THE NLP TRAUMA PROTOCOL

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Post Traumatic Stress Disorder: Overview

Although recognized in various forms from the time of Homer's Iliad to the present, PTSD symptoms have only been recognized as a distinct psychiatric diagnosis since the publication of DSM-III in 1980. It was recognized as Shell Shock in World War One and Battle Fatigue in World War Two. In those contexts it was understood either as a functional disorder, a minor neurosis or as an indication of malingering. In 1951, with the publication of DSM-I, it was subsumed under the general rubric of gross stress reaction. This was a non-operationalized disorder that provided a context for the treatment of otherwise normal people who had suffered through extraordinary trauma. In 1980, after years of continuing experience with Vietnam War veterans, victims of violent crime and personal trauma, PTSD was accorded the status of a distinct psychiatric diagnosis under the group of anxiety disorders. Despite its inclusion in the DSM, its current diagnostic status has not been without controversy (Bodkin, Alexander, Detke, Pope, & Hudson, 2007; Davidson, & Foa, 1991; Foa & Meadows, 1997; Friedhelm & Sack, 2002; McHugh, & Treisman, 2007; Spitzer, Wakefield, & First, 2007)...

PTSD is defined by the DSM-IV in terms of four criteria. The first of the criteria is the traumatizing event. In order to qualify as a traumatizing event both of the following must appear: 1. the person experienced, witnessed, or was otherwise

confronted with one or more events that actually involved or threatened death, serious injury or some other threat to the physical integrity of that individual or others. 2. The individual's response involved intense feelings of horror, fear or helplessness.

The Psychological criteria are divided into three symptom clusters, the re-experiencing cluster, the avoidance / numbing cluster and the arousal cluster. According to Foa & Meadows (1997) the intrusion or re-experiencing symptoms include the hallmark signs of PTSD including nightmares, intrusive thoughts and flashbacks. The avoidance group includes efforts to avoid memories of the traumatic experience and symptoms of emotional numbing. The third symptom cluster includes symptoms of hyper arousal including sleeplessness, irritability and hyper vigilance (American Psychiatric Association (APA), 1994; Bodkin, Alexander, Detke, Pope, & Hudson, 2007; Davidson, & Foa, 1991; Friedhelm & Sack, 2002; Keane, Weathers & Foa, 2000, McHugh, & Treisman,2007; Spitzer, Wakefield, & First, 2007).

Diagnosis is made when symptoms (at least one from the re-experiencing cluster, three from the avoidance cluster and two from the hyper-arousal cluster) cause clinically significant distress or discomfort and have persisted for a minimum of one month (APA, 1994).

PTSD has been traditionally explained as arising out of classical and operant conditioning; depending upon classical conditioning for the acquisition of intrusion and physiological arousal symptoms and operant processes for the symptoms of avoidance. Classical behavioral treatment has depended upon extinction for the resolution of these symptoms. By experiencing repeated exposures to the fear-evoking stimuli or stimulus context without negative consequences, or the presence of competing positive responses,

the fear-based responses diminish and are eventually extinguished. Foa et al. have understood these changes in terms of Rescorla's (1988) interpretation of extinction as the organism's active restructuring of memory to account for mismatches between expectation and experience (Foa, Keane, & Friedman, 2000, Foa & Meadows, 1997).

More recent formulations, set forth by Foa and her colleagues (Foa, Keane, & Friedman, 2000, Foa & Kozak, 1986; Foa & Meadows, 1997), rely upon the bio-informational theory of Peter Lang. Lang (1983) sees emotions as information networks that are presumed to be stored in long term memory as both a set of propositions about the circumstance and a set of motor programs in response to the circumstance. When a person experiences an emotion they evoke three levels of information: information about the stimulus and its meaning in a given context, information about the appropriate response to the stimulus (emotional language, appropriate motor responses and the autonomic responses that support them), and information about the relationships between the stimulus and possible responses. For fearful responses, the networks tend to be coherent, that is, they tend to hold together as consistent patterns of response, they are easily activated -- even by partial stimulus representations -- and whether or not they result in overt action, there is always a characteristic autonomic response.

Treatment of PTSD or other fear-based pathologies are dependent upon two elements: (1) Elicitation of the fearful experience as fully as possible and (2) modification of the memory structure to include information (experiences) that transform the meaning of the memory structure. The PTSD response is generally linked to multiple stimuli and is more easily evoked than other fearful responses. Nevertheless, in order to insure effective treatment, care must be taken to insure that the fear response is evoked as

fully as possible. In transforming the memory structure at the root of PTSD symptoms, new information that is incompatible with some or all of its pathological structure must be incorporated into the memory schema itself. Some of these erroneous patterns include the expectation that fear-related anxiety will persist unless it is escaped or avoided, conflation of unrelated anxiety with the specific trauma-induced anxiety, feelings of personal incompetence as a result of experiencing the anxiety or losing control, and thinking that the anxiety itself is dangerous (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997).

Exposure treatment in its various guises is the most fully understood and best researched of the methods for treating PTSD (Foa, Keane, & Friedman, 2000, Foa & Meadows, 1997). This form of treatment includes such variants as flooding, in vivo and imaginal therapies. In general, exposure treatment has depended upon either direct confrontation with the fear evoking stimulus (whether the actual stimulus/event or conditioned stimuli which evoke the fear response) as in vivo treatment, or upon imagined confrontation with the stimulus event or conditioned trigger, as imaginal treatment.

In all of its varieties, exposure treatment depends upon repeated sessions of prolonged exposure to the feared stimulus until anxiety is reduced. After repeated sessions, anxiety produced by the fear inducing stimulus is reduced. This in turn reduces the negative reinforcement of avoidant and escape behaviors. Exposure therapy accomplishes the following tasks: 1. Repeated exposure to the relevant stimuli extinguishes the fear response and corrects the idea that that anxiety and fear will last forever. 2. Confronting fearful stimuli depotentiates the flight and avoidance responses

by eliminating the possibility for their negative reinforcement. 3. The provision of a safe environment for reliving the trauma adds to information in the memory structure that the memory of the experience may be experienced safely and that it is not identical with the original experience. 4. Long term exposure to the traumatic event or stimulus reinforces its existence as a discrete event, separate from other anxiety or fear producing memories or situations. 5. The conscious choice to relive the trauma transforms feelings of personal incompetence and loss of control into a personal experience of courage and self-efficacy. 6. Repeated exposure to the fear evoking stimulus allows the patient to reevaluate their self image in light of the specific details of the fear-producing event (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997).

