



Chronic Homelessness, Addiction & Pain: A Case Report

George Lindenfeld

RESET Therapy Professional Institute, Arden, NC

Correspondence

George Lindenfeld, Ph.D., A.B.P.P.

22 S. Center Street, Apt 225, Hickory, NC
28602, USA

Tel: +1-828-335-1300.

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Abstract

Through a binaural sound-based nonverbal intervention called RESET Therapy (RT), a key has been found to unlock long-term memory of trauma, pain, addiction, and chronic stress. A sound-based app, Resolve-It! developed by the author and colleague Richard Bruusema for iPhone and Android, serves as a dynamic extension of the traditional therapeutic framework, which transfers clinical support from the therapist's office directly into the user's environment. When acute triggers or sudden stressors arise at home or in the workplace, users are equipped with real-time tools that enable self-corrective interventions, shifting the patient from a reactive state to an active agent in their own stabilization efforts.

To rigorously evaluate the therapeutic efficacy of RT in addressing complex trauma, a targeted initiative was implemented with a chronically homeless volunteer who resides at the Salvation Army Shelter of Hope in Hickory, North Carolina. A comprehensive case report directly substantiates the therapeutic framework proposed by Bessel van der Kolk. According to his paradigm, sustainable trauma remediation depends on a triad of milestones that enable individuals to tolerate and understand their own somatic signals; regulate their autonomic arousal; and restore purposeful action rather than remain paralyzed by a sense of profound helplessness.

A case report is provided of a 50-year-old Caucasian female, named Faith, who engaged in the navigation of overlapping crises that included chronic homelessness, substance use disorder, and debilitating chronic pain. Individuals who face long-term housing instability frequently experience complex health vulnerabilities, where physical trauma and untreated pain drive addictive behaviors as a form of self-medication. To address this deeply entrenched cycle, Faith participated in a structured clinical intervention that consisted of eight individual Reset Therapy sessions. Each highly focused session lasted 30 minutes and offered an efficient, targeted therapeutic framework designed to fit the shelter's limited time availability.

Introduction

The Department of Housing and Urban Development (HUD) estimates that on one night in 2026, 771,480 persons experienced homelessness in the United States. This number equates to 23 per 10,000 Americans. California, for example, accounts for approximately 24% of the homeless population, with around half of the unhoused unsheltered, while approximately 327,000 individuals dwell in transitional or emergency shelters [1].

Approximately 11,626 to 15,512 people in North Carolina experience homelessness on any given night, according to HUD assessments and the 2025 Point-In-Time (PIT) count, which includes about 4,500 to 4,800 unsheltered individuals [2]. Childhood trauma has been identified in 90% of the homeless population, that involves emotional

abuse, parental substance use, or neglect. The Adverse Childhood Experiences (ACE) inventory found that more than half of those surveyed endorsed four or more incidents of childhood trauma through their confirmation of items. 72% experienced physical or sexual violence in their lifetimes [3].

A 2026 review of traumatic experiences found that this type of exposure rigorously affects and negatively modifies brain functions. Neuroimages of resting-state trauma-exposed participants sought to identify specific neural signatures from general trauma-related alterations.

“Target populations included patients with PTSD or individuals exposed to traumatic events without a PTSD diagnosis. . . These studies highlighted alterations in specific brain networks, such as the default mode network, salience

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network, and central executive network, in individuals with traumatic experiences and PTSD. Common findings included alterations in the medial prefrontal cortex and the subcortical regions involving the amygdala and the hippocampus in individuals with PTSD [4]."

Critical brain regions were identified that provide the means to understand the neural substructures related to trauma-related consequences. Neuroscientific inquiry has uncovered much about the biology and neuroanatomy of chronic homelessness, particularly with regard to why this group appears to age at an accelerated rate. In 2013, a group began to follow older homeless adults in Oakland, California, noted that: "Although the participants' average age is 57, they experience strokes, falls, visual impairment, and urinary incontinence at rates typical of US residents in their late 70s and 80s" [5].

In addition to health issues. Homeless persons appear to age at an accelerated rate. Since Margot Kushel began her 2013 study of older homeless adults, forty-two of the original three hundred and fifty contributors died primarily from diabetes, cancer, and heart attacks. It is now well known that physical and mental health problems are prevalent in this population, which include the emergence of signs of dementia, particularly in the frontal and temporal lobes [6]. 2018 follow-up studies of the aged homeless suggest increased symptoms and comorbidities as compared to a housed population. A cross-sectional analysis used participants aged >50 from a shelter, meal program, encampment, and recycle center in Oakland, CA, assessed physical symptoms with screening instruments. Investigators concluded that older homeless adults experience a higher prevalence of symptoms across multiple dimensions [7].

2026, researchers reported that: "Our goal was to understand how aging unfolds across the body, and how early experiences might influence that process..." What we found is that early life adversity leaves a coordinated epigenetic signature that spans multiple tissues—but it doesn't simply accelerate aging in a uniform way... At a molecular level, aging looks very different depending on which tissue you examine. . . Blood, which is most commonly measured in human studies, only captures part of the picture. Some tissues, like the thymus and pituitary gland, showed particularly strong and distinct age-related patterns, while others exhibited more subtle changes [8].

Wear and tear on the body appears to accumulate with repeated or chronic stress. The investigators note that "Allostatic load leads to impaired immunity, atherosclerosis, obesity, bone demineralization, and atrophy of nerve cells in the brain" [9]. The role of interregional brain connectivity, with a focus on cortical circuitry that involves the amygdala, hippocampus, and frontal regions, has been of particular interest in this exploration of homelessness [10].

