Advances in the Treatment of Trauma

Guided Imagery for Trauma Recovery:
Inexpensive, Accessible, and Effective

with Ruth Buczynski, PhD and Belleruth Naparstek, ACSW, BCD
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De-Stigmatizing the Diagnosis of Post-Traumatic Stress

Dr. Buczynski: I think the first thing that we should talk about is whether to call it PTSD or PTS. Lots of people seem to be switching to PTS (Post-Traumatic Stress) from PTSD (Post-Traumatic Stress Disorder). Give us your thoughts on that.

Ms. Naparstek: I think there is definitely a strong move away from calling it Post-Traumatic Stress Disorder. In fact, some soldiers prefer Combat and Occupational Stress. They don’t like Post-Traumatic Stress and that whole phrase could be seeing some disapproval.
There’s a big difference within the military in the Department of Defense, as opposed to the VA – which still uses, for the most part, Post-Traumatic Stress Disorder.

I think PTSD is on the way out for two reasons:

One, you’re not going to get a lot of people feeling happy about being told they have a disorder, especially when it’s a disorder that’s been produced by some insane events. In fact, the typical thing people say is, “PTSD is a normal response to an abnormal situation.”

You have people who are already struggling with the effects of a ricocheting psychochemistry. At the same time, they’re being stigmatized by being told they have a disorder and, as a result, they’re less likely to seek help for it.

It’s just plain unfair to say to somebody that they have a disorder when their brainstem has been hijacked by some extraordinary event.

**Dr. Buczynski:** Say that the trauma was a year, two years, five years ago? Is there ever a time when you would say it’s more appropriate to use the term Post-Traumatic Stress Disorder, or would you just say, *let’s retire that term*?

**Ms. Naparstek:** Interestingly enough, Ruth – and I wasn’t even aware of this until fairly recently – it used to be called an *Acute Stress Reaction*, becoming *Post-Traumatic Stress Disorder* after six months. Now, it’s after one month.

We’re *really* talking about acute stress, and I think we should just retire the term. It’s becoming more and more ‘iffy’ and it’s overlapping into all sorts of things that don’t necessarily make a lot of sense.

### The Symptoms and Categorization of Post-Traumatic Stress

**Dr. Buczynski:** For the people that are new to this, let’s flesh out what some of the signs and symptoms are and if there are times when we need to differentiate between, *this is seen in soldiers, but not so much in people post-car accidents*, or whether it’s *pretty much across the board*?

Maybe they’re not all that different . . . or maybe they are?
Ms. Naparstek: Great questions. For the first part of your question; there are three clusters of symptoms that you’ll see with Post Traumatic Stress, or whatever we’re calling it these days.

The most signature set of symptoms are the re-experiencing symptoms – like nightmares, flashbacks and intrusive thoughts. They have a quality that is very unique to Post Traumatic Stress. That’s the biggie, the one that’s going to help you define this as opposed to other things.

The second set of symptoms is hyper-vigilance. Being in a state of alarm or easily catapulted into a state of extreme anxiety, or terror, or rage; just having all of those adrenergized biochemicals ready to absolutely skyrocket.

That translates into people being anxious a lot and that switching to real fear, or being cranky, annoyed and impatient and that translating into rage.

Finally, the third cluster is what they call numbing avoidance. After you have these crazy alarm chemicals going off in your body, there is a tendency to go into the sedating endogenous opioids, so there’s a numbness, a kind of stoned quality to people. They are disconnected, isolated, and they tend to not want to interact or even leave the house.

Those are the three biggies: re-experiencing, hyper-vigilance, and numbing avoidance.

Now, to part two of your question; is it different in the military as opposed to a Columbine or a car accident?

Dr. Buczynski: Or a rape or a beating?

Ms. Naparstek: Or assault, or a natural disaster?

The answer is, no. You’ll see those three clusters with all of that to varying degrees.

