Episode 245- Dr. Ricky Greenwald: Progressive Counting, the Fairy Tale Model, and Intensive Trauma-Focused Therapy

[00:00:08] Welcome to inSocial Work. The podcast series of the University at Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers and lifelong learning and to promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:37] Hi from Buffalo! Music, sporting events, two ice hockey rinks, climbing walls built in a grain elevator, a zipline from a giant Labatts Beer Can 120 feet in the air. It's all at Buffalo River Works, our downtown waterfronts multi-use facility. I'm Peter Sobota. Fairy-tale models, EMDR, counting methods. Children's games? Not really. In this episode our guest Dr. Ricky Greenwald, a pioneer of trauma treatment for kids, describes the arc of his adventures in learning and developing approaches to treating trauma. Dr. Greenwald describes how requests from practitioners led him to develop scripted interventions and GPS-like rubrics as tools to articulate a repeatable model. This resulted in a practical approach that included what needs to happen in trauma therapy to heal and specifies in order to achieve outcomes. He concludes with recommendations for aspiring trauma therapists. Dr. Ricky Greenwald PsyD. is founder and executive director of the Trauma Institute and the Child Trauma Institute, an affiliate professor at the University at Buffalo School of Social Work and fellow of the American Psychological Association. Dr. Greenwald was interviewed in April of 2018 by our own Susan Green LCSW and clinical associate professor here at the UB School of Social Work. In this podcast you'll hear Dr. Greenwald refer to GPS. We thought we'd let you know what exactly he meant there. GPS, like the GPS in your car, is used for finding direction. Dr. Greenwald describes GPS in the context of trauma treatment as a way of helping you quickly figure out where you are with a client, and for example if the treatment is not going well, this will try to tell you why.

[00:02:24] Ricky this is Sue Green thank you so much for joining us today. I am talking with Dr. Ricky Greenwald and I have to start by saying that honestly Ricky I think you know this already but you are what convinced me that the trauma field is what I wanted to stay focused in. Listening to deliver your curriculum and training in the way that you did in the early 2000s, the way that you talked about it, the way that you connected the frameworks that were already out there it has influenced honestly my entire career. So its a privilege for me to be speaking with you today and I am very excited that many others will be able to hear some of your wisdom. You've been in the fields well over 30 years at this point and very early in your career. I know that you were the child expert in terms of at least in our eyes for Eye Movement Desensitization Reprocessing for children. How did you get into EMDR?

[00:03:31] I learned EMDR in grad school. I was already a trauma therapist. I had been doing a structured directive play therapy with children to help them recover from abuse. And it worked. And when I learned EMDR it was clear to me that this was a much faster and more thorough way of getting the same job done. So I already had a dissertation lined up. I had my committee, I had my proposal approved. Everything was ready to go. And I found myself saying you know I'll get this dissertation over with but when I really want to do this research on EMDR and then I said Well did you hear that if you know why am I doing one thing when I really want to do something else? So I threw out my dissertation it started from scratch did a dissertation on EMDR and children. What I is I called everybody in the world who I'd heard might be using EMDR with children. I called about 30 people. This was in '92, you know very early on. Only about a dozen of them actually had a clue and quite a few of them gave me some good tips on different techniques or experiences or whatever. And then I did some cases and I did my dissertation on it. It kind of became my mission to develop EMDR for children and to get the word out. Ultimately I ended up doing a lot of teaching and a lot

of supervision. My supervisees were telling me nobody has explained this to me before. I found over time that I had actually developed an entire treatment model that I called the Fairytale Model because I tell a fairy tale to to teach it and it's consistent with the other face models of trauma treatment. What happened is I was one of the first EMDR approved instructors approved by the EMDR national association. It was Laurel Parnell and myself in 1996 who were the first independent trainers approved after Shapiro sort of gave it over to the EMDR international association. I used to teach with her book which is an excellent book but it was way too dense for people to learn from. So I ended up explaining it my own way and teaching it my own way. I happened to be working at Mount Sinai School of Medicine in New York City when 9/11 came along and so I ended up doing a lot of work in the school systems post 9/11 in the New York City School Systems and teaching people, not EMDR because that would have taken too long. EMDR is pretty complex. But teaching them how to do child trauma therapy, and we did a bunch of training project in the New York City school system. It worked out pretty well because the beginner therapists, school counselors, school social workers told me wow this is great it's so good to know what to do and the really seasoned therapists said you know, no one's ever told me what to do before. It's kind of odd in our field that you go through all this training and you're still not exactly sure what to do. It's like it's an art. My model was unique in that it included a series of scripted interventions and it also includes a rubric for knowing where you are and whether you've done the job or not. Some people have called it a GPS. You know you get stuck in case you do this three minute consultation following the rubric and you can see what's covered and what's missing. So what I've developed it's largely translational. There is some original work in there but obviously uses a lot of what was out there already, but I've developed a model that is replicable. It's not just here's the theory now good luck. It's actually replicable, I can teach somebody this week and next week they can do what I taught them to do. And so I figured out a way to teach people how to be good trauma therapists. It still helps to be a good therapist. So I had this model that was really working. That was really you know I was able to really train people to do good work and at that point I didn't want to be just Ritchey Greenwald anymore. I didn't want to be the only one teaching the way I was teaching. And so that's when I found it the Child Trauma Institute it was the year after 9/11. So I guess 2002.

