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DISTRESS REDUCTION AND AFFECT REGULATION TRAINING

As described in Chapter 2, treatment-seeking trauma survivors often experience chronic levels of anxiety, dysphoria, and posttraumatic arousal. Many also describe extremely negative emotional responses to trauma-related stimuli and memories—feeling states that are easily triggered and hard to accommodate internally. When faced with overwhelming arousal, distress, and/or emotionally laden memories, the survivor is often forced to rely on emotional avoidance strategies such as dissociation, substance abuse, or external tension reduction activities. Unfortunately, as described in Chapter 8, excessive avoidance often inhibits psychological recovery from the effects of traumatic events. In the worst case, the need to avoid additional posttraumatic distress may lead the hyperaroused or emotionally dysregulated client to avoid trauma-related material during therapy, or to drop out of treatment altogether. As well, emotional states that are aversive enough to overwhelm available affect regulation resources may negatively affect the client's perception of the treatment process and the psychotherapist.

This chapter describes two sets of interventions: those intended to reduce acute, destabilizing emotions and symptoms that emerge during the treatment process, and those focused on the client's more general capacity to regulate negative emotional states. This material is presented early in the treatment part of the book because, in some cases, high anxiety and/or low affect regulation capacity should be addressed before more classic trauma therapy (for example,

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emotional processing) can be fully accomplished (Chu, 2011; Cloitre et al., 2011; Courtois, 2010; Ford et al., 2005). The interventions outlined here can be used at any point during therapy, however. For example, although the relaxation techniques described in this chapter may be initiated early in treatment, these and other approaches to affect regulation may be relevant whenever the survivor experiences escalating or intrusive negative internal states. In addition, the intrinsic development of affect regulation skills usually occurs in the context of repeated exposure to—and processing of—trauma-related emotions, a phenomenon that progressively unfolds as treatment continues.

The techniques presented here are variously described in the trauma and anxiety literature as forms of "grounding," relaxation training, cognitive therapy, stress inoculation, meditation, and anxiety management. However labeled, these approaches all focus on the client's increased capacity to tolerate and down-regulate painful emotional states, both during treatment and in his or her ongoing life.

DEALING WITH ACUTE INTRUSION: GROUNDING

Although much of this chapter is devoted to increasing trauma survivors' affect regulation skills, there are occasions when the clinician may have to intervene more directly in a client's emotional dysregulation. For example, in response to some triggering stimulus or memory, the client may experience sudden panic, flashbacks, intrusive negative thoughts, dissociative states, or even transient psychotic symptoms during therapy. These internal processes can be frightening—if not destabilizing—to the client and can diminish his or her moment-to-moment psychological contact with the therapist. At such times, it may be necessary to refocus the survivor's attention onto the immediate therapeutic environment (with its implicit safety and predictability) and the therapist-client connection.

This intervention, often referred to as *grounding,* can be quite helpful in acute situations. It is also, however, by its very nature, potentially disruptive to the treatment process. Grounding techniques tend to alter the immediate narrative/relational stream of psychotherapy, and run the risk of implying that something is going awry, such that a sudden, "emergency" procedure is required. For this reason, grounding should only be used when clearly indicated, should be adjusted to the minimal level necessary to reduce the client's internal escalation, and should be framed in such a way that it does not

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stigmatize the client or overdramatize the experience. In some cases, other therapeutic interventions may be just as effective, such as gently moving the client's narrative into more cognitive or less emotionally intense aspects of whatever is under discussion (see Chapter 8), or by engaging in some other intervention that does not involve an obvious change in focus.

If, despite these concerns, grounding is indicated (that is, the client is acutely overwhelmed by intrusive symptoms or escalating trauma memories, and psychological contact with the therapist is diminishing), we suggest the following general steps.

1. *Attempt to focus the client's attention onto the therapist and therapy,* as opposed to whatever internal processes are occurring. This may involve—to the extent that it does not trigger the client—shifting one's chair slightly closer to him or her, unobtrusively moving into his or her visual field, or slightly changing one's voice so that it compels more attention. This does not mean, of course, that the therapist yells at the client or behaves in an unduly intrusive manner. In addition, it usually does not suggest that one should touch the client, since physical contact can intensify the client's fear or sense of invasion, or trigger memories. Whether to touch or not is contingent on the specifics of the situation, including, for example, the nature of the trauma and whether the therapist is well known to the client and trusted by him or her.

