust in and respect for people in general
     2. someone should not threaten or otherwise harm them foster losses of safety, security, continuity of both the friend's and one's (the surviving girl's) own life, much less shooting them, and taking my friends life from me (us)"
   o images (concepts and other realities) that
     1. the friendship would go on forever imposes losses of future, continuity, self worth self esteem, trust in relationships, the ability to care, love
     2. the two would live life together results in losses of not only the friend, but the projections of the survivor onto the lost friend - again, the loss of the projections are manifested as a diminishment of the self, that is, losses of self-esteem, self-worth, and as indicated earlier frequently reflected as a loss of "me"
7. If the client used the TRT Phase Two form (normally applied to resolution of long-term trauma sequelae) in step C, the client will likely continue the form's use in this step D
8. Proceed to the next step “E”

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Etiology Reversal: Step E. Facilitate "Second" Emotional Processing

1. Using the same approach (the vase analogy) used in step "B," and remembering to utilize the general facilitation principles recommended under Parallel Guidelines, facilitate feelings identification, experience, expression
2. Where the feelings addressed in step B are usually discovered during the beginnings and middle of grief resolution, those addressed follow identification of contradictions to identity and subsequent loss usually comprise the latter or final phase of grief
3. Like the first emotional address occurring in Step B, these feelings too will probably present twice, but also again, more or less depending on the individual
4. Concentrate on identifying, experiencing and expressing (sharing the identification and experience with the facilitator) one feeling at a time
5. This emotional processing should be one of mourning, felt less or more profoundly depending on the degree of etiology established as a consequence of the event
6. Proceed to the next step "F"

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Etiology Reversal: Step F. Reflect Your (or group's) Perception of Client Value

1. Reflect your, or where group process is used, facilitate the group's perceptions of this person's value; that is, tell the individual what it is about them that you think is valuable as you have come to know this person throughout this clinical process
2. When the client is also a trauma manager, for example, an emergency medical technician, police officer, nurse, counselor, principal, or other ETM professional, in addition to reflecting your perceptions of client value, also affirm the value of the role: the value of the service provided to the community by this helping role
3. Remember! This reflection is not to be confused with the very thorough process of reflection provided under the treatment completion step (5b) for reversing long-term trauma etiology (described in the 3rd and 4th training days of the ETM School); in comparison, this reflection (for near-term etiology reversal) is spontaneous, occurring immediately following the final emotional processing of the traumatic event's effects on existential identity; you will recall that in contrast the reflection used at the completion of etiology reversal for long-term trauma requires fairly extensive planning and possibly to occur over multiple sessions

For additional facilitation assistance, look to the contents in the left window and select, Parallel ETM Facilitation Guidelines: Etiology Reversal of Near-term Trauma
This chapter:

1. discusses application of ETM theory regarding treatment of chemical dependency-caused psychological trauma.
2. considers TRT's address of comorbidity, dual presentations of chemical dependency and other trauma-causing events (like childhood or combat trauma).
3. addresses differences between clinical modalities in the treatment of chemical dependency. However, the differences are not presented within a theoretical-analytical model, but are instead summarized from my experience as the principal writer and audit officer (of six psychological trauma and chemical dependency treatment facilities) who was required to and did routinely explain the clinical differences within the parameters of formal government and other agency licensing compliance processes governing the facilities' operations. I've elected this approach for the sake of saving time, and with the understanding that legitimate exceptions may be taken of my interpretations of the various differences existing between the clinical models described.

**Etiology Reversal of Chemical Dependency Caused Trauma**

TRT resolves the drug use-induced psychological trauma by reversing its etiology attending patterns 1 and 3. Before this reversal can take place, however, the chemically dependent person must achieve between 6 - 10 months of sustained sobriety. In late-stage chemical dependency, like gamma alcoholism, 14 months of sobriety may be required before the trauma can be resolved.

About/Comparison - Contrast/Multiple Sources of Trauma (see the chemical dependency section), describes the physiology, neurological and hepatic changes resulting from chemical dependency that effect the delays in resolving the trauma. The delays provide time for neurological and hepatic damages to, at least in part, reverse themselves.

**Applying TRT with other Therapies Used to Combat the Chemical Addiction**

During the waiting period, the chemically dependent person participates in an assiduous effort to maintain sobriety, which effort includes the use of therapies that are different from TRT. While these other therapies are helping the person to maintain sobriety, they also influence the trauma resolution process that is to eventually be attempted: nosotropically-based (behavioral methods intended to stop the drug use) therapies, although necessary, can also adversely affect etiotropic/etiology reversal efforts (see chapter 14 in the text). Consequently, application of TRT must be preceded by a system of blended therapies that have the effect of maintaining sobriety (through the application of behavioral techniques) and at the same time lead the way to the application of TRT for
the purpose of reverting the etiology attending the psychological trauma resulting from the drug use.

ETM application to chemical dependency is also systemic in its orientation. This systemic component is explained in Clinical/ Family). Because the systemic and intrapsychic elements for chemically dependent people overlap, you may find it beneficial to read that chapter in concert (before or after) with this one (also see About/ Development/ Family)

Chemically Dependent People

This section describes general chemical dependency counseling (without TRT) first, the idea being to show non chemical dependency trained professionals the nature of the traditional and still most pervasively applied alcoholism counseling process. It involves the use of the Alcoholics Anonymous Twelve Step programs. The discussion is followed by a description of this counseling method as it is merged with TRT. Some of the descriptions are provided from the historical (developmental) perspective.

Alcoholics Anonymous
(The Twelve Steps)

Before starting the explanation of TRT's application parallel to the chemically dependent person's use of the Alcoholics Anonymous (AA) program, the preeminent approach to CDP treatment, the following disclaimers about the Twelve Steps, the methodological underpinning of that program, is necessary. None of the comments in this chapter are intended to criticize the Twelve Steps or any aspects of the Alcoholics Anonymous self-help program; which is a competing philosophy or system of care. I believe the AA program to be a fine and very valuable treatment paradigm. Moreover, I recognize that constitutional provisions within that program preclude it from engaging in controversial processes, which could include defending its philosophy and methodology from evaluation and analysis by professionals or anyone existing outside of its organizational processes, including anything discussed here.

However, because AA had developed the philosophy, theory and method for the treatment of chemical dependency in which I was trained and to which I initially subscribed, the primary method used for helping alcoholics to get and remain sober (see Level 4: "ETM Development"), and because those ideas and approaches were a part of the thought systems developed and established within the minds of chemically dependent people, who as a primary treatment provider I was also helping chemically dependent people to address psychological trauma resulting from the use, it is imperative that I explain the simultaneous application of both efforts, so that ETM philosophy, theory and methods and differences between them and the Twelve Steps are clearly understood.

This explanation is provided from the ETM/TRT perspective and is not intended to represent the views of those espousing the use of the Twelve Steps. In keeping with ETM
policy on the treatment of differences between TRT and all other philosophies, theories and modalities, I recommend and encourage that any individual or professional also study or otherwise consider these comments from other vantage points, that is, from the review of the literature (The Big Book of Alcoholics Anonymous, 1939, and many other books and articles relating to the use and value of AA) describing the use of the Twelve Steps as a process for helping people to stop drinking.

Chemical Dependency Counseling: (General) without TRT

Generally, individual (intrapsychically focused) chemical dependency counseling within ETM, and before TRT was utilized in the treatment of CDP's, was comprised of a mixture of different therapeutic processes. They included:

1. Cognitive-behavioral, including forms of Reality Therapy (Glasser, 1975), and Person Centered (Rogers, 1980) Therapy, used in both individual and group therapy (Yalom, 1975) formats.
2. Spiritual conversion via the Twelve Steps.
3. Education, with an emphasis on the disease (chemical dependency) concept.
4. The Twelve Steps, to include the use of supporting pamphlets (Hazelden Publications) for completing the 1st and 4th steps in writing.

When these processes were properly integrated, the CDP was facilitated rapidly through a natural recovery experience. "Natural recovery experience" means that, once sobriety was initiated, and it was accompanied by a modicum of introspection, the experience would automatically occur without the use of the therapies, but not with the clarity of understanding or efficiency of the use of therapeutic energy that accompanied the recovery experience when the therapies were used. Specifically, the natural process followed the Steps and included an awareness that the person:

- Had suffered much emotional pain and disruption to his or her life, or to other's lives, as a consequence of the chemical use.
- Had been unable to control the chemical use (become "powerless" over the use per the first of the Twelve Steps).
- Had been living a life that eventually had become unmanageable as a result of the use (the second part of the the first of the Twelve Steps).
- Had been living in delusion about the use and its effects (Step Two of the Twelve Steps refers to this part of the process as an acknowledgment that the person had become insane during the use period).
- Became willing to turn the control of these processes over to a power greater than himself or herself (Third Step).
- Needed to evaluate him or her self honestly (Fourth Step - make a moral inventory).
- And share this honest appraisal with another person (Fifth Step - often heard by a pastoral counselor).
The idea behind this recovery experience, or the facilitation of it, is that drugs saturate the central nervous system to such an extent that the combination of the incorporated chemicals and subsequent neurological changes effect a new biological and psychological identity; during abstinence (recovery), the unsaturated CNS must separate itself from this identity (level 3 bibliography: Multiple Sources of Trauma, the Chemical Dependency Section for a description of the "new" biology attending drug addiction).

This separation of the non toxic CNS from the toxic one is difficult because the psychology that adapted to the toxic biological reality has a vested interest in maintaining the toxic condition --- without the toxic condition the adapted psychology will gradually lose the physiological underpinnings of its existence. Consequently, when an individual makes a breakthrough to the realization that the use is harmful, the subsequent separation from that use also becomes an extraordinarily difficult process of separating from what had become, during the chemical use period, the only aspects of themselves about which they knew -- the psychological Self that had adapted to the toxic biological states.

During this recovery process, a value of the Twelve Steps is that they facilitate the person's realization that the adapted psychology (the one born out of changed/toxic CNS) is in control of that person, and that such controls result in a profound experience that is equivalent to being lost -- insanity. Because these adapted controls are so influential, and because they continue to exist at some psychological level despite conscious exclamations of determination to be different, and because this continuation of existence is underpinned by biological realities, that is, the brain still needs the drug(s) that has become a part of the neurophysiology, the person realizes that overcoming this apparently or prospectively inextricable system of control requires assistance from something more powerful than the newly emerging chemically-free biological and psychological state.

Thus, this additional power comes, depending on the person and his or her situation, from treatment providers, self-help groups, family members, a higher power as defined by the individual, and/or God. The more capable the combined therapies at helping the person to understand the effects of the chemical use process on CNS and accompanying psychological functioning, and withdrawal from those effects and processes, including the understanding of what can be expected to happen to, and what is expected from, the person during recovery, the more strengthened the person is thought to be in attempting to negotiate the process.

An alternative view is that an equal number of people complete the recovery process without the additional strengthening derived from participation in the helping efforts. Regardless of this view, I doubt that anyone could argue that helping assistance that provides for an interpretation of the experience and emotional processing during it is not something that is valuable to anyone suffering the trauma resulting from pathological chemical use.

An addition in our program to the intrapsychic elements of the recovery process (as it is discussed in this heading) is the systemic effects of the application of TRT to those
surrounding the chemically dependent person. As described in Clinical Family and About/Development, the resolution of the family member trauma resulting from the CDP's chemical use behaviors prevents, in theory, the CDP from projecting his or her own internal experience of trauma resulting from the pathological chemical use on to the family members who are participating in TRT.

Thus, when such projection is no longer available (to the CDP) as a vehicle for avoiding the experience of the internally retained trauma resulting from the use and use behaviors, the emotional pain and loss comprising the trauma begins to be consciously experienced. This conscious experience of the internal dynamics of the trauma, formerly repressed or obfuscated by survival and other defensive processes (denial), is identified as the initiation of a process through which the CDP is constantly confronted with the reality of his or her situation. Chemical dependency recovery and counseling language refers to this process as "bottoming out" or "hitting bottom." Therefore, systemic application of TRT to family members results in the facilitation of the process of "hitting bottom," where such a process is only thought to be an intrapsychic experience in other programs. In other words, some approaches claim that the chemically dependent person must choose sobriety after "hitting bottom," and that until this decision is made, nothing can be done to persuade this choice.

Through facilitation of the ETM family model, the concept of "choice" for sobriety is bypassed through facilitation of the experience that otherwise underpins such notions (the idea that chemically dependent people are choosing things).

To summarize this description of chemical dependency counseling as it is generally understood and provided within the parameters of ETM clinical applications, pathological chemical use is seen to foster an adaptive psychology that when confronted with sobriety, loses its hold on the person, but not without a struggle. This struggle is called recovery as it becomes a process of reclaiming a non toxically affected psychological identity out of one that has emanated from toxic influences.

Although some people argue that help is not needed to make this transition, chemical dependency counselors can at least claim that such help does provide for understanding of the process and the experience of a return to control of life processes. In the ETM program, resolution of the trauma for family members will, as a rule, bring about an increased probability of attaining sobriety when compared to the alternatives that or solely intrapsychically-based.

**Chemical Dependency Counseling (Specific) with CDP TRT**

This section explains the process of integrating TRT's application with other therapeutic elements of the program. The goals shift during this application from primarily attempting to maintain sobriety to resolving the psychological trauma (reversing etiology) caused by the pathological use.
Initiation of CDP TRT
During the Initial Sobriety Period

When the CDP enters chemical dependency treatment in the ETM program, the cause of the dependency is assumed to be biological/genetic (see About/Comparison - Contrast/Multiple Sources of Trauma for a discussion of the arguments about causes of chemical dependency and the relationship of those arguments to trauma resolution activities through the application of TRT).

Treatment consists of a combination of cognitive-behavioral and psychodynamic therapies integrated with a parallel participation in the Twelve Step programs (Twelve Step program attendance is not required, but recommended). The goal is sustained sobriety. Objectives include identification of the drug use's adverse influences on life management processes and the establishment of a commitment to maintain a program of recovery, to eventually include addressing the psychological trauma resulting from the drug use. Myriad other goals, objectives and concepts surround chemical dependency treatment and the attainment of sobriety, but we leave them to other books on the subject, as the focus in this work is primarily resolving psychological trauma resulting from the use.

The CDP is assisted in applying into the Phase One format all trauma-causing drinking/drug use related incidents that may have contradicted the existential aspects of identity. Instead of using the second person language "you," the CDP writes the descriptions using first person language "I." This list of contradicting drug-influenced behaviors are shared with peers, other chemically dependent people. This sharing takes less than one group session. The CDP is facilitated in recalling as many of the episodes as possible before the family confrontation (of chemical use/trauma-causing behaviors) session (see the Clinical/Family Treatment). Because the CDP is able to observe other CDP's progressing through the same process prior to his or her experience of it, the client is aided in understanding what is required to complete the clinical procedure. Thus, this list is fairly accurately written by most chemically dependent participants.

The CDP then participates, with an additional agenda, in the family confrontation session; not only is the confrontation process (described in Clinical/Family Treatment) intended to provide the system with certain benefits, that is, the confrontation provides for the beginnings of reestablishment of communication by the system and the system's identification of the trauma-causing incidents, but the information presented during the confrontation clarifies the CDP’s recollections of those incidents that were left out, for example, incidents caused by chemically-induced blackout. Following the family confrontation, the CDP can make any necessary adjustments to his or her descriptions and then share what is written within the CDP peer group.

Like the family sessions, but unlike other TRT Phase One processes (for other trauma victims) where only one or a few incidents are shared at a time, the CDP client reads all of the incidents to the other CDP's (in the individual CDP group) in one session. This reading by the chemically dependent person of the trauma-causing behaviors usually
takes 45 minutes, depending on the number of incidents recalled, and is profoundly moving for the group members as well as cathartic for the reader.

Thus, within the first 6 weeks of care, the CDP has a foundation in cognitive-behavioral, client centered, Twelve Step and the beginning of the TRT treatment methods. The sharing of the list of contradicting chemical use behaviors marks the end of the acute phase and the beginning of continuing care.

CDP in Continuing Care

Continuing care is integrated within the ETM family treatment program (see Clinical/Family Treatment). Individual CDP continuing care groups, where the focus includes the maintenance of sobriety, are held in 1, 2, or 3 group sessions per week depending on the needs of the CDP. Because these groups are open ended, they are comprised of people who have achieved between 6 weeks to 2 years of sobriety.

Moreover, everyone with over 6-10 months of sobriety is also participating in a CDP TRT group. Consequently, the patient's experience in the continuing care program is influenced by people who participate in both the Twelve Steps and the TRT trauma and loss resolution processes.

When the CDP begins to demonstrate abilities to modulate between emotional experiences and abstract thought, to maintain from session to session recollections of these experiences and other important emotional/intellectual interchanges, the person is referred into a TRT group. The CDP continues at least one continuing care (individual CDP) group and usually drops all others. The purpose of the TRT group is to provide for the resolution of the trauma resulting from the chemical use experience.

The first phase of TRT is usually rewritten to include considerably more detail than was provided in the writing and reading processes of acute care (occurring 6 - 10 months earlier). Then, the incidents described in the rewriting of Phase One are shared with the group. The pace and progression of this rewriting and reading process is the same as the pace and progressions of other TRT participants who have been affected by different sources of trauma.

TRT's Application to Chemically Dependent People; Occurring after sustained sobriety

The application of all 5 phases of TRT to chemically dependent people occurs as follows.

