

Etiotropic Trauma Management™

Trauma Resolution Therapy™



Professional Due Diligence
for the
First Secular Cure of PTSD

By Jesse W. Collins II

The Etiotropic Trauma Management Series
Book VIII

Due Diligence in One Place

This book consolidates all information required to transfer legal authority to facilitate and manage ETM TRT within the public and government sectors. It includes: (1) an empirical framework, (2) an academic comparison and contrast with competing Nosotropic (symptom focused) engineered popular modalities, (3) a literature review, (4) quantified outcomes, (5) the bibliography for the entire *ETM TRT Series* (sources for 32 titles) beginning with the Etiotropic perspective of the full biology of psychological trauma's substrate, and (6) personal experience's influence 30 years ago upon the initiation of ETM TRT's development.

This book is not designed to teach anyone how to administer ETM TRT. Neither is it intended for general audiences. Instead, the book shows prospective Certified ETM TRT clinicians and crisis managers who also are college students, counselors, psychotherapists, researchers and analysts how and why they now have the secular and certain capacities to facilitate a cure for once thought to be incurable maladies, psychological trauma and PTSD. I intended this particular part of the ETM TRT Series to frame the otherwise widespread information into a single place maintained as a hardcopy text. The material gives you what you require to complete due diligence for the administration of a clinical therapeutic model (the work has been in the ETM online Tutorial and earlier additions of the training textbooks since 1986 for the texts and 1994 for the Tutorial). I designed and published the book to make it easier to meet your professional responsibilities. It is also required reading by all ETM TRT Counselors and Managers prior to certification. This information is otherwise available free online in the ETM Tutorial.

Etiotropic.com

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Book VIII

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Author's Message

Author's Thesis and Goals as they underpin all 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 thing I have to say about ETM TRT, showing its meaning for and importance to humanity and concluding with clarification of the model's goals that I've set for it to achieve by the end of the century.

Restating for emphasis, ETM TRT has enduringly, 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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Preface

This book combines the majority of chapters found in the ETM Tutorial that describe ETM TRT's development. It occurred primarily over a seven year period beginning in 1979. Although we finalized our first conclusion in 1986 at the beginning of our training and certification school at the University of Houston, we have followed treatment summaries and participated in staffing of patients continually to the current period through many of the approximately 2500 ETM TRT trained and certified psychotherapists and counselors. As the development compendium of the Etiotropic Series, this book provides the information necessary for accredited professionals and institutions to adopt ETM TRT's clinical treatment applications to their treatment facilities or crisis management organizations. This work also describes the underpinnings of study and research for adaptation of Strategic ETM for its administration in the address of criminal violence and terrorism. Strategic ETM is also supported herein for its address of systems affected by accident and natural disasters.

The Free ETM Tutorial

Virtually all of the text in this book may be read for free in the ETM Tutorial (<http://etiotropic.com/indextutorial.html>) in the Overview (Authors and ETM History) and Professional (Academic and Clinical) sections. That tutorial was used as the representative best example for distance learning on the Internet in the 1997 Federal eleven million dollar grant request by Southern Florida University. It referenced the ETM Tutorial as a national favorite for demonstrating the University's goals within the context of the grant. I've consolidated ETM TRT's development information into this small publication in order to highlight those aspects of the Etiotropic Trauma Management™ Series pertaining to the adoption by health care professionals and organizations of the ETM TRT model.

Empirical Summary

After having developed Etiotropic Trauma Management™ and its clinical component Trauma Resolution Therapy™ (hereafter “ETM TRT”) for over seven years (1979 – 1986), and within a stringently administered, highly competitive, rigorously observed, incrementally codified and unequivocally credible (licensed by government and Joint Commission for the Accreditation of Healthcare Organizations – JCAHO annual and tri-annual audits) specialized group of nationally located psychological trauma and family Chemical Dependency treatment facilities, the ETM TRT model has completely resolved psychological trauma, that is, cured it to the extent that it no longer exists in any identifiable form by the primarily affected individual or family, when applied in accordance with its administration criteria (published since 1985 in all class texts and patient educational materials and online in the ETM Tutorial since 1994) in every instance that it was observed, having done so since removing (between 1983 and 1986) with pedantically focused oversight all interfering exogenous and comorbid variables from the treatment environment. ETM TRT’s “complete resolution” is scalable, immutable and perdurable, meaning that it maintains its phenomenal 100 percent cure rate when applied to qualifying patients no matter the kind of trauma, against all challenges, and for all time. Legal, competent, ethical and exquisite care driven administration to and for patients, not subjects, demonstrates and will explicitly show you and your organization that neither hyperbole, exaggeration, nor even the hint of misrepresentation are used in this summary of ETM TRT’s empirical evaluated capacities to cure psychological trauma and PTSD.

Chapter 1

Personal Experience's Effects on ETM TRT's Development

(First written in 1985)

In the first sentence of his initial book, *Psychological Trauma* (1987), Bessel van der Kolk opines that a writer's, researcher's or clinician's "frame of mind" usually determines both the nature and outcome of the therapy and research. With regard to TRT and Etiotropic Trauma Management, no statement could more accurately characterize not only their initiations, but the motivational thread, impetus, that has seen their development to completion. Although the end product of TRT is a professional therapeutic process that we have attempted to transfer to others via an academic standard, the process that has guided my efforts, my "frame of mind," has been a consequence and function of primarily personal experience - the impact of certain events on my life and their address through the caring and love of my wife.

Personal Experience

My mother lost her father and one of her brothers to disease when I was young: 9 and 10 years of age. These losses affected her deeply. At the same time, she also suffered repeated bouts with severe migraine headaches. The combination of the loss and the headaches resulted in her seeking medical and psychiatric assistance, processes that eventually would lead to tragedy. The era was the mid 1950's.

Her treatments for these conditions included individual psychotherapy, major tranquilizers, hospitalization and shock therapy. She and our relationship changed dramatically following the hospital visits. She became the child and I the adult; she begged me to not let her return to the hospital. For her, shock therapy was a horrendous treatment, and an experience that she said that she could never stand again.

We also were a regularly attending and devoutly religious family - Southern Baptists. Before the illness, my mother sang in the choir. My father was a deacon within the church. Consequently, when the illness occurred, I also sought help for her from this group, including its leadership. These religious people did not know, however, what to do.

Suicide attempts became regular events. My sisters and I prevented our mother's death as a routine matter of family life. To take one example of these efforts, which occurred repeatedly, I remember that I would sit in the hall next to her room, mostly at night, and wait for her to retrieve a belt from a dress in the closet. She would go into the bathroom and shower; I would follow her and untie the belt from around her neck. On each of these occasions I told her that I loved her and wanted her to stay with us; I said that she would get well and that we needed her. Sometimes, when I could no longer stay awake while on guard, my last thoughts before sleep were that I was not strong enough to keep my mother alive and that when I awoke, she would be dead.

When I was 13 years old, and after approximately 3 years of the illness, we again placed her into a psychiatric hospital where, shortly after being admitted, she hanged herself in the shower with the belt from her dress.

Before and during my mother's illness, I did well in school and in other social settings. I was a Cub Scout, for which troop my mother had, before her illness, been the den-mother. During these years, I remember that I was routinely placed in accelerated classes for special students and I usually acted in a leadership capacity; I made student honor rolls. My family participated in many church, school, sports, and other kinds of social activities, and they benefited from the full support and attendance of both my mother and father. I also was stringently physically disciplined, but I believe I had a good early life and, overall, am appreciative for it.

Following my mother's death, I became a truant, runaway, and general disciplinary problem in school. For example, the assistant principal, Mr. Kenneth Gupton, informed me that I had set a record in our school for receiving the greatest number of "pops," a kind of corporal punishment where we were hit in the butt with a board called a "paddle." The model was used to instill discipline at the time. I never sought, nor was I considered a candidate for, counseling, either for my behavior or because of the family's tragedy, although I suspect that some teachers sympathized with me for the loss of my parent - I think they accorded me special consideration. Neither did I express any emotion about the suicide attempts during my mother's illness, nor do I recall expressing any emotion about her death.

Although I was never a member of a gang, I remember that their activities in my neighborhood profoundly influenced my early life; I engaged in physical altercations with such gangs and their leaders. As a child, I was taught to fight against collective coercion. All of these altercations were conducted without weapons; that is, aside

from the truancy, I never engaged in unlawful activities, as morals played an important part of my upbringing and despite the changes that I was undergoing. The only drug that I used was alcohol, and then only shortly before leaving school.

I did do some positive things in athletics. I was the first 3 year varsity football letterman to graduate from my high-school; I was very proud of that accomplishment.

My graduation, however, was not an achievement derived out of my own character or efforts, but was solely a function of another person's wisdom, caring, and insight. Mr. W.G. Burns, the school's principal, provided me with special academic tutoring.

From the time that I was 16 years old, I lived outside of my home and on my own, except for the help of a friend and his mother - Sherman and Ms. Anne LaFollette. I emphasize these people, including Mr. Burns who is now deceased, by stating their names because not only did they help me at that time, but probably were it not for them, and others not mentioned here, my entire life's direction would have been considerably different and more difficult. I also have come to believe that the kinds of people that they were contributed greatly to the primary value of my life, as these kinds of people contribute to the value of others' lives.

Stoicism was the philosophy that I adopted to cope with my mother's illness, her attempts to take her life, and her eventual death. In September 1959, I remember, while standing next to her coffin in the funeral home, thinking to myself that the most important thing that I do was to be strong and dignified. I especially had to be this way when walking in front of the large group of people who accompanied our family to the cemetery. I had to and did show my strength by maintaining composure. Stoicism also provided the foundation for my beliefs about how to cope with everything else as I continued with my life.

There are two additional pieces of information that are important to this part of the story. First, my father, who had stopped drinking when I was two years old, and apparently had a drinking problem prior to that time, and who had not used alcohol during the 12 year period leading to my mother's death, began to drink again within 30 days following that death. He also is deceased now and I do not wish to engage in discussions that would detract from or denigrate his character, as it was an admirable one despite his apparent health problems, and as stated he and my mother gave me, as a child, a good and safe home where I never wanted for food, shelter and love from them. I hope it will suffice to say that in addition to the effects of the death of my mother upon our family, my father's drinking experience beginning immediately

thereafter effected an additional radical change upon the life-style that we had previously known.

The second element of information relates to the psychiatrist who treated my mother. He was well respected in his profession and came highly recommended to my father. However, when the psychiatrist died two years after my mother's death, it was reported to our family that alcoholism had influenced his later years, possibly even contributing to his death. I don't know if this report was true, or if the prospective alcoholism influenced my mother's treatment, but to this day I have never felt any animosity toward that person individually, but have considered the clinical model used for the treatment of my mother and family (which was non existent) to have been incompetent, a view that has increased with time, experience, and research. Because of this belief, one of the most important things that I think that I have done is dedicate my activities to seeing that other people do not experience what my family experienced - they will not lose the lives of their loved ones because of the influence of incompetent ways of doing things, regardless of their political/bureaucratic ascendance. To that end, out of the many people to whom my wife and I have provided care, including the numerous women whose psychological profiles matched my mother's, none committed suicide and all of those of whom I am still aware recovered to lead normal lives.

When I did not receive the athletic scholarship for which I had hoped on graduation from high school in 1964, I joined the U.S. Marine Corps. Marines epitomized for me as a boy personal strength and caring for one's country, two things that were important to me.

Upon completion of boot camp in San Diego and Infantry Training Regiment at Camp Pendleton, California at the end of 1964, I was assigned to a motor transport group at the El Toro Marine Air Facility in California where I trained and worked as a truck and staff car driver. I was reassigned on August 1, 1965 to MAG 36, a group of helicopter squadrons; the Group immediately departed on the aircraft carrier USS Princeton for South Vietnam. On leaving Subic Bay in the Philippines, and two days before the landing, I was transferred for temporary additional duty to a newly forming and so called Air Mobile Assault Company - a group of clerks, helicopter mechanics, truck drivers, cooks, and supply specialists who were converted within a matter of days to infantrymen; the mission was to provide the perimeter guard for the helicopter component of the airbase about to be constructed at Chu Lai. I did make that helicopter landing with that company on August 28, 1965 and served a tour of duty in the Central Highlands of South Vietnam until September 15, 1966.

Because of the controversy surrounding the Vietnam War and other issues related to descriptions of war, I interrupt this story to offer you an option. If you want to avoid this part of the story, click on ["No War."](#) Continue from there and you can still acquire at least a partial understanding of the importance of these events to the development of the ETM and TRT models.

Following the helicopter landing from the Princeton, my initial job of providing the perimeter guard for the helicopter base was, I believe in hindsight, fairly safe duty because larger and undoubtedly better trained infantry units than mine had formed another perimeter 5 miles out from ours; however, the perimeter was not totally enclosed along the coast and mouth of the river that was about 1 mile from our line. Moreover, that perimeter was said to become less protective depending on different operational requirements. Because of bureaucratic processes, about which I was uninformed, I never returned to the motor transport group, spending the first 4 months of the tour in this temporary duty.

While there, I engaged in various infantry, also called "grunt," activities - the mainstay of Marine Corps functionings. The theory at the time was that other (non infantry related) job assignments did not preclude any Marine from being assigned without forewarning to infantry duty. We were supposed to maintain ourselves in a readiness state capable of meeting these primary responsibilities.

Some of my recollections of the times, places, and distances during this 4 months are not totally clear, but I know that my missions and areas frequented were varied. To begin, I remember that the monsoons and the units on the external perimeter controlled the process. This means that only the Vietcong as opposed to North Vietnamese Army (NVA) units were expected to and did operate in our area. For those readers who don't know about the difference, NVA units were large groups of people that engaged in more conventional military confrontations and the Vietcong were often local guerilla fighters opposing the South Vietnamese government and operating from time to time in alliance with the NVA.

In this new capacity as an infantryman, I, with my group, dug and then refilled many holes while changing positions. Filling sandbags and stringing concertina (coils of circular-barbed) wire provided ongoing and extra work details. At night, we manned bunkers, sleeping in shifts in the bunkers or holes an average of 2-4 hours per evening. During the days, I usually made 2 patrols per week; we covered an area that extended to the outermost perimeters and along the river to its mouth, including a long peninsula that adjoined the mouth. I alternated positions in this squad (between 9

to 11 men) in the beginning, but later was assigned the point position as transfers removed the more experienced people; through attrition of personnel, I eventually knew the area better than most. With the exception of my one friend with whom I had come through boot camp and who was stationed with me at El Toro, and who was in this unit through my 4 month stay and beyond, most of the rest of the people in this outfit spent between 4 to 6 weeks with us before transferring back to their regular units. I remember some of these men's names: Tom Walsh (the Bronx), Tim "Toad" Millman (Indiana), John Bryson (Ohio), and Primo Anthony Clemente (Pennsylvania). They were good men with whom to share bunkers at night. Each and others whose names I cannot recall contributed special value to our group - humor, sincerity, selflessness, philosophy, integrity, courage.

I also participated as a member of one of two 4 man teams that manned an outpost on the furthestmost point of a peninsula that jugged into the South China Sea, our location being about 1 mile from the primary (innermost) perimeter protecting the landing pad. Each team lived in a 6 foot wide and 4 foot deep hole dug out of a sand dune and spaced about 50 yards apart from each other; our position was close to a large, dark rust colored coral reef. The mission was to guard against sampans (Vietnamese fishing boats) that might carry VC from the area across the mouth of the river, bay, and around the peninsula and land on the beaches below the cliffs that provided one of the boundaries for the helicopter pad where the squadrons were located. We also provided the defense against the Vietcong's use of the unsecured corridor that ran along the coast, interrupted only by the mouth of the river.

Off and on for approximately 6 weeks, my team also lived just outside of several villages as a part of the initially referenced Combined Action Program (CAP) and eventually to be considered "Vietnamese Pacification" programs. We engaged in numerous activities while on these missions; we were, however, primarily accorded the responsibility of protecting certain villages from the Vietcong. The most meaningful of these experiences involved our bringing corpsmen out (from the base) to the villages; the corpsmen gave medical care to the children. Getting to know those children and care for them, as they would come daily to our positions and stay long periods throughout the day with us, was the truest and probably only treat of the Vietnam experience. Although this was mostly easy duty, even fun with the children, at night it was not easy, but intense. Moreover, our protection efforts, although well intended and administered, were not always successful as the VC hit one of the villages shortly after we were ordered to another location, the idea of the attack apparently being to demonstrate to the South Vietnamese that the protection program lacked efficacy.

This next paragraph is not intended as a complaint, but to rather show the conditions that influenced my later decisions. All of my personal belongings and gear, other than what I had carried in my pack during the initial helicopter landing, were lost during that landing and limited resupply were available to me. For this first 4 months, I wore one pair of utilities (clothes), 1 pair of socks and no underwear, which one pair and the accompanying T shirt I wore when landing were used for cleaning my weapons. A large bottle of Vaseline Hair Oil sent through either a Red Cross or Care package provided the primary lubricant that I used for that cleaning. On a trip back to the base I took one shower, which I did not do again for the rest of that 4 month period; I discovered that as the dirt was removed, my skin was re-exposed to insect bites and so forth, and for which I otherwise had no protection while living in the holes. My leather boots did not do well in the constant exposure to the water; they rotted away within 6 weeks of arrival. I was fortunate to be issued the first pair of new and specially designed "jungle boots" in my size; they had rubber soles and canvas ankle supports, and they never rotted or otherwise deteriorated for the entire tour. However, I rarely stayed in a tent or under a roof and because of the constant rain and water that I lived directly in, that is, the holes I dug often had water in the bottoms and there was seldom the time or place for my clothes to dry (during the first week of the monsoons, my poncho was blown away in a storm), I developed a skin disease. Although it started during that first 4 months, I did not receive medical treatment for the condition, which was my own fault, until infection portended the loss of the lower part of my leg about 6 months after my return to the states. Surgery that removed the affected skin and apparently the fungus or disease seemed to cure the problem forever.

Periodically, seemingly about every 10 days to 2 weeks, the VC would become active, firing during the night at the perimeter positions and engaging in, albeit infrequent, night ambushes. These small attacks served one apparent purpose of keeping everyone fearful, but also prompted counter efforts, which counter-ambush patrols I led on every occasion, as I was informed, that they were necessary. For example, in one instance the VC hit another team that was just manning the peninsula area as my team left. In response, we conducted night ambushes to counter the Vietcong's. Because I knew this area better than most, I was assigned the point position on these efforts. Although on the one hand I was proud of myself for the distinction of having an important responsibility, on the other I was scared because of prospective booby traps, mines, and so forth; in the dark, I believed that I had no defense against them. Moreover, an assumption was that they had hit the first group to draw the larger one out where greater damage could be inflicted, the intended purpose presumably being to show us that we were not defendable. These second

attacks did not happen, however, on any occasion that I was involved in such full squad counter ambush efforts.

On one of the sniper-type night attacks, the machine gunner in my squad was wounded. Aside from the other duties that I have described, I was an assistant to that gunner, which meant that on occasion I carried extra boxes of ammunition and the gun's tripod. This wounding was not very serious, but detrimental enough to necessitate the gunner's being sent to the medical facility; he was transferred shortly thereafter to a squadron in Da Nang. Subsequently, I was elevated in status, but without promotion as I was working outside of my primary MOS (job assignment), to that of a machine gunner for this group. Of note, although I had observed this gun's (M60) operation in Infantry Training Regiment approximately 1 year earlier, I had never fired it, nor did I know anything about its breakdown and reassembly; I would, however, become proficient in these things and the new skills would lead to a change in my experiences.

From time to time, suicide or infiltration teams would attempt to (and did on occasion) run through the landing strip (for jets) and tent areas in other locations from ours. These people carried satchel charges and light automatic weapons with which, respectively, they blew up planes and sprayed tent areas where Marines who ran the airbase had been sleeping. However, I remember all of these experiences - the day patrols, village protection efforts, living in the holes during my time on the peninsula, night ambushes and the infrequent attacks on the bases - to be more frightening than deadly for me and the people in my immediate unit.

Before leaving this description of that earlier period, one of the most pronounced recollections I have of it was the fear that I experienced in carrying out a special assignment that has always stood out to me in my memory, not just because of the job itself, but also because when I began it I didn't know how to accomplish the task. That is, I led 2 man teams on night missions where we would advance, during indications from intelligence that an attack on the base was imminent, in front of the various perimeters that protected the main fortifications. Because I had no training in this specific kind of activity, I borrowed a *Marine Corps Guide Book* from someone back at the base, the purpose of the research to help me learn anew, or remember from training received a year earlier, what I could and should do. I read this book by an oil and wick lamp 30 minutes before conducting my first mission. I don't believe that manual, however, was very helpful, as it didn't seem to cover this particular subject. The lamp, however, was very helpful; it provided, before leaving, soot for covering my face.

In some of these missions, we left from the outpost on the peninsula. These efforts required our traversing short distances of between 200 and 500 yards and longer ones, where departure started from the outpost, of up to, as occurred on one occasion, approximately 2 miles. When exiting the main perimeter, the other person and I would leave just after the sun set and crawl out through the cleared fields-of-fire area past our trip flares and Claymore mines, which I also usually had placed. We would then swim/crawl through a creek that was between 1 to 3 feet deep and full of thick silt, mud, and some sand on the bottom. From there, we would make our way into the jungle where I had the freedom as the head of the team to move to any position that I thought would be the most effective to complete the job. I led these teams even though I was of lesser rank, a private first class (PFC), than most of my partners. No one went with me more than once and the people who were senior to me did not know how to do this work. I remember only one of these people; he was from Philadelphia and he carried a small 25 caliber stainless steel pearl handled semi-automatic pistol, non military issue, in his pocket.

Once I found a spot, which was never in the same place twice and not where the guns from the line could hit us, the other man and I would crawl into a shallow trench, usually dug out with our hands, bayonets, and borrowed K Bar (a special combat knife that was not issued to people of my rank), and lay back to back, the bayonet and knife were placed in my boots; we then covered ourselves in brush. I held a 45 caliber semi-automatic pistol, which was also borrowed, to the top of my chest; I cradled it between my shoulder and neck. Later, after the 45 was shown to be defective, I carried my rifle, an M14. My partner and I would each take a turn watching while the other slept and until it was time to return. We timed our trips back so that we arrived before dawn; the VC were assumed to be working the same area and we did not want them to know, at least easily, our entry and exit points on the perimeter.

Our mission was to intercept and if possible kill the prospective infiltrators before they reached the platoon area or the main perimeter, or to at least alert the command of the impending attack by initiating fire - we did not carry a radio; it made too much noise. The key to the effort was to complete the outgoing and incoming activities as silently as possible, taking the "surprise" to them, the Vietcong. The process was always slow-going and intense, not to mention that I became lost in the dark and rain much of the time. Navigating in the dark was always my principal intellectual weakness. Significantly, I considered each movement, step, or even breath, to prospectively be my last. This description is provided without hyperbole.

I made all of these missions, which were uneventful, for my platoon. There were, however, several accidents where my own platoon members, uninformed or forgetting about the missions, fired on us, or as occurred on one occasion threw a grenade at us, as we tried to re-enter the secured area.

The monsoons ended in mid November; I remember this time as the period when things began to change - NVA activity accelerated and the process became more difficult. That is, there was an increase in downed helicopters, which caused the formation of a special emergency response team; downed helicopters required security. This group was comprised of a reinforced squad and I (carrying the 60) was one of the first members of the team. We prepared for and participated in rapid deployment missions. The team was responsible for the area in the Central Highlands between Quang Ngai province (I believe approximately 50 miles south of Chu Lai) and Tam Ky, a village half way between Chu Lai and Da Nang. In addition to securing downed aircraft, we also were supposed to provide rapid reinforcement of and protection for villages coming under attack by the Vietcong. I also remember that while either as a part of this squad, earlier ones, or in some other capacity, transporting VC prisoners and providing security to villagers who were relocating to avoid NVA regiments. This activity did not result in harm to anyone in our group, that is, we were not hit by the Vietcong; during these actions, neither were any prisoners, villagers or any associated people hurt by anyone from our group.

Near the end of my stint in this squad, which I believe to have been between mid November to the end of December, there was an attempt to insert us by helicopter into an area that, unbeknownst to the command, was controlled by NVA. Their response to us was very intense. As we landed, I remember all of us being on our knees. I bent my head and placed it next to the man's hip who knelt beside and slightly forward of me. I hoped that the bullets could not go through both the bulkhead of the helicopter and his body, especially the hip bone. We were taken out of the zone and then replaced by a Company (200 men) that assigned a smaller and lesser armed squad (they only had 6 men and no machinegun) to assume our previous duties. The captain from the replacement Company said that he was undermanned and that he needed our gun and us. He, notably, asked rather than ordered us to go back with his group to the zone. Our sergeant, who was recently new to this activity, refused the request, stating that he was under other orders from another command, which may have been true. I and others in my squad argued vociferously against the recall and attempted to go with these men from the replacement Company with whom we had begun to speak and who were apprehensive about the heavy NVA presence. Our attempts, however, were thwarted by the NCO's promise that we would be court -

martialled for insubordination. The captain for the replacement grunt company, recognizing the problem with the NCO - I believed that he was terrified, countermanded his orders making it legal for the rest of us to join the replacement Company. As we, absent the sergeant, were about to load back on to the helicopters to go with this group back to the zone our colonel, who was contacted in apparent desperation by the NCO, then reversed the captain's orders, putting an end to the effort.

We listened on the radio during that night to attempts to resupply the company and the smaller replacement squad with ammunition. We also could hear the fighting. The replacement company was hurt very badly. In addition, the position occupied by the 6 men who replaced us was overrun during the early morning hours and we were informed that all of these Marines were killed, which was sad beyond description, and something else - I believed at the time that their deaths could have been avoided had our more heavily armed group maintained the position. Every man in my team carried belt ammunition for the gun and we heard that the other men had run out of ammunition during the evening. They could not be resupplied. I remember that everyone, with the exception of the NCO in charge and who believed that we should have been joyous at not having been in that position with those who lost their lives, felt profound shame and guilt related to this affair. I don't know how regular grunts would have felt if confronted with this situation, but a basic attitude that I and my closest team members in this group shared, was that we always protected each other - we would never let any one of us take on a more dangerous duty alone. Possibly this view was held because we were still relatively new at the time.

Things changed for me when our CO, that is, his helicopter, was shot down on two occasions. In neither of the these events did he have a machinegun or any kind of automatic weapon aboard while on the ground - command ships were unarmed at the time and the colonel carried only a small revolver. Subsequently, I was transferred at the beginning of the fifth month of the tour out of the grunt activities/emergency response team and to helicopter operations, where I served as a part time helicopter gunner, initially on the command ship, and as a full time body guard for the Commanding Officer of that group while he was on the ground outside of secured areas. I liked this job and developed a good friendship with the Colonel's driver, Lance Corporal R. D. Galbraith, who helped me to get this position. He also became my best friend upon our return to the states (and following his discharge).

I was surprised and chagrined, however, when told about 6 weeks later that although I was doing my job well, I would have to return to my original grunt unit from whence

I had been transferred. During non operational periods, I wasn't useful to the group like the other people of my (near) rank. I couldn't perform clerical functions like typing, filing, etc. To avoid this reassignment to what I had come to believe was hell - living in holes in the dirt and sand and frequently making intense, albeit usually uneventful, patrols and night missions, I relearned in a 2 day period how to type, a skill that I had acquired in a course 5 years earlier while in the 8th grade. I barely passed this exam where I was required to and did type a minimum of 20 words per minute. Errors were not counted. Thereafter, I served, in addition to providing the bodyguard and machine gunner duties for the CO, as an aviation operations clerk, of which I was the slowest of the 3 typists, and a ground liaison representative for helicopter operations forward, where there was such a representative, for every operation in which the group engaged between January and September, 1966. This operations clerk job and especially manning it in the forward positions opened an entirely new world to me.

The "forward" operations positions required our moving the headquarters out and next to the grunts where they were engaged in ground operations. The purpose of the move was to match helicopter and fixed wing (jet) operations with infantry needs. In the beginning, this Operations Unit was staffed with 3 to 6 high ranking (major to colonel) officers, a master and staff sergeant, and another lower ranked enlisted man like myself, usually Lance Corporal Wolfe. Other names of members of this group included Master Sergeant Thompson, Major Dooley, Lieutenant Colonel Zitnic, and eventually Gunnery Sergeant Gratton and Major William Goodsell. Again, I regret not being able to recall others' names. They included another lance corporal, one staff sergeant, and other officers who rotated through the group; they were assigned as temporary additional duty from their primary responsibilities as pilots and commanding officers for their squadrons.

Some of my responsibilities in this forward unit included implementing and redesigning for the sake of efficiency aspects of the system that contributed to decreasing the time required for picking up wounded Marines; the faster we got them to C Med at Chu Lai or to the hospital ship *Repose*, the higher the probabilities that they would live. These efforts were called emergency med evac missions; my part in them, although small, represented my most valuable contribution made during the Vietnam War.

When an infantry unit came under attack and sustained wounded that were likely to die quickly if they did not receive immediate aid, someone from the unit would radio our operations command where I or Wolfe would take the radio transmission, yell

"Emergency med evac!" to alert the crews, code the coordinates and the condition, which included determining whether the zone was secured, delineate the smoke color for marking the zone, and then run the final information to the crews, who, on the initial alert, had started warming the engines of the helicopters. I would return to the radio and the map where the wounded's positions were marked and then maintain radio contact with both the helicopter and ground personnel until they made contact with each other, and continue to maintain such contact with one or the other as the mission proceeded. If air support were also required because of ground fire's suddenly making the zone unsecure - the NVA could place direct fire on the helicopter as it landed to pick up the wounded - then I would turn the information over to a duty officer who directed the interaction with the fixed wing pilots, who would then pound the NVA responsible for the insecurity of the particular zone. As these NVA troops were frequently providing such fire either directly out of or next to complex tunnel support systems, securing the zones was not always a function of air support alone, but often required artillery support or the grunts, themselves, sometimes having to assault the positions in order to get their wounded out. I or Wolfe coordinated the radio efforts. Coordination was important because it resulted in speed of extraction. This speed was everything in these operations, and only tempered with standing orders to not take helicopters into unsecured zones. We had too few planes and crews to lose which, when this did occur, it reduced our extraction capacity, not to mention reducing troop insertion and ammunition resupply capacities as well.

There were two complications to the emergency med evac process. First, the NVA routinely threw out their own smoke grenades to direct the helicopter into an unsecured area. Second, the helicopter pilots with whom I spoke on the radio routinely entered unsecured zones against both the standing orders and as I witnessed against the direct orders by the CO to not enter such zones. As these men would take fire and hits to their planes, they would make the first priority the extraction of the infantry wounded they had landed to retrieve. The flying into unsecured zones caused upheaval as a crew member or members would become wounded or be killed, or the planes would go down, or both. A helicopter's downing and prospective loss of its crew required that the chase bird, an accompanying helicopter flying as stand by, enter the zone to retrieve whomever, crews or wounded. Usually, additional med evacs and air support were also required. Extraction or emergency response team insertion activities were required as well.

Our group might coordinate only 4 or sometimes as many as 20 emergency med evac missions in a day, the latter occurring in heated operations where we also conducted 2 to 3 different emergency med evac extractions at a time, and usually coupled with

frequent occurrences of downed aircraft and loss and prospective loss of crews. A part of my job was to relay these changes in aircraft and crew availability so that replacements could be brought in. These replacements came from squadrons that were constantly flying resupply and air cover for infantry activities. Helicopter and crew availability were always stressed because of the infantry's ammunition and rations resupply demands, but emergency med evac superseded these demands, the stress and everything else. With the exception of the first waves of helicopter troop insertions into strike zones, areas where the NVA were located (or supposed to be located) and had decided to do battle, emergency med evac was the priority - the most intense and conscientious effort made by everyone involved.

While on these operations, I remember also being loaned out to provide gun support for a slick (an unarmed UH1E helicopter) to an infantry colonel (I believe also a Fleet Marine Force inspector) who used the craft to move more readily to various infantry positions during an operation. This job involved a multitude of processes including dropping the officer in designated areas and then retrieving him, sometimes staying with him while he conducted the operation from the ground, inspected caves, verified enemy dead and captured arsenals and appraised civilian casualties. That colonel was always giving up the helicopter to shuttle Marine wounded.

In addition, I also volunteered for and flew, when I first began to be a part of these operations, port gunner on emergency med evac, air strike, resupply, troop insertion, and on limited occasions *graves registration* missions. "Graves registration" refers to those missions where Marines who had lost their lives were carried to the places that provided for the processing of their bodies: they were sent home.

Other than that already described, a stress for me and apparently the operations command, as they began to send fewer operations' representatives to the forward positions, sometimes only myself and an officer, Captain Downey, was that the NVA periodically moved small forces (including the use of VC) from their engagement with the grunts and swung to attack us, the nucleus of the forward helicopter command. These attacks happened only about 4 times and involved periodic and sometimes continual incoming automatic weapons fire, which was countered with artillery, Phantom and other fighter responses. In some of these cases, we operated from a large 6 foot deep hole that was dug out by an engineer's bulldozer; other facilities, like at Binh Son, only included a network of trenches.