Resilience

Little is known about the mechanisms that sustain or produce resilience as an adaptive ability. The concept has been explored by multiple disciplines, which ultimately lead to the emergence of a multisystemic perspective [11]. The U.S. Department of Health and Human Services (2015) defines individual resilience as:

"... the ability to withstand, adapt to, and recover from adversity and stress. In other words, resilience can manifest as maintaining or returning to one's original state of mental health or wellbeing or reaching a more mature and well-developed state of mental health or wellbeing through the use of effective coping strategies" [12].

Contrasting the above example [13] exemplifies a more recent multisystemic approach:

"Resilience is the capacity of a system, enterprise, or a person to maintain its core purpose and integrity in the face of dramatically changed circumstances. In human physiology, resilience is the capacity to adaptively overcome stress and adversity while maintaining normal psychological and physical functioning."

The 5 Cs of resilience are a psychological framework on which to build mental toughness and the ability to cope with adversity. The steps serve as pillars to learn and coach the following variables: challenge, commitment, confidence, control, and connection. Among the homeless, introducing the perspective that obstacles can lead to growth rather than being insurmountable threats exemplifies the challenge aspect of resilience. Sustaining dedication to specific goals provides a sense of purpose and embodies commitment.

Promoting confidence by focusing on self-worth and capabilities involves the development of an internal trust system. Attending to matters that one can influence, rather than stressing over things one cannot change, embodies control. Finally, the development of an extended social network characterizes the connection aspect of resilience [14].

Building on this redefinition of resilience, a recent study will be discussed related to PTSD subtypes based on dysfunctional neural networks. 271 veterans (10% female) who completed resting-state MRI and neuropsychological testing underwent whole-brain functional connectivity analyses. At the basic level, the severity of PTSD symptoms was associated with:

"... reduced negative coupling between the limbic network (LN) and frontal-parietal control network (FPCN), driven specifically by the dorsolateral prefrontal cortex and amygdala Hubs of Dysfunction. . . The obtained data suggest that weakened executive functioning, alongside dysfunctional limbic regulation likely represents a neurocognitive subtype of PTSD" [15].

This therapist's clinical observation, based on the aforementioned material, is that regardless of the cortical networks involved, the appropriate pairing of binaural sound frequencies causes them to resonate with an existing impaired trauma circuit in the brain. The uniquely tuned-in pairing modifies the memory reconsolidation process, thereby freeing the participant from the limbic-driven trauma memories. When this occurs, resilience appears to re-emerge as it had prior to the patient's traumatic experiences. When impairment derives from childhood trauma, an opportunity becomes available for the development of more functional coping mechanisms. The author consequently concludes that resilience is a characteristic of an intact, properly functioning neuronal network.

A program for sheltered homeless participants is justified in order to explore and validate sensory-based treatments that have demonstrated efficacy among vulnerable populations. The question is raised whether binaural sound-based intervention, and, where indicated, intranasal infrared light, constructively reset cortical circuitry as it did in combat veterans. The answer is yes, in that significant positive changes have been documented among a number of shelter volunteers. The model has proven effective and may therefore serve other communities who desperately seek to address chronic homelessness.

Substance Abuse

Dual diagnoses of substance abuse and mental health disorders are highly predominant among the chronically homeless population. A cross-sectional study in British Columbia, Canada, identified 500 homeless individuals. The researchers found that those with a dual diagnosis evidenced severe physical and psychological symptoms.

“Without a systematic approach in providing appropriate care to individuals with dual diagnosis, the most vulnerable clients are not only the ones likely to suffer the most but also the ones having the most problems meeting their basic needs” [16].

The escalation of mortality and disease incidence among the chronically homeless have been attributed primarily to addiction disorders. Motivational Interviewing (MI) was thought to be effective in the modification of substance abuse among the homeless population. Databases and other sources were investigated up to 7/2021; a scarcity of studies for improved outcomes for substance abusers among the homeless was found. “The review's mixed findings dissuade the use of MI as a stand-alone substance use intervention in homeless populations” [17].

Long-term housing paths of participants engaged in a Housing First (HF) intervention program in Toronto, Canada, were studied over 5.5 years. The examiners found that the HF intervention was highly correlated with the transition to sustained housing:

“70.4 percent of HF participants vs. 27.9 percent of treatment as usual participants. . . Mood disorders with psychotic features and primary psychotic disorders were negatively associated with the rapid and sustained housing trajectory, and alcohol use disorders were positively associated with a rapid then declining housing trajectory” [18].

Chronic Pain

An English study of participants in shelters revealed a 59% report of chronic pain among residents [19 Fisher]. An average ten-year duration of chronic pain among homeless individuals in shelters was indicated in a Canadian study. The researchers noted that “Only 41% of participants received treatment for their pain, and almost half of them reported the use of street drugs to self-medicate. Wounds were the most reported cause of chronic pain” [19].

Musculoskeletal diseases and orthopedic injuries are one of the lead causes of disability for adults in the United States, with homeless individuals at a much higher risk. A group study conducted among 9,000 homeless men in Toronto from 1995 to 1997 found that men aged 25 to 44 years had a three times higher rate of mortality from being struck by a motor vehicle than the general population. Among those aged 45 to 64 years, the mortality rate was more than 4.5 times higher [20-21].