2. *Ask the client to* briefly *describe his or her internal experience.* For example, "Susan, is something going on/upsetting you/happening right now?" If the client is clearly frightened or responding to distressing internal stimuli, but can't or won't describe them, go to Step 3. If the client is able to talk about the internal experience, however, it is often helpful for him or her to generally label or broadly describe it. This does not mean the survivor should necessarily go into great detail—detailed description of the flashback or memory may increase its intensity, thereby reinforcing the response rather than lessening it.

3. *Orient the client to the immediate, external environment.* This often involves two, related messages: (a) that the client is safe and is not, in fact, in danger, and (b) that he or she is *here* (in the room, in the session, with the therapist) and *now* (not in the past, undergoing the trauma). In some cases, the client can be oriented by reassuring statements, typically using the client's name as an additional orienting device (for example,

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"Susan, you're okay. You're here in the room with me. You're safe."). In other, more extreme cases, grounding may involve asking the client to describe the room or other aspects of the immediate environment (for example, "Susan, let's try to bring you back to the room, okay? Where are we?/What time is it?/Can you describe the room?"). The client might be asked to focus his or her attention on the feeling of the chair or couch underneath him or her, or of his or her feet on the floor. However accomplished, the client's reorientation to the here and now may occur relatively quickly (for example, in a few seconds) or may take longer (for example, a number of minutes).

4. *If indicated, focus on breathing or other methods of relaxation.* This is an example of when breath or relaxation training (as described later in this chapter) can be especially helpful. Take the client through the relaxation or breathing exercise for as long as is necessary (typically for several minutes or longer), reminding the client of his or her safety and presence in the here-and-now.

5. Repeat Step 2, and assess the client's ability and willingness to return to the therapeutic process. Repeat Steps 3 and 4 as needed.

If it is possible for therapy to return to its earlier focus, normalize the traumatic intrusion (for example, as a not-unexpected part of trauma processing) and the grounding activity (for example, as a simple procedure for focusing attention away from intrusive events), and continue trauma treatment. It is important that the client's temporary reexperiencing or symptom exacerbation be neither stigmatized nor given greater meaning than appropriate. The overall message should be that trauma processing sometimes involves the intrusion of (and distraction by) potentially upsetting memories, thoughts, and/or feelings, but that such events are part of the healing process, as opposed to evidence of psychopathology or loss of control.

INTERVENING IN CHRONIC AFFECT DYSREGULATION

In contrast to grounding, which addresses relatively acute emotional intrusions or activations, this section describes psychological interventions in the sustained hyperarousal and anxiety experienced by many survivors of major, chronic trauma.

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Medication

When dysphoria or posttraumatic arousal is of sufficient intensity that it interferes with treatment and recovery, psychoactive medications may be indicated. As described in Chapter 12, pharmacologic agents that target anxiety and/or hyperarousal, or stabilize mood, sometimes may be helpful in reducing such symptoms during trauma-focused psychotherapy. As also noted, however, such medications are not a cure-all for dysregulated emotional states; their efficacy is variable from case to case and may be counterindicated in some instances because of significant side effects. Often, the best approach to high pretreatment arousal and anxiety is to use psychiatric medication, if necessary, but also to apply psychological interventions that reduce anxiety and increase affect regulation skills, as described in this chapter.

Relaxation and Breath Control

One of the most basic forms of arousal reduction during therapy is learned relaxation. Strategically induced relaxation can facilitate the processing of traumatic material during the therapy session by reducing the client's overall level of anxiety. Reduced anxiety during trauma processing both lessens the likelihood the client will feel overwhelmed by trauma-related distress and probably serves to countercondition traumatic material, as described in Chapter 8. In addition, relaxation can be used by the survivor outside of treatment as a way to reduce the effects of triggered traumatic memories. For individuals with especially easily activated anxiety or intrusive reexperiencing, the benefits of calling upon an internal relaxation mechanism cannot be overstated.

There are two general approaches to relaxation training, *breath training* and *progressive relaxation,* both of which are described only briefly here. For more detailed information, the reader should consult the Suggested Reading list at the end of this chapter.

