THE PINNACLE PROGRAM:
Healing Trauma through Principle-Based Living

Everyone has his own specific vocation or mission in life; everyone must carry out a concrete assignment that demands fulfillment. Therein he cannot be replaced, nor can his life be repeated, thus, everyone's task is unique as his specific opportunity. – **Viktor Frankl**

I've been scraping little shavings off my ration of light and I've formed it into a ball and each time I pack a bit more onto it and I make a bowl of my hands and I scoop it from its secret cache under a loose board in the floor and I blow across it and I send it to you against those moments when the darkness blows under your door – **Bruce Cockburn**

Introduction. The Pinnacle Program is a unique combination of accelerated psychotherapy/counseling, performance coaching, and maturational principles designed to help individuals achieve principle-based intentional living while, at once, helping them diminish the symptoms associated with anxiety and traumatic stress. The Pinnacle Program combines the cognitive-behavioral techniques (CBT) of psychoeducation, self-regulation/relaxation, and *in vivo* exposure (Foa, Keene & Friedman, 2000; Follette, Ruzek, & Abueg, 1998; National Institute of Medicine, 2008) with intentionality, personal integrity and internalized locus of control to form an integrated strategy to address the symptoms of anxiety, depression, and traumatic stress. This novel approach allows participants to avoid some of the costs, stigmatization, and disempowerment that are frequently associated with traditional psychiatric treatment. Instead, it provides a simple path for anyone—but especially survivors of trauma--to engage in a powerful process designed to help turn away from a life dominated by painful symptoms and reactivity towards a healthy and disciplined lifestyle based upon one's own individual purpose and principles. The Pinnacle Program helps participants to create, articulate, and rapidly begin living with fidelity to their own "moral compass." By developing this principle-based intentionality, through the principles of self-regulation in the Pinnacle Program, participants enjoy the added benefit of reducing stress-related symptoms. While it may never replace traditional psychotherapy, it does provide a complimentary approach that has effectively accelerated treatment and life satisfaction for scores of clients and hundreds of workshop participants.

Pinnacle™ "Principle-Based" Professional Coaching

The Pinnacle Program was born from a broad eclectic mix of many ideologies, disciplines, and protocols to form a simple, clear, commonsensical approach to counseling, maturation and living that helps people migrate from the reactivity of anxiety, depression and traumatic stress to the comfort and maximal functioning of intentionality. It is rooted in and focused upon helping individuals to live intentionally in the present as a way of rapidly healing their pasts. The methods of the Pinnacle Program are grounded in good cognitive-behavioral therapy (Foa, Davidson & Francis, 1999; Foa & Meadows, 1997; Friedman, 1996) but without the need of a therapist acting in traditional roles for its application (although participants utilizing the Pinnacle Program in a self-help model *will* need to develop a relationship with another person who they can use as a partner/coach/mentor). Imagine CBT in a homeopathic and humanistic form and you come close to conceptualizing the theoretical underpinnings of the Pinnacle model. The Pinnacle Program is less a treatment and more a blueprint for living with

fidelity to one's individual principles that has the by-product of symptom reduction. One of the primary components of this model is helping people to understand how their past painful, fearful, and traumatic experiences lead them to perceive a threatening and dangerous world in the present (Holbrook, Hoyt, Stein, & Sieber, 2001). It also helps them to see how present-day intrusions from these difficult past experiences contaminate their current perceptions, causing them to perceive threat where there is none. Helping participants to understand the negative and symptomatic consequences of sympathetic nervous system dominance caused by the chronic perception of threat motivates participants to develop an internalized capacity for self-regulation. By intentionally maintaining relaxed bodies in the context of these perceived threats normally functioning adults can quickly find physiological and psychological comfort, maximize neocortical (thinking) functions, and regain intentional, principle-based behavior even while we are confronting these threats (Bremner, 2000; Breslau & Kessler, 2001; Critchley, Melmed, Featherstone, Mathias & Dolan, 2001; Porges, 1999). Additionally, it is well-documented that relaxation is a crucial ingredient for the resolution of traumatic stress symptoms and an effective agent in lessening anxiety symptoms (Michenbaum, 1994; Shalev, Donne & Eth, 1996; Wolpe, 1956).

For all its CBT underpinnings, however, the Pinnacle Program is probably best defined as developmental in its approach to healing trauma because it helps people to restart, continue, and accelerate their natural maturational processes. Painful and traumatic past learning along with the subsequent adaptations resulting from these traumatic experiences may cause normal healthy maturation to become thwarted in deference to the constant attention and action that perceived threats demand (Bonner & Rich, 1988; Falconer, 2008; Scaer, 2006; Schnurr, Lunney & Sengupta, 2004). The learning and adaptation that survivors develop from their painful and traumatic history often afflicts them with a heightened perception of threat, even when there is no "real" danger. Depending upon the frequency and intensity of past experiences these perceptions of threat can frequently be ubiquitous, chronic, and symptom-generating (Spilsbury, et al., 2007; Stoppelbein, Greening, & Elkin 2006).
.
Once people understand how and begin to regulate the tension in their bodies and calm their nervous systems they can restart their thwarted natural maturational trajectory (Doublet, 2000; Shusterman & Barnea, 2005). This, in turn, allows them to "get out of the way" of their natural healing processes, leave behind symptoms (Holland, et al., 1991) and find satisfying lives based in their own morality no matter what the external circumstances or conditions (Hamarat, et al.,, 2001). By helping people to articulate their intention (i.e., put into words their own mission and morality) and then, simultaneously, helping them to relax their bodies when they encounter perceived threats they are able to begin to live their lives with fidelity to their principles *and* lower their level of stress-related symptoms (Benson, 1997).

The Pinnacle model utilizes three phases, or sections, over multiple weeks:

Phase I: Education
Phase II: Intentionality
Phase III: Practice (Coaching and Desensitization)

These three phases of the Pinnacle Program are developed and thoroughly discussed later in this chapter.

The Pinnacle Program should not be attempted by or with anyone who is experiencing acute psychiatric distress (e.g., suicidal crises, escalating and/or uncontrollable emotional outbursts, compulsive dangerous and/or self-destructive behavior, regressive functioning, active addiction, etc). These individuals should only work with a trained, licensed, and seasoned (i.e., "trauma-informed") professional who can help them to become stable enough to utilize this model. Once stabilized, this model can be a wonderful adjunct to ongoing therapy and many therapists will be willing to assist their clients in their movement through the Pinnacle Program's exercises and protocols. For the individual who chooses to practice the Pinnacle Program in a self-help format outside of therapy, they will need to cultivate a relationship with another stable person who can serve as a mentor/coach/accountability partner—much like a "sponsor" in a 12 Step fellowship.

The first phase of the Pinnacle Program is dedicated to psychoeducation, helping the participant to understand traumatic learning, perceived threat, and the autonomic nervous system. This phase also includes learning the self-regulation skill of relaxing pelvic floor muscles. This important skill helps participants internally attenuate their own level of arousal instead of becoming "stressed-out" by the capricious happenings of their lives. By practicing this skill hundreds of clients and thousands of workshop participants have found that they are able to enjoy comfort in their bodies and remain free from stress no matter the external stimuli.

The second phase of the Pinnacle Program focuses upon helping participants to develop intentionality. This is achieved by first helping them construct their own personal ***Covenant*** and a ***Code of Honor*** in clear succinct language. ***The Covenant*** is the articulation of our purpose for being alive—a personal mission statement. ***The Code of Honor*** is a statement of the principles that we choose to govern our lives—each person's individual moral compass. In addition to the construction and sharing of these declarations, the second phase also coaches the individual through exercises designed to assist them in identifying the situations and circumstances where they habitually fail to maintain these principles—instances where they "act out" and breach their integrity. As participants gain the insight to see that reactivity, which leads to the behaviors that breach integrity, is simply the result of allowing the sympathetic nervous system to become and remain dominant after an encounter with a perceived threat, they become increasingly motivated to practice the relaxation strategies of self-regulation when encountering these perceived threats. The relaxation of self-regulation allows them to regain comfort, maximal brain functioning and intentionality in these circumstances and situations, usually within a few seconds (Critchley, et al., 2001; Porges, 1999). Said differently, intentional behavior is achieved simply by holding intention in mind while relaxing the body in the context of a perceived threat. The simple elegance of this formula has become the primary engine of change and transformation for the Pinnacle Program. The final activity of this second phase is facilitating a shift from an external to internal locus of control. After an individual has identified the circumstances and situations where they habitually "act out," this shift is achieved by teaching them to self-regulate by relaxing their bodies (i.e. pelvic floor muscles) so that they can achieve intentionality in these "stressful" situations while maintaining comfort.

The subsequent work in the Pinnacle Program, which comprises the third and final phase, is essentially the practice of continually confronting "triggers" while maintaining a relaxed body so that participants can become progressively intentional in more and more contexts of their lives. The more practiced at self-regulation an individual becomes the more they find themselves able to retain fidelity to their Covenant and Code of Honor. Moreover, the more relaxed and intentional (i.e., parasympathetically dominant) a person remains the less symptoms their sympathetic nervous systems are generating. In

other words, by focusing on intentional living by relaxing while confronting perceived threats, this relaxation will likely lessen many of the symptoms of anxiety, depression, and traumatic stress.

However, almost every client who has successfully completed the Pinnacle Program has found at least one situation (many more for those who have active PTSD symptoms) where no matter how hard they try to remain self-regulated and relaxed they still find themselves becoming almost immediately anxious, reactive, and symptomatic. It is hypothesized that this acute reactivity is caused by one or more of their past experiences of traumatic learning intruding into their perceptual system with such intensity that the sympathetic nervous systems become immediately dominant and brain functioning is rapidly compromised (Herman, 1992; Breslau & Kessler, 2001). These intrusions thwart their ability to self-regulate as the sympathetic nervous system is already strongly compelling them to fight or flight. For those who experience this bewildering inability to self-regulate in particular situations and contexts, they will need to revert to traditional methods of desensitization and reprocessing (exposure, narrative, and relaxation) with a trained professional. They will need to find a therapist who can help them to access and desensitize these past painful/traumatic experiences. It should be noted that the primary function and purpose of these traditional methods—Eye Movement Reprocessing and Desensitization (EMDR, Shapiro, 1995) is most utilized and recommended—is to desensitize and reprocess past experiences sufficiently so that the intrusion of perceived threat is diminished to the level that the participant can now self-regulate in the context of the reminders, or "triggers," associated with these memories. Most clients find after a few successful sessions of desensitization and reprocessing with past memories, they are better able to keep their bodies relaxed in future situations in which they confront perceived threats associated with these and different memories.

Most clients have found themselves developing a level of proficiency with self-regulation and a modicum of success in confronting and navigating through "stressful" situations with comfort and intentionality within the first couple of weeks of practicing the Pinnacle Program. As they continue to employ self-regulation in the contexts of perceived threats, they often find themselves amazed at the simplicity of maintaining intentionality, comfort, and principle-based living. However, each and every person who has ever practiced this model will quickly point out that simple is not the same as easy. While it is a simple concept to understand that relaxing one's body in the context of perceived threats yields comfort, maximal neocortical functioning, and the ability to remain intentional; this capacity also requires constant monitoring and regulation while engaged in the moment-to-moment activities of daily life. Maintaining this state of "bodyfulness" demands ongoing focused attention to areas of the body to which many people have rarely paid attention in the past. Most people find that as soon as they lose conscious awareness of their pelvic floor muscles it is not long before those muscles are again clenched and the individual is once again ratcheting upwards toward sympathetic dominance, reactivity, and symptoms.

As was previously stated, the Pinnacle Model is implemented in three phases or stages. It is important for individuals engaging in the Pinnacle Program to be stabilized to the degree that they are not experiencing frequent abreactions or suicidal ideation. It is also important to understand that successful outcomes for participating in this program, like all healing, will be primarily contingent upon the quality of the relationship the individual builds with her or his "partner/coach/mentor" and the degree to which the individual is able to maintain a positive expectancy—hope—that the Pinnacle will work for them. To maximize the quality of the relationship and positive expectancy, it is recommended that individuals choose a partner/coach/mentor who has demonstrated the capacity for overcoming difficulty and hardship in their lives. Additionally, a partner/coach/mentor should be someone with whom the

participant is able to connect and who is able to maintain this supportive connection with warmth, assertiveness, compassion, empathy and challenge. Ideally, a participant will choose someone who is working this model, or something like it, in their own lives.

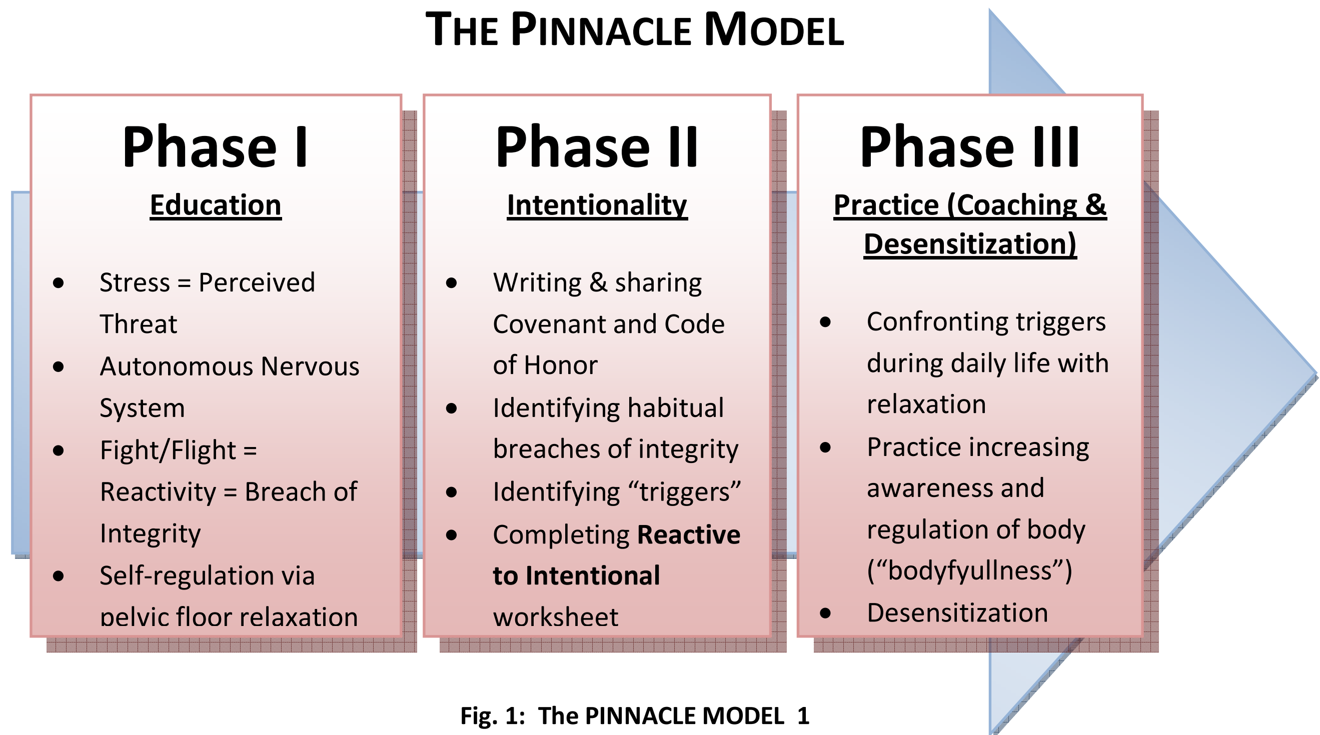


Fig. 1: The PINNACLE MODEL 1

Phase I: Education

Education. When working in therapy, this first phase of the Pinnacle Program can usually be completed during a single session. However, the information shared with clients during this first phase will be reviewed and re-taught throughout the course of treatment. This is also true for readers practicing the Pinnacle Program in a self-help model outside of traditional therapy formats.