One of the four or so attacks, however, was not as easily fended off. It occurred at night, I believe at either the end of January or February, 1966. Only a skeleton crew

of the forward Operations Unit remained at the site, a village called Tam Ky. The NVA (Vietcong) tried to take our position by running through it. A small Marine infantry unit that had coincidentally redeployed during the evening for some rest in this safer zone deterred the attack, but not without the loss of one and I believe several of the Marine defenders' lives. Since first writing this in 1986, I've discovered the unit to have been a platoon from 2nd Battalion, 7th Marines. I do not know the name of the platoon unit, and I doubt that they were recognized for doing anything other than their jobs. This was not considered a big event in the scheme of things, but this group's actions that night were not and will never be small or insignificant to me. They saved my life and the others' lives who were at that position. I would like to thank those who lived and to emphasize the wounded and the families of those who did perish. In 1996, I spoke at length with Captain (then) and later to become Colonel Downey, one of the Huey pilots from the two helicopter crews remaining with us during the night. We recalled the event similarly, both reporting it as the worst single episode of the war bar none (edited 2008).

Aside from the most obvious concern for those men who lost their lives, this was also a difficult psychological experience for me. Coming through it affected me more profoundly than anything has ever influenced my life, either that occurred before the attack or since. The morning following the event, I remember saying to myself that the rest of my life would go upward from that moment. I would make it so. I and others who did this work were always prepared for the NVA to make these moves and attempt to take our positions, which aside from their several unsuccessful efforts related, they did not do while I was in this group.

Updating: Because I didn't know what one was, I left out of the first publication that, and although I did not lose consciousness, I had suffered a traumatic brain injury from an explosion on April 28, 1966. That was my second and last of the tour.

Another extraordinary, devastating, experience occurred as a result of civilian casualties. Where the Vietcong routinely killed villagers, usually for political purposes, I observed, while on one of the later operations, I believe it was in March of 1966, destruction imposed by us. That is, although there was much effort by the commands, especially by the American commanders that I saw, to avoid civilian casualties, I did witness the decision by a South Vietnamese General to target a designated NVA support village near Binh Sohn; tunnel complexes honeycombed the area including the village and from which village the NVA was delivering heavy fire on a Marine battalion. The fire was causing substantial Marine infantry casualties. The village was heavily bombed. The bombing ended the Marine casualties, but at the

same time killed women and children; this was as low a point for everyone involved, and for me the lowest, excepting only the times when I helped to carry dead Marines, when my associates died, and when I believed I was close to death myself.

In the beginning, the operations in which I participated lasted approximately 2 weeks each, and were conducted back-to-back during January and part of February. These efforts involved large task forces of ships and landing craft where we made amphibious landings that were coordinated with air strikes and helicopter troop insertions. I had myriad duties which included making the landings with operations equipment that could not be carried by air. Galbraith, the CO's driver and I spent several days on an LST (landing craft) preparing the equipment for the battle that was to ensue. It was standard old school USMC and Navy amphibious operations where we made landings (Operations Double Eagle 1 and 2) by driving the equipment (in a jeep and trailer) through the surf and onto the beach. We then linked up with the rest of the Operations and headquarters group who had come by air.

In these large and initial (to me) operations, although there were a lot of men, supplies, and ordinance expended, there were not as many casualties on either side, as were to occur later. Then, that later time came and during the period from early Spring to early Summer, the character of these operations changed to become shorter in duration, but much deadlier for each group. All of these battles "Utah," "Texas," "Mississippi," and "Kansas" to name a few were against at least battalion and often division strength NVA units who carried substantial anti-aircraft capacities and who determined when the battles would be fought. That is, they routinely followed and then ambushed our recon teams, and then shot down dispatched emergency med evac helicopters, which downings we responded to with various and necessary levels of force (increasing troop insertions) and which increases resulted in the escalation of the battle until the NVA would break it off by departing the area. These operations came one after another, seemingly almost weekly (but then thinned out later), and usually lasted 2 – 3, but sometimes as in "Texas" 10 days. The stand-by emergency response team of which I was an initial member while performing my infantry duties, grew during this time from squad to platoon size, and then quickly to strengths having company and battalion capacities for rapid deployment.

Throughout this period, both the infantry groups and our squadrons took what the command called moderate to heavy casualties. That is, a single and particularly difficult operation where the NVA decided to engage would cause 50 to 200 Marine infantry to be deceased plus more men would be wounded. Our group would lose 2 - 4 helicopters and their crews or some of them. On the other side of such an operation

200 to 2500 NVA regulars and Vietcong would lose their lives. Of note, with the exception of 1 person, every corpsman that I knew or ever came into contact with, including the two that used to come out to the villages that I protected as a grunt, were either killed or wounded, preponderantly the former.

My guess, and it may be an inflated one, is that during the last 8 - 9 months of my tour I participated in 12 to 15 such operations, many of which were conducted directly out of Chu Lai; the Operations Unit did not go to forward positions with the grunts. Aside from feeling valuable for making a contribution to my unit's efforts, another really good part of this job was that I was able to return to the base at the end of a particular operation where I could shower, stay removed from the insects, eat regular food, and sleep on a cot in a place with a floor and roof. These facilities in the beginning were made of canvas (tents) and later toward the end of the tour nice 15 by 30 foot buildings with wood sides and floors, screened windows, and tin roofs.

I came through the Vietnam war unscathed, with the exception of the skin disease already described and two accidents and 2 TBIs. There were also some other experiences that I have characterized for myself as episodes involving severe weakness on my part. The accidents and experiences of weakness are described here.

The platoon on the hill about 500 yards from my location came under attack during the early morning hours, probably between 1:00 and 3:00AM. I was ordered to carry the M60 to reinforce the attacked group and to go as fast as I could. I remember being scared because tracers were criss-crossing the area. I was afraid of meeting VC, infiltration teams, who might be coming through this sector, but I was more afraid of being mistaken for them by my own people. I remember running very hard along a path that was almost invisible in the dark and rain, and illuminated only periodically by flares the light of which faded quickly as the chutes carrying the illuminations dropped behind the hill up which the path led and on which I was running. I tripped over something and landed face first on the exposed portion of a steel and pointed stake that had been driven 3 feet into the ground; the exposed portion was flanged, sharp and ragged. Apparently, because of the full impact of my body and the added weight of the gun, ammunition, grenades, flares, and so forth, I was knocked unconscious. I don't know how long I lay there, but someone en route to the same area found me lying in the mud and carried me to the medical tent where I was properly attended to. I discovered that my face was paralyzed on the side where it was hit below my left eye. The full paralysis lasted for several days and then diminished over an approximately 3 week period; there were no lasting effects that I knew of at the time.

In the second accident, I was aboard a UH46, a dual bladed helicopter, that when leaving the side of a hill south of Quang Ngai, dropped, quickly and without warning, between 50 to 100 feet to the ground. The helicopter and those of us inside bounced upon hitting the ground; my body hit the ceiling, from where it then was thrown back to the deck. I landed on other Marines and some landed on me. I sustained no apparent injury, although I was shocked and numb for several hours. I never rode in a 46 again.

Some of the periods of weakness to which I have referred occurred when I lost consciousness four additional times to the one already described. Two of these episodes were a consequence of heat exhaustion experienced while on day patrols. I was carried out after collapsing on the trail and flown out by helicopter another time, where while walking through water I fell onto the side of a dike separating 2 rice paddies. I took many salt tablets thereafter. I never passed out from heat exhaustion again. From time to time, I still remember the feel of the heat and the smell of the bacteria that covered the trail as a green slime, and in which my face lay. The putrescent smell was the last thing that I recall as I lost consciousness. Two other experiences occurred when helping wounded. I was holding one man's head while he was in much pain. He was bleeding from his stomach and a corpsman was attending to him and I lost consciousness, but could still hear people talking. When another man was wounded in the leg, which was bleeding profusely in spurts, I was helping to hold his arms and hands when I again became faint and then fell over backwards, passing out completely. The last thing that I remember was seeing the blood and his squeezing my hands hard while I was trying to give him strength. I remember holding them tightly back even when I could not see any longer. I returned to consciousness to find a chaplain (priest) bending over me and preparing to administer whatever they do for people who have died. He was relieved, happy and amused to find that I had just fainted. Because of the paleness of my skin he said that he thought I was dead. I was embarrassed, but too weak, as if an infant, to do anything about it. I couldn't even get up. I remember laying there in the dirt thinking "I am nothing and I have no character"; I could not associate this diminished individual that I had become with functioning in any of the capacities for which I trained and for which I was responsible. However, those 4 episodes passed, each within a matter of hours; one lasted a day.

The final episodes of weakness began to occur during the Spring. On occasion, I began to experience sickness even before exposure to deceased and severely injured Marines. I thought sometimes, in flashes of fear and panic, that the same injuries to them were coming for me next, which thoughts, fears and panic I pushed from my

mind as deranged; I worked to concentrate on helping where I could. I also remember that I was numb for several days following an operation, as if I had become separate from every thing and every one. I was always ashamed of these weaknesses and feelings of incapacitation, but also I always believed that I had otherwise done a good job. Absent the five episodes of unconsciousness and short recuperation periods, and despite my fears, I could be depended upon to do my part. I have not lost consciousness since that year.

There was a time when I thought that I was dead or should have been, and was separated by an explosion from my rifle. By the last of the tour, I could not sleep in even the secure places without it lying next to me on my cot, and under a cover so that the sergeant in charge of the hut wouldn't know that I had it there, locked and loaded with a full magazine - something that was against the rules. At some times, even during uneventful times, I left (at late night) the hut with the roof and floor, and slept in the hole outside the door; I had premonitions of attack, but all were unfounded.

I discussed, on my return to the states, with a Navy doctor some of these things related to the passing out episodes; I thought they had been peculiar experiences. He said that I would probably be all right; I apparently was. That is, until 1981 when I began to have severe reactions to the memories of my experiences. Later then, my psychology would collapse to a new disorder recognized in the DSM-III. Post-Traumatic Stress Disorder (PTSD). I was evaluated stringently by the VA and then accorded a 100% disability for the condition.

During the last 2 - 3 months of the tour, I remember that my duties, with the exception of 2 extremely difficult operations, were primarily clerical; I don't remember going to forward positions with the grunts, or for that matter if there were any such positions manned by our group. I do not believe so.

In one of those operations, June 16, 1966, my immediate CO and directly supervising officer, Major William Goodsell, was killed. In the second one, with only 2 days left in-country, I was sent out, by a newly arriving (from the states) and in my view obviously terrified sergeant as a replacement for him, to the same forward position where the night attack on the forward command referenced earlier occurred. The people that were already there told me when I arrived that they were periodically taking incoming, mortars. Subsequently, I finished my tour in, again, the deepest hole that I could find, a hole that happened to also be filled with 2 feet of rice paddy water; I ended in the same place from where I had started.

Before departing the states for Vietnam, our MAG CO and the man for whom I served as a body guard, Colonel William Gentry Johnson, informed us of his philosophy. He did not believe in heroism. He primarily wanted his men, us, to come back alive. I and the rest my group subscribed to this philosophy - I can only recall one award ceremony where crew chiefs and pilots were given medals for completing a certain number of combat missions. However, and although I was not heroic, I personally and my unit were recognized for having done our jobs well. I received a meritorious battlefield promotion from PFC to Lance Corporal and recommendation from the base physician for a Purple Heart for the concussion and temporary paralysis of my face. I was very proud of the promotion, and recently heard that my family had been notified of it during the war; I'm told that my father was proud of it also. I never knew of the family's notification. I declined the physician's recommendation for the recognition traditionally given to the wounded; I was embarrassed because my injury had occurred from accident, and the effects were not otherwise serious or long lasting. My unit's efforts were acknowledged with a Presidential Unit Citation and Navy Unit Commendation.

Most importantly to me, I was accorded a special 2 day R and R flight as recognition for my participation in the operation where Major Goodsell was killed. In that operation, an 18 man recon team was attacked and encircled by an NVA battalion. Our unit responded with several actions: attempted and failed night ammunition resupply, attempted and failed emergency med evac, and attempted but partially successful night air support and eventual morning extraction by our unit. The sergeant heading the team was accorded the Medal of Honor. In addition to my boss, many of the men on the ground were killed and I believe all were wounded. I would find out later (long after I wrote this the first time) in 1996 that Major Goodsell was awarded a Navy Cross, the second highest Marine Corps medal for individual bravery available.

I would like to note that Major Goodsell was a quiet, nice, soft spoken, and very kind person, a different kind of Marine Corps officer from the image held by people of my rank. As I also recall, he was married and had children. Although the members of my group rarely spoke of it, and I cannot speak for them, I believe that his death hurt us all very badly.

The special flight, where I was the only enlisted man present among approximately 14 officers and pilots who had participated in the operation, was my most valued experience of personal recognition. It is equally important for me to say that I did not think at the time that I deserved to be in this unit because these people were better educated than me; even the few enlisted men had acquired some levels of college, and

they were all well trained to do this work. In this competitive and demanding environment, I was doing well, the best that I could do, to stay with them. So the flight meant to me that I had not only kept up, but that I made a meaningful contribution to these people who I respected very much. I was specifically told by the Group Sergeant Major, a kindly man, that the trip was intended to convey this message to me.

I believe that there were other group recognitions, but I cannot remember their specifics. I was very proud to have been a part of this operations command unit and to have worked with these people, especially because of the admiration I held for the extraordinary character demonstrated by the commanding officers, pilots, crew chiefs and emphasizing corpsmen - a representation of selflessness and caring for fellow men that was so profound that it is impossible for me to relate adequate description in words. Moreover, many of these commanders and senior NCOs, WWII and Korean War veterans, exhibited routinely, daily, acts of courage, integrity and bravery. These men epitomized for me at 19 to 20 years of age what it was to be a Marine and a man. I aspired to be of their character. There were also some very funny people in the operations command.

Although the grunts were not my primary associates in the last 9 months of my tour, from my view they showed a level of personal strength, sheer physical stamina, and determination that are also difficult to relate. I recall coming upon a squad resting at the end of a battle, I believe called "Operation Texas." The officer in charge described to the Colonel who I accompanied how that during the conflict, the NVA, 10 yards from the Marine Squad, had panicked while throwing grenades - the NVA soldiers threw the grenades too soon after pulling the pins, and the Marines were able to throw them back, killing the NVA who then lay close to the Marine squad members. These Marines seemed amazed at the opposition's lack of training: throwing grenades while in close conflict. Some of the squad were even laughing. I don't remember all of the infantry units represented throughout my tour. But 3 included 2nd Battalion, 7th Marines; 3rd Battalion, 7th Marines; 2nd Battalion, 4th Marines.

I characterize Vietnam for myself personally as initially being an attempt to acquire, and then maintain through the duration of the tour, enough courage to do the job. With the exception of the 2 months in the latter part of the summer of 1966, the experience in that country was one of constant intensity and fatigue, mixed with a few noted periods of little activity, some humor, and then followed by other periods that involved terror and horror, to include carnage and death on a scale that I experienced as horrendous. Where I started out as an adventuresome young person who was

willing to take risks, I ended the tour with the view that death during combat was a random event, and in some cases my being alive was and still is a consequence of others' courage, but also accident: NVA ordinance failed to explode and I moved or was moved from positions where the happenstance of the moves alone resulted in my living. I attempted to skew the probabilities of that randomness to my favor by becoming well focused upon completing my missions with my body and life still intact. The most vivid memory I have of this change, outside of what I have already told you, was the thought at the end where I began to doubt that had I been placed again into that situation experienced in the early part of the tour where I had argued to join the 6 men who had replaced us and then who were killed during the night, that I would not have volunteered any longer to go and fight with them - that I would rather have been alive than risk being dead. This was my most shameful experience that I had about myself at the time.

I believed two things about Vietnam. On the one hand I had done my job well. On the other, I had become by the end of the tour a different person who was beginning to be without courage. I did not allow anyone to know, however, the accompanying feelings of increasing fear, terror, guilt and shame. I held them deep within myself and attempted to, and did at times, project the opposite - courage, strength, will, and determination; but I no longer volunteered.

On return to the States, Camp Pendleton, California, I was reassigned to my primary MOS of truck driving where I was supposed to teach new truck drivers how to drive and maintain their equipment in combat conditions. With the exception of the company of my good friend who spent that first 4 months with me, and longer for him, in that infantry unit at Chu Lai, I was profoundly disappointed at not being assigned to a unit where I could be with some of the people with whom I had served in Vietnam, especially the last 9 months. With regards to the new job, this was an extraordinary position to be in because during the last year I rarely saw a truck, much less drove one. Moreover, I had almost 2 years left on my 4 year contract. Subsequently, I was not gung ho.

I was promoted to corporal immediately, and the leadership responsibilities provided me with another perspective on the situation. The new people who were going over to Vietnam were not, in my opinion, being adequately prepared, attitudinally and practically. That is, they were living in fantasy, preoccupied with personal interests that were totally unrelated to that which might confront them; they were not being prepared for the advent that they would be transferred into a different job, as I was so transferred. Because I did not see anyone else who took this prospective problem for

them seriously, I became, in addition to performing my regular duties, a training instructor, NCO, in this newly reconstructed (5th Marine) division, of Iwo Jima fame. I taught these new people, and demanded that they learn, everything that I knew about insurgency (guerilla / terrorist) and counter insurgency operations. The instruction included courses that I designed and also provided the primary instruction on how to protect villages, what to do during an ambush, how to set night counter ambush positions, how to read maps (land navigation) if lost or having to call for air or artillery support, or call for med evac, and I taught every person in the outfit how to dismantle, reassemble and fire M60 and 50 caliber machineguns. These training activities were not well received by these men, including some of the other NCO's and officers, as the general attitude was that these people were motor transport and not grunts. Despite their arguments, I persevered with the effort which gave meaning to me and despite my lack of popularity.

During this time, I became, through meritorious promotion, a "5.0" Marine Corps sergeant. This means that my proficiency and conduct ratings were the best that could be achieved or awarded on the measurement scale. Aside from providing many of the training functions for my outfit, I also was the physical fitness NCO, primary drill instructor, NCO in charge of the civil unrest response, and the NCO who, generally, took seriously the idea of order and discipline during a time of turmoil and upheaval for both the Corps and the country. I worked at being as strong, stable and tough as a person in my position was required to be and as I thought those people, the new Marines in training and transition, needed for what they were about to encounter. The notion that hard and conscientious training could help to keep people alive was not just a slogan to me. I received awards for those efforts, and I was proud of them. I should note that although I gave this effort my determined best, I do not believe the quality of training was comparable to that which would have been received in standard division infantry units; everybody in the command structure would have shared my attitude and conviction, and no doubt would have added greater expertise.

To a man, these people that I had trained for the 14 to 16 months between the fall of 1966 and the end of 1967 were transferred, all in an approximate 3 day period during the beginning of the TET Offensive in January 1968, from their primary MOS's of truck driving to serve as grunts in infantry units that were flown directly into the area north of Quang Tri, South Vietnam. Because of my leadership responsibilities, and although I only had 6 months left on my 4 year contract, I volunteered to return to Vietnam with this group, providing encouragement to those people who needed it, as some were sitting in the barracks crying and all seemed terrified. But, in fact I did not want to go; not only was I scared, but I believed with certainty that this time there

would be no chance that I would return alive. Moreover, I remember the parents of a young Marine who had hated me because of the rigors of the training. They came on to the base and told me that they knew that their son would be safe because he was going with me, and that he had told them about how he trusted me to know what I was doing. I will never forget that mother's and father's faces of stark terror and pain. When this troop movement was over, I, without understanding, was the only qualified person who did not receive orders. From thereafter, and for the rest of my life, this experience has haunted me with a mixture of disbelief at not having received orders to join this group, relief at the time for not having been sent back in, and tremendous guilt for not having gone with them. With sadness, I especially regret to say that my very good friend who had come through boot camp with me and who was the one person who remained with me during that first 4 months at Chu Lai, was also ordered out as part of that troop movement. He was then killed.

During this same period, I was recommended for Officers Candidate School and also offered a billet (position) as a drill instructor at the recruit depot in San Diego. I declined both the Officers Candidate School recommendation and the new job as a drill instructor for recruits. I left military service.

For a person who was a truant and teenage runaway, and at times a person without a home during my adolescent years, my service in the Marines was something about which, overall, I derived much pride - I had been able to do something well that took every scintilla of my courage and character. During the Vietnam war, I knew that my efforts had been valuable to the people with whom I served and to the people of South Vietnam with whom I had contact in the villages. I also believed that this effort had been valuable to the people of my country. Of course, my view became the minority one.

The political controversy about the war was understandable. And as a training NCO, I had studied the history and rationales underlying the War, including the study of NVA strategies for fighting it; they included fighting the War so that the opposition's home support would tire of the conflict. I even taught courses about why we were fighting in Vietnam, and I tried to include opposing theories.

Being politically naive, I did not, however, understand nor prepare myself for the political strategies that attacked our personages. In that regard, the perspectives accorded to us, combat veterans, by initially the antiwar activists and eventually much of the population, were unfathomable, and they carried over from the War, itself, to the rest of our lives.

For example, some of my best friends who had attended college during my time in the service exclaimed, when I did not agree with their views of the War, that my activities in the Marines had been "reprehensible" - "immoral." Films and documentaries most always described us as psychopaths, and these fantasies were also regularly honored.

The attacks affected after-service employment efforts - I was not employable because of my combat experience. Interviewers expressed their political views of the War; they condescended to me. I was lectured to about the value of WWII fighting men and the ignominious conduct of Vietnam veterans. One person even asked if I thought that I was a "tough guy" because we had killed women and children. Tiring of the opprobrium and fearing for my ability to make a living, I regret to say that I removed all identification of my Marine Corps and combat activities from my resume. Hence, to right that mistake, I'm adding them back in now.

These returning home experiences, of which there were many more but too numerous and disquieting to continue to report, were a shocking impact upon my life - a denigration of the best that I had to offer. The experience separated the innermost part of my soul from the country that before the War I had believed in and loved.

With the assistance of my father, I gained employment as a computer operator for an oil company (1968 - 1969). With extra money made from overtime hours, and in conjunction with a partner (another computer operator), I also purchased and rebuilt a 30 year old, 40 foot A.E. Luders yawl rigged sailing yacht. Although I did not have any sailing experience, this had been something I had begun to dream about. I bought books on the subject and taught myself the particulars, applying the book learning to multiple day and night offshore sailing ventures.

My plan was to sail from the Texas Gulf Coast down to the Panama Canal, through it, and then return to the orient, in the process also discovering the islands of the South Pacific. However, I married instead and then sold the boat to my partner, as my plan of sailing back to the orient seemed incompatible with the responsibilities attending stable family life.

I purchased a run-down service (gas) station dealership (for 100 dollars), built the sales volume until it provided a living, and then used eventually increasing proceeds to start a trucking company out of another franchise purchase, a business that I made into the largest of its type in the United States. When the parent company attempted to change to a corporate (as opposed to franchise-based) structure, I initiated and

engaged in anti-trust litigation against that parent, which went bankrupt - ending in the process my legal pursuits.

I concluded as a consequence of the litigation experience, which was no small battle, that the control of the business community belonged to those who understood the intricacies of the rules and languages governing this field. I also was confronted during this time by my lack of education and embarrassment that this lack held for me. Subsequently, I closed my individual businesses and attended Sam Houston State University and then the University of Texas at Austin where I received a degree in Business Administration and Accounting, completing the entire academic effort in 2 and 1/2 years of study.

My next employment venture was with an investment banking firm where originally I worked as a stock broker, but which focus I eventually changed to include corporate finance activities. This is where I learned the fundamentals of research. I recall that my feelings were, upon entry into this group, of deep inadequacy - competitors were Harvard graduates with MBA's (Masters in Business Administration) and the people were, as a rule, coming from a part of society having more social prestige and economic influence than I had brought from my own background, coming from whence I have described. By the end of this professional experience, however, I found that I was adequate and intellectually comparable to any competitor in this field. I eventually received recognition for my efforts in this profession by becoming one of the most prolific producers of revenues for the firm - which was the primary function of the job.

Upon the death of my father in 1976, a person with whom I had struggled in conflict for most of my life following my mother's death, I entered therapy, where I addressed marital problems as the primary issue - my wife wanted a divorce, which did occur despite the therapy.

During this, to say the least tumultuous, period, I became involved with the woman who is now my wife and the person who has had the most profound influence on my current, and most probably my entire, life. She had been involved in different aspects of the alcoholism treatment profession since 1973 and near the time of our getting together was the Educational Consultant for the Texas Commission on Alcoholism for the Texas Gulf Coast Region; it was her job to prevent alcoholism in the region, a population of approximately 3 million people. I am not sure how she did with that group as a whole, but she did save one individual - me. That is, because of her influence, and for which I thank her, and in part because of the psychiatrist who was

providing me with the therapy during this period, I identified my drinking as a problem and then stopped.

In hindsight and with extensive research and study, 1 year later I identified that problem to have been alcoholism; I continued to recover from it through my late entry and participation in the *Twelve Step* program of *Alcoholics Anonymous*. I think that because of that 1 year delay my experience of the *Twelve Step* model was not as meaningful or as important to my life as it was to those people whose initial recoveries were a more direct consequence of that program's assistance. I did continue to attend several meetings per week for a period of 5 years and found the fellowship and the opportunity to focus on the effects that my drinking had had upon my life to be very valuable, and despite the differences between the *Twelve Step* model and the ETM and TRT programs.

At the beginning of 1979, I changed professions to that of an alcoholism counselor; I acquired training and eventual certification. The training entailed approximately 500 actual educational hours (200 were required for alcoholism counselor certification) including attendance in schools and internships provided at the Johnson Institute in Minnesota where the curriculums and internships addressed family alcoholism dynamics, assessment, counseling and intervention. During this period, I joined my wife, who I would like to add declined the offer of the Executive Director's position for her agency (The Texas Commission on Alcoholism and Drug Abuse in Houston) in order that we could establish a private community chemical dependency prevention program based on family intervention, counseling and treatment activities; these activities are explained in the other development chapters.

It is important for me to tell you that throughout most of that nearly 20 year period, to include the times beginning with my mother's illness and continuing throughout my Marine Corps, business, and therapeutic experiences, and to include the period of transition into the alcoholism counseling profession, that neither I nor anyone else ever considered the combat activity to have influenced my life. I know today, however, that Vietnam and especially the return home did affect me profoundly. It provided a subconscious motivation to develop TRT. That is, I did suffer post-traumatic stress disorder from my combat experiences, but did not come face-to-face with it until I stopped drinking. And I think that TRT's applications to other people helped me to understand what happened to myself.

This understanding now underpins one motivation central to my work. I intend that some day TRT will be applied to young people in combat. They will be accorded the

trauma resolution process immediately and routinely following the heinousness and carnage that accompanies combat.

I have shared fighting holes with chaplains (they were not fighting, but taking-cover) and had discussions with them following events jointly experienced as horrific. Chaplains are the people who meet the on-the-scene needs of military personnel affected by such events. And I know that chaplains will benefit from this work; they will be better suited to meet the needs of future young people who serve in similarly difficult situations. And when that application of TRT to combat personnel happens, those fighting men's and women's hearts and minds will become immune to any denigrations, psychological warfare, intended to exploit their trauma - it will be resolved. I believe further that when no trauma remains for these future combat veterans, advancement of a particular political philosophy through attempts to demoralize these people will become an idea/strategy that has seen its passing. It will be replaced with a resurrected and time tested cultural value - the respect for and honor of service men and women.

Since the beginning of the Vietnam memorial activities, like the building of the Washington memorial where families go to express their grief, the delayed parades in the cities across the country, and the creation of the more recent statue depicting the role of women in war, I frequently think of the children, wives, and parents of those men who I saw dead. It seems that on most of those occasions, the first thing that anyone would say was, "He had 2 or 3 children," or "He just had a new baby." Now, I still think of those people, including the dead Marines' family members that I never met. And I would want to meet and to tell them that I was with their fathers, husbands, brothers or sons when they died. To my good friend's 3 small children, I would say if I could: "I knew your father well. He was my friend. He was brave and he looked after me. He was a fine and good man and I am sorry that you've had to live your life without him; I wish that you could have known him."

Because of these thoughts about and memories of these people, I dedicated this book to the men and women whose names are memorialized on the "Wall," their wounded brothers and sisters who served with them, the rest of us who also came home, the South Vietnamese who fought for their freedom, and to the loved ones who shared the experience and were affected by the tragedy.

Sometime in the latter half of 1993, I saw on the CBS news magazine show *60 Minutes* an interview of the Kansas Senator, Robert Dole. During the conversation, Senator Dole spoke emotionally of his wounds received during WWII, the difficulty

of his recovery, and his continuing identification with those veterans that have become street homeless - people outside the system. Although I did not have such injuries with which to identify and contend, for the last 15 years I have felt a deep and never spoken psychological kinship with those veterans that have lived in the remote forests of the Northwest, in the deserts of New Mexico, and in the jungle styled foliage of Hawaii. Even though I have always tried to be successful and so forth, I often used to think that I should be there with them, where I could return to doing what I did on those 2 man night missions - being alone in the jungle. I might have joined these men, who seemed vacant in the interviews, but I believe only to have been hurt, had it not been for my wife's influence on my life, the specific import of which I have described toward the end of this appendix.

As a layman who had entered the experience of therapy in the mid 1970's, my journey through the different helping processes were growth-evoking. Once I realized that something was wrong, the goals for this path became simple: I wanted to learn to understand myself. I also wanted to be able to relate more meaningfully to other people. As I made the transition to the helping professions, my goals were to lessen the difficulties of people who were negotiating similar paths in an attempt to find their own truths. I tried to achieve those goals by relying on the many philosophies and approaches that were available.

My belief at the time, which I took from the literature, my training, and in part my own therapy, was that people were caught in traps of their own making. Fundamentally, the individual (or client) was seen as being responsible for his or her own direction in life. In this vision, life problems occurred because the individual was choosing or allowing the experience in order to meet basic needs. An extension of this hypothesis was that people who chose to stay in such a quagmire were indeed sick, and that when they were ready to get well, they would.

The methods I used pointed out my clients' misdirections and then reflected other possibilities. Once these people had attained an understanding of their mistakes, it was hoped that they would choose, from the broader range of alternatives, new directions that were more beneficial to their personal healths. Although I believed that people's emotional experiences were important, to the extent that I was trained in the administration of client centered and grief resolution therapies, I relegated both the emotions and the therapies which emphasized their importance to a secondary status; emotions were always subordinated to the importance of proper choice-making, positive action-inducing, success-building processes. I thought that the answer for everyone was fairly simple: people needed to learn to be responsible and accountable.

The goal was to help people toward achieving self-actualization. At times, I even condescended to those who did not make the grade - opining that people that remained in debilitating states would never get anywhere by just feeling sorry for themselves. I abhorred the idea of victimization, seeing it as a degenerating philosophy intended to excuse lack of performance.

These were my general, but initial, counseling philosophies and approaches. They would change following the experience reported next.

While writing the *TRT Educational Program* educational materials between 1985 and 1987, I wrote a booklet that described TRT's development from the perspective of my experiences as a person affected by trauma as a child, and then subsequent progressions through a psychological experience related to my mother's death. The purpose of this article was to describe grief so that people who were experiencing it during the therapeutic process or before entering such processes would understand that it was natural. Where I have already reprinted part of that description earlier, that is, the description of my attempts to stop my mother from taking her life, I am reprinting here the conclusion, which occurred 20 years after her death - now (1993) over 34 years ago, because this experience marks the changes in philosophical and clinical perspectives I had of other people who were also affected by trauma.

I was participating in a continuing education training program for counselors. As I listened to the speaker, I noticed that red welts were developing on my arms. I left the training session, which I do not recall as having been especially important or influencing. In the restroom, I found that the red color was spreading across my chest, neck, abdomen and buttocks. I found Nancy, who was in another class, and told her what was happening and that I didn't understand it. I then set out for home, leaving her there to finish the school.

During the drive, tears began to fill my eyes, and I felt as though I were drowning. When I couldn't see the road or the cars in front of me any longer, I pulled to the side of the freeway and began to cry. I didn't even know what the crying was about.

However, when I finally did get home, I discovered what was wrong. I was beginning to do what I had never done before - I was starting to grieve the death and loss of my mother who had died almost 20 years earlier. The difference was that the experience I was having was as if she had died just hours before.

For the next three days, I relived my life as if I were again 13 years old and my father had just received the call that told us of my mother's death. I remembered that while he was on the phone, he began to cry as he tried to tell us what had happened. I felt myself become numb and heard my sister, seeming to talk from a great distance, ask from the kitchen if I was all right. I said that I was and continued putting my football uniform into the washer. Soon the house was filled with people coming to help.