1. TRT Phase One assists the CDP in identifying specific trauma-causing behaviors occurring during toxic periods. Emotions felt while recording the specifics of the events are also included in the descriptions.
2. TRT Phase Two provides for a summary of the events, a reconsideration and thus in-depth identification of the emotional responses to the events, the identification of specific aspects of existential identity contradicted by the toxic behaviors,
specific losses to existential and operational identity resulting from the contradictions, and specific survival responses to the damage and the fact that the contradicting behaviors occurred.

3. TRT Phase Three provides for the identification of survival responses and associated emotional experiences, but within the context of the identifications' purpose being that they provided for the identification of additional contradictions to existential identity. Such survival responses include the delineation of repetitive attempts to cover-up for the initial trauma-causing behaviors and the damage sustained as a consequence thereof.

4. TRT Phase Four assists the CDP in identifying and reconciling the survival response-induced damages to existential and operational aspects of identity.

5. Phase Five provides a review of who the person was prior to the trauma (prior to the pathological drug use), what happened to that person as a consequence of the trauma (the use), what the person had to do to survive vs. who he or she was as a person, and who the person is once the psychological trauma resulting from the chemical use is resolved.

Eight to twelve months is usually required to complete all 5 phases of TRT. The person then exits either to the family treatment processes (see Clinical/ Family Treatment) or from the ETM program altogether.

Relapse

CDP's usually relapse before they get into TRT. Periodically a person will relapse in TRT, but rarely.

When relapse does occur, standard relapse procedures are administered; they include the application of increased structure (more groups and Twelve Step meetings). Twelve Step program attendance is required following relapse.

Relapse usually results in attendance in at least one professional group and one AA group per day for the standard 90-meetings-in-90-days protective coverage. If the person stops quickly and is able to abstain, TRT is continued after a short period of discontinued reading or writing. The person does stay in TRT during this period. If the relapse is lengthy, say 2 to 4 weeks, then TRT is discontinued and the person becomes a candidate to begin the initial treatment cycle again. No CDP who is using is allowed to participate in any TRT or other kind of professional group. Frequently during sustained relapses, interventions are facilitated which assist the person into residential care. After a period of sustained sobriety, and depending on the judgment of the treatment team, the CDP enters the TRT group again.

With the disclaimer that I have not academically followed up on any of these cases for many years, but only periodically met chemically dependent people, their family members, and friends within the community, I have never heard of an individual (CDP) who has relapsed following completion of TRT. Neither has such a relapse been reported.
to me via the professionals now using TRT for the treatment of psychological trauma resulting from pathological drug use.

My guess is that if empirical studies on this subject were conducted (sustained sobriety is not the goal of TRT, but only a prospective additional benefit; the goal is resolution of the trauma resulting from the pathological use), the outcomes would show that no chemically dependent person would return to drug use following the application of TRT.

**CDP TRT for People not Participating with Families**

Approximately 20% of the CDP population receiving care in our programs were single people (no family members were available to participate with these CDP’s). This group participated in the reading of the complete first phase to the peer group, but obviously without the benefit of any systemic reflections of chemical use (trauma-causing) behavior. The members of this single CDP group also then waited the proscribed interval of 6 - 14 months before beginning TRT in full. Incidentally, participation or non participation in family group therapies did not appear to influence the timing of the CDP's entry into TRT.

**Comorbity: Applying TRT when Sources of Trauma present other than that caused by Chemical Dependency**

I take some liberty with the term "comorbity." It usually refers to simultaneously occurring and not always related diseases. I use "comorbity" to refer to simultaneously occurring causes or sources of trauma, which are not necessarily related (not necessarily cause-to-effect).

There is a purpose to this usage, especially when chemical dependency is involved. Many clinicians who are not ETM trained see chemical dependency either as a cause of everything or an effect of the same. When in reality, the science of the biology of chemical dependency shows cogently that the chemical dependency may be a variable that presents simultaneously, even coincidentally, with others. When that view is held, then the scope of the problems confronting the clinician are wider, and I believe reflective of the true clinical challenge. Without "comorbity," one or the other of the issues is usually minimized, which minimization can preclude achievement of any clinical goals. The clinician may then use personal philosophy to blame the patient for the failure.

Comorbity -- in this section, referring to ETM's address of multiple sources of trauma that include chemical dependency -- is referenced to and in About/ Theory/ Multiple Sources of Trauma. It provides formulas for applying TRT to the multiple sources of trauma, which include chemical dependency as a cause of trauma. The science of chemical dependency (as a cause of trauma) is considered in About/ Comparison - Contrast/ Multiple Sources/ Chemical Dependency.
To summarize these two reference chapters and their recommendations, when chemical dependency is one of the multiple sources, it usually is considered the most pressing trauma (it makes the greatest demand for clinical attention). TRT is applied to the chemical dependency-caused trauma, first, and then applied to the others. There are guidelines in the first reference that show how to make those applications.

Importantly for this chapter, because chemical dependency is (eventually) usually documented to early life years, there is a good chance that additional and non chemical dependency related trauma has occurred simultaneously with chemical dependency's. Making matters more complicated, although the pathological drug use may be biologically-based and occurring coincidental with the other trauma causes, like loss of a loved one to disease, accident, or violent crime unrelated to the chemical dependency, the pathological drug use will not only cause trauma but also act as a medicator of it, both that trauma caused by the chemical dependency and the other source(s).

Compounding the multiple sources issue even more, some chemical dependency behaviors resulting from toxic conditions can lead to circumstances where other trauma occurs. For example, when a person gets drunk, through impaired judgement the CDP can enter into circumstances where an accident caused by someone or something else can create the additional trauma. Another and frequent example involves rape of chemically dependent people. Because of judgement that is impaired by the toxic condition, the individual can become easy prey for violent predators. In these circumstances, the chemical dependency (instead of the perpetrators or other causes) is often blamed for the events. This blaming also leads to self deprecation. That supports continuance of the etiology, making its reversal more difficult.

In addition and regardless of the complications encountered because of the other source, it will begin to present during sobriety. Address it interimly (while focusing on sobriety and / or during etiology reversal of the chemical dependency-caused trauma) with TRT Phase One or client centered methods, but do not mistake that partial address for etiology reversal via TRT's full (all 5 phases) application to the additional source. That reversal should occur at a later time per the guidelines provided in the theory section pertaining to multiple sources.

The consequence of chemical dependency's myriad influences on trauma's address is that applications of TRT to the different sources are required over an extended period, and always in concert with maintenance of sobriety. This sounds tough, but CDP's are a much more resilient group of people that they may appear during the chemical use or early recovery stages. And even though the amount of work sounds substantial, and it is, CDP's always conclude that it is better to do it, and to do it completely, rather than to continue to living life within the nightmare of not knowing what happened to themselves.

**CDP TRT: Examples**

This section provides written examples of the application of all 5 phases of TRT in the treatment of psychological trauma resulting from the pathological chemical use.
experience, chemical dependency. Several points should be made about the example, which contains as many different variations of perpetrator behavior that could be applied in the available space.

First, not all CD experiences include this many different kinds of trauma-causing experiences for both the CDP and the family members. For example, only a small percentage of CDP’s are batterers and sexual offenders (although large percentages of batterers and sexual offenders are CDP’s).

Second, the list readings (Phase One) for CDP’s assume that legal matters for perpetrators are properly, legally, and ethically addressed. This book does not cover this subject, as these are subjects for CD counseling (not restricted to psychological trauma counseling).

Third, the Phase One episodes are not written in the detail that a standard Phase One list would be written. The emphasis for this example is on the trauma’s effects, all 4 patterns, and not the descriptions of the episodes. These examples, do, however, represent the standard for writing the first description of drinking/drug use behaviors that are provided by the CDP during the acute phase of care (these episodes are then rewritten, redescribed, when TRT Phase One is begun between the 6th to 14th month following the initiation of sobriety).

Fourth, readers who are interested in the idea of responsibility and drug use are referred to About/ Comparison - Contrast/ Multiple Sources/ Chemical Dependency. There is, however, no reference in this book to the debate in the literature that considers the cause of violence: that is, does the alcoholism cause or disinhibit the violence? We have read that material, completed a review, but have saved it for another work that focuses solely on chemical dependency, perpetrators and psychological trauma.

Fifth, this example was initially written to correspond to a family treatment exercise that included the previous codependency trauma examples as the spouse of this (CDP) character. Thus, these examples are similar to the previous (spouse) episodes, but are provided from the perspective of the alcoholic.

Sixth, the reader is reminded that this example is fiction. It was created to meet professional training needs.

Chemically Dependent Person (CDP) TRT

Results of TRT’s Application to Chemically Dependent People

The results of TRT’s application to chemically dependent people are the same as for other trauma victims. However, there is one CDP result that should be emphasized that does not pertain to other people affected by trauma. They do not have to concern themselves with fears of return to chemical use. Chemically dependent people do. In many cases, then, recovery is a lifetime affair requiring continuous participation in self help programs.
When chemically dependent people complete TRT, however, they do not believe that it is necessary to continue in a recovery program for life. They might (usually do) elect continued participation in the AA groups because they enjoy that program. The chemically dependent person who completes TRT enjoys integration and fellowship with people similarly affected by chemical use as he or she was affected, but not because the CDP considers that such participation is mandatory for the maintenance of continued sobriety.
Chapter 11 Section (a)

Entry, Assessment, Triage, Multiple Sources of Trauma, Parallel Therapies, Begin TRT

Introduction

This is the clinical section. It shows you how to identify and reverse long-term trauma etiology.

Clinical Overlaps with Fast Help

Near term trauma etiology identification and reversal are, although clinical actions, explained in the Fast Help Immediate and Intermediate Trauma Response Protocols. There the clinical action is incorporated into the traumatic event site management, and then continued into the period (approximately and generally speaking 90 days) immediately following the event.

As you will see, near- and long-term trauma for an individual can overlap. Thus, expect overlap between this section and ETMN Fast Help.

Clinical and Fast Help Overlap with Strategic

In addition, clinical responses overlap organizational management ones. For example, addressing etiology (caused by near- or long-term trauma) as it has occurred for the individual participants of an event can have positive systemic, including organizational management, influences; reverse individual and systemic trauma etiology, and preempt individual and collectively manifested symptomatology. This preemptive process produces strategic benefits for organizations otherwise affected by traumatic events.

Although the groundwork for the referenced organizational management (strategic) benefits is provided through the ETM clinical response (described in this and the ETMN Fast Help sections), the ETM management responses required to facilitate these benefits are described in the "ETM Strategic" section. And like the overlap between the Clinical and Fast Help sections, there is also overlap between them and the Strategic element of the site. Overlaps are referenced.
Theory Overlap

The "About ETM" (Theory, Comparison, Contrast, Development, Bibliographical) section(s) support this Clinical section and the Fast Help ones. In addition, ETM facilitation principles and guidelines discussed in the "About ETM" (theory) sections are duplicated in this section.

Patient Education

There are two Patient Education sections included in this Clinical one. The first (found under this "Contents / Assessment - Entry / Entry / Patient Education") provides explanations of what, when and how to apply patient education materials during the entry and treatment application component of the clinical process. The second is a duplication of the patient educational information materials otherwise provided in the "Patient Educational Informational" section. These materials are included in the "Clinical" section so that if you've only downloaded that segment, then you can read the information being simultaneously viewed by your patients. You can stay current with their understandings and perceptions of the clinical process as they proceed through it. That currency will allow you to provide greater support in their efforts to identify and reverse trauma etiology.
Chapter 11 Section (b)

Entry, Assessment, Triage, Multiple Sources of Trauma, Parallel Therapies, Begin TRT

Entry: Introduction

Entry into a clinical process for patients affected by long-term trauma is different from that entry by near-term trauma patients. The latter, for example, present obviously in shock, and there is no long-term development of survival responses (described in the ETM Theory section as the third of four trauma patterns developed as sequelae) to influence the near-term patient's perceptions of clinical assistance. That influence to people affected by long-term trauma, on the other hand is substantial.

For example, development of survival thought - behavior, and a paradoxical decision making / control management apparatus presents a patient who has lost cognitive understanding of the existential and operational identities enjoyed before the traumatic event(s) occurred. In place of that identity is a new one that often assumes life living philosophies that support the new and trauma-imposed identity. More often than not, these same people have entertained assistances from myriad self-help and even clinical activities. Both are usually nosotropic in their orientations; the helping models support denial of the original trauma etiology and consequently support the notion that the new trauma-imposed identity has been the only one representing the individual over life. Supported by the nosotropic-based helping methods, the pretrauma and lost identity remains that way. Moreover, the referenced paradoxical system of control will do everything it can to fulfill its oppositional responsibilities: helping to reverse the trauma etiology and maintain its existence forever.

Your task as facilitator of the etiotropic-based clinical model, Trauma Resolution Therapy (TRT), is to work with the paradox so that it is supported in its first mission of trying to resolve the trauma and neutralized in its second obligation, preventing the trauma's resolution. The best way to do this is to provide cognitive interpretations of ETM's theories of the four psychological trauma patterns, the paradoxical system of control (establishment of the "Survivor), and TRT's method for addressing all of the above, should the theoretical abstract be surmised by the patient to apply to
him or her. At the same time, begin to administer the ETM structure which is designed to reverse the trauma etiology, in the process restoring or otherwise reconstituting identity without the post-trauma deleterious (symptom) influences.

To accomplish this task, you provide 3 parallel processes that begin with the patient's entry into your clinical domain (assuming ETM-based). They include patient education, thorough assessment - evaluation - patient-inclusive treatment planning, and facilitation of a caring response that would otherwise be provided to an individual who has just suffered a traumatic event, albeit in actuality the event in this presentation may have occurred months, years or even decades before the presentation. Moreover, presenting survival responses manifest as apparent aberrant behavior, the patient is still treated with the caring response indicative of recent trauma (more under "ETM Caring Response"). The next paragraph explains the solitary exception to this approach.

Where the presenting survival responses are manifested by aggression (violence, prospective violence and harm to others or self, etc.), the caring response does not take precedence over behavioral confrontation methods otherwise used to counter apparent irresponsible behaviors. As will be explained in the clinical application of TRT sections, violence, trauma-induced or no, must be contained behaviorally in order to provide protection for the patient, third parties, and the therapist / clinic.

**ETM Caring Response**

There are many ways to care for people. Some help is intended to make people be independent, strong. A goal of this method is to teach people to become personally responsible. - the people needing the help learn to be strong and responsible by adapting the helper's stoicism-based philosophies and methods for living life. The people being helped are then thought to be better able to care for themselves

That is not the ETM way of caring. Instead, you might think to yourself when viewing a new client likely affected by distant psychological trauma, "What would I say to this person if he or she were standing outside of a burning house where that person's entire family had just been tragically lost." Without hyperbole, at that moment, everything that person believed that he or she ever was or is ever going to be is gone.
You may say "But all of these clients don't think this way when they present." "The traumatic event is long past." "People must move on with their lives." And anyway, this client now has a lot of problems, which make it difficult to contend with him or her, much less believe that the loss that I referenced is prevalent, or even still pertinent.

You probably will not hear that loss during the entry phase. You no doubt will tire of the defenses - survival responses. But you will find after you've reversed a lot of trauma etiology with Trauma Resolution Therapy (TRT), that regardless of the trauma-causing event or events to which the presenting client was exposed, and despite the presenting thought - behavioral symptomatologia, at the moment of reversal, each trauma victim reconciles that loss for themselves with the same degree of profundity, importance and meaning to that person, that does our person providing the tragic example of horrendous loss of family.

Know that the unresolved loss of identity for the traumatized client is providing the generator of energy that creates most if not all of the defenses, aberrant behaviors, and other survival responses which otherwise might make it difficult to contend with this person; or to make it difficult for the person to contend with him or her self. If you can make it your goal to be with this person, and regardless of the presenting survival responses, at the level of pain and suffering that accompanies that most profound loss, to let them know that you are of the character that can experience that loss with them, that you can feel it with them as fully as they need to feel it, then you are providing caring in the ETM way.

If you've not been through the ETM Professional Training School, do not upon reading this be chagrined about how this profound trauma resolution is to occur through the defenses that you would likely meet in the initial interviews (therapy sessions). The TRT structure will lead you both through those defenses and to the point of the trauma's resolution. You will be taken safely through it. The trauma will be resolved in a manner that is right for each individual's loss. And you'll likely find that you won't have to teach anyone how to be strong or responsible. You won't have to entreat them to follow your way of life. Instead, you will likely learn a greater and new meaning of the concepts of personal strength and responsibility. And their way's of life will be returned to them; and that will be just fine for them.
Patient Education

Generally, the *TRT Educational Program* informs the patient about TRT theory, how to do the therapy, what can be expected from the person's efforts, what will interfere with the therapy, and what is expected from the patient to complete the program. This educational program is specially designed to reduce interference with the therapeutic process.

That interference can be patient initiated - the element of the paradoxical system of control that attempts to prevent the trauma's resolution. The interference can be system initiated - helping philosophies that encourage the trauma victim to use modalities that are not compatible with TRT. The interpretation provided through the education strengthens the person's attempts to reverse the etiology of the psychological trauma, should the TRT approach continue (after exposure to the educational materials) to be the selected method.