In evaluating the efficacy of treatment, Foa & Kozak (1986) suggest that a simple attempt to elicit the fear response, "test probes" may not always be an indication of successful treatment, but might represent a failure to appropriately elicit the fear-response. As a result they differentiate between treatment outcomes and indicia of emotional processing. Emotional processing is the ongoing process of transforming the hypothesized memory structure that encodes the fear response. Signs of effective and ongoing emotional processing include attenuation of the anxiety response within sessions (within session habituation), between session reductions in anxiety at the initial presentation of the fear-evoking stimulus (across-session habituation) and decreases in the physiological correlates of fear (e.g., heart rate, skin conductance, breathing rate, posture, facial expression). Treatment outcomes are conceptualized as final results, and include such things as better adjustment at home and work as well as reduction in symptoms.

NLP: Overview

Neuro-Linguistic Programming (NLP) is a set of tools comprising an epistemology, a methodology and a set of techniques rooted in a strategy for modeling human behavior developed in the mid 1970's by linguist John Grinder and Psychology graduate student Richard Bandler. Grinder, then assistant professor of Linguistics at the University of California, Santa Cruz, was inspired by the transformational grammar of Noam Chomsky. In his adaptation of transformational grammar, Grinder understood that the structure of both language and experience could be modeled in terms of sequences of sensory experience including what was seen, heard, felt, smelled or tasted: the Visual, Auditory, Kinesthetic, Olfactory and Gustatory (VAKOG) elements. When accurately mapped, these sequences would provide the keys not only to modeling the subject behavior but also to modifying unwanted or un-useful behaviors (Bandler and Grinder 1975, 1979; Bostic St. Clair & Grinder, 2002; Dilts, Bandler et al., 1980; Dilts & DeLozier, 2000; Tomas Yeager, 2007, Personal Communication).

Bandler was described by Grinder as natural therapist who had the unique skill of being able to learn and quickly master almost any psychotherapeutic technique. As their collaboration began, Bandler would experientially master a psychotherapeutic approach and together they would parse the more salient aspects of the techniques involved in terms of Grinder's model (Bostic St. Clair & Grinder, 2002).

At Bandler's urging, Grinder first applied his model to Fritz Perls' Gestalt Therapy where he found regular use of verbal patterns already well known to linguists and other patterns which he documented as techniques for behavioral change. Over the

next several years, often at the urging of Gregory Bateson, Grinder and Bandler applied their modeling skills to the patterns and techniques of Virginia Satir, founder of conjoint Family therapy and founding member of the Mental Research Institute in Palo Alto, California; Milton Erickson, often described as the father of modern hypnotherapy; and others. In the course of their researches they created a technique for modeling behavior and a series of tools of general applicability in therapeutic and other contexts as well as interventions for specific pathologies, learning problems and behavioral issues. This basic repertoire was enhanced significantly by the contributions of other early participants in the development of NLP including Robert Dilts, another of Grinder's graduate students; John and Connierae Stevens (Steve and Connierae Andreas), already well known in Gestalt circles; Leslie Cameron-Bandler, Judith DeLozier; David Gordon and Steven Gilligan (Bandler and Grinder 1975, 1979; Bostic St. Clair & Grinder, 2002; Dilts, Bandler et al., 1980; Dilts & DeLozier, 2000; Lewis and Pucelik, 1990; O'Connor and Seymour, 1990).

The end product of these efforts was a set of basic skills and techniques that may be thought of as the basic NLP tool kit. In general, they represent the elements of most NLP-based interventions. According to Dilts and DeLozier (2000) these include primary representational systems, accessing cues, sensory based predicates, the meta-model, pacing and leading, anchoring, reframing, change personal history, Visual-Kinesthetic Dissociation and state management. For our purposes, time-lines and submodalities are considered essential elements of the tool kit.

The NLP Protocol: Overview.

The NLP protocol (Andreas and Andreas, 1989; Andreas, 2007 (unpublished protocol) begins with the establishment of rapport. Rapport is conceived as a state of trust between the therapist and the client which may not encourage disclosure but does facilitate cooperation. Although not strictly necessary from the perspective of classical psychology (Lang, Melamed & Hart, 1970), it represents an important part of the inter-subjective perspective of NLP (Dilts, Bandler et al., 1980).

As a second step, the protocol calls for the elicitation of the fearful response. That is, the client is instructed to access the problem experience or the context that evokes it as fully as possible. This is fully compatible with Foa and associate's requirement that the first step in successful treatment of PTSD is a complete-as-possible elicitation of the fear response (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997). This response is evaluated by the therapist in terms of overt behaviors, reports of distress and more importantly, the physical correlates of fear: changes in skin color, posture, facial expression, heart rate, respiration rate, etc. When the therapist is satisfied that the client has genuinely experienced the fear response, but before it becomes unbearable, he is returned to a safe and calm present by returning his full attention to the present time and context (Andreas and Andreas, 1989; Andreas, 2007 (unpublished protocol)).

This step serves the dual purpose of allowing the therapist to assess the client's ability to access the appropriate affect and will serve as a basis of comparison for assessing whether the intervention has been effective.

Step three involves the creation of a dissociated state that is associated to the therapist's touch as a conditioned response. The dissociation is typically achieved using the visual metaphor of a movie theatre. The client imagines being seated in a theater looking at the screen where there is a large, black and white image of himself performing some neutral activity. He is instructed to imagine himself dissociating from the watcher using one of several images and floating back to a space in the projection booth where he can watch himself watching the movie. This serves the purpose of creating a safe condition separated from the re-experience of the feared event and represents the first of several levels of information to be reincorporated into the memory structure of the event (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997). Once again the therapist assesses the client's compliance by observing the physiological signs of dissociation: stillness, facial symmetry, lack of animation, etc. In accordance with the interpersonal context assumed by NLP and the probability that no one dissociation method will work for each and every client, the Andreas protocol provides several possible means of creating the dissociated state (Andreas and Andreas, 1989; Andreas, 2007 (unpublished protocol); Dilts, Bandler et al., 1980).

When a dissociated state is achieved and conditioned to the therapists touch (anchored, in NLP terminology), the client is given instructions to change the scene on the imaginal screen to a picture of himself before the trauma occurred, when everything was fine. He is then asked to watch himself (the watching self in the theater) as he watches a fast, black and white movie of the traumatic event beginning with the safe context (now on the screen) until he reaches the neutral but safe context that he first imagined on the screen. During the entire viewing the therapist keeps contact with the

dissociative anchor to ensure that the client remains emotionally separated from the content of the film. By viewing himself viewing the black and white movie of the event, the client adds another layer of information to the memory schema, which begins a transformation of the memory structure (Andreas and Andreas, 1989; Andreas, 2007 (unpublished protocol); Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997).

