

Introduction

This is the therapist guide to implementing Safety Behavior Elimination Therapy for PTSD (SBET-PTSD). This treatment is an adaptation of Safety Behavior Elimination Therapy for Anxiety Disorders (SBET-A). It represents the first structured safety behavior treatment for PTSD. It is important to note that the first standardized safety behavior elimination therapy was developed by Schmidt and colleagues in 2013 (in individual format) and then Riccardo and colleagues in 2017 (in group format). The current author developed has own version of safety behavior elimination therapy which has many similarities to the original, while at the same time has some unique distinctions. SBET-A implements acceptance based strategies as methods for countering experiential avoidance safety behaviors. In addition, SBET-A implements attention training interventions as methods for countering negative attentional safety behaviors such as vigilance, rumination, monitoring, and worry. SBET-A also developed its own categorization system for safety behaviors and uses unique metaphors, examples, and clinical descriptions. Finally, SBET also uses the Safety Behavior Assessment Form (SBAF) as an initial assessment and guide for treatment as well as method for monitoring progress throughout treatment (measurement-based care). Preliminary effectiveness data from the SBAT-A protocol showed large effect sizes across anxiety disorders.

Interestingly, safety behavior interventions are notably lacking in PTSD treatment studies. In fact, they are often omitted from protocols or mentioned only superficially. This is somewhat surprising given that early conceptualizations of PTSD include safety behaviors and several of the symptoms can be reconceptualized as safety behaviors themselves. As such, the authors undertook the endeavor to create a safety behavior elimination therapy protocol for PTSD. This was accomplished by taking the existing SBET-A protocol and adapting for use with PTSD treatment. The end result was a significant departure from the SBET-A protocol as PTSD represents a broader, more clinically diverse (and often complex) disorder with several different maintaining factors. Despite these adaptations, the core of the treatment, as a series of safety-behavior-based interventions, remains intact.

One of the departures in SBET-PTSD is emphasizing two types of safety behaviors that maintain PTSD: suppression-related safety behaviors and vigilance related safety behaviors. When treating PTSD, clinicians are faced with the prospect of both processing a traumatic memory and addressing the enhanced and often spreading sense of danger characteristic of the disorder. From a safety behavior perspective, suppression-related strategies play a central role in preventing the processing of traumatic and intrusive imagery. They prevent therapeutic learning around the ability to effectively handle trauma memories (self-efficacy) and their perceived dangerousness (loss of control, threats to physical safety). Likewise, suppression-related safety behaviors prevent the organization and processing of trauma memories into a coherent narrative, contextualized in the timeline of the trauma-survivors life. Vigilance-related safety behaviors are well-known to maintain a sense of danger and prevent threat disconfirmation. Thus, an individual may enter a situation several times, however, if vigilance-related safety behaviors are being deployed therapeutic learning is not likely to occur. This is typically due to the safety behavior attribution and/or near miss attribution, which are commonly made following safety behaviors usage. Despite the need to emphasize these safety behaviors, others types of safety behaviors need to be addressed as well. As such, SBET-PTSD also includes identification and countering of safety behaviors related to checking, escape and evade, avoidance, safety bolstering, worry/planning, miscellaneous, etc.

Another departure was the addition of 3 optional treatment modules that are common clinical features associated with PTSD. These optional modules include: 1) trust-related safety behaviors, 2) withdrawal-related safety behaviors, and 3) rumination. None or all of these modules may be implemented. Typically, one (at the most two) are implemented in a course of SBET-PTSD.

Another departure was making the SBET-PTSD treatment phase-based. This was done to organize the treatment according to its primary interventions: 1) education and monitoring 2) addressing suppression-related safety behaviors; 3) addressing vigilance and threat related safety behaviors; and 4) optional modules. As with SBAF-A, SBAF-PTSD uses acceptance strategies and attentional strategies in a systematic way to counter PTSD-related safety behaviors. Additionally, individual's ideographic safety behaviors and targeted with elimination and countering strategies collaboratively developed by the therapist and patient during treatment. While SBET-PTSD is still in early phases of development, preliminary data suggest large treatment effect sizes. Below is a more systematic overview of SBET-PTSD

Different SBET Phases

Assessment of Safety Behaviors: Preceding treatment, clients are given a baseline safety behavior assessment using the Safety Behavior Assessment Form (SBAF). The SBAF was developed by Goodson and colleagues (2016) to assess safety behaviors in a wide variety of anxiety and trauma-related conditions. It contains 6 subscales: PTSD, vigilance, generalized, social, panic, and health. The PTSD subscale will provide safety behaviors to target in treatment. However, the presence of other safety behaviors will need to be identified as the majority of safety behaviors are ideographically related to patient trauma-structures and fears.

In addition to using the formal SBAF assessment tool, we recommend asking the following questions to identify PTSD related safety behaviors and associated fears.

- What are other behaviors do you do when you feel anxious or in danger?
- How do you manage your anxiety when you experience intrusive memories?
- What kinds of things do you carry to help you feel safer?
- Do you monitor yourself or others when you feel anxious? What are you worried will happen? How do you prevent that from happening?
- Do you scan areas to make yourself feel safer? What are you protecting yourself against?
- Are there any other types of checking behaviors that you engage in?
- Do you try to not think about upsetting thoughts or memories?
- How do you cope with your anxiety and PTSD?

Additionally, the manual contains lists of safety behaviors related to: 1) traumatic memory avoidance; 2) threat and anxiety; and 3) negative beliefs about self; negative beliefs about others; and 4) trust. The SBAF-PTSD scale along with the PCL and IMQ are administered routinely during treatment.

Phase I: Education about Safety Behaviors and PTSD (Sessions 1-3). This phase is dedicated to teaching patients about safety behaviors including what they are, how they maintain PTSD symptoms, how to monitoring them, and how to reduce/eliminate/counter them. The first session involves socialization to treatment, assessing motivation, and establishing treatment goals and expectations. For instance, it is expected that some homework will be done on a daily basis. Likewise, safety behavior practices will often necessitate going places specifically to practice the exercises. It will not be possible to complete this treatment without any changes to one's routine. Additionally, measurement-based are is introduced and explained and the measures that will be completed are discussed. Finally, the two major phases of treatment are explained and the patient selects which one he or she wishes to begin with.

Education and Monitoring: Sessions 2-3 are dedicated to education about safety behaviors, their different categories, and how they maintain anxiety and PTSD. Additionally, patient's major safety behaviors are identified, along with corresponding fears or beliefs, as well as how these have maintained the patient's symptoms over time. A corresponding client workbook helps solidify the education provided in treatment. During this phase, monitoring interventions are also carried out. Monitoring includes identifying safety behaviors in real time as well as the fear or negative belief driving each safety behavior identified. Identified safety behaviors and corresponding negative beliefs or fears are added to the Master List of Safety Behaviors, which is a primary treatment document. In addition, a behavior experiment designed to identify safety behaviors is included as an optional monitoring intervention. In this intervention, patients enter into a challenging situation for the purposes of identifying safety behaviors. Upon completion of the education and monitoring phase, all major safety behaviors have been identified and added to the Master List of Safety Behaviors. The Master List of Safety Behaviors should contain approximately 10-20 safety behaviors that will be addressed in treatment.

Phase II: Intrusive Imagery Safety Behaviors

There are four primary components in this treatment phase, with 3 being standardized. The first is elimination of safety behaviors related to intrusive memories. Common safety behaviors occur as both preventative and restorative strategies. These include: keeping one's mind occupied, keeping oneself busy, pushing memories away, distracting oneself, and not talking about the traumatic memory. Typically, two or three safety behaviors can be identified as the major safety behaviors. Patients are asked to drop these safety behaviors in conjunction with the following three standard interventions:

1) Acceptance of Intrusive Memories and Related Feelings: This is a safety behavior elimination intervention. This intervention begins with education about the paradoxical effects of memory and feeling suppression. Following, acceptance of intrusive memories is introduced, taught, and practiced in-session. With in-the-moment acceptance patients are instructed to recognize and hold intrusive images and then attend to their bodily sensations and feelings. This is continued as homework for the entire treatment and emphasized as a crucial long-term strategy, In addition to real-time practice of acceptance, patients are instructed to spend 10 minutes per day purposefully practicing intrusive memory acceptance. Specifically, they are asked to call-up the intrusive memory and practice holding it and then fulling experiencing ("opening up and leaning in") the feelings associated with the memory.

2) Purposeful Trauma Recall: This is a safety behavior countering intervention and is similar to the acceptance of trauma memories, but more detailed. It begins with the therapist and patient identifying the main images in the trauma narrative. The trauma is slowly walked through with images being identified for each major scene of the trauma ("trauma memory mapping") . Following, the patient is asked to recall and hold the first image and then welcome the feelings. Then the second image is recalled and held and the patient is

instructed to welcome the feelings. Then the third image and so on until the memory is completed. This exercise typically takes 20-30 minutes and the patient is asked to practice each day.

3) Written Trauma Exposure: This is a common practice in PTSD treatment and not unique to SBET-PTSD. This intervention is a safety behavior countering intervention. This intervention includes the patient writing in detail a narrative of the trauma. This is done in session. As the writing occurs, the therapists periodically askes the veteran to stop and feel his or her feelings. Upon completion of the written exposure, the veteran reads the narrative to the therapist. Following, the patient reads the narrative each day over the week and when new details emerge he or she is asked to add them to the end of the narrative. The next week the trauma narrative is written again in session and the new details are added. The patient is again asked to read the new narrative on a daily basis. This practice continues until the patient feels he or she is "done" with the memory and no longer needs to read it. However, therapy moves on to the next phase.

4) Additional safety behavior countering exercises: One of the most common safety behaviors is keeping oneself busy or occupied. This safety behavior may need additional interventions. First, the patient should be asked to conduct an experiment in which he or she does nothing for 30 minutes. Distressing thoughts or memories should be written down in a journal. Following, the patient should be instructed to spend certain periods of time each day doing nothing and journaling memoires, thoughts, and feelings. As the interventions progress, the patients will likely notice a decrease in upsetting memories, thoughts, and feelings. However, the practice of in-the-moment acceptance should be done during these times. This provides opportunities to practice a helpful strategy that generalizes outside of the exercise. When processing these exercises, the focus should be on self-efficacy. That is, that the patient was able to handle whatever memory and related feelings and did not lose control. Another common safety behavior is distractions (e.g., playing audio stories at home or while driving). Again these safety behaviors should be eliminated and framed as opportunities to practice in-the-moment acceptance.

Phase 3: Threat and Anxiety Safety Behaviors

Interventions in phase 3 are all geared towards reducing vigilance and anxiety-related safety behaviors and increasing self-efficacy as it related to activities outside the home (and at times inside). The first interventions are geared towards reducing and countering vigilance. Following, other threat and anxiety safety behaviors are addressed.

Addressing Vigilance: The first intervention is to attempt to reduce vigilance-related safety behaviors. Vigilance tends to be a safety behavior that does not lend itself to dropping in individual components, but rather dropping it in all-or-nothing terms. However, it is important to identify the vigilance-related components that will not be engaged in. If possible, practice dropping vigilance in session or in public with the patient.
The first step is to identify 5-10 challenging situations to for practice purposes. Then strategies for countering vigilance and discussed and agreed upon by therapy and patient. Several strategies can be used for countering vigilance but the most common are: mindful attention away from threat, mindful attention into present activity, attention on signals of safety, gaze fixing, wearing hat down low, mindful walking, sitting with back to entrance and/or people, etc. Once countering is started, patients continue to practice one or two difficult situations per week, with the expectation being daily practice. When processing vigilance countering exercises it is important to discuss the expected fear along with things that may make it more likely to occur with an emphasis on self-efficacy when possible.

Attention Training: Attention Training is a strategy designed to enhance attentional flexibility and increase patient's ability to disengage from vigilance (and rumination). It was created by Wells and collogues as part of Meta-Cognitive Therapy and has good evidence that is helps individuals disengage from vigilance, monitoring,

worry, and rumination. Attention training may be implemented at any time in treatment, but is most often implemented early in the vigilance/threat phase. Patients listen to the ATT recording every day, which is approximately 15 minutes in length for 4 weeks. They also practice shifting attention away from threat (both internal and external) when PTSD or anxiety is triggered. Attention training is not used as a coping skills but a skill enhancer, an exercise that will allow disengagement from negative attentional states.

After countering vigilance is underway, the next step is to address other non-vigilance safety behaviors form the patients Master List of Safety Behaviors. Typically, one or two safety behavior are agreed upon for reduction/elimination, the strategies for reduction/elimination are agreed upon, and practices are carried out as homework. Countering practices usually follow reduction/elimination practices, although they can be carried out at any time the therapist and patient see fit. Countering practices are designed to be a direct confrontation of the fear or negative belief associated with safety behavior usage. Of note, it is not necessary to counter every safety behavior. Usually around 3 fears or negative beliefs are addressed during treatment. Countering exercise may be doing the opposite of the safety behavior or they may be designed to challenge, increase the likelihood, or bring about the fear or negative belief. Typically, 1 fear or negative belief is countered per week with the possibility of several different exercises to counter it. As such, countering exercises are designed with the fear or negative belief in mind.

Optional Phases

The general purpose of the last phase of SBET is to address commonly associated features of PTSD that can be conceptualized as safety behaviors and cause distress and life interference. It is not required that any, or all, of the modules be completed. In fact, it may be preferable to just focus on the one (or at most two) that are most problematic.

The first module in this Phase is trust. In this module education is provided about trust along with common trust-related safety behaviors. Patients are asked to identify their top 5 trust-related safety behaviors and practice countering one each week. Whenever possible, in-session practices should be carried out.

The second module is withdrawal, specifically focused on withdrawal from valued activities and relationships. Education is provided on how PTSD and depression spirals into isolation and withdrawal. Patients are then asked to identify 5 valued activities and relationships and specific assignments are agreed upon and scheduled.

The last module is rumination. First, the differences between rumination and intrusions are discussed. Then education is provided about rumination. Patients are asked to monitor their rumination for one week. Then interventions to address rumination are implemented, such as mindfulness, behavior activation, postponement, and ATT (which is resumed if patients have stopped practicing it).

SBET-PTSD Phases and Interventions

Phases	Interventions	Sessions
Education	Education, socialization, monitoring 1) Develop Master List of Safety Behaviors	1-3
Phase II: Intrusive Imagery Safety Behaviors	1) Acceptance of Intrusive Memories and Related Feelings 2) Purposeful Trauma Recall 3) Written Trauma Exposure 4) Other safety behaviors related to traumatic imagery/memories (keeping self/mind occupied, distraction, etc.)	4-6
Phase III: Threat and Anxiety Safety Behaviors	1) Attention training 2) Counter vigilance 3) Identify 5-10 challenging situations 3) Agree on method of vigilance countering 4) Practice until vigilance is controlled and anxiety down 5) Address other safety behaviors 6) Elimination and countering of other safety behaviors 7) Work through all safety behaviors	4-6
Phase IV- Optional: Trust, Withdrawal, Rumination	1) Identify and counter trust related safety behaviors 2) identify and schedule valued activities and relationships 3) address rumination (monitoring, attention training, postponement, rumination time, mindful engagement in present moment)	0-6

Potential Advantages of SBET-PTSD

There are a number of potential advantages of treating PTSD using a safety behavior elimination framework. First, a safety behavior elimination therapy may be easier for patients to understand because it focuses on a singular behavioral concept (safety behaviors) that is easy to identify (especially when compared to trying to identify latent cognitive schemas) and understand. In contrast, current evidence-based treatments for PTSD such as cognitive processing therapy or skills training in affective and interpersonal regulation, require learning several treatment components, including skills training, cognitive restructuring, and exposure interventions. For example, cognitive interventions for PTSD require a patient to learn to identify automatic thoughts, evaluate their veracity, and then generate new cognitions. This highly deliberate (and often difficult) restructuring process needs to be taught, practiced, and ultimately performed at times when the therapist is not there to help. Further, patients often need to complete the restructuring process during times of heightened emotions and high stress, when cognitive resources are even further diminished. Indeed, recent research has suggested that cognitive therapy is similar in difficulty to learning a second language (Haeffel & Kaschak, 2019).

Second, patients may be able more likely to apply and generalize the simple principle of recognizing and eliminating safety behaviors after treatment has been completed. Thus, continued practice on eliminating safety behaviors may be straightforward and simple enough to result in additional gains post-treatment and less relapse.