Treatment Modalities: Reconsolidation Enhancement by Stimulation of Emotional Triggers (RESET Therapy)

RESET Therapy (RT) is a remedial treatment that uses resonant binaural sound to interfere with the restoration of targeted trauma memories. By selectively identifying resonant binaural sound, the process blocks the negatively hyper-aroused emotional and somatic aspects of trauma from being restored to long-term memory. Memory of a traumatic event is selectively ‘lit up’ (or triggered) in the brain's emotionally sensitive regions through the patient's intentional focus. The goal is to identify

a resonant frequency linked with a disturbing memory. The change in the nature of RT derives from the discovery around the turn of the century (2000) that interference with the memory reconsolidation process can enable alteration of long-term stored emotional memories [22]. The term ‘target’ is employed in RESET Therapy, which suggests that the investigators seek to turn off the ‘switch’ in the brain that produces PTSD symptoms [23].

Within this perspective, change is understood to arise from a deep sensory shift that restores brain circuitry to a homeostatic balance. Through the RT process, harmful worldviews, such as distrust of others, are transformed into more adaptive potential. One might think of it as a type of brain plasticity. A distinctive feature of RT is that, because it is nonverbal, the participant is spared shame and vulnerability associated with the embarrassment of self-disclosure to a relative stranger. While still considered experimental, RT therapy is rapid in its change effects, which requires fewer treatment sessions than conventional psychotherapies.

A uniquely tuned-in binaural sound designed to resonate with an individualized abnormal trauma brain circuit rapidly remediated Post-Traumatic Stress Disorder among combat veterans in a pilot study [24-27]. Based on these results, the study author postulated that the restoration of the neuronal network system among these veterans, one of whom had experienced PTSD for over 50 years, reactivated resilience that was previously absent due to the trauma-induced condition. In this article, the goal is to further explore this phenomenon through a focus on individuals with a history of chronic homelessness.

Resolve-It!

Smartphone ownership currently stands at close to 91% of U.S. adults. Nearly 98% of Americans own some form of mobile phone [28]. The National Institute of Mental Health (NIMH) notes that apps provide a readily available entry point to mental health care, that engage younger clients in treatment. [29].

A 2021 study on homelessness revealed that smartphone accessibility changed behaviors and outlooks among participants, that included their self-health management.

“People experiencing homelessness used the tools on a smartphone to make decisions, take action, solve problems, and use the resources—skills necessary for fulfilling tasks required for effective self-management. Further, consistent access to smartphone technology and transportation empowered participants to meet the requirements for the attainment of social needs” [30].

The author intends to implement an auxiliary treatment instrument called ‘Resolve-It!’ in the current study to facilitate an active treatment process for selected study participants. Resolve-It! provides binaural sound via an iPhone or Android phone owned by the participant. As previously described, aberrant neuronal networks are remediated through the moderation of stored long-term memory via the memory reconsolidation process. A significant variable introduced through the use of Resolve-It! is the establishment of self-control for an individual who typically lacks emotional self-regulation. This objective is attained through immediate access to the iPhone/Android app, that includes being trained in its proper use.

Resolve-It! is introduced after the fourth treatment session, which follows the RESET Therapy phase, thereby enabling the participant to develop mastery in the self-management of the instrument. Targeted difficulties may include stress/trauma

reactions or other factors such as pain or addiction triggers that are stored in key long-term memory sites in the brain. For those participants with hearing impairments, bone-conducting headphones will be provided.

Resolve-It! is designed to use separate, independent volume controls and sound generators for each ear. The Volume Sliders are calibrated in decibels (dB), which range from 0 to 100. The sound intensity depends on the phone's volume control slider. The left ear Frequency Slider ranges from 25 to 500 Hertz (Hz). The right ear Frequency Slider is set to the frequency selected by the primary Left Slider, which creates an additional 20 Hz range. For example, if the primary (left ear) frequency is set at 380 Hz, the secondary (right ear) range will extend from 380 to 400 Hz. When the frequency and offset settings are properly located by the treating therapist or a trained participant, a rhythmic, pulsating sound will be noticeable midway in the mind, which is referred to as the resonant frequency or binaural beat. Resolve-It! is available at no cost through the Apple Store or Google Play Store.



Figure 1: Resolve-It!

Standard Procedures

The volunteer participant was provided with a ½-hour initial introductory session in which criteria for meeting the diagnosis of chronic homelessness were ascertained. In Addition, background information was obtained, that included childhood experiences and pertinent material related to conditions that led to the request for shelter placement. Bluetooth AI was utilized to record progress notes after participant approval.

Subsequent sessions were scheduled weekly for ½ hour. The time restriction resulted from several factors, that included limited participant availability. The facility rules require residents to leave the shelter between 9 AM and 5 PM. Dinner is provided between 5 and 6 PM. The therapist was allowed

to begin patient appointments from 4 PM to 8 PM, excluding dinnertime.

A second reason for the ½-hour session was to ascertain the viability of the treatment process itself for the homeless shelter population. Prior research with combat veterans [22] revealed dramatic positive changes that occurred in the first two-hour treatment sessions. The question was raised as to whether this change effect would occur in the homeless shelter population over a similar time period. In addition to the therapeutic aspects of the session, two to three inventories were administered at each scheduled appointment.

Given the enormous number of sheltered individuals across the country, an effective treatment for this immense population would need to be brief, rapid, and have meaning to achieve change. Finally, a rationale for the treatment was made available, which included the core principle that it was necessary for the participant to 'feel it to heal it'. This statement set the necessary structure and foundation rationale for a treatment approach based on sensory (feeling) aspects rather than cognitive (thought-based) ones.

After the second scheduled appointment, the therapist assigned the participant the task of creating a 10-point hierarchy of emotional triggers, from most severe to mildest. The shelter member was informed that treatment would begin at the next scheduled session. Additionally, the member was told to avoid the introduction of positive recollections into the binaural sound, as this would likely eliminate the emotional aspect of these emotions as well.