[00:08:03] And your Trauma Institute. I mean it is still going very strong, Correct? So it's been well over 15 years at this point that you've had the Child Trauma Institute.

[00:08:14] Yeah I started it out as a training institute. I thought it was going to get really big really quick because I just thought it would. I had such a great product and then that you know it would take over the world. But I found that it didn't work that way. That you know we took on four trainers early on, only kept two of them. It turns out that it takes quite a lot of practice and mentoring and feedback etc. to become one of our trainers, that it takes a lot of work. And so we didn't expand as fast as I thought we would because I was so particular about people doing a really good job. But we did quite a bit of training. I would say about 10 years ago I was personally on the road about three quarters of the time. All over the country, I was in six different countries training and then had children that I didn't want to be away so much and so I started to do more therapy. Now I was still doing some training so I couldn't tell people I'll see you next week. So I started doing intensive therapy. Seeing people you know for full consecutive days anyway but the Trauma Institute so it was the Child Trauma Institute and then I did an EMDR training once in Rhode Island and we had just sent our flyer out advertising all our trainings and somebody at the training, by the way this is an adult focused EMDR training, somebody at the training said oh I got your flyer he said but I threw it out because that's Child Trauma Institute that doesn't have anything to do with me. I'm like you're here at my training what are you talking about? So we decided to add Trauma Institute to the name because we. Yeah it started out it started out as Child Trauma Institute and. But we really focus on all ages so we have a clunkier name now Trauma Institute and Child Trauma Institute. And so I started doing more therapy and then somebody wanted to do an internship with

me. Somebody with 20 years experience in the field and then somebody else who had a nice job wanted to work for us. And I told her you know I can't even pay you anything like what you're getting now because I don't, you know, I don't really have clients for you. It's just like whoever comes along she said, Yeah I'm not looking for a better job I'm looking for a career. I said all right. She then wrote a grant where we were able to provide free therapy to victims of crime locally. So to make a long story short we now have a staff of 17 plus about 10 affiliated trainers which is how we started with affiliated trainers who use our curriculum but are independent. So yeah we're growing like crazy we've got two therapists in Buffalo New York area, we've got a therapist in North Carolina all full time on staff. We've got an office, we've got a bunch of therapists and western Massachusetts and we're still growing.

[00:11:28] Can you talk a little bit more about your stage model the Fairytale model? It's something that I teach. It's the one that I use to teach about based on my experience to Ricky that the way that you have set it up it is digestible and usable for the therapist and also the case manager or anybody that's working with other and wanting to be trauma informed. And so with that being said because it is a GPS and it does allow the user to really meld it to every single case very separately and even within a family setting in terms of where the family might be at. Trauma Therapist stage model. When you think about big picture right now, what is it that you would say works in regards to helping people heal from their trauma. From your experience what needs to happen in order for people to heal?

[00:12:33] Well the main event is the trauma healing itself. The technical term nowadays is Memory Reconsolidation where you take the memory from it's sort of frozen fragmented state where it leads to symptoms you activate it interact with it in such a way that you can kind of digest it heal it make it part of the past something you've grown from. So that's the main event. And there are some really nice methods out there. My favorite is EMDR because it's the leading well-established methods it's the best tolerated and the most efficient. I'm also a big fan of Progressive Counting which is newer but has actually compared it's been matching EMT or in effectiveness and it's seems to be even better tolerated and even more efficient. But there are other methods as well. Now how to get your clients there, that's where the Fairytale Model comes in or any of the face models. And as you mentioned the Fairytale Model isn't only something to guide a therapist. It's sort of like made a model that specifies an order in which you want client client to achieve particular outcomes and how that gets done. There's a lot of leeway. So, you know, you want the client to understand what's going on with them. And how their past trauma and loss experiences affect what's going on with them now. You want clients to have a goal. Have something to work towards so they're willing to do the work you want clients to have a plan of how they're going to do that. So how do you get this stuff, there are a lot of ways to do it. We teach one way but there are other ways also. Then you want the client to be stable enough and safe enough that they're not further deteriorating while they're doing the therapy. You want them to be able to build up their coping skills and behaviours to start working towards their goals. As far as they're able to while they're still traumatized also to build up their affect tolerance so that they're going to be able to do the trauma work without deteriorating. So the Fairytale Model we tell a fairy tale and it's got all these different elements that correspond to faces of of treatment, faces of recovery. And we use the personal trainer metaphor in terms of how we might guide the client to become motivated enough, safe enough, strong enough that they're likely to do well when it comes to the trauma work. Now something else that that happened about a dozen years ago is that I came across something called the counting method which apparently was matching EMDR in effectiveness and efficiency. This is only one study but it was still impressive while being very simple. It was just you know the therapist counts out loud from one to 100 while the client imagines a movie of the, you know, memory from beginning to end. And clients were getting better you know. I've been teaching EMDR for a long time. It's expensive, it's resource intensive, it's complex, it's hard for people to get good at. So I try to find out how to do this counting method and they wouldn't tell me. I asked the