Third, safety behavior elimination therapy maximizes flexibility, which may be particularly important in trauma survivors who have often experience helplessness (Salcioglu, Urhan, Pirinccioglu & Aydin, 2017). For instance, patients can select where to begin treatment (either memory work or threat/anxiety work), whether to complete optional modules (e.g., trust, withdrawal, and rumination), and which safety behaviors to address, and in what order. This may enhance the therapeutic alliance and treatment buy-in, both of which have been shown to be associated with treatment outcome and completion (e.g., Mclane, Barnes, Shofer, & Goodson, 2019; Goodson, Allen, Mullin, Scott, & Weinstein, 2020).

Fourth, the exercises used, and content discussed, in safety behavior elimination therapy are not as emotionally arousing as those used in traditional exposure-based therapies. In safety behavior elimination therapy, problematic behaviors are reduced and related fears and/or beliefs are countered, which is often challenging, but considerably less distressing then prolonged and repeated imaginal exposure of trauma.

Finally, SBET is one of the only PTSD treatments to address rumination, which is an under-recognized clinical manifestation of PTSD. Indeed, research suggests that what are labeled as intrusive memories is often better conceptualized as rumination (Ehlers et al., 2001).

***Non-Specific Factors*:** SBET-PTSD is carried out with a spirit of flexibility, collaborative team-work, an attitude of "no failure, and an emphasis on new therapeutic learning.

Flexibility: Safety behavior elimination therapy maximizes flexibility, which may be particularly important in trauma survivors who have often experience helplessness (Salcioglu, Urhan, Pirinccioglu & Aydin, 2017). For instance, patients can select where to begin treatment where to begin treatment (memory processing or vigilance/threat), whether to complete optional modules (e.g., trust, withdrawal, and rumination), and which safety behaviors to address, and in what order. This may enhance the therapeutic alliance and treatment buy-in, both of which have been shown to be associated with treatment outcome and completion (e.g., Mclane, Barnes, Shofer, & Goodson, 2019; Goodson, Allen, Mullin, Scott, & Weinstein, 2020).

Collaborative Teamwork: The importance of working collaboratively is explicitly discussed in the socialization session. Below is a sample script of how this may be introduced.

> *"Treatment works best when it is collaborative…that means we work as a team. This is very important in this treatment. You will always have the final say on what we do or don't do. There may be times I recommend some things and provide you with the rationale for why I think they would be a good idea, but if you say no, then its no."*

No-Failure Attitude: When conducting SBET-PTSD, it is wise to remember that therapy is working to counter well-entrenched safety behaviors, many of which have positive beliefs associated with them. As such, any steps that are taken towards countering safety behaviors should be met with praise. If the patient was only able to complete one minute of a 30 minute assignment, a fitting response may be, "that may be the most important minute of our treatment thus far." After providing praise and reinforcement, and helping to reframe efforts into success, it is then appropriate to explore with curiosity what made the exercise difficult and what would make a more helpful practice exercise. One expectation to this is if no homework is attempted at all. This is a red-flag that should be addressed when it presents.

Emphasis on New Therapeutic Learning: When debriefing and processing exercises in SBET-PTSD, an emphasis should be placed on the patient identifying what new learning has occurred. This question should be asked after every assignment. It is also useful to ask "what new leanring are we expecting to get out of this exercise" when assigning it as homework. Learning that is particularly important to highlight is learning related to self-efficacy. Changes in self-efficacy are stronger predictors in outcome than changes in threat cognitions.

Socializing the Patient to SBET-PTSD

Provide patients with the following treatment expectations:

a. Sessions are weekly and last 50 minutes
b. Start each session with completing measures (measurement-based care)
c. Then we will set an agenda
d. Sessions will end with homework planning
e. Need to attend sessions and complete homework
f. Discuss motivation for treatment
g. Set treatment goals
h. How to get the most out of this treatment

How to begin socialization:

- *I want to talk with you about how treatment works and what you can expect from our sessions. I'd also like to discuss your goals for treatment and how motivated you are feeling. Finally, I'd like to define the term safety behavior, go over the interventions we will use, and assign our first homework assignment.*

Sessions

- *We'll be meeting weekly and our sessions will be 55 minutes. Usually, treatment is somewhere around 12 sessions, but we never know exactly how many.*

Introduce measurement-based care

- *At the beginning of each session, I will have you complete 2 sometimes 3 brief measures. The measures usually take about 5 minutes and are another way we track progress. We know that including measures into treatment improves treatment outcomes. Let's figure when would be the best time to do the measures. Would you like to do the measures at the beginning of the session or would you like to do them before and send them to me?*
    - *Here are the measures we will use: PCL, SBAF-PTSD, and IMQ*
    - *Your baseline score on these measures were:*
    - *I will track and graph your measures to look at progress*

Schedule for Administering Measures

Phase of Treatment	Measures to Administer
Assessment	1) SLC Pre-Post Packet 2) Full Safety Behavior Assessment Form
Socialization, education, monitoring, and treatment planning sessions:	1) PCL, 2) SBAF-PTSD, 3) IMQ
Intrusive Imagery Processing Phase:	1) PCL 2) IMQ
Threat and Anxiety Reduction Phase, Optional modules, and Moving Forward:	1) PCL 2) SBAF-PTSD
Final Session	1) SLC Pre-Post Packet

Introduce and provide rationale for setting agenda

- *We will start each session with setting an agenda. That is to ensure we cover all the things we need to in our session. I will have some things to add to the agenda and then I will ask you to add things to the agenda). Setting an agenda helps us keep on track and cover all the necessary materials. Does that sound ok to you?*

Introduce Homework

  - *At the end of each session, we will agree on homework. In this treatment some of the homework is already established but most will be created by us. Many times, I will ask you what you think you should do for homework. I want to make sure you know that some homework is expected most every day. As a rule of thumb, we say plan on spending about 30 mins per day on therapy. It will not be possible to complete this treatment without making changes to your schedule What happens if no work is done outside of therapy? Correct, people don't get better. I strongly dislike having to talk with people about not doing homework. But in my 15 years as a therapist, I've never seen anyone get better when they did no homework. There is not failure when it comes to homework. As long as you try, you will benefit and we will learn from it. But if no homework is done, that is a problem. Usually if no homework is done 2 or 3 times we end treatment*

Collaborative teamwork

- *"Treatment works best when it is collaborative…that means we work as a team. This is very important in this treatment. You will always have the final say on what we do or don't do. There may be times I recommend some things and provide you with the rationale for why I think they would be a good idea, but if you say no, then its no."*

Assess motivation for treatment

  - *Therapy is a big undertaking. It is not always the right time for people. For it to work, it needs to take a high priority in your life and you need to put in the time.*
  - *So how is your motivation level right now? How motivated would you say you are? You have to come every week and do homework every day that can be pretty difficult….do you think now is the right time for you? IF so, why?*
  - *On a scale of 0-10 where would you rate the importance of completing this treatment?*
  - *On the same scale, where would you rate your confidence in completing this treatment?*
  - *Your response to this treatment can be minimal it can be moderate or it can be life changing. I've seen all three. Its' really up to you. The 12 weeks will pass by either way….its up to you to be where you want to be when it does.*

Assess treatment goals

- *So where do you want to be when therapy is over?*
- *What goals do you have?*
- *What things do you want to be different or better in your life?*
- *Goals are always better when written down, so can you write down 2 or 3 goals and share them with me?*

Goal #1

Goal #2

Goal#3

The rationale for SBET-PTSD covers the following factors:

Trauma reactions and Anxiety and designed to be temporary
Factors that prevent recovery from trauma include:
1) Cognitive factors: • Threat overestimation >> safety behaviors >> reinforcement of threat overestimation • Vigilance >> processing of threat cues >> maintenance of sense of threat/danger • Intrusive imagery/memories >> safety behaviors >> suppression which reinforces intrusive imagery • Fears/Negative Beliefs >> (i.e., losing control, physical danger) and negative beliefs (self, others, world) >> safety behaviors, which reinforce the fears/beliefs.
2) physical arousal symptoms (FFF) >> safety behaviors >> Reinforce senst of threat
3) Behavior Factors >> Safety Behaviors Ways safety behaviors maintain PTSD • Safety behaviors maintain a sense of threat by preventing new learning about situations, places, and people (they maintain a sense of threat or danger) • Safety behaviors prevent the development of self-confidence related to dealing with situations and people (work like a crutch) • Safety behaviors prevent the processing of traumatic memories and related triggers (suppress and don't heal over time) • Increase anxiety in the moment and over time (process multiple cues of threat)

These are summed up in a diagram that should be gone over several times (in rationale session). It is helpful to have the patient present the rationale to the therapist with the diagram after it has been explained. Fill in each box with patient examples.

Session 1- Socialization

1) *MBC: Administer PCL, SBAF-PTSD, and IMQ*
2) *Provided information about treatment*
3) *Discuss motivation and goals*
4) *Define safety behaviors and provide metaphor or example*
5) *Introduce monitoring, provide rationale and instructions*
6) *Add any safety behaviors identified to Master List*
7) *Add any negative beliefs to beliefs list*
8) *Homework:*
    1) *Monitor Safety behaviors*
    2) *Read chapter 1-2 of client workbook and take notes*

Education about Treatment

What to expect from this treatment

2. Provide client with treatment expectations
    a. Sessions are weekly and last 50 minutes
    b. Start each session with completing measures
    c. Then we will set an agenda
    d. Sessions will end with homework planning
    e. Need to attend sessions
    f. This treatment focuses on reducing safety behaviors through two ways
        i. Systematically reduce or eliminate them
        ii. Counter them or engage in fear-countering exercises where the fear driving the safety behavior is directly tested or confronted
        iii. Two phases of treatment and one optional phase
            1. Processing intrusive imagery
            2. Threat and anxiety reduction
            3. Optional modules include trust, withdrawal, and rumination
    g. Discuss motivation for treatment
    h. Set treatment goals
    i. How to get the most our of this treatment
    j. Define what a safety behavior is
    k. Introduce monitoring and plan out homework

*You can follow this as much or as little as you prefer**

- *I want to talk with you about how treatment works and what you can expect from our sessions. I'd also like to discuss your goals for treatment and how motivated you are feeling. Finally, I'd like to define the term safety behavior, go over the interventions we will use, and assign our first homework assignment.*

Sessions

- *We'll be meeting weekly and our sessions will be 55 minutes. Usually, treatment is somewhere around 12 sessions, but we never know exactly how many.*

Introduce measurement-based care

- *At the beginning of the sessions I will have you complete 2 sometimes 3 brief measures. To be totally honest, It would be preferable if you could complete them before the session, that way we don't have to spend time in session. The measures usually take about 5 minutes and are another way we track progress. We know that including measures into treatment improves treatment outcomes. Let's figure this out right now, would you like to do the measures at the beginning of the session or would you like to do them before and send them to me or share them with me at the beginning of session?*
    - *Here are the measures we will use: PCL, SBAF-PTSD, and IMQ*
    - *Your baseline score on these measures were:*
    - *I will track and graph your measures to look at progress*

Introduce and provide rationale for setting agenda

- *We will start each session with setting an agenda. That is to ensure we cover all the things we need to in our session*
- *I will have some things to add to the agenda and then I will ask you to add things to the agenda).*
- *Does that sound ok to you?*

Introduce Homework

- *At the end of each session, we will agree on homework. In this treatment some of the homework is already established but most will be created by us. Many times I will ask you what you think you should do for homework.*
- *I want to make sure you know that some homework is expected most everyday.*
- *As a rule of thumb, we say plan on spending about 30 mins per day on therapy.*
- *It will not be possible to complete this treatment without making changes to your schedule*
- *What happens if no work is done outside of therapy? Correct, people don't get better. There is not failure when it comes to homework. As long as you try, you will benefit and we will learn from it. But if no homework is done, that is a problem. Usually if no homework is done 2 or 3 times we talk about ending treatment*

Collaborative teamwork

- *Treatment works best when it is collaborative…that means we work as a team. This is very important in this treatment. You will always have the final say on what we do or don't do. There may be times I recommend some things and provide you with the rationale for why I think they would be a good idea, but if you say no, then its no.*

Assess motivation for treatment

- *Therapy is a big undertaking. It is not always the right time for people. For it to work, it needs to take a high priority in your life and you need to put in the time.*

- *So how is your motivation level right now? How motivated would you say you are? You have to come every week and do homework everyday that can be pretty difficult….*

- *Why is now the right time for treatment?*

- *On a scale of 0-10 where would you rate your motivation for treatment?*

- *May want to inspect PTE scores*

Treatment goals

- *So where do you want to be when therapy is over?*
- *What goals do you have?*
- *What things do you want to be different or better in your life?*
- *Goals are always better when written down, so can you write down 2 or 3 goals and share them with me?*

_____

Goal #1: Able to build and establish relationships

Goal #2: Able to trust people

Goal#3: less reactivity – More pause

_____

Headaches are a factor in fatherhood

Define safety Behaviors:

- *This treatment focuses on reducing and eliminating safety behaviors.*
- *Our first task is to come up with a definition for safety behaviors, because the term can be someone confusing.*
- *One would hear the term safety behavior and think that it is a good thing. However, as we mean it, it is definitely not a good thing*
- *First, let's break down the term safety. By safety we mean a very broad term. It is meant to cover physical safety, emotional safety, mental safety, social safety, internal safety, and external or situational safety.*
- *Likewise with the term behavior is used in a broad way. We don't just mean overt behaviors, we also mean the lack of behaviors such as withdrawal or avoidance and mental-attentional behaviors such as vigilance.*
  - *Behavior means overt behaviors such as checking if a door or window is locked.*
  - *Behavior also means withdrawal such as avoiding things or pretending not to notice someone*
  - *Behavior also means mental processes, such as vigilance to threat, monitoring conversations, suppressing unwanted images or memories, or distracting when feeling negative emotions.*

Safety behaviors are defined as strategies used to prevent or reduce anxiety or a perceived threat or a possible negative occurrence. They are also used to reduce anxious arousal or restore a sense of safety after being triggered.

The problem with safety behaviors is, whatever they are designed to do, they maintain and often worsen anxiety and PTSD

Metaphor or example of safety behaviors:

- *Fear of SIDS*
- *Dumbo*
- *Multiple antivirus programs*
- *Son afraid dogs*

Naturally pay attention:

Trust:

Don't accept anything for face value
Relatively good at reading situation and looking at second and third effect
Everybody operates and moves on self-service bias
Hold on to things – Can't let go
Emotional affair with guy on line
Girls almost drowned me – couldn't get over it
Broken promises – sticks with me – when I need help nobody is there
Continually lost faith in those who were going to be there to help me
Inability to trust anyone in general
Protective/Defensive posture
Don't accept that a transitionary part
Horrendous people

Monitoring

Monitoring is one the most important interventions in this treatment. Monitoring not only provides information necessary for successful treatment, but is an intervention in and of itself. There are several reasons why monitoring is important.

The first step in changing any behavior is monitoring the behavior you want to change. This may be especially important with safety behaviors which can occur automatically. Monitoring will help to identify the specific safety behaviors that you use as well as the related situations.

Additionally, monitoring is an intervention in and of itself. That means, when we monitor something it usually changes the frequency of the thing we are monitoring. Most often, monitoring results in a reduction in problematic behaviors as if requires us to be more objective in anxious situations.

In addition, monitoring provides important awareness into triggers (internal and external) and other subtle factors that contribute to engaging in problematic behaviors such as safety behaviors. Thus, the information you learn while monitoring will be used to better prepare you to effectively reduce your safety behaviors in future sessions.

Finally, monitoring allows us to evaluate how successful we are in reducing a behavior. It provides one with baseline information about the frequency of behaviors in certain situations which can be used to measure progress in the future.

Monitoring Recap:

- Help you to identify the specific safety behaviors that you use as well as the situations they are used in.
- Lead to a reduction of detrimental safety behaviors, as it requires you to be more objective in anxious situations.

- Provide important insights into triggers (internal and external) and other subtle factors that contribute to engaging in safety behaviors. Thus, the information you learn while monitoring will be used to better prepare you to effectively reduce your safety behaviors.
- Provide you with baseline information about the frequency of behaviors in certain situations, which can be used to measure progress in the future.