**Patient Education Importance to Clinical Outcomes**

ETM patient educational information profoundly influences etiology reversal's outcome: success or failure. For example, without any patient education information, only about 50% of patients will complete TRT Phase One. It is the first phase of the structured resolution process. If, on the other hand, patients read the TRT Educational Program pamphlets and booklets (informational and instructional aids), then another 25% of patients can be expected to complete TRT. And if a patient views the TRT Educational Program Slide Presentations (computer generated graphic slide presentations of the TRT Educational Program) before beginning or while participating in TRT, then that person has a 100% probability of successful completion of TRT.

**Converting Patient Educational Information to the Internet**

ETM Patient educational information is being translated to the internet, eventually to accompany this tutorial. The information is being translated to the Patient Educational Informational section of this web site.

In doing so, however, substantial changes are required to adopt the materials. For example, the pamphlet and booklet formats must be altered to
accommodate the use of the hyperlink style underpinning web technology. In addition, the 1200 slides comprising the various patient education lectures and so forth, must be converted to the kinds of technology that do not slow down the web transmissions. In that regard, the slide presentations are being translated into Java Applet formats. The hope is that the new technology will be as effective as the previous one (see the preceding paragraph) was in influencing successful TRT outcomes. I expect, however, that the translations may take most of 1997, as the presentations are substantial in size, technology and content. I am hurrying on this project, as I know that the educational materials are very important to the patient's clinical efforts.

In the mean time, the previous system of ETM patient educational materials are available offline. To acquire them, contact your ETM Trainer - Supervisor.

Assessment Steps

This section considers:

1. Assessment Steps
2. Special and Alert Issues
3. Multiple Sources of Trauma (Form 1A and Worksheet)

Assessment Steps

ETM incorporates 3 assessment steps. They are:

1. Identify problems with a standard (usually nosotropic-focused) psych-social evaluation
   - Initiate interviews with a standard psych-social assessment model. It is focused on ascertaining and clarifying presenting problems. Some people use questionnaires designed to elicit information behaviors that may be interpreted as symptomatology.
   - Using the standard, assessment or discovery interviews usually coincide with the trust develop clinical stage. Depending on the interviewer's style, more emphasis may be given to the clinical response necessary for developing that trust, than to the collection of problem identification information.
   - Collecting information for problem definitions also may, again depending on individual style, coincide with educational
information provided during the initial sessions. In this manner, the therapist may provide educational information as responses to patient inquiries and statements. As more educational information is supplied, additional information regarding the presenting problem(s).

- As the interviewer becomes familiar with the etiotropic treatment method for reversing trauma etiology, less emphasis will be applied to noting symptomatology. And the trust building and educational methods will begin to incorporate ETM focuses. They include methods that search discriminately for trauma etiology and sources of trauma. Eventually, the ETM professional will know what the sources of trauma are before the forms (described later) for collecting and categorizing the information are even used.

2. Complete the ETM Psych-trauma Screen (etiotropically-focused evaluation)

- Looking to the "Contents" window on the left, you may select and then review the ETM Psych-trauma Screen" by clicking on Contents / Assessment / Form and then scrolling down through the introduction to the beginning of the form. It asks 10 questions. Each contains additional interrogatories that if answered will facilitate your understanding of the individual's trauma history. You may:
  - asks the questions in an interview.
  - incorporate the contents of the questionnaire into your initial fact-finding or discovery (of presenting problems) interviews.
  - give the questionnaire to the client and ask that it be completed.

3. Apply the information taken from the interviews, various psych-social questionnaires, and the "ETM Psych-Trauma Screen," and that indicates prospective trauma etiology to ETM Form #1A. It is entitled "Sources of Psychological Trauma" and may be found in the ETM Tutorial (Professional / Clinical / Entry - http://etiotropic.org/1clifr1.html) by clicking in the "Content" window on left "Contents / Entry – Assessment / Multiple Sources/ Form." The Subject of multiple sources of trauma will be addressed under the title "Contents / Entry – Assessment / Multiple Sources."
Special Assessment - Alert - Treatment Issues

This section addresses several aspects of the assessment / evaluation process: the consideration of depression, how to address repressed trauma, and using ETM Forms.

Sources vs. Symptoms

As indicated above, the assessment process for ETM is provided within the context of an overall psych / social evaluation where standard consideration is given to the presentation of problems or symptoms - application of the nosotropic method. Once the ETM evaluation is initiated, however, the focus changes to the identification of sources of trauma. From there, except where chemical use symptoms are appraised and noted for the purpose of identifying chemical dependency, symptom identification is generally irrelevant to the treatment process.

Chemical Dependency

If, while collecting psych / social data, chemical dependency infers itself, chemical dependency evaluation instruments should be applied to the prospective chemically dependent person and to family members (see the ETM Tutorial / Professional / Clinical / Family Treatment). Because the instruments for assessing chemical dependency have changed over the last 15 years, and likely will continue to change, I will not include one here. However, I can say that the instrument should provide for a documentation of the chemical use's interference with any major life process and documentation of the person's subsequent continued drug use despite the interference. Moreover, we apply a social / family evaluation that provides for corroboration of these same interferences. The interferences are delineated by the system surrounding the chemically dependent person. Once the chemical dependency is identified, or prospectively identified, it is, respectively, treated as a source or prospective source of psychological trauma.

Depression

Trauma victims often suffer depression. When a history of unresolved trauma is documented, we assume that the depression is both physiologically- and psychologically-based. We make this assumption within the context of current information available on the subject. The
information on depression is not yet unequivocal - depression is not fully understood by the mental health professions. Moreover, because we rarely saw a client who was not affected by psychological trauma, we can't comment on the assessment or treatment of depression absent such trauma.

Regardless of its neuropsychological-basis, trauma-induced depression will usually be alleviated by the end of TRT's application. In the mean time, however, the depression affecting trauma victims is considered in the assessment phase, as well as throughout the application of TRT, as prospectively being endogenous - having its origins in brain functions that are unrelated to trauma. Consequently, special controls are administered starting with the beginnings of the assessment process and continuing through the treatment applications. The controls provide for the safety of severely depressed people (see the next section, "Treatment Planning").

The reader will recall that the pharmacological approach is incompatible with TRT. Thus, if during the assessment phase the treatment provider elects the use of medication as one of the treatment remedies, then that patient exits the ETM program to be treated, in addition to the pharmacological method, probably with a parallel form of psychotherapy, possibly including cognitive-behavioral therapy. This therapy has been shown to be an effective talking remedy for depression. Although trauma victims experiencing depression can almost always be treated successfully with TRT, that is, in lieu of the application of the medication and parallel psychotherapy, should such application be initiated, the probabilities are substantially reduced that a person so treated will ever be a candidate for TRT.

**Repression**

Usually, ETM TRT application will eventually result in the address of all psychological trauma retained within the reality system. Consequently, it is not necessary during the assessment or entry level stages of the therapeutic process to ferret suspected repressed trauma or sources of such trauma. Additionally, the TRT structure makes obsolete the need to breakthrough the "denial" that results from repression. For that matter, there is no aspect of TRT's administration that requires the use of the "breaking-through-denial" method. If this approach is not compatible with the provider's philosophy, then a model other than TRT should be administered to the patient. The questionnaire provided in the addendum to this chapter emphasizes the ETM policy regarding these subjects.
ETM Assessment Forms

Three forms assist the assessment/evaluation process. The first instrument is the "ETM Psych-trauma Questionnaire." A copy of this document, which is self-explanatory, is provided in the addendum to Chapter 11 in the text. Data collected from this assessment process and all others is recorded in ETM form 1A. Follow the form's directions and the provider will be assisted in identifying and codifying the sources of trauma to be considered in the treatment process. If the patient has only been affected by one source of trauma, then the provider should skip form 1B (a worksheet used for evaluation of multiple sources of trauma) and proceed directly to the treatment planning processes (additional forms described in the section on treatment planning). If the patient has been affected by more than one source of trauma, then the provider should transfer the data recorded on form 1A to form 1B. This form is also self explanatory and aids in the determination of which source of trauma should be addressed first, second, and so on. Copies of forms 1A and 1B are provided in this section (see "Contents" to the ETM Tutorial / Professional / Clinical / Entry to the left).

Assessment: Multiple Sources of Trauma

Go to ETM Form #1A entitled "Sources of Psychological Trauma." (It is found by clicking on "Contents / Entry – Assessment / Multiple Sources / Form 1A. Apply the patient information collected during entry to the form. It is self explanatory. But if you need to refresh your memory on multiple sources of trauma theory, and to review guidelines and formulas for determining MPT’s (Most Pressing Trauma), click on the yellow ball in the top right corner. It will take you to "ETM Pro Site Entry" where you can then select "Academic / Theory / Multiple Sources of Trauma (in the navigational menu on the left) at http://etiotropic.org/1abofr1.html."

ETM Form 1A: Sources of Psychological Trauma
If Form 1A, "Sources of Psychological Trauma," indicates more than 1 source of trauma, proceed then to ETM Form 1B entitled "Worksheet for Addressing Multiple Sources of Trauma." Find this form by going to the Contents window on the left and clicking on "Contents / Entry – Assessment / Multiple Sources / Worksheet." (http://etiotropic.org/1abofr1.html)
Worksheet: for Addressing Multiple Sources of Trauma
Follow the Worksheet's directions and determine the first source of psychological trauma to be addressed. Then proceed to the Treatment Planning and Strategies phase, also found by the same name in the same Contents window as the Worksheet.

**Treatment Planning, Strategies, Administration**

This section discusses:

1. Begin with Which Source of Trauma?
2. Use of Group and Individual Processes
3. Stabilization
4. Family Participation
5. ETM Treatment Planning and Strategy Forms

**Begin with Which Source of Trauma?**

You reviewed in the assessment section how to evaluate for one or more sources of trauma. You also selected the hierarchy for the various trauma's addresses. Now, begin to put this evaluative work together with treatment recommendations.

If the patient has only been affected by one source of trauma, refer that person into a TRT process to address that source of trauma. Similarly, if the person has been affected by multiple sources of trauma, refer the person into a TRT process that provides for the resolution of the most pressing trauma first. Make the referral with the intent that the application be followed by TRT's application to other sources via the chronologically descending-order approach. The rest of this section describes the clinical / educational vehicles used in these applications.

**Group and Individual Processes**

TRT is administered in either or both individual and group therapy processes. The groups are open ended and consist of between 4 to 8 participants and one Certified TRT Counselor. Depending on the number of
patients making up the entire program, the groups may be comprised of people who are all addressing the same source of trauma, or the groups consist of people addressing different sources of trauma. The former distribution is preferable.

Conduct TRT groups for 1 hour and 25 minutes, but do not break them if in the middle of a critical passage for any person progressing through the trauma resolution process. Dedicate approximately 75% of the time to TRT's application. Use the remaining time for discussion of current experiences or issues related to the homework component of TRT.

In some programs, a standard (non TRT) group may be conducted parallel to TRT. Offer the standard group on another day (from TRT) and apply a combination of unstructured psychodynamic and cognitive-behavioral models. The parallel group provides patients with a forum for addressing current issues related to relationships, job processes, and general life-living experiences. The standard group is normally more valuable in the beginning of the therapy and less valuable (needed) subsequent to normal TRT progression.

Use individual sessions to discuss progress, address issues unrelated to the application of TRT and to address issues that are too difficult to address in group process. If individual sessions are applied in conjunction with TRT groups, conduct the individual sessions only periodically, that is, during high stress periods usually accompanying the entry or Phase One application stages.

Many TRT counselors apply TRT in individual sessions only and speak highly of the experience. However, such applications, except when used for stabilization (described below), place all of the responsibility for providing the structured feedback onto a single person, the therapist. In contrast, the group application disseminates this responsibility -- the shared experience of traumatic events.

**Stabilization**

Some patients require additional stabilization. They suffer severe depression and suicidal ideation and are unable to function in employment, school, and in other social environments. Cases requiring additional stabilization methods are hallmarked by depression (discussed earlier) and fragility -- it is
demonstrated by extreme withdrawal and wide emotional swings that can include hysteria, hyperarousal, and startle response.

The use of stabilization measures is a function and the responsibility of the judgment of the therapist; the judgment comes from pre-ETM professional training. However, we offer some recommendations. They include increasing the number of individual sessions, consultation, education, anti-suicide contracts, direct and frequent phone contact, cognitive-behavioral interpretations of depression to include providing descriptions of its prospective causes and effects, full day care programming, residential care, and any accepted preventive measures. Usually, as such people are facilitated through the first Phase of TRT, the stabilizing measures are needed less frequently. The client's confidence in the structure of TRT, brought about by the person's understanding of what that structure will allow him or her to accomplish over and above what was previously achievable, will inevitably replace those psychological processes that led to the requirements for additional stabilization.

The ETM program does not use the challenge method to stabilization. For example, ETM does not recommend confronting the client with (1) the morbid view (a description of the patient's body following death) as a means of de-dramatizing suicidal ideation, (2) the selfish perspective (reminding the suicidal person that he or she is only thinking selfishly - as opposed to considering the effects of the suicide on loved ones), (3) telling the person that taking his or her life is a function of choice, or (4) any other method that is based on stoicism philosophy.

These are unnecessarily high-risk methods that are intended, in our view, not so much to mitigate the risk of suicide, but to shift the responsibility for its occurrence away from the helping method, and thus the helper. Suicide is correlated to low levels of the brain neurotransmitter and neurophone serotonin, which lack can be a function of neurobiological changes resulting from the client's unresolved experience of the traumatic event. See the tutorial "Academic" / Neurobiology of Psychological Trauma Etiology and Neurobiology of Etiology Reversal." Also see "Academic/ Comparison / Contrast," Neurobiology of Etiology; Etiotropic and Nosotropic Perspectives). Superficial interchanges based on the helper's projections of philosophy onto the trauma victim requiring stabilization are not only in our view woefully inadequate, but, while engaged in this life or death struggle, also tantamount to spinning the cylinder in a game of Russian roulette.
Family Participation

The ETM Family section on the Clinical main menu addresses family psychological trauma treatment via ETM. Generally, in this section I hope that it will suffice to say that although many people have completed TRT successfully without the participation of their families, the family treatment component is an extraordinary experience for all, patient and treatment providers, who avail themselves of it.

Using ETM Forms for Treatment Strategy and Planning

Apply the information codified on form 1B, the "Worksheet," to one of 3 forms: 2A, 3A, or 3B. These 3 forms recognize the three codification options that are available to the therapist at this stage of the ETM program. The first option (form 2A) provides a treatment strategy for non chemical dependency or codependency related psychological trauma. A copy of that form and an attendant example are provided on the next page. The second option, form 2B, offers a treatment strategy for the chemically dependent person. The sample form 2B is provided on the next successive page. The third option, represented in this section by the third sample form (3B), provides for the planning of treatment strategies for people affected by psychological trauma that resulted from their relationships with chemically dependent people. Each of these 3 forms are accompanied by matching progress notes, problem solving, family assessment and treatment forms.
**ETM Form 1A**  
Sources of Psychological Trauma

**Patient Name**

---

**Jointly Participating Primary Patient (e.g. CDP or Codependent Spouse)**

Information taken from:

1. Patient interviews: notes/pgs N/A
2. Psych/social data: pgs N/A
3. Network data: source(s) N/A
4. Chemical dependency evaluations: pgs N/A
5. Testing: Instruments & pgs: N/A
6. ETM Psych-trauma Screen: Pgs N/A

Does this data indicate the existence of psychological trauma? Yes __ No

1. If not sure, return to non trauma related evaluation procedures until additional data becomes available
2. If "no," end the ETM evaluation program
3. If "yes," identify the sources of trauma and periods (age trauma occurred). Register below

<table>
<thead>
<tr>
<th>Sources</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chemical Dependency</td>
<td></td>
</tr>
<tr>
<td>2. Spouse Codependency</td>
<td></td>
</tr>
<tr>
<td>3. Parent Codependency</td>
<td></td>
</tr>
<tr>
<td>4. ACA Codependency</td>
<td></td>
</tr>
<tr>
<td>5. Other Codependency</td>
<td></td>
</tr>
<tr>
<td>6. Sexual Assault (single Incident)</td>
<td></td>
</tr>
<tr>
<td>7. Sexual Assault (multiple)</td>
<td></td>
</tr>
<tr>
<td>8. Physical Assault (single)</td>
<td></td>
</tr>
<tr>
<td>9. Physical Assault (multiple)</td>
<td></td>
</tr>
<tr>
<td>10. Death of a loved one (single)</td>
<td></td>
</tr>
<tr>
<td>11. Death of a loved one (multiple)</td>
<td></td>
</tr>
<tr>
<td>12. Near Death of Self</td>
<td></td>
</tr>
<tr>
<td>13. Near Death of Loved One</td>
<td></td>
</tr>
<tr>
<td>15. Crisis Mgt. Job (Multiple)</td>
<td></td>
</tr>
<tr>
<td>16. Combat (single)</td>
<td></td>
</tr>
<tr>
<td>17. Combat (multiple)</td>
<td></td>
</tr>
<tr>
<td>18. Injury: Crisis Mgt Job:</td>
<td></td>
</tr>
<tr>
<td>19. Associate's death: Crisis Mgt:</td>
<td></td>
</tr>
<tr>
<td>20. Causing death as a Job Function</td>
<td></td>
</tr>
<tr>
<td>21. Personal Injury/Accident</td>
<td></td>
</tr>
<tr>
<td>22. Disease/Self</td>
<td></td>
</tr>
<tr>
<td>23. Disease/Loved One</td>
<td></td>
</tr>
<tr>
<td>24. Natural Catastrophe</td>
<td></td>
</tr>
<tr>
<td>25. Perpetration of Violence</td>
<td></td>
</tr>
<tr>
<td>26. Other</td>
<td></td>
</tr>
</tbody>
</table>

1. If there is just one source of trauma, skip the next form (1B) and go directly to 2a, 3a, 3b.
2. If there is more than one source of trauma, go to form (1B): "ETM Worksheet: Addressing Multiple Sources of Trauma."
ETM Form 2A
Treatment Strategy - Individual/Multiple Trauma Case
*Not for Chemical or Co-dependency*

Patient Name

Jointly Participating Primary Patient (e.g. CDP or Codependent Spouse)

<table>
<thead>
<tr>
<th>Order of Trauma Treatment</th>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ______________________</td>
<td>First Trauma To be Addressed__________________</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ______________________</td>
<td></td>
</tr>
<tr>
<td>3. ______________________</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>4. ______________________</td>
<td></td>
</tr>
<tr>
<td>5. ______________________</td>
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</tr>
<tr>
<td>6. ______________________</td>
<td></td>
</tr>
<tr>
<td>7. ______________________</td>
<td></td>
</tr>
</tbody>
</table>

Method of Attaining Initial Goals
ETM / TRT Education

1. Lectures: See the TRT Educational Program.
2. Information Aids
   "Welcome to TRT"
3. When the patient enters the first TRT session, provide:
   o How to Do Phase One
   o Giving Feedback
4. Other

TRT
- TRT Name?_______
- Individual ________
- Group___________
- Have you made provisions for addressing the MPT occurring in a period other than the one being addressed in this emphasis?
- Do you have a follow up TRT referral (if necessary)?