Nancy's part in this reliving process became very important to me. Periodically, she would come into the room and lay a hand on my shoulder to let me know that she cared and that I was not alone. From both her professional background and her understanding of me, she knew that I was starting to experience a hurt that had not begun to be resolved until now. From Nancy's view, what might be precipitating this experience was not as important as the reality that it needed an opportunity for expression. She also recognized that for my grief to be ended, I would have to begin where the process had been interrupted and continue through the experience until it was completed.

Each of the re-enacting days corresponded to an equivalent time preceding the funeral. Throughout the experience, I felt as if I were two people. One was an adult living in the world of today. The other was a teenager who had just lost a parent. The recollections were vivid, and I found myself living interchangeably in the two roles.

On the first day, I moved from the many years of shock, confusion, and denial that my mother's death had affected me into embarrassment and shame at having a mother who would take her own life. As those horrible feelings of denigration of her passed, I returned to being numb and in shock, wondering if this would be the end of the experience. Without announcement, another wave of grief almost stopped my breathing and required that I fight for air.

While going for a walk, I relived the experience of several friends' visits prior to the funeral. As I stood unmoving on the sidewalk, I remembered the specifics of our conversations as if my friends were there again and had been walking along with me. The difference this time was that part of me that was still 13 years old was unable to make light of the tragedy or to entertain them as I had tried to do then. This time, it was impossible to be strong and act as if nothing had happened. Later, after the recollection of that visit was gone, the same relatives returned in my memory to share our loss. Again, I couldn't be the proper host or do my duty by trying to be a man, as I had when I was a child, because now I was incapacitated with mourning.

On the following day, instead of being in shock, I was angry. By mid afternoon, the anger had turned into rage. I went into the bedroom and closed the door out of fear and embarrassment that someone, to include my wife, would see or hear me. Once alone, I cursed and pounded the bed until I could no longer lift my arms.

In the evening, the feelings of anger subsided. As my composure returned, I discussed with Nancy what had been happening. I explained that I felt embarrassed, foolish and humbled by having had such a strong emotional reaction to something that had happened so long ago. Her response was that, regardless of the length of time involved, she still felt sadness for me. Throughout the conversation, she never reflected concern about the level of emotion expressed, nor did she try to prevent the emotional cycles from continuing, even though the experience was difficult for her also.

Later that night, I returned to the grieving process. I began to experience a hurt as though my heart had been pulled from my body. What followed were complete emptiness, and an ache and sadness that I didn't think would end. As the experience of the loss became unendurable, I thought in exhaustion and despair that I could not continue to live.

On the third day, I awoke crying. As the morning progressed, the intensity of the expression of the pain increased until I was no longer, in my mind, a man at all, but a child wailing a cry for his mother who was just dead. My chest would not stop heaving and it seemed that the tears would never end.

In the afternoon, and during the same hours in which the funeral had been held, a change took place. While at the height of my experience of the intensity of the pain, it suddenly stopped. At the same time, and at the center of the inside of me, I felt a sensation equivalent to that of a small opening. Initially, the feeling was only of warmth. As seconds passed, though, the sensation grew and took on the additional experience of fullness. Eventually, it filled a space within me that seemed to be as large and deep as the whole of my chest. As this change started, I had at first become frightened. Intuitively, however, I began to realize that what was happening would not harm me. Then, even though in reality I remained intact, I experienced my chest as if it were opening. In that instant, the pain I had known for the last three days changed into a pressure that was just as rapidly released by the outpouring of a me that I had not known was there for most of my life. The experience was so pronounced and real that I was amazed that I could not see what seemed to be rushing from my chest. Simultaneously, I felt complete: as if a very important part of my life

were finally whole for the first time since childhood. In that combined emotional and physical moment, I knew, after 20 years of not understanding, that I was forgiven for not having been able to keep my mother alive.

The reader should know that there was more to this experience, but that this description explains the crux of it. Also, it is noteworthy that during the twenty year span between my parent's death and the expression of the emotion related to it, I was never aware of a single moment when I realized that I felt guilt about not having been able to save her life.

Furthermore, I attribute my ability to have made this passage to my wife's love and caring for me and the way that she responded as the grief experience finally began. Where I had in previous years tried to approach this internally retained experience, but could not because of what I now believe was the interference by control philosophies and methodologies I had adapted as defenses against it (not to mention also being blocked by alcoholism), she dispelled those defenses in that 3 day period. First, she never reflected fear or concern over my loss of emotional control - the collapse of my intellectual controls over my emotions were accepted, allowing me to continue to grieve until the process was completed. Second, she never expressed the view that the amount of time that had passed between my actual loss and the eventual grief experience was something about which she or I should be concerned - there was no condescension of me because I had not gotten over something from the distant past. Third, she did not attempt to change my perspectives by positive inputs or by trying to help me to forgive my mother for taking her own life; nor did she suggest that if I desired, I could choose to let go of the past pain - my pain did not threaten her. And last, but most importantly, she treated me, not as an individual who was sick or ill, but rather as a person who had been severely hurt by the loss of someone he loved - she did not need to create abstractions to obfuscate a lack of understanding of profound emotional pain because she did understand this kind of pain and was not confused by it. The key to her approach was her combined uses of existentialism and caring - I would have to accept the fact that my grief had its own time, direction and requirement of me and she would show her caring for me by remaining with me throughout the experience.

Looking back to that time, I realize that I am the one who finally did the necessary grieving. However, I know, too, that I needed another person who could lend herself to me in a way that would help me complete something I had started long ago and not been able to finish alone.

What I did not know at the beginning of my counseling activities, and would not become aware of until after experiencing the life-changing event I have described, was that my adoption of my initial counseling approaches, like teaching self-determination, control and responsibility-taking to trauma victims, was a direct consequence of the philosophies of stoicism I had adopted as a child while trying to keep my mother alive, and then continued to use as a Marine during combat. I especially used this method when coming home. That is, my efforts to teach trauma victims to be strong, tough and self reliant were actually methods that reaffirmed my attempts to do the same for myself - an attempt to protect me from my own experience of repressed psychological trauma. I did not know, however, that in accomplishing those tasks, my personal loss and grief were simultaneously being kept intact in their places of darkness.

Following the grieving process through which Nancy had helped me, I began to march to the beat of a new drummer - I developed a new desire about life. I wanted to learn how to care about people where they had been hurt, as I had been hurt and hadn't even known it. In short, I was converted from a cognitive- and behaviorist-oriented person who emphasized the attainment of successful and better performance through discipline, education and self motivation, to an existentialist oriented counselor whose primary motivation and intent were to share acute emotional experience.

Subsequent to these changes, I developed a new philosophy. In it, I concluded that personal responsibility, accountability and striving for success were still important attributes and guidelines required in economic and other valued competitive environments, but not applicable in situations where the goal was to get to the bottom of psychological trauma. In that regard, the responsibility for addressing deeply repressed emotional pain and unresolved grief did not lie with the choices of the trauma victim. That is, the concept of individual responsibility-taking could not be projected on to these people, as I had originally thought, and as some of my training had theorized. Rather, that responsibility lay instead with those who surrounded that person. If the individual was caught in a trap, I began to believe that it assuredly was not one of the trauma-affected person's making, but instead the making of inadequate helping methods; they made the matter worse by isolating these people even further.

Those affected by psychological trauma do not need to be condescended to through admonitions to be strong, disciplined, different, better people and so forth. They need someone who has the courage and simple ability to care - to negotiate with them, to

share at the most profound levels of emotional pain, the loss and grief that is otherwise so difficult to address alone.

Although this journey has been made by many other people, I've told it to you because it was also mine. It shows my frame of mind when Nancy and I began to develop Trauma Resolution Therapy. This frame of mind, validated by our observations of TRT's myriad applications and our reviews of the literature, would then lead to the development of a psychological environment, a new life and professional epistemology that provided a perceptual structure that would advance the creation of Trauma Resolution Therapy™ and Etiotropic Trauma Management™, also now known as ETM TRT.

Chapter 2

ETM TRT Development as Applied to Individuals

This chapter describes:

1. The clinical experiences and rationales that led to the development of the first component of the TRT structured approach - TRT Phase One.
2. The developments of TRT Phases One through Five.
3. Development of TRT for adult children of alcoholics (parents).
4. TRT's development as a treatment model for post-traumatic stress disorder caused by chemical dependency's biological and psychological influences on chemically dependent people.

The developments of TRT and the ETM family treatment model occurred simultaneously. Because of the complexity of these two processes, which were both parallel and intermingled, we separate their descriptions into two sections; this one describes the development of TRT and the next one (the next development chapter "Family") describes the development of the ETM family treatment model.

Pre TRT Clinical Experiences and Approaches

If you read the great writers and investigators of psychological trauma and loss: van der Kolk, Scrignar, Freud, Bettelheim, Lindeman, Bowlby, Kolb, Parkes, Kardiner, Hendin, Haas, Horowitz, Kosten and Krystal, you will no doubt find as we did that during the time that TRT was beginning to be developed, that many people who were suffering psychological trauma were not recognized as such. The term "trauma" was assigned, at least in the literature, mostly to people like combat veterans, concentration camp survivors, and sometimes to people who had unexpectedly sustained the loss of a loved one.

The trauma victim populations, spouses and adult children of alcoholics that we were seeing before developing TRT were not perceived yet in that literature as suffering psychological trauma. As evidence of this, Paolino and McGrady's exhaustive review in 1978 of the alternative perspectives of the spouse of the alcoholic showed that most professionals viewed such spouses, not as trauma victims, but as disturbed or

decompensating personalities who because of their conditions sought out the unusual life.

Paolino and McGrady demonstrated that these views were held despite the fact that the only theory shown to have research validity (Jackson's Stress Theory: 1954) supported the opposite conclusion that these spouses were no more abnormal than anyone else who lived with an alcoholic would be normal. The characteristics of spouse behavior were obviously consequences of "adjustment" to the alcoholic episodes.

Once interpreted as "adjustments," however, there still was no investigative work that pursued the delineation of the trauma or the traumatic condition that presumably caused the adjusted psychological state. Worse, this failure to define trauma in this population occurred despite the routine accompaniment of parallel experiences involving battering - some professionals still believed trauma was not happening because the battered spouse was seen to be getting what she truly wanted.

Subsequently, and just before initiating the process that would result in TRT's development, we were not oriented as a consequence of either our training or study of the treatment of this population to the term "psychological trauma," but to other matters related to alcoholism family treatment, like stopping the drug use and helping the family to readjust to sobriety. Therefore, when TRT was developed while working with this population, this developmental and application process served a purpose other than just, generally, helping this group of people. TRT gave us a new definition of the problems affecting spouses of alcoholics and battered spouses. That definition eventually would become our definition of psychological trauma. The definition would then be applied generically to all kinds of psychological trauma.

Since many of the professionals to whom we have provided training have indicated similar progressions to our pre TRT development efforts, we believe that it would be helpful to include at this beginning of this development story some of the concepts and methods related to those efforts so that interested professionals have a more complete understanding of the path that led us away from such use and eventually resulted in the formation of TRT. The reader can also see our limitations resulting from the use of various conceptual and methodological paradigms, and how these limitations were either overcome or how they shaped positively or negatively, depending on your view, the TRT developmental process.

Through this short overview of these concepts and methods, we hope that readers who have used these same ideas and approaches can have a ready understanding of the logic of our system. Readers can see what they have been, are, or are not, using and then compare that perspective and experience to the changes we made in arriving at TRT.

Aside from this effort, our literature review provided in the Academic / Comparison - Contrast chapters describes alternative treatments to psychological trauma and our view of their comparisons to TRT.

Survival Response: An Impediment to Trauma Resolution

Most trauma investigative and treatment efforts found in the literature are focused on the thought/behavioral responses that follow traumatic events. There is good reason for this. These responses not only cause the trauma-affected individual great intrapersonal and interactive difficulties, but they also serve to interfere with remedies. Such was the case for us when attempting to help spouses of alcoholics.

The foundation of these problem-causing responses was, in our view, located in the reality that spouses of alcoholics (from now on called "spouses") had suffered ever-degenerating experiences in their relationships with chemically dependent people who were on a parallel course of decreasing functionality. These experiences included loss, which losses have been explained in detail throughout this book.

The spouses, through their subsequent and unusual adjustment thoughts and behaviors (described in level two theory), were then seen to be protecting themselves from the seemingly incapacitating emotional response of grief resulting from those losses. Parenthetically, this idea that was not as readily embraced at that time as it is today.

We called these protective activities *survival responses*. This survival response was designed to not only protect the person from future trauma of a like kind to that which had already occurred, but also protect the person from the realization of the internal damage already suffered as a result of the actually occurring trauma-causing event(s). Survival responses are also referred to in the literature, and periodically by us, as psychological trauma "defenses" and "symptoms."

The more intense the original trauma, the more tenaciously the survival behaviors resisted resolution. This tenacity came in different forms: chronic self-blame, extreme

withdrawal, psychologically-based amnesia, suppression, or in the other extreme, emotional outburst, hysteria and hyper arousal. The resistances were manifested to the extent that some spouses could not continue to participate in the therapeutic activities (including individual and group sessions that involved discussing the traumatic experiences resulting from the alcoholic's bizarre drinking behaviors).

We attempted to counter these responses or defenses with both cognitive therapies and grief resolution methods, but found that many experiences of loss resulting from abuse had been suppressed too long and the behavioral defenses too well established - the client did not respond as readily to the existential-oriented approaches. This was of course especially true when the spouse needed the defenses to protect her or him self from continuing trauma - bizarre behaviors occurring during and following CNS (central nervous system) toxicity.

Consequently, in the beginning we added to the cognitive and existentially-oriented grief resolution models those tools that were common to our field at the time and believed to help the populations with whom we were working. Some of those tools are described here.

Helping Tools: Psychotherapy

Because I was an alcoholism counselor as opposed to being, say, an analyst or psychotherapist, the reader should know that at the time we claimed no special expertise in the delivery of psychotherapy, a complex helping tool. Aspects of psychotherapy only served as a general model for providing assistance to clients.

However, grief resolution was something that could be facilitated by anyone, for example, a caring individual, and such resolution efforts were applied by people of my profession, including Nancy and me, routinely. The reader may or may not know that grief resolution is a form or element of psychodynamic therapy, a part of which is often included in the psychotherapy module, which clearly is multifaceted to the degree that as a term it is used by both psychodynamic and behavioral-oriented therapists.

The grief model fit the circumstances if the spouse was viewed as having lost something, as opposed to gaining from the attraction into the difficult experience. Application of this model could have been simple - help the person to identify what had been lost and experience the emotional cycles resulting from the loss. However, because many professionals at the time adopted the disturbed personality and

decompensation hypotheses, psychotherapy was seen as being needed to discover, among other things, why a spouse would choose such an experience; another question frequently considered was: "Why would spouses stay in such a situation?"

These other views influenced us and the professions as a whole, to the degree that even if people saw spouses as being affected by loss, the psychotherapy model still managed the perspectives such that the principal goals included identifying and changing symptomatic behaviors, which depending on the view, were either symptoms of the disturbances that placed the spouse in the situation in the first place or symptoms of the losses that resulted from the perpetual degenerative experience. Out of this confusion, which permeated our trainings, the literature, and the professions as a whole, our therapy eventually involved the balancing of grief resolution against facilitation of the spouse's correlation of the previously unresolved loss to current symptoms. Helping people cognitively to adopt a wider perspective of the history of the trauma and how it related to current thought and behavioral processes, then, appeared to be the proper method of dealing with the means through the which the survival responses were thought to defend the person from the internally retained traumatic experience(s).

The role of psychotherapy and its difference from TRT is reconsidered in other components of this book; see the bibliographical and comparison chapters. For now, we summarize this part of the description of psychotherapy by saying that psychotherapy, although used for purposes other than to address psychological trauma, provided the basic approach to treatment. The general idea, which is well documented in the literature, was and is to balance the process of identifying and addressing internal experience with the identification and eventual remedy of the trauma's symptomatology. The eventual aim of this therapy, as described by some, was and still is to help the person to regain psychological control of current life - become a wholly responsible adult capable of functioning in society. At the time, these were our goals too.

Helping Tools: Psychodrama

We supported the general psychotherapy/ grief resolution approach with psychodrama, which was also passed on to us through our training. The use of psychodrama included various methods, one of which was descriptive writing (letters to the alcoholic or perpetrator, parent, former spouse, and so forth). These writing processes assisted the client in sharing the original trauma-causing experience(s) with a group.

This written approach was augmented with other psychodrama techniques. Examples include: role playing, family sculpturing, speaking to an empty chair, art therapy, etc.

The psychodrama made it possible for aspects of earlier trauma-causing events to be portrayed by current group members. Problem situations and involvements from almost any prior period could be re-enacted through such efforts.

When people used these methods, they inevitably saw aspects of that past period as being reflected in current life processes. Thus, a forum was provided through the use of the psychodramas for re-experiencing past pain and at the same time correlating subsequent symptomatology (adjustment behaviors to the trauma) to current life.

Helping Tools: Education

In addition to the psychodrama, educational tools were also used extensively to strengthen the facilitation of the wider view. Books, films, videos, and lecture presentations aided in this effort. The essence of the educational programs emphasized the differences between functional and dysfunctional ("sickness" and "disease" were other terms periodically used in lieu of "dysfunction") people and families.

The educational concept was that people could be shown the differences between right and wrong (correct and incorrect) functioning and then entreated to learn the appropriate way to act, thus solving the problem of "sickness" and "disease" through behavioral conformity and by increasing communication skills, including learning to experience and express feelings and so forth. It is important to note that these educational tools were not developed by us and do not represent the current thesis of our own materials (*The TRT Educational Program*) made available to trauma victims after TRT was developed and that are now used in the ETM/TRT programs.

Treatment

The treatment process was a back-and-forth facilitation of grief per what we understood to be the total of the emotional elements of the experience, that is, shock, denial, anger, depression, acceptance, and understanding, and facilitation of the client's developing awareness of past and present symptoms. When people completed the catharsis that resulted from their becoming aware of what had happened to them, we returned to the application of the techniques described earlier that focused on

fixing or adjusting the survival responses that we considered most hurtful to the person.

This technique required our teaching people how to identify hurtful responses to the trauma as maladaptive behaviors and to make proper choices, that is, to adapt new and more productive behaviors, including new rules governing individual and family behavior to replace the survival responses. In effect, we were listening to past tragedies and then teaching spouses how to lead better lives, to include taking control of their lives.

Everything that we did was taken straight from our training and is correlated to the mainstream ideas and methods of the time (1970's).

Development TRT Phase One

Initially, Nancy and I were each facilitating between 1 to 3 groups per day (4 days a week) averaging 8 patients per group. We also saw many of these people in other therapeutic processes including couples and family group therapies (see About/ Development/ ETM Family). From here on, we note that TRT's development occurred primarily in my groups first. Nancy's groups, then, served inadvertently as controls (see About/ Development/ **Measurement** for the specific numbers of applicable groups and patients).

In the beginning, TRT was only intended in my groups as a management/educational correlate to the therapy, not a therapy in and of itself. Thus, the application of the management assistance was not considered in the context of a scientific experiment where controls are required to validate scientific findings.

However, when TRT became a therapeutic process in its own right (described later) in my groups, Nancy's groups, where the management process was not being administered, then served as comparisons. For example, the separation allowed us to observe the differences between outcomes of people using the developing TRT management system and that these differences were pronounced.

Moreover, the people in the various groups often knew each other. For example, some of the group members attended the *Twelve Step* Al Anon program together. Consequently, when the progresses described in the next 5 sections were being experienced in my groups and then discussed by Nancy and I, they were also being assimilated informally at client interactive levels outside of the therapeutic process.

Eventually, through a combination of discussion between Nancy and me and requests by Nancy's clients to use the new management model, her groups began to use the TRT management process also. Hence, her groups were on an approximately 3 to 6 month difference in time and application behind my own.

This lag provided confirmation to my observations of client progress. Although this validation was not intended to produce scientific findings, say, to convince other professionals to use TRT, it still served its purposes at the clinical level - affirming that we were doing the best for our clients that was possible. Once that affirmation was attained, we made TRT available to anyone who wished to use it, but under the standards set forth in this book (on this site).

Returning to the narrative, as the group members with whom we worked negotiated the combined therapeutic processes (including the pre-TRT models described earlier), we observed that the therapy as it was being facilitated, that is, listening to or re-experiencing the tragedy and then helping the client to interpret symptoms as thoughts and behaviors that needed to be changed, was incongruous. The part of the process that focused on symptoms was becoming increasingly less important.

Focusing on symptoms and trying to change behaviors, or trying to help the person to build a new life, only seemed necessary because the methods we were using were unable to address the internal dynamics of the trauma completely. At the time, neither we nor anyone else (referencing the literature) knew what those dynamics were, short of speculations about generalized repressions of emotional pain and loss related to the meaning of the trauma. Subsequently, we decreased the focus on helping spouses to strengthen cognitive controls and instead helped them to direct their energies toward negotiating the existential elements of the grieving process.

During this period, we only used those aspects of the psychodramas that were most helpful in maintaining this existential focus. We especially used the letter writing approach because it supported the effort to address the internal dynamics of the trauma while at the same time circumventing some of the survival responses that previously had prevented the client's trauma resolution efforts. To take an example, some clients relied on the written description of the event(s) to the extent that neither withdrawal nor hyperarousal were as powerful as defenses and they no longer prevented these people's progressions through the reliving stage of the therapy.

Because of the stabilizing effect the letter writing had on the process through which the event was described, and because of my changing orientation toward attempting

to address the internal dynamics of the trauma and its effects more directly and completely, we changed the letter writing component by removing those elements in it that seemed to hamper that direct and complete effort. For example, when unresolved emotional pain (grief) appeared to become springboards for dissertations of philosophy, strongly held opinion, and so forth, we rechanneled the process back to the grief by restricting the writing to a factual and simple description of the event and expression of emotional pain resulting from the experience. We requested that the rhetoric, to mean expressions of philosophy and opinion, albeit indirect expressions of the emotional pain, be left out. The idea was to retard the indirect expression and move toward a more implicit expression that was unencumbered by the tendency to use the rhetoric as a defense.

It is important to note that we did not learn to do this on our own. Rather, we gleaned it from facilitating many chemical dependency family interventions per the Johnson intervention model (Johnson, 1975) simultaneously (during the same period) with the individual care being provided to those family members involved with the chemically dependent person for whom the interventions were supposed to help (see Clinical/ **Family Treatment**/ and About/ Development/ **ETM Family** for an explanation of the family chemical dependency treatment processes that we used while developing and administering TRT).

The Influence of the Chemical Dependency Intervention Model on Phase One's Development

During the application of the Johnson intervention model (Johnson, 1975), family members described in writing several of the chemically dependent person's drug use behaviors and the family member's emotional responses to those experiences. We then listened to the descriptions in what were called pre-intervention sessions. The objectives of the intervention model in these sessions were to provide the family members with the opportunity to practice the presentation and to weed out those statements and expressions that might raise the drug dependent person's defenses and thus prospectively interfere with his or her decision to seek help. This session also provided for, what at the time was referenced as, "ventilation" of feelings related to the events. Following the pre-intervention session, the written statements were presented to the drug addict in a controlled (pre-planned) intervention setting.

Because the intervention model required a recording of the specific, time, date, place and facts of the drug use episode, as well as some of the emotions felt in response to the event(s), it (the written component of the intervention model) served as a re-

experiencing of the traumatic event. Moreover, the format of that model directed the writers to refrain from accusations, expressions of judgment, philosophy, and anger, and then to express the family member's caring and concern for the chemically dependent person's disease (and despite the extraordinary damage the drug use behaviors created). The final goal of the intervention process was to facilitate the chemically dependent person's decision to seek assistance.

However, our view, developed after facilitating many such interventions, became that the real, truest, value of the intervention model was that it began another and parallel process through which the family members were able to identify the trauma-causing events and some of the effects of those events upon themselves. Incidentally, some of the people who provided my initial training in the model agreed with this perception.

Before all things, Nancy and I believed in the value of a person's having his or her emotional pain heard and addressed for the sake of that person's own psychological health. My personal experience with unresolved trauma and grief established that belief as the center of what I was doing clinically for other people (see ETM Tutorial: Academic / Development / Personal Experience's Influence on ETM's Development).

Because of these attitudes and ideas about what was important in therapy and our responsibilities in facilitating it, we became more and more oriented while facilitating interventions via the Johnson model toward making the focus of the therapy become the listening to that pain expressed during the pre-intervention sessions. We continued this commitment into the groups where we were working with these family members individually (individual family members attended their own group processes that were separate from the rest of the family). There, we used the intervention written format, coupled with other letter writing techniques used and reported by Kopp (1976), to describe the experiences and solely for the purpose of assisting clients to determine the influence of the events, recorded in the writing, on the writers.

Eventually, the intervention process became of secondary importance to the facilitation of the trauma resolution process for the family members. The next paragraphs explain.

When Nancy and I focused on resolving the trauma (which at the time was referred to as grief resolution) that the family member's had experienced, as opposed to focusing on the chemically dependent person's entry into treatment, the intervention elements restricting expression of certain feelings and expressions of care and concern because of the drug addict's disease appeared to be increasingly inappropriate; waiving, that

is, for the purpose of bringing about a successful entry of the chemically dependent person into a treatment setting, one's feelings of anger and outrage about battering, stabbing, shooting, sexual assault or attempted homicide, resulted, per our observations, in suppression and reinforcement of the repression of some of the most important elements of the trauma resolution process. Even though these elements were supposed to be addressed in that model later ("later" refers to a controlled treatment setting) their temporary suppression for expediency (get the drug addict into treatment) tended, from our view, to interrupt the natural (logical) progression that otherwise occurred if the intervention model's restrictions were not used. Once the therapeutic model (process) had become a participant in the planned suppression or additional repression of certain and specific emotional states, that model's opportunities for retrieving those suppressions were limited.

Subsequently, we used those features of the Johnson intervention model in the psychodrama that we believed supported the primary goal of resolving the family member's trauma and abandoned those elements that did not appear to support the achievement of that goal. In that regard, when looking at the family member from the perspective of addressing the trauma and its effects, instead of from the perspective of trying to orchestrate the drug addict into a controlled treatment environment, the limitations on expressions of some feelings and the controlled expressions of care and concern were not used. Expressions of outrage and anger in the trauma resolution-focused letter format were encouraged if they were felt.

If during the recollection of the trauma-causing event the individual felt no caring and concern for the perpetrator, they were not encouraged to place such expressions into the new written format, as they were requested to do in the intervention model. However, the restrictions on expressions of philosophy *were* seen to enhance the existential progressions - the client kept his or her focus on the emotional experience and did not use rhetoric as a diversionary device for avoiding that experience.

The new letter or psychodrama tool took the following form. It encouraged:

1. addressing the perpetrator of the trauma directly by using second person language "You."
2. focusing on the specific time, date, and place the incident (trauma-causing event) occurred.
3. using the past tense for verbs.
4. describing the facts of the event, including a reference and description of use.

5. describing the client's emotional experience of the event and without reservation or restriction.
6. because rhetorical and philosophical expressions were seen to block the process through which emotions could be specifically identified and then experienced and shared, the rhetoric and expressions of philosophy were left out of the descriptions.

Reading the Description

As a rule, each traumatic episode to which a trauma victim was exposed was recorded in the letter writing format described above and then shared with the group, or Nancy or me individually, one incident at a time. Nancy or I would stop the readings between incidents and facilitate the group's feedback, or provide our own in individual sessions. If an individual could not recall clearly some or all of the incidents, which was frequently the case for physical/sexual assault episodes, descriptions of lesser traumatic experiences would be recorded and shared with the group. Through a combination of these readings and listening to others describe traumatic episodes, the more traumatic experiences would eventually be easier to record.

Such special incidents were often written with Nancy's and/or my *assistance* (see the following paragraph for an explanation of "assistance") in individual sessions, one sentence at a time. The experience was always cathartic and slow going, and often written over more than one session.

After completing the writing, the incident would be read and reread in private session until the person said that he or she was ready to read it in the group. It would then be shared with the group members, who would provide feedback via the feedback methods described in the next section.

It is with regret that it is necessary to defend the concept of "assistance" by stating that at no time did assistance involve suggestions of fact related to the description of a particular event. Neither was it necessary to suggest that because a person could not remember an incident that he or she was repressing a sexual assault episode.

Assistance meant and means listening patiently to one word at time as the catharsis ensues. Then the person was helped to describe in writing each word as stated verbally. I am including this paragraph at this time (late 1993) because of recent attacks on trauma victims' memories of traumatic episodes. Virtually all of the

traumatic events recorded in individual sessions were, in the preponderance of our therapy, corroborated where families were available (which was frequently) as participants in the family and individual chemical dependency sessions. In fact, I never worked in a case where the facts were not corroborated by all involved including the perpetrator (when available). There is more on this subject in other parts of the book.

Giving Feedback in TRT Phase One

When beginning TRT, the group process was facilitated under the rules of client centered therapy. That is, group member responses to the shared incidents were spontaneous and there were no restrictions upon them.

However, the problem with this approach was that the groups were comprised of people who were having various responses to the incidents and which responses depended on the group members' own experiences of trauma and the survival philosophies adapted to help them to cope with that trauma. For example, the reading of a traumatic incident could evoke a response from a person who used stoicism to fight his or own experiences of self pity.

These responses usually included admonitions to the reader "to be strong," "to get off the pity pot," "to focus upon their own behavior," and "to make something of their lives by becoming responsible." Other responses included the use of interrogatories such as questions directed toward helping the person to see the relationship of the incident to the development of his or her disease.

Some questions were actually advice-giving processes: "Did the reader go to many Al Anon meetings?" Others were attempts to administer psychotherapy: "What effect did the reader think that the traumatic episode had had upon his or her relationship with a particular family member, like a mother or father, or today's relationships with a husband or child?"

A last and most frequently used survival coping mechanism involved the use of the process through which the listener identified with the reader and the event. This especially happened when the listener still had not completed the resolution process for him or her self.

Inevitably, such people used, in our opinion, their response to another's description of a traumatic episode to divert the focus of the therapy to the listener through the

listener's identification with the episode, and then the sharing of that which had been identified with the group. To re-use an example from Clinical / Long-Term Trauma / **TRT Phase One**, a reader might describe an automobile wreck as one of the trauma-causing events occurring in a relationship with a chemically dependent person. A listener, who had also experienced such an accident, or near accident, would begin to share this similar experience with the reader as soon as the reading was over. Although in some instances the person providing the comparable story may have intended to help the reader by letting him or her know that he or she was not the only person so affected, that is, who had been in an automobile wreck, the use of the identification feedback method would shift the focus from the reader to the person telling the comparable story. We saw this method, when used in this manner, as a means through which the group diverted the therapeutic focus from the trauma and its effects upon the individual who was reading. Subsequently, we invented guidelines (for giving feedback) that avoided these problems. The guidelines are described in "Fast Help" "Parallel ETM Facilitation Guidelines".

Time

In the beginning, we attempted to facilitate the readings into time frames that fit certain program time specifications (such as an 8 week program). The idea was to save everyone money and not become involved in long-term psychotherapeutic processes (ETM Tutorial: About / Development / **ETM Families** for an explanation of why long-term psychotherapeutic processes were not included in the chemical dependency family treatment model).

However, because of our increasing reliance on the existential aspects of the psychodrama, that is, let the trauma victim tell the story in the time that was appropriate for him or her, the objectives of achieving the telling of the story in specific time frames were abandoned. The trauma victim's grief and sharing of the episodes were facilitated within the periods that were required, depending on individual needs.

Returning to the Other Models

Following the participants' completions of Phase One, we returned to facilitation of the therapeutic process per the concept of psychotherapy described in the earlier subsection "Helping Methods - Psychotherapy." However, the existential influence provided by the structured Phase One format also influenced the therapeutic process following completion of Phase One.

In that regard, our orientation did include helping people to identify how the past trauma described in Phase One related to symptoms, but not to the extent that cognitive behavioral methods provided the leadership of this effort. Because our facilitative efforts were oriented toward the existential approach, participants addressed symptoms, in conjunction with other issues, as these issues arose for them, and not because we raised the issues. The result of this approach is recorded in a later subsection entitled "Observations Made Upon Completion of TRT Phase One: The Client's Discovery of Four Patterns of Psychological and its Effects."

Observations of the Effects of TRT Phase One

The use of this particular written and feedback process, the process that was eventually to become TRT Phase One, helped the trauma victim to begin to describe the trauma-causing events and not be interrupted in that description by the previously used survival responses of withdrawal, hyperarousal, or hysteria. Instead of having treatment-ending experiences, the trauma victim entered into a profoundly cathartic experience that was allowed to continue, sometimes over multiple sessions, until it was over.