One way that has been effective in transitioning from the well-trodden landscape of traditional psychotherapy into the realm of the Pinnacle Model has been to offer participants the following challenge:

> *Would you be interested in learning, over the next 30 minutes, how to be stress free in your life?*
>
> Or, if the clinician wishes to engage a more conservative approach, s/he may ask:
>
> *Would you be interested in learning, over the next 30 minutes, how to significantly lessen stress in your life?*

(Note – this intentionally provocative statement is designed to heighten interest and participation from clients. The clinician is about to embark upon a psycho-educational dialogue with their client to help them to understand that, in the Pinnacle Program, intentional relaxation of the muscles in the body *is* the operational definition of "stress-free.")

Most clients cannot resist the temptation to hear how the clinician is going to handle this seemingly impossible task. Even the most recalcitrant clients can usually muster enough willingness and open-mindedness to at least listen, albeit skeptically, for the next half hour. At this juncture clients are asked to identify the sources of stress, or stressors, they perceive in their lives. Most clients recite a litany of objects, people, and activities they believe to be the causes of their stress that might include things like: finances, relationships, work, traffic, economy, etc. Following the creation of this list of "causes," the therapist can now elicit the "effects" of stress from their client: *What effects are all these stressors having in your life?* The answer to this question is usually a summary list of the symptoms for which the client has sought treatment. Effects such as somatic problems (e.g., headaches, GI disturbances, chronic pain, etc.), anger/irritability, sleep problems, over/under eating, substance abuse, relational problems, and anxiety are the more commonly reported effects of these stressors.

Exercise: Take a moment to fill out the table below identifying the causes of stress in your life and then the effects that these stressors have upon you.

Causes & Effects of Stress

Causes		Effects	

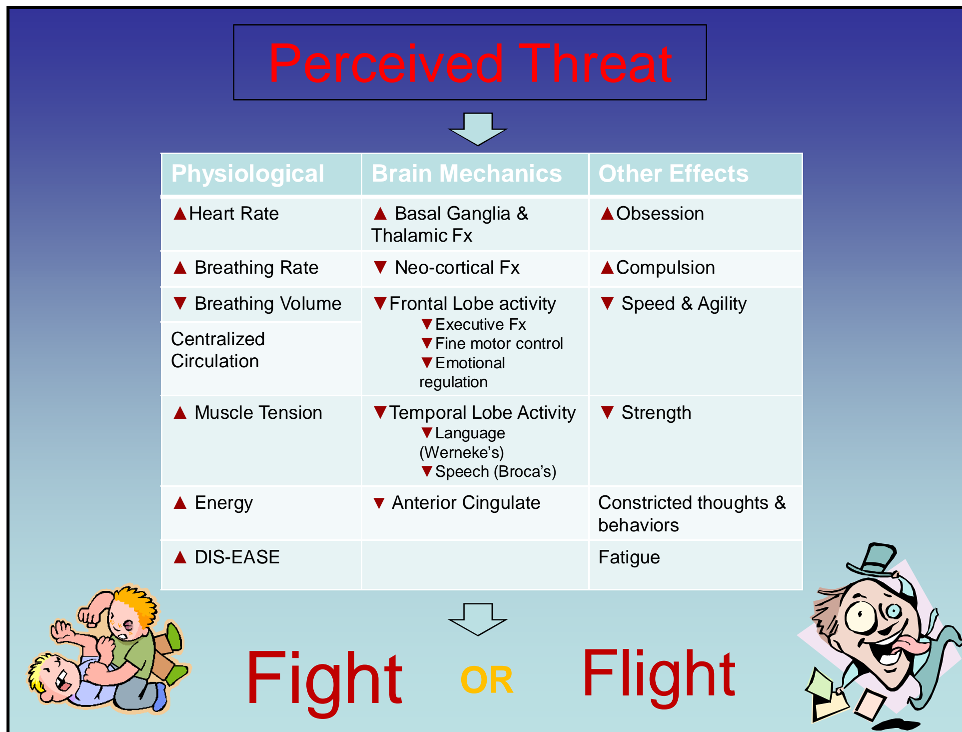
Fig 2. Causes & Effects of Stress

In therapy this next step is tricky and needs to be offered with equal parts compassion and humor. The clinician holds up these two lists and pointing to the lists of "causes" says:

These are NOT the causes of your stress. As long as you believe that these ARE the causes of your stress, there is a good chance you will keep having these (pointing now at the list of "effects.")

Occasionally, clients may become a little irritated with this confrontation and the clinician will need to assure them that they have offered this with compassion and ask them for permission to continue to pursue the REAL cause (there is only one) of their stress. Most clients, by this point, are very much engaged and interested in what is coming next.

The next important step is to reveal the true cause of stress which is: *STRESS = PERCEIVED THREAT*. Perceived threat is the single cause of all stress in human beings. The reason that we experience stress when we encounter financial or relational difficulties or when we are at work or in traffic is because we have learned, through painful or fearful past experiences, to perceive threat in these circumstances. Stress is simply our body and mind's reaction to a danger (Cox, 1992; Hamarat, et al., 2001). It makes no difference in our response whether this danger is real or only perceived. Perceived threat (real or imagined) activates the sympathetic nervous system and a discussion about the changes that take place in the body and brain when the sympathetic nervous system becomes activated is the next step of this first phase of the Pinnacle Program (See **Figure 3** below).



Physiological	Brain Mechanics	Other Effects
▲Heart Rate	▲ Basal Ganglia & Thalamic Fx	▲Obsession
▲ Breathing Rate	▼ Neo-cortical Fx	▲Compulsion
▼ Breathing Volume Centralized Circulation	▼Frontal Lobe activity ▼Executive Fx ▼Fine motor control ▼Emotional regulation	▼ Speed & Agility
▲ Muscle Tension	▼Temporal Lobe Activity ▼Language (Werneke's) ▼Speech (Broca's)	▼ Strength
▲ Energy	▼ Anterior Cingulate	Constricted thoughts & behaviors
▲ DIS-EASE		Fatigue

Figure 3: Sympathetic Nervous System

When we perceive threat our sympathetic nervous system (SNS) activates. During these periods of perceived danger is the only time that our sympathetic nervous system will activate and, if we stay in the context of the perceived threat then the SNS will remain activated to become dominant (Yartz & Hawk, 2001). When we do not perceive threat, or when we intentionally relax our bodies, our parasympathetic nervous system (PNS) becomes and remains dominant (Carlson, 2007).

Parasympathetic dominance may best be described as being "comfortable in our own skin" or "fat and happy." The physiological hallmarks of *sympathetic* dominance include increased heart and respiration rate, decreased peripheral circulation, muscle tension, and increased energy (Sapolsky, 1997). In addition to the physiological changes that occur when we perceive threat, our brain also changes (Critchley, et al., 2001; Porges, 1999; Scaer, 2006). The middle part of our brains (thalmas), our brain stems and basal ganglia—often referred to as the "reptilian brain"—activates concomitantly with the SNS when we perceive threat. While in the context of a perceived threat, real or imagined, these parts of our brain become dominant and while these "reptilian" parts of our brain are becoming dominant, the neocortex, or "thinking" part of our brain is becoming recessive. The neocortex includes the frontal lobe, the temporal lobe, and the anterior cingulate. These structures have been demonstrated to be the housing for our higher and "executive" functions (Goldberg, 2001). These functions include: judgment, reason, discernment, fine motor control, identity, time management/ conceptualization, language, speech, and the ability discriminate between real vs. perceived threat. By application, we begin to see that the longer we spend in the context of a perceived threat (real or imagined) without relaxing our bodies, the more we compromise functioning of most of what is human in our brains. We become progressively less able to think clearly and rationally; compromised in our language and memory skills; less agile and graceful; unable to creatively solve problems; and incapable of "being ourselves" when we remain in the context of a perceived threat without relaxing our bodies. Before we give the SNS a bad name and black eye, however, let's look at some of the benefits of sympathetic *activation* (remember activation vs. dominance). The SNS gives us energy and strength, helps us to focus, supplies excitement, and affords us with joy, anticipation, and ecstasy. That's a lot of good stuff. It's only when the SNS gets stuck in the "on" position that it causes us problems (Sapolsky, 1997; Scaer, 2006). If we can imagine ourselves as automobiles and recognize that we are meant to idle at less than 1000 RPMs (PNS) and cruise at 2500 RPM (balanced PNS + SNS) and occasionally move up into the higher registers of RPMs when we need to pass another car or get somewhere in a hurry (SNS). However, many of us who chronically perceive threat and do not intentionally and regularly relax our bodies are like cars that have the accelerator pedal mashed to floor, in gear, with another foot on the brake. We are spending our days with our RPMs "red-lined," going fast but getting nowhere while we burn out the components of our engines. There is increasing amounts of research that points to this phenomenon as a cause for many diseases and immune dysfunctions (Rothschild, 2000; Scaer, 2006; van der Kolk, 1996)

How did this happen? Good question. The World Health Organization (2007), in a recently published research article, indicated that in high-income countries (North America, Europe, some of Asia, some of South America), we are the "safest" generation to ever live on Earth. We are less likely to personally become a victim of warfare, pestilence, famine, disease, disaster, crime, and several other indices of safety than any previous generation. With "Threat Level: Orange" and the never-ending parade of trauma across the evening news, it doesn't "feel" very safe though, does, it? While we may indeed be the safest generation to walk the planet, we also seem to be the most afraid. What is different about our generation than any preceding it? That's right…the media. We bear witness to exponentially more trauma and traumatic occurrences than did any of our ancestors through the constant bombardment from the media. In 1990, Laurie Pearlman and Linda McCann in their landmark work with vicarious traumatization demonstrated to us that we do not need to be the survivor of a traumatic event to become traumatized—we need only witness it. To illustrate this phenomenon, often in workshops I ask participants: *How many of you in this room have ever been attacked in a parking garage?* Usually no one raises their hand. If someone does, I ask them to sit out on answering the next question: *How many of you find yourself on-guard and anxious when you are in a parking garage?* It is almost always unanimous that all the hands in the room go up. When asked why they experience this anxiety you can

almost see the light bulb switch on as I hear answers like: *the evening news, CSI, the newspaper, my friend was attacked.* These folks "witnessed" trauma in a parking garage and the next and future times they found themselves in that context they perceived threat in a parking garage—where there was no real danger. Add to this the phenomenon of state-dependent learning teaching us each and every time that we experience something painful, fearful, or uncomfortable there is a good possibility that we will perceive future situations that remind us of this original event as threatening. So, said differently, if we are the *survivor* of a significantly traumatic experience (abuse, rape, natural disaster, motor vehicle accident, etc), we are more likely to perceive generalized threat in the future. If we are the *witness* to a traumatic event, through the media, hearing stories, reading, or however we learn about something traumatic happening to someone else, we are likely to perceive threat and be afraid in situations that are similar to those we witnessed but happened to someone else. And, finally, if we *experience* painful, fearful, or uncomfortable incidents in our lives, through the process of association, we are likely to perceive threat in situations that remind us of these occurrences (e.g., putting our hands on a hot stove, receiving criticism, encountering periods of financial hardship). All these learning experiences of the past have the potential to cause us to perceive threat in the present where there is no danger. Again, the SNS does not care whether the threat is real or imagined, it will activate in either instance. If we stay in the context of this threat (i.e., parking garage), without intentionally relaxing our bodies, our SNS will become dominant and we will begin to experience the array of symptoms generated by the SNS (e.g., anxiety, panic, difficulty concentrating, irritability, somatic discomfort, etc). It does not take much insight into this process before we begin to see that, for many of us, threat perception is ubiquitous and chronic occurring hundreds, or even thousands, of times each day.

The original goal of the SNS was to survive—to help our ancestors recognize and rapidly respond to threat. However, over tens of thousands of years we humans have developed a frontal lobe that has given us the capacity for reasoning and discernment. Without the capacities of a neocortex, it is imperative that an animal recognize and respond to every threat for its survival since it cannot tell the difference between a real and a perceived threat. However, once we are able to discern this difference it is no longer imperative, or even useful, to respond to *perceived* threat with an SNS response. There is data to support the compromise of important capacities and skills when the SNS is dominant for extended periods of time. In addition to diminished cognitive and language skills, we can also lose strength, agility, and speed. Any athlete or performance artist will confirm for you that their best performances occur when they are relaxed and PNS dominant. And any martial artist will also confirm that they are better prepared to protect themselves and disable an attacker when they are also relaxed.