Parallel Education
- Interpret differences between TRT and other educational materials.
- Note educational materials.

Parallel Therapy
- Interpret differences between TRT and parallel therapies.
- Note parallel therapies

1. Provide TRT for additional traumas when the first source of trauma has been resolved.
2. See form 2B and form 2C for, respectively, care of indirectly or directly affected families.
ETM Form 2A
Treatment Strategy - Individual/Multiple Trauma Case
_Not for Chemical or Co-dependency_

Patient Name

Jointly Participating Primary Patient (e.g. CDP or Codependent Spouse)

<table>
<thead>
<tr>
<th>Order of Trauma Treatment</th>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ______________________</td>
<td>First Trauma To be Addressed_________________</td>
</tr>
<tr>
<td>2. ______________________</td>
<td>Initial Goals:</td>
</tr>
<tr>
<td>3. ______________________</td>
<td>A. Stabilize acute survival response to trauma.</td>
</tr>
<tr>
<td>4. ______________________</td>
<td>B. Mitigate fear of condition</td>
</tr>
<tr>
<td>5. ______________________</td>
<td>C. Identify trauma-causing event(s), shock and</td>
</tr>
<tr>
<td>6. ______________________</td>
<td>initial emotional responses to the trauma</td>
</tr>
<tr>
<td>7. ______________________</td>
<td>D. Other ____________________________</td>
</tr>
</tbody>
</table>

Method of Attaining Initial Goals
5. Lectures: See the TRT Educational Program.
6. Information Aids
   "Welcome to TRT"
7. When the patient enters the first TRT session, provide:
   o How to Do Phase One
   o Giving Feedback
8. Other

3. Provide TRT for additional traumas when the first source of trauma has been resolved.
4. See form 2B and form 2C for, respectively, care of indirectly or directly affected families.
ETM Form 3A  
Treatment Strategy – Individual / Multiple Trauma Case  
Chemically Dependent Person

Patient Name

Jointly Participating Primary Patient (e.g. CDP or Codependent Spouse)

<table>
<thead>
<tr>
<th>Order of Trauma Treatment</th>
<th>Acute Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>First Trauma To be Addressed________________________</td>
</tr>
<tr>
<td></td>
<td>Initial Goals:</td>
</tr>
<tr>
<td></td>
<td>A. Stabilize acute survival response to trauma.</td>
</tr>
<tr>
<td></td>
<td>B. Achieve sustained and continuous sobriety (see master treatment plan for chemical dependency treatment).</td>
</tr>
<tr>
<td>2.</td>
<td>C. Identify trauma-causing event(s), shock and initial emotional responses to the trauma.</td>
</tr>
<tr>
<td>3.</td>
<td>D. Reestablish communications with family (if participating).</td>
</tr>
<tr>
<td>4.</td>
<td>E. Prepare patient to begin TRT at 6-10 mo. sobriety.</td>
</tr>
<tr>
<td>5.</td>
<td>D. Other ________________________________</td>
</tr>
<tr>
<td>6.</td>
<td>________________________________</td>
</tr>
<tr>
<td>7.</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

Method of Attaining Initial Goals
## Etiotropic Trauma Management Trauma Resolution Therapy
### Training – Certification Program

<table>
<thead>
<tr>
<th>ETM/TRT Education</th>
<th>TRT</th>
<th>Parallel Education</th>
<th>Parallel Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lectures: See the TRT Educational Program.</td>
<td>• TRT Name?_______</td>
<td>• Interpret differences between TRT and other educational materials.</td>
<td>• Interpret differences between TRT and parallel therapies.</td>
</tr>
<tr>
<td>2. Information Aids</td>
<td>• Individual _______</td>
<td>• Note educational materials.</td>
<td>• Note parallel therapies</td>
</tr>
<tr>
<td>a. &quot;Welcome to TRT&quot;</td>
<td>• Group__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. &quot;Chemical Dependency, Trauma and Loss&quot;</td>
<td>• Have you made provisions for addressing the MPT occurring in a period other than the one being addressed in this emphasis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. When the patient enters the first TRT session, provide:</td>
<td>• Do you have a follow up TRT referral (if necessary)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o &quot;How to Do Phase One&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o &quot;Giving Feedback&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Provide TRT for additional traumas when the first source of trauma has been resolved..
2. See form 2B and form 2C for, respectively, care of indirectly or directly affected families.
Patient Name

Jointly Participating Primary Patient (e.g. CDP or Codependent Spouse)

<table>
<thead>
<tr>
<th>Order of Trauma Treatment</th>
<th>Acute Care</th>
</tr>
</thead>
</table>
| 1. | First Trauma To be Addressed
| 2. | Initial Goals:
| 3. | A. Stabilize acute survival response to trauma.
| 4. | B. Protective response where indicated (see master treatment plan for crisis focus).
| 5. | C. Identify trauma-causing event(s), shock and initial emotional responses to the trauma. At the same time, delineate drug use behaviors.
| 6. | D. If involved with actively using and violent CDP, separate from exposure to life threatening drug use behaviors.
| 7. | E. Where appropriate CDP recovery allows, reestablish communications between family members (if participating).
| 8. | F. Other |

Method of Attaining Initial Goals
**ETM/TRT Education**

1. Lectures: See the TRT Educational Program.
2. Information Aids
   - a. "Welcome to TRT"
   - b. "Chemical Dependency, Trauma and Loss"
3. When the patient enters the first TRT session, provide:
   - o “How to Do Phase One”
   - o “Giving Feedback”
4. Other

**TRT**
- TRT Name? _____
- Individual ________
- Group__________
- Have you made provisions for addressing the MPT occurring in a period other than the one being addressed in this emphasis?
- Do you have a follow up TRT referral (if necessary)?

**Parallel Education**
- Interpret differences between TRT and other educational materials.
- Films, video and lectures depicting alcoholism, drug addiction, psychology and the effects of drug use behavior on families.

**Parallel Therapy**
- Interpret differences between TRT and parallel therapies.
- Note parallel therapies

1. Provide TRT for additional traumas when the first source of trauma has been resolved.
2. See form 2B and form 2C for, respectively, care of indirectly or directly affected families.
Chapter 13 Section (a)

Evaluating for Trauma's Resolution

Finding an Evaluation Criterion for Trauma's Resolution

About / Theory / Measuring for Trauma Resolution describes the ETM method for measuring for trauma's resolution.

Until the time of this writing, trauma resolution and etiology reversal were described from three points of view. There was the objective (observations of symptom reduction) view that came from the clinician's perspective, the subjective (the client's description of the resolution experience -- self report) view that came from the trauma victim's perspective, and the ETM perspective, which was and still is comprised of a mixture of both the objective and subjective perspectives, but under special criterion and guidelines. This chapter considers the first two methods as their deficiencies contributed to the establishment of the ETM measurement approach.

Objective Perspective (Symptom reduction)

The objective view results from an appraisal of symptoms by someone other than the trauma victim. Van der Kolk (1987, pg. 12-14) explains this approach in his study of resolution; he quotes Horowitz's (1976) description of trauma resolution: "the capacity to recall the trauma at will, while being equally capable of turning one's mind to other matters." In this approach, one that is dependent upon the clinician's observations of behavior, trauma resolution is determined by the ending of certain symptomatology: the inability to recall the trauma at will and without becoming obsessed by the experience while making the recollection.

Other attempts to clarify, understand or define "trauma resolution" through the appraisal of symptoms are provided through van der Kolk's review of studies of kidnapped (Terr, 1983) and rape (Burgess and Holstrom, 1974) victims. In both of these studies trauma victims were observed periodically over a matter of years. The symptoms of the trauma were seen as continuing, inferring that resolution was a protracted and indefinite process with an inconclusive ending.
There are several problems with the symptom focused approach to determining resolution. They are overviewed in the rest of this subsection.

First, in the literature, symptoms are described as coming and going without consistent or predictable patterning. Their non appearance does not mean that the PTS condition does not exist (Bower, 1988). Van der kolk (pg. 14) describes his own studies (1985) of the failure of the focus on certain symptoms to provide a consistent means of measuring or testing for PTSD. Furthermore, he also describes (1987, pg. 14) Laufer's criticisms of the DSM diagnostic criterion for determination of a PTSD, both intrusive reexperiencing and denial are required for a positive diagnosis. They (quote: Laufer et al., 1985) call for a clearer bidimensional approach in defining PTSD, in which either dimension may dominate, at the exclusion of the other, at different stages.

Thus, based upon the literature's consideration of symptoms, delineation of them is an unreliable method of determining that the PTS condition exists; symptoms may not always be present or apparent, or they may reappear at any time. In our observations of symptoms, however, the symptoms only "come and go" or reappear, as a rule, if the client is using psychoactive substances, drinking alcoholic beverage, simultaneous (between sessions) with the application of the therapy. When the use is ended (and the person uses the structured TRT process as directed), the symptoms disappear and do not come back, at least during the periods in which we have seen or otherwise had contact with the individual (often as long as 2 years as the client may have been engaged in other treatment processes: see Clinical/Family).

We were careful to observe in the literature whether those conducting their studies accounted for the prospective influence of such drug use as a parallel therapy (medication). None did, except where general comments were made about the undefined levels of reductions of such use in certain situations, which studies, in the main, told us that parallel drug (alcohol) use was occurring while the studies on symptoms were being conducted, but the parallel drug use was not being accounted for: the drug use was not being considered as an interfering, or at least influencing, variable as we consider it to be.

Thus, the symptom reduction measurement method is a reliable evaluative device if used to determine if trauma resolution is occurring or has occurred.
in the application of TRT, and when no parallel drug (alcohol) therapies are interfering with the process. However, the literature does not support measurement of symptom reduction as a determiner of trauma resolution because the manifestations of PTS symptoms are shown in those studies to be indiscriminate. Moreover, symptom appraisal methods that have attempted to evaluate for a particular therapy’s effectiveness in the treatment of PTSD have been shown, with one exception (Solomon, 1992), to be inconclusive; the exception is that flooding is demonstrated to have a consistently positive effect across all kinds of trauma.

A second problem with the symptom approach, and again, one that is also not recognized in the literature, is that a focus on symptoms, survival responses, with the intent to eventually change those symptoms as a condition for recognizing that resolution has occurred, will paradoxically reinforce the very survival defense structure that protects the person from experiencing the damage resulting from the trauma (see chapters 3 and 14 in the text). Therefore, symptom focused approaches that rely on measuring, defining and determining behavior, can themselves become an integral part of the trauma's defense structure, thus removing the primary value of its (symptom focused) approach; assuming our theory is correct, when the method becomes part of the problem, the symptom focused method must lose its claim to objectivity -- objectivity is an illusion.

The third problem with the nosotropc model is that the locus of the responsibility for trauma resolution is assumed by the observers to lie within the ontology of the trauma victim. "Locus of responsibility for the trauma's resolution" means that the trauma's resolution is a function of what the individual does or doesn't do toward resolving the trauma. In this concept of resolution, the victim may resolve the trauma or not.

Moreover, in terms of time and conclusion, the resolution process is indeterminate. We suspect that this attitude about resolution is a consequence of the use of psychotherapy and non structured grief resolution models in the treatment of trauma victims.

The idea spawned by these models is that the Self that is damaged by the trauma and loss will progress, that is, restore the damaged state to non damaged levels, at a pace that is existential in its orientation and to be determined by an undefined actualizing component of the Self. In some instances, there is little to no consideration for the role of interfering
variables and the prospects for these variables' adversely influencing the Self's attempts to work out of the trauma's effects.

Consequently, without knowledge of the prospective interfering variables influences and a knowledge of how TRT's structure accelerates, defines, and concludes the resolution process to include preventing interfering variables from influencing that Self's efforts, there is no consideration by the observers that the resolution of psychological trauma can be anything other than a solitary effort and the primary responsibility of the trauma victim. Observations (provided in the literature) of trauma resolution are influenced by these ideologies/philosophies about and methods for resolving trauma: ideologies, philosophies and methods that are not listed by the scientific approach as influencing criterion for determination of trauma resolution. Conclusions about resolution are unknowingly determined before evaluations are begun.

To make this point clearer through contrast, if measurers of trauma were TRT trained, none would bother measuring trauma resolution in individuals who are attempting to resolve the trauma alone because without special assistance coming from outside of that individual, trauma resolution, etiology reversal, would be considered practically impossible (in cultures where interfering variables occur as a routine matter). If such resolution is going to occur, it will be a function of what those surrounding the trauma victim do or don't do (they do or don't preclude cultural interfering variables from preventing individual resolution efforts) and not a function of the trauma victim's particular personality or activities.

In other words, if psychological trauma etiology is not emphatically identified by those surrounding the trauma victim, and then reversed, rarely will people be able to resolve trauma on their own while living in a culture dominated by trauma coping philosophies and drug use that prevent resolution. The culture will guarantee no resolution occurs (see pages 310-312).

To summarize the use of the objective (symptom focused) perspective in appraising whether trauma resolution has occurred:

1. The literature does not support symptom reduction measurement as a viable determiner of trauma resolution because symptoms are shown in those studies to come and go.
2. Symptom reduction measurement can be a viable determiner of trauma resolution in TRT (but under the special criteria described in the last paragraph under this subheading and as considered in the next highlighted summary) because, unlike the evaluative efforts described in the literature, TRT guidelines require consideration of social alcohol use as a parallel and highly likely interfering variable, and that when such use is precluded, and when the TRT structure is appropriately applied, the symptoms do not reappear.

3. Evaluative processes that focus on the presence of symptoms as the primary measuring device, tend to infer that the goal of the therapy should be to reduce such symptom activity. If symptom reduction is made the primary goal of therapy, such a goal will interfere with the trauma resolution process -- it will become caught up, and eventually controlled by, the paradoxical formation created in response to the damaged existential identity and the incapacitated operational identity. Thus, symptom-focused measurement approaches can lose their objective status because they become, unbeknownst to the researcher or therapist, a participating clinical variable: a part of the systemic psychopathology of psychological trauma.

4. The objective perspective, as it is represented in the literature, presumes that the initiation of and responsibility for the trauma's resolution is a function of individual ontological makeup, which at least, it may not be, and from the TRT perspective, certainly is not as long as the surrounding system introduces interfering variables, stoicism and drug use.

5. The objective approach, which relies chiefly on the delineation and categorization of symptoms, is demonstrated as having conflicting variables (as described above and under this subheading), and thus is only reliable under special conditions (described under the heading: "ETM Perspective"). Because of those conflicting variables and special conditions, measurement of symptom reduction cannot be considered as the primary means of determining trauma resolution.

**Subjective Perspective (Self-report)**

As a rule, self reports, when taken by themselves, are considered anecdotal data; the data is considered unreliable because the information cannot be verified by a third and unbiased party. The evaluator cannot get into the mind of the trauma victim, nor can the data be codified and evaluated within the context of accepted statistical methods; control groups are required.
Moreover, self-reports, when taken from people under the preconception that trauma resolution is a function of individual responsibility and ontological makeup (where systemic interference is not recognized), usually include the subject's (trauma victim's) general descriptions of feeling states, other psychic conditions such as thoughts and attitudes about the traumatic event, and changes (or lack of change) in living experiences; general elicitations of such information are subject to myriad meanings and they are not conclusive. Consequently, the subjective perspective, when limited by preconceptions of trauma resolution and generalizations about psychic conditions, also does not provide an adequate measuring vehicle for trauma resolution.

(Forming the ETM Definition of Trauma Resolution)

Because no logical means existed for determining trauma resolution, and because the structured approach provided us with what we believed was both a clearer definition of trauma and its resolution, Nancy and I developed our own criterion for making that determination. In this perspective, the appraisal of trauma resolution as it occurs within the context of the application of TRT, the measuring device is a combination of subjective and objective methods, but with the application of special criterion that have evolved out of our observations of the trauma resolution therapy process. Trauma resolution per these special criterion involves self-reports and the facilitator's observations.