Reset Therapy was introduced to the participant at the third scheduled appointment, and she was instructed to bring her phone to the session. Faith was initially without her headphones due to forgetfulness or other factors. The binaural sound procedure was found to be effective whether or not headphones or earbuds were used. A SUDS scale (subjective units of distress) that ranged from 10-0 was introduced to determine the initial level of distress experienced and the level experienced that followed treatment. The lower-level trigger in the assigned hierarchy was initially used as a target to introduce the participant to Reset Therapy.

The first of two procedures was also introduced, referred to as the Subjective Method for the selection of a resonant sound frequency. In this context, after adjusting the Volume Sliders to a somewhat loud but non-harmful level, the therapist requested that the participant focus on bodily changes, such as heart rate, muscle tension, and sweating, and to wave at the most intense level after the initiation of the triggering scenario. The Release Slider was next used, with Faith asked to wave when the bodily sensation was significantly reduced. The production of a resonant binaural beat through the use of both frequencies was the expected result. Faith was asked next to maintain focus on the selected trigger for 5 minutes. After this experience, the pre- and post-SUD scale measures were obtained.

In Stage one, fourth session, the therapist introduced 'Mikey's Way' as an alternative procedure that utilized subconscious ideomotor energy to identify resonant frequencies. The therapist illustrated a pendulum to show the subconscious mind's ability to respond nonverbally. Faith was told that this procedure must only be used to identify resonant sound frequencies. Her introduction to the procedure included test questions, such as Faith's appropriate birthday, to induce instrument movement. At this point, the participant used Reset Therapy to identify resonant frequencies.

Stage two included sessions five through eight, at which point, Faith self-implemented the Reset Therapy procedure. As noted previously, the primary goal of this training was to develop the user's competence in the RT intervention. Faith was instructed to gradually increase her time exposure to the selected binaural beat to a maximum of 15 minutes. Within these sessions, troubleshooting was conducted to ensure that she fully understood the process.

Screening Instruments

ACE Inventory (ACE)

The study that identified ACEs was conducted well over 20 years ago [31] and involved over 17,000 people, by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente Health Plan. ACEs appear to do their damage in two principal ways: First, by the provocation of a chronic stress response in the brain (and thus body), which lowers immunity to disease and is instrumental to the development of a variety of mental and physical illnesses – as well as our capacity to recover from them. Secondly, it is due to the long-term disease-producing effects of behavioral and habit disorders. The combined effects of chronic stress and risky behaviors and habits induce a host of disease states and social problems, often by adolescence and, if not, by young adulthood. The widely recognized cutoff level for Adverse Childhood Experiences (ACEs) is 4 or higher. [32].

Brief Resilience Scale (BRS)

The Brief Resilience Scale (BRS) is a 6-item self-report measurement for those 18 years and older designed to assess an individual's ability to bounce back or recover from stress, adversity, and challenging life circumstances. The scale evaluates one's ability to recover from adversity on a scale of 1 to 5. The BRS uniquely focuses on the core definitional aspect of resilience, the capacity for adaptive recovery and return to baseline function after experiencing difficulties. The cutoff for low resilience is a mean score below 3.0. [33].

The Beck Depression Inventory (BDI-II)

The Beck Depression Inventory (BDI-II) is a 21-question self-report questionnaire used to measure the severity and behavioral manifestations of depression. It assesses emotional, cognitive, and physical symptoms that consist of 21 symptom categories (e.g., sadness, pessimism, loss of energy, changes in sleep). Statements are ranked by severity and rated on a scale from 0 to 3, that yield a total possible score of 0 to 63. Cutoff scores are used to measure the severity of depressive symptoms, with total that scores range from 0 to 63. [34].

Beck Anxiety Inventory (BAI)

Beck Anxiety Inventory (BAI) is a 21-question tool used to measure the severity of anxiety symptoms. It focuses primarily on psychophysiological symptoms, which makes it particularly useful for the identification of issues like panic and somatic stress. The total score is the sum of all 21 items, which ranges from 0 to 63. [35].

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) has displayed excellent psychometric properties across a wide range of samples that include the Clinician-Administered PTSD Scale (CAPS), the gold standard structured PTSD diagnostic interview [38]. The PCL scores also have demonstrated excellent internal consistency, test-retest reliability, and diagnostic utility. The PCL was updated in 2015 to reflect changes in the fifth edition of the Diagnostic and Statistical Manual (DSM-5). A

standard cutoff score for the Post-traumatic Stress Disorder Checklist for DSM-5 (PCL-5) is 31 to 33 [36-37].

Verbal Rating Scale (VRS)

Verbal Rating Scale (VRS) provides a list of adjectives that describe different levels of pain intensity, with patients asked to select the adjective that best represents their pain. The scale reflects the extremes of this dimension, from 'no pain' to 'extremely intense pain', and sufficient intervening adjectives to capture gradations of pain intensity that may be experienced between extremes. [38].

Case Report

6/17/2026: Faith was provided with an Adverse Childhood Experiences (ACEs) questionnaire, which attained a score of 7, that included the experience of unwanted sexual contact as a child. She perceives that this has greatly affected her overall status. On the PCL-6, she earned a total of 55 points, which exceeds the 33 to 34 cutoff score, which clearly placed her within the Severe PTSD group. On the Brief Resilience Scale (BRS), she scored 2.8, which fell within the Low Resilience range, that suggests that she has experienced difficulties in adapting to varied circumstances.