Immediately after the completion of the black and white movie, the client (who has been instructed in the process beforehand) is instructed to imagine himself stepping into the picture on the screen (the safe neutral picture after the movie ends) and to imagine reliving the entire movie, backwards at high speed, from within his own body, in full color, and ending the experience associated into the picture of himself before the trauma occurred. The rewind of the traumatic event can be understood as adding significant new information to the fear schema and, if successful, resulting in a restructuring of the client's response to the original eliciting stimuli (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997).

After completing the reversed movie, the client is again asked to access the memory or stimulus event. His response is monitored for the indicia of fear and anxiety and compared with the original fear access in step two of the protocol. If no physiological signs of fear or anxiety appear, several attempts are made to reaccess the event, the stimulus, or the fear itself. This series of "test probes" is used to overcome the problem of confusing successful relearning with failure to appropriately elicit the fear response. Further, by focusing upon physiological indices, there is no need to rely simply upon the client's report (Foa & Kozak, 1986).

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The following protocol is taken largely verbatim from unpublished sample protocols submitted by Steve Andreas and Tim Halbom (2007, personal communications). The procedure was originated by Richard Bandler and first appeared in his *Use Your Brain for a Change* (1985). An expanded version of the procedure appeared in the Andreas' description in the *Heart of the Mind* (Andreas & Andreas, 1989). Dilts and Delozier (2000) provide a slightly different version of the protocol in their *Encyclopedia of Systematic NLP*.

PHASE ONE

Prescreening.

Before proceeding with the treatment of PTSD, it is essential to ensure that the client meets specific diagnostic criteria. This step establishes exclusion criteria. In the case of the following protocol it is essential that "the client's difficulties are essentially a phobic, instantaneous conditioned response to a stimulus related to a traumatic event" (Andreas, 2007, unpublished communication). Andreas cautions that this relatively pure incidence of PTSD is to be distinguished from problems that represent the client's responses to the meanings of the event in the client's larger life and the impact of such events on the client's sense of self worth. The protocol will not be effective for those dimensions of the problem. If both kinds of response are present the client must be advised that the protocol will work for the phobic elements--eliminating flashbacks and other immediate panic responses to reminders of the traumatic event—but will not work

with larger life issues which will require other kinds of treatment. Assent to the limitations of the procedure are a crucial defining factor for the appropriate use of the protocol.

This accords with DSMIV criteria which define the stimulus event as a crucial element of diagnosis. In order to qualify as a traumatizing event both of the following must appear: 1. the person experienced, witnessed, or was otherwise confronted with one or more events that actually involved or threatened death, serious injury or some other threat to the physical integrity of that individual or others. 2. The individual's response involved intense feelings of horror, fear or helplessness (American Psychiatric Association, 1994; Foa & Meadows, 1997; Keane, Weathers & Foa, 2000; Davidson & Foa, 1991). A listing of DSM symptoms is provided as Appendix I.

For this protocol to work effectively, the problem must 1. Be rooted in the personal experience of trauma threatening death or injury to one's self or others, and 2. Be expressed as an intense, suddenly arising experience of the trauma symptoms usually experienced as flashbacks or panic reactions.

This protocol does not address secondary issues including substance abuse, marital disturbances, work problems, etc. While in some cases these may be positively impacted, they will, for the most part, require separate treatment.

Rapport and Framing

We note from the outset that most cognitive approaches to PTSD do not emphasize rapport. Insofar as exposure techniques rely on the elicitation of the fear response and its extinction or habituation through lack of reinforcement, the technique may be rather mechanical. Lang, Melamed & Hart (1970) have shown that the exposure

techniques do not require rapport, and can even be accomplished without the physical presence of a therapist.

NLP begins most of its interventions with the establishment of rapport. This is done for several reasons. NLP views change work as occurring in the subjective space between two or more people. NLP also assumes that each person has a distinctive map of the world that does not in all points correspond either to another person's map or to the common reality with which they must deal. In order to communicate across this representational space and to establish a common set of understandings for such communication, rapport is an essential tool (Dilts, Grinder, Bandler, & Delozier, 1980).

Rapport may be understood not only as the establishment of a state of trust or empathy between persons but also as a state of mutual sensitivity to the meanings and values held by the participants in the communication. Moreover, given that NLP often requires the client to perform relatively sophisticated behavioral tasks, a felt sense of rapport is a crucial element in the protocol (Dilts et al., 1980).

Rapport may be established in several ways. Specific techniques may include postural matching, matching breathing, predicate matching, matching voice tone rate and volume. In general, however, presenting an open and honest concern for the client and carefully eliciting feedback to ensure that you have correctly understood their meaning usually produces a significant level of rapport. This can be deepened by matching their use of language predicates and their paralinguistic behaviors. Rapport is usually manifested by a dance of matched movement, breathing and other paralinguistic elements as the participants consciously or unconsciously enter a phase of physical communication

(Andreas & Andreas, 1989; Bandler & Grinder, 1979; Dilts et al., 1980; Dilts & Delozier, 2000).

Rapport may also be crucial for trauma work as it can provide a significant link to the present as a safe place or context should the elicitation of the problem state grow too intense. Insofar as a strong rapport has been established it serves as a positive physiological reference point for the remainder of the work. In NLP terms the establishment of rapport may be considered an anchor or conditioned response to a positive present state elicited by the practitioner's physical presence. In such cases the client can be called back into the present with a physical touch and the demand that they look the practitioner in the eye and breathe with them.

Framing is a verbal explanation that establishes a common cognitive map of the intended process. *It* provides a meaningful context for the intervention. It sets up specific expectations about the procedure, gains crucial permissions (for touching in the case of a physical anchor), and is used to defuse any anxiety associated with treatment. In practice, it allows the practitioner to set the limits on discomfort that the client may experience and serves to review the general procedures to be used. Framing also serves to separate the intervention from other forms of treatment that may have been unpleasant or ineffective. In doing so, it serves to eliminate anxieties related to reliving the trauma or losing control. Finally, the frame is important in establishing a relationship in which the client is empowered to stop and question the procedure as necessary (Andreas, 2007, Unpublished).

Andreas suggests that the frame be set as follows:

> Explain that you will be doing a short visualization process with them that is ordinarily comfortable overall, but sometimes has a very short period of moderate discomfort.
>
> Ask about any previous therapy or attempted interventions, and explain how the process you will use is very different, in particular, that it does not involve "reliving" the traumatic events or "catharsis" or "release" of feelings.
>
> As part of the process you will use, you would like to be able to put your hand lightly on their forearm during part of the process, and demonstrate this by placing your hand gently on their forearm and holding it there briefly, asking, "Would that be all right with you?" Then ask, "Do you have any questions or concerns before we begin? If they have any concerns about doing this process, respond to those congruently, and assure them that if any questions or concerns arise at any time during the process, it is fine to interrupt it and tell you what they are. (Andreas, 2007, Unpublished)

Accessing the problem state

According to Foa and her colleagues (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997), elicitation of the problem state is the sine qua non of effective trauma treatment. They also warn specifically against the use of ineffective probes or questioning techniques that fail to elicit a valid physiological experience of the trauma induced anxiety or fear. The NLP protocol relies on multiple questions and the assessment of physiological concomitants of anxiety. A simple verbal answer regarding

the problem state is never sufficient; the practitioner must be able to identify the specific indicia of anxiety and fear as they arise in the client's physiology in the present time. If there is no physiological response that indicates that the phobic response has been triggered, the intervention will not be successful (Andreas, 2007, unpublished; Andrreas & Andreas, 1989; Bandler, 1985; Bandler & Grinder, 1979).