Self-Report

Numerous self-reports have been taken at the end of the trauma victim's use of the 5 phase structured psychodynamic process. Virtually in every case, those people reported that the trauma had been resolved. To them, "resolved" carried a special meaning; it is described next. Simultaneously, the facilitator has observed the trauma resolution process, even experienced it with the patient. Both, the client and the facilitator/observer, combine to present the following criterion that demonstrates resolution, etiology reversal.

1. The acute emotional pain and loss resulting from the event is addressed to the extent and degree that the person feels fully "heard" or "finished" with the experience or that the emotional pain is
"completely addressed, resolved, and reconciled"; further address, resolution, and reconciliation is unnecessary. In addition, the counselor who has made the journey with that person also experiences a similar sense of completion from that person. The individual also explains that if further address of emotion is necessary, the person would, with confidence, know what to do; the person would know what was required to address any recurring experience. In our facilitation of TRT, such additional needs were rare; we have no recollections of an example of an individual's demonstrating a need to return to, or an interest in returning to, a discussion of the traumatic event for the purpose of addressing emotional pain and loss resulting from that event. Nor have we ever heard of such a requirement by any of the 1000 (at the time of this writing in 1992-93) professionals trained and certified to administer TRT.

and

2. The person has an understanding of the following (A - D):
("Understanding" refers to a well grounded intellectual [rational/cognitive] and experiential [empathic, intuitive, emotional, and for some, spiritual] realization.)

- A. Who the person was prior to the trauma's occurrence.

"Who the person was prior to the trauma's occurrence" means that the person identifies specific values, beliefs, images, and realities that are considered to be the essence of those aspects of Self that are recognized as having comprised the psychological Self that existed before the event occurred.

- B. What happened to the person as a result of the trauma.

"What happened to the person as a result of the trauma" means that the person recognizes the specific effects that the traumatic event had on existential and operational aspects of identity. "Specific effects" refers to those continuums of thought comprising Self images, values, beliefs, and realities that were interrupted and that as a consequence of the intrusion, resulted in loss of certain aspects of that Self; the aspects of loss are also identified with specificity. "Specific effects" also refers to any reductions in interactions between the individual's use of certain attributes; for example, reductions in the abilities to manage the system of values, etc., analyze and plan life processes without
encumbrance, and to feel, empathize and, in some cases, care about one's self and others.

o C. **The difference between what the person had to do to survive and who the person was (during the trauma and the following period).**

The reference to "differences between survival thought/behavior and personhood" means that the individual identifies all changes in behavior and thought undergone as direct and indirect responses to the trauma-causing event, and that the responsibility for those changes lie with, and within the context of, the event itself and the subsequent (that is, the period in which the trauma was not being addressed, reconciled or resolved) and unrecognized damage to the existential and operational elements of the psyche directly caused by the event. "Differences" also refers to the identification of those survival responses and behaviors as consequences of the damaged psyche and not of personality traits attending the undamaged psyche -- the person.

o D. **Who the person is now that the trauma is resolved.**

"Who the person is now that the trauma is resolved" means that the person has

- appraised the pre-trauma identity, the damage to that identity, and the survival identity adapted as a response to the trauma, and
- assimilated the elements of those pre-trauma identities that are acceptable to the ontology of the individual, as that individual exists today; the person is no longer encumbered by the damage previously sustained as a response to the trauma-causing event.

When the trauma victim provided a self-report that the trauma had been resolved, that is, the trauma victim described his or her understandings of the trauma and its effects upon the person's life -- the description was provided within the criterion described in "1" and "2: A,B,C and D" from the foregoing, the standard for trauma resolution under the ETM definition had been met. The trauma had been resolved. The etiology created by the event has been reversed.
Facilitator's Observations -- Validation of Resolution

Validation of the trauma victim's self-report that the trauma has been resolved is accompanied by the facilitator's determination through observation of the therapeutic process that:

1. all contradictions to values, beliefs, images and realities, including both contradictions created by the initial trauma and the survival responses, have been identified.
2. all losses stemming from those contradictions have been resolved; "resolved" means that they have been identified, experienced, expressed, understood and accepted.
3. all contradicted values, beliefs, images and realities have been reconstituted.
4. all grief cycles (described in Part One of the text) related to the individual's passage through the process of identifying the trauma-causing event, its damage to existential identity, survival responses that also damage existential identity, and identification of that specific damage, and reconciling all such damage described herein have been fully negotiated. "Fully" means that no elements of the psychological trauma patterns remain to be addressed.

Observations of TRT Including a Comparison to Selected Therapies

The following are general comments about TRT's results, to include a comparison to some predominant approaches used in the treatment of the noted populations. Before making these comments, we list several qualifiers.

- We recognize that authors are not always the best evaluators of their own therapeutic efforts and inventions.
- Scientific analysis of the efficacy of therapy is itself in question.
- Scrignar, (1988), van der Kolk (1987) and Hendin and Hass (1984) reported no research validating, with confidence, the value of one remedy over another.

With that said, over a 7 year period (1979 to 1985), Nancy and I provided, either directly, or indirectly through the supervision of the activities of other professionals, therapeutic services to many people (see ETM's Historical Overview under the Level 4 Development). In addition, at the time of this writing (1992), over 1000 professionals have been certified as ETM
counselors. According to the periodic interactions between many of these people and our agents, the professionals trained over the last 9 years have provided TRT to their clients as well. ETM is provided in individual practice and in clinical facility settings where treatment teams are utilized.

Moreover, the TRT short form is routinely applied in crisis management organizations, to include school districts. The rest of this section is based on these experiences, our practice and professional testimonials.

At the time of Nancy's and my direct service endeavors, our focus was on helping people to the best of our abilities, observing the criterion required for a successful outcome, and ensuring those criterion were met (see About/Development/Historical). There was no intent to provide qualitative and quantitative test results for the therapeutic community, except as were required under the government and Joint Commission for the Accreditation of Hospital standards; audits of our work were routinely made by licensing authorities (again see ETM's Historical Overview under the Level 4 Development).

In the beginning of TRT's development, that is, between 1980 and 1981, I applied the TRT model to two groups (8 members in one group and 6 in the other) comprised predominantly of battered spouses, women and one man who lived with and/or were beaten by violent alcoholics; Nancy provided in a similar number of groups and to a similar number of and likely affected people some of the models (not TRT) that were in vogue at the time (described in the development section).

TRT was introduced in my group, not as a therapy, but as an ancillary process: an educational means for helping people to organize and manage their understandings of the various trauma's myriad effects (this initial application is described in detail in "Individual TRT" development). Not only were the outcomes of the applications of the new management system extraordinary, shown to have profound therapeutic value, but this value was related by my group members to the members in Nancy's groups. Apparently many of these people knew each other, often through their associations in the Twelve Step programs.

Nancy's group members then asked for the opportunity to use the new educational and management system. Thereafter, Nancy's group members were administered the model to those who wanted to use it; the results were
the same as in my group: extraordinary. We then made TRT available to anyone who wanted to use the program.

We have not participated in statistical evaluations of the TRT model's viability because we know that it does reverse etiology and exclusion of controls (people who do not have TRT available to them) from TRT would prevent us from meeting our ethical responsibilities. We did not experiment on trauma victims as such experiments are reflected in the literature (see the bibliography).

Every known response accorded by ETM trained and certified professional's has validated the value of TRT.

Even though we did not and do not engage in experimental projects intended to compare therapeutic processes with TRT, we were repeatedly confronted with the use of other modalities by clients who were participating in parallel treatment processes. We were also apprised of situations where newly training (in TRT) professionals attempted to use the various models (not TRT) underpinning their professional experiences and prior to learning about TRT.

From these experiences (addressing TRT's differences from other therapies) we were able to ascertain enough of an evaluative view to report general observations and express subsequent opinions, that is, make claims about, the therapeutic efficacy, in part relative to the other approaches, of TRT. Such observations, opinions, and claims are presented here with the understanding that validation of them can only occur through applications of the TRT model under ethical guidelines and by people other than ourselves. The use or experience of the model by practitioners independent of us is the best means for substantiation of our experiences and subsequent opinions -- letters and other reference are available under About/Professional References.

Furthermore, the ETM Professional Training School accords professionals with the opportunity to experience the TRT model's applications first hand in training sessions. We believe that this approach is the most effective, ethical, and responsible means for transferring the knowledge of the TRT and ETM models to others so that they can determine the clinical viability of the models for appropriate clients (see ETM Certification).
When TRT is applied as described in this book and shown in the *ETM Professional Training School*, the administrator of the model can expect application results to include:

- the trauma victim's ability to discuss or consider the traumatic event(s) and then change topics of discussion.
- the ability to modulate (easily) between emotion and abstractions, including the ability to solve current problems that evoke emotion, even to the extent that the memory of the traumatic event is rekindled.
- an end to dissociation and its effects.
- an ending of the paradoxical system of thought that we posit controls conscious perception and decision making, to include analytical and evaluative, processes.
- an understanding of who the person was prior to the trauma, what happened to him or her during the traumatic experience, how the person changed in response to the trauma, and who he or she is now that the trauma has been resolved.
- separation of the person from psychological fusion with the perpetrator of the event (reversal of what many call the Stockholm syndrome or codependency).
- withdrawal from pathological systemic processes.

From a comparison perspective, ETM administrators are likely to find that:

- those who've completed TRT appear considerably more stable than those who are embroiled in a cyclical process of constantly evaluating their activities, all the while assigning various theoretical conceptualizations as to why they behave the way they do.
- chemically dependent people who have completed TRT are not afraid that emotional stress will precipitate relapse. Rather, they experience emotional pain like other people without equating its occurrence with a prospective return to chemical use.
- chemically dependent people who complete TRT do not assume responsibility for having caused their illness, nor do they believe that the illness or disease occurred as a result of character defects, personality disorder, or as a consequence of any other psychological causal theory; the experience is assumed to be biological in its origin and orientation.
- if the TRT participant is an adult child of an alcoholic in addition to being chemically dependent, the person will be able to distinguish
between trauma experienced as a child and trauma resulting from the drinking/drug use; the result is likely to be the reconciliation of a profound conflict in identity.

- programmed positive affirmations and the repetitive use of slogans or therapeutic jargon are not necessary as a way of interacting or living life.
- the term "co-dependent" is needed only as a reference for study and never as a therapeutic self-intervention device.
- with regards to trauma victims eventually looking like they are being responsible citizens; they do so, but without having to repeatedly extol the concept of responsibility as do those who have not fully resolved the trauma, reversed the etiology.
- choice is found to be an automatic extension and expression of free will regained as a direct response to the trauma's resolution; etiology reversal is equivalent to free choice. People who have resolved trauma through TRT do not invoke the concept of choice for the purpose of reminding themselves that they can choose their way out of their situation; TRT patients make such decisions automatically without the redundancy inherent in the behavioral injunction "I choose" to do this or that.
- trauma victims do not allow an incompetently managed system of social controls to further harm the trauma victims' psychology or to adversely influence that person's life in general.

Generally, almost everyone who has completed TRT, and been involved in other therapeutic endeavors, has reported that TRT is the Cadillac (at the time "Cadillac" was intended to mean "the best") of therapy. We have numerous testimonials that support this praise. Although not available for publication, independent audits of client exit evaluations upon exiting treatment (in institutions other than our own) showed TRT to be the most valuable care element of the continuum.

**Testing Criterion**

TRT will resolve trauma if:

0. external factors (nosotropically-based models like psychotherapy, cognitive - behavioral/ analytical - interpretive, pharmacological, and ongoing threat to life by a perpetrator) do not interfere with TRT's application.
1. the TRT participant does not use drugs (including the social use of alcohol) at any time throughout the therapeutic process.
2. the therapist does not use drugs (including social use).
3. the person does not suffer additional physiologically-based mental illnesses (for example, manic depression or schizophrenia).
4. the patient's prior medical history does not include pharmacological applications; for example, tranquilizers, anti-depressants, etc.; although TRT may be able to help these people, the previous applications may alter neurology (see the theory and bibliographical sections), and the past alterations could interfere with TRT's application despite their current discontinuance.
5. the therapist follows the directions for facilitating TRT; those directions have been provided in this book and are reiterated through the application of TRT experience within the professional education and training module known as the ETM Professional Training School.
Part Two

Comparison and Contrast
Chapter 14: Comparison and Contrast

Psychology of Etiology

TRT Patterns and Structure

This section considers information that supports and conflicts with the:

- TRT theory of 4 psychological trauma patterns.
- TRT structure, including consideration of other structured approaches.
- Paradoxical response to trauma.
- TRT/ETM applications: a comparison to other clinical approaches to the treatment of psychological trauma.

Four Psychological Trauma Patterns

This subsection reviews literature related to the psychological aspects of the TRT theory of the 4 psychological trauma patterns. The review includes the consideration of: pattern delineation; the traumatic event as an ongoing experience in memory; contradicted values, beliefs, images and realities (existential identity); loss; and grief (emotional) cycles.

Pattern Delineation

None of the studies of psychological trauma that we could find categorized the effects of that trauma on the psyche with the organization and specificity of the 4 psychological trauma patterns described in our own theory. However, numerous psycho dynamic oriented writers constantly refer to the myriad of effects of trauma on the psyche, to include basic considerations for the experience of the initial trauma and attempts to survive following that experience. We think Dr. Bruno Bettleheim, in his descriptions of psychological trauma experienced by concentration camp survivors during WWII, and notably himself a survivor of Dacau, best portrays the idea that psychological trauma is comprised of related issues: patterns (the emphasis through the use of italics is ours).
Survivorship consists of two closely related, but separate issues. *First is the original trauma:* in this context, the personality disintegrating impact of being imprisoned in a German concentration camp which completely destroyed one's social existence by depriving one of all previous support systems such as family, friends, position in life, while at the same time subjecting one to utter terrorization and degradation through the severest mistreatment and the omnipresent, inescapable, immediate threat to one's very life. *Second, there are the life-long aftereffects* of such a trauma, which seem to require very special forms of mastery if one is not to succumb to them. (Bettleheim, 1979, p. 24)

In this description, the person must contend with both the reality of the original trauma and the trauma's effects. TRT patterns one and two correlate to Bettleheim's description of the original trauma. Patterns three and four relate to the "life-long effects."

The idea that the four patterns can be linearly connected and sustained as an entity is supported neuropsychologically by Dr. Donald Hebb's Cell Assemblies Theory (*Organization of Behavior*, 1949). Hebb's argues that the brain is not always a function of helping the organism to relate to its environment, but that it can become a function of relating to itself within itself. In an interview by Restak (1984), Hebb explains this view as the formation of cell assemblies that support psychological entities within the brain. Kolb (1987) describes cyclical (pattern) relationships between the effects of the event on neurophysiology, the role of emotion and subsequent correlation of the neurophysiology and emotion to the production of neurophysiological/behavioral symptoms. These patterns, although not delineated in terms of the relationship of contradicted existential identity to loss, are generally related (parallel) to the patterns described by us in the TRT theory of psychological trauma.

**The Traumatic Event as an Ongoing Experience in Memory**

The reporting of flashbacks (DSM) and lifelike dreams provide for the best evidence that the trauma is recorded in memory as an ongoing experience. In some cases, the dreams and flashbacks are experienced eidetically, a clarity equivalent to that of viewing a motion picture (Van der Kolk, 1987, pgs. 69 - 70).
Contradicted Existential Identity

Our organization of existential identity, for example, existential identity is
equal to values, beliefs, images and realities, resulted from our listening (see
About/ Development/ Individual) to trauma victims describe what they had
lost as a result of, say, a beating by a spouse. As described in Section 4a, we
attended during this period of TRT's development a course in General
Behavioral Marital Therapy (GBMT). It was developed and taught by a Dr.
Weizman, a professor at the University of Oregon.

Weizman had developed a method through which couples could describe in
writing a multitude of different values and beliefs about the constitution of
the marriage agreement. Because the spouses of alcoholics (and spouses of
batterers) were attempting to describe similar realities as basic expectations
that had been sundered by the alcoholism and the violence, I saw a parallel
between the GBMT approach to marital therapy and our helping spouses to
identify such sundrances.

Subsequently, I developed the Matrix (described in other sections of this
information system) to be used as a means of helping these people to codify
the large numbers of values and beliefs being intruded upon and large
numbers of losses that are correlative to such intrusions. For physically
damaged people, I added "images" and "realities" to the values and beliefs
category.

This addition was originally made for people who sustained disfigurements
to their faces as a result of blows by an intruder. For example, a nose that
was broken, a tooth knocked out, a broken jaw, or a discoloration of the face
(bruises), produced alterations in the individual's facial image and physical
reality (and perception of reality) of themselves.

As this identification method was applied to people affected by automobile
accident or combat where either a disfigurement had occurred, or had been
observed as occurring for another person, say in the line of duty while
carrying medical evacuees during combat in Vietnam, the image and reality
delineations had the same effect as the similar identifications had had for
physically assaulted and disfigured people.