Monitoring of safety behavior will occur for 1-2 weeks and will be done primarily as homework. Again, monitoring is an important component of this treatment and should be carried out with due diligence.

The "Where, Which, Why SB Monitoring Form handout can be used to practice monitoring in session. This form asks you to identify WHERE the safety behavior was used, Which safety behavior was used, and WHY the safety behavior was used.

The "where" is the situation. What situation caused anxiety or distress and resulted in safety behavior usage? This could be at home, at work, at the supermarket, with friends, watching TV, talking with family member etc. Feelings of anxiety or distress are the best clue that you should fill out a monitoring form.

The "which" is the particular safety behavior you engaged in. Remember safety behaviors can also be mental strategies such as being vigilant or monitoring.

The "why" is the feared outcome that associated with the safety behavior. What is the safety behavior designed to prevent or protect against? What might happen if you did not engage in the safety behavior? What is at the heart of the anxiety? What do you fear the most? Keep digging until you are able to identify the core fear.

Use the Where, Which, Why handout to practice completing the monitoring form in-session

WHERE-WHICH-WHY (WWW) SB Monitoring Form

- WHERE- (where are you, what was the trigger):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior…what feared outcome were you trying to prevent):

- WHERE- (where are you):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior… …what feared outcome were you trying to prevent):

- WHERE- (where are you):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior…what feared outcome were you trying to prevent):

WHERE-WHAT-WHY (WWW) SB Monitoring Form

- WHERE- (where are you, what was the trigger):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior…what feared outcome were you trying to prevent):

- WHERE- (where are you):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior… …what feared outcome were you trying to prevent):

- WHERE- (where are you):

- WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well):

- WHY- (why did you engage in the safety behavior…what feared outcome were you trying to prevent):

WHERE-WHICH-WHY SB Monitoring Form

---

1) WHERE- (where are you): *ACME*

2) WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well): *Scanning people and making contingency plans*

3) WHY- (why did you engage in the safety behavior…for what purpose): *This protects me from being attacked or caught off guard*

---

1) WHERE- (where are you): *At home*

2) WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well): *Re-checked the locks on the doors and windows*

3) WHY- (why did you engage in the safety behavior…for what purpose): *This is to prevent an intruder from breaking in….to protect my family*

---

1) WHERE- (where are you): *At the VA*

2) WHICH- (what safety behavior did you do (remember safety behaviors can be mental strategies as well): *Stand in the hall instead of sitting in the waiting room*

3) WHY- (why did you engage in the safety behavior…for what purpose): *Feel more comfortable*

Homework for this week:

1) Read chapters 1 and 2 in workbook
2) Monitor safety behaviors

Session 2- Treatment Rationale

1) *MBC*
2) *Set Agenda*
3) *Review Homework*
4) *Add safety behaviors to the Master List*
5) *Present treatment rationale*
6) *Present main treatment interventions*
7) *Go over diagram*
8) *Homework*
    1) *Prepare to present diagram to therapist*
    2) *Read about main treatment interventions*

Review of Monitoring

So part of the homework was to read chapters one and two.

What stood out to you?

What did you learn?

Do you have any questions?

Let's review the reading and see which categories applied to you

Vigilance*

Suppression

Escape & evade*

Worry and Rumination

Avoidance and Withdrawal

Safety Bolstering

The next part of your homework was to monitor your safety behaviors. Let's review what you found

Situations	*Safety Behaviors*	*Fears*

Why do Anxiety and PTSD Persist

Anxiety and PTSD (A&P) are designed to be temporary.

They are an emotional response to some kind of stressor or trauma, and their primary function is to keep us safe and alive. Part of the emotional response, is a new-found sense of threat or danger after a trauma has occurred.

But A and P and the sense of threat is designed to be short-lived. That is, the majority of individuals who experience it, do so for relatively brief periods of time (several weeks to 6 months).

Then, for many, the symptoms and sense of threat gradually fade away. This occurs because the original danger is no longer present, they gradually return to their normal lifestyle and routines, and they process what happened to them. These represent recovery factors

So when A&P become chronic it means that one or more of those recovery factors have not occurred. And In these situations that sense of threat will persist, along with the other symptoms of anxiety and PTSD….and they often continue to persist for months and years or until treatment is sought.

There are several factors that can get in the way of recovery, but they have one thing in common, they all motivate usage of safety behaviors.

Let's talk about how symptoms of anxiety and PTSD manifest. They do so through three channels: Physical, mental, and behavioral. Let's start with the physical channel

The physical channel includes symptoms related to physiological arousal, often referred to as the fight, flight, or freeze response (FFF). These symptoms are common in A&P and are often quite uncomfortable and can even feel dangerous in their intensity. The FFF is our bodies built in defense system that prepares us for action and helps us to survive. Unfortunately, many different things present in trama become paired with the FFF response. Then in the time after trauma, things that resemble stimuli present during the trauma will trigger the FFF response. This communicates to our minds, that we are in danger, which in turn results in safety behaviors (escape, avoid, evade, etc). In this way, the FFF response motivates safety behaviors and maintains PTSD and anxiety. And one is unable to learn that those things that resemble trauma stimuli are not dangerous.

Another unfortunate thing about the FFF symptoms, is they tend to spread. You may have noticed that more and more situations trigger the FFF response and subsequent safety behaviors. Thus, PTSD and anxiety spread over time.

Common physical symptoms related to anxiety include elevated HR, sweating, increased breathing, nausea, muscle tension, trembling or shaking, flushing in the face, heat, etc.

I would be interested in knowing what type of physical symptoms you experience?

1.

2.

3.

4.

5.

The second channel is the cognitive channel, and this includes everything that happens inside our head, but most important for us are: anxious or threat-based thoughts, intrusions (images/memories), and attention towards threat.

Lets start first with anxious and threat-based thoughts. When anxiety or threat is triggered it affects our thinking in two ways every time.

1. *Anxiety increases the perceived severity of a threat. We call this Catastrophizing. This is why when we hear a noise at night our first thought is it's an intruder. This is why if our kids are late coming home we think they've been taken and sold on the black market. This is why when we say something dumb we think everyone will know about it and laugh at us. So that's Catastrophizing.*
2. *Anxiety increases the perceived likelihood of the threat occurring. That is, it makes it feel as if it definitely could happen. We call this Jumping to Conclusions. This is why we feel our worries may very well come to pass despite the fact that 91% of worries don't occur. This is why, if I feel anxious about having a heart attack, sensations and pain in my chest area seem to be a sure sign the big one is about to hit . This is why, if i feel anxious in public, it seems likely that some kind of attack may occur. .*

In a true sense, anxiety and threat-based thinking actually tricks your mind. It makes a threat seem more severe and more likely to occur. This is the entire purpose of anxiety, so that you respond appropriately to life threatening things, such as tigers, snakes, hippos, bears, war, etc. But in our society today, most of the old-time threats are no longer present, but the old-time parts of our brains are as active as ever.

How do these thinking patterns maintain anxiety and PTSD? What does one do when they feel a serious threat is likely to occur. ….they engage in safety behaviors. So anxious thinking maintains anxiety by causing safety behavior usage. And safety behavior usage maintains anxious thinking by preventing us from learning that the threats we fear are less likely to occur, and if they do occur, they are not likely to be the worst possible outcome.

Intrusions (images and memories)

Intrusions not only bring back pain, hurt, but they also bring back feelings of threat and anxiety.

So how might these maintain anxiety and PTSD?

Correct, we try to suppress the intrusions and related feelings and prevent them from coming back again.

Unfortunately, this only makes them come back more frequently.

It also prevents one from emotionally processing the traumatic memory.

As such, intrusive memories will follow a person in defiance of the adage that time heals all wounds.

Threat-related attention – Vigilance

Another type of cognitive process that maintains A&P is vigilance or attention towards threat.

Vigilance can be external (for physical danger) or internal (for emotional danger) Vigilance increases the perception and processing of cues of threat. As we process more threat our anxiety increases and new learning about situations is prevented.

For example, if we leave a mall after being vigilance for 30 minutes, we don't leave feeling it was safe, we leave having processed numerous threat cues which results in the near miss attribution (all the things that could have happened) IN this way, we don't learn that situations are relatively safe and vigilance is not always needed.

The third channel is behavior.

The primary behavior we focus on are safety behaviors. In fact, this entire treatment focuses on reducing, eliminating, and countering safety behaviors.

It could be said, that safety behaviors are to anxiety like overeating is to obesity or smoking is to lung cancer….They cause and maintain them.

Safety behaviors maintain anxiety and PTSD through several different pathways:

Ways safety behaviors maintain PTSD

1. Safety behaviors maintain a sense of threat by preventing new learning about situations, places, and people (they maintain a sense of threat or danger)
2. Safety behaviors prevent the development of self-confidence related to dealing with situations and people (work like a crutch)
3. Safety behaviors prevent the processing of traumatic memories and related triggers (suppress and don't heal over time)
4. Increase anxiety in the moment and over time (process multiple cues of threat)

A&P is associated with fears and/or beliefs:

The most common negative beliefs are about self, others, and the world. What are some of yours? What safety behaviors do these result in?

The most common types of fears are fears of losing control and fears of attack or physical danger. What are some of yours? What safety behaviors do these result in?

Give one or two examples if needed

So beliefs motivate safety behaviors and safety behaviors reinforce beliefs.

What if I believe I am a lousy coper and I'm too reactive and just don't handle things well.. What kinds of thoughts will I have when I encounter difficult situations. I may have thoughts such as "I can't handle this" or "this is too much." These types of thoughts increase my anxiety and decrease my confidence. As a result, I may leave early or give up after a short period of time. This then reinforces the belief that I am a lousy coper.

Research has demonstrated that changes in beliefs about ones ability to handle things (self-efficacy) are one of the strongest predictors of treatment success. As such, during this treatment, we need to vigorously identify and counter any beliefs that may be related to negative self-efficacy.

Can you identify any negative beliefs or fears you hold?

1.

2.

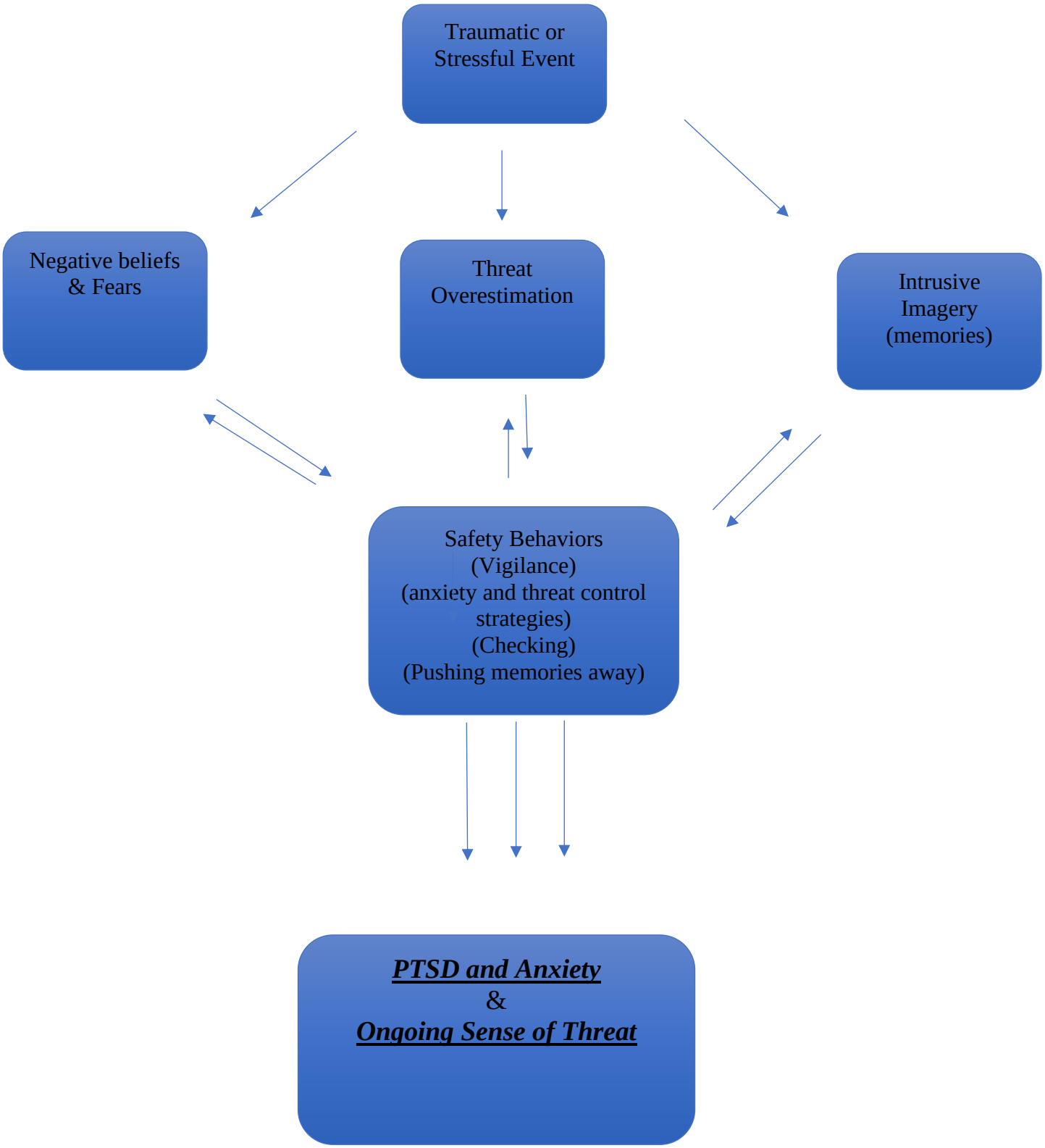
3.

4.

5.

What types of safety behaviors do these drive?

GO OVER DIAGRAM



So how do we address safety behaviors:

1) Systematic reduction or elimination
    - Give a non-PTSD example
    - Give a PTSD example
2) Fear-Countering exercises
    - Give a non-PTSD example
    -Give a PTSD example

Two primary phases of treatment:

1) Intrusive imagery Processing-
    - This primarily focuses on countering suppression by practicing recalling intrusive memories and fully experiencing related feelings
        - Acceptance
        - Purposeful trauma recall
        - Writing the trauma

    - As you complete these exercises the memory will become less upsetting and will come back less.

2) Threat and anxiety reduction
    - This primarily focuses on countering vigilance by practicing dropping it in challenging situations
        - As you so this more and more, you get more control over your vigilance and your anxiety goes down and your confidence will go up
    - This phase as focuses on reducing and countering other threat-related safety behaviors
        - Again, as you reduce these safety behaviors your anxiety will go down and your confidence will go up.