More specifically, after establishing rapport the practitioner should ask about the problem state. Halbom (2007, unpublished) suggests the following questions:

1. What is your problem and how does it present itself?
2. What is the specific event or events that caused it?
3. When does it trouble you most?
4. What are the symptoms associated with it? Where are any unpleasant feelings located in the body?
5. What is it like when you experience these symptoms?

It is important to understand that most NLP interventions may be pursued content free. That is, the practitioner does not need to know the specific content of the presenting problem; physiological changes should be enough. If the procedure is pursued as a content-free intervention, then the notations regarding the client's verbal behavior are somewhat mooted (Andreas & Andreas, 1980; Grinder & Bandler, 1979; Dilts & Delozier, 2000; Dilts et al., 1980).

As the client responds to each question the practitioner is to attend to the physiological and paralinguistic elements that reflect heightened arousal and the

elicitation of the problem response. Andreas (2007, unpublished) reports that one of the most reliable signs of having identified an appropriate trigger, is the fast onset of the physiological and paralinguistic symptoms of fear or trauma. These symptoms may include changes in breathing, heart rate, skin tone and color, vocal pitch and speech rate. Muscular tension, tremors and postural changes may also be noted as the client moves into the problem state. It may be useful to make notes as to what the client was saying as the symptoms began, whether they were focused inwardly or outwardly, in an associated or dissociated state. The practitioner should note the specific predicates used in describing the stimulus whether visual, auditory or kinesthetic and, if mixed, in what sequence the language was used.

These responses serve three essential purposes. 1. They allow the practitioner to clearly identify the problem state in terms of its physiological concomitants and to verify that it is an appropriate phobic response that arises quickly and intensely. 2. They allow the practitioner to identify the specific trigger or stimulus that evokes the state in terms of the client's own descriptive behavior at the time of symptom onset. 3. By providing a typical response to the eliciting stimulus, they provide information that can be used to identify the problem state, should it re-emerge in the testing phase after a failed or incomplete treatment. By extension, their absence in the testing phase will signal the success of the treatment (Andreas, 2007, unpublished; Andreas & Andreas, 1980; Bandler, 1985).

There are more subtle elements involved here. First, the series of questions, asked in the context of a rapport centered about awakening the problem state, engages the practitioner and client in a reciprocal relationship of successive approximations that

begins to activate the autonomic system, sensitizing the client to the relevant stimuli. Second the conscious elicitation of the flashback or phobic state represents a first layer of cognitive restructuring as described by Foa and her colleagues (Foa & Kozak, 1986; Foa, Keane & Friedman, 2000).

According to Foa, the treatment of PTSD, or other fear-based pathologies is dependent upon modification of the structure of the traumatic memory to include information (experiences) that transform the meaning of the memory structure. In transforming the memory structure at the root of PTSD symptoms, new information that is incompatible with some or all of its pathological structure must be incorporated into the memory schema itself. Some of these erroneous patterns include the expectation that fear-related anxiety will persist unless it is escaped or avoided, conflation of unrelated anxiety with the specific trauma-induced anxiety, feelings of personal incompetence as a result of experiencing the anxiety or losing control, and thinking that the anxiety itself is dangerous (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997).

Recent research into the molecular basis of memory has revealed the phenomenon of memory reconsolidation. A growing body of work is revealing that upon evocation, at least certain types of long term, "permanent," memories are rendered labile and become subject to change and manipulation. This phenomenon is apparently distinct from extinction phenomena which are believed to lay down new memory traces but leave the original memory unaffected. By adding corrective experiences to traumatic memories, we are apparently actively modifying the memory itself (Bouton, 2004; Bouton & Moody,

2004; Doye're, Debiec, Monfils, Schafe & LeDoux, 2007; Nader, Schafe & LeDoux, 2000; Tronson & Taylor, 2007).

Here, the participation of the client in consciously accessing the problem state begins the restructuring of the problem state using the Ericksonian technique of prescribing the symptom. By actively participating in eliciting the problem state, the client gains an experience of control over what was understood to be an uncontrollable and unpredictable traumatic response. This is also represents an instance of the therapeutic use of Bandura's concept of self-efficacy in the context of PTSD treatment (Bandura, 1997; Erickson & Rossi, 1980; Haley, 1973; Watzlawick, 1974; Watzlawick, Weakland & Fisch, 1974; Watzlawick, Beavin & Jackson, 1967).

Break state

Because the State just accessed is, by its nature traumatic, it is important to interrupt the state's development as soon as possible after its identification. Andreas recommends moving into the client's field of vision and changing the topic by discussing the weather, favorite foods or any other innocuous topic. Such state interruptions are a mainstay of NLP and can be found throughout the literature. (Andreas & Andreas, 1987; Andreas & Andreas, 1987; Bandler, 1985; Bandler & Grinder, 1979; Bodenhammer & Hall, 1998; Halbom, 2007, Unpublished; Watzlawick, 1974; Watzlawick, Weakland & Fisch, 1974).

Dissociation and treatment frame

The bulk of the treatment is now carried forth in the imaginal context of a movie theatre where the client watches and or participates in several versions of the traumatic event. To begin with, have the client imagine that he or she is seated in a movie theatre.

On the screen is a still image of them performing some neutral activity in a safe context. As they watch, have them dissociate from the image of themselves sitting in the theatre in one of the following ways: Imagining a physical dissociation by floating away to a projection booth behind a Plexiglas barrier, floating away from the body and imagining that they are standing behind the body holding their own shoulders and monitoring their own embodied state or by distorting the image sufficiently that no association to the image is possible. Andreas suggests the following language.

a. "Leave your body in that seat, and move up to the projection booth of the theater, so that you can see yourself sitting in the middle of the theater, watching that black and white image on the screen. . . .