Although, at the time, I looked in the literature, and have since reviewed it
on numerous occasions, I have found no one else who has studied this aspect
of the psychology and in terms of loss as a response to specific
contradictions to values, beliefs, images and realities as we organized it. In Hofer's (1984) article on biology of bereavement (relationships as regulators) he also indicated that he knew of no studies on this general concept, his statement on the subject being:

"Do the chronic background symptoms of bereavement occur to the same degree in this case in which the loss is not one of actual interaction but of hopes, expectations, and memories?" (1984, pg. 191).

In support of this concept, there have been numerous workers who view loss as a consequence of changes in the internal psychological dynamics. One such person is Dr. Henry Olders. He argues that Losses occur in ways other than by death or separation, for example, losses occasioned by giving up childhood attachments.

Changes during development can be experienced as losses for which mourning is adaptive (1989, pgs. 272 -273).

Olders then references Fleming and Altschul (1963) on their belief that separations provide effects on ego development; Brice's (1982) view that loss is an ordinary and expected result of life process, including change, is also referenced by Olders.

Parkes's (1972, 1987) describes the effects of loss of a loved one on identity; but the description is provided in terms of the individual's having to establish a new identity now that the old one, established in the relationship with the deceased family member, is gone. Parkes' focus is on showing how people redevelop that new identity.

**Loss**

Loss is often studied in the literature in the context of separation from a loved one. Thus, separation-based loss is studied in the context of bereavement (also see the next subsection entitled "Grief Cycles").

Lindeman delineates symptoms of grief resulting from loss in his classic article on bereavement (1944). Bowlby has written extensively on attachment and loss (1969, 1980) and is recognized as one of the primary investigators and theoreticians on the subject; Bowlby's analysis of the literature on loss is recognized as a hallmark in scientific endeavors to understand loss. Parkes' (1972, 1987) Bereavement is also a classic book about loss that describes grief and its process and facilitation as it affects
adults who have lost a spouse to death. Bowlby and Parkes are, or have been, cohorts and their work overlaps. Parkes' second edition (1987) also considers the value of grief therapies in facilitating loss; and the second edition has a section on psychological trauma. Osterweis, Solomon and Green produced *Bereavement: Reactions, Consequences, and Care* (1984), a scientific approach to the study of loss and bereavement that includes the scientists' emphasizing a conceptual framework for future study of the subject. Hofer, who is a contributor to the aforementioned scientific group (the chapter on the biology of bereavement), has produced additional articles on loss and grief, most notably the one article on relationships as biological regulators (1984).

These works by Osterweis, et. al. and Hofer provided us with the underpinnings of our understandings about the endocrine, immunological, and other biological responses to trauma and loss, and subsequently initiated this aspect of the TRT theory related to the endocrine response to trauma and loss. All 7 of these writers' views are discussed again in additional subsections and their works include well developed bibliographies substantiating their ideas and methods.

As indicated in the previous subsection on contradicted existential identity, loss resulting from trauma not necessarily related to loss of a loved one, but to loss of abstractions about the ongoing aspects of life, are harder to find. Other than the references in that section, van der Kolk describes the "essence of psychological trauma" as a "loss of faith in the continuity of life." (van der kolk, 1987, p.31). Walker (1990) recommends helping PTS victims by assisting their identification and reconciliation of intangible losses related to the inner construction of the self.

The literature is replete with animal studies where the consequences of separation (loss) on psychology, neurobiology, endocrinology and immunology are considered. Some of these studies are considered later, but may primarily be found in van der Kolk's extensive review of the subject (1987).

Loss is the central linkage to depression. Although there are examples of endogenous depression (the occurrence of depression unrelated to external events), the literature is full of data demonstrating that many depressions have their roots in the ending of relationships (bereavement) and loss resulting from psychological trauma.
Grief Cycles

Ramsey (1981) describes grief cycles in the application of Grief Confrontation Therapy (GCT), a 7 day model used in Europe to assist people who have not completed the bereavement of the loss of a loved one. Ramsey's delineation of the grief cycles or patterns are almost identical to those observed by us and reported in Part One, chapters 2 - 10. Ross (1969) also noted patterns in the processing of emotion following recognition of the pending mortality.

Of course, Bowlby (1980) and Parkes (1987) delineate both cognitive and emotional patterns of grief for people who are experiencing the loss of a loved one. Some of these patterns are closely related to those observed and reported by us (Part One). In an early work depicting the effects of tangible loss on family members of chemically dependent people, Kellerman relates the emotional and behavioral processes observed as affecting those people to grief (1976).

Repressed emotion resulting from loss and disruptions in life activities is well known. However, we find no hypothesis that the emotion resulting from psychological trauma is repressed in 3 unresolved grief cycles as we have suggested that it is being retained.

Paradoxical System of Control

Other than repeated references to the difficulties associated with the management of survival responses to trauma, which responses are referred to as, depending on the treatment model being applied to the particular trauma victim, disease characteristics, maladaptations, characterizations or symptoms of disorder, codependency behaviors, or character defects, we found no specific support for our interpretation of survival responses as emanating from a paradoxical system of control underpinned by neurobiological processes. Perhaps this lack of specific support is a function of the use of the TRT structure itself; only patients using the structure and completing TRT commented on the divided self that had been engaged in the internal tug-of-war; professionals not privileged to observe TRT's application may not be aware of the paradoxical system that influences the psyche to the degree that it controls the trauma victim's perceptions, thoughts, interactions, decisions, and behaviors.
There is some general support for the idea that the paradoxical system of control presents the patient and therapist with difficulties. One example has already been quoted at the beginning of this comparison section.

Second, there are the life-long aftereffects of such a trauma, which seem to require very special forms of mastery if one is not to succumb to them. (Bettleheim, 1979, pg 24).

Kolb (1987) quotes and paraphrases Freud as saying that the war neurosis (combat psychological trauma) is a function of the combat veteran's response to the trauma being at opposite with his or her moral perspective of how the veteran was supposed to respond. Lindy (1983) describes how society must and does adjust its laws, that is, its determination of responsibility for behavior, to veterans (and other people) suffering PTSD: people who, as a response to the traumatic event and its internal effects, are conducting themselves outside of the norm. The closest description to our interpretation of the paradoxical system of control, however, is Dr. Bruno Silvestrini's (from now on referred to as "Silvestrini") theory (1990) of "The Paradoxical Stress Response." Silvestrini's theory as it relates to the TRT theory of the paradoxical system of control is explained in the next subsection.

Silvestrini's "Paradoxical Stress Response"

Silvestrini posits that there are two biological stress responses.

He calls one of these responses the "orthodox" response; it provides for necessary survival activities during and following the traumatic event. Examples provided of such necessary activities include dilation of the pupil, increased blood pressure and heart rate, redistribution of blood flow to tissues requiring the additional nutrients, increased coagulability, stimulation of energy producing cell functionings, depression of some instinctual adrives like hunger and sex, increased alertness, stronger muscle capacities, and analgesia (Silvestrini, 1990, pg 6).

The other biological stress response is called the paradoxical stress response; it produces the opposite functions and outcomes provided by the orthodox one. Silvestrini's examples of the behavioral manifestations of this response include increased sexual and hunger activity, passivity, mental pain, etc. (pg 7).
Silvestrini suggests that this opposite or paradoxical stress response is responsible for such conditions as obesity, bulimia, panic attacks, some sexual deviations, depression, and alcoholism. The biological underpinning of the paradoxical stress response is not known, but is hypothesized to be, like its orthodox counterpart, initiated through adrenergic activity: stimulation of epinephrine.

Silvestrini's theory supports the TRT theory of the paradoxical system of control by bringing attention to the idea that some behavioral opposites are occurring during and following survival for some people. Moreover, the ideas that these opposites are biological in their basis and that they produce conditions that in themselves become psychopathological (like depression and compulsivity) are also supportive. The obvious (you may want to return to this part after reading section 2) differences are that:

1. the paradoxical system of control (from TRT theory) is hypothesized to be only one system that is represented by alternating functions between what Silvestrini calls the orthodox and paradoxical stress responses.
2. the paradoxical system of control (from TRT theory) has its basis in defending the person against loss, which itself is a neuropsychological paradox whose basis begins in memory and then precipitates a cascade of responses throughout the noradrenergic, hypothalamic-pituitary-adrenal cortical axis and adrenal medulla systems. In contrast, Silvestrini's paradoxical theory is based on the biology of the adrenergic (sympathetic system) response alone.

**Structure**

We found no comparable structure to TRT's, other than that discovered in the GBMT course and which effects on TRT’s development have been described in preceding paragraphs and in About/ Development/ Individual.

There are, however, other models that use structure. Some of them include letter writing (Kopp), grave visitation and use of pictures of the deceased (Williamson) to facilitate grief resolution, psychodrama to include reexperiencing the events through art forms like family sculpturing (Satir) and art therapy.

The most pronounced structure comes in the form of Grief Confrontation Therapy (GCT) and Guided Mourning Therapy developed by Ramsey.
Ramsey's work, as already described, is directed primarily toward grief resolution: loss of a loved one.

A review of Soloman, S.D., (1992) describing the various treatment approaches to psychological trauma and their effectiveness shows that psychological trauma treatment models that use some element of flooding, which is used by Ramsey, provides an edge in obtaining some form of success. That article considers some of the efficacy of some of these approaches when applied to the treatment of post-traumatic stress disorder, the viability of the use of flooding is shown to have the across-the-board strongest positive outcomes. "Flooding of memories" is of course an important, but only small, element of the TRT process.

Scrignar (1988, pgs 147 and 148) offers what we consider to be the best rationale for the use of structure in the treatment of PTSD when he describes the "information overload" that can occur when using the psychodynamic model to help the trauma-affected individual to reconcile the myriad effects resulting from the trauma. Scrignar quotes leaders who have made attempts to assist people in making these reconciliations (quote Horowitz, 1974, 1980; Brende, 1981, 1984; and Crump, 1984).

General Comparison of TRT to Alternative Concepts/Therapies

Since 1984, at least 4 scholars, Scrignar, van der Kolk, Hendin and Haas, have addressed psychological trauma in 3 important (to us) books (Hendin and Haas write together, 1984). Although there have been other efforts that have defined psychological trauma and codified its effects, we emphasize these works because each frames the trauma slightly differently: for example, from the perspectives of cognitive/behavioral, psychodynamic, and neurobiological concepts that lend themselves to pharmacological therapies.

In addition to providing literature reviews of the subject, each of these presentations also offer concepts or framings of psychological trauma that both support and conflict with the ETM theory and methods presented in this book. Those three works as presented from the perspective of that support and conflict, are overviewed here with four other methodological conceptualizations -- hypnosis, conversion, psychotherapy and grief resolution -- that overlap in practice to the previous 3 mentioned (non ETM)
Theories and methods. Cognitive/Behavioral Concepts and Methods; Scrignar's 3 E's

The cognitive/behavioral approach to the treatment of post-traumatic stress is addressed in this section from two perspectives. They include a general consideration of cognitive/behavioral theory and methodology as applied to psychological trauma; the cognitive/behavioral concepts and some of the methods are compared to TRT. Scrignar's perspectives, his delineation of the 3 E's and his treatment modality for them, are then considered.

**Cognitive/Behavioral**

The cognitive/behavioral treatment model approaches psychological trauma from the perspective that post-traumatic stress is a disorder (also called PTSD) characterized by certain symptoms. The condition of trauma victims affected by PTSD is distinguished as being clinically different from the condition affecting trauma victims who are not manifesting the proscribed symptoms. The focus of therapy is on helping the individual to identify the symptoms as unusual and destructive; the patient then learns to change the symptomatic behavior.

The theory underpinning this approach is that the symptoms are maladaptively learned responses to the traumatic event; the effects of this event can also have a neurobiological basis. The cognitive/behavioral idea is that these responses can be unlearned, in behavioral terms, and in the process hopefully right the neurophysiological changes that have resulted from the event.

Some of the methods utilized to help the individual accomplish the goal of symptom reduction include, desensitization, relaxation therapy, the use of biofeedback machines and cognitive/behaviorally oriented group therapies. The underlying concept is that if it were not for the manifestation of the trauma through symptoms, treatment would not be necessary. Thus, therapy is thought to be most helpful if the symptoms are addressed directly and the person is taught new coping skills that are not controlled by the trauma.

Although controlled studies validating the efficacy of any model used in the treatment of PTSD are scarce, some believe the behavioral approach will eventually be proven to be the most effective. (Scrignar, 1988, pgs. 149,150). Obviously, cognitive-behavioral concepts and methods have their origins in the nosotropic approach to psychological trauma.
Comparison of TRT to Cognitive/Behavioral

There are both similarities and differences existing between TRT and cognitive/behavioral concepts and methods. Each is explained in its own subsection.

Similarities

Both TRT and cognitive/behavioral models posit that learning is an important element of the reversal of the PTS condition. Both models use relearning as a means of altering the psychological and neurological elements of the psychological trauma, albeit the focus on what is being relearned is different (next subsection).

TRT uses cognitive therapy to identify the event and its rational and experiential effects. Writing, which includes the achievement of tasks, could be considered a behavioral feature of TRT.

Differences

There are several pronounced differences between the TRT and cognitive/behavioral models. They are described here.

First, TRT learning (or re- or un-learning) concepts are applied equally to all 4 psychological trauma patterns. In contrast, cognitive/behavioral models apply learning or relearning to, as a rule, the third pattern only -- the survival responses, which are referred to as symptoms of PTSD.

Second, in ETM/TRT theory, cognitive/behavioral models are interacting directly with the paradoxical system of control; they are trying to reform that (paradoxical) system in order to change the symptoms emanating out of those controls. TRT's structure specifically precludes such attempts to change the paradoxical system of control or the symptoms, the idea being that to engage in such an effort strengthens the controls that prevent the identification and reconstitution of existential aspects of identity (see Clinical/Long-Term Trauma/ TRT Phase Three and Facility Operations).

Moreover, TRT relies on the application of structured grief resolution methods concomitant with cognitive learning and relearning to provide the identification and reconstitution (of existential identity) processes. The cognitive/behavioral model does not, as a rule, give consideration to such
existential-based, grief/loss resolution needs: the need to identify, experience, express, understand, and accept loss and accompanying emotion retained in the subconscious as both a result of contradictions to existential identity and as damage to the same. We assume that such loss resolution focused methods are relegated by behavioralists to psychodynamic methods and thus are not used by behavioralists because of philosophical differences that exist between those methods and the behavioralism approach.

The third and most profound difference between TRT and cognitive/behavioral models is shown in the following. In the TRT approach, symptoms of psychological trauma are not required to initiate treatment. The occurrence, as opposed to the symptoms, of the trauma-causing event(s) activates the need for treatment regardless of symptomatology.

There are two reasons for this approach. One is that PTS symptoms come and go (Laufer, 1985, van der Kolk, 1985, and Bower, 1988) and thus are not reliable for ascertaining whether a problem exist (see appendix A). The other is that neurobiological changes initiated by a traumatic event can spawn secondary changes at any time following that event, and frequently not within a timely fashion -- it may be years before secondary neurobiological changes occur, which then may catapult, unsuspectingly, the individual into a dangerous neurological state, which then may produce symptoms like depression, etc. These changes occur as a consequence of the individual functionings and capacities of synaptic pathways and the interactions of certain neurotransmitters like serotonin, dopamine, and norepinephrine and other important neurochemicals like the neuroenzyme monoamine oxidase (see About/ Comparison - Contrast/ Biology).

No one knows when the postsynaptic receptors can become overworked or overloaded and no longer support the neurotransmitter/modulator processing. Nor does anyone know when fluctuations in MAO can bring about the depression.

Once these changes do occur, the remedy is placed on the defensive. It is trying to reverse the neurotransmitter deficits, which deficits may have accelerated the problem by producing thought/behavioral manifestations of depression and so forth; a degenerating cascade of destructive sequelae can ensue. Thus, cognitive/behavioral models, which are by definition and philosophy nosotropically (symptom) -focused, symptoms have to be
manifested in order to apply the remedies -- symptom reduction methods, can only be reactive responses to the neurophysiological time-sensitive problems.

In contrasts, ETM only needs the initial trauma-causing event to have occurred for the therapy to be initiated (see "Fast Help" sections describing the application of TRT to long- and short-term trauma, emphasizing the latter as the most proactive of the two methods). ETM/TRT do not have to wait for symptoms to manifest. Thus, TRT is not subject methodologically and philosophically to the happenstance of secondary neurotransmitter and other neurochemical over-or under-interactions.

In other words, the cognitive/behavioral model is, by definition and methodology when considering the time capsule effect, that is, the potentially explosive realities of a PTS-affected neurobiology, reactive. TRT, on the other hand, is, by definition and methodology, proactive, when considering the same factors.

Scrignar's Three E's

An important study of post-traumatic stress disorder has been provided by Dr. C.B. Scrignar, himself trained under the noted behavioralist Wolpe. In his book, Post-Traumatic Stress Disorder (1984, 1988), Scrignar describes the "3 E's" as the key to diagnosing and delineating the traumatic experience (pgs. 11-35).

The first E stands for environment. In this context, the term environment represents the relationship of the externally generated traumatic event to the physiology and psychology of the person. Scrignar explains in some detail how the various senses respond to the traumatic events.

From this description, he progresses logically to the second E, which stands for encephalitic aspects of the trauma. "Encephalitic" refers to the brain's adaptive mental responses to the environmentally initiated trauma.

The third E references the person's endogenous response to the trauma. "Endogenous" refers to the way the trauma affects the person's physical status. Examples include psychosomatic manifestations of the trauma.