guy in New Haven and lead author on the study I said Can I take a training? Well we don't have one right now. All right. Can I see your treatment manual? We're revising it. So I can find out how to do it. And then a month or two later I was teaching a group at a children's hospital in northern Israel. And on the fourth day normally I would teach a child modified version of prolonged exposure which is what I taught you 20 years ago. But I had this counting method on my mind so I asked the group I said to myself I teach you something that I never tried before. They said sure it was the fourth day. We liked each other by then. I said that I'm not going to teach you the right way. I'm going to change it to make it better for children. I thought 1 to 100. You know I'm a personal trainer. That's too much too soon. That's going to be overwhelming. Let's just start with a little movie of ten, I'll count from one to ten out loud while you watch the movie in your mind of the memory from beginning to end, then next 20, then next time 30, next time 40 etcetera. Well it worked really well. This counting method was great. I had another group somewhere else next week we did it again. Everybody liked it. I was surprised how well it went. Finally a couple of weeks later I got the treatment manual. Here it is we revised it here it is. And that's when I realized how much I messed up. I thought I was only changing a couple little things but in the counting method you only guide the client to watch this movie in their mind during the counting once at the beginning of the session and then the whole rest of the session you'd guide the client on how to talk about what happened in the movie and their reactions to it, which actually is more like prolonged exposure which is much slower method and more of an ordeal harder for clients to tolerate and gets very high dropout rates. So this is when I realized I had inadvertently developed something, now it hasn't been tested so that's just my opinion. It hasn't been directly compared to the counting method. But you know what we kept in progressive counting is just doing these imaginal exposures during during the counting over and over again without making the clients talk about it unless they choose to.

[00:18:17] And you say the movie is it matched to someone's trauma or loss? Is that where you...?

[00:18:25] Well, yeah. You got to decide what what memory you're working on. So this is a way to work on a trauma memory so that if this is a movie it's just somebody coming home from work and putting their stuff away and everything is normal and then the end of the movie is after the bad part is over. And so the trauma you're not still in the middle of the trauma you've gotten to the other side. We've done quite a lot of work with this in the last dozen years. We've got two published comparisons with the EMDR. I choose MDR because that's the champ. PC, Progressive Counting has matched. EMDR in effectiveness. It seems to be a little less emotionally intense for clients not even as difficult as EMDR. And again EMDR is already better tolerated than the more conventional trauma focused CBT methods. And then PC has been found to be more efficient than the EMDR. Again EMDR is already more efficient than the other leading brands. We've got data on two more studies and we haven't crunched the numbers yet that will be due in the next few months but the eyeball is consistent with that. It looks like we're getting about the same results a little faster with very very low dropout rates for both. So I'm excited about PC and one of the reasons I'm so excited about it is because it's gonna be a chance to teach more people the Fairytale Model. It takes two thirds the training time as EMDR, cost is about half because you can have 12 people with a trainer instead of 10. So it's not as resource intensive to learn as EMDR. And it seems to be for the most part faster and easier for clients. It's not necessarily better than EMDR. Now and then you know EMDR can solve a problem that PC can't solve and vice versa. But I think when our next couple studies come out assuming that the results are consistent we're going to be ready to really ramp out. There'll be a lot more demand for the training and that will be our opportunity to teach a lot of people how to be really good trauma therapists using our treatment model which is replicable. You know you can I can teach it you can do it. So then in another five or ten years when xyz comes out that beats PC we've got a lot of people how to be good therapists. That's that's really my goal.

[00:20:40] What is so striking about certainly my experience with you too over time is that you allow yourself to be in a position of not knowing that certainly you find something that seems to

work. It does work. Yet you still allow yourself to be open to what else is out there. How do you keep that kind of stance anchored for yourself?

[00:21:03] I know a lot of people are really wedded to their method and they just develop that. And that's not a bad thing. I've published on I think six different trauma resolution methods by now. I'm best known for EMDR and for PC but one of my books has prolonged exposure in it. I've coauthored a paper with traumatic incident reduction. I've been doing some work with the flash technique lately. I don't care you know if it works. So for me it's not about this technique or that technique it's about how do we help therapists to be good clients so that clients can get what they need and heal and move on with their lives. So whatever we can do to make that better it's just a kind of hacking around and trying things out which I think a lot of therapists do. I've just systematized it a bit.