It’s a little spooky, the degree to which things do look the same, more or less. However, with combat trauma, there is an added dimension of moral injury, which is more about guilt, sadness, and a sense of having transgressed core values that they hold dear.
Dr. Buczynski: We’ll get into that a little bit later, but let’s finish setting the stage. Why has guided imagery been particularly effective for the treatment of trauma?

Ms. Naparstek: I backed into this intuitively and then figured out why it works later, but I think it works so well because guided imagery sits in the same primitive, survival-based structures of the brain that are intensely impacted by traumatic stress.

This is a biochemical and neurophysiological condition and it hits the nervous system and the biochemistry in a very intense and profound way that we’ve only begun to understand.

Guided imagery is one of those techniques—by no means the only one, but it’s a good one—because it goes to amygdala, brain stem, temporal lobes; all of those midbrain and brainstem places are impacted.

Dr. Buczynski: We’ll spend most of our time talking about guided imagery, but what other techniques are also effective?

Ms. Naparstek: I’m very partial to mindfulness-based stress reduction—any kind of meditation, yoga, chi gong, moving meditations, breath work, even something as simple as progressive muscle relaxation—the sorts of things that hit the body. I am also very impressed by what energy psychology—the acu-point tapping and acupressure methods—can do. It’s not what we learned in school—at least, not what I learned, back in 1965.

Dr. Buczynski: Why is guided imagery sometimes called the lazy man’s meditation?

Ms. Naparstek: I call it that because it requires practically nothing of the end user. It’s often a recording that you can half-listen or fall asleep to. It will still get into the part of your brain that needs addressing, unlike mindfulness meditation, which I have huge respect for but takes a certain amount of discipline and training for most people.

Guided imagery requires nothing. You don’t have to be smart or disciplined. You don’t have to be awake. You don’t have to be mentally healthy or have good concentration. It carries you.
Guided Imagery and *Re-Experiencing*: Fighting Horror with Health

**Dr. Buczynski:** Have we researched how it works?

**Ms. Naparstek:** Research shows impact on symptoms, but I don’t think it necessarily tells you why it works the way it does.

**Dr. Buczynski:** Let’s back up and talk about the research and its impact on symptoms. Would you say it’s one of the techniques that has been fairly well investigated?

**Ms. Naparstek:** I would say medium-well. I give credit to Jon Kabat-Zinn for getting a huge amount of research out there for mindfulness-based stress reduction. Guided imagery isn’t even close to that, but it has medium exposure.

> “With guided imagery, you’re combating the horrific images with healthful images.”

What we found, particularly with veterans, is that it will reduce all three clusters of symptoms – including the *re-experiencing* one, which used to be the toughest, stickiest, peskiest set of symptoms to get rid of.

With guided imagery, you’re combating horrific images with healthful images, so it goes right to the spot. It does reduce the arousal symptoms and the *avoidance numbing* symptoms, but – most impressively – it reduces the *re-experiencing*.

**Dr. Buczynski:** Tell me about some of the studies; what have they done and how do they study this? I’m assuming they’re using randomized control?

**Ms. Naparstek:** Yes. Most were pilot studies that evolved into randomized control trials. Probably the biggest batch of work is by Jennifer Strauss at the Durham Veteran’s Administration (VA).

She studied military sexual trauma among veterans – women who had been traumatized as far back as Vietnam, who still remained highly symptomatic in spite of the fact that they had been in therapy, been on medications, and tried support groups.

She inserted a study into their lives where they had to listen to guided imagery for twelve weeks, for half an hour a day, five days a week (which turned out be more than they needed). And they improved *significantly*. She then switched and studied male combat veterans and found even better results, so that was exciting.
Guided Imagery in the Military: Following Orders to Combat Stress

Dr. Buczynski: Have we researched how it works?