Scrignar's opinion is that people suffering post-traumatic stress disorder need cognitive behavioral forms of therapy as opposed to a "personality
overhaul." The "overhaul" remark is an apparent reference to some psychodynamic models that explore pre-trauma childhood issues as if they are related to the current problem (Scrignar, 1988, pg. 148).

Scrignar's own application of this cognitive-behavioral approach includes the use of a method through which a rubberband is placed on a patient's wrist, and then snapped when a thought believed to be a symptom of the trauma crosses that person's mind. Apparently, the pain of the rubberband's snap against the skin of the wrist dissuades further such thoughts, likely PTSD symptoms, from manifesting themselves.

Another of Scrignar's methods involves the therapist's yelling "Stop" at the patient when thoughts that are apparently PTSD symptoms are presented. Scrignar says his patients seem to like both the rubberband snapping and yelling methods (1987, pg. 161).

I recommend reading Dr. Scrignar's book, not only because it provides a fuller description of this approach, but because his work in total provides a great resource document that aids in understanding post-traumatic stress disorder.

**Comparison: TRT to the 3 E's**

The primary similarity between the 3 E's and TRT theory is that both recognize the locus of the individual's problem as damage resulting from an externally initiated event, as opposed to the locus being defined as originating in non externally initiated intrapsychic issues. Other than that, TRT theory can be correlated to the three E's as follows.

The loss resulting from the initial trauma is an internal psychic contradiction resulting from the environmental (first E) effect (the trauma-causing event). Neurological etiology underlying contradicted existential identity and neurological symptomatology underlying survival responses can be correlated to the encephalic aspects that produce second E thought processes and third E endogenous conditions.

The principal difference between the three E's and the loss model's theory is that TRT is concerned with providing an internal psychic model (theory) as a guide to etiology-reversal (reconstitution of values, beliefs, images, and realities via structured loss resolution), where the 3 E's provide for a tracking of environmental influence-to thought response-to physiological effect that
does not rely as much on identification, understanding, or resolution of loss. In this way the 3 E’s become the basis for delineating symptoms, which in turn are then apparently intended to be directly responsive to a behavioral/learning treatment approach.

Because TRT does not focus on changing behavior, that is, trying to change behavioral responses to the trauma, but rather TRT addresses all 4 patterns of the trauma’s influences on existential and operational identity evenly, and despite the parallels between the concepts, the 3 E’s theory provided by Scrignar is not incorporated into the TRT trauma definitional process, other than as support for the concept that PTS is a function of an externally initiated event, in contrast to its being considered a function of a particular personality.

**Psychodynamic**

From a psychodynamic treatment perspective, the remedy to post-traumatic stress has become a process of assisting the individual in recounting the traumatic experience as many times as necessary. Simultaneously, feelings experienced at the time the event occurred as well as those feelings experienced during the therapy session, are expressed.

In addition, Hendin and Hass (1984) concluded in the treatment of PTS as it affected combat veterans, that the retelling of the story and the sharing of feelings must be accompanied by an eventual understanding of the meaning of combat to the particular individual. The "meaning of combat" to Hendin and Hass, was found to be the "veteran's subjective, often unconscious, perception of the traumatic events of combat" (p. 36). Thus the "meaning" of the traumatic experience was dependent on the individual reality system of the person who existed prior to the combat experience, the combat experience itself, and the way in which the person responded at the time.

This attempt by Hendin and Hass to codify the "meaning of combat," which underpins most psychodynamic applications, for example they determine the meaning of the trauma to the person, is similar to the process used in the second, third, fourth, and fifth TRT phases. In those phases the feelings, contradicted values, subsequent loss, survival responses, and additional loss are identified. Like Hendin and Hass, we agree that this "meaning" for each trauma victim, regardless of the trauma's cause, will depend on the original
values and beliefs (reality system) being contradicted and the nature and intensity of the traumatic event as it relates to those pre-trauma variables.

Although there are several differences existing between TRT and unstructured psychodynamic models, and which differences are addressed in other selections (About/ Comparison - Contrast/ Distinguishing ETM) including the later one in this section entitled "Psychotherapy," there are two primary differences that stand out over all others. Those differences result from the effects of the paradoxical system of control on unstructured efforts to address the specific damage done to specific values, beliefs, images and realities contradicted by the traumatic event versus the lack of effect that the paradox has on the structured approach.

In the first difference, during application of the non structured effort, the therapy's attempt to establish conscious control mechanisms, to include that component of those mechanisms responsible for modulating between emotional experience and abstract understanding, will always be occurring within an ongoing battle with the paradox: the goals of the paradox in this battle are to maintain the Survivor's existence and maintain the psychological trauma etiologies. To achieve victory over the paradox's controls, which victory is no small feat as great scientific and artistic skill is required on the part of the individual administering the therapy (see "Psychotherapy"). Even then, the probabilities that the damage reflected in all four patterns will be allowed by the paradox to be addressed in their entirety are highly unlikely --- complete resolution, full etiology reversal, will not occur except in the most profound therapeutic circumstances.

In contrast, the neutralization of the paradoxical system of control by the structure relieves the conscious control mechanisms of the responsibility to produce an effective modulator because the modulation is occurring through the unconscious first: the trauma resolution process facilitated through the application of the structure automatically results in the restoration of control (operational identity) which includes the eventual return of the capacity to modulate both consciously and unconsciously between emotional experience and abstraction, and without interference from the paradoxical system of control. Moreover, the resolution process via the structured approach is mechanical in nature to the extent that complete resolution is practically unavoidable: incomplete resolution will only occur when external variables like drug use or other helping methods (outside of the TRT application) influence the administration of the structure.
With regards to the second difference, during the application of the unstructured psychodynamic approach, especially where there is little to no knowledge by the therapist of the initial trauma, the TRT theory posits that the paradoxical system of control will automatically divert the individual's efforts from the address of the initial trauma -- the first two psychological trauma patterns, by refocusing attention upon the third and fourth patterns. In so doing, the Survivor strikes a deal with the helping modality: the survival thoughts and behaviors and subsequent damage to existential identity are assumed to be the principal problems. The Survivor accepts responsibility for the presenting problems and commits to a lifetime of self-discovery, self-analysis, and responsibility-taking.

The person then uses this self-evaluative/ responsibility-taking model to cope with life and in so doing become a productive citizen. Regrettably, neither the therapist nor patient know of the continuing existence of the first two psychological trauma patterns. The outcome can only be that the person must struggle throughout life never actually knowing what happened to him or her self and thus remain pitted in an ongoing and internal tug-of-war that is always controlled by the paradoxical system of control and the unaddressed two psychological trauma patterns (patterns 1 and 2) that underpin it; the initial and subsequent total etiology has not been reversed and remains unreversed indefinitely.

**Pharmacology**

Dr. Bessel van der Kolk (van der Kolk, 1987) does not represent in his book that he is biased toward a particular remedy in the treatment of psychological trauma. However, he did offer for some years one of, if not, the dominant research review, study, and explanation of psychological trauma from a biological/neurological perspective (I think this dominance was changed with the advent of Kosten's and Krystal's, 1988, and Charney's, 1993, works; both academic efforts are considered in the neurobiology bibliographical chapter), which can be interpreted to conform to pharmacological approaches, and which approaches he does also review.

In van der Kolk's presentation, CNS change results from the externally generated trauma-causing event. Included in this change are reductions in the capacity to produce various neurochemicals --- norepinephrine, serotonin, and dopamine. Reductions or depletions of these and other neurochemical stores and processes underpin the formation of defenses,
symptoms of the trauma. Such symptoms include hyperarousal, hysteria, startle response, repeated reliving of the event, increased drug (psychoactive) use, depression, and aggression. Endorphin activity stimulated by attempts to address the trauma result in increases in the various neurochemical activities making the address difficult for both patient and practitioner (see About/Comparison - Contrast/Biology). "Difficult" means that wide emotional swings, hyperarousal and hysterical reactions to the attempted remedy, block the direct address.

From this biological/neurological perspective, van der Kolk considers the recommendations and trials of other professional's and his and their application of various medications to offset the symptoms' blocking (to treatment) effects. Once interrupting symptoms are stabilized through medicating techniques, van der Kolk describes a host of talking therapies including individual and group psychotherapies that may be administered in the treatment of the PTSD. My impression from reading the cases in his book (van der Kolk, 1987) is that van der Kolk does not always apply psychoactive substances in the treatment of psychological trauma.

In the pharmacological approach, medications appear to be used both as tranquilizers of the emotional response to the trauma and as blocking agents against CNS responses to the victim's reliving the experience to the extent that hyperarousal and hysteria preclude attempts to resolve the trauma. Van der Kolk reports that although there have been various experiments with different drug based applications to PTS sufferers, no studies confirm or detract from the use of such applications.

The primary difference between TRT and the pharmacological approach to therapy is that TRT uses its structure to provide a perspective of, and approach to, the trauma's resolution that relies on the controlled release of neurochemicals through a similarly controlled identification, experience and expression of specific grief responses to specific trauma-initiated damage to both the existential and operational elements of identity. Through the structured, that is, the ordered and concomitantly occurring experiential/cognitive learning processes, it is assumed that natural neurochemistries initiated by the controlled grief/learning experience, restore depleted neurochemistries (neurotransmitters, modulators and neurophones) to pretrauma levels and, at the same time, restore synaptic capacities to bind with the necessary neurotransmitters, to pretrauma
functionings (see ETM neurobiology theory and related bibliographical chapters).

Evidence of the restoration is demonstrated through the dissipation of symptom activity, the previous evidence that the depletions had occurred. Medication is not administered (as a rule) simultaneous with the use of TRT because the medication, depending on the type and class, blocks the neurochemical interactions that underpin the experience and expression of the very symptoms that when manifested under the application of the TRT structure, become remedially responsive to the controls provided by the structure and the following of the learning path to understanding also provided through the structure's use.

As indicated, that "understanding" is experiential-and cognitive-based. That is, the passage through and to understanding involves the experience of specific grief resolutions through specific cycles of grief resulting from the delineation of specific contradicted values, beliefs, images and realities, and specific loss resulting from those contradictions.

In our view and experience (see About/ Theory/ Drug Use for a discussion of our observations of the effects of pharmacological approaches mixed with TRT), blocking of the neurochemical interactions underpinning any symptoms, especially those demonstrating the intensity of the repressed trauma, blocks the trauma victim's entry into and subsequently progressions through the concomitant learning process, that is, the negotiation of grief cycles and simultaneous with cognitive identification and reconciliation of the trauma's effects upon the existential identity. As indicated, the neurobiological bibliography chapter explains the biological path for resolution referenced here.

Basically, we believe that the logic and evidence is with the TRT view, and that the application of pharmacological approaches is, generally, an exercise in guesswork: ongoing experimentation. Our position is that if controlled grief/cognitive learning is shown to mitigate and end all symptomatology, and medications are shown to interfere with those processes, then the burden of proof for the validity of the pharmacological approach lies with those advocating those administrations.

Anyone who assiduously studies this claim will likely find that it is not only true, but that the experiments with pharmacological methods should be
terminated for ethical reasons: the pharmacological approach is likely to be shown to interfere with the remedy for psychological trauma, except where comorbid with biologically-based mental illness like borderline personality disorder and manic depression exists.

Consequently, medication is not administered (as a rule) simultaneous with the use of TRT. This recommendation strengthened through agreement of the delivery of TRT by professionals. Clearly, I cannot control the applications of medications by physicians, but do assert control of, through the certification process, the proper delivery of ETM/TRT.

In that regard, physicians are notified that the application of TRT is prohibited (as a rule) simultaneous with the application of pharmacological approaches. There are numerous compatible therapies, for example, psychotherapy, that provide physicians who believe in the pharmacological approach with appropriate alternatives to TRT.

**Hypnosis**

In certain cases, both behavioral and psychodynamically trained therapists recognize hypnosis as valuable in precipitating abreaction. In this context, emotion is viewed as a defense against disruptions in logical thought processes. The abreaction is considered a necessary venting of emotion that helps to remove obstacles to achieving the goals of positive change of symptomatic behavior.

At the time of this writing there is a great deal of controversy occurring over the validity of memories retrieved through the use of the unconscious regression method provided by hypnosis. We cannot comment on this controversy, as we are not experts on hypnosis. Moreover, we have never allowed its use in conjunction with the application of TRT.

**Psychological as Opposed to Theistic Elements of Conversion**

In our experience, the conversion approach is overwhelmingly the predominant means, although not a clinically controlled one, through which trauma is resolved --- worldwide. Such methods are intended to go to the heart of the trauma and end its effects, not only upon the psychology of the individual, but the spiritual aspects of human existence.
As a rule, the literature does not address the application of conversion methods to the PTS condition. However, in practice all secular therapies like TRT must be provided in the context of reality systems based in some form of non secular belief (at least 80% of the time).

From our experience of facilitating the trauma's resolution with TRT, which itself is reported by clients as going to the heart and soul of the Self and ending the deepest and darkest voids in human life, and being required to facilitate this experience within the context of the individual's spiritual/religious beliefs, we have come to recognize the conversion approach as having dual psychological effects (as indicated in the next paragraph, I do not speculate about spiritual effects), positive and negative.

For some, the conversion approach does, by itself and without the need of TRT or any other assistance, expunge the psychological damage done by the trauma-causing event and does completely restore the individual to a new psychological life experience, if not restore them to pre-trauma existence. For others, some psychological aspects of the conversion method appear to serve as a means through which the internally retained trauma is denied. The psychological aspects of the method keep the individual in emotional and intellectual turmoil.

Consequently, the principal similarity between conversion and TRT is that both have the psychological capacity to resolve trauma completely, and do resolve trauma completely. A principal difference is that TRT will resolve the trauma completely in every case, and never serve to assist the individual in denying that the internal damage still exists in any case.

I cannot speak to the theology of the conversion method. I am not an expert on spirituality or theology. In part because of this lack, ETM is presented as a secular program and offers no theological interpretation to its users.

I can say, however, that numerous pastoral counselors representing myriad religious and spiritual beliefs have trained in ETM and have reported using the model in the treatment of psychological trauma by their constituents, and without apparent infringement on the patient's religious/spiritual beliefs.
Psychotherapy

Although a complete description of the differences between psychotherapy and TRT requires considerable explanation, there are several simple, general, explanations of those differences.

First, psychotherapy, as viewed by many practitioners, requires a balanced, but nonetheless dual, therapeutic approach; psychotherapy attempts to resolve the trauma and restore control, that is, to ameliorate, alter, or in other ways change the effects and influences that the trauma's symptomatology have had on the psyche. The TRT structured approach resolves the trauma and reconciles its effects, but without attempting to strengthen controls; there is no attempt to alter or change symptomatology.

Second, some psychological trauma experts think of psychotherapy as an art form, a mixture of scientific understanding, interactional skill, intuition, caring and trial and error efforts, all of which work toward the achievement of the dual goals --- resolving the trauma and restoring control. In contrast, the facilitation of TRT is a mechanical process that only requires caring as the principal attribute accompanying the client's use of the structure. The structure replaces the need for the highly specialized guesswork attending the artistic elements of psychotherapy.

Third, many forms of psychotherapy (certainly not all) require the maintenance of an objective orientation between therapist and patient; the purpose of this objectivity is to facilitate the therapist's ability to apply his or her art to meet the client's needs. In the five phase structured process, because the structure replaces the requirement of the artistic skill, objectivity, other than that required to follow directions, is not the basic orientation --- overt and expressed caring underpins the relationship.

Fourth and finally, the artful use of transference, the process through which the patient reexperiences the traumatic event or history by transferring elements of that history to the therapist and then working through the experience positively with the therapist (as opposed to again experiencing the previously negative outcome), is, in some forms of psychotherapy, the engine or driving component of the therapeutic process. It helps the patient and psychotherapist to discover together the source of the current dysfunction, the initial trauma-causing event. Through the bonding and trust
they both use the transference process to explore and eventually relive the event(s).

When the structured approach is applied, the trauma victim uses the phase one guided writing process to go directly to the event. The nebulously defined and often protracted period of exploration and discovery that accompanies the use of transference is replaced with a highly focused and controlled approach to the trauma.

In addition, the reexperiencing of the traumatic event is not the thrust of the therapeutic process as it is in psychotherapy, but only a small, albeit initial, component of the entire 5 part TRT process. Thus, the need to relive the experience through transference onto another is lessened.

Moreover, where one of the goals of the therapist's use of transference is to help the patient to learn positive and healthy adaptations to the traumatic episode after it has been relived, the structured approach makes no such attempt, as changing of adaptations to the trauma is unnecessary if the trauma itself is purported to be completely resolved: the etiology is reversed. In other words, the TRT structure practically makes the application of transference an unnecessary psychodrama technique, that is, when used in the treatment of psychological trauma.

**Grief Resolution and Cancer Treatment**

In his study (Spiegel, 1989) of 87 terminally ill patients, Dr. David Spiegle reported that when these people participated in a group therapy process that focused on resolving the grief resulting from the imminent death of themselves and the difficulties inherent in waging the treatment battle, they lived an extraordinary average 18 months longer than people who did not use the approach.

Dr. Spiegle, in a PBS television documentary, attributed these results to the reduction or dissipation of the emotional pain comprising the person's grief response to the illness and imminent death. Through this dissipation, a phenomenon occurred --- the mind and body were thought to be strengthened in their abilities to resist the degenerating disease, which strengthenings apparently then added to the lengths of time they were expected to, and actually did, live. Dr. Spiegle hypothesized that the identification, experience and expression of the emotional pain and loss
removed blocks to these people's abilities to apply themselves completely in combating the degenerative physical process associated with the illness.