Though treatment we also see changes in negative beliefs and fears and overall situations and people start to look less dangerous

Homework

1) Learn the model and present it to therapist
2) Read chapter 3 and 4 in workbook
2) Continue to monitor safety behaviors

Session 3- Completing the Master List of Safety Behaviors and Getting Started

1) *MBC*
2) *Set Agenda*
3) *Review Homework*
4) *Complete Master List of Safety Behaviors*
5) *Get started*

Completing the Master List of Safety Behaviors and Getting Started

- Use Safety Behavior Master List form
- Begin going over the safety behaviors on the list
    - See if there are any to add
- Have patient change or remove any that are not central
- Have patient add any that may be central but are not present
- Looking for around 15 (20 max) anxiety/threat safety behaviors
- Looking for around 3-5 trauma memory related safety behavior
- Next, identify the core fear/negative beliefs associated with each safety behavior
- Put 3-5 core fears or beliefs in a table
- Have patient choose one safety behavior and have him practice dropping it
- Plan out specifically how it will be eliminated or reduced
- Go over different strategies for eliminating/reducing
- Use Safety Behavior Practice Form and Debriefing form

Safety Behaviors Master List- Anxiety and Threat

Safety Behavior Fear

1) –
2) –
3) –
4) –
5) –
6) –
7) –
8) –
9) –
10) –
11) -
12) -
13) -
14) -
15) –
16) –
17) –
18) –
19) –
20) –
21) –
22) –
23) –
24) –
25) -

Safety Behaviors Master List- Trauma Memory

Safety Behavior Fear

1) –
2) –
3) –
4) –
5) –
6) –
7) –
8) –
9) –
10) –

Fears and Negative Beliefs

General strategies for safety behavior elimination-

1. DO NOTHING: One of the most common and effective strategies is "do nothing." That is, in response to anxiety, do nothing to alleviate it or reduce a negative outcome. This strategy is as follows: Acknowledge, accept, and DO NOTHING.
    a. In this strategy accepting and welcoming anxiety are similar.
2. Systematic reduction: When eliminating safety behaviors, you don't have to begin with complete elimination. You can start by reducing a safety behavior and then move to eliminating it. For instance, you may want to start by checking that appliances have been unplugged only once. Then the following week you would practice not checking at all.
3. Place safety behaviors on time schedule: Some safety behaviors need to be done. However, you want to break the anxiety-safety behavior connection. As such, instead of performing the safety behavior in response to anxiety, it should performed in response to a time schedule. For instance, checking on your child once before bed.
4. Postponement: Safety behaviors can be postponed. For instance, if the safety behavior is leaving situations early, you can postpone leaving for a set period of time.
5. Outright elimination: Some safety behaviors do not lend themselves to reductions and should be eliminated outright.
6. Recognize, drop, and refocus. This strategy (or some form of it) can be used for dropping mental safety behaviors. This strategy is one that often needs to be repeated within practice sessions.
7. Blocking: Physically preventing the safety behavior from occurring. For example, sitting with back to people so one cannot scan them.
8. Attention away from threat cues: Focusing attention opposite of anxiety preference. This will vary according to disorder
9. Replacement: Seek support instead of reassurance

Safety Behavior Elimination or Fear Countering Exercises and Debriefing

Safety Behaviors to address	
Fear countering exercises to practice	
Situations to practice in or Avoided Situation to Confront:	
How often will I practice	
What method will you used to reduce safety behavior	
Other factors to consider	

Rate my success in following the plan (0-10):

What did I learn from completing this exercise?

Homework:
Practice dropping selected safety behavior – Follow written plan
Complete debriefing forms

INTRUSIVE IMAGE PROCESSING PHASE

Session 1: ADDRESSING SUPRESSION

- *MBC: Administer the PCL and IMQ*
- *Provide Education about suppression*
- *Provide Education about Acceptance*
- *Practice in-the-moment acceptance of Intrusive Imagery & Anxiety*
- *Provided practice log*
- *Assign Homework:*
- *Practice in-the-moment acceptance of intrusive imagery and anxiety*
- *Practice recalling intrusive imagery or anxiety and related feelings for 10 minutes per day*

Suppression- The universal safety behavior-

- *The first is the last-* This strategy is the most important in the long-term recovery from anxiety and PTSD
- *Suppression is one most common safety behaviors in anxiety and PTSD*

- *Suppression means pushing down (or away) or trying to control the anxiety & PTSD. =*

- *Arguable 50% of anxiety and PTSD is caused by attempts to not have or control anxiety and PTSD (i..e, suppression)*

Suppression worsens Anxiety and PTSD

- *We know from decades of research that the more you try to not have any internal experience, the more it happens. The more you resist, the more it persists. It's just the way our thoughts and emotions work, especially anxiety and PTSD.*

- *So attempts to control anxiety and unwanted memories occur in several ways, but the result in the same…persisting anxiety and PTSD.*

Rebound Effect:

- *Imagine pushing a beach ball under the water as far as you could…..When you finally release it, it comes rushing back up. Our anxiety and intrusive images work the same way. The more we try to hold them down, the harder they come back up. It's just a matter of time. Usually minutes to an hour And that leaves us feeling upset from the actual negative emotional experience, but also out of control. SO we've added to it.*

Different ways suppression maintains anxiety and PTSD:

1) Prevents the processing of traumatic memories

2) Prevents us from learning that traumatic memories are not emotionally dangerous

3) Prevents us from learning self-efficacy, which just means confidence. Self-Efficacy is the single most important predictor of treatment success.

IT IS UNLIKLEY THAT ONE WILL RECOVER FROM ANXIETY AND PTSD WITHOUT ELIMINATING SUPRESSION

SUPRESSION & ACCEPTANCE

- *Suppression is a restorative safety behavior. It is done to reduce arousal or sense of threat after anxiety or PTSD has been triggered*
- *the long-run, one of the most important recovery factors is addressing suppression*
- *How do we address suppression: We counter it with ACCEPTANCE*
- *Acceptance prevents the rebound effect and allows for processing of anxiety and intrusive imagery*
- *Once we start work on acceptance, we continue to practice it throughout all of treatment*
- *Acceptance is the only way out of hell*

Read Vietnam Veteran Meditation Retreat Story

It had been eight years since my return {from Vietnam} when I attended my first meditation retreat. At least twice a week for all those years I had sustained the same recurring nightmares common to many combat veterans: dreaming that I was back there facing the same dangers, witnessing the same incalculable suffering, waking suddenly alert, sweating, scared.

At the retreat, the nightmares did not occur during sleep, they filled the mind's eye during the day, at sitting, during walking meditations, at meals. Horrific wartime flashbacks were superimposed over a quiet redwood grove at the retreat center. Sleepy students in the dormitory became body parts strewn about a makeshift morgue on the DMZ. *What I gradually came to see was that as I relived these memories as a thirty-year-old spiritual seeker, I was also enduring for the first time the full emotional impact of experiences* that as a twenty-year-old medic I was simply unprepared to withstand.

"I began to realize that my mind was gradually yielding up memories so terrifying, so life-denying, and so spiritually eroding that I had ceased to be consciously aware that I was still carrying them around. I was, in short, beginning to undergo a profound catharsis *by openly facing that which I had most feared and therefore most strongly suppressed*."

"*At the retreat I was also plagued by a more current fear, that having released the inner demons of war I would be unable to control them, that they would now rule my days as well as my nights. But what I experienced instead was just the opposite. The visions of slain friends and dismembered children gradually gave way* to other half-remembered scenes from that time and place: the entrancing, intense beauty of a jungle forest, a thousand different shades of green, a fragrant breeze blowing over beaches so white and dazzling they seemed carpeted by diamonds."

"*While the memories have also stayed with me, the nightmares have not. The last of the sweating screams happened in silence, fully awake, somewhere in Northern California many years ago."*

Suppression:

1) *Prevents trauma memories from being processed*
2) *Increases trauma memories*
3)

What is acceptance and how is it practiced

What is acceptance:

- Acceptance is an active process of feeling what you feel, thinking what you think, remembering what you remember, sensing what you sense.
- It involves the willingness to let your experience be exactly what it is.
- If you're not willing to accept it, you're stuck with it.
- Acceptance involves leaning into difficult images or feelings or situations
- Acceptance involves "holding" what every images or feelings come up and allowing yourself to fully experience them.
- Acceptance even involves trying to make difficult feelings worse or focusing on the most difficult image
- Acceptance means that no place is 100 percent safe and some risk needs to be assumed in order to live a meaningful life
    - Acceptance involves assuming the risk of living

THE FIRST SAFETY BEHAVIOR PRACTICE: Welcoming Anxiety

- One of the most common safety behaviors in anxiety is trying not to have anxiety
- This is also one of the safety behaviors that keeps people the most stuck
- A significant portion of anxiety is trying not to have anxiety. I would estimate it at 50 percent.

What happens when we try to not have anxiety or get rid of it?

- Suppression – Rebound effect
  - We have it more and we become more distressed by it
- Prevents us from learning that anxiety is not dangerous
- Prevents us from developing confidence in our ability to handle it
- Have you ever been in a situation where you were not supposed to laugh?
- What happens the harder you try to fall asleep?
- Try pushing a beach-ball under water….what happens the harder you push?
- If you are not willing to have it you are stuck with it…
- Attempting to control our pain paradoxically creates suffering
- Life shrinks as anxiety grows

ANXIETY IS A PARADOXICAL EMOTION. THE MORE WE TRY TO NOT HAVE IT THE STRONGER IT IS. THE MORE WE ACCEPT IT THE WEAKER IT IS.

WELCOMING INTRUSIONS

This is a mindfulness script that allows you to practice acceptance of anxiety. For the first 5 minutes just practice following your breath in and out. When your mind wanders, just bring it back to your breath. Don't try to change your breath, just observe it. Practice for 10-15 mins

Next, bring something to mind an image from your trauma. Purposefully hold the image or images in your mind's eye. Regardless of what image or images come, just hold them in your mind's eye (15- 30 seconds).

Now, focus in on your body, notice what physical sensations you have. Notice where you feel them and what it is that you feel. Fully embrace the physical sensations. Feel all of it and block nothing (30-60 seconds).

Now identify whatever feelings you are having. For instance, say to yourself, I feel anxiety, or I feel angry, or I feel sadness. You may also greet the feeling like with an attitude of acceptance. I feel anxiety, hello my friend. Stay as long as you wish. You can do this with any other feelings you recognize. 15 seconds

Now go back and bring up the image or images. Once again, hold them in your mind's eye. If it slips away bring it back, if it intrudes or overwhelms, just allow it and open your mind to it (15- 30 seconds)

Now go back to your body. focus in on your body, notice what physical sensations you have. Notice where you feel them and what it is that you feel. Fully embrace the physical sensations. Feel all of it and block nothing (30-60 seconds).

Again acknowledge whatever feelings you are having. For instance, say to yourself, I feel anxiety, or I feel angry, or I feel sadness. You may also greet the feeling like with an attitude of acceptance. I feel anxiety, hello my friend. Stay as long as you wish. You can do this with any other feelings you recognize. 10 seconds

Go through a 3rd repetition. Continue practice for 15 minutes. You may want to debrief following and write down your experiences with welcoming anxiety and what you learned from the exercise.

How do we practice acceptance in the moment:

- In-the-moment acceptance practices involves:
- HOLD AND FEEL

2-Step
Step 1: notice anxiety, intrusive image or threat and hold image for several seconds
Step 2: Focus all your attention on what you feel in your body…..notice and hold the physical sensations…completely open yourself up to them….lean into them..try to make them more intense….
Continue this for 1 minute

Homework:

1) Practice in-the-moment acceptance

2) Practice 15 minutes per day of thinking about the trauma or anxiety and feeling related feelings

3) Log practices and any relevant notes

In-the-Moment Practice of Acceptance of Anxiety and Unwanted Thoughts:

Do not engage in any safety behaviors when you feel anxious. Fully accept the anxiety without doing anything. Below are steps for fulling accepting anxiety or other types of distress

---

6-step
Step 1: Recognize and greet with and attitude of acceptance. "welcome my old friend"
Step 2: Hold the memory or anxious image in your mind's eye
Step 3: Notice feelings and physical sensations and allow yourself to fully experience them
Step 4: Return to holding the memory or anxious image in your mind's eye
Step 5: Return to noticing feelings and physical sensations
Step 6: Repeat one more time

2-Step
Step 1: notice anxiety, intrusive image or threat and hold image for several seconds
Step 2: Focus all your attention on what you feel in your body…..notice and hold the physical sensations…completely open yourself up to them….lean into them..try to make them more intense….
Continue this for 1 minute

Log Practices Below

Practice Notes

1.

2.

3.

4

5

6

7

8

9

10

Identify different suppression safety behaviors

Safety Behavior	*Fear*

Session 2: Purposeful Trauma Recall (1-2 sessions)

1) *MBC*
2) *Review of homework*
3) *Set Agenda*
4) *Record Session*
5) *Provided rationale for Purposeful Trauma Recall*
6) *Provided instructions*
7) *Carry about the exercise for 30 minutes*
8) *Debrief and process*
9) *Homework:*
    1) *Practice in-the-moment acceptance and log*
    2) *Listen to purposeful trauma recall recording*

Rationale for Purposeful Trauma Recall

1) In the past session we worked on eliminating or reducing supersession and vigilance

2 Today we will take a step further and engage in a fear-countering exercise called purposeful trauma recall

By way of review

3) Pushing trauma or anxious imagery away makes them worse
- Brings them back more (rebound effect)
- Prevents them from getting processed (unfinished business)

4) Purposeful trauma recall involves identifying images associated with the trauma in chronological order and bring them to mind and feeling the associated emotions

5) That means we allow ourselves to think and feel about in detail…all the hurt, pain, bad, shameful details.

6) what will happen as a result of purposeful trauma recall is:

1- reverse the cycle of trying not to think about it – which makes it worse >> we will purposefully think about it which will reduce the emotional impact of the memory
2- Learn that you can handle the memory >> no need to avoid it >> it is not easy but you have the necessary resources to handle it
3- Learn that the memory is just a memory and it is not emotionally dangerous >> you won't lose control or go crazy

Purposeful Trauma Recall- Filling in the memory with context and connecting to feelings

Notes

Step 2: Get some repetitions in: Repeat for 30 minutes

Bring the start point image to mind (give contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what emotions you are feeling. Also notice what physical sensations you are having. Allow yourself to fully feel them. Lean into the feelings and sensations if possible.

Now move to the next image (give brief contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what sensations are present in your body. Allow yourself to fully feel them. Lean into them. Now notice what emotions you are feeling. Welcome them and allow them to be fully present.

Now move to the next image (give brief contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what sensations are present in your body. Allow yourself to fully feel them. Lean into them. Now notice what emotions you are feeling. Welcome them and allow them to be fully present.

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Now move to the next image (give brief contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what sensations are present in your body. Allow yourself to fully feel them. Lean into them. Now notice what emotions you are feeling. Welcome them and allow them to be fully present.

Now move to the next image (give brief contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what sensations are present in your body. Allow yourself to fully feel them. Lean into them. Now notice what emotions you are feeling. Welcome them and allow them to be fully present.

Now move to the final image (give brief contextual information). Hold the image that comes and visualize it in detail. Now, check in with your feelings. Notice what sensations are present in your body. Allow yourself to fully feel them. Lean into them. Now notice what emotions you are feeling. Welcome them and allow them to be fully present.

If you don't have all the contextual information you can substitute, now move to what happened next. Hold in your mind's eye the image that comes.

Repeat for 20-30 minutes and then debrief

Debriefing: Ask the questions you feel are relevant

1. What was that like for you?
2. What stood out?
3. What feelings were most common?
4. What images were the most difficult?
5. What did you learn from doing this?
6. What actions of yours stood out?
7. What actions of others stood out?
8. How did this event change how you view yourself and others?
9. what images were most difficult
10. are their parts you are trying not to think about
11. What images are the least distressing
12. what physical sensations did you notice
13. what feelings did you notice
14. how do these relate to negative beliefs about self
15. How do these relate to negative beliefs about others

Homework

1. Listen to trauma recall or do trauma recall on own for 30 minutes per day
    - Alternate between listening to the recording and taking yourself through the exercise
2. Continue to in-the-moment acceptance of intrusive memories, anxiety, and difficult feelings

Session 3- Writing the Trauma Narrative (1-2 sessions)

1) *MBC*
2) *Review of homework*
3) *Set Agenda*
4) *Provided rationale Trauma Writing*
5) *Provided instructions*
6) *Carry about the exercise for as long as it takes*
7) *Debrief and process*
8) *Homework:*
    1) *Practice in-the-moment acceptance and log*
    2) *Read trauma narrative 20 minutes per night*

Writing of the Trauma Narrative -

- Today we will engage in a second fear-countering exercise related to the traumatic memory.
- We will spend 30-45 minutes writing the trauma memory

Rationale

1) extensive evidence has accumulated to show that writing down traumatic events helps to process them
2) Purposefully writing down the memory allows you to get out all of the pain and hurt that came along with this event and connect it with the trauma.
3) The more you write about the memory the easier it will become and the more confident you will feel
4) As you progress, the memory will intrude less and less and you will feel a greater sense of mastery and control Writing about the memory results in less spontaneous intrusions.