Ms. Naparstek: We’ve been doing some work at Fort Sill, Oklahoma; we’ve had a couple of studies there. We had a really good idea, although the execution may have left something to be desired. We thought, Okay, there’s a big problem with soldiers distrusting therapists and refusing to go to behavioral health, and feeling stigmatized because of this disorder. We know this from quotations that they have.

We thought, Let’s just forget behavioral health. We’ll go to the command side. We’ll have their squad leaders and their platoon leaders order them to listen to guided imagery and make them fill out surveys on Survey Monkey, and we’ll see how that goes. We got three hundred soldiers.

The commanding general at Fort Sill was terrific; he said, “Absolutely. Let’s try it.”

Unfortunately, the army moves very quickly and we didn’t know that a whole bunch of our three hundred subjects were going to be re-deployed or transitioned to other posts and we couldn’t track them down because of privacy issues.

In spite of that, we did a lot of studying. We did out-briefing of the soldiers to find out how they felt about the guided imagery and being told they had to listen to it. Some are older, but most of these guys are kids – nineteen, twenty, twenty-two. These out-briefs were hilarious, but basically what they said was, “I resented being told I had to listen to this. I thought this was never going to work for me. This is stupid.”

“Half of them ended up listening to the imagery after the study was over, when they were stressed or they couldn’t sleep.”

But they were being hounded by their platoon sergeants, so they did it. Interestingly enough, I would say maybe half of them ended up listening to the imagery after the study was over when they were either stressed or they couldn’t sleep. I thought that was pretty cool and I had some great conversations with them.

Dr. Buczynski: So it seemed to work when it was more top-down?

Ms. Naparstek: It’s hard to say. It would be great to compare this top-down thing with a way of doing it through peers. But it’s not something I can design, especially with a group that moves around so much.
The Beneficial Effects of Trauma on Soldiers

Dr. Buczynski: Now, how pervasive is trauma with soldiers?

Ms. Naparstek: People are saying thirty percent but I’m guessing that’s low. I would say it’s probably closer to thirty-five or forty and it depends on a lot of factors; how many times people have been deployed, where they were deployed and what they saw. There are some soldiers who have been deployed eight or nine times, so it’s pretty extraordinary.

I think all of them are impacted to some degree, but I think Tedeschi and Calhoun have done studies showing that for some soldiers, along with post-traumatic or combat stress comes what they call Post-Traumatic Growth or Post-Traumatic Advantage. They can become a much more mature, compassionate, realistic, grounded human being for having experienced difficult things.

“Some soldiers have been deployed eight or nine times— their exposure to trauma is extraordinary.”

Dr. Buczynski: Does that last? Do they find that that experience becomes a life-long growing experience?

Ms. Naparstek: That’s a great question. I don’t think we have the timeline to really answer it, but my guess is that it’s more like a near-death experience. When people are impacted by something like that, it is profound. It goes deep, it lasts and they have a different view of themselves and the world as a result.

The Treatment of Moral Injury: Healing Human Values

Dr. Buczynski: Let’s talk more about moral injury. How did you come across it and how would you define it?

Ms. Naparstek: I first came across the term when I was sitting in on a keynote by epidemiologist and psychiatrist, Charles Hogue—who I think is terrific. He said, regardless of how many you want to count as having post traumatic stress, moral injury is something that affects a huge number of soldiers and can lead to post-traumatic stress.

By moral injury, I mean when you either do or witness things that go against your profound moral code of how one should be in the world. It puts ethics up for grabs in impossible ways. The result of

“Moral injury is something that affects a huge number of soldiers and can lead to post-traumatic stress.”
*moral injury* is usually profound sadness, grief, and guilt.

It isn’t necessarily a soldier; it could be somebody who’s been in a car accident and felt they should have gone back in the car and pulled out the kid, or somebody who was in an earthquake and felt they should have looked after the people around them. There are a lot of situations that can feed this *moral injury*.

I think it’s a wonderful term. It gives due respect to the best part of our humanness.