The trauma victims that used this process attributed their abilities, that is, to do what they had never been able to do before, to the structure - the combination of the written format and the group feedback processes. As a rule, trauma victims reported (these reports provided for the foundation of Clinical/ Long-Term Trauma/ **TRT Phase One's** descriptions of what the therapist can expect from applying Phase One) that the structured process allowed them to:

- recall events previously forgotten (only partially remembered).
- share stories previously not sharable - they were too emotionally painful to discuss or no one had previously been interested in listening to them.
- identify emotional pain previously unidentifiable.
- experience that pain to a degree that was appropriate for him or her, and not have that experience interrupted by internal blocking processes, or outside influences (other people admonishing the reader to adapt various philosophies as a response to the emotion or the event).
- 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), we made the following observations of their participation in it. Those observations included:

- the clients' passing through emotional and intellectual blocks that previously had prevented similarly affected individuals from progressing through the process through which the trauma came to be addressed directly.
- the inevitable; once the writing and reading process was initiated, it would not be stopped (except in those special circumstances and under the special conditions described in chapter one of the text).
- the clients' progressions through a steady and consistent, albeit cyclical, state of catharsis until this aspect (to be determined later as the "entry level of the entire trauma resolution process") of the emotional elements of the trauma had been experienced, expressed, and reported as heard.
- the patient's repeated passages through the experiences of shock, horror, and terror, but with the confidence to negotiate such passages and remain psychologically intact.

Observations Made Upon Completion of TRT Phase One: The Client's Discovery of Four Patterns of Psychological Trauma

When group members completed TRT Phase One, they indicated that the process for them was not over. In fact, virtually every person participating in the writing, reading and group feedback process demonstrated, not necessarily through a return of survival responses, but through discussion, that they were pursuing a discovery of the meaning of the trauma to themselves, to their identities.

This meaning, as it was discussed, was on the one hand generalized, but on the other reflected in specific patterns. I noted four such patterns of discovery, or attempted understanding and discovery, of this meaning of the trauma.

1. There was a realization that the incidents were themselves contradictions to the elements of identity that had comprised the individual. These elements of identity were existential in their orientation and provided for the foundation or fiber of the person. "Existential" refers to the person's values, beliefs, images and realities.
2. As a result of the contradictions brought about by the intrusions, trauma-causing incidents, the person sustained losses, including intangible losses, which usually had been suppressed or repressed, and now as a result of having

completed TRT Phase One, were starting to surface for understanding, experience and interpretation.

3. The person had changed during the trauma, and become another person. We attributed this perception of change to the trauma victim's increasing awareness, following the reading of the description of the incidents, of how he or she had acted during the traumatic events, and thereafter. These changed thoughts and behaviors were disconcerting as they also tended to have resulted in contradictions to the individual's beliefs about how he or she was supposed to have thought and behaved. That is, these thoughts and behaviors following the trauma resulted in additional contradictions to existential aspects of identity - values, beliefs, images and realities.
4. These contradictions to existential identity resulted in more losses, which also apparently had been repressed during the entire period preceding the resolution process, and which now were starting to also surface for understanding and reconciliation.

Initially, the consideration of these four patterns of contradicted values, beliefs, images and realities, and the losses and changes sustained therein, were addressed through traditional group therapy methods having both client centered and cognitive-behavioral orientations. However, at the time that we were making these observations we attended a course in General Behavioral Marital Therapy, which although it was not intended for the treatment of psychological trauma, chemical dependency or codependency, provided us with the idea of continuing the use of the written processes in helping the trauma victim to better understand the meaning of the trauma, as was reflected repeatedly to us through the four patterns described here. Eventually, these additional efforts to bring clarity to this meaning would constitute the development of the rest of the Trauma Resolution Therapy (TRT) treatment process. The beginning of this additional effort is described in the next subsection.

Development TRT Phase Two

While we were applying Phase One and then addressing the rest of the patterns of the trauma through traditional psychodynamic methods, we attended a training program in General Behavioral Marital Therapy (GBMT). Although the focus of the course was not oriented toward chemical dependency or psychological trauma, we were impressed by the extensive use of written materials for codifying different marital values, beliefs, etc. The idea stimulated by this experience was that a picture of the trauma could be derived by codifying in writing the patterns we were observing in the

part of the treatment process that followed the trauma victim's completions of Phase One.

The difficulty for our clients at that stage was that the structured approach (Phase One) had provided such a clear understanding of the initial effects of the trauma, that the prospective address of the patterns of trauma reflecting general damage to existential identity, appeared too overwhelming to contemplate because the large numbers of traumatic events to which the trauma victims had been exposed resulted in very large numbers of values, beliefs, etc., being contradicted. In fact, Scrignar (1988) describes this issue, overwhelming numbers of psychodynamic variables, as the reason that psychodynamic models have not been very successful in the treatment of psychological trauma. As one would suspect, the losses spawned by this degree of destruction were also overwhelming to consider.

In that regard, after TRT's development and its introduction to the Houston community, clients and counselors-in-training routinely reported to us that members of the *Twelve Step* programs, to include some of its leaders (people who had used the *Twelve Step* program for long periods), expressed in an apparent reference to the competing TRT program, their disbelief that those "other methods" that purported to address and then resolve all the grief and loss resulting from life with an alcoholic were capable of such an accomplishment.

These people, who had addressed their traumatic experiences through the *Twelve Step* model, a completely different methodology from TRT, posited that it would be impossible to address all of the grief and loss, as the damage, meaning the unresolved grief and loss, to such individuals (spouses of alcoholics) "was too extensive to be directly addressed by anyone or anything." I have also personally heard such comments expressed on numerous occasions, and not just by people participating in the *Twelve Step* programs.

I do not tell this story to stimulate controversy or denigrate those people for their comments; the story is presented as a sample of attitudes that I have heard from virtually everyone who has either been affected by trauma, or who provides treatment for it. The idea that it would be possible to enter the arena of such damage and then reverse it, *especially with an idea of reversing it entirely*, was then, and still is today (by non TRT trained people) a concept that is not considered - the internal damage is too great.

Consequently, this view, which also influenced our perspectives during TRT's development, resulted in the original intent to *only* provide the additional written materials as a means of managing the many contradictions to values, beliefs, images, and realities and subsequent loss into a process through which they could be more readily understood as they related to the initial trauma-causing events and the emotional pain resulting therefrom, and already described and expressed in Phase One. It was with this limited purpose in mind that we came home from the GBMT training program and began to design the written processes, procedures and forms that would help our clients to achieve these limited goals - management and clarification of the effects of the original trauma-causing events.

Initiation

Before setting out the design for Phase Two, we reviewed our notes of the previous year taken from our clinical use of Phase One. The conclusion of this review was that the second psychological trauma pattern observed at the completion of Phase One could be extrapolated to a single form. This form was comprised of a Matrix - interrelated columns and rows of information.

Initially, there were four columns. The first column contained a summary of the trauma-causing events the patient had shared in Phase One. The second column was a reiteration, re description and summary of the emotions experienced when first writing Phase One and also experienced again now when filling out this form. The third column was a simple description of the values, beliefs, images and realities contradicted by the event. The fourth and, in the beginning use of the form, last column was for identifying and depicting losses directly resulting from the contradicted values, beliefs, images and realities recorded in column 3. The rows were established by taking one incident described in Phase One and applying it horizontally across the four column form. For example, a single physical assault incident recorded in Phase One and already shared with the group would be applied to the form by:

- Summarizing the assault in column 1 to the extent that it is distinguishable from other assaults and events described in Phase One.
- Copying into column 2 the feelings and emotional states already previously recorded in writing in the original Phase One description of the assault, and then recording any additional feelings experienced while making this entry.
- Thinking about and recording into column 3 the values and beliefs contradicted by the assault provided in the Phase One description.

- Thinking about and recording into column 4 any losses sustained as result of the contradictions.

The Matrix effect would occur as approximately 5 incidents taken from Phase One were applied to a single sheet of paper (8 1/2 by 11 and applied horizontally). Thus, if a person had recorded 25 trauma causing episodes in Phase One, Phase Two's format would result in the use of approximately 5 pages, each consisting of the 4 columns and 5 rows (a single incident per row) of data.

Later, a change was made; we added a fifth column next to the column providing for the identification of losses. This column (5) would provide for the identification of survival thoughts and behaviors manifested as responses to the trauma; the recall was easier to make when correlated to the filling-in of the other columns in the Matrix.

Reading TRT Phase Two

As indicated at the beginning of this chapter, our original and singular intent was that the Matrix be made available to the client to help him or her to manage, that is, better understand or become more clear about, the large numbers of contradictions to values, beliefs, images and realities and subsequent losses sustained as a result of the large numbers of trauma-causing events. In this initial idea, the client was to complete the form and then discuss his or her discoveries or clarifications with the group. However, in private sessions with the first person to complete the entire 5 column Matrix, I came to believe that the work had greater meaning than just as a management clarification process and that this meaning was too difficult to paraphrase. Therefore, the communication of the written effort should not be relegated to general discussion.

After consultations with Nancy, who was not facilitating this group, I recommended that this particular client read the fully developed Matrix to the other participants; she was to provide this reading similarly to the way that she had read Phase One. However, because I did not want her to have to revisit each experience individually, as we had already revisited each incident through the detailed reexperiencing process provided in her reading of Phase One, I recommended that she share the completed Matrix in one, or possibly two, group sessions.

The woman read her work from beginning to end without stopping. She started with the summary of the first incident provided in the upper left corner of the first page and proceeded across the page to Column 5, the detailed description of survival

responses. Then she returned to the first column and read across again to Column 5. She continued this process until over 50 incidents of psychological trauma had been shared with the group. The group was held over as it took approximately 2 hours to complete the exercise. The members of the group were deeply and profoundly affected; they were intellectually and emotionally moved by what they had heard and could see as a consequence of her efforts. It was as if the reader had constructed a painting that included every detail of the traumas' *direct* and destructive path through, not only her psychology, but ontology. Nothing, related to the traumas' *direct* impact upon her identity, was left to question. She knew this, and we knew it too.

Moreover, gone was the prior confusion that had accompanied what before the reading had been these previously unknown effects of the trauma-causing incidents. Gone also were the extraordinary expressions of intense and sometimes volatile expressions of emotional catharsis of the Phase One readings. Those emotional responses were replaced with her expressions and experiences, and then as also felt and expressed by the group members, of hurt, sadness, and consistently experienced mourning.

The new emotional experiences were also accompanied by something else not gained through her passage through Phase One. While reading Phase Two, and especially as she progressed toward her conclusion of the reading, her voice changed to the extent that I, and the other group members, as reported by them, felt her absolute determination to end this damage and rid herself of that which had caused it. That is, through this exercise, the writing and reading of the Matrix, we observed the reader as beginning to make a major change in her life - she had begun the process through which she eventually would regain control of that life.

To that end, her writing and reading of the Matrix, that had originally only been intended to support and clarify her understandings of the effects of the traumas, became a new therapeutic experience in and of itself - not only did the process provide for a more complete understanding of the traumas' effects upon her, but it also facilitated additional emotional and intellectual resolution of those effects. Simultaneously, the new process provided for the reconstitution of those previously sundered psychological elements that had initially resulted in what she had experienced as her loss of control. Through this reconstitution, those controls began to be returned to her.

The rest of the group members completed the new form, TRT Phase Two (The Matrix), and shared their efforts with the group over the next several months.

Outcomes for these group members were identical to the first reader's. Eventually, the Matrix was made available to all trauma victims in all groups.

Facilitating the Phase Two Reading Component

As explained in the previous section on reading TRT, the reading process was initiated by encouraging the person to read the Matrix in its entirety - in one or two sessions. Over a period of 3 years, and as a result of listening to the readings of hundreds of Matrixes, we concluded that facilitating a reading of TRT Phase Two involves the facilitation of a balance between the client's address of the effects of the individual trauma-causing incidents and those effects as seen from the perspective of the traumas taken as a whole, and then what meets the group's needs as a whole.

Thus, when considering the bigger picture, reading all the incidents in one session provided the optimum outcome - the view of the traumas as a single painting. When considering the smaller view, reading only one incident's application to the Matrix and then facilitating the group's feedback, this kind of reading provided for the optimum focus upon the effects of that one trauma-causing experience.

The third factor, meeting the overall group process's needs, involved the consideration of all patient's needs to read the various TRT Phases in which they were working. This meant that in a single session, it was the group's, including the individuals' who were reading, benefits to hear from various people working in different Phases.

Consequently, guidelines for facilitation of the reading of TRT Phase Two were established to provide that the Matrix would be shared with the group based on the counselor's discretion of the appropriate numbers of incidents to be read for the particular client, but with the underpinning of that discretion being the counselor's realization of the value of all three processes and the need to try to meet each.

Progressions in Phase Two: Summarized

The beginning goal of providing a written form to assist the trauma victim in managing or clarifying the initial trauma's various effects was superseded by the unexpected development of an expanded therapeutic process. That process was described in chapter 2 as occurring on 3 levels:

- The client's negotiations of 2 parallel grief cycles. One cycle was related to the reconciliation of losses stemming from the initial trauma only. The other cycle was related to losses resulting from all of the traumatic events taken as a whole.
- The client's resolution of the trauma: This "resolution" involved the client's passage through the grief cycles (A and C) described in Clinical/ Long-term Trauma/ **TRT Phase Two**, and to the extent that the components of the cycles (emotions and shock) pertaining to the losses resulting from the initial trauma were fully identified, experienced, and expressed, simultaneous with the client's intellectual reconciliation of values, beliefs, images and realities contradicted by the event(s), to include the identification, experience and expression of losses resulting from the specific contradictions, and the eventual reconstitution of existential identity to its pre-trauma existence.
- The client's regaining of control: "Regaining control" began with the client's ability to reconstitute existential identity to not only pretrauma levels but to also select values, beliefs, images and realities based on the client's ontology. "Regaining control" was also observed to be a function of decision making no longer controlled by survival initiated paradox, restored interaction between rational/ cognitive and experiential attributes, and interaction between all of those attributes and existential identity. We referred to this restoration of control as the restoration of operational identity. Restoration of operational identity underpinned the person's ability to identify sources of trauma accurately and choose a path that brought the trauma-causing events to an end. Thus, restoration of operational identity resulted in the beginnings of the process through which free will and choice were regained.

Importantly, trauma resolution and regaining control/choice, as these concepts are described in this definition, were never a function of the client's conscious efforts. That is, resolution and regaining control did not require that the client develop conscious management (to include evaluative, analytical, and interpretive) modes in order to change, or to maintain such change for, themselves.

The resolution and regaining control described here was always a direct consequence of the TRT structure's facilitation of those processes. In that regard, the structure provided by Phase Two replaced the need for cognitive controls to the extent that the client's progress in resolving the trauma and regaining control superseded progress made through any previously used methods, especially to include cognitive behavioral and non structured psychodynamic methods (provided under our applications).

In other words, the structure was observed to play a therapeutic role in and of itself to the extent that it replaced the need for the therapy to help the person develop cognitive interpretive capacities as a function of the resolution and regaining control processes. These capacities were reinstigated automatically, from within the unconscious, and simultaneous with the restoration of existential and operational identities.

Something Still Remained

Even though the initial trauma was resolved, the client still reported an awareness of issues related to his or her "part" in the process. "His or her part" was ascertained by us to refer to the client's changes undergone, or ways of thinking and behaving, that followed the initial trauma-causing events. These changes and ways of thinking and behaving and the address of their effects on existential identity necessitated the development of TRT Phases Three and Four. Phase Three's development is described next.

Development TRT Phase Three

Originally, TRT Phase Three was supposed to be the simplest TRT Phase to complete. The original idea was that following completion of Phase Two, the client would record on a separate sheet of paper all survival responses, survival thoughts and behaviors, to the trauma, and then share the writing with the group.

This exercise was intended to provide a transition from a focus on the initial trauma, reversing of its etiology, to a focus on the trauma victim's own behaviors that were thought to be prospective responses to that etiology and the event(s). There was a problem, however, that was extraordinarily difficult to overcome and took many years of TRT's application to solve. This problem was especially difficult to reconcile because its existence was not only a function of the peculiarities of the way psychological trauma retained itself in memory, but because other therapies, helping methods outside of TRT to include self-help and other professional efforts, strengthened these retention processes - the very processes that TRT was trying to help the client to overcome.

This section describes this problem as it affected Phase Three's development; we also explain how the problem was reconciled.

Survival Responses: General Effects on Helping Efforts

If an observer/helper, or for that matter the trauma victim, focuses only upon the survival responses to the trauma, that is, focuses on the third psychological trauma pattern instead of upon all 4 patterns, the survival responses will appear to be the person's primary problem. When such perspectives are held and conclusions are reached, the primary goal of the helping process becomes: assist the trauma victim to overcome the survival responses; assist the person to regain control. This means helping the person to develop better coping responses to the trauma.

The predominant methods used by trauma victims, friends, family, self-help programs, and helping professionals to accomplish this task, that is, develop better coping responses to the trauma, are the cognitive-behavioral/analytical-interpretive methods. These methods include strengthening conscious understandings of thought and behavior, evaluating for their meaning within internal psychic processes to include relating them to certain emotions, and developing ongoing interpretive skills that are then used to mitigate and to control the survival thought/behavioral responses.

In our experience in providing both the cognitive-behavioral/analytical-interpretive and TRT methods to populations described in this book, and through our observations of our clients who, either before their entry into TRT or during their participation in it, were well versed in the cognitive - behavioral/ analytical - interpretive approaches, we concluded that attempts to strengthen controls used by the conscious to help an individual to cope with the effects of a particular trauma, before those aspects of the trauma that reside in that subconscious have been resolved, *will provide for a return of the conscious experience of control, but will simultaneously and proportionately provide for the strengthening of those factors, also existing in that same subconscious, that prevent the trauma's resolution.* Those resolution prevention factors are comprised of opposing logical processes that exist to the extent that they form a paradoxical condition for the trauma victim - the person is pulled in opposite directions.

Helping efforts that strengthen the resolution prevention factors, the paradoxical condition, can, and often do, have the opposite effect (of helping) - they can actually hurt the person. That is, the trauma underpinning the need for the controls cannot be resolved after the strengthened controls have been applied. Thereafter, the trauma victim's situation can be made worse - the unresolved trauma remaining in the subconscious can continue to weaken the very controls that were established by the

conscious for the purpose of helping the person to cope with the trauma. Thus, attempts to establish coping controls with the conscious, for example, through the use of cognitive - behavioral/ analytical - interpretive methods, without consideration for the effect that those controls have on the factors that prevent the trauma's resolution, can result in the development of control mechanisms that, eventually and paradoxically, become hindrances to the regaining of *unfettered control*. "Unfettered control" means that the etiology is expunged so that it no longer plays havoc with the individual's attempts to control psychological life processes.

The Paradoxical Condition: Specific Effects on Disease, Dysfunctional Family, and Responsibility Models

When we used the term "hindrances" in the previous paragraph, we were referring to how the cognitive-behavioral and analytical-interpretive components of certain therapeutic models provided the client with a thought system for evaluating his or her own behavior and then changing it, but making the change before the etiology was reversed and subconscious controls related to the trauma's retention were replaced with first, subconscious, and then later, conscious controls that had been returned as a function of the etiology reversal process. Our experience was that such pre-etiology reversal established thought systems became, unbeknownst to all participants in the therapeutic process, incorporated into the person's consciousness, and then inevitably controlled by, the paradoxical condition.

Thereafter, the therapeutic model for managing the effects of the trauma became an extension of the paradox - a defense against resolving the trauma at the same time that it was attempting to help the person to get over it. Examples of such management applications with which we had to contend included:

1. the disease or codependency model as applied to people affected by a relationship with a drug addicted person.
2. a systems models that taught people that they came from a dysfunctional family, then taught them to evaluate their conduct in light of the dysfunctional family reality, and to change those interactive methods that were influencing current relationships.
3. models that taught that responsibility and choice were philosophies that if adopted fully, could serve as a panacea for personal problems.

Importantly, we note here, before describing in more detail how these models influenced, and in some instances, interfered with the application of TRT, that it is

not our intent to berate these therapeutic efforts. In fact, we believe that outside of TRT, all of these models have substantial therapeutic value. However, the purpose of this section is to explain TRT's development, which includes a description of philosophical and methodological obstacles overcome during that development. In that our original training and practice involved our use of the models discussed herein, TRT's development within the context of that use and training should be considered. Moreover, most of the professionals who have attended our schools have also been well trained in these models - this section should clarify differences between them and TRT, and in the process explain the latter's development.

The Paradoxical Condition: Effects on the Disease Model

The disease model's apparent control by the paradox was demonstrated when trauma victim's engaged in several repetitive processes to include:

1. observation and evaluation of personal thoughts and behavior
2. determination that such behaviors were functions of disease (codependency)
3. deciding that the behaviors must be changed.

The methods for such change usually included rigorous appraisal of the behaviors, taking responsibility for their occurrence, or, in the *Twelve Step* programs, exorcising the behaviors and the underpinning disease through conversion, to include prayer.

Our experience, and which is also supported in principle by advocates of the disease model, was that where this approach did end some of the disease's symptoms for some people, a lifetime commitment to identifying, evaluating, and exorcising those, or similarly recurring, symptoms was required for that ending to be perpetually sustained. People had to maintain vigorous maintenance programs.

In our view taken from working with the same populations in parallel TRT treatment processes, the process of repeatedly identifying, evaluating and exorcising "disease" behaviors forever, ever-continuously, was a series of repetitive processes that were only necessary because the damage to existential identity caused by the initial trauma-causing events had not been resolved by the processes in first place. Furthermore, the cyclical process of repetitively addressing recurring symptoms became, also in our view, a new symptom - compulsion to eradicate unwanted thoughts and behavior; the new symptoms, the clinical exercises, themselves, replaced the old disease behaviors that had been exorcised.

These new symptoms' manifestations within the therapeutic process, itself, were exemplified by the client's shifting of focus from the internal emotional pain resulting from the prospective identification of contradicted values, beliefs, images, and realities (and subsequent loss) to a focus upon the trauma victim's own behavior; in the other model's terminology, this behavior was considered the "disease." Where conversion was a part of the therapy, such shifts in focus to personal behavior and commitment to change that behavior were accompanied by the repeated use of abstractions - turning the pain resulting from the unaddressed emotion over to the higher power or supreme being. The entire shifting-of-focus process was usually consummated by the repetitive reliance upon the use of a never-ending source of slogans - "Let go," "Turn it over," "Get off the pity pot," "It's water under the bridge," "Keep coming back," etc.

After many years of observing simultaneous application of both the TRT and disease models and studying the origins of the latter, we concluded that the disease model as it generally was applied to trauma victims, especially those whose trauma resulted from protracted exposure to the chemical use behaviors of a loved one, was derived out of the traumatic experience itself. In that vein, we also concluded that the disease methodology was created out of the paradoxical condition suffered by trauma victims and consequently had the effect of helping other trauma victims to cope and to lead better lives, but provided that help, unbeknownst to its developers, within parameters that assure that the paradoxical condition maintains its existence and controls on both the person being helped and the helping process. In other words, we eventually concluded that the disease model as it was applied to non alcoholic trauma victims, and which model had provided one of the underpinnings of our previous trainings, was actually an extension of the paradoxical condition that controlled trauma victims' perceptual, interpretive, and remedial processes.

The Paradoxical Condition: Effects on the Dysfunctional Family Systems Model

In the dysfunctional family systems model, the analytical-interpretive method, when used with the systems approach, helped people to evaluate current and early family dynamics to the extent that the dynamics and the individual behaviors adopted from them were interpreted as dysfunctional. Once the interpretation was made, the individual would seek to change the dynamics and the behaviors. In our view taken from looking at the two models (TRT and the dysfunctional systems model) as they functioned side by side (see About/ Development/ **ETM Families**), the paradoxical condition has the same effect on the dysfunctional systems approach as the condition has on the disease approach. That is, the trauma victim becomes caught up in a

repetitive, never-ending, process of identification, evaluation, and change of ever-continuing and so called dysfunctional family dynamics.

Again, the repetition inherent in the therapy becomes comingled, manifested, in the survival responses; the therapy becomes controlled by the condition the therapy is designed to overcome. Examples of such controls by the paradox and simultaneous manifestations in the therapy include

1. repetitive (in this use to refer to "seemingly unending") evaluations of current behavior correlated to investigations of family of origin dynamics to discover the historical source of the behavior in question
2. repetitive use of interrogatories as inquiries about the relationship of standard role dynamics to current unwanted behaviors
3. the recurring need to objectify the behavior of the individual and system for the purpose of defending against the repetitively recurring symptoms.

Eventually, we concluded that these cognitive-behavioral/analytical interpretive methods, and even though they were framed as systemic techniques, including what in the late 1980's came to be known as family-of-origin therapy, actually were instrumental in maintaining the paradoxical condition; they on the one hand helped to restore the experience of control, and some actual controls, but on the other hand shifted the focus from the direct address of the damage that had resulted to existential identity and was still being retained in the subconscious. Worse, this model supported the patient's survival responses of self blame by stating that the inherited dynamics were responsible for the patient's having chosen, albeit unconsciously, the current or latest situation where additional trauma was occurring.

The problem with this assumption was that when such views of attraction were held (see About/ Comparison - Contrast/ **Multiple Sources**), the denial of the existence of the current trauma was reinforced - there could be no trauma because there was no surprising behavior; the person could not be surprised, traumatized, because he or she had chosen the experience.

The Paradoxical Condition: Effects on the Responsibility/Choice Model

The responsibility/choice model has numerous variations. However, it can also be explained simply by stating that being responsible means identifying and evaluating personal behavior, to include survival responses to the trauma, accepting responsibility for what the person has done, and then changing those behaviors

deemed inappropriate, hurtful, or maladaptive. This change includes becoming personally responsible for choices made by the individual and following the trauma.

The primary difference between this model and the previous two is that it, as a rule, doesn't frame, tag or in other ways interpret the survival thoughts and behaviors as "disease-," "codependency-," or "dysfunctional family-" based. Moreover, the pure responsibility/choice model does not use or become intertwined with the use of conversion therapy where the responsibility for control (fixing the behaviors) is turned over to a higher power or supreme being (the approach of the *Twelve Step /* disease model).

However, the responsibility/ choice model *is* similar to the other two in that the person again becomes caught up in a cyclical process of identification, evaluation and attempted change of ever-occurring survival responses, and from the responsibility model's perspective, ever-occurring *ir*responsible behaviors, to which the individual is always trying to overcome by becoming responsible. Again, the repetitive processes of identification, evaluation, and attempted change become incorporated into the paradoxical condition and, eventually, again from our view of watching both models interact in parallel, controlled by the paradox.

The Paradoxical Condition: Effects on the Application of TRT Phase Three

Because TRT Phase Three provides for the identification and evaluation of survival responses, what the 3 models described above reference as disease, dysfunctional, or irresponsible behaviors, Phase Three too was susceptible to becoming an extension of the paradoxical condition. The condition still remained because the 2nd etiology (in psychological trauma pattern 3) still remained. Moreover, the parallel or previous use by trauma victims of the alternative models (with TRT) would result in a co-mingling of the identification and evaluative elements of Phase Three with the identification and evaluative elements of the disease, dysfunctional family, or responsibility models.

Thus, when clients reached Phase Three, they identified the survival responses and evaluated them as such, clients also engaged the third component of the other models - but not a component of TRT Phase Three - *they began to try to change the behaviors*; inadvertently strengthening the paradoxical condition. Worse, this strengthening occurred to the extent that further attempts to resolve the rest of the trauma, reconcile contradictions and loss resulting from survival responses, were made more difficult, if not impossible. Indications of this difficulty were that, unlike

clients not so influenced, the clients who were participating or who had participated in the parallel cognitive - behavioral and analytical interpretive models continued to manifest not only the symptoms described in About / Theory / Psychological Etiology/ **Paradoxical System of Control**, but the dichotomous interaction of those symptoms as well.

The Paradoxical Condition: Combining Strategic Therapy with TRT Phase Three - Reversing the Paradox

Because the cognitive – behavioral / analytical - interpretive models were seen by us as becoming integrated into the controls of the paradoxical condition, and unbeknownst to either the trauma victims or the professionals advocating them, we concluded that these methods could no longer be treated neutrally. "Neutrally" means that we initially made no comments about the other therapies.

Moreover, we had even referred our patients to those self help programs (for example, the *Twelve Step* programs for people involved with chemically dependent people) that employed the differing philosophies and therapies (see the family treatment chapter and the next development chapter for further explanation of the relationship of the ETM family therapy program and the parallel influence of the *Twelve Step* model's application to the same populations).

This neutral position to the other therapies was, however, eventually abandoned - the competing models were interpreted, via *strategic* therapy, as interfering external therapeutic variables via the application of strategic therapy. "Strategic" means that we took specific steps to prevent the interference. The steps are listed here.

First, we informed all clients, through the development of our own educational materials, that TRT was different from the cognitive-behavioral/analytical-interpretive models. The locus of the difference was in the goals. Disease, dysfunctional family, and responsibility models would help them to change their behaviors - to be better citizens and so forth. TRT would help them only to resolve the trauma. There was *no intent* in the TRT program to make people more responsible, recover from disease, or get rid of family traits handed down over multiple generations, change behavior, become better employees, have stronger careers, marriages, or become successful citizens. TRT was administered because the trauma had happened to them; we thought this fact was adequate justification for administration of the therapy.

Second, we removed from our nomenclature any terminologies or philosophies that might engage and then support the paradoxical condition. Such terminologies and philosophies included those characterizations which were intended to frame the effects of psychological trauma into a mode where the cognitive-behavioral/analytical-interpretive models provided the basis of the helping approach.

For example "disease," "behavioral disorder," "maladaptive behaviors," "character defects," and any term that was used to vilify or characterize a survival response as something that everyone was mad at, and hence wanted to change, were struck from the therapeutic lingo. This strategic ending of the tendency to incorporate therapeutic jargon into coping mechanisms was extended to the application of TRT through curtailment of the use of TRT language to the extent that survival responses were considered as natural and logical responses to the trauma, and even though they may result in the contradictions to existential identity.

Third, although we did not recommend that patients who were already participating in the *Twelve Step* programs when they presented cease that participation, we did stop referring, with the exception of chemically dependent people, our patients (those who had no previous experience in the *Twelve Step* - Al Anon or ACA programs) into those programs. Furthermore, we notified patients with *Twelve Step* backgrounds of the differences and potential conflicts before the prospective client entered TRT (see Training/ **Cases**). We eventually came to believe that the differences in the therapies were too profound, and the value of the other efforts was offset by the depreciating effect that they had on the client's etiology reversal efforts in TRT.

Fourth, and most importantly, when patients began to do TRT Phase Three, we asked them 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. More specifically, we asked that if they were inclined to change the behaviors portrayed in the list of survival responses (provided by Phase Three), *that they postpone trying to make such changes until they had completed TRT entirely, all five phases of TRT*. Then, they could return to the cognitive - behavioral/ analytical - interpretive methods if they were so desired, or as they chose to follow the advice provided by other helping processes.

Observations of Client Progressions: TRT Phase Three

As indicated in previous sections, before we began to use the injunction that recommended that the client not attempt to change (until completing all of TRT)

survival responses otherwise identified and evaluated in Phase Three, the application of Phase Three was interfered with by the client's simultaneous use of other modalities (cognitive - behavioral/ analytical - interpretive) where the goal was different from TRT's - the opposing goal was to establish a conscious system of controls used for interpreting thought and behavior so that it might be changed (vs. TRT's goal of resolving the trauma, etiology reversal). When this interference occurred, the trauma victim's use of self-blame was rekindled as the primary survival response - the trauma victims saw their own behaviors and thoughts as contributing to the trauma. Inevitably, this heightening of the survival responses led to the recurrence of symptoms and their dichotomous interactions to the extent that the trauma victim could not continue the passage through the trauma resolution process.

That is, the client's use of parallel cognitive-behavioral/analytical-interpretive modalities at this stage of the TRT process prevented its completion, reversal of the second etiology. However, when the injunction was used and abided by clients, the trauma victims had a demonstrably different therapeutic experience. That different experience included (these observations also provided the basis of expectations described in Clinical / Long-Term Trauma / **TRT Phase Three**):

- A direct connection of the trauma victim's own behaviors, survival responses to the trauma, with the initial trauma-causing event and its effects on identity - those effects being contradictions to values, beliefs, images and realities, loss to identity resulting from those contradictions, and incapacitation to operational identity.
- The beginning of the passage through grief cycle B to the extent that the person identified, experienced, and expressed the first emotional components comprising that cycle. Those components included shock, disbelief and fear.
- The continuation through grief cycle C to the extent that the readers identified, expressed, and experienced deep and profound sadness resulting from their seeing a complete and non expurgated picture of the survival responses, and as those responses were considered as a part of the effects of the many traumas comprising a single life event.
- Operational identity continued to be re capacitated - there was increased interaction between rational-cognitive and experiential oriented attributes and between all attributes and the existential identity. This capacitation was exemplified by increased capacity to modulate between intellectual and emotional experience, to decide what was best for him or her self, and to make choices, based upon individual needs and interests now being portrayed out of the newly reconstituting existential identity, about life's directions.