Progressive Relaxation

This technique involves clenching and then releasing muscles, sequentially from head to toe, until the entire body reaches a relaxed state (Jacobson, 1938; Rimm & Masters, 1979). As clients practice progressive relaxation on a regular basis, most are eventually able to enter a relaxed state relatively quickly, if not

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automatically. Some practitioners begin each session with relaxation exercises; others teach it initially in treatment, then utilize it only when specifically indicated, for example, when discussion of traumatic material results in a high state of anxiety. Two points should be made about the use of relaxation training in the treatment of posttraumatic stress: (1) use of this technique alone (that is, in the absence of coexisting trauma-processing activities) is unlikely to significantly reduce trauma-related symptoms, per se (Rothbaum, Meadows, Resick, & Foy, 2000), and (2) clinical experience suggests that a minority of traumatized individuals may have unexpected anxious or dissociative reactions to induced relaxation (for example, Allen, 2001; Fitzgerald & Gonzalez, 1994) or may not be able to successfully self-induce a relaxed state. Those who are chronically flooded with flashbacks and other reexperiencing symptoms may be less likely to gain from relaxation training (S. Taylor, 2003). In our experience, progressive relaxation can be quite helpful, when indicated, but the client should be monitored for possible, seemingly paradoxical, increases in anxiety or arousal during this procedure.

Mindfulness-based Breath Training

Although progressive relaxation is successfully used by some clinicians, our preference—all other things being equal—is to teach breathing techniques. When stressed, many people breathe in a more shallow manner, hyperventilate, or, in some cases, temporarily stop breathing altogether. Teaching the client "how to breathe" during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client learns to breathe in ways that are more efficient and more aligned with normal, nonstressed inhalation and exhalation, there is usually a calming effect on the autonomic nervous system.

Breath training generally involves guided breathing exercises that teach the client to be more aware of his or her breathing—especially the ways in which it is inadvertently constrained by tension and adaptation to trauma—and to adjust his or her musculature, posture, and thinking so that more effective and calming respiration can occur (Best & Ribbe, 1995). There are a number of manuals that include information on breath training during trauma treatment (for example, Foa & Rothbaum, 1998; Rimm & Masters, 1979).

One simple breath training protocol, offered here, is Mindfulness-based Breath Training (MBBT)[1]. This exercise is very similar to the protocol

[1]A version of this protocol has been adapted for the treatment of acute burn survivors (Briere & Semple, 2013).

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presented in the earlier second edition of this book, except that it includes reference to mindful attention and slightly changed breath instruction.

First:

1. Explain to the client that learning to pay attention to breathing, and learning to breathe more slowly and deeply, can both help with relaxation and be useful for managing anxiety and, when relevant, pain. Note that when a person gets anxious or feels panic, one of the first things that happens is that his or her breathing becomes shallow and rapid. When we slow down fearful breathing, fear, itself, may slowly decrease.

Then:

2. Have the client rest in a comfortable position. This will typically involve sitting in a chair with his/her spine relatively straight, shoulders relaxed, hands on lap, and legs together with feet flat on the floor.
3. Go through the following sequence with the client -- the whole process should take about 10 to 15 minutes.
    a. If the client is comfortable with closing his or her eyes, ask him or her to do so. Some trauma survivors will feel more anxious with their eyes closed, and will want to keep them open. This is entirely acceptable.
    b. Ask the client to try to pay attention "just to breathing" while doing this exercise. If his or her mind wanders (e.g., thinking about the trauma, the future, or about an argument with someone) or he or she is distracted by physical pain, the client should gently try to bring his or her attention back to the immediate experience of breathing. Note that the client is not trying to suppress these distractions, but instead is only returning his or her attention to the breath. It may be helpful to suggest the image of breathing in peace and strength, and breathing out tension.
    c. Ask the client to begin breathing through the nose, paying attention to the breath coming in and going out. Ask him or her to pay attention to how long each inhalation and exhalation lasts, without trying to speed up or slow down his/her breaths. Do this for 3 breath cycles (sets of inhalation and exhalation).

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d. Instruct the client to start breathing more into his or her abdomen. This means that the belly should visibly rise and fall with each breath. It may be helpful to invite the client to place a hand on his or her abdomen so he or she can feel it rise with more diaphragmatic breathing. This sort of breathing should feel different from normal breathing, and the client should notice that each breath is deeper than normal. Ask the client to imagine that each time he or she breathes in, air is flowing in to fill up the abdomen and then lungs. It goes into the belly first, and then rises up to fill in the top of the chest cavity. In the same way, when breathing out, the breath first leaves the abdomen, and then the chest. Some clients find it helpful to imagine the breath coming in and out like a wave. Do this for another 2 or 3 breath cycles.