"Now place your hands on the Plexiglas screen in the front of the projection booth and feel the hard surface of the Plexiglas separating you from the image on the screen. . . ."

b. "Now I want you to physically take a step back, imagine that you are standing behind you, and that other you is facing away from you. Now place your hands on the shoulders of that image of yourself—so that you can feel the posture and muscle movements of that person in front of you—and keep them there."

c. "I want you to imagine that you are in a very large movie theater, sitting in the front row, but very far off to one side, so that the screen looks very narrow and thin to you, and since you are off to the sides, you can't hear the sound very

well. See a black and white still image of yourself in a neutral context (talking to a friend, doing the dishes, etc.) up on the screen, and notice how tall and thin you look in that distorted image. . . ."

d. "I would like to hold a small tuft of your hair at the back of your head, and gently pull your head straight back an inch or two, to hold your head in that position to assist you in doing this process. Would that be all right with you?" Then reach out and hold a tuft of hair right where the curve of the back of the head meets the neck, and gently pull the client's head *straight* back, making sure that the client does not roll the head up or down, (or side to side) as you do this. (Andreas, 2007, unpublished).

Dissociation ensures that the client will not be resubjected to the emotional impact of the original trauma. Nevertheless, contact with an imagined self watching the screen, and/or having the capacity to monitor postural and breathing changes that the client might exhibit if watching the imagined movie, are enough to ground the experience in the unique physiology of the problem state. In light of reports by Foa and Kozak (1986) that observing emotional responses and attending to representations of such responses can be crucial elements in eliciting emotional memories, the instruction to observe the watcher in the theater may be a crucial element in this phase of the procedure.

As in the elicitation phase, the practitioner will observe the client for signs of dissociation. These may include stillness, lack of facial expression and animation as well as changes in breathing and posture. As the client moves into the dissociated state, the

practitioner should ask for permission and anchor the state (Andreas & Andreas, 1980; Bandler, 1975).

Anchoring the Dissociation

When the practitioner is sure that the client is moving into the dissociated state he should then ask for permission to anchor the state. Anchoring is a general word in NLP that can mean almost anything from a structured classical conditioning procedure using multiple iterations to produce the association between stimulus and response to a simpler mnemonic that may represent a species of one-shot learning with the client's approval. Rescorla (1988) indicates that this is a reasonable understanding of the range of classical conditioning phenomena. In this context, the anchor is established by a gentle touch on the client's arm timed to correspond with their manifestation of signs of dissociation which may include relaxed posture, breathing, facial expression, tone of voice, etc.

Andreas (2007, unpublished) describes the procedure as follows:

> When you observe this, ask the following: "Now I would like to gently place my hand on your forearm, and keep it there, to stabilize this state and to remind you of where you are. Would that be all right with you?" Then place your hand or a few fingers gently on the client's forearm and hold it there.

Classical NLP texts indicate that in order to create an effective anchor the practitioner must take some care to make the conditioned stimulus distinctive and repeatable. It is best, when using a touch stimulus as suggested by Andreas, locate it in a place where it can be easily accessed and repeated in a reliable manner. Practitioners may often use blemishes, wrinkles, distinctive indentations or other marks to ensure that

their anchors can be replicated as to place. There should also be an effort made to use the same level of force or pressure to create and evoke the anchor. While other sensory modalities may be used to create anchors, touch anchors—kinesthetic anchors—seem to be the preferred mode in this kind of work (Bandler & Grinder, 1979, Dilts & Delozier, 2000).

As in all NLP work the anchor should be tested to find out whether it works. The test can be made by releasing the touch stimulus and, after inviting the client to return fully to the present, touching them again in the same place with the same pressure (invoking the anchored state) and watching for the physical indicia of dissociation. If there is no response, the anchoring procedure may be repeated several times (the classical paradigm) until an appropriate anchor is created and tested. In the case where the client is not invited fully back into the present associated state, the anchor may increase the intensity of the dissociation. This will be revealed by the intensification of the physical symptoms of dissociation. Once again, client testimony is insufficient to accurately assess the dissociated state. Whether anchored or not, it must be evaluated by the practitioner in terms of specific sensory data.

Dissociated Movie

Once the dissociated anchor is established, the main portion of the procedure begins. This consists of two visual exposures played out in the client's imagination. The first is an imagined, dissociated, black and white movie beginning at a time before the trauma began and ending at a safe time after the trauma ended. The second is an associated color movie, played backwards and ending, likewise, in an associated, safe place. Both fantasies may be understood as restructuring the meaning of the traumatic

event and as increasing the client's sense of self-efficacy regarding the experience (Bandura, 1997; Tronson & Taylor, 2007).

In the first imagined exposure, dissociation is maintained by use of several techniques including: 1. the anchor stimulus, 2. instructions to watch the movie in black and white and 3. further instructions for the client to watch herself in the movie, from a perspective outside of her own body as if a disembodied other were going through the event. Associated imagery is typically experienced from within the subject's own body and experienced as if through their own senses; dissociated imagery is seen from without. The absence of color also enhances the sense of dissociation from the situation (Andreas & Andreas, 1989; Bandler, 1985; Bandler and MacDonald, 1987; Dilts & Delozier, 2000).

The first fantasy exposure begins with instructions that the client observe a black and white picture of herself on the screen of the movie theatre at a time before anything ever happened. As the client focuses on the imagined picture, she is directed to listen to the instructions all of the way through before proceeding. Again, Andreas provides the following instructions:

> Now close your eyes and see a black and white still image of yourself before that incident, *before* anything bad happened.
>
> I want to give you complete instructions before you do anything.
>
> In a few moments I'm going to ask you to watch a black and white movie of that unpleasant event, *seeing yourself* going through it, all the way to a point *past* the end of it, where you can see that you survived, and you're OK again.

When you get to the end of watching that movie, and you can see that you are OK, I want you to stop that movie as a still, black and white image. Keeping your eyes closed, you can nod your head to let me know that you have finished doing that.

"Do you understand? Great, go ahead and do that. . . ."

(Andreas, 2007, Unpublished)

In earlier versions of the procedure, the client is invited to observe the movie from the dissociated position and simultaneously to watch the dissociated watcher in the movie theatre, noting the physical signs of whatever discomfort they may be experiencing (Andreas & Andreas, 1989).

If the client nods to indicate that the procedure was successful and that he is now in a comfortable place--watching a safe, disembodied image on the movie screen--the practitioner may let go of the dissociative anchor and proceed to the next step. This assumes that none of the indicia of trauma noted in the accessing phase are observed in the client's demeanor, breathing, color, posture, etc. If the practitioner is unsure, he can ask the client how they experienced the exercise. If there is any indication of distress, especially mild distress, have them repeat the procedure several times until they can go through it without distress (Andreas & Andreas, 1980; Bandler, 1985; Dilts & Delozier, 2000).