Most importantly, we found that the more proficient we became at facilitating this experience, that the part of initial goals involving our "teaching people how to live better lives" (described at the beginning of this chapter/section) was increasingly less appropriate. In other words, the better we were at helping clients to reconstitute existential identity sundered by the event(s), the less that advice and interpretations of behavior were needed.

The next subsection describes the rest of the trauma resolution process. It includes reversal of the second etiology.

Development of Phase Four

Developing TRT Phase Four was correlated to Phase Two's development, except that the myriad and redundantly manifested survival responses dictated a differently styled Matrix; it included 3 columns instead of 5, and there were some additional differences attending the first column's summary. This subsection explains these changes and supporting rationales.

First, there was much duplication in the kinds of survival responses to the various traumas. I believed that the *categories* of response that were being manifested in the phase three descriptions were the primary considerations of the management process, as opposed to focusing on each individual response.

In that regard, we listened to both applications for five years and concluded, unequivocally, that the categorization of the survival response is the most valuable method. For example, a trauma victim may have listed in Phase Three 25 descriptions of "covering up" for a perpetrator's activities, 40 "lying" incidents, 75 responses of "inappropriately accepting responsibility" for the traumatic events, and many more categories depicting similar responses.

To account for these repeated similarities, the worksheet (demonstrated in chapter 4) was added, allowing for codification of the many responses into the like categories. The categories were then listed in descending order in the 1st column. Where in the 1st matrix the 1st column had supplied the client with a summary of each trauma-causing event, the 1st column of the second matrix provided a summarization of the various categories of survival response.

Second, recollection of specific emotions resulting from specific survival responses tended to orient clients who had been involved in other therapies (that involved the

client in analyzing their own thoughts and behaviors as the mainstream of the approaches) toward focusing on the survival responses again. This focus might occur to the degree that client's in some cases would begin to blame themselves again for "their part" in the trauma.

Moreover, the categorization shifted the identification of feelings from a recollection of specific feeling states to a process through which the emotional experiences were approached collectively. Feelings were experienced and expressed during the reading process (when interrupted for processing).

This method of expressing feelings verbally in response to the categories worked very well in that people usually experienced the same feelings when reflecting on identical and repetitive survival thoughts and behaviors. Consequently, the column depicting emotional response to survival behaviors and thoughts was dropped and replaced by the general (oral only) identification and expression of feelings experienced in response to the identification and expression of contradicted values and shared losses.

Third, no transition was required for further clarification of the trauma's effects because there were no more effects to identify, other than the cyclical process involving the occurrence of more of the same survival responses and same contradictions and loss, which categories were, in the main, already identified. Therefore, the last column in the first matrix following the column which provided for the identification of losses, was removed from this matrix.

Development of Phase Five

TRT Phase Five provides a summary of the Trauma Resolution Therapy process and a means through which the person looks back at all that he or she has accomplished in the therapy. In addition, this self interpretation of the therapeutic experience is augmented by the TRT group's participation with its view of the person and the therapeutic experience.

We have not always concluded the therapy this way, however. We began TRT by providing group member letter writing to the client who had completed the four phases and was about to exit the program. This exercise included a letter written by the exiting patient and to him or her self. All the letters described how each person saw and experienced the exiting patient throughout the therapeutic process.

This letter was general in nature except that it reflected both positive and confrontive (clearly, non attacking - constructive criticism) perceptions. In one session, the group members' letters were read to the person first, and then followed by that person's reading of his or her perception of him or her self. This experience was very moving and everyone loved doing it, especially the person who was the focus of the reading.

I had an alternative view about this exiting process. That view was that it was cognitive and interpretive, and in that regard operated contrary to the existential processes inherent in the trauma resolution activities provided by the first four phases of TRT. My view was that the ending implied an absolute conclusion to the resolution process.

My experience through observations of some clients following completion of TRT was that there was a suggestion that in the profound instances of psychological trauma, the internal processing would continue at unconscious levels for a period following the completion of Phase Two and to continue past completion Phase Four. This conclusion was based on no outward signs of symptomatology, but the differences in physical countenance and demeanor.

Specifically, upon completion of Phase Four such people (intensely affected) manifested a return of all the operational controls discussed earlier. However, at some period following that experience, which I calculated in about 10 people to range up to 30 months following the completion of Phase Two, the client's demeanor would change to reflect physical beauty through the experience of happiness and joy to the extent that there was hardly a representation of the person who had initially entered the program.

I concluded from these observations (made of people no longer in our therapy) that even though the trauma was resolved consciously by the end of Phase Four, additional internal processing of the resolution experience could continue to affect the person positively for an undefined period thereafter. I also concluded that the foundation of this suspected internal processing was existential in orientation and followed the tenets of natural grief resolution - the person had been through a dramatic life change before the therapy, and the therapy itself was dramatic in its resolution. Time was required to assimilate these changes.

Consequently, I suggested to Nancy that the positive closure and ending, although fun and heartfelt, might lift some people out of this existential processing before they

were ready to be through with it on their own. Thereafter, we discontinued the closure until a later change would again effect consideration of this issue.

That change was brought about by the newly developing *TRT Education Program* (described in ETM Patient Educational Information) which was a graphic depiction of the theory enunciated in chapters 1-10 and 12 of the text. These graphic models provided a pictorial interpretation of psychological trauma and the trauma resolution therapy process.

The overall impact on the issue of existential vs. cognitive/ interpretive closure was that the graphic models would emphasize cognitive understanding and at the same time allow the existential elements of the therapeutic dynamics to follow their natural course. In that regard, the cognitive - interpretive - based closure was no longer considered a prospective interference with existential processing. Thus, the closure was added back to the TRT Phases; the returned addition became TRT Phase Five.

In this new closure, we added more structure. First, we designed a worksheet that provided for a summary of specific losses as those losses had impacted the person at intrapsychic, interactional and systemic levels. Moreover, we had delineated the 4 patterns by this time and included this delineation into the loss summary.

An example of that form, which has now been used for 10 years, is provided in the application section as TRT Phase Five (A).

Then we reconstructed the letter format to help the person interpret the effects of the paradoxical system of control on their post-trauma experiences. The format for that form, along with an example of its use, is also provided in the "Application" section of chapter 5 in the text. This letter writing process has become known as TRT Phase Five (B).

The new closure, coupled with the application of the *TRT Educational Program*, appeared to have moved the assimilation period (for some intensely affected people), previously observed as lasting considerably past the completions of Phase Four and the earlier version of Phase Five, to the immediate culmination of the therapy. In that regard, people completing Phase Five hardly resemble, not just in the loss of symptoms, but in actual physical change, to include for lack of any other term, beauty. These observations have been validated by other professionals.

In that regard, I have concluded that my observations of physical beauty change were not functions of hyperbole and countertransference relating to any attempt to validate our efforts and importance, that is, unless all the professionals using the model and reporting the same thing, are suffering hypnotic transference processes. Whatever the case, the reader who is a Certified TRT Counselor is always invited to evaluate for this particular dynamic, a physical change of the trauma victim's countenance and demeanor to the degree that physical "beauty" is reflected as if emanating from deeply within the person, and upon completion of TRT Phase Five, or shortly thereafter.

For the reader's information, most people, including many professionals, refer to the change in even more dramatic terms. They call it a miracle.

Development of ACA TRT

TRT's application to ACA's was provided in concert with the treatment of spouses (of alcoholics) long before ACA treatment via the ACA disease models were developed during the 1980's. In fact, 8 full ACA TRT groups were being conducted in our facility prior to the competing ACA movement's (of the 1980's) development in our community.

When this competing process did begin, I was contacted and asked for my opinion and support of these activities, which I declined because of the differences in goals and clinical concepts. Thereafter, my most pronounced recollections of the difficulty of treating ACA's in our unit was the extraordinary interference provided by the clients' uses of parallel therapies adopted in the various self-help programs.

I have already explained this conflict in part under the heading "Development TRT Phase Three."

Generally, the primary effect of this conflict on development of TRT's application to this special group of people is that we increased the educational component at the front end and withdrew such people from the therapy quickly where necessary, incompatibility was presented, as it was deemed unethical to place such traumatized individuals into additional trauma by pulling them into different directions (see Training/ Cases for a discussion of ETM's ethical response to the differences).

Development of Chemical Dependency TRT

We did not apply TRT to chemically dependent people at first because there were too many factors influencing such an approach. Once they were overcome, application of TRT to chemically dependent people was the same as its application to other trauma victims - simple. Those factors are presented here.

First, the *Twelve Step* program of *Alcoholics Anonymous* provided for the predominant philosophy, theory, and method for treatment of this population - chemically dependent people. Our application of TRT to the same group, at least during the initiation of its use, would have to take a back seat to the other (AA) program.

Moreover, no one in the self-help programs understood trauma resolution for chemically dependent people as it was possible through TRT. Consequently, there would be no, nor was there in the beginning, support in those programs for the TRT effort.

Clearly, such support, especially including the use of sponsors within those programs, was very important, as those familiar with chemical dependency counseling can testify. For those not familiar with the use of AA "sponsors," such people, sponsors, helped to integrate new entries into the *Twelve Step* self-help process. Sponsorship was a common method of helping people to make transitions from the professional treatment processes to the ever-continuing recovery effort provided through Alcoholics Anonymous.

Second, certain neurochemical and hepatic realities resulting from the protracted and pathological chemical use precluded a timely application of TRT to CDP's. CDP's had to wait until at least 6 months of sobriety had been attained before beginning TRT.

Thus, these people, unlike the other populations, were establishing their recovering identities in different thought systems, "thought systems" being attitudes and methods that provided for the assimilation and processing of past and current feelings, thoughts, events and experiences about pre-and post-sobriety life. These thought systems, usually a mixture of cognitive-behavioral and client centered therapies, and the *Twelve Step* programs (including conversion), were designed for maintaining sobriety and not for resolving trauma.

In fact, once these thought systems became established in the minds of the chemically dependent people, the systems of thought themselves acted as impediments to the application of TRT. "Impediments" means that cognitive-behavioral and conversion based coping systems inclined the individual toward coping with the trauma rather than resolving it per the existential oriented resolution approach provided by TRT. Thus, the primary conflict and subsequent challenge was to determine how we could continue to use these other methods for attaining sobriety, and then later carve out enough therapeutically sequitur psychological room, "psychological room" being the provision for a logical interface of diametrically opposed therapeutic processes, in which to employ the TRT modality.

Third, there was a war going on at the time about whether chemical dependency was a disease. The significance of this conflict was that considerably more energy had to be dedicated to the selling of the disease concept to the CDP than would otherwise have been required to be provided had the political opposition to the idea not been so vociferous.

Such political opposition views when expressed in the media were always front page discussion in CDP recovery groups where chemically dependent people believed they could still drink responsibly. Because TRT was not philosophically reliant upon the disease concept (albeit sustained sobriety was required) for achievement of its goals, the "goals" being to resolve the trauma resulting from the pathological use, the extra emphasis of the disease model due to the stress of ideological conflict interfered with the consideration of the presentation of a second or parallel idea - pathological chemical use created a post-traumatic stress condition and that TRT could be helpful in addressing the condition by resolving the trauma: reversing the etiology.

Fourth, CDP's were seen by many professionals and the public as causing, that is being responsible for, their own problems. Where TRT was used to address psychological trauma, usually resulting from events or processes beyond the individual's control, it was hard for many, that is, members of the public, professionals, family members, and the chemically dependent people themselves, to accept TRT's applications to people who were thought to have brought their problems and experiences upon themselves. The idea that chemical dependency was a disease usually did little to allay the contradicting responsibility idea.

Fifth, although the post-traumatic stress treatment industry (as it has been known for the past 15 years) was only just developing in 1981, it nevertheless had formed

enough of a view about chemical use by PTS affected individuals to confound the process further. As a rule, professionals from the PTS field either

1. adopted the stress/psychological causal theory for alcoholism without question - they only viewed pathological chemical use as a symptom of a post-traumatic stress condition and never a cause of that condition, or
2. the PTS professionals rarely gave chemical use any consideration at all, other than as a device for measuring the apparent success or failure of their therapeutic efforts; clinical progress was marked by reductions in drug use.

The world of chemical dependency treatment as described in this book was a foreign experience for those forming the predominant PTS concepts and methods of the time. My view is that the concept that chemical dependency is a cause of the post-traumatic stress condition, as opposed to its being a symptom, remains a foreign view for this group of PTS professionals today - more than a decade later.

Eventually, that is after several years of attempting to apply TRT within the context of the problems and conflicts discussed in this section, we identified the post-trauma condition as a primary issue requiring address. Thus, we did address the post-trauma issues as primary variables and despite the obvious problems and conflicts.

The means for providing that address is described in Clinical / Chemical.

Chapter 3

ETM TRT Development as Applied to Families - Systems

This chapter:

- Describes the development of the ETM family psychological trauma treatment model that is shown in the ETM Tutorial / Professional / Clinical / Family Treatment.
- Compares the ETM approach to other chemical dependency family treatment concepts and approaches.
- Provides a means for proving the theory that the pathological chemical use causes dysfunctional family characteristics, as opposed to the dysfunctions causing the chemical use.

A correlate to this chapter is provided in the tutorial at Professional / About / Development / History and in the last chapter of this book. It describes the family-based prevention efforts made by Nancy and me in the inception of our program. As a part of those efforts, we pursued the study of family chemical dependency treatment which was one of the underpinnings of the prevention model described in that (history) chapter.

This section addresses only the family treatment clinical element of that process and how it related to the eventual development of the ETM family treatment model (ETM Tutorial: Professional / Academic / Clinical / Family Treatment).

Development of The ETM Family Psychological Trauma Treatment Model

Generally, in Houston, Texas, where we began our prevention/counseling efforts, chemical dependency (at the time called alcoholism and drug addiction) was treated as a psychiatric disorder - the pathological use was viewed and treated as a symptom of underlying mental illness or psychological dysfunction. The alcoholism - disease - concept as described by Jellineck (1951) was considered and used in this community, but usually in the context of the disease's only being a secondary (symptom) as opposed to *primary problem*. Later, we will explain "primary problem."

Within the parameters of the secondary delineation, we routinely found wide ranges in opinion as to the constitution of appropriate treatment. For example, some practitioners gave no thought to the chemical use other than to measure it; the measurement served as a barometer of the patient's abilities to come to grips with the underlying mental problems.

In this approach, the chemically dependent person continued to use drugs (drink alcohol), but with the expectation that the drug use would eventually be controlled. The drug addict would learn to drink and use drugs responsibly.

Another prominent influence on treatment philosophy and approach came, of course, from Alcoholics Anonymous. In this program, chemical dependency was indeed viewed as a disease, but one that had conflicting origins; the disease was viewed as resulting from underlying psychiatric disorders (character defects), and the disease was seen as a biological development (an allergic response to alcohol). This program (AA) made the achievement of abstinence a primary goal of the modality.

During this beginning period there were several hospital and private practice based programs that combined the psychiatric and AA approaches; the person had a disease caused by an underlying psychiatric disorder. Abstinence from alcohol use was the goal. However, this group as a whole did not appear to have yet (during the 1970's) adopted the idea that drugs other than alcohol should also be precluded from use.

Family treatment for chemical dependency meant that the spouse of the alcoholic attended Al Anon or that the spouse was treated in psychiatric settings, often under the concepts of disturbed or decompensating personalities. Frequently, these modalities, treatments for disturbed and decompensating personality and participation in Al Anon, were combined.

In Houston there were many other ongoing treatment processes for non diagnosed chemical dependency. For example, marriage and family therapists and just about every other kind of psychological specialist were treating people's "problems," but seldom if ever under the consideration that chemical dependency was an issue.

During this period, Nancy and I traveled to other geographical areas of the country known at the time to provide internationally recognized excellence in the treatment and care of chemically dependent families. One of these regions was Minneapolis, Minnesota.

In that community, we discovered a different concept of chemical dependency and family treatment. Chemical dependency received a primary diagnosis. In this concept, the cause of the illness or disease was either psychological or biological.

However, the main consideration was the disease's development. The theory and treatment focused on helping the person to realize the disease's effects and to involve themselves in a program of recovery from the illness. Psychiatric diagnosis, per those we were seeing in Houston, were seen as distracting the person from accepting the "problem" as a primary disease and interfering with the chemically dependent person's commitment to the recovery program. The disease was all consuming and powerful and the person needed to turn his life (and recovery) over to a program of care dedicated first to maintaining sobriety. The second goal was to help the person to increase quality of life.

Apparently, even though this idea and approach had come to dominate the treatment environment (in the Minnesota area) for the previous 20 years, there was considerable underlying consternation by those psychiatrically-oriented practitioners who still believed in the non-disease etiology. However, this psychiatric group, unlike its psychiatric constituents in Houston, had apparently lost its political power in these treatment settings. Their concerns were expressed as a voice of the minority. The psychiatric perspective became the oppositional view.

Family therapy for the treatment of chemical dependency was also considerably different from that offered in Texas. In Minnesota, family therapy as an application of treatment for chemically dependent people and their family members was, generally, a wider process that often included more than the spouse of the chemically dependent person.

Also, there was a concerted effort to provide the family therapy in a way that was consistent with the concepts and treatment that were being applied to the chemically dependent person. For example, as in the treatment of the chemically dependent person, the family members were assisted in addressing the effects that the chemically dependent person's disease had had on them. They also were assisted in realizing their parts in the process, "process" in this use being the chemically dependent person's illness as manifested within the dynamics of the overall system.

Within this general context of chemical dependency family treatment, there were many different concepts and approaches. These differences will be addressed in detail in later paragraphs as the differences added to our learning experiences and the

development of the systems model we eventually used for the treatment of the PTS aspects of the chemical dependency's effects on the system.

For now, however, this part of the introduction to the development of the PTS theory and treatment aspects of our systems model can be concluded by summarizing the differences in the appearances of progress of people living in the two geographical locations and exposed to the different conceptualizations and methods. In the northern groups, family members and chemically dependent people, generally:

- objectified their experiences with alcoholism as a process that had profoundly affected them.
- identified specific aspects of those effects, including intrapsychic, interactional and systemic patterns of thought, interaction, and other behaviors.
- addressed much emotional pain and loss related to those effects.
- identified and followed a certain plan for continuation of individual, relationship, and family recovery from their experiences with the alcoholism.
- were concerned with defining life and relationships after the effects of the chemical dependency had been addressed.
- envisioned themselves as normal people.

In the southern groups, family members (spouses) and chemically dependent people, generally:

- were confused.
- had no understanding of how the chemical dependency had affected them or their relationships - relationships were still embroiled in the chemical dependencies' effects.
- were in constant emotional pain (and in some cases continuing denial of that pain) resulting from the alcoholism.
- were in a constant pursuit of definition of themselves.
- were unaware of any differences between pre-and post-alcoholism identities.
- viewing themselves as abnormal personalities.

Based upon these observations, we concluded that the Minnesota concepts and treatment approaches provided the professional path and direction best suited for us. Thereafter, we learned that model and plunked it down into Houston (a first for that community) and continued our relationships with the Minnesota groups through continuing training, consultation, and treatment affiliation.

The Initial Family Program: A Product of Consultation

To start our family treatment efforts, we trained and interned with, and then engaged as consultants, the Johnson Institute, Minneapolis, Minnesota. We then duplicated, with that group's assistance, their program in Houston.

We observed both positive and negative aspects to the approach.

Thereafter, we looked to the literature to help us to better understand what we were seeing. Although this review substantiated the basis of this program's direction, it also helped us to realize that the family care concepts used by this model were not completely formed and that goals and methods of treatment should and could also be expanded.

This section describes that initial family treatment process and those realizations.

Assessment/Evaluation - Intervention - Residential Acute Care - Outpatient Aftercare

The initial family program recreated from and with assistance of the Johnson Institute provided a continuum of care that began with assessment counseling and ended with aftercare. In total, the program in Minnesota was comprised of 6 components. Ours used 5 of these components.

The Johnson programs are described as I recall them here.

- *Assessment and Evaluation*

It was a matter of routine that chemically dependent people were recalcitrant to participation in any appraisal or evaluative process that suggested that the focus would be chemical use. The assessment was often conducted with and from information provided by either a spouse, parent, or older child of a chemically dependent person. That individual was encouraged to bring to the assessment process supporting family members. Data depicting chemical dependency was collected from as many family sources as possible. A copy of the evaluation instrument is available in the appendix of Vernon Johnson's book, *I'll Quit Tomorrow*, or the form can probably be acquired through

training with that institution. An additional note, this form was hailed by virtually every compliance auditor as the best evaluation instrument for chemical dependency every seen.

- *Concerned persons support groups (including chemical dependency education)*

These groups were initially provided to those people (involved with chemically dependent people) who were deemed to not have adequate ego strength to confront the chemically dependent person's chemical use behaviors. It was in these groups where we initially began to move away from the Johnson Model and focus the therapeutic effort on the treatment of family members as trauma victims as a *primary* consideration of care. Over a period of years, these groups changed to become TRT groups; they were the primary means for providing intrapsychic care to people traumatized by bizarre chemical use behavior - sexual/physical assault, infidelity, theft, accidents, homicide, suicide, and so forth.

- *Family intervention training (including chemical dependency education) and intervention facilitation*

After the family met with the chemically dependent person (and provided that person with data depicting the severity of the chemical use problem), he or she invariably decided to participate in a treatment process. The chemically dependent person and the family were provided with care options from which they selected a primary care program that specialized in family treatment.

- *Residential acute care - conducted in facilities (compatible programs were not available in the Houston area) closely subscribing to (or paralleling) the philosophical tenets of the Johnson Model*

Residential acute care usually involved the chemically dependent person (from now on also referenced as "CDP") in a 4 week program. The CDP was facilitated out of denial that the use was a problem and then eventually through several phases of attitudinal adjustment to the illness, including admitting the problem, compliance with the therapy, acceptance of the seriousness of the problem and then surrender to a dedicated effort involving long-term recovery (Johnson, 1975). In the third week of this program, the family attended a daily assortment of combined therapeutic processes in

which they were facilitated in addressing the chemical dependency's effects on themselves, their own behaviors during the chemical use period, and relationship peculiarities that existed either before or during the advent of the chemical dependency. A high point of the family treatment program came when family members were facilitated in confronting the chemically dependent person with his or her drug use behaviors and their effects on the family members. Although this process had transpired in part during the family intervention experience, in that process there was less candidness due to the need to progress into a safer therapeutic environment. "Safer" means residential care. Safer was also necessary because of the volatility of the situations, that is, considering some CDP's propensity for violence. Usually, the family component was an emotionally cathartic experience for everyone involved and instrumental in facilitating the CDP into realization of the severity of the problem and the CDP's acquiring an understanding of the need to do something about it. It is also important to note that a primary goal to achieve in this residential care was that the chemically dependent person complete the first 5 "Steps" in the parallel Alcoholics Anonymous self-help program. This completion was also at the time a source of controversy between the regions; up North, such completion was routine, but down south, completing the first 5 steps was thought to be an overwhelming task and one that did not fit with the Southerner's (Texans') views of the appropriate usage of the *Twelve Steps*.

- *Family aftercare to follow the acute residential care*

Family aftercare usually meant couples groups - as a rule the children did not participate in the process. The groups, when they were components of the residential facilities, were routinely conducted by the senior (person with the longest sobriety) chemically dependent person. The objectives were to provide for discussion and support as the couples progressed out of the acute phase period. The modality was a mixture of some client centered therapy and AA oriented slogans and discussion. People were encouraged to continue in the AA programs, especially when problems arose and even more especially when the problems portended relapse (return to use) or prospective relapse. Spouses attended Al Anon and incorporated the tenets of that program into their aftercare groups.

- *Specialized or advanced treatment of families where the chemically dependent person had sustained over two years sobriety*

This program was a realistic one in the Minnesota community because there was a 20 year base of people completing programs similar to those described above (although the family component had only been available for 10 years). However, in Houston, family care was rare for such populations as most people had not been through the kinds of care where the chemical dependency and its effects had been distinguished from other issues. Consequently, although we did participate in working with such families in Minnesota, we did not engage in such care in Houston, at least at this beginning stage of the family chemical dependency program's development.

As we implemented this program, we eventually were confronted with certain realizations about the program's influences on the definition of the family dynamics of chemical dependency and the need to adapt the model to those realizations. The next section is about those realizations and initial adaptations (initial changes to the model).

Observations and Discussion of Problems

Generally, the intervention-residential primary care-outpatient aftercare model was based on several concepts. The first was that people affected by chemical dependency, including family members, were, as a rule, normal people who were suffering a disease. Second, they did not need long-term psychotherapy that addressed issues unrelated to the chemical dependency. Such address was thought to shift the CDP's and spouse's intellectual energies away from the foremost goal, recovering from the alcoholism disease and family disease, that is, respectively chemical dependency and what was eventually to be coined "codependency." Third, they only needed generalized support to continue discussions that elicited some feelings and that, in the main, kept people connected to, motivated to attend, the *Twelve Step* programs. Although this process appeared to be more valuable than anything else that was currently available, it was not a conclusive, complete approach. "Inconclusive" means that in our opinion taken from our observations of the aftercare process:

- Relationship conflict resulting from alcoholism and drug addiction was swept under the rug by the modality itself. "Swept under the rug" means that when relational conflict arose, members were encouraged, instead of to fight out the conflict interactionally (directly between the two parties), to address the conflicts indirectly, only as intrapsychic issues; the relationship partners were encouraged to use the conversion elements of the *Steps* to ascertain the nature

of such conflict ("nature" being a disease-based defect in character), and then exorcise that defect and thus the conflict through rigorous and honest self-evaluation, delineation of character defects as these "defects" were being reflected in the relationship, and a system of prayer designed to remove the defects.

- Invariably, where the conflicts were addressed directly (and with professional facilitation) the conflicts' roots were discovered to lay in the damage done by the partner's alcoholism and to the (non alcoholic) spouse's identity. It was clear through such interactions that the confrontation modality provided during the acute phase of family care had not provided an adequate address of that damage. Moreover, when the damage did manifest itself in relational conflicts, it was treated under the predominating model (the *Twelve Steps*) as a problem for the spouse because he or she did not recognize the "disease" as it had affected either or both of the chemically dependent person and spouse. In other words, when unresolved trauma from the experience of the active alcoholism was manifested in current interactional issues, such manifestation was treated as the disease itself and something both parties would have to overcome through the conversion method.
- A problem of logic for these people arose through the use of the disease model. The question invariably presented was how could people remain or still feel anger toward the chemically dependent person in recovery, if that person was truly seen to have a disease? Worse, if the person did feel such anger, it was considered by many (not us) as an indication of that person's own disease - in some denominational uses of this approach, anger was an indication of dysfunction.
- The model being used tended, because of its disease emphasis, to be weighted in terms of focus upon the chemically dependent person. "Weighted focus" means that successful care was determined by sobriety alone, and that consequently the family members, as well as those facilitating the modality, were all focused on that outcome. Thus, the chemically dependent person tended to become the focus of care rather than the family itself maintaining the focus.

Eventually, our conclusion was, assuming there was merit to the idea that chemical dependency was a primary problem interactionally (see the next paragraph), that the concept of co-dependency and the family disease that pervaded the use of the model provided through consultation, were in effect consequences of a lack of definition of the interactional dynamics of psychological trauma resulting from the pathological chemical use period and a lack of knowledge on the part of the health care providers

as to how to address that damage within the context of the interactional dynamics. Furthermore, the *Twelve Step* model's use of conversion and the intrapsychic oriented problem solving approach to address interactional issues was itself serving as a limitation upon the definition of, and subsequent opportunity for, interactional-based (as opposed to intrapsychic-based) resolution. To solve this problem, we returned to the literature.

Looking for Help in the Literature

The literature explained (and as also was taught in our training) that systems theory is a formation of perspectives that are focused on the interrelationships existing between a certain group, the individual members of that group themselves, and the group as a whole. Each system is comprised of various rules, roles, and communication patterns. These variables are then balanced with each other through system homeostasis. Some times, systems theory is supplanted in practice by a focus on the primary relationship comprising or initiating the system - the marriage. As a rule, most systems perspectives viewed (as described in more detail below) drinking and drug use as a symptom of problems with or breakdowns in one or a combination of any of those variables (See Paolino and McGrady, 1977, pg. 115-116).

Prior to the formation of our initial family program efforts, most marital/systems therapy studies concerned themselves with measuring several ideas. The first was whether marital therapy could reduce the propensity to drink excessively (Burton and Kaplan, 1968, Gallant et al, 1970, Meeks and Kelly, 1970). The second measurement was on marital satisfaction following therapy (Burton and Kaplan, 1968, Gallant et al, 1970, Meeks and Kelly, 1970). That is, was there an improvement in communications, sexual activity and problem solving capacities and actual problem solving. A third measurement was of the effects of spouse participation in treatment on the prospects of successful sobriety (Smith, 1969). Although each of these studies reported conclusive findings, that couples therapy did reduce pathological drinking activity, that there was increased satisfaction with interpersonal dynamics, and that spouse participation in treatment was imperative if sobriety was a goal, Paolino and McGrady (1978, pgs. 118-119) found these efforts to be inconclusive. As a rule they did not meet scientific standards necessary for reaching valid conclusions. In addition to Paolino's and McGrady's reviews of these (and other) studies, Steinglass (1976) provided a review of the literature addressing family therapy and its effects on the treatment of alcoholism. He found that although the family therapists were enthusiastic about their work and the effects of it, no hard scientific evidence supported their conclusions. Our impressions taken from our own review of these

same studies (this review was conducted between 1980 and 1981) was that although some family therapists certainly grasped the concept of delusion and denial associated with chemical use, to include the family member's delusionary states, many family therapists did not seem to have the same degree of wariness in such measurements that we had developed, and were continuing to develop. Clearly, our consideration of the issue of measuring successful sobriety following treatment was that such measurements were made by us with much circumspection.

Satir, Haley, Bowen and Wegsheider (both Sharon and former husband Don)

Given the inconclusiveness apparent in the literature, we looked (for additional leadership in the practice of marital and family therapy) to some of the primary contributors to the development of marital/family treatment philosophies, concepts, and treatment methods. Those leadership processes influencing our efforts included the writings and training programs of Virginia Satir (herself a consultant to the Johnson Institute), Jay Haley, Murray Bowen, and a lesser known, but nonetheless important, writer, Don Wegsheider.

Virginia Satir

Virginia Satir offered several important concepts of family care. First, she emphasized the importance of helping family members to work toward, establish, and then maintain proper, open, communications. The value of open communications was supported, albeit inconclusively as evaluated by Paolino, McGrady, 1978, and Steinglass, 1976, in the family therapy studies described above. Generally, everyone agreed, and still do agree, that teaching alcoholic families how to communicate is a wonderful thing, and that had they known how to do it in the first place, no one in the family would have needed to turn to alcohol and drugs. Second, Satir also emphasized the importance of roles within the family. Family members were seen to have acted out or been assigned roles having to do with performing certain functions for the family as whole. The functions included, but were not limited to, becoming a focus of blame, the acting out or depiction of emotional disruption, or relational isolation.

Eventually, systems oriented therapists influenced by Satir (and other role interpretation-oriented therapists) defined many different such roles, again including, but not limited to, scapegoating, rescuing, placating, leading (heroism), providing for comic relief, passivity, passive aggressiveness, controllers and perpetrators. The idea was to assist family members in identifying their roles, especially where such roles

had been assigned by the system, and then, apparently, choose other roles or functions that were conducive to the ontology of the individual. Such choices were thought to increase feelings of efficacy within the system, and enhance communications efforts, thus helping to restore, or add to, individual and family esteem and worth.

Jay Haley

Although we studied Dr. Haley's written work and critiques by other scholars, the following is taken from training sessions conducted by him. These are my recollections of that experience.

Dr. Haley introduced us to the concept of strategic therapy where the therapist orchestrates (directs) the system so that it returns to social/productive functioning; to achieve such functioning is, if I remember correctly, a primary goal of the therapy. In this regard, he explained (in his training sessions) that goal delineation was very important and that the goals of his methods were to:

- Get people out of hospitals.
- Get them back to work or school or reintegrated into the particular social system in which they were involved.

In his videos, Haley demonstrated interventions on families who were being affected by one or more family member's addiction to alcohol or heroin. Both addictions were treated as symptoms of the families' problems.

In the alcohol related case, the children were not going to school and complaining to the therapist about the extraordinary problem of their father's constant intoxication (severe alcoholism). The therapists in the taped session ignored the consideration of the alcoholism raised by the children, and worked with the father so that he eventually directed the children back into school.

"Worked with" was described as a method of "propping up" the part of the system that was actually passive, but that needed to be the leader of the system. Thus, "working with" involved the therapist's telling the father what he needed to do and then supporting him in doing it - telling the children they had to go back to school.

I asked Dr. Haley about the issue of alcoholism's being considered a disease and what was he going to do about it in this case. His response, as I recall, was that the

alcoholism was always treated as a symptom and that when treated accordingly, "fathers would stop all that drinking and carrying on."