**Dr. Buczynski:** Tell me your thoughts on treating it in a psychotherapy situation.

**Ms. Naparstek:** It needs to be countered by some *benevolent moral authority* who is listening. You want to encourage your patient or client to speak to you if they can, but they may need to speak to a priest, minister, or rabbi.

They may need to speak to somebody that they hold as the moral icon for their life. If they can do that, it can be a huge help; some kind of benevolent, compassionate, understanding moral authority – who may or may not be you, the therapist.

You can encourage people to do good deeds, to give back to the community, or to help other soldiers. A lot of them do this automatically because it’s where they are naturally drawn.

In terms of being in the military, the biggest driver of motivation is concern for the mission and your fellow service people. It’s natural to help people find a way to be useful to their brothers and sisters, who are more than just brothers and sisters when it comes to the military.

**Dealing with the Difficulties of Re-Entry**

**Dr. Buczynski:** Let’s stay with soldiers and service people and talk about re-entry.

**Ms. Naparstek:** It’s really hard, because you’ve been someplace with a brotherhood that is indescribably close and tight. These are people who, even if you don’t like them, you’d kill for them and you’d die for them.

“Soldiers have been in a brotherhood that is close and tight . . . They’d kill and die for each other.”
That’s not your typical social system, in my neighborhood anyway. You’ve got somebody coming back to regular life, which seems pallid. Not very interesting or exciting, certainly, but also just a different planet.

If you also feel contaminated by some of the things you’ve seen and done, then you’re going to feel outside the pale. There’s much you don’t want to describe; it’s too hard to even try. If it’s moral injury-related or even just social system-related, it’s too big a job to try to bring your wife, kids, parents or friends into where you’ve been.

The really unfair thing about reentry is that just as they’re coming back to this different planet and old life that is no longer familiar to them, they’re losing their buddies. Everybody is being spread to the winds.

Even if they stay in the military, they’re going to change command when they get back. They’re going to lose their friends and everything is up for grabs; it’s terrible. It’s a really bad system and I don’t know why they do that.

Dr. Buczynski: Have they studied that?

Ms. Naparstek: Yes, and every commander I’ve ever spoken to says, “Yeah, we really need to change that” – but they don’t.

Dr. Buczynski: Let’s say you’re a physician or a nurse treating a family member who has a serviceperson coming home. What should you keep in mind?

Ms. Naparstek: I would advise family members to be sensitive, gently watchful, give people their space. Let them re-enter at their own pace, and occasionally ask when they can be useful. Watch for things like substance abuse, which is something that could happen; or watch for dangerous behavior like driving too fast – things that will pump-up adrenaline because they’re missing it.

Watch for signs of distress, like nightmares. There are some good books to check out, to find things you can do to start re-regulating that hyper-alert, hyper-vigilant state, and that’s huge in and of itself. If you can just help somebody sleep and help them calm down when they start feeling agitated, you’re going to be a huge help.
The Importance of Sleep in Recovering from Trauma

Dr. Buczynski: Speaking of sleep, I imagine that can be a pretty significant issue.

What have we found that’s helpful?

Ms. Naparstek: I could go on and on about this, but the sleep issue is probably the one that has to be rectified or remediated first. If somebody isn’t getting sleep, in about three weeks they’re going to be a mess – it doesn’t matter what else they’re doing.

The guided imagery and simple progressive relaxation help. There are some acupressure tips that help, as well as mindfulness meditation – if the person has the patience to learn it.

There’s an item on the market called the Fit Bit. I have no commercial interest in this product. It’s the size of a thumb drive and it measures your exercise and your activities: walking, running, steps, etc.

It also measures your sleep efficiency and it’s so small that you can wear it and it doesn’t interfere with your sleeping. It will tell you how many times you wake up in the middle of the night, or how long you’ve just been lying there, staring into space, thinking your thoughts as opposed to really sleeping. The Fit Bit knows.

A friend of mine who is a retired colonel from the Pentagon, who was at the Pentagon when it was hit, is quite public about it and gives talks about it.