If the client has continuing but not acute difficulty with the procedure, the procedure may be modified by instructing the client to watch only the top half of the movie, followed by only the bottom half or to watch only every third second of the

movie—all the way through, followed by every second second of the movie—all the way through, followed by every first second of the movie (Dilts & Delozier, 2000; Andreas, 2007, unpublished).

If the client displays signs of acute distress, the practitioner should interrupt them, distract them and reorient them to a safe present in rapport with the practitioner. As noted, this may be done by reorienting them to the weather, some pleasant diversion or what they were doing immediately before entering the therapeutic situation. Milton Erickson used a similar technique of reorientation to novel or irrelevant stimuli to create hypnotic amnesias (Erickson & Rossi, 1954; Haley, 1973).

Because of the possibility of strong reactions it may be useful to begin the procedure, after establishing rapport and setting the frame, by creating a neutral, safe or dissociated anchor. This has been suggested by Dilts & Delozier (2000), as well as Halbom (2007, unpublished).

If the client cannot run the imaginal exposure movie through without significant distress, the practitioner should go back to the third step and recreate the anchor for the dissociated state. Once an effective anchor has been established the first part of the procedure, dissociation and watching the movie may proceed.

When the client has successfully watched the black and white dissociated movie without distress, remove your hand from their arm and then move on to the next step.

Associated Movie Reversal.

The next step involves a further level of memory restructuring. Beginning with the safe representation of the client at the end of the dissociated black and white movie, the client is asked to imagine stepping into the movie and to experience the entire

sequence, fully associated, in color, in reverse, at very high speed (two seconds or less). This has several effects. Once again, the client is manipulating an event which has until now been experienced as beyond his control. He now takes control by accessing the event and by modifying it in terms of its direction, sequence and perceptual qualities. By running it backwards he dissociates from the trauma and recodes the memory as lessening through time and ultimately disappearing. By running the movie quickly, he furthers the dissociation from the event by overwhelming the capacities of short-term memory, and completing the whole sequence before negative emotional processes have a chance to build up. Before negative emotions even begin to develop, the client has entered a clear memory of a safe place before the event occurred and his most current experience of the event is backwards. Andreas provides the following language:

> "Have you ever seen a movie run backwards? Or a videotape in fast rewind? In a moment I'm going to ask you to step *into* that still image on the screen, and re-experience that event *backwards* and in *color*, but with you *inside* that experience, so that you *feel* yourself moving backwards, and I want you to do this very fast. Run that movie backwards in about a second and a half, or perhaps as much as two seconds, until you get back to the beginning, before anything bad happened. Is that clear? OK, go ahead."
>
> Be sure that they do this *very* rapidly, and then ask what that was like for them? (Andreas, 2007, unpublished)

Bandler(1985) Suggests the following language when describing the backwards movie:

> All the people will walk backwards and everything else will happen in reverse, just like rewinding a movie, except you will be *inside* the movie. Run it backwards in color and take only about one or two seconds to do it…. (p.44).

Although Andreas suggests only one iteration of this step both Dilts & Delozier (2000) and Halbom (2007, unpublished) recommend several iterations of stepping into the safe black and white picture and running the associated, reversed, color movie after testing for its effectiveness.

Test

Once the client has completed the procedure and has returned to a present neutral state, the practitioner must determine whether the procedure has had the desired effect. Again, in harmony with the observations of Foa and colleagues (Foa, Keane, & Friedman, 2000; Foa and Kozak, 1986; Foa & Meadows, 1997), simple probes are insufficient. The determination of success must be made based on physiological indicia. Once again the practitioner should make every effort to evoke the problem state. Ideally this is done using the same questions and probes used to access the problem state with special attention to those questions that were associated with a clear physiological reaction. If there is no reaction, the intervention is presumed to have worked. Nevertheless, every attempt must be made to evoke the traumatic response so as to confirm that it has been dealt with. At this point it may be useful to systematically probe each sensory system for possible triggers for the problem behaviors.

In this context it may be very important to use imagined futures, alternate scenarios and to exhaust every possibility for eliciting the trauma. By so doing one

eliminates the possibility of having only created a contextually limited extinction of the fear behavior and allows for positive verification that the fear is gone (Bouton, 2004; Bouton & Moody, 2004).

When the practitioner is satisfied that she cannot evoke the PTSD response, she can continue on to the next phase.

Phase 2

Phase two involves the creation of alternative versions of the original event. Andreas recommends its use only if there was actual physical trauma involved in the original traumatizing event. Although Halbom recommends its use more generally, as do Dilts & Delozier (2000), the content of the intervention implies the existence of physical injury. Nevertheless, insofar as the exercise represents the possibility of layering the now labile (Tronson & Taylor, 2007) trauma experience with other versions of the event, this phase may be useful in all cases.

Revised movie

Phase two continues the program of changing the structure of the memory now moving from dissociating from the emotional content and establishing a sense of self efficacy with regard to the events, to creating alternative versions of the memory.

Having removed the emotional impact from the memory, the client is now instructed to revisit the memory but to create a version of the experience where they were not injured; something different happened. Perhaps someone intervenes; perhaps the client makes a different decision or makes a different turn. The new movie should recreate the problem situation as nearly as possible but somehow without the problem.

Dilts & Delozier (2000) suggest that the client may be instructed to include experience and knowledge, now their's, that they might not have possessed at the original event. Both Andreas and Halbom suggest that the client imagine that they are a stunt actor playing through the same scenario—immune from injury. The new movie is to be experienced as a fully associated fantasy.

Break State

After one run through of the new movie, have the client break state by reorienting to the present and thinking of some neutral or pleasant activity, such as something that they did earlier in the day, or their favorite movie.

Rerun Revised Movie

Rerun the revised movie with a brief break after each repetition. Both Halbom and Dilts & Delozier recommend breaking state after each repetition. Repeat this sequence eight to ten times. This procedure layers a neutral or relatively positive memory over the original experience. It represents a further modification of the memory structure. In this case it specifically targets content related to physical trauma.

Debrief

As above, ask the client how they experienced the procedure. The practitioner should observe the non-verbal behavior of the client. At this point the client should display a resourceful and untroubled physiology. It should be free of the indicia of trauma elicited at the evocation stage and should be more congruent and balanced than at the end of the Phase One treatment.

Halbom suggests that the practitioner have the client describe the original traumatic situation while the practitioner calibrates for successful dissociation from the

negative affect. If any evidence of negative affect remains, the steps of phase 2 are to be repeated.

OUTLINE PROTOCOL

Phase One

1. Prescreening.

- Apply exclusion criteria.
    - The client's difficulties are essentially a phobic, instantaneous conditioned response to a stimulus related to a traumatic event.
    - It includes flashbacks and other immediate panic responses to reminders of the traumatic event
    - It is not centered in the client's responses to the meanings of the event in the client's larger life and the impact of such events on the client's sense of self worth.
- The problem must 1. Be rooted in the personal experience of trauma threatening death or injury to one's self or others, and 2. Be expressed as an intense suddenly arising experience of the trauma symptoms usually experienced as flashbacks or panic reactions.