> *What is RIGHT ACTION, the right use of your will, when you perceive a threat but are in no danger?*

Answer: RELAX your body. This is the most important question that you will ever be asked because from the "right" answer to this question flows intentionality, comfort, and maximal performance. Often in workshops, I hear participants tell me that right action is to change our perception and I whole-heartedly agree. However, it is nearly impossible to change perception when the SNS is dominant due to diminished neo-cortical functioning. So, best to relax our bodies for 20-30 seconds and allow our SNS to dissipate and the frontal lobe to engage to that we can: (a) be comfortable in our bodies; (b) maximize our intelligence and bring to bear all our past learning (i.e., change perception); and (c) shift from reactive "fight-or-flight" behaviors to intentional and principle-based actions.

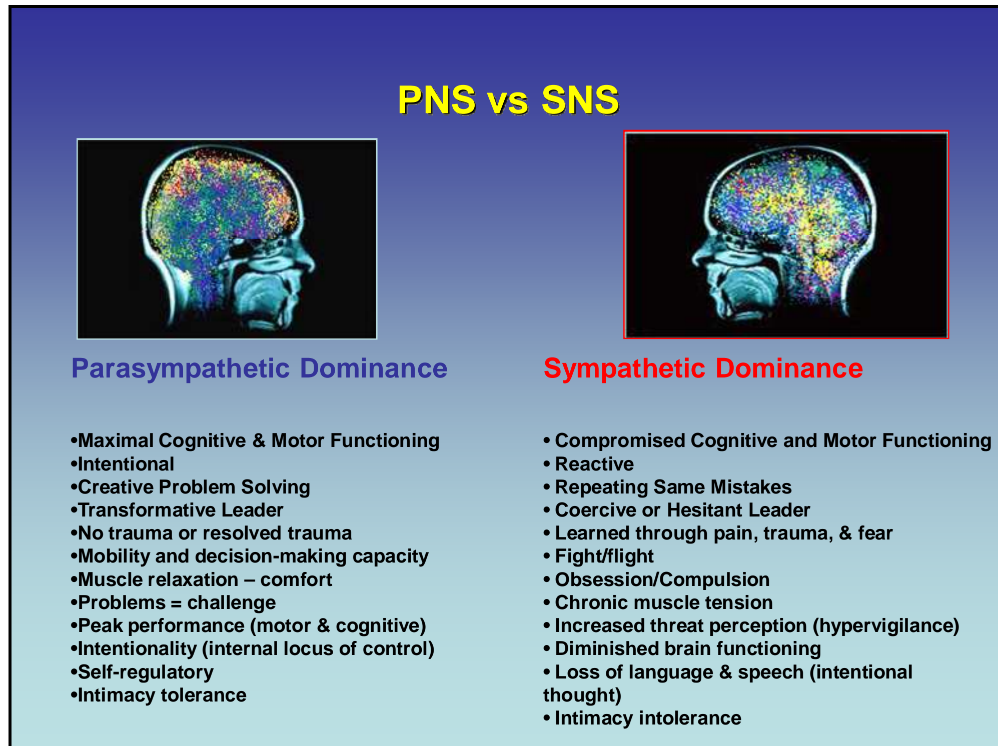


Figure 4: PNS vs. SNS

Intentionality vs. Reactivity. If we continue to perceive threat without relaxing our bodies then our sympathetic nervous system will become and remain dominant, flooding our body with energy and chemicals (Yehuda, 2001). All that muscle-clenching, heart-racing, and shallow breathing is compelling us toward one of the two inexorable goals of the SNS—fighting or flying (Cox, 1992; Sapolsky, 1997). With the SNS dominant we are increasingly compelled to fight or fly *and* we are continuing to gradually lose neocortical functioning (Critchley, et al., 2001; McNaughton, 1997; Shusterman & Barnea, 2005). As this energy continues to ratchet upwards with our neocortical functioning continuing to lessen we will soon find ourselves acting in ways we do not want to act—compulsively and against our will (Takahashi, et al., 2005: Yartz & Hawk, 2001). As an example, let's say that someone criticizes us at a meeting and we perceive this criticism as a threat (Later we will explore and make "good sense" why we perceive these threats during seemingly innocuous occurrences and while we are perfectly safe). Our face flushes, fists clench, and jaws tighten as we think of several ways to defend ourselves. We decide to say nothing thinking that it is best to just allow the remark to pass, choosing instead to remain focused on the content of the meeting and compassionate towards our co-workers. However, we notice that we are still uncomfortable (e.g., flushed face, clenched fists, tight jaw) as we become progressively irritated by the remark that occurred a few moments ago. Continuing to perseverate on the comment (therefore remaining in the context of the perceived threat) our SNS continues to ratchet upward while, at the same time, we are losing frontal and temporal lobe functioning. Presently, while still in the meeting, we find ourselves targeting angry looks and making sniping comments towards the offender (fight). After the meeting is over we find ourselves actively avoiding contact with this person for days, weeks, months, or even years (flight). What happened? Our intention was to simply ignore the critical comment and stay true to our intention of being compassionate, tolerant, and remain attendant to our

work. We did not want to get drawn into these interpersonal politics and we certainly do want to develop and maintain resentment, knowing that it is causing us more harm than it is anyone else. However, it felt as though we were powerless to stop ourselves even with our best effort.

This concept is the central pillar of the Pinnacle Model—helping people to understand and make "good sense" of why they act like they do and then to help them transform from entrenched, reactive, fight-or-flight behaviors to principle-based intentionality with comfort in their bodies. What those of us who chose to live lives of intention quickly learn is that strife and willpower are rarely effective tools towards facilitating this transformation. In the example above, with which most of us can resonate, a THRESHOLD was crossed and we became compelled, against our will, to fight or fly. When we have lost too much of our neocortical functioning and we are compelled to act, due to SNS dominance, we can no longer hold on to our intention and we instead become compelled to protect ourselves from the perceived threat. We "act out," against our will, with the SNS now in control. We say things we don't mean, we hurt those we care about, we isolate, we over-eat, we over-spend, we drink and/or use drugs, and we engage in other forms of self-destructive behaviors to either run, fight and/or soothe the discomfort of SNS dominance. All behavior directed by the SNS will have the goal of either getting away from or neutralizing the perceived threat. Again, it does not matter if the threat is real or perceived. As long as we continue to perceive a threat without relaxing our bodies, we are destined for reactive behaviors. What's even worse is, prior to acting out against our principles and breaching our integrity, we will have endured several moments to several hours of uncomfortable SNS dominance. This is the very definition of STRESSED OUT!

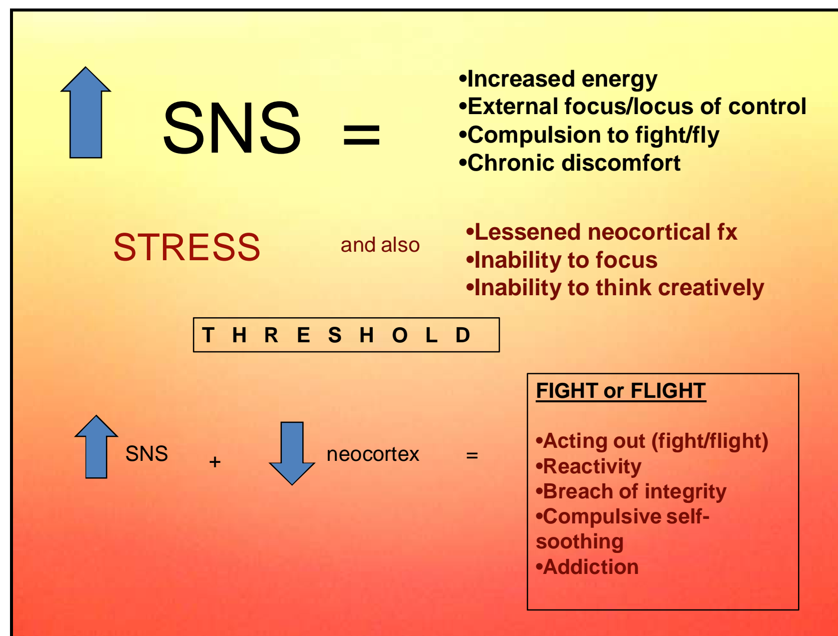


Figure 5: Threshold

Anytime you have acted against your will, breached your integrity, or done anything for which you are ashamed, chances are you engaged in these actions while your sympathetic nervous system was dominant (Takahashi, et al., 2005). It is likely that these behaviors were, in some form, an attempt to

achieve safety from a perceived threat (rarely a "real" one) by flying or fighting. Clients who have participated in the Pinnacle Program found early in their work that they were frequently acting in ways that they did not want to act. They were fighting with spouses they loved, yelling at children they cherished and dreading work they had chosen as their mission. They learned that many, if not all, of the myriad of symptoms they were experiencing were a result of chronic sympathetic dominance. In my own experience, working with thousands of clients, I have come to embrace the bias that ALL the symptoms my clients report to me are caused by one of two sources—organicity (something wrong structurally or biochemically) or chronic sympathetic dominance. For those whose symptoms are caused by some organic cause--a structural anomaly or biochemical imbalance--they will usually need some form of organic treatment (e.g., surgery, medication, diet, lifestyle change, etc). They may still benefit from psychotherapy but it may be insufficient when the cause of the symptoms is organic in nature. For those clients whose symptoms are a result chronic SNS dominance there is much hope. Human beings (with the possible exception of those with Antisocial Personality Disorder) cannot live in chronic breach of their integrity without suffering symptoms. People who are the most symptomatic also seem to live in frequent betrayal of their mission and their principles. They breach their principles and fail to maintain intentional behavior because they have failed to relax their bodies in the context of perceived threats. As we teach our clients to develop and maintain relaxed bodies in the context of perceived threats, not only do they begin to find themselves able to maintain their principle-based behavior—being the people they intend to be—they also find themselves becoming progressively less symptomatic. They are prohibiting SNS dominance and instead are enjoying the relaxed comfort of PNS dominance no matter the external situation or circumstance. Intentional, principle-based living achieved through relaxation in the context of perceived threats lessens our non-organic symptoms.

Clinical Note:

Clinical professionals who wish to facilitate clients' navigation through the Pinnacle Program will want to develop this previous material into language that is comfortable for themselves and their clients. Having mentored several clinicians through the process of becoming adept with the Pinnacle Model, I have discovered that it takes some time to develop mastery with this complex information. It is recommended that readers take some time to familiarize themselves with the literature in the bibliography, speak with experts in the area of human nervous functioning and disorders, and practice for themselves these principles. Six to twelve months is not an uncommon period of time required to gain mastery with the psycho-educational concepts and ideas of the Pinnacle Model.

Self-Regulation. The final component of the Educational Phase of the Pinnacle Program is teaching self-regulation (Gentry, 2002; Perry, 2007). The use of term "self-regulation" is different from "relaxation," even though relaxation is a crucial part of self-regulation. Self-regulation, for use in the Pinnacle Program, is defined as: *the process of sufficiently and immediately relaxing and keeping relaxed one's body so that the sympathetic nervous system does not achieve dominance.* This means an individual must develop sufficient mastery of a set of relaxation skills that they can implement at any time to shift from SNS to PNS dominance—no matter what the external circumstance or situation. Additionally, it also requires they develop the capacity to monitor themselves for SNS activation and then implement these relaxation strategies to prevent the SNS from achieving dominance. Said differently, self-regulation is the development and ultimate mastery of the ability to internally attenuate our own level of arousal, anxiety, and stress (i.e., SNS dominance) to a level of comfort that facilitates maximal

neocortical functioning and intentional principle-based behavior. Said even more simply: STOP CLENCHING!

Traditional relaxation approaches employed in the service of mental health treatment proven to be useful but require attention, dedication and are not always immediately effective with every individual. Maintaining a relaxed and comfortable body while engaged in the activities of daily life—especially when those activities involve frequently confronting perceived threats is extremely challenging. Progressive relaxation, paradoxical relaxation, meditation, autogenesis, even diaphragmatic breathing all require the client to disengage from their current activities to some degree while they attempt to bring about relaxation by one of these methods making concurrent sustained attention on work or other activities of daily living extremely difficult. These methods work wonderfully--when a person has ample time and space to engage in these deeper relaxation protocols (Jamison, 1996). It is recommended to individuals who practice these and other methods continue their practice. However, the Pinnacle Program asks them to add the skill of self-regulation to their toolkits.

Self-regulation, as defined and employed in the Pinnacle Program, is simple but it is not easy. It involves a commitment to life-long practice of developing and maintaining relaxation of the pelvic floor muscles (e.g., psoas, sphincter, and pubio-coccyx or "Kegel" muscles). The muscles of the pelvic floor and, more specifically, the psoas muscles have been gaining attention as an important area for the regulation of anxiety and stress (Bercelli, 2007; 2009; Heim, et al, 1998; Krost, 2007) I have called this ongoing identification and regulation of muscle tension "bodyfulness." While "mindfulness" challenges the client to disengage from trying to controlling thoughts and just notice them while attempting to relax, the "bodyfulness" of self-regulation asks her/him to not attend to thoughts at all but instead maintain an awareness and relaxation of their pelvic floor muscles (Jamison, 1996; Kabat-Zin, 1990) . Relaxation of the pelvic muscles can bring about an immediate and profound relaxation of the entire body—often within 20-30 seconds. Slower and deeper breathing, reduced heart rate, relaxed core and peripheral muscles and reactivation of neocortical function are all benefits of a relaxed pelvic floor. It is difficult, if not impossible, to generate the visceral effects of fear and SNS (e.g., elevated heart rate, clinched muscles, shallow breath, diminished cognitive functioning) when the pelvic muscles remain relaxed. In other words, if you can keep the muscles between your waist and thighs relaxed and unclenched, the rest of you will likely be comfortable and PNS dominant, no matter what is happening around you. I have had reports from many clients who, before they learned pelvic floor relaxation, were so phobic or scared that they could not engage in certain activities (flying, driving over bridges, getting shots, and even skydiving). As they learned and began practicing self-regulation they were able to engage in these activities and reported that they had no sense of discomfort or fear. Probably the most important point about pelvic floor relaxation as a strategy for self-regulation is that people can do it while they are engaged in other activities. It takes practice and determination, but after a few months most clients who have practice this method find that they can effectively attend to the dialectic of relaxing their pelvis while engaging in work, performance, school, relational encounters and the other activities of life. However, pelvic floor relaxation never seems to become automatic and requires constant attention, or "bodyfulness." Individuals wanting to remain comfortable, maximally functioning, and intentional will need to willfully practice this simple skill of pelvic relaxation moment-to-moment for the rest of their lives. Simple, but not easy.