When the interviewer, who had observed and then shown clips of the grief resolution group therapy techniques administered by the facilitator, confronted Dr. Spiegle --- the interviewer stated that Spiegle was "rubbing these people's noses in the reality of the illness" and not letting them escape it, Dr. Spiegle responded to the confrontation by addressing the alternative positive thinking modalities. In these contrasting methods, people did not dwell on the real and prospective loss, but rather emphasized the use of the intellectual/cognitive capacities of the mind to overcome the illness by conceptualizing a positive outcome and holding to that view despite degenerative physiological experiences.

As I recall the interview, Dr. Spiegle referred to this concept and method as, instead of the "power of positive thinking," the "prison of positive thinking" because people who were suffering an ever-degenerating physical illness could not address the emotional pain resulting from that degeneration without belying the modality --- the person continued to degenerate despite positive thoughts to the contrary.

This approach then, was considered a mental "trap" which apparently worked to "trap" unresolved grief in the subconscious, which then presumably reduced the mind and body's capacity to resist the assaulting illness. The idea, then, of Dr. Spiegle's approach was to remove that trap for people by allowing them to address their grief and in the process reduce the amount of psychological and biological energy required to sustain the unresolved grief; the energy presumably being diverted for the physical battle being waged against the illness. Such energy could then be directed toward fighting the illness with the prospects, according to the outcome of the study, for substantially greater results.

Although there is no claim by us that Trauma Resolution Therapy can be used to extend life for those people who are fighting physical illness, we do say that TRT is based on a concept that is similar to Dr. Spiegle's ideas --- if a trauma victim is helped to address the previously unresolved emotional pain and loss resulting from the trauma-causing event, regardless of the nature of the event, then these trauma victims will see their full capacities returned as an aid in the particular struggle in which the person is involved; for example, a physical illness, a combat veteran's attempts to come to grips
with the experience of a war, a battered spouse's fight against an alcoholic husband's domination, an adult child's battle to overcome the effects of repressed sexual assault episodes, a mother's real or prospective loss of a child to a gang, homicide, suicide, or drugs.

Where Spiegle uses grief resolution and client centered psychodynamic therapies to achieve these tasks, TRT uses its structure to identify and resolve the trauma. The ETM theory of the biology of this process is described in About/ Comparison - Contrast/ Biology and About/ Theory/ Biology/ Etiology and Etiology Reversal.
Part Three
Training and Certification
ETM Certification Clarification

ETM TRT Certification does not give permission to any person to administer TRT or any counseling service to any one unless the respective state government authorizes that service to be provided through its clinical provider licensing programs.

ETM Trainers Certify that an individual has completed the ETM TRT professional training course. The ETM Certifying Authority certifies ETM course graduates as Certified ETM TRT Counselors, Associate Counselors, Managers, Counselors in Training and or Trainers.
Chapter

Etiotropic Trauma Management™

Trauma Resolution Therapy™

(ETM TRT)

Counselor, Associate Counselor, Manager and Counselor in Training

Clarification of Certification Information and Agreements

Pronouncement and Agreement 2.0 (1st primary update since 1986)

This is Pronouncement 2.0 dated July 31, 2009

Introduction

Competence and permission to administer ETM to members of the public are provided through completion of the ETM Professional Training School and compliance with the ETM Certification Agreement. It is supported by this document updated in 2009. The School, ETM Certifying Authority and the Agreement, together, are referred to as the ETM Professional Training and Certification Program.

ETM Certification Clarification

Posted 7/31/2009

ETM TRT Certification does not give permission to any person to administer TRT or any counseling service to any one unless the respective state government authorizes that service to be provided through its clinical provider licensing programs.

ETM Trainers Certify that an individual has completed the ETM TRT professional training course. The
ETM Certifying Authority certifies ETM course graduates as Certified ETM TRT Counselors, Associate Counselors, Managers, Counselors in Training and or Trainers.
Establishing ETM Certification

Since the ETM School's beginning in 1986, virtually all ETM School qualifying graduates have elected ETM certification. Upon completing the ETM School, these professionals have agreed that the rationales and guidelines that underpin ETM certification are necessary for the ethical transfer of proper authorizations to administer ETM to the public. Those rationales and guidelines are explained in this section.

Purposes and Ethical-Legal Underpinnings of ETM Certification

ETM certification serves 3 purposes. First, it provides professionals with specific criteria and guidelines for the authorized administration of ETM. Second, certification assures members of the public who are seeking assistance via the ETM model that it will be delivered within a reasonable standard, the same one that provided the motivation for the referral. Third, the certification process meets natural responsibilities shared by the authors of ETM and its administrators (ETM counselors, associate counselors, managers and Licensed Trainers).

ETM's authors and their representatives, supervisor trainers, are meeting their responsibilities to the model's end users, trauma victims, by ensuring that ETM counselors, associate counselors, managers, and Licensed Trainers receive the training necessary to administer ETM: its theory is properly conveyed to and understood by the prospective ETM professional. The administrator completes the shared responsibility (shared duty to the end user) relationship by agreeing to comply with the criteria and guidelines for the proper administration of ETM as delineated in the text, the ETM School, and in accordance with the criteria and guidelines for the delivery of professional services governed by the professional's primary licensing authority and attending organizational management standards.

The method for consummating the arrangement between the ETM author(s) and ETM counselors, managers, and Licensed Trainers is the ETM Counselor (also manager and presenter) Certification Agreement. Consequently, ETM Certification, as stipulated in the pertinent ETM (Counselor, Manager, or Presenter) Certification/ (License for Trainers) Agreement, provides a framework through which all parties involved in the ETM model's disseminations can meet their ethical responsibilities to the public. With noted exceptions, facilitation of ETM by non ETM certified professionals or individuals abrogate this framework. Thus, facilitation by non ETM trained or certified professionals or individuals is not, except under the referenced special conditions, authorized by the ETM certifying authority.

Kinds of ETM certifications:

- Certified ETM Counselor
- Certified ETM Associate Counselor
- Certified ETM Manager
Etiotropic Trauma Management Trauma Resolution Therapy
Training – Certification Program

- Counselor-in-Training
- Licensed ETM Trainer (Currently in this pronouncement 2.0 Not Available)

Certified ETM Counselor

The Certified ETM Counselor designation provides recognition that an appropriately credentialed professional has successfully completed the ETM Professional Training School (including the online school and its beta version) and is in compliance with the ETM Counselor Certification Agreement. An appropriately credentialed professional, in this use meaning that the professional retains a valid license, certification, or degree from a recognized authority, for example, a state government or academic institution, to provide therapeutic assistance to the public. Examples of an appropriately credentialed professional include, but are not necessarily limited to, psychiatrists, psychologists, MSWs (Masters in Social Work), licensed professional counselors, chemical dependency counselors, some pastoral counselors (referring to those who retain a publicly approved and granted license), and people with advanced counseling degrees (where no government licensing authority prevails).

The Certified ETM Counselor designation authorizes professionals to administer, within the parameters of the professional's own (primary) licensing or certification authority, the ETM program. ETM Certification does not provide the authority to participate in the delivery of psychotherapeutic services not recognized or otherwise covered under or in the professional's primary licensing program.

Certified ETM Associate Counselor

The second ETM Certification provides people who have a need to address or in other ways manage, or participate in the management of, psychological trauma, as such management falls within the purview of special organizational situations. "Special organizational situations" refer to those situations where government agencies, educational institutions, certain non profit (not referring to churches) like community based agencies, organizations and medically-based (hospital) programs require an employee to function as a participant in the management of trauma-causing events or people affected by such events, and with regards to ETM TRT in a training role. Examples of organizations that meet the "special situations" criteria include, but are not limited to shelters and halfway houses for children / adolescents, battered spouses, and other similarly affected people. Other examples of people qualifying for the Associate ETM Counselor designation include, but also are not limited to, emergency medical services, administrative, nursing, school counselors, teaching and law enforcement personnel. The Associate ETM certification is valid only within the context of that, or similar, employment. The certification does not transfer to private practice, unless proper credentialing or special permission from the ETM Certifying Authority is otherwise attained.
Criteria / Limitations / Upgrades: Associate ETM Counselor

The Associate ETM Counselor certification is subject to the following limitations and criteria for the administration of the ETM program:

1. Assessment, evaluation and the formation of treatment strategies must be supervised (co-facilitated) by a Certified ETM Counselor.
2. Facilitation of the TRT long form, all 5 written phases as applied to long-term trauma, must be supervised (co-facilitated) by a Certified ETM Counselor.
3. Facilitation of the TRT short form for addressing near-term traumas must be supervised (co-facilitated) by a Certified ETM Counselor.
4. Subject to ETM Certification Authority approval, the Associate designation may be upgraded (without retaking the training program) to Counselor or Manager certification upon acquisition of proper and legal credentialing within the particular clinical professional organization by the individual’s local governing authorities.

Certified ETM Manager

The ETM manager certification recognizes that a professional (not necessarily clinical) has completed the ETM School and agrees to apply, where organizationally appropriate, the approach to organizational management process and in a manner commensurate with the ethical and professional training guidelines governing the particular organization's operations. Examples of professionals who qualify for the ETM manager certification include school principals and administrators, school district superintendents, school counselors, emergency medical, fire and police chiefs, military officers, hospital/treatment facility administrators and hospital marketing personnel, and government agency supervisors and managers.

Licensed ETM Trainer (no further trainer licenses are available at this time in 2009)

The ETM Trainer license recognizes that an individual has successfully completed the ETM Trainer training process and is authorized to present the ETM School to the group of professionals designated (to receive ETM training) by the related ETM Training Module Agreement and in accordance with that agreement.

The ETM Licensed Trainer is authorized to provide ETM professional supervision to ETM Counselors, Associate Counselors, Managers and Presenters.

Students and Counselor-in-Training

A student and counselor-in-training (CIT) may attend the ETM School and acquire both the cognitive and experiential aspects of the theory for the purpose of eventually becoming an ETM certified clinician: the student or CIT may pass the exam and participate successfully in the experiential component of the curriculum. The CIT may
receive a certificate noting completion of the school.

There are, however, some prospective differences for this participant's training and eventual certification from the training of licensed clinicians. For example, a licensed professional or person employed in a special position that requires an understanding of experiential forms of therapy is assumed by an ETM School Presenter to be thoroughly trained in such experientially-based models; the student or CIT, however, may or may not be so trained. Thus, the Presenter conducts this special training (for students and CITs) with an eye toward conveying some of the additional information that often accompanies such facilitation exercises; both the student and the CIT require more attention from a Presenter than is otherwise administered by the ETM School to other participants: the additional training is a function of the relationship between the Presenter and the student and is outside of the training scope of the standard ETM curriculum.

Accepting such a training relationship is the responsibility, choice, of the Presenter. We recommend that the student complete a prerequisite in grief resolution or client centered therapy, or have considerable practical experience in the use of these therapies before attending the ETM School. Regardless of whether the student or CIT successfully completes the ETM School, neither the student nor CIT qualify for associate ETM certification status unless the particular student or CIT is employed in a professional position that requires the special certification. The student or CIT may, however, upon the eventual attainment of a particular professional license or upon gaining pertinent employment recognized as appropriate ETM TRT on the job training by the ETM Certifying Authority, qualify for and be accorded either ETM Counselor Certification or associate certification, depending on the license attained or employment gained.

**Clinical Certification Disclaimer**

ETM certification does not provide permission to non credentialed / non professional people to administer the clinical component (TRT) of ETM to the public. Specifically, ETM certification does not provide authorization to any individual who is not properly trained and licensed generally as counselor to engage in the business of providing psychotherapeutic or other professional therapy services, to include providing those services in private practice settings.

**ETM Certifying Authority**

The certifying authority for the ETM certification program evolves from the precedent established through the program's historical existence and a natural need to ensure that professionals who administer ETM are properly trained and functioning in agreement with the guidelines for that administration as set forth in that program. Jesse Collins (and Craig Carson in his absence), by virtue of his (1) creation of the ETM model, (2) uncontested superior knowledge of the model’s functionings whereby that knowledge was gained as the model’s developer with his wife over 7 years in its highly credentialed clinical treatment settings, and its implementation of its strategic application in its numerous organizational management environments for initially 15 years, and then from
staffing and supervision of clinical and strategic management issues for a full 30 years (by 2009), (3) rights and responsibilities as set forth in the ownership of the intellectual properties referenced in the ETM Tutorial and as attends copyright law, and (4) are the determiners of what constitutes being "properly trained" and administrative "guidelines."

Any person designated by the author(s) as a Licensed ETM Trainer has the author's permissions to professionally convey ETM theory to other clinicians / managers and to recommend for ETM certification by the ETM Certifying Authority qualified professionals as ETM Counselors, Associate Counselors or Managers.

The ETM Certifying Authority may change or discontinue the ETM training and certification program as determined by that authority.
ETM TRT Counselor, Associate, Manager and Counselor in Training Certification Agreement

2.0

*ETM certification is subject to this (following) agreement as it is attended by Pronouncement 2.0.*

Upon successful completion of the ETM TRT School, the Certified ETM Counselor, Associate Counselor, Manager, or Counselor in Training agrees to:

1. Use the ETM model where appropriate for the purpose of helping people affected by psychological trauma to resolve that trauma (reverse its etiology) in accordance with the definition of trauma resolution (etiology reversal) provided in the ETM School, and in accordance with the guidelines for administering the ETM TRT models, as those guidelines are presented in the ETM Tutorial information system; questions, interpretations or conflicts regarding the phrase “in accordance with” administration of ETM TRT are, respectively, answered, provided, or reconciled only by the ETM Certifying Authority and for validity must be given in writing by the ETM Certifying Authority.

2. If a theoretical disagreement between the Certified ETM Counselor and the information system arises pertaining to the proper application of ETM TRT to a particular academic issue, the ETM counselor will submit the disagreement and supporting documentation to the ETM Certifying authority in writing; that authority responds will respond in writing with a hypothetical solution that will be acceptable or not to the clinician who will either facilitate the model by the information system as directed or not use the ETM TRT model as a treatment option in instances that reflect the contradictions given the particular academic issues raised.

3. In an actual as opposed to hypothetical case, if a conflict between theories arises, the clinician should always follow those professional standards which assure that no harm should occur to any patient while that counselor is providing his or her clinical services; the counselor should consider the prospectively conflicting theories and later reconcile any such conflicts with the ETM Certifying Authority, always administering the case under the ethical and legal standards first promulgated by the local governing authorities.

4. Apply ETM ethically. The counselor will refrain from applying ETM in a way that interferes with other therapeutic processes. The counselor will follow the ethical standards governing the counselor's or therapist's particular discipline of professional study and practice.

5. Refrain from soliciting people into the ETM program. "Solicit" means to "entreat." There is no restriction against offering ETM to anyone. "Offering" refers to notification of services and education about the same.
6. Comply with the criteria for ETM Certification or Associate Certification; the preceding discussion provides the referenced criteria.

7. Comply with copyright law when using all ETM materials and publications. Compliance includes not changing ETM TRT educational materials from the form presented by its authors, or copying or setting to celluloid or any storage presentation technology (like computer technology) any ETM TRT information without the express permissions of the author or his designated authority, in this instance to include Craig Carson. Note on the home page of http://etiotropic.com that ETM and TRT and their full names, and all educational materials shown on the website, to include the ETM Tutorial, are federally registered U.S. copyrights and are given in addition to national U.S. Copyright Agency protection by international copyright authority.

8. Not in engage in professional training unless designated as an ETM Trainer by the ETM certifying authority. "Training" means to impart the intellectual material with the intent that it may be used by a professional in the treatment of anyone or organizational management.

9. There is no stipulation that precludes a Certified ETM Counselor's or manager's providing ETM education and educational materials (created by the ETM authors) to professionals, laymen, or clients, as long as such provision is in accordance with copyright law and agreements with the ETM certifying authority. "ETM education" refers to the process through which people, including professionals, are informed about the ETM theories and methodologies, but without the intent to convey the information for the purpose of providing the receiver of the information with the authority to administer the ETM models to the public or to any person; professional ETM training must be provided by an authorized ETM Trainer.

10. Regardless of the type of ETM TRT Certification acquired from the ETM TRT Certification Authority, an ETM TRT counselor will not engage in the facilitation of ETM TRT with any person if the counselor does not have approval from the local State or Federal governing authority to provide these or comparable clinical services in that community and regardless of employment obligations that may require an individual to provide such otherwise illegal counseling services.

11. Although the Certified ETM Counselor, Associate ETM Counselor, ETM TRT Manager, and Counselor in Training designations are currently permanent, they are conditional on compliance with this agreement. Compliance is determined and interpreted by the judgments and decisions of the ETM TRT Certifying Authority. For emphasis, place counselor initials here _________ to acknowledge having read and understood this paragraph.

Clinical ETM TRT Certification Disclaimer

ETM TRT certification does not provide permission to non credentialed / non government authorized professional people to administer the clinical component (TRT) of ETM to the public. Specifically, ETM certification does not provide authorization to any individual who is not properly trained and licensed by state or other government authority to engage in the business of providing psychotherapeutic or other professional
therapy services, including TRT, and to also mean providing those services in private practice or any agency settings, non profit or otherwise.

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