In the heroin example, the addiction (by the adult male children) was considered a symptom of the children's not having separated properly from the parents - they had not left home. The therapists worked with the parents in facilitating their ordering the children to leave the home, get their own living quarters, and employment, and take care of themselves. If my recollections are correct, the statistics quoted were that this method cured the addiction in most such cases.

Murray Bowen

Dr. Bowen's theory of family alcoholism was (is) that it was a consequence of the undifferentiated self beginning in the psychological construction of the parent, and then subsequently handed down to the child, and then that child's carrying of the undifferentiated self into adulthood/marriage, where stress resulting from the lack of differentiation was manifested by symptoms - alcoholism. The alcoholism caused more stress and destruction to the psychologies of everyone involved. The result is a degenerative spiral for the family.

Treatment is a function of helping family members to learn to appraise the family dynamics as the therapist would appraise them. Following such appraisals, to include objectification of individual, relational and system behavior, the family member could withdraw from the pathological activities and thus end the individual, relational, and systemic cyclical (degenerative) processes.

Don Wegsheider

Don Wegsheider's book (pamphlet) treated chemical dependency and its effects on families as a primary problem. I don't know if this small booklet is in print any longer, but I remember that in this description, the locus of dysfunction lay in the pathological chemical use's effects on individual, relational, and systemic dynamics.

Later, apparently, Sharon Wegsheider Cruse, Don Wegsheider's ex wife, produced the *Family Trap*, a pamphlet that described specific roles and rules adapted by family members in response to the chemical dependency. Ms. Cruse's work also reexplained what her previous husband had described as certain kinds of repressed feelings and inner held thoughts as usually experienced by family members characterized in the various roles.

It is significant to note that in her later book, *Another Chance: Hope and Health For the Alcoholic Family* (published after we had made our changes to the TRT/ETM configuration in 1981. In that configuration (described in Clinical/ Family Treatment), she enunciated these experiences as the family disease of chemical dependency - a primary, progressive, chronic and prospectively fatal process (the "family disease" was also a characterization used by the Johnson Institute).

It is also noteworthy that Sharon Wegsneider was an associate of the Johnson Institute (1978) just prior to our training there, and that she gave credit (in her book) for a portion of her realization of these dynamics to her experience of listening to many intervention processes; interventions that were facilitated by Mary McMahan. In our original book, we gave credit to Ms. McMahan for similar meaningful learning / training experiences.

Treatment concepts as expressed by these two writers/therapists, the Wegsneiders, was, as I understand, influenced to a large degree by Virginia Satir's methods. However, the Wegsneiders addressed chemical dependency as a primary problem affecting the system, as opposed to the pathological use being treated as a symptom of the system's dysfunction, so treated and referenced by Ms. Satir, Dr. Haley, Dr. Bowen, and most other family therapists of the times.

Corroboration of One of the Theoretical Constructs

Clearly, there were two theories depicting conflicting, even mutually exclusive, alternatives to the treatment of the systemic aspects of chemical dependency. The chemical dependency could be treated either as a symptom of the dysfunctional system or the pathological use could be treated as a cause of that apparent dysfunction. Eventually, we proved for ourselves, beyond any question or doubt, that the characterizations of system interactions that were posited to be causes of chemical dependency, were in actuality, natural post-trauma responses to a series of repeated trauma-causing events resulting from an external variable - psychoactive drug interaction with certain neurological and other biological chemistries, inevitably manifested by bizarre behavior, the trauma-causing event(s). This subheading describes that proof as it satisfied our understandings and counseling needs.

The proof that the system's interactions, otherwise thought to be causes of chemical dependency, were actually natural post-trauma responses to drug induced behavior. The initiation of the trauma-causing events, lay in the relationship of two facts.

First, TRT provided for the delineation of extraordinary events that, according to the reports given, contradicted the established identities. The contradictions also were purported to result in losses to those identities. Moreover, TRT provided for substantial supportive testimony about the relationship of those contradictions and subsequent losses to behavior.

Second, when shared in clinical settings with the alleged perpetrators of those extraordinary occurrences, the perpetrators corroborated the facts of the events on every occasion, except where the event occurred during a prospective blackout (= alcoholic chemically induced amnesia), thus completing the transition from the theory or allegations that psychological trauma-causing events had occurred to a determination of fact that they had occurred. In addition, because data related to the events was collected from many sources (other than the spouse and perpetrator), that is, from parents, grandparents, uncles, aunts, cousins, neighbors, business associates, teachers, children, adult children, and other involved persons such as priests, pastors, M.D.'s (internists), and clinicians, the perpetrator's corroborations were also corroborated.

Importantly, none of the symptom-based arguments, other than Bowen's general recognition and interpretation of the cyclical destructive processes resulting from the accelerated drug use, ever identified, much less considered, the facts of these events as they were related to the direct cause of psychological trauma as a primary therapeutic variable affecting not only intrapsychic identities, but interactional and systemic aspects of identities, and the relationships and systems themselves.

Conclusions

We concluded from 1) our observations of the model as it was being applied, 2) our review of the pertinent research and literature of the time, and 3) the substantiation of the basis of the model through the application of TRT, and simultaneous with the receipt of corroborating statements by all parties involved, including the perpetrator of the events, that the concepts underlying the model were generally correct. Apparent system dysfunctions were a consequence as opposed to a cause of chemical dependency. But the consequences were not completely defined.

Furthermore, the therapeutic model, although it exceeded chemical dependency family care standards provided in any other part of the country (as we were able to determine the existence of such care), was still not a complete system of care for families so affected. The model's focus on the chemically dependent person and not

on resolving the trauma of all those involved would likely result in the continuing interference of that unresolved trauma with the intrapsychic, interactional and systemic lives of the individuals comprising the system, as well as upon the relationships and system themselves.

Transition

Given our conclusion that the model initially provided in the consultation was correct in principle, but not fully defined in terms of theory or application, we returned to the consulting organization with the idea of discussing, and then correcting where there was agreement, the contradictions in the model (as those contradictions have been described in the previous paragraphs). We also elicited discussion and input from the various acute care facilities (organizations) with whom we had referral relationships. Generally, there was timid agreement and vociferous dissent with our view that the current (the time was 1980-1981) model tended to focus the therapeutic process on the recovery of the chemically dependent person and away from the system as a whole.

This subsection overviews, as I recall them, both the dissenting and affirmative positions, and then delineates the outcome of the consultation.

The Dissenting View

The dissenting (against our proposition) view was that the Al Anon self help Twelve Step program provided, if attended regularly and the Steps adhered to, the necessary focus for the non chemically dependent component of the family.

We argued of course, that the CDP's attendance in AA and the spouse's attendance in Al Anon, were not family treatment, but rather parallel intrapsychic treatment processes. We agreed that they had value, but they did not serve to address the interactional dynamics related to the systemic aspects of the recovery process.

In fact, there was considerable support for the dissenting view from those facilities where there was no process through which the CDP's chemical use behaviors, as experienced from the family's perspective, were shared with that person (the CDP). This view was that couples should not participate in a couples group at all for at least the first two years, as intrapsychic recovery needed to occur prior to making attempts to address relationship issues. Clearly, we had already addressed this issue in our

aftercare groups by offering a choice to the various couples returning from their participations in residential acute care. Invariable, the choices were made as follows.

Where the spouses had participated in open family process, that is, the family members shared their experience of the chemical use behaviors with the CDP in residential acute care, the couple chose to participate in a couples group in aftercare. Where there was no such address of the chemical dependency experience, couples routinely elected the individual (non couples) aftercare format.

Furthermore, it may be valuable to note that before such alternatives were available in our program, mixed couples, those that had addressed the chemical use experiences together and those who had not, could not function as a couples group process. The couples who had begun the process of addressing the past chemical uses issues could and did, with assistance from a facilitator, address additional issues from the drinking period and issues of conflict occurring during the current period.

Such direct address of past and current issues was extraordinarily frightening for the couples who had not yet broached, together, the emotional pain resulting from experiences had during the chemical use period. The apparently frightened couples tended to shut down the therapeutic interchanges ongoing between the couples that were attempting to fight out (discuss openly) past and present conflicts.

Moreover, the frightened group viewed the direct conflict resolution processes as a return to the pre-recovery periods. Clearly, even interning chemical dependency counselors whose recoveries were steeped in the Al Anon and AA modalities alone, supported this view. The argument was that the goals of the *Twelve Steps*, as enunciated in the *Big Book of Alcoholics Anonymous*, were that "God wanted everyone to be happy, joyous and free" and that the direct conflict resolution processes in the couples group were not reflecting the achievement of those goals.

Obviously, those conflicts demonstrated the existence of another problem. The aftercare program as it previously was defined, that is, the program relied principally on the therapeutic value of the self-help programs as parallel therapies, and because of their ascendancy in the community and in the minds of alcoholism professionals, was not a process of facilitation of a consistent therapy for which the therapists was primarily responsible for the logic and value of the process.

The true direction, logic, and value was derived from a program written and controlled by someone else - the authors of the Twelve Step programs. In this

configuration, the self-help programs were accorded the primary responsibility for the therapy and the outcome, and the professionally facilitated component was only an adjunct.

Consequently, definition of family therapy for families affected by chemical dependency in this joint approach was always limited by the reality that there were no interactional components in the *Twelve Step* programs - the primary provider.

The Affirmative View

As I remember, there were several people, whose names I cannot recall, at the Johnson Institute who acknowledged our considerations as having merit. These people also recognized the controversy that would result from a moving away from the aftercare model controlled by the parallel *Twelve Step* (all of these people attributed considerable value to the *Twelve Step* programs) process.

I also was told by a head of the family care programs that discussions had been held about the need to orient the focus to complete family care from the initiation of that care to the final outcome, that such discussions were being held on a national (research) level, and that the consultants were participants in these discussions.

As indicated, the dissenting opinions (expressed above), were also existing in both the consulting organization as well as those groups providing the residential acute care components with whom we maintained referral relationships. In this environment of contrasting opinions, all of which were coming from people who were at the apex of understandings (national and international perspectives) of available family care for chemical dependency, we asked for, and received, collaboration to develop a model that would achieve the goal of defining and then providing the most complete family chemical dependency treatment program possible. Moreover, we asked that where no such model existed for replication, that we be afforded the best thought as to what was hypothesized to be the most advanced approach possible, to include a consensus of everyone's dream family care chemical dependency program, and without regard to funding limitations or prospective political controversy.

"Without regard for political controversy" as I use it here, means that we asked for the conceptualization of a program that followed the logic of the therapeutic issues, as those issues were identified in terms of *all* variables including those not being addressed by a particular group's modality, regardless of that group's influence on the current definition and administration of the current therapeutic effort. It was

important that these opinions be freely expressed and without regard to fear of operating outside of the parameters of the chemical dependency movement's parental (founding intellectual) authority - the *Twelve Step* programs.

The formation of this conceptual framework for addressing families affected by chemical dependency and as it eventually was integrated with our own opinions derived from our development of TRT is described in the next 2 subsections.

Consultation Recommendations

The new idea for chemical dependency family care was that all participants in the family, the relationships that existed within the family, and the family as a whole should be accorded equal consideration within the therapeutic definition and within the application of the therapeutic process. This meant that each person in the family, including all children who were old enough to talk, the spouse and the chemically dependent person, parents and grandparents where available, would be engaged in the therapeutic process from beginning (assessment, evaluation, diagnosis) to end (aftercare).

There were several programs that were providing the leadership for this kind of thorough effort. I believe one program's name was *Family Renewal* in Minneapolis, Minn. Apparently, that program was 10 weeks in length, 4 hours per night, 5 nights per week.

Each family member was accorded his or her individual and group therapy process, the group being comprised of peers with similar roles - fathers, mothers, adolescents, children, adult children and so forth. There was a couples group, where the marital issues were addressed, and a family group process, where family issues were considered.

Although we were not privileged to train with this group directly, thus were unable to study their theories and applications directly, one of our consultants had been involved in that effort. Our understanding from this indirect experience was that the idea was to address all dynamics at intrapsychic, interactional, and systemic levels.

There were other programs referenced as providing background to this conceptualization. However, I cannot recall their names.

Although the theoretical underpinnings of those providing the consultation was the "primary family disease" concept, that is, the primary problem with the family was that it was affected by the chemical dependency, as opposed to the vice versa view that the family's problems were causal to the pathological chemical use, the theories and applications actually recommended by the several people participating in the consultation discussions were, when taken as a whole, and in my view unintentionally, eclectic - the inadvertent mixture of mutually exclusive ideas and processes. Family dynamics were treated as both a cause and effect of chemical dependency.

For example, the message during the intervention phase of care was that chemical dependency was a disease that created destruction for the family. In the acute phase of therapy, any of the therapeutic conceptualizations might suggest not only helping people to address the emotional and behavioral aspects of the chemical use's effects, but helping people to ascertain prior family (of origin) patterns of behavior, including roles assigned or adapted out of that family of origin, and the contribution of those adaptations to the current family dynamics. This was recommended and done in practice despite the obvious theoretical contradictions and subsequent ramifications for, interruptions to the logic of, the family treatment process.

In other words, our consultants, who were at the national forefront of defining the concept of the chemical dependency's effects upon the family as a primary issue, had not, as I recall, defined the conceptualization to the extent that their model was, throughout the entire continuum of care, differentiated from competing family care groups - "competing family care groups" being family treatment professionals who followed the conceptualizations and strategies of Bowen, Haley, Satir, and other family therapists similarly suited to their orientations. Modalities used for effecting system change were equally eclectic. They were drawn from behavioral, cognitive-behavioral, analytical-cognitive, client centered, grief, rational-emotive, reality, and strategic therapies, among other things.

The locus of the problems could be seen as existing at any of the intrapsychic, interactional, or systemic levels, or a combination of all three. In the end, the philosophy of care was based on eclecticism, expediency born out of, in my opinion clarified through hindsight, a lack of clear cut definition of problem identification; the idea was to do whatever seemed to work for each case. The expression "seemed to work" was also not totally defined.

I make these criticisms academically, within the overall view that, at the time, the people at the Johnson Institute, including their founder, Vern Johnson, were the most forward thinking, courageous and caring group of professionals with whom I ever had the opportunity to meet and to work. Without a doubt, their sole interests and concerns were for the well being of chemically dependent people and their families. Johnson Institute professionals set the standard for caring and the delivery of quality health services to which I strived to equal.

Parting from the Consultants

In that we had already ascertained that the majority of those approaches that were based on the view that the dysfunctional system caused the chemical dependency were not based in fact, and that the dynamics reflecting the apparent dysfunction were consequences of the chemical use (see previous heading: Corroboration of One of the Theories"), we elected to use the apparently corroborated model, but within the dimensions of the recommended intrapsychic, interactional and systemic stratifications of care as suggested in the consultation.

Clearly, our development and use of TRT made the chicken and egg - symptom or cause - argument in chemical dependency family treatment a non conflict. As a consequence of this different understanding, we abandoned the eclectic or what I came to believe was actually the confused, approach and focused conceptually on defining further the damage resulting from the chemical dependency.

The outcome? We incorporated the intrapsychic, interactional and system formats recommended in the consultation, but with the specific intent to use these 3 stratifications of care to help those affected to

1. understand how the experience had affected them at individual, relational and family levels, and
2. how to restart or rebuild themselves at these three levels.

As it would turn out, and as we are about to explain, the path that we followed in developing TRT as a treatment modality at individual levels would dramatically influence the definition and subsequent application of treatment modalities at the interactional and systemic levels.

Transition to Outpatient Acute Phase Chemical Dependency Treatment - A Controversy of the Times

During the period of transition to a full family treatment model, we were required to address another controversial issue - acute care treatment in outpatient settings for the chemically dependent person. Although CDP outpatient acute care was provided regularly in the self-help programs, and routinely in therapeutic settings where abstinence was either a non or secondary goal, outpatient acute treatment for the CDP was not considered a viable alternative in the treatment environments in which we were involved because outpatient could not match either the quality of care or probabilities for successful sobriety attained in the acute residential care facilities. However, because of our application of TRT to the spouses of chemically dependent people, a change was occurring to which we did not yet grasp the significance.

As the spouse progressed through the process of resolving the trauma resulting from his or her experience of the CDP's drug use behaviors, the chemically dependent person would automatically present for care. Although we recommended residential care for every one of these people, most would only participate in an outpatient format. We researched outpatient (CDP treatment) models throughout the country (they were rare), and eventually provided in our practice what we considered to be the best of such programs.

Initially, the outpatient CD program required CDP attendance 5 nights per week and day participation in Alcoholics Anonymous. I will address the results of our overall program later. However, for now I hope it will suffice to explain that there was enough CDP sobriety attained through this method to eventually consider the outpatient approach for some people when we initiated our new family treatment program. It is also important to note that the quality of sobriety attained in the comparable periods, for example, time spent at St. Mary's, Hazelden (Minneapolis), CDU Baton Rouge or F. Edward Hebert, New Orleans, or other facilities using aspects of the primary disease model, vs our *initial* outpatient efforts, was not comparable.

"Not comparable quality of sobriety" means that those people participating in the outpatient group were not as thoroughly committed to the disease concept, nor did they have as strong a relationship with the *Twelve Step* programs as did those completing the referenced residential models. This was true regardless of the intensity with which we applied those methods that involved helping those relationships (with

AA) to become established. However, as we implemented our new family treatment model, we would attain different ideas about, and results in, CDP outpatient care.

Treatment for the Family Disease of Chemical Dependency

As indicated in the previous subsections, the basic idea behind the chemical dependency family disease model was to help people to address the effects of the chemical dependency as a primary experience and to make this address occur at intrapsychic, interpsychic, and systemic levels of existence and interaction. To this end, we adopted a special participation policy that required everyone's attendance in the program.

The policy, the eventual final product of which is described in Clinical/ **Family Treatment** under "Participation Policy," generally provided for the intervention upon the alcoholism and the prevention of the system's inevitable efforts to derail the trauma resolution, as well as sobriety, processes.

Assessment and evaluation processes provided for the collection of data. Assessment instruments at the time involved the collection of data from all participants for the purposes of first, determining prospective chemical dependency, and then second, helping people to understand the effects of the prospective pathological use upon themselves. As indicated in Clinical **Family Treatment's** discussion of entry-level clinical processes, the assessment and evaluation, which eventually would include strengthened recollection efforts (as a result of the application of TRT), provided for therapeutic interventions on both individual and systemic-based denial that the pathological use was an issue. The assessment, evaluation, and TRT processes also helped to document the prospective beginnings of the chemical dependency.

Of note, the degree of denial of chemical use as a problem is always directly related to the degree of intensity of the trauma experienced as a result of that drug use. In other words, denial of chemical use as a primary issue in the assessment phase is almost always followed by discovery of drug related physical/sexual assault in the trauma resolution phase, events that were eventually corroborated by the perpetrator's themselves, as well as by third parties.

Clearly, professionals not trained in the relationship of pathological chemical use to the occurrence of psychological trauma-causing events and the subsequent denial by patients of both the trauma and the use, were always astounded to learn of these relationships and the degree to which the understanding of them altered the

professional's perceptions of what was transpiring during the assessment phase. Routinely, professionals not understanding these special relationships between trauma, denial, and pathological chemical use, would argue that the presenting people were all "intelligent" individuals with "integrity" who would certainly "know" what was happening to themselves; because of this intelligence, integrity, and knowledge, it was impossible that such pathological processes could be ongoing, especially simultaneous with the therapist's ongoing therapeutic efforts.

Equally routinely, such professionals were chagrined to discover these processes *were* existing unbeknownst to everyone involved, including the professional (see Clinical/**Family Treatment**). Clearly, intelligence, integrity and knowledge have nothing to do with the consideration or determination of the existence of unresolved trauma, especially as it results from pathological drug use.

Acute Phase - Residential

The term "Acute Phase" was adapted to represent that portion of the therapeutic effort preceding and then including the family's confrontation of the chemical use behaviors. When first introducing this program, some of the confrontation was still being conducted in the CDP's third week of inpatient treatment in the residential care facilities. Thus, there was a problem for this group of patients (family members whose CDP's were hospitalized) with meeting certain time, travel, and logistical realities.

We also chose those programs whose treatment teams were informed of our efforts, our therapeutic ambitions to provide complete family care. In this way, the two treatment processes were relatively integrated depending on the particular understandings of our program by the family therapists conducting the in-hospital family component.

In these relationships, we were considered the primary provider, and the residential care facility the secondary service provider. The difficulties with this approach for the population served were that considerable family member energy and subsequent therapeutic focus became caught-up with a combination of the fear of the confrontation within a hospital and the forced (brief) time to address the painful issues, as opposed to addressing them when ready (and over protracted periods). However, even though it was difficult, the family's reported the residential family experiences as profoundly rewarding and deeply meaningful.

Prior to the family's participation in the hospital program component, each family member was provided a support group comprised of peers. For example, there were 3 different children's groups. The ages ranged from 5 to 7, 8 to 10, and 11 to 13. Teen groups were divided by ages 11 to 15 and 16 to 18. Thereafter, children were accorded groups as adult children. We also provided groups for spouses, parents, and significant others.

Goals were limited to identifying and expressing feelings about the changes that were occurring (the CDP was getting sober and now in a treatment setting) and helping group members to recall specific incidents of chemical use behavior.

Two additional processes made available to the family members while the CDP was in the hospital included multiple family sessions (2 sessions per week) and parallel educational processes (4 hours per week). The family, support, and educational processes were oriented around disease and family disease philosophical concepts. TRT groups were provided to the spouse (or parents when the CDP was an adolescent). Usually, however, the spouse or parents had entered TRT groups some months prior to the entire family's entry into the acute phase.

Clearly, most of our client base was drawn from environments and situations where no one else (other treatment providers) knew how to do anything about a chemically dependent person who was recalcitrant to assistance. Rarely, at this stage of our program's development, did we receive referrals made up of CDP's who were *choosing* to get help for themselves.

We placed the term "choosing" in italics to emphasize that most CDP's only chose to get assistance after some form of intervention had taken place. I saw the concept of choice when applied to these people as a function of ever-narrowing options.

The same groups and processes were provided to the family's when they returned from their experience with the CDP during family week at the particular hospital program. The CDP's return usually followed his or her completion of the fourth week, at which time he or she would be reintegrated back into the family process ongoing at our facility.

This reintegration included the provision of educational materials that emphasized the role of continuing care, a peer group comprised of chemically dependent people, a multiple family group, couples group, individual therapy where necessary and participation in the *Twelve Step* programs. In those days, and for many years to come,

participation in our program was conditional upon the CDP's parallel participation in the *Twelve Step* program.

Acute Phase - Outpatient

Acute phase outpatient was both similar and different from residential acute care. Those similarities and differences are described here.

First, the families did experience considerable fear (stress) related to the prospective confrontation, but not to the degree felt when having to change facilities (and towns, as no such comparable facilities were available in our community). The families also enjoyed being able to remain with the same treatment team (during the family confrontations of chemical use behaviors all support and TRT counselors participated in the session) throughout the entire process. And of course participation in the acute phase of the outpatient process made it easier for us - clients bonded to the outpatient treatment team throughout the entire treatment process, enhancing trust and facilitating the families' entries into the continuing care component.

Second, the most obvious and greatest concern in outpatient treatment of CDP's was the high prospect for a return to chemical use or continuation of such use, and unbeknownst to family and treatment team personnel. In those days, drug testing (urine samples) was not readily available. Even in later years, the lack of timeliness in receiving such reports interfered with the therapeutic effort; a person could be using for a week, disrupting all processes (explained later) before appropriate action could be taken.

Generally, we addressed this problem (relapse) by interpreting a return or continuation of use to be an unwilling event, that is, an indication of the degree of pathology (loss of control) associated with the use; in such cases, residential care was required as an additional supportive (stabilizing) device. A condition for all CDP's participating in outpatient acute care was that if they returned to use or could not stop using in the first place, they would enter residential care. If the CDP did not agree to this condition, the person was not accepted into the outpatient program.

Third, I do not believe my skills as an alcoholism counselor were, at the beginning of our efforts, comparable to some of those skills that I had witnessed being provided in some chemical dependency residential programs, especially those offered in the Minnesota area. I compensated for this possibility by hiring special staff that were well grounded in such training. However, these people were used to the support of the

inpatient environment and thus had to learn something new, especially as that newness involved treatment of all members of the system as well as the system as a whole, and in an environment where the care could be provided until it was completed (as opposed to short term, 28 day, care).

Fourth, inpatient residential care was different because it provided for an incubator styled environment. An argument can be made that there is a real need for the person (CDP) to be removed from the stresses associated with both family interactions and work distractions. In such an environment the person can concentrate on initiating recovery processes. The outpatient environment is the opposite. The treatment process is interfered with by both the realities of work and family interactional related stress. Thus, the CDP's concentration on initiating recovery processes is interrupted, making the initiation of such recovery processes more difficult. It was and can also still be argued, that this was reality, as different from the transitory reality of the inpatient incubator, and that it is valuable for the person to have to contend with that reality.

Fifth, hospital detoxification was clearly and unequivocally necessary for some people. Regrettably, most residential programs would not consider patients for detox only (3 to 7 days) because the presence of such people undermined the programs's admonitions to the others that 28 days was a necessary requirement to provide complete care. Of note, because of this particular issue, many residential care providers took an antagonistic view toward our outpatient and short hospitalization (detox only) efforts.

After years of implementing the program described in this section and Clinical/Family Treatment, I eventually would and did conclude that the long 28 day inpatient programs are only necessary for those people where either the family is not available to participate in a program comparable to the one described herein, or the person elects to attend an intrapsychic based approach only; competent outpatient family treatment reduces the need for long-term hospitalization.

Family Confrontation of Chemical Use Behaviors - residential acute care

In the residential facilities where the staff were untrained in TRT, an underlying idea by some staff, certainly not all, was to address all the emotional pain resulting from the use within the particular time period allotted (usually one week for the family). (I should say before beginning this description, that different counselors and facilities had different attitudes and policies about the proper address of emotion; a few were

similar to our own, but many were, as I recall, similar to that portrayed in the following discussion.) Once addressed, the pain no longer would be in the way of realizing and accepting both individual (to include chemical dependency/codependency) and family disease concepts. Although everyone involved was assured that feelings were natural and regular experiences, that is, emotional pain was a natural and regular part of this process, some slogans accompanying the confrontation effort included, as I recall, a reference to the hostility, hurt, anguish, rage, shame, and other emotions commonly expressed in such meetings as "garbage" or "baggage" that needed to be identified and expressed within the facility, and then "left there" so that they no longer interfered with the new relationships - what happened in the past was a function of the disease and the pain from that past would only interfere with that realization.

Thus, the realization that the CDP, the individual family members, and the family as a whole had a disease was the primary goal of the therapeutic process. In this way, all behaviors and subsequent damage resulting from the use during the disease period were relegated to an unintended status. They were not intended.

Emotional pain was then expected to be shared, experienced quickly, and then let go. All participants would then continue in AA and Al Anon (or Al Ateen) for the rest of their lives. The purpose of this attendance was to provide for a constant reminder of their ongoing and never-ending recovery from the disease and a correcting process to control ever-recurring indications of the diseases - disease behaviors, character defects, and so forth.

In some of the facilities, the advent of family therapists to the process provided for the identification of family dynamics, interactional patterns. This effort included the identification of various roles played by the family members. Also, certain marital dynamics, for example, when one partner was overly passive or another was overly dominant, were pointed out as disease dynamics. In some instances, marital dysfunction was shown as originating in family of origin dynamics.

The actual methods for facilitating these expressions, realizations, and understandings were multiple family groups; they were applied in the marathon style. In these processes, the families would meet in groups comprised of 4 or 5 families, at first without the CDP's (mornings), and then with them (in the afternoon sessions). The first morning was usually intense; the session involved arguments about the purposes for, or value of, being there, discussions about the educational materials and disease concept, and questions about whether the process worked.

In the afternoon, either one or two of the families would sit in the center of the group and confront the chemically dependent person with their experiences of his or her drinking or drug use behavior. This was always very dramatic and cathartic for all involved. There were few restrictions on the expressions; the restrictions are described below. In fact, expressions by family members were vociferous.

The chemically dependent person would listen to these expressions and respond with expressions of shame, sadness, deep remorse or hostility, a combination of all of the above, or stoically - there was no expression at all. After the family finished its interactions, they received feedback from the other families who had observed the process.

This program, referenced in early drug family treatment models as the "fishbowl approach, continued Monday through Thursday and until all of the families had reached conclusion to the process. As a rule, so called pathological defenses were strong at the beginning and non existent at the end.

The conclusions were, at one end of the continuum, acceptance of the CDP's and individual family member's diseases, forgiveness of the chemically dependent person's behaviors, a breakthrough in previously held denial by the chemically dependent person. The breakthrough was accompanied by a sincere commitment to maintain sobriety at all cost, an exchange of expressions of love between all family members, and a deeply felt commitment by each family member to participate in an ongoing recovery process from his or her disease.

At the other end of the continuum, the chemically dependent person remained in denial - stonewalling a goodly portion of the clinical process.

However, family members usually received a profound experience and committed to continuing their recovery from the family disease regardless of the chemically dependent person's attitude. Clearly, there were many more outcomes represented by the first description than the latter.

It is important to note that in these processes there was no attempt to shame or denigrate the personhood of anyone involved, especially to include the chemically dependent person. Expressions were not allowed to be presented in the context of judgment of the behaviors as indications of personal ontology, but as indications of the so called disease behavior.

Shifting to Treatment for the Systemic Effects of Psychological Trauma

As we changed to the different approach, one with an emphasis on outpatient delivery influenced by our work with patients in TRT, chemical dependency family treatment began to look and sound like treatment for the systemic effects of psychological trauma. This change began to first manifest itself in our emulation of the confrontation model described in the previous heading to outpatient care. This section demonstrates the beginnings of the shift in focus to the treatment of systemic effects of psychological trauma and the eventual development of the model described in Clinical/ **Family Treatment**.

Family Confrontation of Chemical Use Behaviors - outpatient acute care

Several differences existed between the outpatient family confrontation method and the residential care approach. The differences are considered in this subsection.

First, the development and facilitation of TRT had so influenced our learning about the patterns of grief underpinning the storage in memory of psychological trauma, that we did not hold as much stock in big and initial breakthroughs as did the residential programs' hold such stock. Although we knew the confrontation was the most dramatic event for both patients and facilitators, there was much more to the process of resolving and reconciling psychological trauma than was being experienced in the rapid breakthrough programs. This observation and opinion were born out in continuing care, and as we have described in clinical/ Family Treatment / **CD Family: Continuing Care**.

Second, it was unnecessary to "get all the emotional pain out" during any particular period. There were plenty of groups, including continuing multiple family group processes through which the emotion could be expressed. Thus, the marathon technique, although valuable, was not required to force a quick removal of such pain, that is, expunge or extricate the pain immediately. In this regard, no admonitions to leave any particular amount of pain and move on to acceptance of the disease concept were ever made.

Moreover, because TRT provided us with a different definition of the experience of trauma and its resolution, all emotional pain was respected as a natural component of the trauma's retention. That pain's expression was also accepted as a natural

component of the resolution process. In addition, we also knew that once TRT established the person on the path to individual trauma resolution via TRT, all emotional pain and loss would be completely addressed in the end.

Emotional pain in our program was never thought of as something that was an interference with the acceptance of an abstraction, for example, the disease concept. Thus, no one referred to unresolved emotional pain as interfering "garbage" or "baggage."

A third difference resulted from the influence of TRT's first phase on the trauma resolution process for the family. The first phase allowed the events to be described in an orderly way that eventually lead to the identification of, not only emotion as expressed in the residential confrontation model, but the damage to the existential and operational elements of identity. That damage included contradicted values and shared loss pertaining to the relationships of all involved and the system as a whole.

Because this orderly introduction to the trauma resolution process worked so well for family members on an individual basis, we decided that it would probably have a beneficial effect on the family as a whole. Consequently, we replaced the confrontation process described as occurring in the residential settings with the TRT format provided in the first phase, except that the idea was for the family to share their lists in one setting.

Each of the family members would complete his or her description of the trauma-causing events before this sharing occurred. Such completions were facilitated in individual TRT and support groups and with the assistance of TRT counselors in individual sessions.

Because the people, spouses, with the most incidents to describe had usually been participating in TRT for months prior to the family's entry, their descriptions were well developed. Where they were not well developed, the descriptions were constructed to a level that were considered to be adequate for the CDP, family member, and family as a whole to share in the family session.

Later, as the family member continued in TRT, the list would be developed in its entirety, and as needed to meet the complete trauma resolution needs of the individual. Where we eventually tried to accomplish this so called confrontation within times comparable to the residential care programs, we eventually dropped time

constraints and had the exchanges when all parties indicated that they were ready. This readiness usually occurred between the 6th and 12th weeks.

Fourth, the goals of the family confrontation were also different in that there was no intent to use the process to bring about a breakthrough in CDP or family member denial of disease processes. Neither was there an intent to facilitate a transition to forgiveness or the adaptation of a particular abstraction such as the disease concept. And lastly, the process was not intended to help people to recognize disease or family of origin patterns of behavior, especially for the purpose of changing any of those patterns.