e. Explain that once the client is breathing more deeply and fully into the belly and chest, the next step is to slow the breath down. Ask him/her to slowly count to *three* with each inhalation, pause, then count to *four* for each exhalation – in for three counts, pause, then out for four counts. Remind the client that exhalation should take a little longer than inhalation. At the end of both inhalation and exhalation, the client should pause, and only beginning inhaling or exhaling again when he/she begins to feel the need to do so. The actual speed of the counting is up to the client, although it should be slower than usual. The client may need to experiment with the appropriate speed of breathing[2]. Once he or she has found the right speed, he or she should continue for 2 additional breath cycles.

f. Remind the client to focus his or her mind on counting during breathing, and to redirect his/her attention to counting whenever he or she gets distracted by pain or a thought, feeling, or memory. Encourage the client to focus his or her attention on the current moment, on counting within the breath, not on memories of the past or worry about the future, breathing in strength and peace, breathing out tension. Suggest that if the client does not recall what number he or she was on when he or she lost track, he or she should start again with "1" at the next inhalation. Note that is normal to loss track of counting, and that doing so is not "bad," but that he or

[2]With ongoing practice, some clients find that their breath slows further over time.

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she is learning to let go of these distractions; to stay in the present moment, while relaxing and breathing. The object is only to note that his or her attention has wandered away and to return attention to counting within the breath. The clinician should emphasize that it is not "bad" or "wrong" to get distracted by thoughts or feelings of pain in the body. Rather, it is important to just note that one's mind has wandered away, and then just to redirect attention to counting the breath.

4. At this point, have the client practice counting within breaths for another 5 minutes or so. Once 5 minutes have passed, invite the client to open his or her eyes (if they were closed), and come back to the room. Discuss with the client what his or her feelings and thoughts were during the exercise, and any problems that arose. Validate and support the client's willingness to do the exercise, and normalize any wandering of thoughts or distractions (e.g., "that's just what the mind does")—while at the same time encouraging the client to continue focusing on counting the breath and nothing else.

5. Ask the client to practice the breath counting part of this exercise by him- or herself for 5 to 10 minutes a day. He or she should choose a specific time (e.g., in the morning or evening), and make this exercise a regular part of his or her daily routine. Suggest he or she glance at a watch or clock when he or she thinks 5–10 minutes has passed, but not to look at the clock/watch too often. If the client does not have a watch, and no clock is available, he or she can just guess when 5–10 minutes has passed, and stop then. Appendix 2 contains a handout that the client can use to remind him- or herself of the steps of MBBT.

Eventually, the client can extend this exercise to additional times in the day as well, for example, during stressful situations or medical procedures, when in physical pain, or whenever he or she feels anxious. Importantly, MBBT is especially helpful in deescalating triggered negative emotional states during titrated exposure. For this reason, the clinician may choose to begin and/or end exposure sessions with MBBT, and use it midsession whenever therapeutic exposure is associated with destabilization or momentarily overwhelming emotional stress.

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After the first 1 or 2 sessions, inquire as to whether doing the exercise has yielded any benefits for the client, including decreased anxiety, pain reduction, or a greater ability to relax. If not, normalize the situation, stating that MBBT sometimes takes a while to work. If it is proving helpful, note and praise any progress.

It should be reiterated that although relaxation training of whatever type is often a helpful component of trauma therapy, it is not always necessary or indicated. Some clients are neither so hyperaroused nor so anxious that they require special intervention in this area. Other clients (and therapists) find relaxation training too mechanistic, or a distraction from the relational process of psychotherapy. Like some other techniques presented in this book, relaxation training is an option, not a requirement, for trauma treatment.

MEDITATION AND YOGA

Another approach to affect de-escalation and regulation involves (1) dispassionately noting negative, repetitive, and habitual thoughts and feelings, and then moving one's attention toward certain, other processes (for example, the breath), and/or (2) engaging in activities (for example, specific movements or physical positions) that produce positive states and preclude or lessen negative ones. The former is often referred to as *mindfulness meditation*, whereas the latter is best represented by *yoga*. Both approaches recently have been embraced as methods not only of affect regulation, but also potentially as interventions for trauma-related distress. Although these methodologies will be reviewed briefly below, the reader is referred to Briere (2012a); Emerson and Hopper (in press; 2011); Waelde (2004), and Chapter 10 for more detailed discussion.