2. Rapport and Framing

- Establish rapport and frame the intervention as
- a short visualization process with that is ordinarily comfortable, but sometimes has a very short period of moderate discomfort.
- Ask about any previous therapy or attempted interventions. Explain how the process is very different, from other therapies.
- It does not involve "reliving" the traumatic events or "catharsis" or "release" of feelings.
- Gain permission for touching—the kinesthetic anchor.
- As part of the process you will use, you would like to be able to put your hand lightly on their forearm during part of the process. Demonstrate this by placing your hand gently on their forearm and holding it there briefly, asking, "Would that be all right with you?" Then ask, "Do you have any questions or concerns before we begin? If they have any concerns about doing this process, respond congruently, and assure them that if any questions or concerns arise at any time during the process, it is fine to interrupt it and tell you what they are.

3. Accessing the problem state

- Decide whether to proceed with or without content.
- Ask about the problem state.
    - What is your problem and how does it present itself?
    - What is the specific event or events that caused it?
    - When does it trouble you most?
    - What are the symptoms associated with it? Where are any unpleasant feelings located in the body?
    - What is it like when you experience these symptoms?

- Continue questioning and probing until client responds.

- If the procedure is pursued as a content-free intervention, then the notations regarding the client's verbal behavior are somewhat mooted.
- Attend to the physiological and paralinguistic elements that reflect heightened arousal and the elicitation of the problem response.
- Look especially for fast onset of the physiological and paralinguistic symptoms of fear or trauma.
- Note changes in breathing, heart rate, skin tone and color, vocal pitch and speech rate. Muscular tension, tremors and postural changes may also be noted as the client moves into the problem state.
- As appropriate, make notes as to what the client was saying as the symptoms began, whether they were focused inwardly or outwardly, in an associated or dissociated state.
- Note the specific predicates used in describing the stimulus whether visual, auditory or kinesthetic and, if mixed, in what sequence the language was used.

4. Break state

- Interrupt the state's development as soon as possible after its identification.
    - Move into the client's field of vision and change the topic by discussing the weather, favorite foods or any other innocuous topic.

5. Dissociation and treatment frame

- Have the client imagine that he or she is seated in a movie theatre.
- On the screen is a still image of them performing some neutral activity in a safe context.
- Have them dissociate from the image of themselves sitting in the theatre in one of the following ways:
    - Imagining a physical dissociation by floating away to a projection booth behind a Plexiglas barrier,
    - Floating away from the body and imagining that they are standing behind the body holding their own shoulders and monitoring their own embodied state
    - Distorting the image sufficiently that no association to the image is possible.

6. Anchoring the Dissociation

- Ask for permission to anchor the state.
- "Now I would like to gently place my hand on your forearm, and keep it there, to stabilize this state and to remind you of where you are. Would that be all right with you?"
- Place your hand, or a few fingers gently on the client's forearm and hold it there.
    - Take some care to make the conditioned stimulus distinctive and repeatable. It is best, when using a touch stimulus as suggested by Andreas, to locate it in a place where it can be easily accessed and repeated in a reliable manner.
    - Use the same level of force or pressure to create and evoke the anchor.
- Test the anchor should be tested to find out whether it works.

- If there is no response, the anchoring procedure may be repeated several times (the classical paradigm) until an appropriate anchor is created and tested.

7. Dissociated Movie

- Have the client observe a black and white picture of herself on the screen of the movie theatre at a time before anything ever happened.
- As the client focuses on the imagined picture, she is directed to listen to the instructions all of the way through before proceeding.
- Instructions:
    - In a few moments I'm going to ask you to watch a black and white movie of that unpleasant event, seeing yourself going through it, all the way to a point past the end of it, where you can see that you survived, and you're OK again.
    - When you get to the end of watching that movie, and you can see that you are OK, I want you to stop that movie as a still, black and white image. Keeping your eyes closed, you can nod your head to let me know that you have finished doing that.
    - "Do you understand? Great, go ahead and do that. . . ."
        - (Optional alternative) The client may be invited to observe the movie from the dissociated position and simultaneously to watch the dissociated watcher in the movie theatre, noting the physical signs of whatever discomfort they may be experiencing.
- **<u>If the client indicates that the procedure was successful</u>** and that he is now in a comfortable place, watching a safe, disembodied image on the movie screen, let go of the dissociative anchor and proceed to the next step.
    - This assumes that none of the indicia of trauma noted in the accessing phase are observed in the client's demeanor, breathing, color, posture, etc.
- **<u>If the practitioner is unsure of success</u>**, he can ask the client how they experienced the exercise. If there is any indication of distress, especially mild distress, have them repeat the procedure several times until they can go through it without distress.
- **<u>If the client has continuing but not acute difficulty</u>** with the procedure, the procedure may be modified by instructing the client to watch only the top half of the movie, followed by only the bottom half or to watch only every third second of the movie—all the way through, followed by every second second of the movie—all the way through, followed by every first second of the movie .
- **<u>If the client displays signs of acute distress.</u>**
    - Interrupt the procedure, distract and reorient to a safe present in rapport with the practitioner.
    - This may be done by reorienting them to the weather, some pleasant diversion or what they were doing immediately before entering the therapeutic situation.
- **<u>If the client cannot run the imaginal exposure movie through without significant distress</u>**, the practitioner should go back to the third step and recreate the anchor for the dissociated state. Once an effective anchor has been

established the first part of the procedure, dissociation and watching the movie may proceed.
- When the client has successfully watched the black and white dissociated movie without distress, remove your hand from their arm and then move on to the next step.

8. Associated Movie Reversal.
- Begin with the safe representation of the client at the end of the dissociated black and white movie.
- Have the client imagine stepping into the movie and experience the entire sequence, fully associated, in color, in reverse at very high speed (two seconds or less).
    - "Have you ever seen a movie run backwards? Or a videotape in fast rewind? In a moment I'm going to ask you to step into that still image on the screen, and re-experience that event backwards and in color, but with you inside that experience, so that you feel yourself moving backwards, and I want you to do this very fast. Run that movie backwards in about a second and a half, or perhaps as much as two seconds, until you get back to the beginning, before anything bad happened. Is that clear? OK, go ahead."
- Ask: what was like for you?
- (Options) Andreas suggests only one iteration of this step
- Dilts & Delozier and Halbom recommend several iterations.