Instructions for Trauma Writing

- I will be here but will not interrupt your writing.
- Please start from the start point and end at the end point.
- Please include as much detail as possible, including everything that happened, what you felt, what you saw, heard, smelled, tasted, thought, said, did, etc. No detail is too small.
- Its ok to become upset and cry. Its okay if you cry the entire time. Its also okay if you feel scared, shamed, guilty, or any other negative feeling. You job is to allow yourself to feel whatever comes up.
- I know this is difficult, but I also know you can handle it.
- Sometimes when we start trauma writing symptoms can increase. Please understand that this increase is temporary. As you keep writing your symptoms will start to decrease and eventually become much less than they were before the writing.
- Sometimes there can be an urge to skip over the most difficult parts due to embarrassment or shame or anxiety. Please make every effort to not skip over anything.
- Please write it in the language you would normally use. Its ok to use swear words or terms that you might not use around your grandmother
- Every few minutes you will hear me ask, “what is your level or where are you or what are you feeling)
- If the memory is brief, we may have you write it several times
- After you have written for 30-45 minutes, please answer two questions:
    - How did this event affect my life
    - How did this event affect how I view myself and others
    - What did I learn from writing this trauma

PLEASE BEGIN ON THE NEXT PAGE

Trauma Narrative Writing

Trauma Narrative Writing

Trauma Narrative Writing

Trauma Narrative Writing

Trauma Narrative Writing

Trauma Narrative Writing

Trauma Narrative Writing Debriefing

1) How did this event impact my life

2) How did this event impact how I view myself and others

3) What did I learn from writing this trauma

Homework:

1) Continue to practice in-the-moment acceptance of intrusions and anxiety

1) Please read the narrative you wrote for 20 minutes per day

2) Please add any additional detail that you remember to the end of the account. These will get incorporated next week

3) Remember to allow yourself to feel whatever comes up during the reading of the trauma account

Session 4- Re-Writing the Trauma Narrative

1) *MBC*
2) *Review of homework*
3) *Set Agenda*
4) *Provided instructions*
5) *Carry about the exercise for as long as it takes*
6) *Debrief and process*
7) *Homework:*

1) *Practice in-the-moment acceptance and log*
2) *Read trauma narrative 20 minutes per night*

Trauma-Memory Re-Write

Additional Rationale:

- Trauma memories are fragmented and disorganized in nature. Writing them helps to organize the memory and contextualize it in time and space which is needed for your mind to process it. Adding new details in the time line of the trauma helps to organize the memory and thereby process it.
- A story needs a beginning, middle, and end. And the story line needs to fit together. Filling in the story line along with the beginning, middle, and end helps to finish the stories business. When the story is finished, you can put it on the shelf and chose when you want to read it or revisit it. It becomes a chapter in the story of your life, no longer the central event or the event that casts a shadow over all other parts of your life.
- By re-writing the trauma and adding in additional detail we are helping to finish the story and place it in the context of your life in its entirety.
- Also remember that the more you write and read the trauma account the less upsetting in becomes

Instructions:

- I will be here but will not interrupt your writing.
- Please start from the start point and end at the end point.
- Please include as much detail as possible, including everything that happened, what you felt, what you saw, heard, smelled, tasted, thought, said, did, etc. No detail is too small.
- Also add into the narrative the details that your remembered over the past week
- Its ok to become upset and cry. Its okay if you cry the entire time. Its also okay if you feel scared, shamed, guilty, or any other negative feeling. You job is to allow yourself to feel whatever comes up.
- I know this is difficult, but I also know you can handle it.
- Sometimes when we start trauma writing symptoms can increase. Please understand that this increase is temporary. As you keep writing your symptoms will start to decrease and eventually become much less than they were before the writing.
- Sometimes there can be an urge to skip over the most difficult parts due to embarrassment or shame or anxiety. Please make every effort to not skip over anything.
- Please write it in the language you would normally use. Its ok to use swear words or terms that you might not use around your grandmother
- If the memory is brief, we may write it several times
- After you have written for 30-45 minutes, please answer the following questions:
    - How did this event affect my life
    - How did this event affect how I view myself and others
    - What did I learn from writing this trauma

Trauma Narrative Re-Write

Trauma Narrative Re-Write

Trauma Narrative Re-Write

Trauma Narrative Re-Write

Trauma Narrative Re-Write

Trauma Narrative Re-Write

1) How did this event impact my life

2) How did this event impact how I view myself and others

3) What did I learn from writing this trauma

4) How can I grow from this

Homework:

1) Read new trauma account for 20 minutes each day
2) Continue to practice in-the-moment acceptance

**Please note: You will be asked to read the trauma narrative nightly until you feel you have sufficiently processed it and it no longer bothers you significantly. However, we next session we will move onto the next phase of treatment. You and your therapist will decide together when to discontinue reading the trauma narrative. **

Optional- Session 5- Addressing other trauma memory related safety behaviors- (1-2 sessions)

1) *MBC*
2) *Review of homework*
3) *Set Agenda*
4) *Identify safety behavior(s) to be addressed)*
5) *Develop plan for eliminating or countering*
6) *Homework:*
    1) *Practice in-the-moment acceptance and log*
    2) *Practice new safety behavior intervention(s)*
    3) *Read trauma narrative daily as long as necessary*

Addressing Other Safety Behaviors related to Trauma Memories – Optional

- Other common safety behaviors related to trauma memories include:

1) Keeping oneself busy and one's mind occupied
2) Distractions
3) Not talking about the military or the trauma with others

1) Keeping oneself busy and one's mind occupied (1-2 Session)

Step 1: The patient should be asked to conduct an experiment in which he or she does nothing for 30 minutes.
Step 2: Distressing thoughts or memories should be written down in a journal and looked at as an opportunity to practice acceptance
Step 3: If trauma-themed thoughts and images came up, make schedule 30 minutes of doing nothing (sitting on couch and looking out window) on a daily basis.
Step 4: Spend 30 minutes purposefully thinking about the things that come up the most
Step 5: Continue practice until trauma memories surface less

2) Distractions such as always having a story or music playing:

Step one: Experiment with dropping the distractions and see what happens
Step two: If needed, systematically reduce the amount of time using distractions
Step three: If trauma memories or themes come up, use this as practice for accepting

3) Not talking about the military or the trauma with others

Step one: Explore with patient if this trauma is appropriate to share with others
Step two: If yes, experiment with telling one person the story.
- Make sure to prepare patient for many different reactions

Step three: Identify other individuals to tell the trauma to

If the trauma is not appropriate to share with others:
Step one: Identify what about military can be shared with others
Step two: Experiment with telling one person information about the military
Step three: Identify several other people that veteran can talk with about the military
- Prepare for different reactions

All experiments and exercises should be debriefed.

- Emphasize self-efficacy when every possible
- Discuss what was learned with each exercise related to the fear driving the safety behavior
- Discuss what this means for moving forward with respect to the safety behavior and fear
- Ask what would make the fear more likely and attempt to construct an experiment to test it.

Homework

1) Practice in-the-moment acceptance and log
2) Practice new safety behavior intervention(s)
3) Read trauma narrative daily as long as necessary

THREAT AND ANXIETY REDUCTION PHASE

Session 1 – Vigilance and attention training and experiment

1) *MBC*
2) *Set agenda*
3) *Review homework*
4) *Introduce vigilance*
5) *Introduce attention training*
6) *Agree on behavior experiment*
7) *Homework*

Vigilance and Attention Training

What is vigilance:

Automatic selective attention towards cues of threat. It is an automatic process. Vigilance can be both internal and external. It results in processing of more cues of threat, resulting in more anxiety or unwanted internal experiences. Vigilance is designed to keep us safe and in when true threat exists it is highly adaptive. But in the absence of a true threat, it maintains a false sense of danger and alarm. Vigilance is heightened threat detection.

Two types of vigilance: External and Internal

1) Vigilance towards external threats is a preventative safety behavior that increases detection of cues of threat and maintains anxiety and a sense of danger.

2) Vigilance following anxiety and unwanted memories is a restorative safety behavior designed to monitor for subsequent "internal threats" such as intrusive imagery or anxious thoughts. Vigilance following an intrusion or anxiety increase the likelihood of additional intrusive memories or anxiety by through the monitoring process.

Remember: After anxiety or an intrusive image has been triggered, vigilance towards threat is automatically deployed. This increases anxiety in situations and/or re-triggering of intrusive images and anxiety.

In general, vigilance maintains a sense of threat (which is the central defining feature of PTSD).

Vigilance is automatic and has a "pull", both of which make it difficult to interrupt.

Practice is needed in "attention training" to counter vigilance and its negative effects

Vigilance countering the is practice of strengthening threat-opposite attention and requires skill-based practice and learning.

That is, we need to increase our attentional control and flexibility to effectively counter threat-based vigilance

Acquiring this skill gives us greater control over where we place our attention which results in a significant reduction in anxiety and PTSD symptoms

Step one: Build up attentional flexibility – Practice in-session

- Formal Attention Training Technique
  - Describe attention training
  - Begin by listening to ATT recording on a daily basis
    - This continues for at least 4 weeks
    - Recording is 15-17 minutes long
- Informal Attention Training
  - Mundane Task Focusing & Meditation
  - Mundane Task Focusing
    - Practice focusing attention while completing mundane tasks (attention is on the mundane task)
    - Focus attention back on task through the following
      - Touch: What does the activity feel like? What is the texture like (e.g., rough, smooth)? Where on your body do you have contact with it? Are there areas of your body with more or less contact with the task?
      - Sight: What do you notice about the task? What catches your eye? How does the task appear? What about the light... the shadows... the contours... the colors?
      - Hearing: What sounds do you notice? What kinds of noises are associated with the task?
      - Smell: What smells do you notice? Do they change during the task? How many smells are there?
      - Taste: What flavors do you notice? Do they change during the task? What is the quality of the flavors?
  - Meditation
    - To begin the practice, sit down in a chair and adopt a relaxed and alert posture, then ask yourself, *what am I experiencing right now?* What thoughts are around, what feelings are around, and what body sensations? Allow yourself to just acknowledge, observe and describe these experiences to yourself, without judgment and without trying to change them or make them go away. Spend 30 seconds to 1 minute just doing this.
    - Now bring *your focus of awareness to your breath*, focusing on the sensations of your breath as it moves back and forth in your belly. Binding your awareness to the back and forth movements of the sensations in your belly from moment to moment, and letting all thoughts go. Maybe say to yourself 'relax' or 'let go' on each outward breath. If your mind wanders away to other thoughts, feelings and sensations – again do not try to change them or make them go away. Simply acknowledge their presence, allowing them to be there, then letting go with your attention and focusing back on your breath. Spend about 1 or 2 minutes doing this.

- Now *expand your awareness to sensing your whole body breathing*, being aware of sensations throughout your body. If there are any strong feelings around, maybe saying to yourself "whatever it is, it is OK, just let me feel it." Allowing yourself to breathe with these feelings, and if your mind wanders to bothersome thoughts or sensations, just acknowledge and let go of these - focusing back on sensing your whole body breathing. Continue doing this for about another 1 or 2 minutes.

Step two: Practice focusing attention away from threat when anxious in public or when anxiety or PTSD is triggered, both externally and internally.

Focusing vigilance away from threat differs according to the nature of the threat.

1) Unwanted memory or image

- Re-focus externally
  - Focus on immediate surroundings
    - Things you can see
    - Things you can hear
    - Things you can smell
  - Focus on the task you are engaged in
  - Start a task and fully engage in it
  - Mindful walking
  - Fully engage in interaction if with someone

2) Sense of threat or danger in situation

- Refocus internally or into present activity or prevent vigilance towards threat
  - Focus attention on cues of safety or lack of danger
  - Unfocus your gaze & lower line of sight by 30 degrees
  - Refocus into interaction if with someone one
  - Fully engage in an activity – read label on food item
  - Mindful walking

3) Feelings of anxiety- Depends on the type of anxiety

- Refocus internally (mindful walking)
- Refocus externally (different aspects of situation, focus on conversation, focus on activity engaged in or engage in an activity and focus on it)
- Stay in the situation (do not leave because of anxiety)
- Do nothing to lessen your anxiety

4) Negative thought processes such as rumination or worry

- Focus externally
    - Refocus on activity at hand
    - Initiate an activity and focus your attention on it
    - Focus attention on interactions with individuals
- Focus internally
    - Go for walk using mindful walking

ALL THESE WILL REQUIRE REPEATED EFFORTS IN SITUATIONS. VIGILANCE HAS A STRONG PULL AND YOU WILL FIND YOURSELF RE-ENGAGED IN FOCUSING ON PTENTIAL THREATS. IF YOU NEED TO RE-FOCUS AWAY FROM THREAT 100 TIMES IN A GIVEN PRACTICE, THIS IS A SUCESSFUL PRACTICE. DON'T GET DISCOURGED AND HAVE PATIENCE. YOU WILL GET BETTER AND BETTER AT THIS AS TREATMETN PROGRESSES.

Set up Behavioral Experiment to test control over vigilance:

- Identify a difficult situations that would cause you to feel unsafe or uncomfortable
- Identify two times you can go during the upcoming week – need to stay for 30 minutes
- Time 1, use all your vigilance-related safety behaviors. Rate your peak anxiety (0-10) and the top 3 safety behaviors used.

- Time 2, try to drop your vigilance safety behaviors. When you notice that you have slipped back into vigilance, use recognize, drop, and refocus away from vigilance
- Rate you peak anxiety (0-10)
- Rate how successful you were in dropping vigilance (0-10).

Situation- Stay for 30 minutes	*Peak Anxiety*	*Top 3 safety behaviors*
Time 1- Use all vigilance safety behaviors		*1.* *2.* *3.*
Time 2- Drop vigilance-related safety behaviors *Use recognize, drop, and refocus when you slip into vigilance*		*How successful were you in dropping vigilance? (0-10)*

Rate my success in following the plan:

Homework:
1) Carry out behavior experiment
2) Practice attending away from threat after triggered
3) Practice attention training

Session 2 – Addressing vigilance (1-4 sessions)

1) *MBC*
2) *Set agenda*
3) *Review homework- Review Experiment*
4) *Beliefs associated with vigilance*
5) *Discussion of the end goal of reducing and countering vigilance safety behaviors and identification of patients goals*
6) *Identification of challenging situations and method of vigilance countering*
7) *Homework: Elimination and countering of vigilance safety behaviors*

This session we will start eliminating safety behaviors related to vigilance

- This can be difficult for veterans as there exists positive beliefs associated with vigilance

Positive and Negative Beliefs related to Vigilance

1) SBs related to vigilance keep me safe
   "You never know when something might happen"
2) They help keep me prepared
   "I don't want to be caught off-guard"
3) They help keep me sharp
   "complacency is the bedfellow of defeat"
4) They can't be controlled
   "I could never not be vigilant"

Patients positive beliefs

Beliefs about vigilance	Safety Behavior	Feared outcome

What is the end-goal of vigilance-related elimination practices?

1) So you have the ability to choose to use vigilance-related safety behaviors. So it is under your control. The end goal is not to abandon all vigilance forever. This would not even be possible. But, we want you to be able to choose when you want to switch it on and when you want to switch it off

2) Increase comfort / enjoyment and decrease anxiety in situations. Increase your ability to be present during life activities. This is not possible with hypervigilance

3) Increase confidence in inherent abilities to handle situations

** To reach these goals you will need to practice dropping vigilance – Frequently (you have spent many hours practicing hypervigilance)

** To reach these goals you will need to practice dropping vigilance in many different situations

** To reach these goals you may have to overshoot the mark with your practice

Patients Goals:

1,

2.

Identify around 10 challenging practice situations

Commonly avoided situations:

- Public spaces
- Entertainment-related activities
- Social situations
- Family events
- Community activities
- Group-based activities
- Being out at night

Practice Situations: Identify 5-10

Identify Strategy to use for countering vigilance

Possible Strategies for reducing and countering vigilance:

1. Recognize, Drop, and Refocus
2. Attentional engagement in the present moment activity
3. Mindful walking
4. Attentional focus on cues of safety or non-danger
5. Unfocused gaze and lower line of sight
6. Fix gaze (for example, gaze at feet to prevent looking at hands or mid-section)
7. Wear a hat down to limit vision
8. Wear hoodie to limit vision
9. Purposefully stand or sit with back exposed to people
10. Full engagement in conversation
11. Look at phone to block scanning
12. Wear earphones and listen to music
13. Read newspaper or book in public

**if they are doing attention training, it may make more sense to use methods such as refocusing attention away from threat and full engagement in present activity

**If they are not doing attention training, consider more blocking type of methods

** Regardless, work on having back exposed is strongly encouraged

** Combining methods is a useful strategy for making practices more challenging (exposing back and wearing headphones with music)

** it is important to relay that this is a type of training. As with any type of training, mistakes and slips are to be expected. The guiding principle is if one slips into vigilance 100 times then recognize, drop, and refocus 100 times**

Have veteran select the countering method

- In processing inquire into the need to change if practice did not go well

if you can practice in session, do so

*Vigilance lends itself to being addressed as a whole (instead of its component parts).