Mindfulness-based techniques were introduced, with the therapist encouraging Faith to practice diaphragmatic breathing and to intentionally pause between sentences to slow her speech rate and to enhance her awareness and presence. These interventions targeted Faith's symptoms of anxiety, trauma, and depression, which facilitated her exploration of her experiences and senses. Faith responded positively to the exploration of her trauma, indicating a willingness to attend additional sessions, reflecting her motivation for change.

It is evident that Faith presents with significant symptoms related to substance use, trauma, depression, and anxiety. Her history of meth use has led to severe cognitive impairments and legal issues, while her traumatic childhood experiences contribute to her mental health struggles. These symptoms severely impact her daily functioning, which includes her ability to maintain stable employment and healthy relationships.

Faith's anxiety manifests in social situations, which leads to visible shaking and difficulty in communication. Although she reports no current suicidal ideation, she has a history of self-harm, and she acknowledges past suicidal thoughts. Overall, her symptoms indicate a high level of functional impairment across various areas of her life that necessitate continued therapeutic intervention.

(Doc): Talk to me about your drug history.

(Faith): I smoked marijuana and drank at the age of fourteen. I liked the feel of it because it made me feel different, more open. As a child, I kept to myself a lot, and I thought I should be more outgoing and be like other people. I also had a lot of nervousness that I didn't think other people had. I was afraid of everything, like being in a group of kids. I was afraid to speak up in class. I kinda wanted to hide away and keep to myself.

I found out that when I drank and when I smoked weed, it was the opposite. And I thought society would like me better that way, and people would accept me because I was overweight in elementary school all the way through high school. They would make fun of me, call me names. One boy stabbed me with a pencil in my hand. I still have a very faint mark on my hand from it. They would threaten to beat me up, and this was on a daily basis. I used marijuana and drank pretty frequently. I

would drink more heavily on the weekends.

I became sexually active at age fourteen. Back then, it wasn't really seen as bad as it is now because he was seven years older than me. At the age of forty-nine, I started to use meth, and that caused me a whole slew of problems, just like the drinking did. I never got in trouble with the law for it, but I would get into fights with people. I would start out with happy, fun times, then switch in an instant and get angry.

Ninety-nine percent of the time, when I would drink, I would cut myself or hurt myself because I felt guilty and disgusted with myself. The self-hate would be there. Other times, I would cut myself or bite myself or punch myself in the head. It made me focus on how I felt, but as I said, most of the time when I would drink, I would cut. There were times I cut when I wasn't drunk, but it was almost guaranteed.

I feel guilty about the meth because I've been through AA and had six years sober at one point from both alcohol and marijuana. And at forty-nine, I decided to put my lips to a pipe of meth and smoke it, knowing that I'm an addict. I thought to myself that I would do it once, put it down, and be done with it. I went hard with the meth. I smoked a lot and snorted a lot. I can remember exactly how I felt, but I couldn't explain it, indicating her struggle to articulate her sensations and experiences when under the influence.

(Doc): Reset Therapy was discussed with her as a means to assist her with a more viable way to cope with reality and to develop the means to find alternatives to her current homeless situation. She was asked to develop a list of triggers or circumstances that negatively activate her. Faith reported current distress related to personal space as a primary difficulty.

6/24/2026: Faith initially rated her discomfort on a Subjective Units of Distress (SUDS) scale at 7-8 when someone stands close or near to her. She was provided with the Beck Anxiety and Depression scales, and she attained a score of 27 on the anxiety scale, which placed her in the Severe Anxiety range. On the depression scale, she scored 30, which also placed her within the Severe Depression range.

(Doc): When asked, Faith identified herself as a chest breather, and she was open to learning an alternative way that would reduce her stress. She was provided with instruction in diaphragmatic (belly) breathing procedures. Doing this briefly produced a sense of relaxation within her. She agreed to practice this type of breathing for five-minute periods several times a day, with the objective of fully implementing it within several months of practice.

Reset Therapy was introduced to her as an intervention to assist her with a more viable way to cope with reality and to develop the means to find alternatives to her current homeless situation. She expressed openness to this novel treatment that focused on bodily sensations and subconscious processes rather than verbalizing past trauma experiences. At this point, the therapist discussed the use of a sound-based desensitization app called Resolve-It!, with guided imagery of someone being physically close to her, to trigger her personal-space issue.

Faith was engaged and cooperative, following instructions to imagine proximity, and she reported that her distress level was 10 on a 10-point scale. The therapist provided psychoeducation about the emotional brain's role in triggers and introduced a metaphorical 'contract' with a subconscious guide Faith named Charity to foster resilience. Faith demonstrated understanding and motivation, actively participating and practicing deep

breathing through the experience.

The subjective method of RT was implemented, with Faith monitoring her heart rate, muscle tension, and sweat gland activity. She adjusted the Volume Sliders, with the therapist then slowly adjusting the Frequency Slider until Faith waved, indicating elevated distress levels. The therapist then slowly adjusted the Release Slider after instructing Faith to wave when the stress level reduced.

After the specified binaural sound exposure period of five minutes, Faith reported that the sound used in the session became one of calm and helped reduce her tension, noting, "I didn't feel as tense with that sound." Faith acknowledged her usual tendency was to avoid thinking about her triggers, but she showed openness to the new treatment approach, stating, "This is fast. It's weird. I'm used to talk therapy, but this does awesome things." She rated her discomfort after the intervention at a 2 or 3, indicating significant improvement.

6/30/2026: The therapist introduced an alternative method to the subjective one used previously to further engage Faith's subconscious resilience. Faith reported feeling significantly improved since the last session, stating that distress related to her target issue decreased further from a prior rating of 8 to 1. She shared that the trigger did not bother her much after the previous session.