9. Test
- Determine whether the procedure has had the desired effect.
- Make every effort to evoke the problem state.
- Use the same questions and probes used to access the problem state with special attention to those questions that were associated with a clear physiological reaction.
- If there is no reaction, the intervention is presumed to have worked.
- Systematically probe each sensory system for possible triggers for the problem behaviors.
- When the practitioner is satisfied that she cannot evoke the PTSD response, she can continue on to the next phase.

Phase 2

1. Revised Movie
- The client is instructed to revisit the memory but to create a version of the experience where they were not injured; something different happened.
    - Perhaps someone intervenes, perhaps the client makes a different decision or makes a different turn.
    - The new movie should recreate the problem situation as nearly as possible but without the problem.

- (Option) Dilts & Delozier (2000) suggest that the client may be instructed to include experience and knowledge now their's that they might not have possessed at the original event.
- (Option) Andreas and Halbom suggest that the client imagine that they are a stunt actor playing through the same scenario—immune from injury.

2. Break State

- After one run through of the new movie, have the client break state by reorienting to the present and thinking of some neutral or pleasant activity, like what they did earlier or their favorite movie.

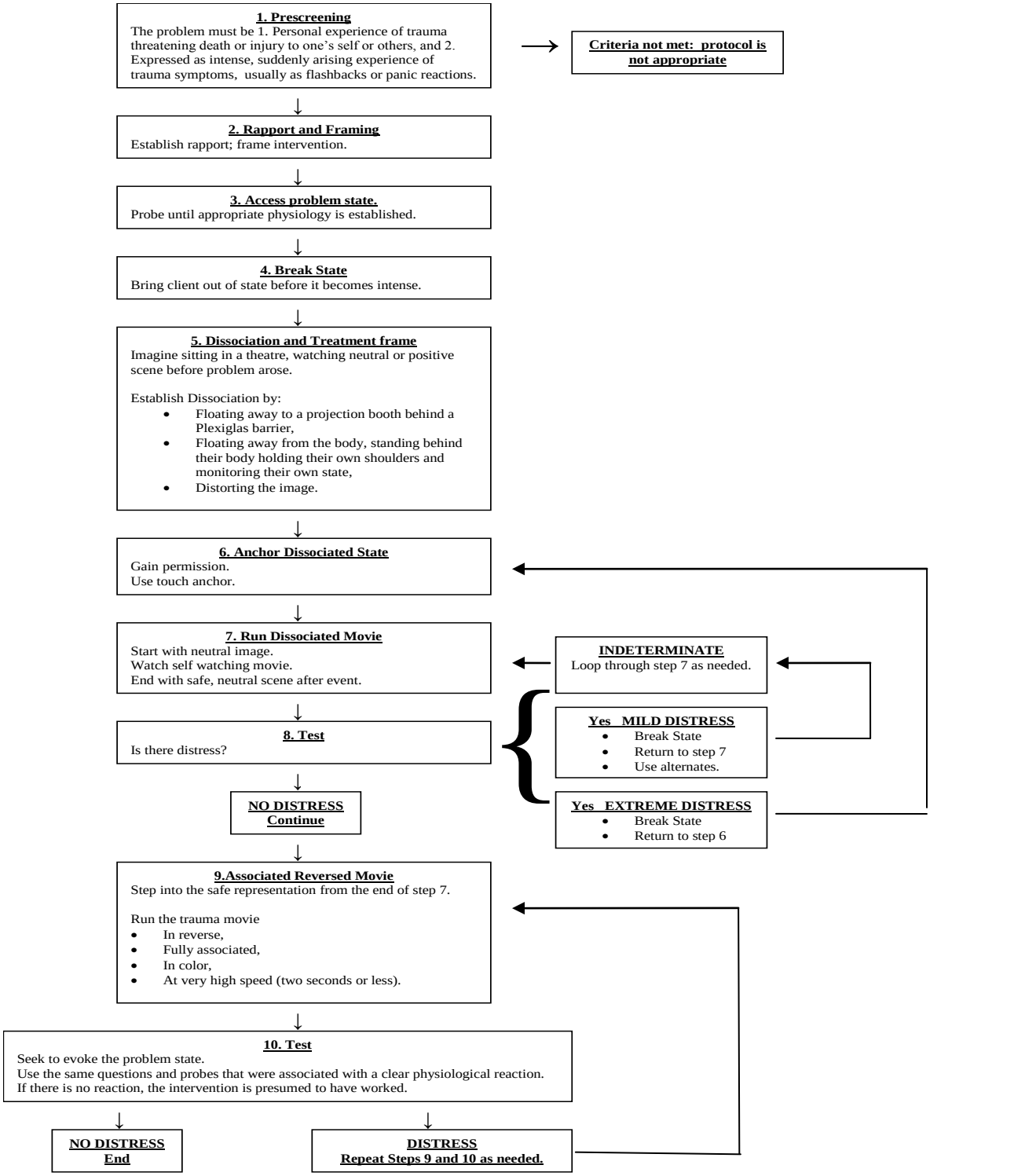
3. Rerun Revised Movie

- Rerun the revised movie with a brief break after each repetition.
- Both Halbom and Dilts & Delozier recommend breaking state after each repetition.
- Repeat this sequence eight to ten times.

4. Debrief

- Ask the client how they experienced the procedure.
- Observe the non-verbal behavior of the client.
- The client should display a resourceful and untroubled physiology free of the indicia of trauma elicited at the evocation stage.
- It should be more congruent and balanced than at the end of the Phase One treatment.
- (Option) Halbom suggests that the client describe the original traumatic situation while the practitioner calibrates for successful dissociation from the negative affect.
- If any evidence of negative affect remains, the steps are to be repeated.

BASIC PTSD PROTOCOL



Appendix I

DSM-IV diagnostic criteria for Post Traumatic Stress Disorder (PTSD)

The diagnostic criteria for Post Traumatic Stress Disorder (PTSD) are defined in DSM-IV as follows:

A. The person experiences a traumatic event in which both of the following were present:

1. the person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
2. the person's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in any of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions;
2. recurrent distressing dreams of the event;
3. acting or feeling as if the traumatic event were recurring (e.g. reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those on wakening or when intoxicated);
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by at least three of:

1. efforts to avoid thoughts, feelings or conversations associated with the trauma;
2. efforts to avoid activities, places or people that arouse recollections of this trauma;
3. inability to recall an important aspect of the trauma;
4. markedly diminished interest or participation in significant activities;
5. feeling of detachment or estrangement from others;
6. restricted range of affect (e.g. unable to have loving feelings);
7. sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:

1. difficulty falling or staying asleep;
2. irritability or outbursts of anger;
3. difficulty concentrating;
4. hypervigilance;
5. exaggerated startle response.

E. The symptoms on Criteria B, C and D last for more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

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