Her name is Colonel Jill Chambers and she was a special assistant to four different chairs of the Joint Chiefs of Staff. She was the person who put together the concept that became Comprehensive Soldier Fitness, using the positive psychology principles of Marty Seligman and a bunch of his staff.

She’s really given a lot of thought to this whole issue of combat stress and what to do to remediate it and how you can language it in ways that will feel right to a soldier.

Jill was in the Pentagon when it was hit on 9/11. She was trapped in a bathroom and had nightmares of airplanes chasing her. She suffered tremendous losses and stopped attending funerals after her twelfth; it was just brutal. Her sleep was disrupted for about nine years, and she just thought she was this tired person.

My son’s boss introduced her as somebody that would be a good person to know in order to learn more about the army. I mentioned to her that we had this sleep imagery and if she wanted to try it. She was
willing to try anything. She used it for about three weeks and by the end she was sleeping like she hadn’t slept for years.

And she went nuts – she’s a very enthusiastic person, and she started telling everyone about this sleep imagery and how it makes you sleep. Her partner, Michael Peterson, a terrific country western singer, had his own sleep issues and he started listening to it, too. Bottom line, they were introduced to the Fit Bit, which measures sleep efficiency and they were getting good scores.

I would have been very happy with either one of their scores, but they were curious to see if their sleep efficiency scores would get better if they went back to listening to guided imagery. So, they did this little two-subject anecdotal study.

They got terrific results; I think Jill gets up once a night now – enviable – and Michael only three times, down from eight. It’s just one example of a simple method that can get the job done. It doesn’t require insight and catharsis and all the things that we learned to be so good at producing, for and with, our patients.

Dr. Buczynski: There was another device that you had mentioned to me.

Ms. Naparstek: This is another discovery that I’m very excited about, because it makes things easier for people; it’s like the good side of technology. I also don’t have any interest in this company, but this is a Playaway; it’s smaller than the size of the cassette, but on the back it’s a pre-loaded player.

This is wonderful for people who are digitally challenged. When returning from the military with traumatic brain injury, there’s often a lot of confusion. A lot of people have some cognitive difficulty managing a CD player or an iPod.

The Playaway simplifies things because there are only one or two things you can play on it. It’s very portable and it’s almost impossible to degrade. The army gave these out to soldiers overseas because they knew it wasn’t going to get wrecked.

The Dos and Don’ts of Treating Post-Traumatic Stress

Dr. Buczynski: Let’s talk about treating military people and, specifically, some of the mistakes that therapists, physicians or nurses make when they’re treating people.
Ms. Naparstek: I think the biggest mistake that people tend to make is assuming that they don’t need to know anything special in order to treat this population. What makes the most sense is to think of yourself as a cultural anthropologist, studying a new culture that you need to get up to speed on. It has different values, jokes, norms, and expectations. Just knowing some of those things can be helpful.

My biggest piece of advice is, don’t think you have everything you need to treat this population although it wouldn’t take much to get you up to speed. Many therapists typically make mistakes because they try to make comparisons between what their patient experienced and civilian trauma.

Don’t do that – take my word for it. People are going to be offended by that, and they’re going to think, Oh, she doesn’t get it. Just listen and ask questions.

Another thing that people, both civilians and therapists, often ask is “How many people did you kill?” Don’t. It seems obvious, but therapists tend to not look service people in the eye. I’m not sure why and I don’t think they know they’re doing it, but that was a huge complaint that I heard from so many military coming back, “Look me in the eye. Don’t hide behind your desk or your credentials. Don’t try to impress me.”

An important value and norm within the military is that you don’t brag about yourself or try to impress. You do the Gary Cooper thing, those of you who are old enough to know who that was; you just low-key it.

Don’t bring your politics in there because it doesn’t belong and there’s no point. Do not talk about philosophy, the nature of war, the rightness or the wrongness. That’s your problem, not theirs; they tend to not be particularly political.