The simple goals of this new confrontation model were that the family be able to address the chemical use behaviors as loss-producing, and eventually to be called trauma-causing, incidents - the beginning of understanding of the trauma's effects upon the family as a whole. In other words, the sharing of each person's first phase with everyone else in the family had the same effect on the system as did the sharing of the first phase in individual TRT had on the one person.

The mechanics of the outpatient confrontation model were also different from the format used in the residential model, as well as different from the way the incidents were shared in TRT group. With regards to the former, differences between the outpatient and residential approaches, the "fishbowl" method was used if a family elected it so. They invariably did select that multiple family group vehicle.

Sexual (abuse/assault) issues were screened and addressed between victim and perpetrator in private sessions. Depending on the appropriateness of the situation and interests of the victim, battering (physical assault), homicide, or any issues involving carnage, for example, physical mutilation of people, were addressed depending on the decisions of those involved and the observers. Children were not participants to such readings. Although there was considerable emotion experienced and expressed during the process, "getting the emotion out" was not the intent, focus, or point of the process.

Continuing Care

There were 5 differences between the previously used continuing cares and the one we eventually developed and used with many families for many years (described in Clinical/ Family Treatment, **CD Family: Continuing Care**).

First, in the earlier approach, the acute care portion of the process was the primary care component of the program and the continuing care, called "aftercare" was only supportive of the acute care effort. Moreover, the goals of aftercare were fairly undefined. The methods were confused (non sequitur) and the processes incompletely (did not include all family members) attended and, in many treatment programs, not even existent. In the new continuing care model, the opposite was true. The acute phase was comprised of important elements, but as has been explained, they were only secondary in importance to the therapeutic efforts and progress made in the long-term process - the place where the real battle for sobriety, recovery, and trauma resolution occurred and was won.

Second, the key to chemical dependency family treatment, and later to become the key to any system affected by any kind of psychological trauma, is to facilitate the resolution of trauma resulting from the chemical use behaviors (or any trauma-causing event) for the individual members of the system simultaneous with and in parallel process to the resolution of the trauma at individual relationship and systemic levels, and most importantly with the individual trauma resolution therapy effort being the ascendant therapeutic factor determining the prospects for the progress of the system as a whole (see Clinical/ **Family Treatment**). In practice, this means that while the family was participating in its continuing care family (always multiple family) groups and couples (marital) groups, the goals, purposes, and processes making up those efforts were directly and primarily influenced by the trauma resolution process that was occurring in the individuals' TRT groups.

Third, when the individual trauma resolution processes were completed or in the process of being completed such processes directly impacted the psychopathologies influencing the perpetration of the trauma to the extent that there occurred either an ending of the psychopathology (in chemical dependency terms this meant the initiation, establishment, and maintenance of sobriety) or a separation from it.

Fourth, family therapy techniques that addressed the consequences of the trauma's effects on relationship and systemic functioning, that is, structural and rule changes, boundary erosion, projection, fusion, and the degeneration of management controls, as if those effects were actually the reasons for the family's presentment as opposed to the trauma's not having been resolved being the reason for presentment, were eventually in the new program viewed as having a deleterious effect upon the system's, relationships', and individuals' trauma resolution efforts to the extent that trauma resolution would not occur at any of those levels.

And fifth, these families were no longer viewed at presentment as "dysfunctional;" neither were they seen as suffering the "family disease of chemical dependency." They were, instead, seen as a *highly functional* system of interactive processes that were protecting the system and its individual members from the past, current, and ever-thought-to-be continuing occurrence of psychological trauma resulting from bizarre chemical use behaviors.

In the end, what used to be called the "family disease of chemical dependency" became nothing more than a natural, that is to be expected, systemic response to psychological trauma. This conceptualization would eventually provide the underpinnings of the new approach - the ETM chemical dependency family treatment program described in Clinical/ Family Treatment.

Chapter 4

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.
- ETM TRT as it compares 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 of 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 Bettelheim, in his descriptions of psychological trauma experienced by concentration camp survivors during WWII, and notably himself a survivor of Dachau, best portrays the idea that psychological trauma is comprised of related issues which form a pattern.

(The upcoming 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. (Bettelheim, 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 Bettelheim'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 neuropsychological by Dr. Donald Hebb's Cell Assemblies Theory (*Organization of Behavior*, 1949). Hebb 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 ETM Tutorial: About/ Development / **Individual**) to trauma victims describe what they 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 Older.

Parkes' (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 while experiencing 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.
(Bettelheim, 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 drives 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.

Silvestini'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 Silvestini 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, Silvestini'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 re experiencing 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 (1981). 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 ETM Tutorial: 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 behaviorists to psychodynamic methods and thus are not used by behaviorists because of philosophical differences that exist between those methods and the behaviorism 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 ETM Tutorial: 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 behaviorist 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 rubber band 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 rubber band'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 rubber band 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 not reversed 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 comorbidity 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 re experiences 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 re experiencing 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 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 Academic / Comparison – Contrast / Biology and Academic / Theory / Biology / Etiology and Etiology Reversal.

Chapter 5

Multiple Sources of Trauma

This chapter addresses:

1. The effects of pre-trauma psychological variables on the formation of a PTS condition
2. Comorbidity of Chemical Dependency and psychological trauma
3. Comorbidity of ACA / spousal trauma

Introduction

Literature reviews of the ETM theory for addressing multiple sources of trauma are best directed to 3 subjects: the importance of pre-trauma psychological variables, comorbidity of chemical dependency and psychological trauma, consideration of ACA and spouse trauma. These 3 subjects present the preponderance of arguments against the ETM theory for addressing multiple sources of trauma, which tends to run contrary to Nosotropically-influenced diagnostic and treatment planning modules.

Before beginning, an overview of our rationales for addressing these 3 subjects might be helpful. Pre-trauma psychological variables are important to the multiple sources of trauma theory because they tend to divert attention from the address of the most recent trauma; treatments begin with the current trauma and then are switched to other problems that existed before the traumatic event. The etiology is not identified and reversed because of the diversion. The literature sheds helpful light on this conflict. Comorbidity of chemical dependency and psychological trauma appears to be a classic representation of the chicken-egg (Which came first?) conflict. The literature, however, shows that this appearance is deceptive; there are clear lines of fact and logic that guide professionals through this difficult issue. Lastly, after reaching the age of majority (adulthood), adult children are argued to be attracting into situations that cause additional trauma. For example, adult children are accused of attracting into marriages where the new partner batters the adult child; the battering reminds the adult child of the old days, satisfying a need to return to or in other ways continue them. The problem with this view is that it minimizes the trauma received from the battering, and the etiology resulting from the assaults may not be identified

and corrected; this prospect is antithetical to ETM logic, so the conflict between the two ideas must be addressed. They are.

Pre-trauma Psychological Variables

The psychological professions have heretofore focused on pretrauma psychological variables as a prospective cause of PTSD. We believe this focus is actually a challenge to the concept of the existence of the condition. The argument turns on whether pre-trauma psychological variables ("pretrauma psychological variables infers dysfunctional pretrauma variables") exist to the extent that they are responsible for the post-traumatic stress experience. That research is considered here along with the ETM/TRT perspectives of the issue.

Conclusions by leading PTS scholars about the role of pretrauma variables in the formation of a PTS condition are mixed. Scrignar states "research does not indicate a clear-cut relationship between pretraumatic personality and the development of a PTSD" (Scrignar 1988, pg. 148). Van der Kolk states "There is a strong relationship between pre-existing personality factors and chronic PTSD symptomatology" (1987, pg. 12). Both van der Kolk and Scrignar provide reviews of the literature that support their conclusions. Herbert Hendin and Ann Pollinger Haas also address the same and similar data in their book on post-traumatic stress and its effects on Vietnam veterans (1984). We emphasize their description of the data by paraphrasing it in the next several paragraphs because we believe it best explains the contrasting views.

Hendin and Haas explain that at the beginning of the history of the treatment of trauma, the focus was on catharsis, or what Freud called "abreaction." His view was that people suffering trauma needed to pass through the emotional experience accompanying it. When the catharsis itself failed to produce the desired change, Freud shifted the focus to childhood issues, assuming therein lay the deeper cause of the stress reaction (quote Freud, International Universities Press, 1921). Immediately following World War II, two other approaches to therapy continued to explain the stress from war as having its origin in early childhood (sexual) and/or family issues (quote Saul, 1945, Litz, 1946). Saul and Litz identified linkages with childhood histories that provided a prospective cause of the stress other than the combat experience itself. In support of Saul and Litz, Brille and Beebe (1951), found that World War II veterans who became psychiatrically disabled were 6 times more likely to have suffered personality disorders prior to the service. Additional perceptions of preservice predictors of post-traumatic stress came from (quote) Hunter (1978), Yager (1976), Worthington (1978), and Heltzer (1979). A study by Heltzer in 1987

(addressed in a later paragraph) and not included in Hendin and Haas's 1984 publication, supports the idea that preservice (pre-trauma) psychological variables play a role in producing a PTSD.

In contrast, Hendin and Haas show that another group of researchers found data that countervailed the pretrauma variable idea. This data would show that the post-traumatic stress experience was a consequence only of the combat or persecution experience. These studies were not limited to combat veterans, but included the study of trauma's effects on WWII civilian casualties and concentration camp survivors. For example, Leo Eitenger found that 99% of 226 Norwegian citizens held in concentration camps experienced post-trauma disturbances for some years. "Eighty seven percent had persistent nervousness and irritability, 60% had sleep disorders and 52% had continuing nightmares" (Hendin quotes Eitenger, 1969). In Hendin's and Haas's review of Eitenger's study, the two therapists concluded that "the majority of these cases could be diagnosed as suffering from post-traumatic stress" (p. 35). In other words, virtually everyone in the sample suffered post-traumatic stress, thus ruling out the theory that the symptoms relating to the experiences of the traumas were results of earlier personality disturbances; unless, of course, it could have been determined that everyone in the town suffered personality disorders prior to their abductions.

Abram Kardiner, in his work with combat veterans (1947), reached an opposite conclusion from that expressed by Freud, Litz, Saul and Brille. Kardiner found that the stress response was due to the nature of the combat experience. In a study of civilians affected by trauma, Horowitz (1976) concluded that the symptoms are strikingly similar and that almost everyone will report the same experiences given the extent of the traumatic event. In a large study of the consequences of post-traumatic stress, Frederic Hocking (1970) reports: "There was no correlation between the symptoms and the preexisting personality or any other factors in the patient's earlier life." Hocking concluded that pre-existing personality characteristics do little more than determine how long an individual can tolerate the situation before the onset of neurotic symptoms. Thanks to Hendin and Haas for that review.

We have two views about the issue of pre-existing psychological variables as causal or contributing to the development of post-traumatic stress. The first is that post-traumatic stress has been (and still is) minimized. The intrusion from the trauma itself is considerably more profound than is recognized by the first group's analysis of those who do not show symptoms of post-traumatic stress. Specifically, we believe Eitenger's findings are comparable to other groups suffering post-traumatic stress.

Thus, most people who have experienced trauma are seriously affected by it. We believe further that studies describing trauma victims as unaffected by the trauma have not adequately accounted for the dissociation (next paragraph) experienced by the trauma victims. Subsequently, the studies do not account for the denial of the trauma and its symptoms. An example is Heltzer's statistical review of post-traumatic stress disorder in a catchment area survey of the general population (Heltzer, et. al. 1987). In this review, the study found that 5 of 965 men suffered post-traumatic stress disorder. Three were wounded Vietnam veterans, 1 was a non wounded Vietnam combat veteran and 1 was a beaten and mugged civilian victim. Others listed (as a part of the 965 man sample) who had experienced trauma included 12 more wounded Vietnam veterans, 28 more Vietnam combat veterans, an additional 68 beaten and mugged people, and an equal number of combat veterans from other wars.

None of this group qualified as suffering post-traumatic stress disorder. There were three interviews, one by questionnaire, one by phone, and one face to face. The statistics were gathered in conjunction with concurrent attempts to identify 40 other psychiatric disorders. As we understand, no consideration was given to denial of the trauma and its symptoms other than through the survey's methodology for acquiring the information; there was a reference to the possibility that some of the symptoms may have been "forgotten." We suggest that it is highly unlikely, if not impossible, for any beaten or mugged person, to complete the life cycle without showing symptoms of post-traumatic stress to someone. The idea that 68 such beaten and mugged people, and another 80 combat veterans, some of whom were even wounded, could be randomly found that had not produced post-traumatic stress symptoms is, for me, beyond the realm of possibility.

In support of our criticism, additional studies are finding that trauma results in dissociation rather than just an anxiety reaction as currently recognized in the DSM-III definition of PTSD. The result, according to Arthur S. Blank, a member of the committee that drew up the original post-traumatic stress diagnosis, is that "In general, the role of dissociation in PTSD has been underestimated." (Bower, 1988). Blank concludes that "the disorder is more difficult to recognize because traumatic memories and emotions are shut out of consciousness and often cannot be talked about by the survivor." Appendix A provides additional literature review (Laufer, 1985, van der Kolk, 1985, 1987) of the problems with PTSD symptom presentation.

We do not believe that the evidence shows that trauma and attendant survival responses are a consequence of pre-existing conditions except as that earlier state,

existential and operational components of identity that existed prior to the trauma's occurrence, has been intruded on by the event.

Furthermore, searches for pre-existing variables that contribute or cause the PTS condition are themselves in existence only because the traumas underpinning those conditions were not resolved completely in the first place. In other words, reverse the etiology and pre-existing conditions are irrelevant.

Comorbidity: Chemical Dependency and PTSD

This subsection considers chemical dependency-caused trauma. The subsection also addresses comorbidity of chemical dependency, chemical dependency-caused trauma, and PTSD resulting from trauma not caused by chemical dependency.

"Chicken or Egg" in PTSD and Substance Abuse

The post-traumatic stress field generally considers drug abuse and alcoholism to be symptoms of stress caused by the underlying post-traumatic stress condition. The literature has not, as a rule, addressed the pathological chemical use experience as a cause of post-traumatic stress, but mostly as an effect (van der Kolk, 1987 quotes Lacousierre). In addition, many summaries of post-traumatic stress symptoms include alcohol and drug abuse at the top of the list. Hendin and Haas (1984) speak directly to the issue of chemical dependency disease treatment vs. post-traumatic stress treatment. As I recall from their text, their view is that the chemical dependency treatment facilities with whom they have had association are so caught up with the disease concept and getting people sober, including the application of their particular modalities, which I presume refers to the *Twelve Step* programs, that the chemical dependency treatment people miss the underlying post-traumatic stress condition that, in some PTS expert theory, is the cause of the pathological use. Scrignar (1988), the most prolific identifier of PTSD symptoms, on the other hand excludes substance abuse or chemical dependency as a symptom of PTSD.

Kosten and Krystal (1988) make what we believe to be the best neurobiological argument for the PTSD-causes-chemical dependency-view by showing a prospective relationship between the neurobiology of psychological trauma (also reviewed in section 2 - this appendix) and the neurology of chemical dependency. Generally, that relationship is hypothesized to be a function of a stress (trauma) induced locus ceruleus to hypothalamic pituitary axis activity that overloads opioid receptor functionings until they become desensitized, culminating in the need for exogenous

opioid or other alternative receptor binders. Ethanol, although not a receptor-binding oriented drug, has the effect of mollifying the locus ceruleus (noradrenergic) activity by anesthetizing it. Such anesthetic effects are demonstrated in studies on the relationship of noradrenaline and alcohol (quotes Lynch, M., 1983 and Brick, J., 1983). Thus, from Kosten's presentation pathological drug use becomes a biological consequence of PTS.

The most comprehensive review of PTSD and substance abuse studies has been produced by Terence M. Keane, Robert J. Gerardi, Judith A. Lyons, and Jessica Wolfe (1990 - from now on referenced as "Keane"). Keane reviews the research on Vietnam veterans and substance abuse (Vietnam veterans are the only group of trauma victims for which there is empirical data on the relationship between trauma and substance abuse) and in the context of various substance abuse theories and political mandates for the studies. Generally, Keane finds that the studies are equivocal in determining the trauma/substance abuse relationship. Some of this equivocation is a function of methodological problems with the studies; Boscarino (1981) and others are quoted. Where Boscarino believed the data demonstrated a statistical link between combat and substance abuse, Keane demonstrates that no such conclusion could be reached based on this data. Some equivocation is a function of contradicting views. For example, Egendorf (1981) shows a prospective relationship between combat and substance abuse while Heltzer (1984) is shown by Keane to produce the opposite by representing no linkage between combat and the abuse, but showing possible linkage between the abuse and preservice factors.

Keane does establish, however, an absolute relationship existing between heavy substance abuse problems and those veterans seeking treatment in VA inpatient facilities. That is, between 63 to 80 percent of presentments (Sierles, 1983, Keane, 1983, and Keane pg. 43) at VA facilities are suffering substantial substance abuse problems. Keane recommends that to fully understand what he calls this "chicken and egg" (pg. 44) and prospectively "dual disorder patient" controversy, studies need to be made of non or social chemical use PTSD sufferers as it "clearly is impossible to study PTSD when it is accompanied by substance abuse."

Edgar Nace (1988) is more specific about the relationship of PTSD and substance abuse when considered from a remedial perspective. Nace points out that both chemical dependency (quote Galanter, M., 1982, and Moore, R., 1972) and PTSD (Blank, A., 1985) are not as a rule diagnosed by the psychiatric profession. Nace includes a number of other references, statistics, and prospective rationales supporting the idea underlying this failure by the treatment community (pg. 10).

In support of the ETM approach to identifying both issues, Nace presents assessment criteria that closely parallels the ETM model. Moreover, because of the proclivity to deny both variables as problem issues, the assessment process is continued into and through the treatment experience. Nace is also unequivocal that the substance abuse needs to be addressed first, via abstinence and possibly a more confrontive therapy, and the PTSD addressed later with "a carefully timed titration of affect" pg. 24. Nace does not in this article, however, identify psychological trauma, that is, the 4 psychological trauma patterns described in the TRT and ETM models, as a specific consequence of the pathological chemical use.

The "Skewed" Effect

In his book *A Natural History of Alcoholism*, (1982) George Vaillant followed the lives of over 600 people for 45 years (he did not conduct the data accumulation himself, but appraised the data from studies begun before he became involved with the project). Vaillant's idea prior to beginning the interpretations of the data was that psychological variables would be found that predicted alcoholism. He reported that he was "surprised" to find that no such predicting variables existed (ABC interview, 1987). One of his conclusions was that attempts to determine true psychological traits as opposed to those appearing after the onset of the alcoholism is like looking into a pool of water and attempting to detect the true location and size of a fish that is swimming below the surface. The nature of the light's reflections in the water skewed the actual location and size of the fish and make true identification of location and size impossible.

We believe the "skewed" perspective by Vaillant is one of the best bodies of research supporting the TRT four patterns theory as it is extrapolated to people affected by psychological trauma caused by chemical dependency. That is, the information supports the idea that pre-pathological chemical use psychological personality traits and variables are different than post-pathological use traits and variables, which we hypothesize to be the first and third psychological trauma patterns; respectively, the first pattern evolves from toxic thoughts and behaviors that contradict existential identity (pre-trauma personality traits and variables) and the third pattern evolves from survival responses that contradict existential identity. Moreover, the finding that pre-trauma, pre-pathological chemical use, variables are no more identifiable (abnormal) in this population than in non pathological chemical users (controls), gives evidence that there is something (values, beliefs, images and reality) to contradict during the onslaught of the pathological chemical use.

Biology of Alcohol Use as a Cause of the Four Psychological Trauma Patterns (Cause of Dissociation)

If there is substance to Vaillant's findings (described in the preceding paragraph) and our proposal that the pathological use provides its own intervention upon the pre-use psychology and that the pathological use culminates in contradictions to existential identity and the subsequent development of defenses, that is, survival responses (the third psychological trauma pattern), then there must be an explanation for how intrabiological influences bring about the original (from the pathological use) prospective psychological changes, and a body of evidence that supports the explanation. In fact, we have found a number of comprehensive works that offer substantial insights into different aspects (and specifics) of the biology of chemical dependency and its influences on neuropsychology and behavior. They include: *The Molecular Pathology of Alcoholism* (1991) by Palmer, "Biochemical Basis of Alcoholism: Statements and Hypotheses of Present Research" (1985) by Topel, *The International Handbook of Addiction Behavior* (1991) by Glass, "Hepatic Encephalopathy Coexistent with Alcoholism" (1991) by Tarter, Arria, and Van Thiel, "Neurohormonal Basis of Alcoholism" (1990), S. Parvez, H. Ollat, I Nevo, Y. Burov, and H. Parvez, and "Ethanol and Neuromodulator Interactions: A Cascade Model of Reward" (1990) by Blume and Kozlowski).

Referring to these and other works, this section will review:

1. The effects of *alcohol* use induced physical/molecular trauma upon brain functionings with an eye toward the influence of the damage on thought and behavior.
2. The effects of alcoholism induced physical/molecular trauma to liver functioning on neurological processes and subsequent thought and behavior.
3. "Alcohol" is the most used drug and the one having the most far reaching effects. For purposes of saving space, we explain through our overview method alcohol's influences - referencing where to find the other drug effects like opioids/cocaine, which have similar and dissimilar biological influences, and which are pronounced in their own right.

Biological Effects of Alcohol Use-Caused Trauma on Neuropsychology - Outcome on Thought and Behavior

Psychological trauma resulting from the direct interaction of chemical use on brain physiology is a function of physical trauma upon and subsequent exogenously

induced change to neuronal structure and functioning, the net effect of which is dissociation of the psychology that provides ongoing management for the organism.

For purposes of simplification, Littleton (1991) provides a restricted explanation for some of the molecular factors underlying intoxication, tolerance, and dependence. Through focus on these 3 processes, dissociative neuropsychological effects spawned by the biological processes are apparent.

Littleton, accompanied by disclaimers about his attempt to simplify these issues, explains that alcohol has both anxiolytic and anesthetic effects on the central nervous system. Anxiolytic is thought to be a positive reinforcer during the initial level of intoxication and the anesthetic effect is less positively reinforcing; numbing and incapacitation occur to the degree that there is loss of control. These two effects are then described as components of intoxication, the molecular basis of which (Littleton's explanation) is the subject of the next 2 paragraphs.

Anxiolytic effects occur as a function of ethanol's influence on the electrical component of the charge; most specifically, ethanol affects GABAergic neuronal processes - the principal CNS neuronal structures responsible for inhibitory activity. GABA neurotransmitters bind on GABA receptors and then open Cl⁻ ion channels that allow the Cl⁻ ions to cross the membrane. Cl⁻ ions inhibit the neuron's movement toward the action potential, which inhibition provides for a reduction in the prospects for action potentials to be transmitted along the membrane - excitability is reduced. When alcohol enters the area around the GABA synapse, it interferes with the GABA (A) receptor functions, resulting in the continued opening of the Cl⁻ channels and an increase in the amount of Cl⁻ ions to flow across the membrane, increasing the likelihood of inhibition of the neuron. The net effect is reduction in neuronal excitability; the neuron inhibited by the affected GABA receptors results in fewer action potentials - the anxiolytic component of intoxication.

The anesthetic component of intoxication is explained by Littleton as being a function of alcohol's molecular interaction with the process that carries the charge through the synapse. Alcohol reduces the flow of Ca²⁺ ions, apparently pre synaptically, which reduction reduces neurotransmitter release. Because reductions in neurotransmitter passage across the synaptic gap will have an effect on membrane depolarization, which is required for the action potential to be released, the Ca²⁺ ion interference has synaptic transmission and electrical charge conductance influences: apparently to mean fewer transmitter releases results in fewer bindings and more Cl⁻ ions flowing across the receiving neuron's membrane (that carries the charge; the excitatory neuron

is inhibited. Thus, intoxication is a function of the strengthening of the inhibitory effect of GABAergic activity (anxiolytic) and a reduction of synaptic transmission of neurotransmitters (anesthetic), the locus of such reduction being a proportionate reduction in Ca^{2+} ion availability to the pre-synaptic membrane.

According to Littleton, the development of tolerance and dependence to alcohol is a consequence of neuronal structural and functional adaptation to the ethanol's influences on GABA and Ca^{2+} activities; those influences being the molecular substrate of intoxication that was just described in the immediate previous paragraphs. This adaptation is both decremental and oppositional.

Decremental adaptation is described by Littleton as resulting from the neuron's changing of itself to prevent the alcohol's entry into the membrane and synaptic areas. Thus, such prevention can lead to increasing tolerance without dependence.

Oppositional adaptation, however, leads to both increasing tolerance and dependence. That is, while comingled with alcohol, the neuron adapts during withdrawal by developing itself as the opposite of its state while functioning in interaction with the alcohol molecule. In this opposite neuronal adaptation, GABA loses its effectiveness when binding with GABA receptors and the number of Ca^{2+} channels increase, producing the opposite neuronal activity that occurs during intoxication. Respectively, the adapted molecular state effects a reduction in Cl^- ions otherwise used to inhibit the action potential (to produce the anxiolytic component of intoxication) and an increase in Ca^{2+} release, causing an increase in the prospects for neuro transmission of the charges (the opposite of the anesthetic effect occurring during toxicity). This physical change then produces hyperexcitability after the drug is eliminated from the CNS, which excitability is again assuaged through alcohol's reincorporation into the functional and structural neuronal activity.

Dependence then increases with a corresponding increase in Ca^{2+} channels and decreasing effectiveness of GABA on GABAergic receptors. A "vicious circle" ensues, according to Littleton, where the neuronal adaptation to toxicity requires greater toxicity to offset the increasing adaptation - cell functional and structural alteration. Ca^{2+} channel capacity in the neuron's membrane is hypothecated to be a function of genetic determination - the capacity to produce more or less channels is determined by the particular genetic structure. The greater that capacity the more pronounced the cycle.

The behavioral correlates to this cyclical molecular process include

1. the highs and disordered thoughts and behaviors occurring during intoxication (= anxiolytic and anesthetic effects) which is underpinned molecularly by the Cl^- increases and Ca^{2+} decreases
2. the production of withdrawal symptoms as the drug is eliminated from the neuron(s) and the increased number of Ca^{2+} channels produced during the intoxication as offsets to it begin to flow Ca^{2+} ions.

The GABAergic failure results in closed Cl^- channels - a reduction in Cl^- to provide its inhibitory effects. The results are neuronal hyperexcitability and behavioral hyperexcitability.

In a very comprehensive review of the various CNS factors related to alcohol consumption, "Neurohormonal Basis of Alcoholism" (1990) by S. Parvez, H. Ollat, I. Nevo, Y. Burov, and H. Parvez (from now on referenced as "Parvez") shows the comprehensive effects of alcohol consumption on the totality of CNS process. Because of the completeness of these effects, there should be no doubt for anyone reading Parvez about the alterations, incurred as a result of the use, to the substrate of existential identity - virtually every neuronal system related to the formation and maintenance of that identity is affected.

To begin, Parvez shows (pg. 154) that the key ingredients to memory retention, among other things to include the capacity for autophosphorylation of second messenger activity like cAMP and Tyrosine, respectively, the accelerating components of LTP and the messengers themselves, without which there would be no long term potentiation (existential identity substrate), are inhibited by alcohol. Moreover, the inhibitory effects on all neuronal protein phosphorylation influence the elemental functions of cell process required to sustain psychological function; alcohol reduces neurotransmitter release and membrane activity required for processing of charges through ion channels and so forth - the basic elements required to produce neuron excitability.

In addition to the effects of alcohol at the level of the cell and synapse, where neuronal charge, LTP, and memory storage occur, a wider picture is presented through Parvez's consideration of alcohol's effects on the basic neurotransmitter systems. For example, alcohol is shown to affect the noradrenergic, dopaminergic, serotonergic, and GABAergic transmission systems. Some of these effects, which occur based on genetic differences influencing the various systems, are described by Parvez.

- Noradrenergic systems are stimulated during intoxication, but retarded after prolonged use (Pgs 161 - 162).
- Like the noradrenergic system, the dopaminergic system also is overworked during intoxication; the result is the depletion of the system's capacities to function properly during withdrawal. The reapplication of alcohol replaces the altered dysfunction (pg 165).
- Serotonergic activity is stimulated in the beginning of the alcohol consumption and depleted over a longer period involving chronic use (pg 168).
- In support of Littleton (described earlier), Parvez also shows that ethanol influenced GABAergic activity stimulates Cl⁻ (increasing inhibitory effects on the neuron) during the short run, but depresses GABAergic capacity to function over the long run - more alcohol is needed, which when withdrawn unmasks the GABAergic deficits brought on by the use. Examples include: "personality and behavioral disorders, anxiety, mood disorders, and psychotic manifestations, etc."

Effects of Alcohol on Liver Functioning and Subsequent Effects of Hepatic Trauma on Neuropsychology

Aside from the direct effects of alcohol on neurophysiology, that is, as a source of trauma, there are indirect neurological effects that result from alcohol's influences on liver functioning - alcoholic liver damage leads to alcoholic brain damage. Like the neurophysiology of alcoholism, liver (hepatic) issues are also complex. For a thorough explanation of alcohol/alcoholism and the liver, we reference in Palmer's *The Molecular Pathology of Alcoholism*, 1991; "Alcohol and the Liver," C. Lieber, (1991) and "Alcohol and Aldehyde Dehydrogenases," Jornval, H., Persson, B., Krook, M., and Hempel, J., (1991). See also "Vulnerability to Alcoholic Liver Disease," Arria, A., Tarter, R., Van Thiel, D., (1990), and "Genetic polymorphism of the alcohol metabolizing enzymes as a basis for alcoholic liver disease," Grant, D., (1983).

An overview of Lieber's (1991) introductory explanation (pgs 60-62) of alcohol's metabolism and subsequent pathological effects on the liver follow. About 90% of ethanol is oxidized by the liver. The other 10% is processed through other organs like the lungs and kidneys. Depending on the amount of alcohol and the kinds of metabolism provided by the liver, including hepatic dysfunctions, the 90% figure will or will not be achieved. Circuitously, failure to oxidize alcohol properly culminates in

liver pathology and liver pathology increases the likelihood of the failure to metabolize.

There are several pathways or means through which the liver metabolizes alcohol, but only one of import for this summary - alcohol dehydrogenase or ADH, an enzymic "system" that mediates ethanol metabolism. I emphasize "system" because an important feature of ADH is that it is comprised of many like, but at the same time slightly different, components. These differing components are more important when considering the genetic aspects of alcoholism, thus we will return to these differences in the section on genetics. In the mean time, the central role of alcohol dehydrogenase is its enzymic function of oxidation of ethanol; hydrogen is "transferred from the substrate to the cofactor nicotinamide adenine dinucleotide (NAD), converting it to the reduced form, NADH." During this chemical process, the system becomes overloaded with NADH - there is not adequate removal (of NADH) capacity. Acetaldehyde is produced, which is then converted by aldehyde dehydrogenase to acetate. These reactions in the liver produce overabundances of reducing agents which overages then adversely influence the ability to continue the otherwise homeostatic metabolic process; in the interim, myriad liver metabolic disorders are initiated. In layman's terms, the chemical reactions in the liver are not adequate to process the alcohol through the body and they (the reactions) become in and of themselves contributors to additional failed attempts to process the drug - neurotoxins are produced and remain in the blood to effect neurological functioning. The subsequent disorder in which we are most interested because of its linkage to neuropsychological change is hepatic encephalopathy.

In "Hepatic Encephalopathy Coexistent with Alcoholism," (1991) Tarter, Arria, and Van Thiel (from now on "Tarter") describe the process through which liver pathogenesis causes neurological damage with attendant thought and behavioral changes (symptoms). Importantly, the locus of the neurological change is continued even after abstinence and until the liver pathology is reversed. This hepatic/brain combination for pathology is such that liver transplants are shown to reverse the encephalopathy. The following is a summary of pertinent segments of Tarter's explanation of hepatic encephalopathy (pgs 206 - 220).

Chronic alcoholic hepatic encephalopathy is underlied by cirrhosis and is called portal systemic encephalopathy (PSE), which name describes its cause II a portal shunt, or alteration, that sends the blood around the portal side (where the portal artery is located) of the liver and in the process prevents it from removing neurotoxins from the blood. Where PSE's most acute effects occur in later stages of the disorder,

some of the effects begin with the onset of cirrhosis, which on the average occurs during the person's most productive years (third to fifth decades). Thus, when we write in this section about PSE's acute effects incurred in the latter stages of cirrhosis, those effects have their beginning at a much earlier time in the alcoholism/liver pathology - the effects are assumed to be graded (explained by Tarter in a later chart).