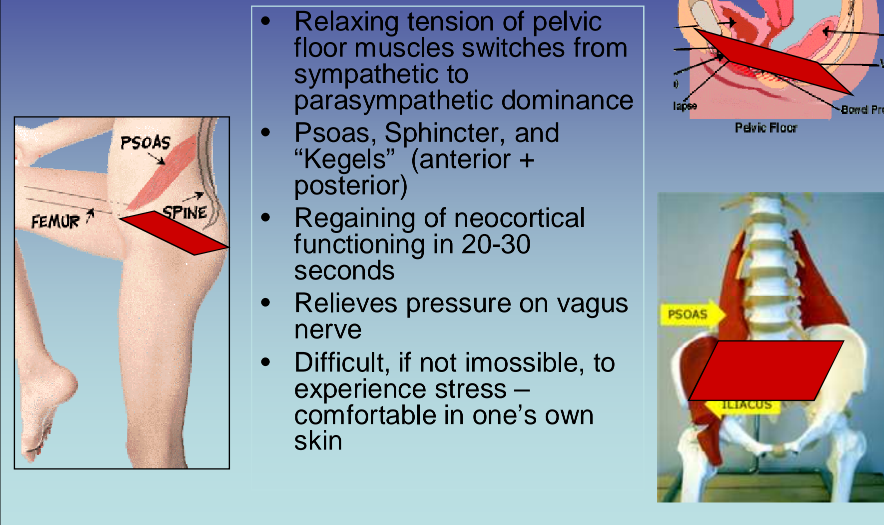


Figure 6: Self Regulation

Why does the relaxation of the pelvic floor muscles result in profound systemic relaxation that affects both body and brain? Well, we're not certain. I discovered this technique from Emergency Medical Technicians (EMTs) when I learned their protocol for assisting a person who is suffering an attack of tachycardia, or dangerously fast heart rate. Paramedics are taught to use a process that is called a *val salva* maneuver that triggers a *vaso-vagal* response (Lim, et al., 1998; Waxman, et al., 1980). This response is accomplished by having the patient "bear down," with a gentle downward and outward pressure, as though they are having a bowel movement. This action, in most patients, produces a significantly precipitous bradycardic (slowed heart rate) response within a few seconds (Kinsella & Tuckey, 2001). This response is known to occasionally cause heart attacks with geriatric patients when they go to the bathroom (Sikirov, 1990). I became increasing curious how manipulation of the configuration of the muscles in one's pelvis could have such a profound effect upon heart rate. While I have been able to find precious little information or data regarding these muscles and the effects they have, except in the area of incontinence, what I have found has led to the vagus nerve (Porges, 1992). The vagus nerve is the 10th cranial nerve. It is the longest nerve in the human body, hence its name—*vagus* is Latin for "wanderer." It is connected to the roof of our mouth, follows the carotid artery into the chest and terminates at the perineum (where the legs join together). The vagus nerve is intricately connected to the regulation of the PNS and the SNS, as it controls and/or regulates many of these functions in both our bodies and our central nervous systems. We know vagal nerve stimulation can and does have a profound effect on mood and is a growing treatment for some of the most recalcitrant mood disorders. We also know that mild manipulation of the vagus nerve can cause a person to pass out, have extreme heart rate variability and, during periods of extreme stress, has been linked to paralysis (i.e., conversion disorder) and dissociation (George, et al., 2000).

We have much to learn about the vagus nerve and, after multiple attempts of scouring the literature; I have been unable to find any articles that give a satisfactory explanation for the mechanics and relationship between pelvic floor relaxation, the vagus nerve, and PNS vs. SNS dominance. I am unable to provide a good citation that supports the notion that when you relax your pelvic muscles then the rest of your body relaxes and you are able to think clearly and act intentionally. I do, however, invite you to try it. If it works for you, then you may wish to continue to utilize it as a method for self-regulation. It will certainly cause no harm. Scores of clients and thousands of workshop participants have reported to me that the quality of their lives transformed from practicing this simple skill of relaxing their pelvic muscles when they experience perceived threat. Comfort, maximal functioning, and intentionality follow in its wake.

A detailed explanation of self-regulation, SNS vs. PNS dominance, and the procedure for pelvic floor relaxation is contained in **Appendix 1: Self-Regulation** at the end of this chapter. I make copies of this handout available to all my clients and workshop participants. Please feel free to copy and disseminate this handout. It is recommended that you practice the exercise contained in the handout and complete 30 seconds of totally relaxing your pelvic floor muscles. When you have completed the 30 seconds, notice how you feel. You will likely notice that you are comfortable, sleepy, relaxed, your breathing will have slowed, and the muscles elsewhere in your body will have released. For those people having some difficulty establishing a "felt sense" of their pelvic floor muscles (anecdotally, this is about 10% of the clients and workshop participants), I do a "Kegel Exercise" with them (Kegel, 1951). This is done simply by asking a person to tighten for five (5) seconds the muscles they would use if they wanted to stop urination mid-flow. Tighten these muscles as tight as you can for the five seconds and then release with a deep breath. Take a second deep breath and then release these muscles even more profoundly. I ask participants to then memorize this sensation of pelvic relaxation and to replicate it anytime they feel tense, perceive a threat, or are aware of any stress in their bodies. For those that continue to have difficulty establishing a "felt sense" of their pelvic muscles, I will refer them to a message therapist, neuro-muscular therapists, or Doctor of Osteopathic Medicine and tell them to ask for help in locating their psoas and "Kegel" muscles. A good practitioner of kinesiology will be able to help you to locate and release these muscles.

Clinical Note:

When working with clients at the conclusion of this session of treatment and after a client has been able to successfully get and keep their pelvic muscles relaxed for a short period of time I congratulate them on learning one of the most important skills they will ever learn. Before they leave the session I playfully ask them the following question:

> *So, are you leaving this session knowing how to never experience stress again…for the rest of your life*

From most of my clients I get a grumble, a smile, and something like: "Yeah, but I didn't know it was going to take this much work." As they leave the session, I take heart knowing that I have given maximal attention to both the therapeutic relationship and positive expectancy—the two MOST powerful predictors of positive change. They (and now you also) have been equipped with powerful and necessary information to help them live lives of comfort and intention.

Whether it takes one or two session to complete this Educational Phase of the Pinnacle Program, with its completion you will likely witness a growing sense of hope and anticipation from your client. As you

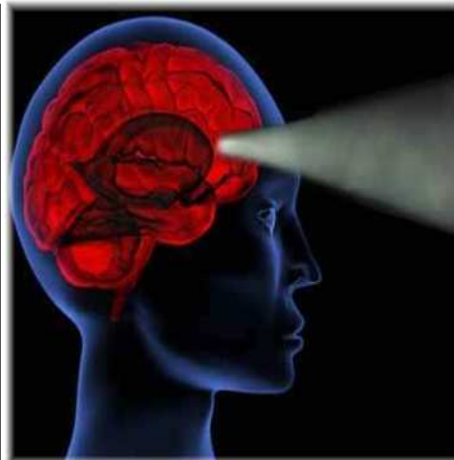
reinforce for them the understanding that as they practice relaxing their bodies, in the form of pelvic floor relaxation, they will be able to enjoy immediate comfort, maximal functioning, and be able to live with fidelity to their own principles and morality it is likely that they will be excited about continuing the work towards developing and maintaining this capacity. With the completion of this phase, I ask my clients to complete, as homework, the **Pinnacle Exercises** that will help them to articulate their Vision, their Covenant, and their Code of Honor. I ask them to find 60 – 90 minutes of contemplative time where they can work on these exercises without interruption or encroaching demands. A copy of the template for these exercises may be found in **Appendix 2** at the end of this chapter. Use the template to construct and complete a statement of your Vision, Covenant, and Code of Honor. You should be as succinct and clear as possible in the completion of this exercise.

For those reading this article and wishing to engage in the Pinnacle Program in a self-help model, please read and complete the Pinnacle Exercises contained in **Appendix 2**. After completing these exercises, you will want to recruit a person and/or network of people that you can use for support, sharing, and accountability. You will use this person or these people throughout your work with the Pinnacle Program. In selecting your support person/network, it is best to work with others who are engaged in some form of self-healing and actualization—someone who is empathetic and committed to helping you become the person you wish to be. You may decide to begin the Pinnacle Program with a group of others who wish to practice this model of self-help in their lives. The Pinnacle Program lends itself quite well to work in a group format (Note: If you do choose to work within a group please contact Dr. Eric Gentry via email (eg@compassionunlimited.com)and assistance to structure the group will be provided.

Phase II. Intentionality

DO I GO WHERE I AIM MYSELF?

- Requires self-regulation
- Mission-driven
- Internal locus of control
- Principle-based
- Tolerance of pain for growth
- Maturation of spirituality



2168 miles. 5,000,000 steps. 2,000 bug bites, 21 blisters, hypothermia and a stress fracture.

In the summer and fall of 1996, I thru-hiked the Appalachian Trail from Mount Katahdin, Maine to Springer Mountain, Georgia. I spent the first night of the six-month hike at Daisy Pond Shelter, 2.3 miles south on the AT from Mt. Katahdin. It was the first of hundreds of three-sided sleeping shelters that dot the trail about every six miles all the way from Maine to Georgia. I was cold, scared and alone. I discovered in that shelter, like the hundreds that were to follow, a notebook was maintained for each hiker to write whatever thoughts or information that they would like to leave for future hikers that would pass through the shelter in the days and weeks to come. These notebooks increasingly became an important source of news, entertainment, information, connection, and comfort for every hiker on the AT. Sometimes funny, sometimes sad, and sometimes poetic these notebooks were savored at the end of the day at each shelter and most days I added my thoughts and feelings to this patchwork narrative. On that first night in that first shelter I opened and read the first page of that first notebook. Here is what it said: *The first step of a journey is great not for the distance it covers but for the direction it heralds.* I laid there that night meditating on this truism—on what a first step declares and the potency of that declaration. After all was said and done, that first step provided me with enough momentum and entropy to take the next five million and complete what only 5% of those who take that first step complete—a thru-hike of the Appalachian Trail.

Phase II: Intentionality. This second phase of the Pinnacle Program focuses first on helping the individual to articulate and share his/her Vision, Covenant, and Code of Honor. Once you have completed the Pinnacle Exercises and constructed these three documents, it is important that you develop a relationship with one or more individuals who can serve as your coach/accountability partner. You should make a photocopy of your Vision/Covenant/Code of Honor for your partner. You will be returning over and over again to these documents in future meetings. Now, schedule your first meeting with your partner/mentor/coach.

This first meeting is an important moment in the trajectory of your healing and self-actualization. With the completion of the Pinnacle Exercises you are emerging, stepping forward as best you can with a declaration of who you are and how you *choose* to be. We will want to lend to this moment all the gravitas that it deserves and you will want to select as a partner to witness this declaration someone who can also extend this reverence. Additionally, a few moments spent discussing with your partner the process of writing your Vision, Covenant, and Code of Honor is time well spent. A conversation that includes difficulties, challenges, and triumphs are all worthy of discussion in this early part of the first meeting with your partner.

Next, you can discuss with your partner your experiences with self-regulation. Did you attempt to self-regulate during times of anxiety, stress, and perceived threats? What were the outcomes of these attempts? Do you need some remediation for self-regulation skills?

Clinical Note:

The comments I most often hear, in these early sessions, is that my client was able to find comfort, relaxation, and had some minor success *when they remembered to relax their bodies.* However, most will have only practiced self-regulation a few times between sessions. It is important for the clinician to begin with encouragement and good motivational interviewing techniques. One example of this might look something like the following: *So, you* were *able to self-regulate during a few experiences over the past week and you were able to be comfortable in your skin and act like you wanted to?* [Client acknowledges] *Hmm. And when you forgot to self-regulate, you were uncomfortable and "acted out", right?* [Client acknowledges] *Where am I going with this?* This playful confrontation reinforces for the client that s/he is able to choose to act differently but must do so by remembering to first relax their body instead of trying to "think their way through."

For clients who fail to complete the Pinnacle Exercises, some time should be spent discussing the meaning of this shortcoming. Are they committed? Do they wish to negotiate to complete these exercises for the next or future session? Is there something else more emergent that needs attention? Is there something that is thwarting their belief that they can change? All these are appropriate discussion for those who fail to complete the exercises. For those who articulate a desire to continue but, for whatever reason, were unable to complete the exercises, I help them to complete an abbreviated version of their Covenant and Code of Honor. I ask them to identify three words that best describe their purpose for being alive and then I ask them to identify three words which represent the principles they choose as their own personal code—their moral compass. I then use these six words to help them move through the following exercises of the session.

Appendix 3, at the conclusion of this chapter, contains a worksheet that will assist you in navigating through the concepts, activities and exercises of this second phase of the Pinnacle Program. Contained in the **Reactive to Intentional Worksheet** are the five main components of this phase of the program. These are:

1. **Covenant/Code of Honor**
2. **Reactive Behavior/Breach of Integrity**
3. **Intentional Behavior**
4. **Triggers**
5. **Narratives**

This portion of the work in the Pinnacle Program will be addressing each of these five components in relation to one or more reactive behavior, helping you to prepare to transform this habitual reactivity into intentional, principle-based behaviors. Please print and have ready to utilize **Appendix 3: Reactive to Intentional Worksheet** for this portion of the work. **Figure 7** below is a facsimile of and corresponds with the **Worksheet**.