Meditation

Meditation represents a broad category of inwardly directed practices, typically involving sitting or lying in a specific position, or walking in a certain way, while focusing on one's breath or some other internal sensation or process. In most instances, the meditator learns to maintain this attention for relatively long periods of time, noting inevitable distracting thoughts and feelings without judgment, then returning to his or her ongoing focus of

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attention. As described in Chapter 10, a number of studies indicate that meditation has positive effects on both physical and psychological well-being, generally by reducing stress, increasing equanimity, and, sometimes, prompting existential insights about the basis of suffering. Among the positive impacts noted in the literature are improved blood pressure and other cardiovascular functions, and reduced psychological or physiological problems, ranging from fibromyalgia and chronic pain to anxiety, depression, substance abuse, eating disorders, aggression, and posttraumatic distress (Bormann, Liu, Thorp, & Lang, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Rosenthal, Grosswald, Ross, & Rosenthal, 2011; T. L. Simpson et al., 2007; see, also, Chapter 10). Although it is not entirely clear exactly how meditation impacts stress, it seems likely that it decreases arousal of the autonomic nervous system, reduces preoccupation with negative or upsetting thoughts, lessens psychological reactivity, and broadens psychological perspective. For these and related reasons, meditation is increasingly suggested by clinicians—empirically oriented and otherwise—for those suffering from trauma-related symptoms, although not without some cautions and contraindications, as described in Chapter 10.

Yoga

Like meditation, yoga is a contemplative exercise that, over time, appears to improve psychological and physical functioning (Emerson & Hopper, 2011). Involving careful stretching, and specific movements, postures, and positions in specific sequences, it also includes attention to breath, meditation, relaxation, diet, and a specific philosophical perspective. Yoga not only appears to calm the mind, but it also may increase physical strength, flexibility, and capacity, with associated reductions in psychophysiological stress (R. P. Brown & Gerbarg, 2009; Harvard Mental Health Letter, 2009). Recent research suggests that regular involvement in yoga practice may be associated with improvements in posttraumatic stress, anxiety, and depression (R. P. Brown & Gerbarg, 2009; Descilo et al., 2009; Janakiramaiah et al., 2000), although some studies have significant methodological flaws.

Obviously, meditation and/or yoga is not for everyone, and many trauma survivors do not begin such practices solely as a method of stress reduction or affect regulation. However, many trauma-exposed people find themselves drawn to such contemplative practices and gain significantly from them.

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Increasing General Affect Regulation Capacity

Above and beyond immediate methods of distress reduction, such as grounding, relaxation, and meditation or yoga, there are a number of suggestions in the literature for increasing the general affect regulation abilities of trauma clients. All are focused on increasing the survivor's overall capacity to tolerate and down-regulate negative feeling states, thereby reducing the likelihood that he or she will be overwhelmed by activated emotionality. In some cases, such affect regulation "training" may be necessary before any significant memory processing can be accomplished (Cloitre et al., 2011; Courtois, 2010).

Identifying and Discriminating Emotions

One of the most important components of successful affect regulation is the ability to correctly perceive and label emotions as they are experienced (Linehan, 1993a). Many survivors of early, chronic trauma have trouble knowing exactly what they feel when activated into an emotional state, beyond, perhaps, a sense of feeling "bad" or "upset" (Briere, 1996; Luterek, Orsillo, & Marx, 2005). In a similar vein, some individuals may not be able to accurately differentiate feelings of anger, for example, from anxiety or sadness. Although this sometimes reflects dissociative disconnection from emotion, in other cases it appears to represent a basic inability to "know about" one's emotions. As a result, the survivor may perceive his or her internal state as consisting of chaotic, intense, but undifferentiated emotionality that is not logical or predictable. For example, the survivor triggered into a seemingly undifferentiated negative emotional state will not be able to say, "I am anxious," let alone infer that "I am anxious because I feel threatened." Instead, the experience may be of overwhelming and unexplainable negative emotion that comes "out of the blue."

The clinician can assist the client in this area by regularly facilitating exploration and discussion of the client's emotional experience. Often, the client will become more able to identify feelings just by being asked about them on an ongoing basis. On other occasions, the therapist can encourage the client to do "emotional detective work," involving attempts to hypothesize an experienced emotional state based on the events surrounding it (for example, the client guessing that a feeling is anxiety because it follows a frightening stimulus, or anger because it is associated with resentful cognitions or angry behaviors). Affect identification and discrimination sometimes can be fostered by the therapist's direct feedback, such as "It looks like you're feeling angry. Are

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you?" or "You look scared." This option should be approached with care, however. There is a certain risk of labeling a client's affect as feeling *A* when, in fact, the client is experiencing feeling *B*—thereby fostering confusion rather than effective emotional identification. For this reason, we recommend that, in all but the most obvious instances, the therapist facilitate the client's exploration and hypothesis testing of his or her feeling state, rather than telling the client what he or she is feeling. The critical issue here is not, in most cases, whether the client (or therapist) correctly identifies a particular emotional state, but rather that the client explores and attempts to label his or her feelings on a regular basis. In our experience, the more this is done as a general part of therapy, the better the survivor eventually becomes at accurate feeling identification and discrimination.