Tarter (by quoting Zieve, L., 1979) describes the etiology of PSE:

1. Decreased brain glucose and oxygen consumption.
2. Increased ammonia levels in the blood, brain, spinal fluid and muscles.
3. Increased glutamine levels in the brain, spinal fluid and muscles.
4. Increased short chain fatty acid levels in the blood and possibly in the brain.
5. Decreased normal neurotransmitter levels in the brain.
6. Increased false neurotransmitter levels in the brain, blood, urine and muscles.
7. Increased mercaptans in the blood, brain, breath and urine.
8. Altered amino acid ratios.
9. Decreased affinity for hemoglobin for oxygen.
10. Increased concentrations of neurotransmitter metabolites in both the brain and spinal fluid.

Early stage behavioral symptoms of PSE mimic some "functional psychiatric disturbances" (pg 208). They include: "euphoria, depression, mental slowing, inappropriate affect and behavioral and sleep disorders" and "hysteria." In addition, Tarter quotes Bernthal, P., (1987) by printing his (and Tarter's) chart depicting the graded (4 stages) presentation of PSE's effects on 6 factors, and then offers various methods for screening for the differences between similar symptoms for some psychiatric disorders and PSE caused encephalopathy. You can find Tarter's chart summary in Tarter, 91, pg 210.

Importantly, Tarter demonstrates that PSE induced cognitive impairment can be reflected in testing prior to other symptom manifestations. Other tables in this article describe the PSE/cognitive relationship including emphasizing reversibility of the impairment through time, and especially reversing the impairments through liver transplants (Table IV, pg 218).

Before closing this description of alcohol-effected liver influences on CNS functioning, Parvez shows (pgs 154 - 155) that during the liver's metabolism of alcohol through the ADH (alcohol dehydrogenase) enzymic pathway, acetaldehyde is produced that condenses with catecholamines forming tetrahydroisoquinolines or

"TIQs." This substance "binds with neuronal membranes" and has other CNS effects including "inducing neuronal lesions in catecholaminergic and serotonergic systems." Other hepatic influences on neuronal functions and systems are described in the same section.

Genetics

This section addresses 3 questions related to genetics. They are:

1. What is the known role of genetics in the biology of drug use-caused psychological trauma?
2. What is the prospective role of genetics in the same issue?
3. What is the relevance of the first 2 questions and their answers to the proposition that biological alterations to liver and neural functionings and structures cause an individual affected by chemical dependency to also be affected by psychological trauma resulting from the direct use?

The third question is answered first because it goes to the heart of the relevancy of this section.

Question (3)

Genetic information provides a non personality-or non psychological-related etiological element of the multifactorial process involving pathological use, which as previously described leads to biological damage that continues the use and the advent of additional damage, including interruptions to the psychological management system. This information argues that pathological use can be initiated or not from within a cell - a genetic code is giving biological commands that influence the biologies' responses to the use instead of the commands coming from a system of cognitive logic imparted by society for the purposes of maintaining social control (admonitions to use drugs responsibly) and then adapted by the individual. In that regard, if the genetic etiology is true, or eventually proven so, then it will eventually require changes in social management theory and application, as it would be incongruous to keep telling people to use drugs responsibly should it be found that such advice is not possible to follow.

Because such didactic advice giving approaches represent the current and predominant social management method, the method itself controls the perception of the use: people *have* to be responsible for it because there is no other way to manage

everyone who uses drugs. It follows under this method that if we see people as responsible for the use, such application of responsibility is inseparable from the correlate that they have also chosen the use - they are to blame for it. If such blame is assigned, it is necessary to find a reason, which the psychological causal theory provides. That is, there is something that the individual is doing, thinking, or feeling as result of those activities and thoughts, either consciously or unconsciously, that requires pathological use. Subsequently, it is impossible to simultaneously see the effects of the use as an interruption to the psychological system of management because the ascendent view is that the system is getting what it really wants and needs. In contrast, the genetic view that the use is a consequence of the non psychological-related biological activity makes obvious the psychological trauma resulting from the use because the pathological drug use is seen as an obvious intrusion - the use is imposing upon the psychological system of management the opposite of what it wants or needs. In other words, the availability and selection of the particular social management method (social assignment of responsibility for the use) has been the determining factor as to whether the psychological trauma resulting from the chemical use will be identified and addressed, regardless of the truth of its existence or not. Heretofore, this culture's adapted management methods have assured that such trauma will not be identified or addressed - resulting in controversy stemming from genetic facts about the subject and consideration of additional and related facts. The relevance of the questions pertaining to the facts surrounding genetic data related to chemical dependency and their individual/social effects are that the questions and answers directly impact society's and its leadership's, including its clinical leadership's, abilities to consider not only the fact that psychological trauma results from the chemical use, but that the current social methods used to manage related issues are prospectively incorrect ones.

Question (1)

With regards to question (1) (What is the known role of genetics in the biology of drug use-caused psychological trauma?), there are two kinds of answers: cellular findings of fact and empirical/statistical data related to heritage of pathological chemical use. The former are considered first; the latter are considered later.

Currently, the literature reports 4 genetic factors influencing pathological chemical use; two are liver and 2 are neuronal. Three of the 4 are related to alcohol metabolism and the other is related to other substance (cocaine) abuse. We address the liver first and neuronal second.

The two liver influences are functions of a reverse effect; that is, the genes prevent certain people from being able to metabolize alcohol easily. The basis of this prevention lies in the hepatic productions of aldehyde dehydrogenase (ALDH). A mutant form of this hepatic-based enzyme results in over production of acetaldehyde during the metabolism of alcohol. The overages then initiate autonomous system activity - faster heart rate and respiration, the "flushing" effect, which tends to make alcohol consumption too difficult. The genes that produce the ALDH mutant responsible for this processing are codified and unequivocal in their location and effect. This "flushing" effect influences about half the oriental world population, approximately 500 million people, and various and lesser percentages of other races. You may find discussions and explanations related to the hepatic genetic influences in the following articles: "Molecular Genetics of alcohol metabolizing enzymes," 1991, by Akira Yoshida; "Alcohol and Aldehyde Dehydrogenases" by Jornvall, Persson, Krook and Hempel (1991); "Genetic Factors in Alcoholism" by Cook and Gurling (1991); "The Role of Alcohol Metabolizing Enzymes in Alcohol Sensitivity, Alcohol Drinking Habits, and Incidence of Alcoholism in Orientals" by Agarwal and Goedde (1991); from *The Molecular Pathology of Alcoholism* by Palmer (1991); and "Genetic Aspects of Alcohol Abuse" by Adityanjee and Murray from *International Handbook of Addiction Behavior* by Glass (1991).

The neuronal genetic influence is reported in "Genetic Predisposition in Alcoholism: Association of the D2 Dopamine Receptor TaqI B1 RFLP With Severe Alcoholics" (*not the study argued about prior to this publication period* - 1993) by Blume, Noble, Sheridan, Montgomery, Ritchie, Ozkaragoz, Fitch, Wood, Finley and Sadlack. This influence is shown to be related to the presence of an "allele of the D2 dopamine receptor gene with severe alcoholism" (pg 59). Blume states (59) the importance of dopamine in alcohol CNS processing: "The dopaminergic circuitry in the mesolimbic/mesocortical pathway has been asserted as being important for behavioral reward and reinforcement (quote Koob, 1988 and Wise, 1989)." Also from Blume: "Alcohol's ability to stimulate dopamine release in the brain points to a possible connection between the reinforcing effects of this substance and dopaminergic circuit." Uhl in "Substance abuse vulnerability and D2 receptor genes" (1993) shows the other association between substance abuse behaviors and the "restriction length polymorphism (RFLP) markers TAQI A1 and B1 at the dopamine D2 receptor (DRD2) gene locus in Caucasians" (pg 83).

Reviews of familial alcoholism abound in the literature (none are better than Cook's and Gurling's, 1991, and from which we quote here) and pretty much agree that the twin adoption studies, that is, Cadoret and Gath, 1978; Cadoret, 1980, 1985, 1987;

Goodwin, 1973, 1974, 1977, and Bohman, 1978 support the genetic propensity for alcoholism and that violence (sociopathology) in the accompaniment of alcoholism has a genetic predisposition (Cloninger). The adoption studies are apparently most valuable because they are able to measure children who were adopted at birth into non alcoholic (parental) environments and which children still become alcoholic despite the lack of environmental influences. Importantly, all of these studies can be questioned in terms of certain statistical/methodological processes employed. However, the consensus by most reviewers is that the Goodwin and Cloninger studies hold-up despite the scrutiny. Importantly, most of these kinds of studies where the families histories have been the focus are now being addressed with the new capacities available through gene technology similar to that reported by Blume, Noble and Uhr (1993).

Question (2)

I raised question 2 (What is the prospective role of genetics in the same issue?) because, in studying the current information, I found and had it emphasized to me that the findings so far are only the very beginning of this investigative process. For example, known genetic influences on the aldehyde dehydrogenase alleles has been discovered from the in-depth scrutiny of only 1 and partially 2 of 5 different isoenzymes of the aldehyde dehydrogenase enzymic system. In addition to this, there are 5 more isoenzymic components of the hepatic alcohol metabolizing enzymic system alcohol dehydrogenase, for which none of the 5 structures have been (at the time of these reviews) mapped. This is just the hepatic considerations. The neuronal ones for the vast and complex neural actions are nothing less than comparable to space exploration, and these voyages are just beginning also, at least this is the commentary provided by the majority of the reviewers I have read and that are noted in this subsection. Moreover, the technology is changing so fast that these new pictures are becoming available almost faster than reviewers of the investigations can keep up.

Conclusion: Chemical Dependency

There is overwhelming evidence of the changes in the molecular foundations of existential identity as well as indisputable evidence that the changes have occurred to the degree that they rarely resemble that pre-use, pre-trauma, identity. Moreover, these changes can occur absent the influence of a simultaneously occurring stress response. That is, although environmental factors that cause stress can contribute to the alcohol's effects on neuronal system functioning, the damage can occur just from

the use itself and without the stress factor, and in the process then create its own stress factors.

Multiple Codependency: Spouse /ACA

The application of the ETM multiple sources of trauma theory, principles, and guidelines to multiple codependency ("codependency" is the current usage) experiences provides for the sharpest examples of conflict existing between the ETM approach and other programs. This subsection addresses those conflicts by focusing on non alcoholic spouses of chemically dependent people; the non alcoholic spouses are also adult children of alcoholics. The question to be answered in this section is: What is the evidence and rationale for addressing the trauma resulting from the later relationship before addressing the earlier trauma.

The predominant theories that challenge the multiple sources approach are technically called disturbed personality and decompensation hypotheses, psychic determinism, and addictive (or compulsive -) behavior disorder. These models define the locus of the spouse's problem as the early childhood intrapsychic makeup of the spouse (the spouse's problem originated during early childhood); recently, some theoreticians are suggesting the spouse's problems are genetic. The decompensation hypothesis has taken this intellect a step further; it posits that the alcoholic drinks excessively for the purpose of mirroring the spouse's degenerating condition. Because these models also, as a rule, project the spouse into the relationship with the alcoholic because of the earlier childhood problems, that is, the spouse is believed to have attracted into the marriage because of the earlier problems, we consolidate these technical descriptions into one convenient term: the attraction theory.

Now, with the advent of the ACA (adult child of an alcoholic parent) movement begun in the early 1980's, the attraction theory has been accorded more usage; ACA's who marry chemically dependent people are perceived as attracting into those relationships to meet early childhood needs that are pathological, apparently because of the alcoholism's influences on parenting. The ACA wants to relive the alcoholic childhood by marrying an alcoholic.

Methodologically, the overt intent of the attraction theory is to provide an interpretation of personal behavior that helps spouses to realize the flaw, that they are attracting into bad relationships to meet earlier and degenerate childhood needs, then help the spouse to address the childhood issues and begin to take responsibility for their decisions; the spouse begins to strengthen cognitive controls. The spouse is then

supposed to make new and more constructive choices that bring about less degenerative or destructive relationships.

This idea, when compared to ETM theory, is considered from first, the issue of the therapeutic purpose of the attraction theory as compared to the ETM program's purpose, Second, the differences between ETM and attraction are considered from the perspective of some of the factual information that has historically been related to the attraction theory.

In the first perspective, consideration of the methodological purpose of the attraction theory as compared to the purpose of TRT, there is no need in TRT to provide or strengthen cognitive controls to spouses of alcoholics for the purpose of helping them to choose better paths as the attraction theory provides such assistance. The resolution of the trauma through TRT results in rational and cognitive oriented controls automatically being returned to, or incorporated into, decision making processes as existential identity is reconstituted and operational identity is restored: etiology is reversed. Moreover, strengthening of cognitive controls before the trauma has been completely resolved, can result in the inadvertent strengthening of those defenses that help to keep the trauma retained in the subconscious, thus diminishing the prospects for reversal of the etiology resulting from the trauma experienced as a spouse.

Worse, the attraction theory's premise that the spouse chose the abusive relationship to meet internal psychological needs initiated out of childhood trauma, infers that the spouse wanted to experience the denigrating process occurring within the marriage. When TRT has been applied under the guidelines provided by the ETM approach, the identification of the specifics of the trauma-causing events usually carries with it an explanation, to include a specific description of the entry into the relationship. These specifics, followed by the trauma's resolution, provide a different picture (from the attraction theorists) of spousal entries into relationships with alcoholics. The conclusions reached by both patient and therapist about the entry (the conclusions are reached after the etiology has begun to be reversed) were that:

- the perpetrator was adept at hiding the propensity to assault - there was no choice about something that was not seen.
- the idea that anyone could identify perpetrators of assault before the onset of chemical dependency (a primary and frequent underpinning of the perpetrator's pathological condition) is a fantasy constructed as a consequence of distorted hindsight (as Vaillant explained, such distortions of alcoholic post pathological use personality was a product of a skewed representation of the

original personage) and a simultaneous lack of understanding by anyone making such a determination of how chemical dependency and associated violence are developed and harbored within both intrapsychic and interpsychic elements of personal psychology.

- No one stated to the spouse at the beginning of the relationship that it would likely provide her or him with psychological or physical disfigurement, and a similar psychological and physical damage to her or his future children. The spouse in turn did not state that this was the choice.
- With regards to the second perspective, the issue of the facts, research data related to the attraction theory is historically clear cut. Paolino and McCrady (1977) discovered in an exhaustive review of the literature on spouses of alcoholics that not only does empirical research refute the attraction theory (quote Ballard, 1959, Corder, 1964, Lanyon, 1970, 1973, Rae and Drewery, 1972, Mitchel, 1959, and Kogan, 1963), but the literature also indicates there is no empirical data that support's the attraction theory at all (Paolino and McCrady, 1977). Moreover, considerable research supports the opposing view that cultural (i.e., religious, economic, and social) rather than psychological factors provide the greatest influence on who becomes involved with whom (quote Orford, 1975). And finally, the Stress Theory (Joan Jackson, 1954) stating that non-alcoholic spouses of alcoholics are no different than anyone else would be who lived in an alcoholic relationship is supported by a number of empirical studies (quote Jackson, Kogan, 1965a, 1965b, Haberman, 1964, Bailey, Haberman and Alksne, 1962, Bailey, 1967, Paolino, McGrady and Kogan, 1977). In this landmark review of the research on the alcoholic marriage (*The Alcoholic Marriage: Alternative Perspectives*), Drs. Paolino and McCrady concluded that "the research of Haberman (1964), Bailey et al, (1962), Kogan and Jackson (1965b) Bailey (1967) and Paolino et al, (1977), strongly invalidates the decompensation (disturbed personality) hypothesis and supports the general concepts of the stress theory." (1977, pg. 77).

There are several additional considerations of fact left unaddressed by the attraction theory. Those considerations include no explanations for:

- relationships beginning before the 1600-1700's, probably because prior to that period relationships were, as a rule, customarily assigned to meet family or social political needs. The attraction theorists presumably believe co-dependency per the disturbed personality and decompensation concepts to be phenomenons of only the 19th and 20th centuries.
- those abused children who as adults married into stabilized relationships.

- why childhood abuse is recognized as true and legitimate experiences of trauma and spousal abuse is considered as less such an experience - the abuse was secretly desired, so there could be no true or legitimate experience of trauma.

In addition, the fact that some ACA's have married chemically dependent people does not prove that ACA's are somehow drawn to such marriages abnormally. Given the frequency of chemical dependency in our society, a considerable number of such marriages of ACA's to chemically dependent people can be expected simply by chance. Our discovery through the treatment of multigenerational alcoholism with complete (see appendix E, section 4b) families (60 to 70 year old chemically dependent people with participating children ages 30 to 50) was that children from alcoholic homes are no more likely to marry chemically dependent people than are people without such back-grounds. Approximately 70% of those children had married non chemically dependent people. We found additional information by looking at ACA's from another perspective. When the adult child presented alone and without the complete family of origin, that person almost always was faced with other more current chemical dependency related issues. Either the person was married to an actively using chemically dependent person (60%) and had not yet discovered this to be true, or the adult child was chemically dependent him or herself (50%) and was yet unaware of this additional problem (10% overlap). We seldom met the ACA in this group who married into a stabilized system or who was not chemically dependent, as we observed in the multigenerational group. Our conclusion was that, generally, ACA's with current chemical dependency issues represent the predominant population of ACA's seeking assistance. Those not faced with current chemical dependency issues are, generally, not looking for help. In other words the ACA group at this beginning stage of its movement (this paragraph was originally written in 1987) is comprised of individuals who can identify childhood issues as factors, but not as readily identify current chemical dependency problems as primary concerns. Thus, we believe the samples from which the attraction theorist have drawn their conclusions, that is regarding ACA's seeking assistance, are skewed and substantially distort those conclusions.

Obviously, however, a considerable problem remains: children from alcoholic homes have approximately one chance in three of being assaulted twice by the trauma resulting from chemical dependency. Within this context, we believe that the chief value of the attraction theory as used by some professionals is that it motivates ACA's to address their childhood experiences resulting from chemical dependency. However, this value is considerably offset by the theory's telling the twice-victimized

spouse that he or she unconsciously chose the second relationship to meet "sick" needs. We believe that this sad and incorrect view perpetuates the trauma that has resulted from the spousal experience of alcoholism by supporting the spouse's survival view that if the experience was planned or contrived (unconsciously) then it was something that was wanted all along; if it was "wanted" then there could be no trauma to identify and resolve. In this scenario, the use of the attraction perspective becomes a means of denying the internal damage resulting from the most recently occurring trauma - trauma resulting from the spousal relationship.

Conclusion

The reader is likely to not be surprised to find that I end this section by concluding that the ETM approach to the treatment of multiple sources of trauma is well supported by my review of the literature.

Chapter 6

Authors: ETM TRT History

Nancy and I began developing ETM in 1979. We are the authors of all ETM materials copyrighted from 1981 - 2009. I began translating ETM to this (Internet) information system in 1994.

For health reasons (described in an addendum found at the end of this page), Nancy and I are retired from basic ETM clinical and management dissemination activities. I do, however, provide system administration for the Web based technical elements of the **Online Etiotropic Trauma Management – Trauma Resolution Therapy Training – Certification Program**. It is different from this tutorial in that the tutorial is available for free study and reference, and the online program attaches a fee for a full and structured professional facilitated curriculum. It provides database storage and processing of the student's (professional therapist – counselor – other manager) course conferencing discussions, forum, study, testing functions and other indicators of progression.

Chemical Dependency Family Counseling, Vietnam Combat, and Cost Accounting

As described later, Nancy and I developed ETM and TRT while participating in the chemical dependency profession as counselors, and consultants to and administrators of inpatient and outpatient settings. We were fortunate to train at institutions internationally recognized for their excellences and extraordinary advances in treatment of and social response to virtually all addiction permutations. The advances were particularly noted to include a primary focus on the family. That focus would result in the initiation of both ETM and TRT. In depth descriptions of those initiations and follow throughs are provided in the Professional / Academic / Development sections.

There were two more pre development factors. Both pertained to earlier skills and experiences taken from employments unrelated to counseling. In the first, I served a 4 year contract as an enlisted man with the United States Marine Corps. As a PFC, I worked in a combat role in Vietnam between 1965 and 1966. In one assignment, I was part of the first installation of Combined Action Programs. I, with two teams

comprised of 4 men each, lived in villages and worked in conjunction with limited (2 man teams) South Vietnamese militia to defend villagers against communist assault, and to support corpsmen as they provided healthcare to those villagers. In a second duty, I participated in many of the jobs attending helicopter operations. Upon returning home, I served the last two years (1967 and 1968) at Camp Pendleton, CA. As pertaining to that job's influences on ETM, I worked as an anti guerrilla warfare training NCO for the 5th Marine Division.

In hindsight, Those experiences gave me an affinity for, or capacity to assist, people affected by severe trauma. In addition, the experiences would also later in ETM's system application provide insight into the needs of organizations influenced by battle trauma. My book **Guerrilla Warfare's Pathogenesis and Cure** and attending crisis management programs were a direct consequence of my combat experiences. Where they relate to a counselor's training or patient's assistance, I'll make them available in limited translation.

In the second employment, I worked in the investment banking field. I received academic credentials, a BBA in Accounting and Management, from the University of Texas at Austin. I also earned a Registered Representative (of the NYSE and other financial institutions) license required in stockbroker and corporate finance activities. Like the combat, the accounting had a significant influence on TRT's development. Extinction of identity, which is ETM TRT theory of psychological trauma etiology, is a host of traumatic event caused and apparently scrambled contradictions to values, beliefs, images, and other realities. Myriad losses attend the contradictions, making the whole matter seem indecipherable. Scrignar (1987) stated that this damage was so overwhelming that it overloaded the psychodynamic helping model, making it impossible for clinician and patient to address the destruction. But were it not for the tools available to me and used in corporate finance to address complex cost accounting problems, there would have been no evaluative model from which to identify and clarify the consequences of traumatic events. When that identification – clarification was provided through the accounting framework, the solution to Scrignar's 'overload' followed. It dissipated immediately. In listening to hundreds of battering descriptions by spouses of chemically dependent persons and people with other kinds of trauma, the developing trauma consequences accounting model provided a view that facilitated the incremental codification of the etiology and its symptoms. That solution became the basis of resolution in Trauma 'Resolution' Therapy.

I attribute ETM's and TRT's developments primarily to the confluences of chemical dependency family clinical work, accounting business and Vietnam combat histories.

From Alcoholism Counseling to Psychological Trauma Professional Leadership

Because alcoholism counselors are usually not looked to for clinical, professional, or academic leadership in the field of psychological trauma, 3 questions pertaining to our background - credentials, and thus ETM's TRT's credibility, merit answers.

How and why did such people, alcoholism and drug abuse counselors:

1. become involved in the psychological trauma field?
2. produce a clinical/prevention management model different from that which dominates the psychological trauma discipline?
3. create an academic curriculum and certification program for the transfer of the ability and authority to use the models by professionals of all disciplines?

Detailed answers may be found at Professional / Academic / Development. The rest of this 'Authors: ETM History' overview summarizes them.

Development Environment - Responsibilities

Beginning in the late 1970's we started (in Texas), with consultation from the Johnson Institute of Minnesota, a family intervention chemical dependency and violence prevention program. It quickly became a clinical treatment process for spouses / family members of alcoholics, alcoholics and other drug addicted people, and eventually anyone afflicted by chemical dependency induced traumatic life experiences.

Having considerable success with these efforts, we opened and managed an additional 5 facilities. Importantly, all were government licensed (the first in the state) or JCAH accredited, which authorities mandated annual detailed audits. They required extensive explanation, definition and rigorous defense by us of theory and methodology as they pertained to client progress. All phases of care, to include entry, treatment planning, acute and continuing care (the latter lasting no less than 2 years) were monitored for progress by the auditing process. Making compliance considerably more complex than other (competing individually - intrapsychically focused) approaches, patient families participated and were charted fully over the entire 2 year period, with each member (to 5 - 7 years of age) having his or her own

peer group, individual counseling and interactive family group therapy (3 to 4 families per group).

Other factors influenced our efforts. All facilities were multi- disciplined. Subsequently, they were staffed with Social workers, Alcoholism and Drug Abuse Counselors, Psychologists, Psychiatrists and other mental health workers, all licensed in their respective professions. Moreover, these people routinely interacted through our facilities in intervention, treatment and case management circumstances with the courts, probation departments, children protective services, police (including domestic violence units), family service centers, correction, and parole administration elements of our communities.

As CEO, clinical directors, primary owners of the facilities and authors of ETM, Nancy and I had several responsibilities that in meeting, strengthened ETM's early development. First, we were required to understand fully the various doctrines (theories and methodologies) accompanying the staff's many training backgrounds. Second, those understandings had to be interpreted so that the otherwise often competing modalities became integratable with our developing ETM approach (next paragraph) into a homogeneous clinical model. Third, we ensured that it complied with the stringent facility licensing auditing processes, formalizing it into facility clinical and management protocols. Unlike circumstances where other academically credentialed professionals, for example, an MD Psychiatrist, might be in charge of a facility or individual case management, by virtue of the licensing - compliance processes, the formalized protocols, and the knowledge of our own model, we bore and met those duties and all attending final responsible parties.

Producing a Different Clinical Psychological Trauma Theory and Methodology

The referenced 'developing model' (preceding paragraph) originated from use of the Johnson intervention approach (Johnson, 1980 Select 'References' #127). For the purpose of getting the drug dependent person into a treatment environment, the model required a focus by family members upon the chemically dependent person's drug use behaviors. Because they were very often traumatic, the model elicited considerable pain from family members as the events were recalled.

Making a major change (1979 - 1981) from the Johnson approach, we concluded that the first priority, as opposed to that of getting the chemically dependent person into treatment, should be upon the family members' pain, facilitating them to identify,

understand and reconcile its intrapsychic, interactional and systemic origins. They were always the trauma-induced erosions to family member identity (values, beliefs, self - family images, and other realities) that were caused by the chemically dependent person's drug - using behaviors. We referred to this destruction as the trauma's etiology.

Having listened to many hundreds of these identification and reconciliation efforts, we found repeating presenting patterns in the process. Codifying them, we invented a series of written and patient - therapist interactive procedures that when utilized by the therapist and family members, strengthened their capacities to negotiate the patterns more effectively and efficiently, culminating in the straightforward address, and thus eventually what came to be our model's definition, of trauma etiology's 'reversal', or 'resolution.'

The procedures comprise ETM's referenced structured approach. It was and is named Trauma Resolution Therapy (TRT). ETM derives its base name, 'Etiotropic,' from that structure's focus upon, and resolution / reversal of, trauma etiology.

At the time (1979 - 1985), virtually everyone else (clinically speaking) used a symptom - behavioral (Nosotropic) approach. It identified untoward family member behaviors and attempted to correct, change, control them, defining their etiologies, in some Nosotropic ideological variations, as neurosis stemming from childhood developmental issues. Spouses of chemically dependent (and violent) people were seen through the prism of the Nosotropic model as attracting to the trauma. Other ideas interpreted aberrant systemic activity as dysfunctional, ascribing its etiology to unlearned communications skills. The learning failures had been passed down intergenerationally. Subsequently, the Nosotropic approach provided no definition of and treatment response to the etiology resulting from the drug use behavior caused trauma.

Eventually, TRT was found to provide the same treatment benefits to all trauma victims. Along with this application, it became our responsibility to define, convey and otherwise dispense ETM and TRT clinical theories and methodologies to interested professionals. Increasingly more often than not, those professionals did not practice, or interpret themselves as practicing, in the chemical dependency intervention - treatment environments.

System Management and Violence Prevention

From an organizational management perspective, ETM was first developed to implement TRT in treatment facility settings. Secondly, ETM provided a management theory and methodology for consultations to the referenced community social management resources. Thirdly, and most importantly, our work with treatment of trauma victims, intervention on perpetrators, and done in conjunction with referenced community social, educational, and legal service resources, produced our ETM theory and plans for preventing violence within our culture.

Transition: Focus on Education

During a very difficult financial time for all of Texas, the mid 1980's, we ended our direct service activities and created the academic and certification programs that now convey the skills and the authority required to administer the models to the public. The programs, which include the ETM Professional Training School and this ETM Tutorial, are a synthesized compendium of the body of actual and academic work produced over the past 26 years (now updated at year 2004).

In 1986 we were asked by the University of Houston's chemical dependency counselor's course to provide an advanced curriculum based on the ETM TRT model. We did and it was taught until 1990 when at that time we were contacted by other academic systems to teach our school through them. We did. ETM TRT got additional history of teaching around the state of Texas, and next door in Louisiana. We built several curriculums. One taught clinical applications of ETM TRT to treatment programs, including private practices. Another had a background in combat and was designed for the military. A third emphasized crisis management in Schools, to include a focus on near term trauma addressed by ETM TRT. And a fourth demonstrated ETM TRT application on the EAP industry model. All models were taught through such academic and other programs like the University of Texas El Paso, Permian, School of Public Health University of Texas, University of Houston, clinical hospitals, Austin Independent, Fort Worth, Dallas and 150 plus other districts in Texas. The work with combat chaplains for the US Army produced the book today called Guerrilla Warfare's Pathogenesis and Cure. Their needs and the system work done in schools, police departments, EAPs, children protective services, and etc. contributed to the development of the Strategic Application of ETM theory and implementation. That model was studied by one of our school districts (client) who before hand studied competing models. After applying ours through to September, 1994, the program's leadership was invited by the management of the Texas

Education Agency to present its findings to the Annual Symposium of Principals, Superintendents and Counselors. The 6000 participants heard that ETM TRT was the best of the programs studied and the recommendation that every principal and counselor in Texas should be ETM TRT trained and certified.

As you can see under the Health Addendum below the next heading, we were unable to follow through with statewide delivery for health reasons. In fact, excepting the work of trainers and certified clinicians, ETM TRT has been withdrawn from our contributions since that time in 1995, when the health problems began to intrude on academic activities, and until now, when some improvements in my treatments are allowing limited return to the ETM TRT training certification work in late 2004 and early 2005.

Deserving of its own emphasis, the academic effort included (by itself) a 2 year investigation of, and engendering of a theory for, psychological trauma etiology's substrate. I did this because no one else (all focusing on the Nosotropic substrate) had, and our clinical approach defined etiology as no one else had either (at the time; 1991 - 1994). It was the first dissertation on the subject. Ten years later, it is still the primary consideration of the neurobiology of psychological trauma etiology and its reversal with ETM.

For you to appropriately use ETM and TRT, you will eventually have to evaluate for yourself whether or not this author's academic study and research supports their (ETM TRT) theories and methods. Also speaking for my wife, we wish you good luck and hope that all of the sections and the online ***ETM TRT Training Certification School*** are valuable to your pursuit of trauma's understanding and resolution for your patients, clients and associates.

Addendum regarding health influence on ETM TRT's dissemination:

In 1995 and 1996, at the height of our installation of trauma crisis management systems for school districts (161) in Texas (see the paragraphs above), Nancy and I each sustained major depreciations in health. They not only stopped the ETM work with schools, but have gone on to affect this life's work, apparently, we are told, forever. For Nancy, she was found to have and treated for breast cancer. Compounding the difficulties of her situation, within the year a truck lost control on the other side of the highway and came into our lane, hitting us head-on. Nancy sustained brain injury, a malady that still adversely affects her. At the beginning of 1996, I was in a bizarre oral surgery accident where a suction apparatus was used and

intended to retrieve a lost tooth root tip. The device when applied within the walls of the maxillary sinus became entangled in the major Trigeminal facial and cranial nerves, causing me irreparable damage, manifested by chronic pain – now atypical Trigeminal Neuralgia. I'm told that this is a lifetime condition, as is Nancy's brain injury. The Trigeminal Neuralgia has neurological ramifications that retard my professional and social skills dramatically, enough to have placed our trauma management activities on hold for about a decade until 2006. I'm formerly disabled by the injury 100%. We have an experimental brain surgery planned for this year should treatment providers agree. Nancy was diagnosed at the end of 2006 with Lymphatic Leukemia, usurping her energies and my time. This cancer is addressed constantly and has yet to enter remission.

The work I do with ETM TRT is now done within the context and limitations of the condition. I have limited speaking capacities, reducing my communications on the phone and bringing an end altogether to educational presentations. While new medicines are allowing me to reconnect to the work process through writing, I still rely on ETM TRT Trainers to maintain most contact with clients. I'm grateful to them for their steadfast efforts when filling in for me.

I am grateful most of all that my wife's Breast cancer condition has been in remission now for 9 years following the surgeries and radiation treatments. Regrettably, however, the Lymphatic – Leukemia continues its adverse influences upon her and as her helper my life.

Chapter 7

Finding an Evaluation Criterion for Trauma's Resolution

ETM Tutorial section Professional / Academic / Theory / Measuring for Trauma Resolution describes the ETM method for measuring for trauma's resolution.

Until the time of this (1992) 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 nosotropic 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.

- 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.

- **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*:

- 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.
- the TRT participant does not use drugs (including the social use of alcohol) at any time throughout the therapeutic process.
- the therapist does not use drugs (including social use).
- the person does not suffer additional physiologically-based mental illnesses (for example, manic depression or schizophrenia).
- 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.
- 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*.

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**This chapter serves as the bibliography
for the entire Etiotropic Series**

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