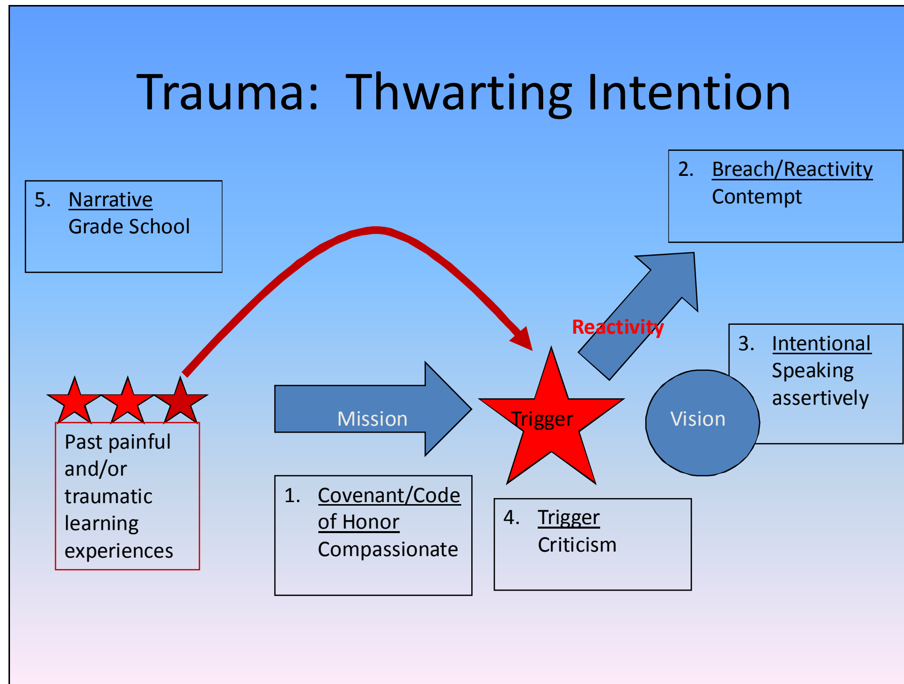


Figure 7: Reactive to Intentional

1. Covenant/Code of Honor. Using the Worksheet, identify a few principles from your Covenant or Code of Honor that you habitually breach during the course of a day or week. What are the primary points of your moral compass? *How do you **want** to act at home, at work, at school?* Write in a few words that define the principle behind your intention (e.g., kind, friendly, helpful). In the example in **Figure 7** above, you can see the example is "Compassionate." We are using for this example the scenario that was discussed earlier in this article during which the subject was criticized in a meeting and then engaged in reactive behavior.

2. Breach of Integrity/Reactivity. In this second box you are asked to identify your reactive behaviors—the instances where you habitually breach either your Covenant or your Code of Honor. This is simply facilitated by selecting one of the tenets of your Covenant or one of the principles of your Code and asking yourself: W*here do I find myself failing to be _______________ (compassionate, frugal, honest, trustworthy, kind, etc).* I usually offer an example of such a breach from my own life (my Covenant sits framed on a table in my office). One I frequently share with clients is: *Every morning I wake up and make a petition to be an instrument of love and peace on this planet…then I get behind the wheel of my car* <smile>*. It is hard to reconcile the intention of being an instrument of peace while yelling at someone to get out of my way.* In addition to getting a smile from my client, this disclosure usually helps them understand the look and feel of these instances of reactivity. Another metaphor that is helpful is that of a train on its tracks. The Covenant and Code of Honor are the "tracks" that you have laid that say "this is my path…this is who and how I choose to be." You are the train, chugging along the rails of your intention. Describing the ways in which you end up "in the ditch" is a helpful aid in understanding reactivity. Whatever way you use is fine as long as you are able to describe the specific behaviors in which you engage that are repetitive, reactive and represent a breach of your integrity. "Contempt" is identified as the reactive behavior in **Figure 7** above.

3. Intentional Behavior. To complete this third box you will need to find behaviors alternative or opposite to your breaches of integrity—behaviors that you would like to practice in the similar situations. These behaviors should be actions that represent fealty to your Covenant and Code of Honor. In the example above, “speaking assertively” to the criticizer represents intentional behavior. This is contrasted with the harboring of contempt that is identified as the reactive behavior which, by engaging, the subject breaches her/his integrity.

4. Triggers. Explaining and helping participants understand and identify their “triggers” may be the most challenging part of the Pinnacle Program. Triggers are the real-world objects or occurrences that we experiences as perceived threats. Triggers can be anything perceived by the five senses—something felt, heard, seen, smelled, or tasted—that activates the SNS. We usually encounter triggers a few seconds to a few minutes before engaging in reactive behavior, although this latency period can be longer. Triggers most often addressed in the Pinnacle Program tend to be relational encounters but they can be anything from an old song to a particular date (i.e., anniversary) or time of day (i.e., bedtime). Triggers are present remembrances, or “little flashbacks,” associated with previous experiences of pain, fear, and/or trauma causing us to perceive threat when we encounter these objects or occurrences. Failure to relax our body in the context of one or more of these triggers leads to SNS dominance that, in turn, leads to reactive behavior and breaches of integrity. We want to begin to recognize our triggers and confront them with pelvic floor relaxation. If we can keep our bodies relaxed during and immediately after an encounter with a trigger then we can confront these situations with: (1) a comfortable body without stress; (2) maximal neocortical functioning with creative intelligence for problem-solving; and (3) the ability to maintain intentional behavior where previously we have been reactive.

The best way to discover and confront triggers is by developing an ongoing awareness of (pelvic floor) muscles tension—or “bodyfulness”. If our muscles are clenched, then we have encountered a perceived threat. Tracing backwards in time from the moment of awareness of our tightened muscles to find whatever we have encountered that might have been perceived as a threat will help us to grow this capacity for finding triggers. Being reminded that “stress” is caused only by perceived threat and that every time we experience stress during their day we are perceiving some kind of threat (real or imagined) will help us orient toward looking for the triggers that precede and precipitate this perceived threat (See **Fig 1. Causes and Effects of Stress** on page 6). As we develop this capacity for “bodyfulness,” we begin the transformative process of migrating from an external locus of control in which we are victims of the capricious whims of our environment and circumstances to intentional and principle-based living with internal control of our anxiety and fear.

After encountering a trigger, we find that we have a “window of opportunity” in which we must relax our bodies if we want to maintain intentionality. Depending upon the individual, a few seconds to a few minutes of experiencing sustained threat perception will lead to progressive SNS dominance and the diminished frontal lobe functioning. In this state of constriction we become increasingly compelled to fight or fly while, concurrently, we will experience loss of intention, memory, language skills, and creativity. It does not take long in this condition for us to lose the ability to intervene for ourselves in a productive manner and, once again, we may find ourselves acting out, “in the ditch”, and repeating the same mistakes of our pasts. For most people, and I include myself here, it takes a significant number of times of ending up “in the ditch” and harvesting the pain, frustration and shame that comes from these reactive behaviors before we become willing to apply the simple solution of relaxation to the problem.

Said differently, many of us have to fight and struggle with these situations long and hard enough until we have suffered enough pain that we can finally surrender to this simple solution—See **Fig 8**.

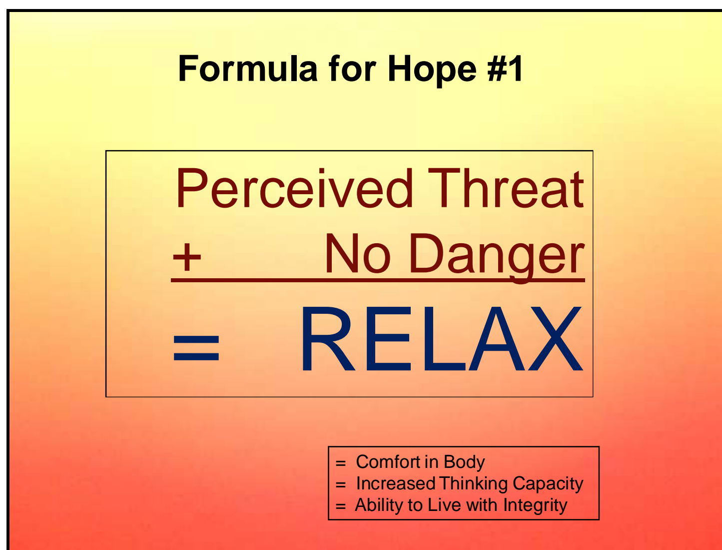


Fig. 8: Formula for Hope #1

Clinical Note:

This insight can become a useful motivation tool for later sessions with our clients when we can ask them: *Have you had enough pain yet or do you need some more?* This question should always be attenuated with compassion and loving-kindness, not with sarcasm or aggression. However, the judicious use of this question will help underscore for your client that s/he now has a choice--where before they were condemned to repeat these same mistakes they can now choose to relax their body for 20-30 seconds to regain comfort and intentionality.

5. Narratives. This may be the most exciting part of the Pinnacle Program—helping individuals attach narratives and meaning to their triggers and helping them make "good sense" of their perceived threats. There are darned good reasons why we perceive threat where there is no *current* danger. The reason that we perceive threat in the present while encountering objects or situations that hold no real danger for us is not because we are crazy. It is because of the intrusion of past painful or traumatic experiences into our present perceptual systems. Any painful past experience, no matter how brief or seemingly innocuous can erupt into present consciousness causing us to perceive threat where there is none. There are literally millions of these past experiences by the time we reach adulthood. Add to this fertile and fermenting compost the experiences of secondary traumatic stress we experience through the media, or our work for those of us who are caregivers, and it is obvious that there is an infinite number of potential past experiences that shape the perceptions of objects and activities of our daily adult lives towards that of perceived threat.

Before beginning this process of maturation most of us, when we encountered a trigger, did one of two things—we tried to either neutralize or avoid the threat. We rarely, if ever, confronted the trigger with relaxed bodies. The cost of this avoidance strategy was that we remained anxious, reactive and diminished in our functioning every time we encountered these triggers. We became victims of our environment, having to fight or flee to manage stressful circumstances. The hidden costs of this strategy were even greater. Because every time we encountered a perceived threat we experienced a certain level of SNS activation and, if we remained in the context of this threat for a period of time, SNS dominance. Then we employed some form of attack or avoidance. This meant that the level of arousal we experienced when and if we did ever confront a trigger remained high, not ever diminishing because we had not yet successfully relaxed our body in the context of these triggers. One single time of confronting a trigger with a relaxed body begins the process of desensitization. After the first time of keeping our bodies relaxed throughout an encounter with a trigger (20-30 seconds) the trigger will never again produce as much arousal as it did in previous encounters. The more times we relax in the context of the trigger, by the process of reciprocal inhibition or desensitization, the less intense the arousal will be in subsequent encounters. We become less reactive in our behaviors and more comfortable in our bodies as past experiences have less and less effect upon our present functioning. Said differently, we heal our past by relaxing our bodies in the present. This is a primary transformational engine of the Pinnacle Program—knowing that we can unchain ourselves from the trauma and painful learning of the past with simple self-regulation.

In the past, when we encountered triggers with SNS dominance and diminished neocortical functioning we were unable to use language very successfully in these situation. We forgot the things we learned, we stumbled over our words, and we experienced a never-ending loop of obsessive, less-than-helpful, thoughts. This diminished neocortical functioning accompanied with the compulsion of the SNS to get us out of danger pre-empted any attempts we might have made to understand why we were so afraid when there was no real danger. As we begin to bring relaxation to the equation and remain PNS dominant through an encounter with a trigger we can begin to ask ourselves: *Why am I so frightened? What experience(s) from my past has/have caused me to perceive a threat in this situation?* We begin to mine the experiences that have led us to perceive threat in the present. We begin to make "good sense" of why we are so afraid. As we are able to make sense and understand why our SNS has become activated and why we perceive threat in the present—honoring the experiences of the past where we learned through pain, fear, and trauma—we begin to experience some compassion and respect for ourselves. We discover that we were not sick or defective; we were simply adapted to a world where pain, fear, and trauma were normative. We are no longer in need of this adaptation and we can begin to let it go; finding comfort, maximal functioning, and intentionality instead.

It has long been understood that imaginal exposure to traumatic memories paired with relaxation is an effective treatment for traumatic stress. Almost all effective treatments for posttraumatic stress utilize this construct of reciprocal inhibition—pairing of exposure and relaxation--in some form to facilitate desensitization that helps clients lessen symptoms of posttraumatic stress. Beginning in the late 1980s, we began to see that the type of exposure was important. The construction and sharing of complete chronological narratives of traumatic experiences, paired with relaxation, was more effective than simply talking at random about parts or fragments of the trauma. Helping survivors of trauma to construct and share their narratives has a powerful ameliorative effect upon the symptoms of traumatic stress, especially the re-experiencing symptoms (e.g. flashbacks, nightmares, psychological or physiological arousal with cues). The Pinnacle Program creates a simple and naturalistic method for individuals to begin to construct and understand these narratives for themselves. As we practice

relaxing our bodies and confronting triggers instead of avoiding them while engaged in the activities of our lives, we can begin to pay attention to the narratives that will begin to spontaneously emerge.

An excellent example of this process is illustrated by an experience with a recent client. A 30 year-old married female who is employed full-time and also a full time student had been in therapy with me for six sessions. Her complaints, upon intake, were uncontrollable crying, compulsive behaviors, and dysthymia, or chronic low-grade depression. We had been navigating through the Pinnacle Program and she reported having some success with pelvic floor relaxation, finding some degree of comfort and ability to be intentional in situations in which she had previously engaged in compulsive behavior. She also reported that she was having difficulty remembering to relax her body but when she did remember, she said that her quality of life was getting much better. On the seventh session she presented for therapy and reported that her husband was experiencing depression and had spent several days of the past week "on the couch," refusing to look for work or engage in any activities. My client reported that, in the past, this behavior would make her angry and she would attempt to coerce her husband into gainful action. However, this time she said that she sat down with her husband on the couch and said the following: "*When I was a child and my mother was depressed and despondent, it meant that I was soon going to be cold, hungry or dirty. I am an adult now. I know that I will not be cold, hungry, or dirty when you are not present with me. I love and desire you no matter what."* There were tears in both our eyes as she related this story to me. This experience is a perfect example of the elegance with which clients can find resolution of their painful past without having to engage in regressive therapy to desensitize the memory. Instead, she was able to bring a modicum of healing to her past, present, and future by relaxing her body in the present and practicing intentionality—it was part of her covenant to love and desire her partner no matter what.