Faith disclosed a recent hospitalization due to breathing difficulties and swelling that required diuretics, steroids, and blood pressure medication. She reported sleep difficulties after hospital discharge and expressed low motivation for treatment today but agreed to proceed with guidance. Faith was curious and engaged with the new intervention introduced during the session.

(Doc) We will do the second procedure today. I believe that the way I showed you today is more accurate. The bottom line is you want to get the correct frequency to resonate with the target. I call this way 'Mikey's Way' from the old cereal ad: Mikey likes it. Mikey represents your subconscious mind. If you were about to put your hand on a hot stove, Mikey would pull it back right away without you giving it thought. Mikey triggers your subconscious reaction. You can call Mikey any name you choose.

(Faith) I'd like to call her Charity.

(Doc) I like that. I will demonstrate this aloud, and when I ask you to do it, you will do it silently in your mind. I'm going to talk to Mikey and ask him to do something for me. So, Mikey, I'm going to give you three women's names, and when I give you my mother's name, please move the crystal in a yes direction. Was her name Sally? Was her name Mary? Was her name Ruth? What happened when I said the name, Ruth?

(Faith) It's moving like it's saying yes.

(Doc): In your mind, pick the name of someone who truly loved you, and two names that you don't know. Ask Charity to move it when you give the loved one's name. Do it in your head. What's happened?

(Faith): It's moving in a circle, and when I say the loved one's name, it moves in a straight arc.

(Doc): So that's your yes. Ask it one other secret that you want no one to know. Ask it if that's true. Come up with two false secrets.

(Faith): It's moved yes with the correct secret and it's circled with the false ones.

(Doc): Most therapies are based on talk and thinking things out. I believe that it doesn't work well for people who have trauma. That's why I'm here to inquire, to find out if 'Charity's Way' could help people in your kind of situation.

(Faith): I'm excited to try it when I feel better physically.

7/07/2026: Faith reported that her treatment is going well and that being in close proximity to the therapist, which normally causes discomfort, has become more manageable. She identified noise as a significant trigger and rated her initial discomfort at 9 on a 10-point scale.

(Doc): And which of the two ways of the sound treatment do you prefer? The first way, we monitored your heart rate and tracked your muscle tightness; all of that was subjective. Then we did 'Charity's Way'. Which way do you prefer?

(Faith): I prefer "Charity's Way". Should I do it now?

(Doc): Absolutely, do it for 10 minutes. Faith selected loud sounds as a target that disturbs her, and she provided a SUDS level of 10 at the start. I opened the door, slammed it, and let other people's noise into the room. What was that like for you?

(Faith): None of it bothered me as I listened to the sound. I think that's amazing, and I like it.

(Doc): Faith shared the above information after use of the sound-based desensitization technique for 10 minutes during the session. She reported that her discomfort level decreased to around a 1 or 2. She expressed optimism about the treatment's potential to change her life and reduce her pain, showing interest in applying the technique independently for pain management. Faith also disclosed concerns about pain that impacted her mental state and work capacity, but she also showed motivation to learn self-management strategies.

7/14/2026 - (Doc): Faith expressed that the sound used in the last session calmed her and helped reduce her tension, noting, "I didn't feel as tense with that sound." The therapist provided psychoeducation about the emotional brain's role in triggers and introduced a metaphorical contract with a subconscious guide she named Charity to foster resilience. Faith demonstrated that she understood and had sufficient motivation, actively participating in the adjustment of sliders on her device and her practice with deep breath techniques. No resistance or distress was observed in the session.

The therapist emphasized the importance of maintaining a stress-free period after the intervention to consolidate gains that included a 5-hour stress-free period after the intervention to consolidate gains. Faith was instructed to bring headphones to the next session to enhance treatment efficacy. The next session was scheduled to build on these interventions and assess progress.

7/21/2026: (Doc) So first off, how's your treatment going?

(Faith): Well, in here, good, but I have not consistently done it outside of here.

(Doc): So, this is your app-based tool to change your life.

(Faith): I have overworked myself trying to find an apartment. I've been clean on my drug testing since the thirtieth, but it's just not out of my system yet. I bought my own drug test from Amazon that detects up to fifteen percent THC. I took the drug test, and it showed a very faint negative, so it will take a little longer to get this stuff out of my system. I'm drinking more water.

(Doc): Compare this sound-based treatment to the traditional stuff.

(Faith): With this therapy, I'm able to use the tool and get rid of an issue or lessen it dramatically within minutes.

(Doc): I'd like to do a brief session with you now, with a focus on the bully experience that occurred in your childhood. Let's do ten minutes this time, and I'd like you to do it on your own.

(Faith): I have to ask Charity to move this when it connects to the feeling of being bullied, right?

(Doc): Yes, when it connects to the feeling. Then you ask her to get the Release Frequency set so the feeling goes away.

8/04/2026: (Faith): I did a session on the bully when we last met, and at the start, I had feelings of disgust. When I did it, it was at a ten level, but after, it went down to a 4, and the feelings weren't as intense. I'm over it. I actually made an appointment to see another therapist to continue my treatment since we're wrapping things up.

(Doc): That's wise of you. Let me ask what's going to stop you from using stuff again?

(Faith): Well, I can use the app, and I'm going to Celebrate Recovery, and I'm able to discuss it with people. It's like they do the twelve-step kinda thing. They're somebody else I can share testimony with, and then you go into small groups. Should I continue to use the sound therapy?