Don’t offer reassurance that everything’s going to go back to normal, because it’s not. It’s going to be different; it could be worse for a while and then better or it could be both. It could be a lot better, but don’t say it’s going to go back to the way it was. What that will tell them is you don’t know.

Dr. Buczynski: Tell us some of the do’s. What would you like to see people doing?
Ms. Naparstek: One big thing is to be familiar with the effective methods that you can teach people. It’s fine if you don’t know how to do it yourself, just know people in the community who do know things like meditation, guided imagery, EMDR, thought field therapy, emotional freedom technique, Tapas Acupressure Technique. There are so many fabulous methods and something will suit somebody.

Encourage them to get a lot of physical exercise and to use some sort of moving meditation; all of that is really powerful. Neuro-feedback and bio-feedback is terrific. My all-time favorite is somatic experiencing and therapeutic massage. We’ve had some wonderful studies combining guided imagery with healing touch for Marines who were severely traumatized coming back to Pendleton. There are so many things you can help somebody get into and you don’t have to be the expert on all of them, you just have to know how to get them going for your patient.

“Imagine an uncontaminated place, free of stress and filled with nurturing images.”

How to Introduce Guided Imagery into Your Practice

Dr. Buczynski: Since you’re an expert on guided imagery, let’s talk about what a person should keep in mind if they would like to introduce guided imagery into their practice and might want to construct a particular sequence for a particular patient.

Ms. Naparstek: That’s a great question and there are lots of ways to go about doing this.

One: start with simple relaxation, because that could be all you need for your person. Start by teaching them some basics of counting breath or relaxation response, repeating a word or phrase that’s comforting with the breath, or body scanning--something simple like that.

Although it’s become a cliché, you could help them go to their happy place. You could help them imagine a place that is uncontaminated and absolutely free of stress and filled with nourishing, nurturing images.

During that time and that place, you might want to eventually build on that and have them interact with a figure from their life who is there to offer support, some advice or words of comfort.
You could have them interact with and go inside their body to see what’s going on in there and structure that. There are so many ways to do this. When I first started learning about guided imagery, I just listened to every single person I could find who had made a cassette tape, because that’s what they had then.

It helped me to just listen to some wonderful work from *Ericksonian Hypnotherapy* by David Illig, Emmett Miller, Louise Hay, and Bernice Segal. I think that was pretty much it, at the time. At some point, I thought, “Well, I’d like to put this together with this,” and see what I could come up with doing it by myself.

Build on relaxation and then have some sort of relaxing place and then provide some sort of interaction. If you have somebody who’s been certified by Marty Rossman and David Bressler’s Academy for Guided Imagery, you could have a local expert in the area come show you how to do that kind of guided imagery.

**Using Technology to Connect with Trauma Victims**

**Dr. Buczynski:** Before I let you go, we were talking this morning about some work that Health Journeys was doing with tragedies like school shootings. I think some of you on this call might want to take this idea and do something like it for yourself; you’ll see what I mean in a moment. Can you just describe a little bit about it?

**Ms. Naparstek:** Yes, I think one of the gifts of digital technology is making interventions available to traumatized populations: interventions in the form of downloads or at the screen listening and watching.

We started this with Hurricane Katrina when we built a webpage for people who needed to go somewhere in order to get some kind of relief.

It explained a typical set of reactions to a catastrophe like this, what symptoms or reactions you might be having and what you can do for it. It offered several free downloads so you could listen at the screen and see if you could re-regulate your biochemistry and neurology; if you could, then you were on your way to getting much better.

**Dr. Buczynski:** And you prepared this page so that the school could put it on their site?

**Ms. Naparstek:** Yes, we did this in Tucson after the shootings there, with the Andy Wilds clinic and the Chardon High School Site. The counseling center from Virginia Tech used a modification of the page as well. You
can basically give the resources to somebody at no cost to yourself. It’s a lovely way to be generous, because to afford people downloads is very easy to do.