- In processing ask if any vigilance safety behaviors are not being dropped during practices.
- If so, make sure to include those specifically in future practices.

*it is acceptable to begin with selective vigilance dropping or with safety partner

- Scan once upon entrance

- Scan once every 5-10 minutes
- Practice with spouse if this makes it easier
- Phase this out after 1-2 weeks

*when assigning practice exercises, make sure to agree on the time of the exercise

attempt to get a range of challenging situations

attempt to get a range of types of situations

*Use the safety behavior practice and debriefing form to plan practices

*Agree on the number of practices and the length of each practice

*Select 1-3 situations per week to practice

*With each processing, ask how successful the patient was in dropping vigilance (0-10)

*In processing, ask about peak anxiety and what it would have been if full vigilance were occurring

*In processing ask about the core fear or belief

*Prior to practice, ask what might get in the way of completing the exercises

-

Safety Behavior Elimination or Fear Countering Exercises and Debriefing

Safety Behavior(s) To Drop:	VIGILANCE
What is/are the feared outcome(s)?	
Situations to practice	1. 2. 3.
Method of dropping to be used	
Number of practices & duration of each	
Any other instructions	

Rate my success in following the plan:

What did I learn from completing these exercise?

Homework:
1) Practice eliminating or countering vigilance safety behaviors
2) Keep practicing attention training and focusing attention away from threat
3) Continue to practice in-the-moment acceptance 4) Continue to read trauma narrative if necessary

Session 3- Addressing non-vigilance related safety behaviors (1-3 sessions)

1) *MBC*
2) *Set agenda*
3) *Review Homework*
4) *Agree on practices*

If continuing with vigilance practice: Select the next avoided situations to confront

1.
2.

What is the fear that is being addressed:

1.
2.

What vigilance countering methods will be used

1.
2.

What fear-countering exercise can be carried out

1. Consider combining vigilance countering methods
2. Sit in public place and close eyes (park, public bench, etc)
3. Consider more practice with back exposed to people

Eliminating non-vigilance safety behaviors

TO this point, we have been focusing on vigilance-related safety behaviors. IN this session we will start to address all threat-related safety behaviors
Using the Master List of Safety Behaviors, select next safety behavior(s) to address:

Recommended that 1-2 new safety behaviors be selected.
1.
2.

Identify method of elimination for each safety behavior
1.
2.

What fears are associated with each?
1.
2.

Planning for weekly exercise:
- What situations will you practice in?
-What elimination method will you use?
- What might get in your way?
-What learning do we hope to get out of these exercises?
-Is there time to practice in-session?
Use the Safety Behavior Elimination or Fear Countering Exercises and Debriefing to plan the exercises

Tips for dropping each type of safety behavior

Checking-

If you engage in checking safety behaviors, systematically reduce the number of checks you allow yourself. Start by allowing yourself to check twice. Then move to checking just once. Then move to not checking at all. Some safety behaviors should end with one check and some should end with no checks.

Alternatively, try to engage in no checking and visualize the feared outcome – guided threat appraisal.

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Escape & Evade safety behaviors

If you engage in escape, avoid and evade (EE) safety behaviors you will need to practice staying, entering, and engaging behaviors.

If you escape situations you will want to practice staying (e.g., get comfortable and plan on staying for a good while). Pick two situations and see how long you can stay. If it is a social situation, be the last to leave. If you are talking with someone, don't end the conversation, stay until the other person ends the conversation.

If you avoid situations you will want to practice entering and staying for as long as possible. Identify two situations that may cause trauma reminders or anxiety and stay for at least 30 minutes. Again, see how long you can stay. Be prepared to experience anticipatory anxiety. Count on your anxiety going down the longer you are able to stay. Also count on it getting easier the more you enter into the situation.

Tip- Don't leave a situation because of anxiety, leave after a certain amount of time has passed or an event has ended…break the anxiety-escape cycle

****

Planning safety behaviors

IF you engage in excessive planning behaviors you will need to reduce and/or eliminate it. This will also require that you tolerate the initial discomfort and uncertainty that will ensue. You can practice not planning parts of the day, not over planning certain activities, or not engaging in any planning all day long. You will need to be on the lookout for mental planning that may occur automatically. When you notice this, use the recognize, drop, and refocus strategy. Remember, planning is associated with difficulty tolerating uncertainty. Tolerating uncertainty is associated with reductions in anxiety. Practice welcoming uncertainty and taking a "wait and see" attitude.

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Safety Bolstering

If you engage in safety bolstering safety behaviors you can practice longer and more frequent periods without the safety aid. Alternatively, you could try to straight elimination. For instance, if you carry a gun, each day you could carry it less and less. Or you could stop carrying it at all. Both methods work. One works faster and maybe more difficult in the short-term.

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Fear-Countering Exercises

- Identify the next fear countering exercise
- Typically one additional fear countering exercise is agreed upon each week
- Questions to ask in identifying useful fear countering exercise
    - -what is the next step in confronting the fear behind this safety behavior
    - -what would the opposite of the safety behavior look like
    - -How far can you push yourself with this fear
        - How many different ways can we counter this fear
    - -How often should the exercise be practiced
    - What problems might be encountered
    - -How difficult do I expect this to be?
- -Complete debriefing form after daily practice
- -Try to carry out fear-countering exercise in-session (may need longer session times)
- -Process the exercise after
    - What was learned about the fear
    - What was learned about ability to cope

Weekly Fear Countering Exercise: _____

examples of fear countering exercises

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Fear of intruder = leave door unlocked for a set period of time

Avoid situations or leave early = stay in situation for 30 minutes OR be the last to leave a social gathering

Fear of safety in public = wearing a hat low to block vision; sit with back to others; read the newspaper in public so it entirely blocks your view; wear headphones and play music, leave cell-phone at home

Fear of making the wrong decision = 1) do the first thing that comes to mind; 2) flip a coin to determine what you do or buy

Fear of safety at home = turn off security cameras, place weapons in safe, check on kids only once per night, leave window or door unlocked, leave window or door slightly open, leave car door open or windows down

Difficulty in conversations: strike up as many conversations as possible, don't be the one to end the conversation, practice talking about yourself and sharing information, share some private information

Driving vigilance: First practice dropping vigilance, then push up mirrors and drive

Fears of darkness: Go for progressively longer walks at night, Go into public places at night, leave cell phone at home

Difficulty with social situations: plan to attend as many as possible, host a social gathering, be the last to leave social gathering, act engaged and welcoming during conversations, pay people compliments, share things about yourself

Fear of being targeted: Take same route to work every day; leave out some personal information

Worry about future catastrophes: Spend 20-30 minutes per day imagining the future catastrophe happening

Excessive planning: engage in spontaneous, unplanned activities without any contingency planning

Concerns about trash on the side of the road: go to trashy road, stop and pull over and kick several trash items

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Safety Behavior Elimination or Fear Countering Exercises and Debriefing

Avoided situation to confront:	
Safety Behaviors to address	
Fear countering exercises to practice	
Situations to practice	
How often will I practice and what will be the duration	
What method will you used to reduce safety behavior	
Other factors to consider	

Rate my success in following the plan:

What did I learn from completing these

Homework:
1) Practice vigilance dropping and/or fear countering
2) Practice dropping new safety behaviors or fear countering
3) Practice threat-opposite attention
4) Continue to practice in-the-moment acceptance
5) Continue to read narrative once per day

***NOTE- the following modules cover these materials but provide more information**

Special Module: Checking

1) *Complete self-report measures*
2) *Set Agenda*
3) *Homework review*
4) *Checking: The safety behavior that keeps on taking*
5) *Construct plan for checking safety behaviors*
6) *Agree on homework*

Checking- The safety behavior that keeps on taking: They are among the most common and they reliably lead to more checking and more anxiety.

- Checking behaviors are done to reassure oneself that a particular threat has not, or will not, occur.
- Checking can be internal (checking heartrate, rehashing a conversation) or external (checking locks and windows, re-reading an email multiple times before sending).
- Although checking behaviors make people feel better during the times that they are used, they can be detrimental because they prevent one from learning that the feared outcome is unlikely.
- Checking reliably leads to more checking…Much like a disease, it spreads. Much like some vaccines, its effectiveness weakens over time. That is, the amount of relief gained from checking diminishes, leading to more checking.
- Checking is a central safety behavior in almost every anxiety disorder and PTSD and OCD
- Checking safety behaviors can be very resistant…that is, it is less likely to reach the desired end goal.
- Reducing checking has a similar feel to just "white knuckling" it, which is ineffective in the long-run
- There also may be a mismatch between the therapeutic goals of reducing checking and the clients motivation in particular areas.
    - For instance, in PTSD, reducing perimeter checks is a frequent target, however, it rarely moves past the first phase, which is usually starting with a certain number of checks. This could be because clients don't see the harm in checking and would rather be safe than sorry especially when it comes to safety of their family. Thus, they may not be as motivated to reduce certain types of checking
- As opposed to reducing slower and more methodically, being more aggressive is likely a better strategy.
- Below are strategies for increasing the effectiveness of checking safety behavior reduction interventions

Strategies to increase the effectiveness of reducing and eliminating checking behaviors

Strategies	Examples
Assess client's motivation to reduce each checking safety behavior and work on those that have higher motivation ratings	1. Have client rate his/her motivation for each checking safety behavior on a 1-10 scale
Faster reduction schedules and use fear-countering much earlier than with other safety behaviors	1. While checking on reduced schedule, spend 10 minutes imagining the worst possible outcome from not checking – guided threat appraisal 2. Similarly, the first 3 times anxious thoughts come up about checking less, spend 5 minutes writing or imagining the feared outcome 3. Concomitant safety behavior reduction and fear-countering (checking is reduced to twice per day and 20 minutes per day is spent writing about worst or feared outcome of not checking) 4. Variable schedules of reduction with days 1 or 2 days of no checking interspersed throughout week 5. Faster reduction schedules 6. Experiment with cross-scheduling. In one week have client reduce 3 or 4 different checking safety behaviors-
Create mini-hierarchy of checking safety behaviors	Have client rank order the difficulty of each checking safety behavior

Traditional strategies to counter checking:

Step 1. Identify the fear driving the checking
Step 2. Agree on what "normal checking is"
Step 3. Patient reduces checking to 2 times per day (sometimes it is higher)
Step 4. Patient reduces checking to 1 time per day
Step 5. Patient does not check (spouse or partner is charged with the checking)
Step 6. Patient purposefully leaves door unlocked for specified period of time

Plan for Reducing Checking

Step 1.
Step 2.
Step 3.
Step 4.
Step 5.
Step 6.
Step 7.
Step 8.
Step 9.
Step 10.

Special Module: Escape and Evade- The safety behaviors that evades confidence

1) *Complete self-report measures*
2) *Set Agenda*
3) *Homework review*
4) *Escape and Evade: The safety behaviors that keeps you doubting*
5) *Construct plan escape and evade safety behaviors*
6) *Agree on homework*

Escape and Evade-

Escape and Evade (EE) safety behaviors performed to remove oneself from threatening situations, people, or activities

EE involve spontaneously avoiding activities or situations, dodge people or interactions, or escape situations early.

EE are and performed to prevent a perceived feared outcome or threat

EE safety behavior reify that situations, places, activities, etc, are dangerous

EE safety behaviors are often used to reduce anxious arousal or perceptions of threat.

EE safety behaviors result in a sense of relief, that reifies the threat and reinforces the behaviors, both of which increase EE usage in the future

EE safety behaviors are thought to be some of the most detrimental, especially related to self-efficacy

EE safety behaviors result in learning such as: "I could not handle it" or "it was too much for me"

EE safety behaviors can also have negative relationship and interpersonal consequences

EE safety behaviors often occur when perceived threat presents itself unexpectedly

Examples of EE behaviors:

- **look busy while out in public so others won't talk to me**
- **Leave situations if too many people are there or start to arrive**
- **Leave family gatherings early to be home before dark or to avoid interacting with others**
- **Not engaging fully with others…remaining distant and guarded**
- **Pretend not to notice someone**
- **Leave events when anxiety is experienced or when triggered by something**
- **Avoiding eye contact**
- **Stopping conversations early**
- **Sticking to safe and familiar places and situations**

EE elimination and countering will need two types of practices

1)planned practices

&

2) spontaneous practices – this means being ready when situations present themselves

Examples of ways to address EE safety behaviors

Step 1- Monitoring – if specific EE safety behaviors are not well identified

Step 2- Identify the fear or negative belief behind EE safety behaviors

-When processing practices always discuss what is being learned about the fear or negative belief

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Planned countering of EE safety behaviors

- EE safety behaviors lend themselves to countering measures as opposed to dropping or eliminating measures.
- Eliminating EE safety behaviors is difficult. It is hard to know what "don't leave early" or "don't cut conversations short"

Step 1 - Systematically increase the difficulty of planned countering exercises -

- Construct stronger and stronger tests of the fear or negative belief
    - Stay in public place for 20 minutes
    - Stay in public place for 30 minutes
    - Stay in public place for 45 minutes
    - Stay in public place for 60 minutes
    - Stay in public place for 60 minutes and say hi to as many people as possible
    - Stay in a public place for 60 minutes and start up 1 conversations
    - Stay in a public place for 60 minutes and start up 3 conversations
    - Stay in public plan for 60 minutes, say hi to people, start up conversations and exposure your back to people

Spontaneous practices of countering EE safety behaviors

1) Identify rules of engagement for spontaneous challenges

**Examples of Rules of engagement

- When feeling the urge to escape, postpone by 10 minutes
  - When 10 minutes is up, attempt to postpone by another 5 minutes
- When you unexpectedly see someone in public, seek them out to say hi
  - After saying hi, practice small talk for increasing amounts of time
- When in a conversation, don't be the one to end it. Stay until the other person ends the conversation
- At activities and functions, set a time that you will not leave before
  - Work up to being the last one at activities or functions
- When interacting with others, act happy to see them and practice being fully present.
  - Remember that feigning warmth results in the same positive reactions that genuine warmth.
  - Normal conversational flow includes asking about the other party and then talk about oneself. Make sure that both occur
  - Be fully present. This works as a double practice as you will need to drop vigilance to do so.
  - Remember to not be the one to end the conversation
- Maintain appropriate eye contact
  - Appropriate eye contact means holding one's gaze while listening and allowing gaze to wander more when talking (but still holding as much as possible)
- Remember to practice self-efficacy mantra if needed, "I can handle this"
- General rule of thumb for staying is 30 minutes

** most important** - Never leave a situation or activity in response to anxiety. Leave when certain amounts of time have passed or certain challenges have been met

DROP EE SAFETY BEHAVIORS AND WATCH YOUR CONFIDENCE GROW

Special Module: Addressing Withdrawal and Avoidance

Complete self-report measures

Set Agenda

Homework review

Education about withdrawal and avoidance as safety behaviors

Valued activities and valued relationships

How to avoid Avoidance

Agree on homework

Feedback

Withdrawal: The retreat safety behavior

- Anxiety (and depression) result in disengagement from life…A person enters safety mode and withdrawal ensues - *Lack of engagement with important relationships and activities*
- Withdrawal safety behaviors are done to minimize threat and discomfort or in response to a sense of dread or lack of motivation about engaging in important activities .
- As we withdraw, we engage in fewer activities, spend time with fewer people, and engage in more "comfort" activities
- We find ourselves sitting at home, watching more TV, losing contact with important others, and living a limited and less active lifestyle. We also find ourselves having a more difficult time relating to others…this only causes us to feel worse
- Life may start to become restricted or limited as we sink further into withdrawal. We may lose touch with important relationships, cease meaningful involvement, stop engaging in important activities….Engagement in personally meaningful activities and relationships is known as valued living. Withdrawal prevents valued living

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Avoidance: The mother of all safety behaviors

- Avoidance is a specific type of withdrawal.
- Withdrawal is broad while avoidance is more specific
- Avoidance safety behaviors are restricting and limiting
- The more anxious we feel about a situation the more we try to avoid it.
  - Don't learn to feel comfortable again
- The more we engage in avoidance safety behaviors the less confident we feel in our ability to handle challenging situations.
- Different types of avoidance
  - Situations and activities
  - Experiential avoidance (avoiding things that are emotionally upsetting or arousing)
  - People and relationships
  - General involvement
- Chronic avoidance safety behaviors result in atrophy of life

Withdrawal and avoidance safety behaviors both*:*

Diminish confidence

Restrict and limit life

Both motivated by negative emotions

Both negatively reinforced

Prevent emotional learning and keep a person stuck

Valued activities and relationships diminish

Anxiety, PTSD & Depression
(decreased energy, no motivation, withdrawal, avoidance)

Activity level goes down
(stop going to the gym, stop getting things done, stop socializing, less likely to be in contact with others, confidence suffers, life is more restricted)

Symptoms worsen
(ruminating, anxious, stuck, people suck, don't want to be bothered; everything annoys me, I can't go there, I can't do that, it's too much)

Activity level goes further down
(little to no activity, few relationships, no contact with others)

STUCK

The three-pronged attack: Valued activities, valued relationships, countering avoidance

Valued activities

Step 1. Commit yourself: To break the withdrawal/avoidance safety behavior spiral, you need to commit yourself to engage in activities….REGARDLESS OF HOW YOU FEEL.