Identifying and Countering Thoughts That Antecede Intrusive Emotions

It is not only feelings that should be identified—in many cases, it is also thoughts. This is most relevant when a given cognition triggers a strong emotional reaction, but the thought is somehow unknown to the survivor. As suggested by some clinicians (for example, Cloitre et al., 2002; Linehan, 1993a), affect regulation capacities often can be improved by encouraging the client to identify and counter the cognitions that exacerbate or trigger trauma-related emotions. Beyond the more general cognitive interventions described in Chapter 7, this involves the client monitoring whatever thoughts mediate between a triggered traumatic memory and a subsequent negative emotional reaction. For example, upon having child abuse memories triggered by an authority figure, the survivor may have the unconscious or partially suppressed thought, "He is going to hurt me," and may then react with extreme anxiety or distress. Or the survivor of sexual abuse might think, "She wants to have sex with me," when interacting with an older woman, and then may experience revulsion, rage, or terror. In such cases, although the memory itself is likely to produce negative emotionality (conditioned emotional responses, or CERs; see Chapter 8), the associated cognitions often exacerbate these responses to produce more extreme emotional states. In other instances, thoughts may be less directly trauma related, yet still increase the intensity of the client's emotional response. For example, in a stressful situation the client may have thoughts such as "I'm out of control" or "I'm making a fool of myself" that produce panic or fears of being overwhelmed or inundated.

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Unfortunately, because triggered thoughts may be out of superficial awareness, their role in subsequent emotionality may not be observed by the survivor (Beck, 1995). As the client is made more aware of the cognitive antecedents to overwhelming emotionality, he or she can learn to lessen the impact of such thoughts. In many cases, this is done by explicitly disagreeing with the cognition (for example, "Nobody's out to get me," or "I can handle this"), or merely by labeling such cognitions as "old tapes" rather than accurate perceptions (Briere, 1996; see also Chapter 10). In this regard, one of the benefits of what is referred to as *insight* in psychodynamic therapy is often the self-developed realization that one is acting in a certain way by virtue of erroneous, "old" (for example, trauma- or abuse-related) beliefs or perceptions—an understanding that often reduces the power of those cognitions to produce distress or motivate dysfunctional behavior (see Chapter 7).

When the thoughts that underlie extremely powerful and overwhelming emotional states are triggered by trauma-related memories, the therapist can focus on these intermediate responses by asking questions such as "What happened just before you got scared/angry/upset?" or "Did you have a thought or memory?" If the client reports that, for example, a given strong emotion was triggered by a trauma memory, the therapist may ask him or her to describe the memory (if that is tolerable) and to discuss what thoughts the memory triggered. Ultimately, this may involve exploration and discussion of four separate phenomena:

1. The environmental stimulus that triggered the memory (for example, one's lover's angry expression)

2. The memory itself (for example, of maltreatment by an angry parent)

3. The current thought associated with the memory (for example, "He/She hates me," "I must have done something wrong," or "He/She is blaming me for something I didn't do")

4. The current feeling (for example, anger or fear)

These triggered, often catastrophizing cognitions (that is, expectations or assumptions of extremely negative outcomes) can then be discussed as to their relevance to the current situation. In such instances, the client is generally asked to explore the accuracy of such thoughts, their possible etiology (often involving childhood abuse, neglect, or other maltreatment), and what he or she

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could do to address such thoughts (for example, remind himself or herself that the thought is not accurate or that it is "just my childhood talking"). As the client becomes better able to identify these cognitions, place them in some realistic context, and counter them with other, more positive thoughts, he or she often develops greater capacity to forestall extreme emotional reactivity, and thereby better regulate the emotional experience.