Warning:

While the Pinnacle Program offers a self-help process for developing and understanding how our traumatic history has affected our present functioning, participants should remain mindful that uncovering traumatic material always has the potential to be overwhelming and, in some cases, debilitating. It is important for participants of the Pinnacle Program, whether they are currently working with a therapist or practicing this model in a self-help capacity, to create for themselves ample opportunity to regularly share these narratives with their therapist or their coach/mentor/partner. We should share these narratives only with people who have demonstrated *their* capacity to self-regulate and bear witness to the stories of our past without needing to "contaminate" them with their own anxiety. Developing the understanding and the subsequent narratives of our past experiences that have led to perceived threat in the present is only half of the work. The full relief from our traumatic and painful past comes only when we share these experiences with a compassionate and empathic listener. If we are chosen by another to be a listener to their narratives, we will want to listen empathetically but dispassionately. We will not want to be reactive to their stories and instead help them to make "good sense" of why these experiences have caused them to perceive threat in the present while encouraging them to (a) remain relaxed while delivering their narratives and (b) self-regulate when they encounter triggers related to these narratives in the future. Finally, if you or someone with whom you are working in the Pinnacle Program becomes acutely symptomatic (i.e., sleep problems, depression, suicidal thoughts, self-destructive behaviors, etc), do not hesitate to contact a licensed professional familiar with traumatic stress and its treatment for consultation.

This second, or intentionality, phase is concluded by completing the **Worksheet** upon which you will identify some triggers that you will likely be confronting over the next period of time (i.e., week). Extra copies of the **Worksheet** can be copied so that you can work towards self-regulation, intentionality, and narrative construction on several "reactive behaviors" simultaneously. It is also suggested that you maintain a journal in which you can record your thoughts, feelings, insights, and narratives as you navigate through the Pinnacle Program.

Phase III
Practice (Coaching and Desensitization)

Phase III: Practice (Coaching and Desensitization). The third phase of the Pinnacle Program is also the least structured. For many clients this phase and subsequent sessions will look more like performance coaching than therapy. It will simply involve more of what has already been done—helping them identify triggers, encouraging them to practice self-regulation, and helping them to make good sense of how their past experiences have resulted in perceived threats in the present. Additionally, we will want to make ample opportunity for them to share their narratives of trauma, pain, and fear and support whatever affect comes with these narratives. For clients who have minimal to moderate levels of posttraumatic stress, this version of the Pinnacle Program is often sufficient. They are frequently ready to terminate therapy with satisfaction in 6 – 12 sessions.

For those participants who are employing the Pinnacle Program in a self-help model, this phase involves the continuing practice of confronting triggers with relaxed bodies and regular meetings with your partner/coach/mentor to report progress, share narratives, and address problems. This third phase works well in a small group format (5-8 participants) of 60 – 90 minutes during which each participant can take a turn to discuss successes and challenges they encountered during the intersession between group meetings. The support and identification participants experience in a group format is even more potent than individual meetings with a partner.

This phase of participation in the Pinnacle Program, however, often takes on a different timbre for individuals who have significant levels of posttraumatic stress. They often find themselves--after successfully completing the first two phases of the Pinnacle Program--frustrated, angry, and sometimes hopeless that their progress in this third phase has not been more bountiful. It is important for the participant who encounters early "failure" with the Pinnacle Program not to give up. Often these early difficulties are simply pointing to a more intensive traumatic and traumatized past that will need some focused clinical work—usually of a short duration—before they find themselves becoming successful with the Pinnacle model.

For participants of the Pinnacle Model who experience these setbacks in the third phase and are unable to negotiate the confrontation of triggers while keeping their bodies relaxed; who are finding themselves continuing to act in ways that are breaches of their integrity there is still much hope! If you are one of these people then it is recommended that you consult a psychotherapist specializing in treating traumatic stress—it is even further recommended that you consult one who is trained in Eye Movement Desensitization and Reprocessing (http://www.emdr.com/clinic.htm)--and explain to them your work with the Pinnacle Program. If they are good trauma therapists who are trained in EMDR, they will immediately understand when you describe to them your difficulty remaining self-regulated while confronting triggers and will be able to help you to desensitize and reprocess your past traumatic memories sufficiently that, following this successful brief treatment, you should find yourself able to successfully confront these triggers with a relaxed body and intentional behaviors. It is further recommended that you create a consulting relationship with this therapist, much like you would with a dentist or family doctor. You may decide that you want to desensitize and reprocess additional trauma memories with this therapist or you may decide to return to the self-directed practice of the Pinnacle Program. Either way is fine as long as you are not experiencing increased symptoms (e.g., sleep problems, anxiety, depression, suicidal thoughts, compulsive or impulsive behavior, etc). If you are experiencing exacerbated symptoms of traumatic stress, you should continue to work with a therapist until you have become stabilized for at least two – four weeks.

As participants continue to practice the Pinnacle program, they find themselves able to practice intentional living with increased simplicity—even though self-regulation continues to require ongoing "bodyfull" awareness. It is at this juncture that participants begin to discover the ultimate simplicity of the Pinnacle Program that is summarized in the "Formula for Hope #2" in **Fig. 9** below:

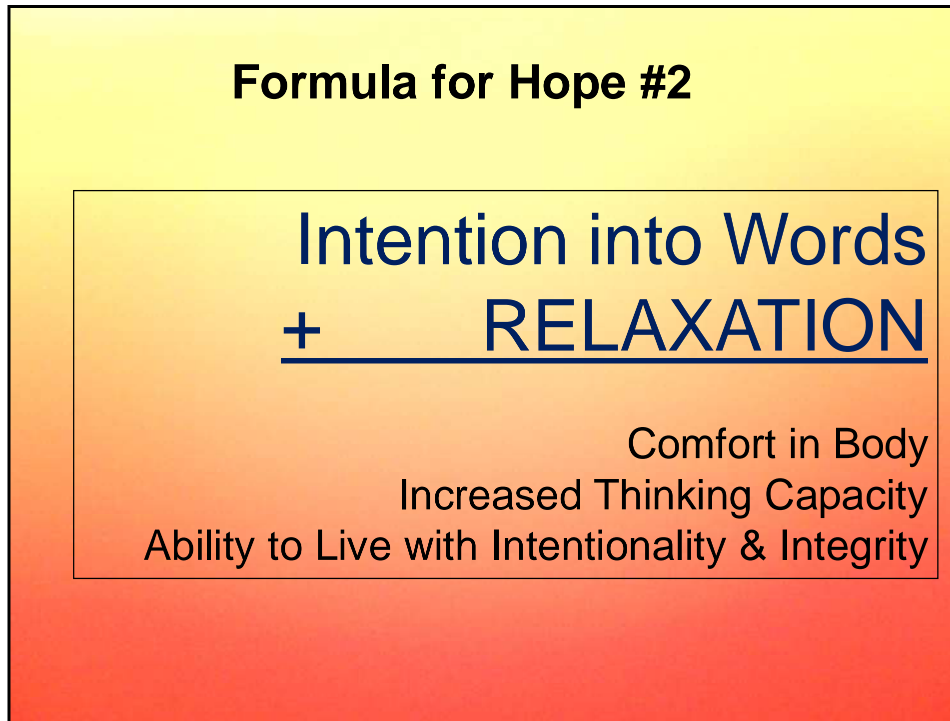


Fig. 9: Formula for Hope #2

Clinical Note:

Clinicians will need to utilize all their relational skills to reassure their clients that this is simply part of the process healing and some brief additional therapeutic activities need to be completed before they will be able to enjoy the full benefits of their hard work. Helping them to make sense of why they are falling short of being able to remain self-regulated and intentional during the activities of their lives is valuable for both the client and for maintaining the therapeutic relationship. It is crucial to help clients gain the insight that they are being intruded upon by their trauma memories with such ferocity that they are becoming immediately overwhelmed, SNS dominant, and reactive. It is also the therapist's task to help them understand that this continued reactivity is not a moral failing on their part. It is, instead, a testament to the intensity of the "injury" they suffered, and continue to suffer, from the traumatic experiences of their past.

Using the **Worksheet**, we can point to Square #5 and explain to our clients that the intrusions from their past traumatic experiences are coming forward into present consciousness with such intensity ("lightning bolt" on the **Worksheet**) that is preventing them from being able to practice self-regulation when they encounter certain triggers. We ask them to identify the triggers they have experienced over the recent past that produced reactive behaviors. We then explain to them that it is likely that these triggers represent a memory or group of memories that were traumatic or painful experiences. We further explain that their adaptation to these traumatic and painful experiences was to orient themselves to avoid anything in the future that reminded them of these experiences. Anytime they encountered a reminder they perceived it as a threat, their SNS activated and they frequently attempted to avoid contact with this reminder.

Work over the next few sessions will focus upon helping our clients to desensitize and reprocess the trauma memory(ies) associated with the trigger(s). The goal of this desensitization and reprocessing work is to diminish the intensity of the intrusions--the perceived threats--sufficiently so that our clients can begin to self-regulate and remain relaxed when confronting these triggers. In the Pinnacle Program this is always the single goal of regressive desensitization and reprocessing work with our clients. We do not employ our therapeutic skills to develop insight or to trigger abreactions or to change beliefs. While all these may occur as byproducts of this work, the goal remains only to desensitize and reprocess the memory sufficiently so that our clients can practice self-regulation without being overwhelmed in the present. It is important that the clinician work with whatever method of desensitization with which they enjoy a sense of mastery. Cognitive Behavioral Therapy (e.g., Direct Therapeutic Exposure, Dialectical Behavioral Therapy, Prolonged Exposure, Cognitive Processing Therapy, etc); Neuro-Linguistic Programming (NLP)/Hypnotic Methods; Traumatic Incident Reduction (TIR); Narrative Therapy; and the TRI Method all have been the subjects of published studies that report effectiveness with PTSD symptoms. Eye-Movement Desensitization and Reprocessing (EMDR), however, is the recommended method of treatment for this phase of treatment. The procedure and philosophy of EMDR fits perfectly with the Pinnacle Program. For those who are aware of the EMDR Protocol, the “triggers” from the Pinnacle Program fit perfectly as the “target” for the EMDR set-up. EMDR, better than the other methods mentioned above, facilitates the client to desensitize and reprocess multiple trauma memories that may be associated with a particular trigger inside a single session. The other methods, while all have their value, require that each trauma memory be addressed individually and the use of one of these other models may require a longer treatment trajectory to achieve sufficient desensitization.

Clients who are able to successfully desensitize and reprocess a set of trauma memories and find that they are now able to effectively relax their bodies in the context of triggers that had previously been overwhelming often gain a renewed sense of hope and commitment to therapy. As they experience themselves successfully maintaining intentionality, where they previously capitulated to their fear, clients begin to believe that they just might be able to find a life that is no longer based in fear, pain, avoidance, and despair. They begin to see the possibility of living a life of principle-based intention and a pathway to a future where, truly, anything is possible for them. Lost dreams awaken.

Conclusion

The Pinnacle Program has provided relief from chronic fear, anxiety, obsessive thoughts, compulsive behavior, traumatic stress, and depression for scores of clients and hundreds of workshop participants. While there is yet no published research on the effectiveness of the Pinnacle Program, it is built upon and around protocols and principles of cognitive-behavioral therapy that have demonstrated effectiveness for treating anxiety, depression and traumatic stress. While this program is not offered here as a substitute for traditional therapeutic approaches it is, however, offered as a framework within which an individual can augment and accelerate traditional approaches to psychotherapy by living lives of intention. For some, the Pinnacle Program will allow them to make significant gains in symptom reduction and intentional living with minimal needs for traditional psychotherapy. The main difference between this program and psychotherapy is that the goal of the Pinnacle Program is to help clients live an intentional, principle-based life in alliance with their own personal morality. The goal of traditional

psychotherapy is symptom reduction. As I have attempted to demonstrate in this writing, the Pinnacle Program may accomplish this symptom reduction as a byproduct instead of the goal. This shift in focus and process produces a significantly different "feel" to psychotherapy and self-help. Instead of the allopathic model in which the therapist is the "doctor" who brings healing to patient; in the Pinnacle Program the therapist/helper is more of a "midwife" who supports the process of natural healing while assisting the client in removing the impediments to their own maturational trajectory. In this self-help version of the Pinnacle Program, the participant selects his or her own partner/coach/mentor for this process. The Pinnacle Program will help individuals to establish a pathway towards intentional living to begin to become the people they have always wanted to be, living the way they want to live, regardless of their history or present day situations. The Pinnacle Program may provide a pathway of healing for some individuals that will allow them to completely circumvent traditional psychotherapy. Others may need a little help from a caring professional throughout their process.

As a self-help model, the Pinnacle Program is poised to become the first of its kind to show effectiveness in treating the symptoms of traumatic stress, anxiety and depression. No self-help models have been discovered to demonstrate effectiveness with significantly lowering the symptoms traumatic stress in the literature reviewed for this article. It will be interesting to see whether the Pinnacle Program will be able to provide this lessening. I have watched countless clients lower their symptoms and, much more importantly, begin to live principle-based lives with which they are satisfied through practicing the simple principles of this program. I have received literally hundreds of emails from workshop participants who, after one day of training, have told me that their lives have transformed as a result of implementing these principles and practices. Currently the Pinnacle Program as both an adjunct to psychotherapy and as a self-help protocol is experimental. I am unable to make any scientific claims as to its effectiveness or to its safety—although it is difficult to see how it could be harmful. I am in the process of beginning research on this model and only time and careful data collection will be able to demonstrate conclusively whether the Pinnacle Model is effective for either symptom reduction or in facilitating intentional living leading individuals to greater satisfaction with their lives. I do, however, expect that positive results will follow. You are invited to conduct your own research. If you find the practice of the principles and exercises of the Pinnacle Program helpful then continue to utilize this program, free of charge, for as long as you find it helpful. If you do not find it useful, you have lost precious little in your attempts. If you do choose to apply the Pinnacle Program to your life, I would appreciate hearing from you, whether the program has been helpful or not. My contact information appears at the end of this article.

The single most exciting thing about the Pinnacle Program, for me, is its immediacy for hope. The ability to show clients how, within a single session, they can move away from years of suffering with the symptoms of traumatic stress and anxiety brought on by the chronic dominance of the sympathetic nervous system into the comfort and intentionality of parasympathetic dominance is frequently staggering for both the client and the clinician. To witness the dawn of hope upon the faces and in the hearts of those suffering survivors who sit across from me and for whom there has been no hope, sometimes for decades, count among the greatest experiences of my lifetime. Since beginning to employ the principles of the Pinnacle Program, this has become an ever more frequent occurrence.