Step 2. Identify valued activities: Identify activities you feel are important or bring meaning, enjoyment, or purpose to your life

- These may be valued activities that you stopped engaging in or valued activities you have yet to engage in.
- This may require research or looking or trying out new and different things
- Important life areas can be helpful- see list on this handout

Step 3. Write down valued activities

- Place the list of activities where it will be seen frequently

Step 4. Schedule valued activities

- Activities that are written down and scheduled are much more likely to occur
- Even if you don't have a schedule, this is still important to do
- It is rare that I have seen valued activities be engaged in consistently without use scheduling

Step 5. Make valued activities the top priority at the time they are scheduled to take place

Step 6. Expect and prepare for pushback

- Your anxious/depressed mind will try feverishly to talk you out of going
- Added to this, you won't feel like going
- Added to this, you probably won't feel a lot of enjoyment initially
    - This is why people stay stuck
- Be prepared for this and just do without thinking

Step 7. Be present during the activity: Don't analyze if you are enjoying the activity or how you are feeling during the activity- This will ruin it. Just be present in whatever activity you are engaging in.

Step 8. Be in it for the long-haul

- Not every activity will go well. But if you keep engaging in valued activities, over time you will reap the rewards.

1) Identify and plan 5 valued activities
    a. Valued activities can be with important / meaningful or enjoyable
    b. Select one activity per week, schedule it, and do it

c. See page below for important areas of life
d. See schedule below to schedule it

Valued activity	Plan for carrying out activity; Problems that may occur; Safety behaviors to avoid
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Important Life Areas:	Valued Activities
1) . **Education/ Training**: Would you like to pursue further education, or receive specialized training? What would you like to learn more about? What is important to you about your education and training?	
2. Employment/ Career: What type of work would you like to do? What kind of employee would you like to be? What is important to you about your work?	
3. Hobbies/ Recreation: Are there any special interests you would like to pursue, or new activities you would like to do? What is important to you about your free time?	
4. Volunteer Work/ Charity/ Political Activities: What contribution would you like to make to the larger community?	
5. Physical and Psychological Health Issues: What is important to you about your general health, diet, sleep, exercise, etc.? What are your goals for this mental health treatment? Are there issues other than depression you would like to address?	
6. Spirituality: Are you a spiritual person? If so, what does spirituality mean to you? What does a spiritual life mean to you?	

7. **Responsibilities:** What new daily responsibilities would bring a sense of accomplishment?	

Valued relationships

- Relationships and social connections are among of the strongest predictor of wellbeing
- Relationship problems are common in anxiety, depression, and PTSD
- While problems in relationships and socializing may not be your fault, it falls on you to improve them….others are not going to change

Step 1. Identify 5 valued relationships

- Romantic/partner
- Family
- Friends
- Other people you value

Step 2. Take the necessary steps to reach out and establish or re-establish connections with valued others

Step 3. Be willing and be committed:

- Be willing to meet each person where they are at
- Be committed to establishing and then maintaining the connections
- You are in it for the long-haul, no one interaction or relationship failure should lessen your commitment

Step 4. Express your desire to connect and work together to come up with plan for staying in contact

- Remember there are multiple ways to connect from telephone, to text, to visiting, to mutual activities, to emails, to letters, to social media, etc.

Step 5. When possible, establish a routine or schedule of contact

1. Calling your brother every Sunday
2. Breakfast with your daughter every Saturday
3. Family event every Monday evening
4. Call friend at least once per week
5. Organize a friends lunch
6. Date night once per month

- The more specific your plans the better

Tips for improving relationships

i. Don't keep score
ii. Don't hold onto grudges
iii. Drop your emotional guard
    1. Let the person know that he/she is important to you
iv. All relationships are difficult (including friendships) and take hard work and some forgiveness
v. Be mindful of your judgments and reactions towards others (and yourself).
    1. Assume positive intent
    2. Use the question, "am I sure" when you find yourself judging
    3. Practice acceptance and tolerance of being human
vi. Allow others to be upset
vii. Repair relationship ruptures as soon as possible

Identify and Plan Valued-Relationships

- Identify the important relationships you want to re-establish, improve, or maintain and write an action plan in the right column.

Valued relationship	Action plan: what might get in the way; what safety behaviors to avoid; what specific activities to you want to engage in (remember, connecting or reaching out is an activity)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Counter avoidance:

Avoidance safety behaviors are sneaky
Our anxious minds provide all the necessary reasons for continuing to avoid

Step 1. Identify 5 avoided situations or activities

Identify situations to practice dropping safety behaviors

Situations to practice dropping vigilance
Situations/activities to practice dropping monitoring
Ways in which you escape or evade
Things that you have to do but are dreading or procrastinating
Situations that cause anxiety or discomfort, but hold some value to you
Neighborhood/community/church/family activities
Zoom meetings
Joining an organization
Volunteering your time

The single best thing about countering avoidance is the growth in confidence that occurs.

Avoided situation or activity	Action plan: When will you go, what may get in the way, can you put it on the schedule, how will this help with your confidence
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

USE THIS SCHEDULE FOR VALUED ACTIVITIES, RELATIONSHIPS, AND AVOIDED ACTIVITIES

Schedule: Please specify day and time you will carry out each activity. This will increase the likelihood of it occurring. Or at a minimum specify the day and if the activity will be occur in the morning, afternoon, evening, night.

	Valued or enjoyable activity	Valued relationship	ATT Training Practice
Monday			Gather Eggs Out
Tuesday			Gather Eggs 8:30-8:45
Wednesday			Gather Eggs 12:30-12:45
Thursday			Gather Eggs 10:00-10:15
Friday			Gather Eggs 10:00-10:15
Saturday			Gather Eggs 10:00- 10:15
Sunday			Gather Eggs
Notes			Gather Eggs: 1)Give full attention to the task. Use breath to keep your focus. Notice sights, sounds, feelings, etc. 2) As many times as your mind wanders – bring it back- this is part of the exercise. Its ok if it happens `100 times.

Homework:

1) in-the-moment acceptance
2) countering attentional safety behaviors
3) schedule one valued activity, one relationship activity, and one avoided activity

Countering vigilance without attention training

2) *MBC*
3) *Set agenda*
4) *Review homework*
5) *Introduce vigilance*
6) *Agree on behavior experiment*
7) *Homework*

Threat and Anxiety- Getting ready and Experiment with Vigilance

What is vigilance:

Vigilance towards external threats is a preventative safety behavior that increases detection of cues of threat and maintains anxiety and a sense of danger.

Automatic selective attention towards cues of threat. It is an automatic process that results in processing of more cues of threat, thereby increasing anxiety and the perceived need for vigilance. . Vigilance is designed to keep us safe and in when true threat exists it is highly adaptive. But in the absence of a true threat, it maintains a false sense of danger and alarm. Vigilance is heightened threat detection.

Vigilance is a preventative safety behavior that increases detection of cues of threat and maintains anxiety and a sense of danger.

In general, vigilance maintains a sense of threat (which is the central defining feature of PTSD).

Vigilance is automatic and has a "pull", both of which make it difficult to interrupt.

In order to successfully treat PTSD, vigilance must be addressed

Set up Behavioral Experiment to test control over vigilance :

- Identify a difficult situations that would cause you to feel unsafe or uncomfortable
- Identify two times you can go during the upcoming week – need to stay for 30 minutes
- Time 1, use all your vigilance-related safety behaviors. Rate your peak anxiety (0-10) and the top 3 safety behaviors used.

- Time 2, try to drop your vigilance safety behaviors. When you notice that you have slipped back into vigilance, use recognize, drop, and refocus away from vigilance
- Rate you peak anxiety (0-10)
- Rate how successful you were in dropping vigilance (0-10).

Situation- Stay for 30 minutes	*Peak Anxiety*	*Top 3 safety behaviors*
Time 1- Use all vigilance safety behaviors		*1.* *2.* *3.*
Time 2- Drop vigilance-related safety behaviors *Use recognize, drop, and refocus when you slip into vigilance*		*How successful were you in dropping vigilance? (0-10)*

Rate my success in following the plan:

Homework:
1) Complete vigilance experiment

OPTIONAL MODULES- TRUST

1) MBC – PCL, SBAF-PTSD, IMQ
2) Discuss progress with ongoing interventions:
    1) in-the-moment acceptance
    2) continued practice dropping vigilance
3) Education about PTSD and trust, withdrawal, and rumination
4) Identification of 5 trust related safety behaviors
5) Plan for dropping trust-related safety behaviors and fear countering activities
6) Homework
    1) Identification of practice exercises for the trust-related safety behaviors

What does it mean to trust?

Why is trust difficult after trauma?

1) Negative views of others
2) changes how we interact with others
3) changes what we process with respect to others
4) trust becomes viewed as all or nothing (instead of on a continuum, which is where it belongs)
5) PTSD often results in trust being withdrawn at perceived offense and then never given again
6) Vigilance for trust offenses is common
7) Trust requires at least a small amount of vulnerability, which can be very difficult after trauma
8) Lack of trust is a strategy to keep oneself emotionally safe
9) People are strange when you're a stranger

<u>Some myths about trust</u>

1) Trust myth- If I trust someone, I tell them everything
2) Trust myth – If I don't trust someone, I can't talk to them at all
3) Trust myth- If I trust someone I will tell them my deepest secrets, problems, and negative experiences & they have to understand
4) Trust myth- to trust means to share things about myself---Fact- trust also means listening and understanding others
5) Trust myth- trust can't be mended once its broken

Lack of trust is maintained by the same principles as other PTSD symptoms>>> safety behaviors

- Trust safety behaviors prevent new learning and ability to trust others
- Need to relearn how to allow self to trust others

Why is trust important?

- Trust is necessary for connection & connection is necessary for relationships & relationships are necessary for wellbeing

Continuums of Trust

Trust differs across different relationships

1) Intimate relationships: Complete trust ⟷ No trust
2) Family relationships: Complete trust ⟷ No trust
3) Friendships: Complete trust ⟷ No trust
4) Co-worker: Complete trust ⟷ No trust
5) Acquaintance: Complete trust ⟷ No trust
5) Neighbor: Complete trust ⟷ No trust
6) Groups and organizations: Complete trust ⟷ No trust
7) Strangers: Complete trust ⟷ No trust
8) Self: Complete trust ⟷ No trust

Different aspects of trust

Sharing: Oversharing ⟷ Under-sharing
Assumed intentions: Positive ⟷ Hostile
Willingness to engage: Overly-engaged ⟷ withdrawn
Stance: Open/welcoming ⟷ Closed/uninviting
Attitude: Supportive ⟷ Judgmental
Expectations: Flexible ⟷ Rigid
Interest: Interested ⟷ Uninterested
Tolerance of err: Willingness to forgive ⟷ One and done

Identify where you are in each area
What safety behaviors does this result in
Read and identify relevant safety behaviors below

Safety behaviors related to trust

1) Don't bother to connect with others or forming new relationships
2) Hold back on expressing affection
3) Difficulty expressing compliments
4) Difficulty sharing feelings
5) Difficulty sharing about oneself
6) Unwilling to talk about things that are "trivial" or "stupid"
7) Avoid staying in contact with important others
8) Decline invitations to social activities
9) Avoid inviting people into your home
10) Avoid engaging in activities of shared interest with others
11) Emotionally guarded and withholding and distant
12) Quick to criticize others
13) Unable to forgive other for slights and disrespect – hold onto grudges
14) Avoid eye contact or stare-down
15) Avoiding topics that may get you emotional
16) Avoid getting involved in community or organizations
17) Monitor others for signs of disrespect
18) Easily offended
19) Keep score (I called him/her last its his/her turn to call me)
20) Difficulty apologizing

Identify top 5 trust-related safety behaviors

1.
2.
3.
4.
5.

Identify ways to drop or counter each

Safety Behavior	Elimination or Countering measure

Work on one or two per week for the next two or three weeks

See below for examples of trust related countering exercises

Trust and relationship related fear-countering behaviors

1. Start conversation with stranger
2. Pay someone a compliment
3. Express affection
4. Act of kindness
5. Act of service
6. Say Hi to 10 people
7. Talk to someone even if they don't understand you – try to understand them
8. Practice small talk
9. Share your story
10. Share something about yourself you usually don't
11. Say hi to neighbors
12. Stop and chat with neighbors
13. Visit neighbors
14. Have a neighbor over for tea or dinner
15. Share how you feel
16. Ask others about how they feel
17. Act interested in others
18. Act in a way that is warm and welcoming to others
19. Practice active listening
20. Express vulnerability (in intimate relationships)
21. Practice positive judgements- Find something positive or replace negative judgements with positive ones (assume positive intent, give others the benefit of the doubt).
    a. Example. "This person sucks…but he is probably just having a bad day…he may even be a good person":

*in order to feel more and connect more with others we first have to start acting the part
*Acting warm and interested in others (even if you don't feel it) results in positive evaluations from others and better conversations (Lesson- you don't have to feel it to do it)
*clarify what you want to change in this area…what are your values…what behaviors would be congruent with those values

Safety Behavior Elimination or Fear Countering Exercises and Debriefing

Safety behavior to address :	
Countering exercise to practice:	
People or situations to practice with/in	
How often will I practice	
Other factors to consider	

Rate my success in following the plan:

What did I learn from completing these

Homework:
1) Practice trust countering exercise
2) Complete debriefing form
3) complete values inventory and rumination measure
3) Continue to practice in-the-moment acceptance
4) Continue to practice dropping vigilance

WITHDRAWAL

1) MBC – PCL, SBAF-PTSD, IMQ
2) Discuss progress with ongoing interventions:
    1) in-the-moment acceptance
    2) continued practice dropping vigilance
    3) trust countering
3) Education about PTSD and trust, withdrawal, and rumination
4) Identify next trust-countering exercise
5) Discuss withdrawal and PTSD
6) Homework

Withdrawal and PTSD

- Trauma and PTSD results in disengagement from life…A person enters safety mode and withdrawal ensues - *Lack of engagement with important relationships and activities*
- Withdrawal safety behaviors are done to minimize threat and discomfort or in response to a sense of dread or lack of motivation about engaging in important activities
- Withdrawal is common in PTSD, depression, and anxiety.
- As we withdraw, we engage in fewer activities, spend time with fewer people, and engage in more "comfort" activities
- We find ourselves sitting at home, watching more TV, losing contact with important others, and living a limited and less active lifestyle. We also find ourselves having a more difficult time relating to others
- The more we engage in withdrawal safety behaviors the more depressed and unmotivated we feel….and the more depressed we feel the more we engage in withdrawal….A vicious cycle ensues.
- Withdrawal also decreases ones quality of life.
- Life may start to become restricted or limited as we sink further into withdrawal. We may lose touch with important relationships, cease meaningful involvement, stop engaging in important activities and relationships or what is known as valued living

PTSD & Depression
(decreased energy, no motivation, withdrawal)

Activity level goes down
(stop going to the gym, stop getting things done, less likely to be in contact with others)

Symptoms worsen
(ruminating, anxious, stuck, people suck, don't want to be bothered; everything annoys me)

Activity level goes further down
(little to no activity, no contact with others

STUCK

Valued activities

e. To break the withdrawal safety behavior spiral, you need to commit yourself to engage in activities….REGARDLESS OF HOW YOU FEEL

f. Identify activities you feel are important or bring meaning, enjoyment, or purpose to your life

   i. If you've had PTSD for years you may have forgotten what these are….You may need to be willing to try out new things

b. Correct approach to engage or re-engage in valued activities

   ii. Be willing

   iii. Be open

   iv. Be committed

      - Be in it for the long haul, not every activity will go well

   v. Expect to feel unmotivated early

      - commit self to follow-through regardless of motivation level

   vi. When possible, put valued activities on a schedule

      - Twice as likely to occur

   vii. Approach activities with the intention of fully involving yourself

      - DO NOT FOCUS ON HOW YOU ARE FEELING OR IF YOU ARE ENJOYING YOURSELF DURING THE ACTIVITY- THIS WILL RUIN IT

   viii. Keep your attention focused on the main purpose of the activity-

      - If you go to church, focus on the sermon
      - If you go to the store, focus on the food items you are buying
      - If you go out to a meal, focus on the food and the person you are with
      - If you go to a movie, focus on the movie
      - If you go for a walk, focus on the walk, the scenery, or the sensations in your body
      - If you are talking with someone, focus on the conversation
      - Remember your mind will wander and be hypervigilant for threat…Bring it back to the present moment with patience and compassion
      - Be willing to drop your guard in situations where the risk is no more than minimal

2) Identifying and planning valued activities
    a. Valued activities can be with important / meaningful or enjoyable
    b. Select one activity per week, schedule it, and do it
    c. See page below for important areas of life

Valued activity	Plan for carrying out activity; Problems that may occur; Safety behaviors to avoid
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Important Life Areas:	Valued Activities
1) . **Education/ Training**: Would you like to pursue further education, or receive specialized training? What would you like to learn more about? What is important to you about your education and training?	
2. **Employment/ Career**: What type of work would you like to do? What kind of employee would you like to be? What is important to you about your work?	
3. **Hobbies/ Recreation**: Are there any special interests you would like to pursue, or new activities you would like to do? What is important to you about your free time?	
4. **Volunteer Work/ Charity/ Political Activities**: What contribution would you like to make to the larger community?	
5. **Physical and Psychological Health Issues:** What is important to you about your general health, diet, sleep, exercise, etc.? What are your goals for this mental health treatment? Are there issues other than depression you would like to address?	
6. **Spirituality:** Are you a spiritual person? If so, what does spirituality mean to you? What does a spiritual life mean to you?	
7. **Responsibilities:** What new daily responsibilities would bring a sense of accomplishment?	