Trigger Awareness and Intervention

There is another cognitive intervention that can help the survivor maintain emotional equilibrium in his or her daily life: The clinician can help the survivor learn to identify and address triggers in the environment that activate intrusive negative feelings. Although, as noted in Chapter 2, activated memories of trauma are not intrinsically negative phenomena, they can motivate behaviors that—although sometimes effective in reducing triggered distress—may be maladaptive or even self-destructive in contexts where attention and adaptive strategies would be more helpful. Successful trigger identification can facilitate a greater sense of control and better interpersonal functioning by allowing the client to alter situations in which these triggers might occur and problem-solve emerging negative states before they produce behavioral problems. Ultimately, as noted later, trigger interventions help increase affect regulation and tolerance.

Trigger identification and intervention is generally learned as a regular component of therapy, so that it can be called upon later when the survivor encounters a trigger in his or her environment. Importantly, it is often hard to figure out exactly what to do when one has been triggered; it is better to have previously identified the trigger (among others), its etiology, and its solutions, in the context of therapeutic guidance and support.

As described by one survivor, the development of intervention strategies prior to being triggered is like creating a "message in a bottle": preplanning about what to do when triggered (the "message") can be developed for later use (placed in a "bottle") and called upon once the individual is triggered (the bottle "floats" to the triggered circumstance, allowing a more measured and thought-out approach to what otherwise might be a crisis situation).[3]

[3]Another, more structured version of trigger identification and intervention, specifically targeted at adolescents and young adults, involving a "trigger grid" worksheet, can be found in Briere and Lanktree (2011) and at http://johnbriere.com.

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In this regard, trigger identification can be taught as a series of tasks:

1. *Identify a given thought, feeling, or intrusive sensation as posttraumatic*. This is relatively easy in some cases. For example, it may not be difficult to recognize an intrusive sensory flashback of a gunshot as trauma related. In others, however, the reexperiencing may be more subtle, such as feelings of anger or fear, or intrusive feelings of helplessness that emerge during relational interaction. Typical questions the client can learn to ask himself or herself include the following:
   - Does this thought/feeling/sensation "make sense" in terms of what is happening around me right now?
   - Are these thoughts or feelings too intense, based on the current context?
   - Does this thought or feeling carry with it memories of a past trauma?
   - Am I experiencing any unexpected alteration in awareness (for example, depersonalization or derealization) as these thoughts/feelings/sensations occur?
   - Is this a situation in which I usually get triggered?

2. *Evaluate stimuli present in the immediate environment, and identify which are trauma reminiscent* (that is, "find the trigger"). This typically involves a certain level of detective work, as the client learns to objectively evaluate the environment to see what might be trauma reminiscent, and thus potentially a trigger. Examples of triggers the client might learn to recognize, depending on his or her trauma history, include these:
   - Interpersonal conflict
   - Criticism or rejection
   - Sexual situations or stimuli
   - Interactions with an authority figure
   - People with physical or psychological characteristics that are in some way similar to the client's past perpetrator(s)
   - Boundary violations
   - Sirens, helicopters, gunshots
   - The sound of crying

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In some cases, the trigger will be obvious and easily recognized. In others, the client may have to work hard to identify what may be triggering him or her.

3. *Employ an adaptive strategy.* This usually involves some version of "improving the moment" (Linehan, 1993a, p. 148), whereby the survivor reduces the likelihood of an extreme emotional response. Examples include the following:

   - Intentional behavioral avoidance or "time outs" during especially stressful moments (for example, leaving a party when others become intoxicated, intentionally minimizing arguments with authority figures, learning how to discourage unwanted flirtatious behavior from others)
   - Analyzing the triggering stimulus or situation until a greater understanding changes one's perception and thus terminates the trigger (for example, carefully examining the behavior of an individual who is triggering posttraumatic fear, and eventually becoming more aware of the fact that he or she is not acting in a threatening manner; or coming to understand that a given individual's seemingly dismissive style does not indicate a desire to reject or ignore as much as it does interpersonal awkwardness)
   - Increasing support systems (for example, bringing a friend to a party where one might feel threatened, or calling a friend to "debrief" an upsetting situation)
   - Positive self-talk (for example, working out beforehand what to say to oneself when triggered, such as "I am safe," "I don't have to do anything I don't want to do," or "This is just my past talking, this isn't really what I think it is")
   - Relaxation induction or breath control, as described earlier in this chapter
   - Strategic distraction, such as starting a conversation with a safe person, reading a book, or going for a walk, as a way to pulling attention away from escalating internal responses such as panic, flashbacks, or catastrophizing cognitions
   - Delaying tension reduction behaviors (TRBs; see Chapter 2) and "urge surfing" (see Chapter 10). These strategies can be especially helpful for the triggered survivor, and thus are described in detail next.