If there is any way that I can assist a reader of this article in helping to implement the Pinnacle Program in their lives or the lives of others, I welcome your contact.

Send inquiries and comments to:

J. Eric Gentry, PhD
Compassion Unlimited
3205 South Gate Circle #9
Sarasota, FL 34239
(941) 720-0143
eg@compassionunlimited.com
www.compassionunlimited.com

Bibliography

Benson, H. (1997). *The relaxation response*. New York: Avon Books.

Bercelli, D. (2007). *A bodily approach to trauma recovery*. www.traumaprevention.com/index.php?nid=article&article_id=67.

Bercelli, D. (2009). *The revolutionary trauma release process: Transcend your toughest times*. Namaste: Vancouver, BC.

Bremner, J.D. (2000). The neurobiology of Posttraumatic Stress Disorder in E. Fink (Ed.) *The Encyclopedia of Stress.* Academic Press: San Diego, CA.

Breslau, N & Kessler, R. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: an empirical investigation". *Biological Psychiatry* 50(9): 699–704.

Carlson, Neil R. (2007). *Physiology of Behavior* (9 ed.). Pearson Education, Inc.

Committee on Treatment of Posttraumatic Stress Disorder, National Institute of Medicine (2008). *Treatment of posttraumatic stress disorder: An assessment of the evidence*. Washington, D.C.: National Academies Press.

Cox, C.L. (1992). Perceived threat as a cognitive component of state anxiety and confidence. P*erception and Motor Skills*, 75(3:2), 1092-1094.

Critchley, H.C,, Melmed, R.N., Featherstone, Mathias, C.J., & Dolan, R.J. (2001). Brain activity during biofeedback relaxation. *Brain: A Journal of Neurology*, 124(5), 1003-1012.

Doublet, S. (2000). *The Stress Myth.* Chesterfield, MO: Science & Humanities Press.

Falconer, E.M. (2008). *Inhibitory control in posttraumatic stress disorder (PTSD).* A defended dissertation at University of New South Wales. http://handle.unsw.edu.au/1959.4/40156

Foa, E.B., Dancu, C.V., Hembree, E.A., Jaycox, L.A., Meadows, E.A., & Street, G.P. (1999). The efficacy of exposure therapy, stress inoculation training and their combination in ameliorating PTSD for female victims of assault*. Journal of Consulting and Clinical Psychology, 67*, 194-200.

Foa, E. B., Davidson, J.R.T. & Frances, A. (1999). The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *The Journal of Clinical Psychiatry*, 60.

Foa, E. B., Keane, T.M. & Friedman, M.J. (Eds.). (2000). *Effective treatments for PTSD* New York: The Guilford Press.

Foa, E. B. & Meadows, E.A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology*, 48, 449-480.

Follette, V.M., Ruzek, J.I., & Abueg, F.R. (1998). *Cognitive behavioral therapies for trauma*._New York: Guilford Press.

Friedman, M. J. (1996). PTSD diagnosis and treatment for mental health clinicians. *Community Mental Health Journal, 32,* 173-189.

Gentry, J. E. (2002). Compassion Fatigue: A Crucible of Transformation. *The Journal Of Trauma Practice, 1*, 37-61.

George, M.S., Sackeim, H.A., Rush, A.J., Marangell, L.B., Nahas, Z., Husain, M.M., Lisanby, S., Burt, T., Goldman, J .& Ballenger, J.C. (2000). Vagus nerve stimulation: a new tool for brain research and therapy. *Biological Psychiatry*, 47 (4), 287-295.

Goldberg, E. (2001). *The Executive Brain: Frontal Lobes and the Civilized Mind*. Oxford Press: New York.

Hamarat, E., Thompson, D., Zabrucky, K.M., Steele, D., Matheny, K.B. & Aysan , F. (2001). Perceived stress and coping resource availability as predictors of life satisfaction in young, middle-aged, and older adults. *Experimental Aging Research*, 27, (2), 181 – 196.

Heim, C., Ehlert, U., Hanker, JP & Hellhammer, DH (1998). Abuse-related posttraumatic stress disorder and alterations of the hypothalamic-pituitary-adrenal axis in women with chronic pelvic pain. *Psychosomatic Medicine*, Vol 60, Issue 3 309-31.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

Holbrook, TL, Hoyt, DB, Stein, MB, & Sieber, WJ. (2001) Perceived threat to life predicts posttraumatic stress disorder after major trauma: risk factors and functional outcome. *The Journal of Trauma: Injury, Infection, and Critical Care*: 51(2), 287-293.

Holland, JC, Morrow, Schmale, J, Derogatis, L, Stefanek, M, Berenson, S , Carpenter, PJ , Breitbart, W, & Feldstein, M. (1991). A randomized clinical trial of alprazolam versus progressive muscle relaxation in cancer patients with anxiety and depressive symptoms. *Journal of Clinical Oncology*, 9, 1004-1011.

Jamison, R. N. (1996). *Mastering chronic pain: A professional's guide to behavioral treatment*. New York: Professional Resource Exchange.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delta.

Kegel, A.H. (1951). Physiologic therapy for urinary stress incontinence. *Journal of the American Medical Association*, 146 (10), 915-917.

Kinsella, S.M., & Tuckey, J.P. (2001). Perioperative bradycardia and asystole: relationship to vasovagal syncope and the Bezold–Jarisch reflex. *British Journal of Anaesthesia,* 86 (6), 859-868.

Krost, B. (2007) Understanding and Releasing the Psoas Muscle http://www.naturalreflexes.com/pages/Psoas.html

Lim, S.H., Anantharaman, V., Goh, P.P. & Tan, A.T. (1998). Comparrison of treatment of supraventricular tachycardia by Valsalva maneuver and carotid sinus massage. Annals of Emergency Medicine, 31 (1), 30-35.

Mandle, C.L., Jacobs, S.C., Acari, P.M., Domar, A.D. (1998). The efficacy of relaxation response interventions with adult patients: A review of the literature. In (Ed. C.E. Guzzetta) Essential readings in holistic nursing. Aspen: New York.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* (1), 131-149.

McNaughton, N. (1997). Cognitive dysfunction resulting from hippocampal hyperactivity—A possible cause of anxiety disorder? *Pharmacology Biochemistry and Behavior*, 56 (4), 603–611.

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual: For assessing and treating adults with Post-Traumatic Stress Disorder (PTSD).* Waterloo: University of Waterloo – Institute Press.

Perry, B. D. (2007). Self-Regulation: The Second Core Strength. *http://teacher.scholastic.com/professional/bruceperry/self_regulation.htm#bio*

Porges, S. (1992). Vagal tone: A physiologic marker of stress vulnerability. Pediatrics Vol. 90 No. 3, 498-504.

Porges, S. (1999). Emotions: An evolutionary by-product of the neural regulation of the autonomic nervous system in (Eds. C.S. Carter,I.I. Lederhendler, and B. Kirpatrick) *The Integrative Biology of Affiliation*. MIT Press: USA.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W. W. Norton & Company.

Sapolsky, R.M., (1997). *Why zebras don't get ulcers*. New York, NY: W.H. Freeman and Company.

Scaer, R. C. (2001). *The body bears the burden: Trauma, dissociation, and disease*. Binghamton, NY: The Hawthorne Press.

Scaer, R.C. (2006). *The trauma spectrum: Hidden wounds, human resiliency.* Basic Books, NYC

Schnurr PP, Lunney CA, Sengupta A (2004). Risk factors for the development versus maintenance of posttraumatic stress disorder. *Journal of Trauma Stress* **17** (2): 85–95.

Shalev, A., Bonne, O., & Eth, S. (1996). Treatment of posttraumatic stress disorder: A review. *Psychosomatic Medicine, 58(2),* 165-182.

Shapiro F. (1989). Efficacy of the eye movement desensitization procedure: A new treatment for post-traumatic stress disorder. *Journal of Traumatic Stress, 2 (2*), 199-223.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures*. New York: Guilford Press.

Sikirov, B.A. (1990). Cardio-vascular events at defecation: are they unavoidable? Medical Hypothesis, 32 (3), 231-233.

Shusterman, V. Barnea, O. (2005) Sympathetic nervous system activity in stress and biofeedback relaxation. *Engineering in Medicine and Biology Magazine, IEEE.*_24:2, 52- 57

Spilsbury, JC, Belliston,L, Drotar, D, Drinkard, A, Kretschmar, J, Creeden, R, Flannery, DJ, & Friedman, S. (2006). Clinically significant trauma symptoms and behavioral problems in a community-based sample of children exposed to domestic violence. *Journal of Family Violence*, 22(6), 487-499.

Stoppelbein, LA, Greening, L., & Elkin, TD. (2006). Risk of posttraumatic stress symptoms**:** A comparison of child survivors of pediatric cancer and parental bereavement. *Journal of Pediatric Psychology*, 31(4), 367-376.

Takahashi, T., Ikeda, K., Ishikawa, M., Kitamura, N., Tsukasaki, T., Nakama, D. & Kameda, T. (2005). Anxiety, reactivity, and social stress-induced cortisol elevation in humans. *Neuroendocrinology Letters*, 4 (26),351-354.

van der Kolk, B. (1996). The black hole of trauma. B.A. van der Kolk, & A.C McFarlane, L. Weisaeth, (Eds) *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York: The Guilford Press. 3 – 23.

Waxman, M.B., Wald, R.W., Finley, J.P., Bonet, J.F., Downar, E.. & Sharma, A.D. (1980). Valsalva termination of ventricular tachycardia. Circulation, 62, 843-851.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition.* Stanford: Stanford University Press.

World Health Organization (2007) . The world health report 2007 - A safer future: global public health security in the 21st century. Online at: *http://www.who.int/whr/2007/en/index.html.*

Yartz, A.R. & Hawk, A.W. (2001) Psychophysiological assessment of anxiety: Tales from the heart. In (Eds. M. Antony, S. Orsillo & L. Roemer) Practitioner's guide to empirically based measures of anxiety. Springer: New York.

Yehuda R (2001). "Biology of posttraumatic stress disorder". *Journal of Clinical Psychiatry* 62 -17: 41–46.

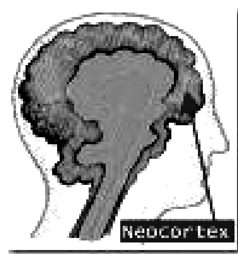
Transformation

From Sympathetic to Parasympathetic

Recent brain imaging research has begun to demonstrate that anxiety is a brain killer--the more anxiety a person experiences, the less effectively our brains operate. It is becoming increasing apparent that professional and personal effectiveness requires self-regulation skills. By relaxing the muscles of the pelvic region (i.e., kegels, sphincter, and psoas), we are able to affect profound systemic muscle relaxation. This relaxation facilitates a shift in the autonomous nervous system from the *sympathetic* system (i.e., fight-or-flight reflex utilized during periods of perceived threat) to the *parasympathetic* system (i.e., relaxation and optimal functioning utilized during period of safety). By maintaining this pelvic relaxation, we are able to thwart the autonomous nervous system from shifting to sympathetic dominance each time we perceive even the mildest threats (i.e. criticism).
By practicing the release and relaxation of these muscles, we can gradually shift from sympathetic to parasympathetic dominance. The rewards of this transformation include comfort in our bodies, maximal motor and cognitive functioning, ability to tolerate intimacy, self-regulation, internal vs. external locus of control, ability to remain mission/principle driven, increased tolerance, increased effectiveness, and increased health of our body's systems.

What happens when my sympathetic nervous system is dominant?

When you perceive a threat, your body responds to either neutralize or move away from this perceived threat. This is true for all species of living things and is known as the "fight or flight reflex." If we are truly in danger of loosing our lives, then this reflex is arguable useful. However, we are rarely confronted with threats and circumstances that are this dyer in our daily lives. Instead, we perceive some mild threat and our sympathetic nervous systems activates and we find ourselves trying to either kill or run away from our boss, co-worker, or spouse. This over-active and very sensitive threat identification and early warning system is the cause of all stress.



When our sympathetic nervous system is activated and dominant, we are preparing for battle or flight. Our circulation becomes constricted, heart rate increases, and our muscles become tense and ready to act. Inside our brains, the neocortex becomes less functional while the brain stem, basil ganglia, and

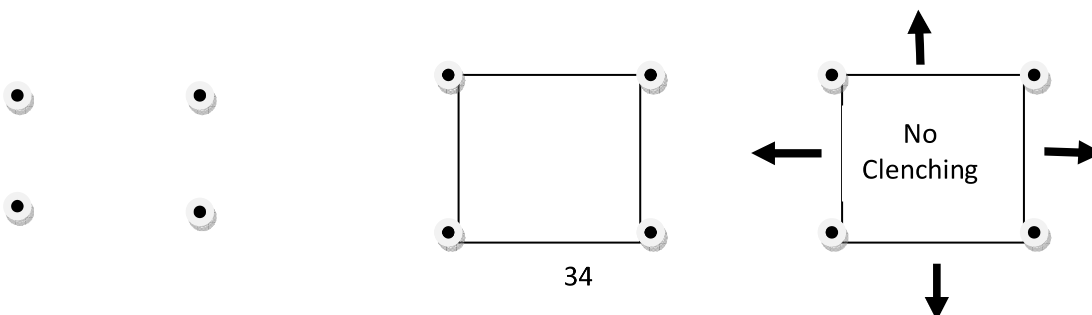
thalamus become more active. This is because the perceived need to survive has superseded all other brain functioning. As we become more "stressed" and the longer we are in this state of sympathetic dominance, the more likely we are to compromise the functioning of higher order brain systems such as language, speech, motor activity, filtering, and compassion. This loss of functioning may partially account for why people have trouble thinking logically during "stressful" times, or why they have trouble being kind when they perceive threat, or even why they have trouble with peak physical performance (i.e., sports) when they are "nervous." By simply relaxing and keeping relaxed our pelvic muscles we can reverse this process of sympathetic dominance and return to parasympathetic systems. This return to parasympathetic dominance will allow the individual to regain optimal functioning of speech, language (remember intentional thought is simply talking to ourselves—something for which we need to be able to create language and speech), motor coordination, filtering, and compassion. Once the individual has been able to successfully transition from sympathetic to parasympathetic dominance, without external agents (i.e., drugs) and without regard for the external events (i.e., crises) then the individual has become self-regulatory. A person who becomes skilled in making this transition has developed an internal locus of control and is no longer a victim of circumstances.