Valued relationships

- Relationships and social connections are among of the strongest predictor of wellbeing
- Relationship problems are common in PTSD
    - Avoidance
    - Withdrawal
    - Feeling distant/cutoff
    - Anger
    - Numbing
    - High levels of emotional distress
- While problems in relationships and socializing may not be your fault, it falls on you to improve them….others are not going to change
- Tips for improving relationships and social connections?
    - Put in time
    - Schedule activities together
    - Practice listening
    - Practice sharing
    - Be careful of judgements and assumed intentions
    - Let things go
    - Don't keep score
    - Don't stonewall
    - Allow others to be upset
    - Repair relationship ruptures as soon as possible
    - Practice unconditional acceptance
    - Take an interest

Ways to re-connect or stay connected

- Start by reaching out (and reconnecting if necessary) with the people who are important to you.
    viii. Take the responsibility on yourself
- Be willing and committed – Remember the goal- to improve your relationships with others
    i. Don't keep score
    ii. Don't hold onto grudges
    iii. Drop your emotional guard
        1. Let the person know that he/she is important to you
    iv. Remember there are multiple ways to connect from telephone, to text, to visiting, to mutual activities, to emails, to letters, to social media, etc.
    v. You are in it for the long-haul, no one interaction or relationship failure should lessen your commitment
    vi. All relationships are difficult (including friendships) and take hard work and some forgiveness

- Establish a routine or schedule of contact
    1. For example, calling your brother every Sunday
    2. Breakfast with your daughter every Saturday
    3. Family event every Monday evening
    4. Call friend at least once per week
    5. Organize a friends lunch
    6. Date night once per month
    7. The more specific your plans the better

- Be mindful of your judgments and reactions towards others (and yourself).
    - Assume positive intent
    - Use the question, "am I sure"
    - Practice acceptance and tolerance

Identify and Plan Valued-Relationships

- Identify the important relationships you want to re-establish, improve, or maintain and write an action plan in the right column.

Valued relationship	Action plan: what might get in the way; what safety behaviors to avoid; what specific activities to you want to engage in (remember, connecting or reaching out is an activity)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

USE SCHEDULE BELOW FOR ACTIVITIES AND RELATIONSHIPS

Schedule: Please specify day and time you will carry out each activity. This will increase the likelihood of it occurring. Or at a minimum specify the day and if the activity will be occur in the morning, afternoon, evening, night.

	important Activity	Enjoyable Activity	Relationship Activity
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Notes			

Homework:

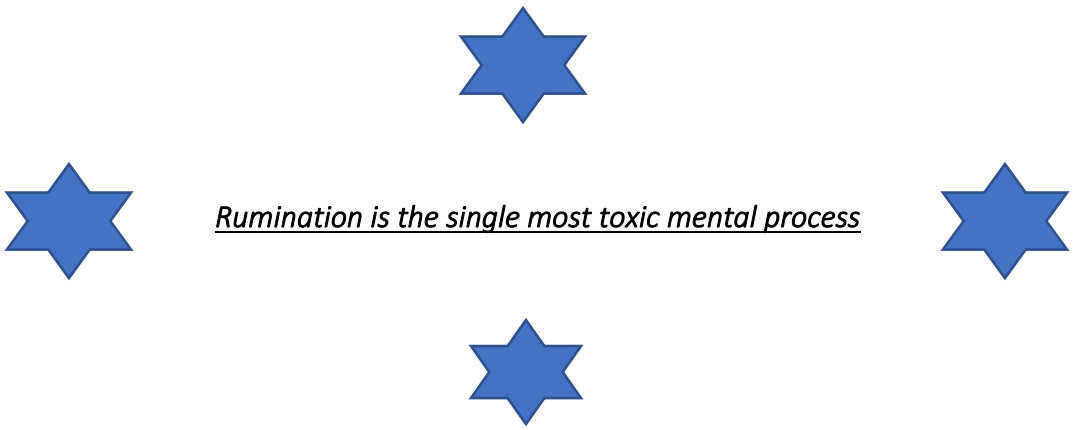
1) in-the-moment acceptance
2) countering vigilance
3) schedule on activity and one relationship activity per week
4) Trust-related countering

RUMINATION

1) MBC – PCL, SBAF-PTSD, IMQ
2) Discuss progress with ongoing interventions:
    1) in-the-moment acceptance
    2) continued practice dropping vigilance
    3) Trust-related countering
    4) Valued actions
3) Education rumination and PTSD
4) Recognize, drop, and refocus
6) Homework
    1) Identification of practice exercises for the trust-related safety behaviors
    2) Continued valued actions
    3) Monitor rumination or
    4) Active intervention to reduce rumination

What is rumination

- Repetitive, negative thinking about self, others, problems, situations, past events, past decisions, past wrongs, comparisons with others, memories, etc.
- Repetitive thinking about symptoms experienced, as well as the consequences, meanings, and causes of the symptoms
    - Other terms: Brooding, dwelling, obsessing, perseverating
    - Often involves negative comparisons
    - Often involves "why" types of thinking and attempts to figure problems out
- Rumination involves a sense of being "stuck" in ones thoughts



Rumination and PTSD

- Rumination is often confused with intrusive memories.
    - Both involve repetitive thinking about an event and negative emotions
- However, there are important differences between rumination and intrusions
- Rumination makes PTSD symptoms worse
- Rumination may limit the effectiveness of PTSD treatments
- Rumination prevents the processing of a traumatic memory, even though it is being thought about a lot

Intrusive memories	Rumination
Uncontrollable recollection	Volitional thinking (usually of event and all related problems)
Strong negative emotions	Negative emotions – but less strong
Brief – actual intrusions do not last long	Long-lasting, without resolution
Mostly visual – some involve other senses	Mostly verbal, with some imagery; Analytical thinking about trauma, causes, and consequences; Why questions are common
Usually followed by attempts at suppression	Often self-perpetuating
Focused on specific episode(s)	Broad focus on episode(s) and impact on life
Unwillingness to talk about with others	Willingness/compulsion to talk about with others >> can often lead to interpersonal problems

Consequences of Rumination and PTSD

- Rumination increases intrusive memories and reactions to memories
- Rumination maintains negative emotional states
- Rumination maintains depression and anxiety
- Rumination increases anger and resentment
- Rumination worsens relationships

Other consequences of rumination

- Sustains feelings of distress and negative mood states—
- keeps attention focused on negative information (aspects of self, situation, others, memories, etc.)- Intensifies negative thoughts and worsens mood
- Populates mind with negative thoughts and doubts about self-worth >> Magnifies importance of failures, discounts achievements, recall more negative information, and results in gloomy predictions about the future

- Also increases anger, negative feelings, anxiety, feelings of helplessness, sadness, distress, insomnia, hopelessness, tiredness and pessimism, as well as decreased positive emotional states, increased physical symptom reporting, negative self-evaluations, diminished feelings of c control, delayed recovery from stressful events, worse memory functioning, and thought to be part of a causal chain leading to long-term health consequences

Examples of ruminative types of thoughts

1) why can't I handle this
2) I feel terrible
3) Will this ever get better?
4) Why don't I feel like doing anything
5) Why did this happen to me
6) What does this mean about me
7) What if it goes wrong
8) Why am I still thinking about this
9) My trauma was nothing compared to_____
10) What is wrong with me?

Other information about rumination

- Rumination makes PTSD (and life) worse
- Rumination is often context dependent (happens more during certain activities, situations, or times of day)
- Rumination never leads to resolution
- Rumination feels like being stuck in a round-room of thoughts
- Ruminators have elevated beliefs that it is helpful for problems solving

Frequent Topics of Rumination in PTSD:

1) Trauma- what led up to it (e.g., decisions) and what the consequences have been
2) Symptoms- attempts to figure out how to control them; how difficult they are to deal with; how upsetting they are; perceived lack of control; how they are affecting ones life; how they are affecting ones relationships; how others can't understand how difficult they are
2) Current state of life
3) Perceived slights, disrespects, wrongs, unfairness
4) Short-comings of self and others
5) Lack of understanding from others
6) comparisons with others
7) comparisons with how one used to be
8) Comparisons with how one should be

Functional analysis of rumination

1. The context/situations that influence (e.g., trigger) rumination and associated behaviors
    a. Specifying when, where, how, and with whom it happened
    b. Specifying when, where, how, and with whom it does not happen
2. The usefulness/function of the rumination
    a. What is the purpose/goal of the rumination
    b. What are the consequences
    c. What are the advantages and disadvantages
    d. What is avoided as a consequence of the rumination
3. The development of the behavior
    a. When did it start
    b. How was it learned and from whom
4. Other options instead of rumination
    a. Key focus is on identifying and assessing variability (e.g., what is different between the times when rumination results in helpful versus unhelpful consequences? What is different between the times rumination is relatively brief versus extended? What happened just before rumination stopped (external interruptions or shift to more helpful thinking). Identifying useful thoughts at the end of a bout of rumination and encouraging their use as an explicit strategy earlier in the sequence can help patients to condense out the unhelpful section of the ruminative bout.
5. Contextual Factors

    a. Early in the morning, late at night, being along, feeling tired and bored, increased physical pain and tension, sitting and doing nothing (having a coffee or a smoke), feeling disorganized and under pressure, withdrawing when upset (most often to bedroom)
    b. Use this information to alter routines and environments
    c. Increasing structure and activity and especially shifting balance of activities from routine chores and obligations towards more self-fulfilling and absorbing activities
    d. Encourage patients to slow down, do one thing at a time, pace their activities (without taking on too much) may help reduce sense of rushing around and begin under pressure which feeds into rumination

Interventions for rumination

1) Monitoring
2) Awareness – Early recognition
3) Recognize, drop, and refocus
4) Alter environmental and behavioral contextual factors
5) Behavioral activation
6) Mindfulness
7) Attention training
8) Postpone rumination
9) Prescribed rumination time

Rumination Homework week 1:
Monitor rumination
Rumination Homework week 2:
Actively attempt to reduce rumination through any above strategy

Special Considerations- Worry

Special Considerations: Worry

- Worry is a common with PTSD and ranges from worry about safety of self and others to extensive planning in attempts to minimize uncertainty in the event that something should happen.
- Worry is preventative and done in to prevent future or possible threat or harm
- Worry prevents corrective learning about the likelihood of future catastrophes from occurring. Despite repeated non-occurrence, worry continues and the perceived likelihood of catastrophes remains high
- They prevent patients from re-learning a sense of relative comfort and security and maintains a looming uneasiness that anything can happen at any time.
- When negative outcome does not materialize, the safety behavior attribution is made.
- Worry – vigilance for distal threats – attempts to problem solve
    - Planning = Vigilance for distal threats- attempts to increase perceived control, predictability, and certainty. Decrease likelihood of negative outcome (e.g., wasting time, wrong decisions)
- Done to prevent a threat, misstep, or mistake or catch it early or problem solve to prevent it.
- Automatic mental processes that involve attentional focus
- keep a person on-guard, preoccupied, tense and anxious
- Often occur in response to uncertainty
- Prevent us from learning that feared outcome is unlikely… a recent study showed that 91% of worries never come to pass.

Common safety behaviors related to worry

1) Worry about safety of self or others
2) Worry about possible catastrophes
3) extensive preparation and planning
4) Checking on loved ones to assure that they are ok
5) Planning out routes to work (or different routes)
6) Over-prepare

Ways to reduce worry & rumination

1. Attention Training Technique (ATT)
   - ATT is similar to an attention workout that results in increased flexibility, increased ability to enter into and out of attentional states and mental sets.
   - Strong evidence exists that it reduces vigilance/worry/monitoring/rumination.

ATT comprises three externally focused auditory attentional tasks: 15 minutes
   - Selective attention (5-6 mins)
   - Attention switching (5-6 mins)
   - Divided attention tasks (2-3 mins)

ATT is not a direct strategy, but should be thought of as increasing and strengthening attentional flexibility- thereby increasing the effectiveness of the direct strategies
The main problem with negative attentional states is inability to disengage from them
Prior to beginning:

How much control do you have over
How much time a day do you spend

Instructions:
   - Sit in a comfortable but alert position
   - IF a window is in the room, open it at sit with back to the window
   - If no window just make sure there is room behind you
   - Keep eyes open and fixed on one spot
   - If unwanted thoughts, memories, feelings, of physical sensations surface treat them like background noise and return to the exercise

Practice in-session

Debrief following:

How was that for you?
Was it difficult?
Did anything stand out?

2. Regular Meditation Practice

- Mindful meditation will also increase attentional flexibility
- Decrease reactivity to thoughts and emotions
- Increase ability to focus attention in-the-moment (present-mindedness)
- Enhances general wellbeing
- Recommended meditation practices:
    - Mindful meditation on the breath
    - Mindful meditation on thoughts – observing thoughts as they come and go
    - Mindful meditation on feelings- Observing feelings and internal sensations

<u>Direct Strategies for Worry & Rumination</u>

1. *Recognize, Drop, and Refocus (RDR)*

- This is a practice-based intervention. One that requires diligence and patience. If you have to RDR 100 times during an exercise than do it 100 times. That is part of the process and you are benefitting from recognizing and refocusing attention.
- Step one: Recognize when engaging in worry or rumination
- Step two: Mentally tell self to drop or let go of worry or rumination
- Step Three: Refocus attention to present-moment activity or opposite attention action ((if worry or rumination refocus to present moment)
- Practice, practice, practice

2. *Mindfulness- Opposite attention*

- Informal mindfulness practices
- Practicing focusing attention opposite of anxiety tendency
- This is also a practice-oriented strategy
- Practice during anxious and non-anxious situations/times
    a. Worry & Rumination
        i. Present-moment mindful practices

3. Postponement and worry (or rumination) time
   - This is most applicable to worry, planning, and rumination
   - Postpone and also have time to worry, plan, or ruminate for 20 minutes
     - Plan out specific time for worry or rumination

4. Worry fear-countering: Spend 30 minutes writing out most worrisome possible feared outcomes

   Practice this every-day for 2 weeks

   Habitation to feared outcome

   Learn it is unlikely

   Learn that most severe is not likely

   Increase efficacy