[00:21:55] You are doing a lot of intensive therapy lately. What's that about?

[00:22:00] Well I started out doing it because I couldn't see a client next week because I was off training somewhere and I've found that I came to prefer it over other therapy formats. Somebody comes in on Monday morning with a presenting problem. And by Wednesday afternoon or Friday lunchtime or whatever it takes. You're saying good work have a good life. So we're working and not just me but all our therapist this is mainly what we're doing now is working with clients for full consecutive days 9:00 to 5:00. It seems like a lot and it is a lot. But clients can do it. I don't know why but they can do it. And here's one way of looking at it. You go to the mechanic, the mechanic says you know you're driving with bald tires. That's not a good idea. So tell you. You come in once a month each time you come I'll change one tire for you in a few months you'll be good to go. That would be crazy right? And yet that's how we operate as a mental health profession. We say well you know you're you're suffering. You're at risk. You're you're out of work or you're out of school you're at risk of losing your family or whatever it is. So you come for 45 or 50 minutes a week and in a year or two we'll have you where you want to be, if by the way you don't deteriorate while you're waiting to get better. That may have made sense a lot of years ago when therapy was all about gradual insights, coping skills, Incremental work. But now that we have trauma healing with these memory reconsolidation methods like EMDR or PC it doesn't make sense to chop that up into little pieces. And if you ask 100 clients would you rather achieve your therapy goals next week or next year. I would say about 100 of them will say next week. So not only do you get your treatment results a lot faster but you're also cutting out most of your dropout rate because life doesn't intervene. You're cutting total treatment hours by about 50 percent because you don't have to do all the hello and goodbye that takes up so much of every session and it should. But you know you cut that out. You also won't need most of the coping skills. You know when you're working an hour a week you better work on coping skills so your client can hang on while they're waiting to get better. But the best stabilization intervention is trauma healing. That's more stabilizing than so-called stabilization interventions because when somebody is not traumatized anymore they're stable. You're cutting out hellos and goodbyes, you're cutting out most of the coping skills. It's kind of like binge watching a season of a TV show. There's no ads there's no recaps. It's all progress. We've been doing a lot of intensive therapy. We've been collecting data on it. And there's even though it's still considered innovative there is some research on it and it's pretty clear from all the research that you're getting about the same final results, you're just getting it a lot faster. Yeah I think this is gonna become one of the standard types of treatments that are available and that are preferred in many situations. Once we and some others publish enough research on it that's one of the things we're doing now. You know where we're doing a lot of work still with EMDR and PC we're doing a lot of work with intensive therapy and just trying to continue to develop trauma therapy so that it's more efficient, better tolerated so more people can get what they need as quickly and effectively as possible.

[00:25:54] And that's for adults and kids is what you're talking about here with intensive therapy? We've talked about a lot of things obviously. Would you say you have a current focus?

[00:26:05] Well it's kind of all of those things where I'm really happy that that organization is growing because that allows us to train our staff really well and some will stay with us and we're thrilled about that and some will move on and we're thrilled about that because we really want to get this methodology into the field we want it mainstreamed. So as the research accumulates we'll do more and more training and teach it that way. So we're really working on developing intensive trauma focused therapy as a standard of care.

[00:26:40] And so do you have advice for those looking to pursue a clinical career path?

[00:26:45] I do. Couple of things that I usually advise people. One is to find out what you really care about and pursue that. If you work on things you should feel like you should be doing it doesn't always go so well. I've heard a statistic. I'm not sure it's true but it probably is that there are more ABDs than Ph.D.'s. In other words more people that don't finish their dissertation and never get their degree than people actually did finish their degree. And I think that's partly because life is challenging but partly also because people pick projects that aren't quite right for them they do things that they think they're sort of supposed to do. And it's very hard to push yourself through challenges when you're not really inspired. So one piece of advice is to find your passion and pursue that through the things that you're excited about. That's going to take you to more places that you're excited and then the other thing a lot of times people ask me specifically they say you know I want to be a trauma specialists and so where should I go? Well now you can go to UB School of Social Work. It's a good place to get a trauma informed professional education. And that may be one or two other schools out there by now as well. But even so what I really advise people to do is get good generalist training and experience before specializing because you really want to know what everybody knows before you become an expert in one particular thing. So those are my main pieces of advice.

[00:28:27] Is there anything else risky that that you want to add before we sign off?

[00:28:33] Well only that it's been a pleasure talking to you and I hope we get to do it again before another five years goes by.

[00:28:38] I know. Well thank you.

[00:28:42] You've been listening to Dr. Ricky Greenwald discuss intensive trauma treatment on inSocialWork.

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