**Dr. Buczynski:** You build a page and then contact the people and say, “Would you like to put this page on your site?

**Ms. Naparstek:** I would recommend saying that you have some public information, good health education about the nature of stress and post-traumatic stress.

Say on the page, *Skip this, if you don’t want to know this and just go to the downloads. You don’t have to understand it in order for it help you, but if you want to know how it works, here it the information.*

**Dr. Buczynski:** Could you put a section on sleep?

**Ms. Naparstek:** Sleep, general stress, focus and concentration, anger and forgiveness. You can use all sorts of samples, and they can sit at the screen for twenty minutes or so.

Chardon High School in Ohio had a terrible shooting and the Beachbrook Clinic, an agency that treats children, took the lead in terms of mental health.

They made the site available to everybody and the Beachbrook people get back statistics as to how many people use it. For any given day, we can provide that and put that on their server.

That also helps a public agency like Beachbrook when they’re applying for grants and gives them the ability to say, “We serve this number of people with this number of interventions after this tragedy.”

**Dr. Buczynski:** My brother works as manager at a place that had an occupational accident with a machine and a person actually died. It wasn’t in his department, but it was nonetheless a very tragic event for this small company with under a hundred employees. He said several people quit afterwards; they just could not cope with the memory.

I don’t know whether anyone responded from a health and mental health point of view, but this is certainly something you could prepare to donate as a service so that it could be put up. Or you could partner with someone.
Ms. Naparstek: We’d be happy to show people what we’ve put up. I’m not sure how to arrange that, but I would be happy to give people a link to see what we did and to see how much of that they would want to replicate. But I think, for a therapist in a community, that’s a great service to provide.

Dr. Buczynski: Or even a physician or a Public Health Official in a town could help and I’m sure some of the people on this call work in those capanitates, and I know that there are people on this call who are teachers and so forth. We’re having tragedies in school systems more and more and knowing what one might do to respond could be an important thing. Give us the link afterwards and I’ll include it.

Ms. Naparstek: As the army would say, “This is a force multiplier.” Because you can’t be everywhere but this allows you to have so many more tools to offer.

Dr. Buczynski: And there are people who don’t – or won’t – seek out one-to-one services who might take part in something like this.

Ms. Naparstek: A lot of kids in schools, for sure, and a lot of people, period.

Dr. Buczynski: I’m sorry, we’re out of time, and there’s so much more we could talk about.

Belleruth and I get together now and then; I go see her at the Cape or she comes to my house, and we have lots of conversations on all this and call each other frequently to catch up on the latest work that’s being done.

It was great for me to have a chance to share you with all the people all over the world who are concerned about the treatment of trauma. Thanks very much for being a part of this.

Ms. Naparstek: Thanks so much for having me. It was a lot of fun, and thanks for what you’re doing – talk about force multiplying!
About the speakers . . .

**Belleruth Naparstek, ACSW, BCD** is a psychotherapist, author, and guided imagery pioneer. She is the creator of the popular Time Warner Health Journeys Guided Imagery audio series. Her audio programs have been involved in over two dozen clinical trials. Belleruth Naparstek is the author of three books, including *Invisible Heroes: Survivors of Trauma and How they Heal*.

As Prevention Magazine noted, Belleruth has been quietly creating an underground revolution among mainstream health and mental health bureaucracies, by persuading major institutions such as the U.S. Veteran’s Administration, the U.S. Department of Defense, The American Red Cross, Aetna U.S. Healthcare, Kaiser Permanente, and so many others, and nearly 2000 hospitals, mental health centers, recovery clinics, and vet centers—to distribute her guided imagery recordings, in most instances free of charge to recipients.

**Ruth Buczynski, PhD,** has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she’s been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she’s expanded into the ‘cloud,’ where she’s developed intelligent and thoughtfully researched webinars that continue to grow exponentially.