(Doc): I think you ought to ask Faith to take it totally and to let her guide you. Let her take you to where you need to go so you don't have to go through getting addicted again. It's also important that one of your goals be that you prepare your body for whatever changes are necessary for you to have a healthier life. This is our seventh meeting, and I'd like to meet with you one more time to wrap up. I want to give you post-tests to measure changes in you, but I don't want to do that right now.

(Faith): I can do that.

Table 1: Pre- and Post-Treatment Scores.

Faith	Pre-treat Score	Category	Post-treat Score	Category
PCL-5	55	PTSD	3	Negative Screen
BRS Resilience	2.2	Low	4.0	Normal
Beck Depression	30	Severe	2	Minimal
Beck Anxiety	27	Severe	4	Minimal
Pain Level (VRS)	7	Severe	5	Moderate

The implementation of RESET Therapy (Reconsolidation Enhancement Stimulation of Emotional Triggers) as the primary therapeutic modality directly accounts for Faith's highly robust treatment trajectory. Through the utilization of targeted sound frequency stimulation to disrupt and down-regulate the hyper-excited startle response, RESET Therapy successfully targeted the participant's core neurological trauma loops. This precise intervention facilitated the rapid reconsolidation of traumatic memories, shifting them from affective, high-distress states to processed memories.

Faith's Brief Resilience Scale (BRS) scores demonstrated a profound improvement in adaptability following the treatment intervention, rising from a pre-treatment baseline of 2.2 to a post-treatment score of 4.0. On the BRS, a baseline score of 2.2

indicates low resilience, which reflects a severely compromised ability to bounce back or recover from stress, which is highly characteristic of individuals overwhelmed by chronic trauma. The post-treatment increase to 4.0 signifies a shift into the normal-to-high resilience range, indicating that the participant successfully reclaimed her psychological buffer. This dramatic upward trajectory suggests that she cleared the constant neurological burden of trauma; Faith fundamentally restored her natural ability to adapt to stressors, cope with adversity, and effectively bounce back from life's challenges.

At the start of treatment, Faith exhibited a Posttraumatic Stress Disorder Checklist (PCL-5) score of 55, a value that clearly indicates severe, clinically significant trauma distress. After the intervention, this score plummeted to 3. This represents a 52-point absolute reduction. To put this achievement into perspective, the established Minimum Clinically Important Difference (MCID) for the PCL-5 ranges between 5 and 10 points. The observed drop exceeds this threshold multiple times over, which confirms that the improvement is not merely statistically significant, but has resulted in a profound life alteration for this participant.

Faith's Beck Depression Inventory (BDI) score plummeted from a baseline of 30 down to a post-treatment score of 2. Her baseline score signified severe depression, a state frequently exacerbated by chronic trauma, which traps the nervous system in a constant loop of survival-driven exhaustion. By successfully resetting emotional triggers, the RT broke this chronic stress cycle. This targeted neurological relief effectively alleviated the downstream vegetative and cognitive symptoms of severe depression, leaving Faith with a post-treatment score that reflects minimal to no depressive symptoms and a state of complete clinical remission.

Parallel to these shifts, Faith's Beck Anxiety Inventory (BAI) score transitioned from a baseline score of 27 (moderate anxiety range) to a post-treatment score of 4 (minimal anxiety range). This 23-point decline reflects a significant reduction in the somatic and cognitive expressions of autonomic hyperarousal, such as tension, palpitations, and subjective fear.

The patient experienced a clinically noticeable reduction in discomfort, shifting from a pre-treatment Numeric Rating Scale (NRS) pain score of 7 (severe) to a post-treatment score of 5 (moderate). This two-point drop represents a positive initial response to the intervention, indicating that the treatment successfully mitigated symptom intensity. While a score of 5 indicates the patient is still experiencing a significant, uncomfortable level of moderate pain, the downward trend suggests that the current therapeutic approach is moving in the right direction.

Residual Symptom Management

To safeguard against relapse and fortify long-term psychological resilience, the following targeted interventions are recommended:

- **Routine Booster Protocols:** Schedule periodic RESET Therapy booster sessions at 3-month and 6-month intervals, or on an as-needed basis, to address any latent acoustic startle reactivity triggered by unexpected environmental stressors.
- **Relapse Prevention and Triggers Blueprint:** Collaborate with the participant to construct a personalized relapse prevention plan that clearly outlines early warning signs of decompensation, specific environmental triggers, and immediate self-soothing or professional coping resources

Prognosis

Given Faith's exceptional responsiveness to RESET Therapy and the down-regulation of symptoms across all clinical domains, the prognosis for long-term future functioning is highly favorable. The swift transition from severe depressive affect and moderate autonomic hyperarousal to mild and minimal ranges, respectively, indicates strong neurological plasticity and robust psychological resilience.

Occupational and Social Functioning

With the elimination of the disruptive startle response and debilitating depressive episodes, Faith is expected to exhibit heightened executive functioning, improved workplace productivity, and enhanced capacity for interpersonal connection.

Autonomic Stability

The dramatic stabilization of the Beck Anxiety Inventory score to a minimal baseline suggests that the participant's nervous system is no longer locked in a chronic fight-or-flight state, lowering the risk of stress-induced physical exhaustion or cognitive burnout.

Maintenance Potential

Assuming adherence to the outlined residual symptom management protocol, Faith is well-positioned to maintain full clinical remission from PTSD and successfully navigate future environmental stressors with adaptive, top-down cognitive strategies.