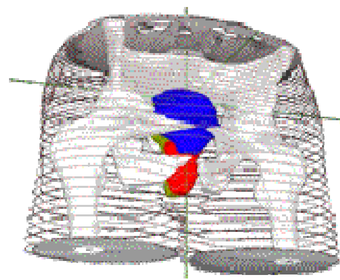
Where are the Pelvic Muscles? How do I find them?

While conducting seminars students often ask me this question. I cannot help but to feel a twinge of sadness when this question is asked. The sadness comes from the awareness that the person asking this question has learned to be unaware of these muscles. People who are not aware of the muscles in their mid-body are not aware for good reason—it has been a coping strategy since childhood. Children who grew up in anxious and dangerous environments learned to keep their bodies tight in anticipation of danger. With no skills for self-regulating, these children often learn to numb and dissociate their awareness away from the pain in their bodies. These children grow into adults that have difficulty being "in" their bodies—difficultly in monitoring and regulating muscle tension and, ultimately, anxiety.

EXERCISE:

1. While sitting, put your hands under your butt.
2. Feel the two pointed bones upon which you are sitting .
3. Now, touch the two bony points on your right and left side just below the waist.
4. You have made a touch memory for four distinct points. Connect those four points to make a square.
5. Now, allow your breath to get to the area in the middle of the square. Also, allow the square to expand.
6. Release and relax all muscles that traverse the area of the square so that there are NO CLENCHED muscles in the square.





No Clenching (sphincter, psoas, and kegels relaxed)

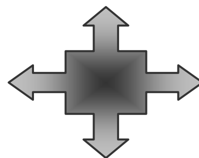
What now the my Pelvic Muscles are relaxed?

Simple, keep them that way. If you are able to keep your pelvic muscles released and relaxed for 20 – 30 seconds then you will begin to notice the clear differences in yourself as you transition from sympathetic to parasympathetic dominance. You will first notice comfort in your body. As you release the tension and stress that you yourself have been generating you will become aware that your body is comfortable—no matter what is going on around you. Your thoughts may still be racing and producing warning messages. If this is happening, DO NOTHING; just concentrate on keeping your pelvic muscles relaxed. This will be difficult for many people because since childhood we have taken action when we experience this alarm. However, if we are able to keep our pelvic muscles relaxed then we will be rewarded with a lessening of "stress" and the restoration of optimal functioning in our thinking and actions. With this self-regulation, we will be able to comfortably seek creative solutions to problems and situations that used to leave us baffled, exhausted, and frustrated.

By developing and practicing the skills of self-regulation we will find ourselves able to maintain fidelity to our intention--our mission. We will find that we no longer need to react to every little crisis as though it is a life-or-death situation. We will become free from our pasts to live for ourselves the lives that we create without having to be perpetually "on guard" for the next danger. We will be able to function at peak effectiveness anytime we choose—a transformation indeed.

Sympathetic = Reactive = Stress = Diminished Functioning= No Choice

Parasympathetic = Intentional = Comfort = Optimal Functioning = Choice



You Choose

Living a Principle-Based Life

Foundation Exercises

To build a great building, much care must go into both planning and constructing the foundation of that building. The same is true for building a great life. For those who have decided to embark upon developing and maintaining a life that is lived according to principles, instead of the capricious whims of circumstances and the impossibility of unachievable outcomes, then you must first become intimate with your own principles.

Compassion Unlimited has developed three important exercises that will help you to make explicit these values and principles so that you can begin to intentionally live in accordance with them.   By completing the enclosed Vision Statement, Covenant, and Code of Honor exercises, you will have developed the important foundation of your principle-based life. The Vision Statement Exercise will help you to clarify where you are going—the outcomes and final destinations of a principle-based life. The Covenant Exercise will take you on a journey through your life up to the present, helping you to extract the important elements, affinities, and expertise to articulate the purpose of your life—your Covenant. Finally, the Code of Honor exercise will guide you through the selection of ten to twelve principles that become the pathway for your mission, the tenets of your integrity, and will help you to accelerate the achievement of your goals.

All the future work in the PINNACLE Program will utilize the fruits of these exercises to help you to maintain fidelity to your principles. By maintaining this fidelity, you assure yourself that you are traveling the fastest and simplest path toward achieving your vision. The tools and skills you will learn and practice during your work with the Program will aide you in overcoming the obstacles that have previously slowed or thwarted you in your attempts to achieve your vision.

Give yourself an hour or so of uninterrupted and relaxed time to complete the next few pages of exercises. You are creating the foundation for your new life, so be intentional with your words. However, you will always be able to change, edit, update each of the three documents you are about to write—knowing that they are organic and will continue to change and evolve. Do your best and it will be a perfect place for us to start our work.   Let's get started.

VISION STATEMENT EXERCISE

Your vision statement is an extremely important tool in developing and maintaining a principle-based life. You vision describes the outcome and payoff of all your hard work. It is where you will end up if you follow your mission and stay true to your principles. Your vision articulates who you are and what you are doing when you are where you want to be. This exercise is designed to help you articulate your vision.

Preparation

Complete the Mission Statement Exercise before writing your Vision Statement. You will be able to cull much of the principles and language for your Vision Statement from this previous exercise.
Use the "Retirement Party Visualization" exercise from the CD *The Accelerated recovery Program for Compassion Fatigue: A Self-Guided Resiliency & Recovery Series* (Baranowsky & Gentry, 2002. Psych Ink Resources. www.psychink.com). This exercise will help you visualize yourself at your own retirement party and allows you to "see" yourself having already arrived at you vision. This exercise is an excellent way to stimulate your thinking and emotions toward writing a perfect vision statement.
If you are unable to acquire the CD, then take a few moments (10-15) to clear your mind and begin to image yourself getting where you want to be, doing what you want to do, and, most importantly, being the person that you want to be. Jot down a few notes.
Suggestions

- A vision statement should be contained within a 2-5 sentence paragraph, written in the present tense (i.e., "I am financially secure" instead of "I will achieve financial security").
- A vision statement should be global instead of specific (i.e., "I am a national leader in the field of financial planning" instead of "I have 450 active clients").
- A vision statement should be written in the first person (i.e., "I am a successful and respected corporate attorney").
- A vision statement is your achievable dream—your carrot dangling from a stick that keeps you moving and on track. Make certain that the vision statement you write provides you with sufficient motivation and inspiration to keep you committed to your mission during the lean and difficult times.
- Your vision statement articulates you achieving and fulfilling the purpose of your life—the reason for your being.
- Make certain that your vision statement is for you—not your spouse, your parents, your children, your boss.
- Write your vision statement without regard to fear or risk (Who would you be if you never experienced fear?)
- Remember your vision will become more refined the better you know yourself and your mission. Write your vision today with all the information you have available to you knowing that it is possible that it may change tomorrow. There is no "wrong" way to write a vision statement. Get writing.

COVENANT EXERCISE

A Covenant is designed to provide its author with direction, purpose and motivation towards actualizing all of his/her potentials--professional and personal. It is written in an active and declarative voice and should empower its writer with a clear vision of her/his "best self"…the persons we are becoming. This exercise is designed to help you bring into focus this "best self" and to identify pathways to facilitate the continued evolution toward this goal

An empowering Covenant:

1. Represents the deepest and best within you. It comes out of a solid connection with your deep inner life.
2. Is the fulfillment of your own unique gifts. It's the expression of your unique capacity to contribute.
3. Is transcendent. It's based on principles of contribution and purpose higher than self.
4. Addresses and integrates all four fundamental human needs and capacities. It includes fulfillment in physical, social, mental and spiritual dimensions.
5. Is based on principles that produce quality-of-life results. Both the ends and the means are based on true north principles.
6. Deals with both vision and principle-based values. It's not good enough to have values without vision - you want to be good, but you want to be good for something. On the other hand, vision without values can produce a Hitler. An empowering mission statement deals with both character and competence; what you want to be and what you want to do in your life.
7. Deals with all significant roles in your life. It represents a lifetime balance of personal, family, work, community - whatever roles are yours to fill.
8. Is written to inspire you - not impress anyone else. It communicates to you and inspires you at the most elemental level. (Covey, 1997, p.107)

Preparation

1. Time-limited exercise. *Take five minutes and complete the following questions:*

a. *Why are you alive? What is your purpose for being on this planet?* _________________

____
____
____
____

b. *What do you want to be when you grow up?*_____________________________________

____
____
____
____

c. *What dreams do you have for yourself that are yet unfulfilled?*

____
____
____

____

d. *What do you want to be when you grow up?*____________________________________
____
____
____
____

e. *What are your greatest strengths?*____
____
____
____
____

Stop. Review the above and circle the top five (5) in each category. What does this tell you about yourself? Where are you in alignment with your values & principles; where are you out of alignment? *Take a moment to simply write down your thoughts after reviewing the above:*

____
____
____
____
____
____
____
____

Practice[1]

Practice with the following sentence forms to start to create your vision and mission for yourself. Take one minute to complete each unfinished sentence.

It is my covenant:

To live:
____
____
____

To work:
____
____

[1] - adapted from: Covey, S.R., Merrill, A.R., & Merrill, R.R. (1997) *First things first.* New York: Simon & Schuster

To continue:

To love:

To be:

To become:

To believe:

To promote:

To strive:

To seek:

NOW WRITE YOUR COVENANT

MY COVENANT

My Code of Honor

Exercise

This exercise is the last of three in helping you to establish the foundations of a principle-based life. If your vision statement represents the destination of your life and your mission statement represents your purpose, then your principles are the methods that you utilize to perform your mission and to achieve your vision. Your principles articulate your integrity—by what laws and rules that you will chose to live. Using a train metaphor, your vision statement is the destination, your mission statement is the train and its fuel, and your principles are the tracks upon which the train glides. The better you are at remaining on the tracks of your principles, avoiding derailment, the more quickly and effortlessly you will achieve your vision.

<u>My principles</u>

Below is a list of words that can be constructed into "Code of Honor" principle-based statements (example: Honest = "I am honest in all dealings with others and myself").

Honest	Conservative	Effective
Challenging	Liberal	Scientific
Approach vs. avoidance	Moderate	Creative
Ethical	Tolerant	Detailed
Frugal	Conservative	Compassionate
Faithful	Outspoken	Resilient
Sense of humor	Assertive	Powerful
Commitment	Service	Responsible
Hopeful	Greedy	Productive
Joyous	Efficient	Just
Courage	Leader	Passionate
Truth/truthful	Facilitative	Secure
Parenting	Optimistic	Loving
Non-violent/peaceable	Farsighted	Strong
Fearless	Self-confident	Active

Pick 10-12 words from the above list and write sentences that describe you living these principles perfectly all the time (i.e., "I remain hopeful in all situations"). It is understood that you will not be able to maintain these principles 100% of the time and is the focus of our work. You will, however, become progressive more efficient in living within your principles as you practice some of the tools you will learn in the Pinnacle program. Remember, with this exercise you are laying the tracks toward your vision upon which you will practice your mission day in and day out—make certain that the principles you choose are really the rights ones for you.

To thine own self be true.

Appendix 3: Reactive to Intentional Worksheet

REACTIVE to INTENTIONAL

5.

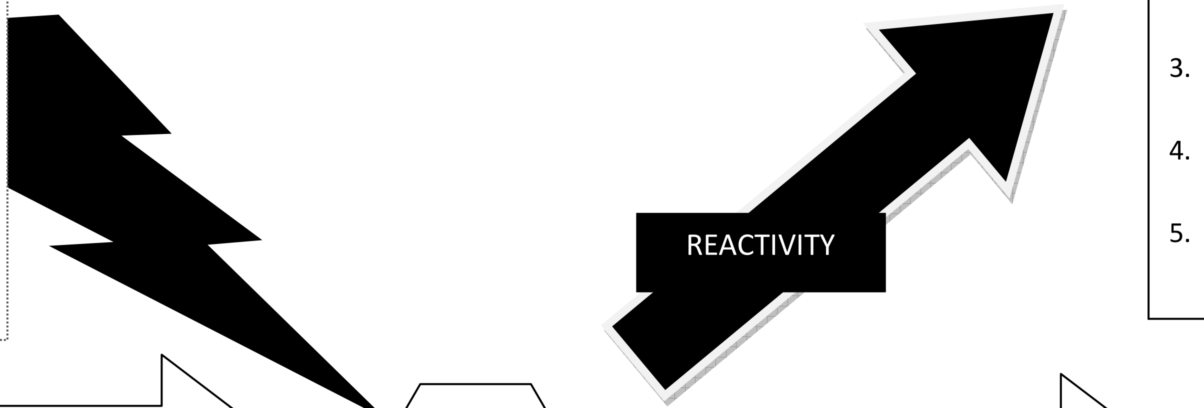
Past Learning (Narrative)

- ____________________
- ____________________
- ____________________
- ____________________
- ____________________

2.

Breach of Integrity/Reactivity (‘Acting Out” Behaviors)

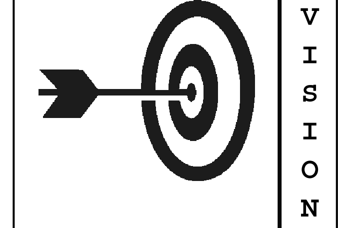
1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________



Intentionality + Principles

Trigger: Perceived Threat

Intentionality + Principles



V I S I O N

1.

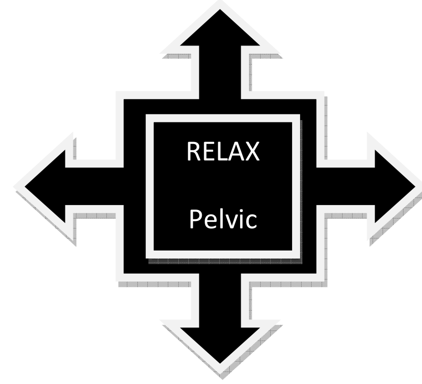
Code of Honor

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

4.

Five Common Triggers

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________



3.

Intentional Actions

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________