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Delaying Tension Reduction Behavior

Triggered phenomena can be reduced by intentionally forestalling TRBs until they become less probable or lose some of their power. In general, this involves encouraging the client to "hold off," as long as possible, on behaviors that he or she normally would use to reduce distress when triggered (for example, self-mutilation, impulsive sexual behavior, or binging/purging) and then, if the behavior must be engaged in, doing so to the minimal extent possible (Briere & Lanktree, 2011).

There are probably at least two important aspects of this strategy. First, many survivors learn that their TRB responses are to some extent reflexive: Given sufficient attention and thought, such behaviors could be delayed or avoided without too much difficulty. For example, a person whose immediate response upon being triggered into a negative state is to self-injure might discover that, in fact, the upsetting feeling was ultimately tolerable, and that his or her threshold for self-mutilation was, in that instance, unnecessarily low. Second, as noted by Marlatt and Gordon (1985) and others, many triggered emotional states that otherwise would motivate a TRB or episode of substance abuse have a relatively short half-life: If the individual can sit out the activated emotional state, it will often pass in a matter of minutes, thereby obviating the need for maladaptive behavior.

Urge Surfing

Regarding the limits of activated distress, the client may be taught to "urge surf" (Bowen, Chawla, & Marlatt, 2011), as described in greater detail in Chapter 10. When triggered into a state in which a TRB is likely (for example, rage associated with a memory of childhood abuse), the client can attempt to enter a mindful perspective (as presented in Chapter 10) and then, rather than act, "ride out" or "surf" the emotion and associated urge to tension reduce, until it peaks and then fades away. Notably, in both delaying and urge surfing, the survivor does not try to suppress triggered thoughts or feelings, but rather changes his or her relationship to them.

Although the therapist should take a clear stand on the harmfulness of most TRB responses to triggering, and work with the client to terminate or at least decrease their frequency and injuriousness, he or she should not appear to judge the client regarding TRBs: Value judgments about the wrongness or immorality of a given behavior—other than activities that harm others—are rarely helpful. Such statements not only increase guilt and shame, but they

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often "drive the therapy underground" by forcing the client to keep things (in this case, continued tension reduction) from the therapist.

Because TRBs ultimately serve to reduce distress, client attempts to delay their use (or "surf" them) provide opportunities to develop affect tolerance. For example, in the delay approach, if a survivor is able to try to not binge eat or act on a sexual compulsion following a triggering situation, if only for a few minutes beyond when he or she would otherwise engage in such activity, two things may happen:

1. The client may be exposed to a brief period of sustained (but temporarily manageable) distress, during which time he or she can learn a small amount of distress tolerance.
2. The impulse to engage in the TRB may fade, because the emotionality associated with the urge to engage in the TRB often lessens if not immediately acted upon.

With continued practice, the period between the initial triggered experience and the actual TRB may be lengthened, the TRB itself may be decreased in severity, and affect tolerance may be increased. An added benefit of this approach is that the goal of decreasing (and then ending) TRBs is seen as not stopping "bad" behavior, but rather as a way for the client to learn affect regulation and to get his or her behavior under greater personal control.

Importantly, inherent in either of these approaches is the possibility that it will not be entirely successful. It is an unavoidable fact of clinical life that tension reduction and other avoidance behaviors are survival based and are therefore not easily given up by the client. Nevertheless, by empowering the survivor to engage ("allow") the aversive state and consciously attempt to change his or her normal response to it, the circumstance is also changed and new behavior is often possible.

Affect Regulation Learning During Trauma Processing

In addition to the above, it appears that affect regulation and tolerance can be learned implicitly during the ongoing process of longer-term, exposure-based trauma therapy. Because, as discussed in later chapters, trauma-focused interventions involve the repeated activation, processing, and resolution of distressing but nonoverwhelming distress, such treatment slowly teaches the

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survivor to become more "at home" with some level of painful emotional experience and to develop whatever skills are necessary to deescalate moderate levels of emotional arousal. As the client repetitively experiences titrated (that is, not overwhelming or destabilizing) levels of distress during exposure to trauma memories (Chapter 8), he or she may slowly develop the ability to self-soothe, reframe upsetting thoughts, and call upon relational support. In addition, by working with the client to deescalate distress associated with activated CERs, the therapist often models affect regulation strategies, especially those involving normalization, soothing, and validation. However developed, this growing ability to move in and out of strong affective states, in turn, fosters an increased sense of emotional control and reduced fear of negative affect.

SUGGESTED READING

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