References

1. Collins C. Why has the US homeless population been rising? EconoFact. Published 2025. Accessed August 25, 2026. <https://econofact.org/why-has-the-us-homeless-population-been-rising>
2. North Carolina Housing Coalition. Homelessness in NC rises 19%: Annual Homelessness Assessment Report. Published 2025. Accessed August 25, 2026. <https://nchousing.org/homelessness-in-nc-rises-19-annual-homelessness-assessment-report/>
3. Liu M, Luong L, Lachaud J, et al. Adverse childhood experiences and related outcomes among adults experiencing homelessness: a systematic review and meta-analysis. *Lancet Public Health*. 2021;6(11):e836-e847. doi:10.1016/S2468-2667(21)00189-4.
4. Imtiaz S, Panico F, Catalano L, De Biase R, Sagliano L. Brain network alterations in trauma and post-traumatic stress disorder: a systematic review. *Academia Neurosci Brain Res*. 2026;2(2). doi:10.20935/AcadNeurosci8253.
5. Maxman A. What are the biological consequences of homelessness? *Sci Am*. Accessed August 25, 2026. Scientific American article
6. Kushel M. Older homeless adults: can we do more? *J Gen Intern Med*. 2012;27:5-6. doi:10.1007/s11606-011-1925-0.
7. Patanwala M, Tieu L, Ponath C, Guzman D, Ritchie CS, Kushel M. Physical, psychological, social, and existential symptoms in older homeless-experienced adults: an observational study of the HOPE HOME cohort. *J Gen Intern Med*. 2018;33(5):635-643. doi:10.1007/s11606-017-4229-1.
8. Sadoughi B, Petersen RM, Patterson SK, et al. Age and early life adversity shape heterogeneity of the epigenome across tissues in macaques. *Science*. 2026;392(6804):eaea4922. doi:10.1126/science.aea4922.
9. McEwen BS. Protection and damage from acute and chronic stress: allostasis and allostatic overload and relevance to the pathophysiology of psychiatric disorders. *Ann N Y Acad Sci*. 2009;1032(1). doi:10.1196/annals.1314.001.
10. Helpman L, Zhu X, Suarez-Jimenez B, Lazarov A, Monk C, Neria Y. Sex differences in trauma-related psychopathology: a critical

- review of neuroimaging literature (2014-2017). *Curr Psychiatry Rep*. 2017;19(12):104. PubMed Central
11. Ungar M, Theron L, Murphy K, Jefferies P. Researching multisystemic resilience: a sample methodology. *Front Psychol*. 2021;12. doi:10.3389/fpsyg.2020.607994.
12. Ackerman CE. How to measure resilience with these 8 resilience scales. *PositivePsychology.com*. Published 2021. Accessed August 25, 2026. *PositivePsychology.com*
13. Parrino L, Vaudano AE. The resilient brain and the guardians of sleep: new perspectives on old assumptions. *Sleep Med Rev*. 2018;39:98-107. doi:10.1016/j.smrv.2017.08.003.
14. Davis-Monthan Air Force Base. A moment of resilience: the 5Cs. Facebook. Published 2020. Accessed August 25, 2026. Facebook video
15. Jagger-Rickels A, Stumps A, Rothlein D, et al. Impaired executive function exacerbates neural markers of posttraumatic stress disorder. *Psychol Med*. 2021;1-14. doi:10.1017/S0033291721000842.
16. Schütz C, Choi F, Song MJ, Wesarg C, Krausz KL, Krausz M. Living with dual diagnosis and homelessness: marginalized within a marginalized group. *J Dual Diagn*. 2019;15(2):88-94. doi:10.1080/15504263.2019.1579948.
17. Orciari EA, Perman-Howe P, Foxcroft DR. Motivational interviewing-based interventions for reducing substance misuse and increasing treatment engagement, retention, and completion in the homeless populations of high-income countries: an equity-focused systematic review and narrative synthesis. *Int J Drug Policy*. 2022;100:103524. doi:10.1016/j.drugpo.2021.103524.
18. Lachaud J, Lancheros CM, Nisenbaum R, Stergiopoulos V, O'Campo P, Hwang SW. Housing First and severe mental disorders: the challenge of exiting homelessness. *Ann Am Acad Pol Soc Sci*. 2021;693(1):178-192. Article record
19. Fisher R, Ewing J, Garrett A, Harrison EK, Lwin KK, Wheeler DW. The nature and prevalence of chronic pain in homeless persons: an observational study. *F1000Res*. 2013;2:164. doi:10.12688/f1000research.2-164.v1.
20. Hwang SW, Wilkins E, Chambers C, Estrabillo E, Berntorp E, Wu A. Chronic pain among homeless persons: characteristics, treatment, and barriers to management. *BMC Fam Pract*. 2011;12:73. doi:10.1186/1471-2296-12-73.
21. Kale NN, Marsh J, Kale NK, Miskimin C, Mulcahey MK. Musculoskeletal injuries and conditions among homeless patients. *JAAOS Glob Res Rev*. 2021;5(11):e21.00241. doi:10.5435/JAAOSGlobal-D-21-00241.
22. Schiller D, Monfils MH, Raio CM, Johnson DC, LeDoux JE, Phelps EA. Preventing the return of fear in humans using reconsolidation update mechanisms. *Nature*. 2010;463(7277):49-53. doi:10.1038/nature08637.
23. Lindenfeld G, Rozelle G. PTSD: brain on fire: a RESET therapy (QEEG) brain map analysis case study of an Afghanistan combat veteran. *Academia.edu*. Published 2015. Accessed August 25, 2026. *Academia.edu*
24. Lindenfeld GL, Rozelle G, Hummer J, Sutherland MR, Miller JC. Remediation of PTSD in a combat veteran: a case study. *NeuroRegulation*. 2019;6(2):102. doi:10.15540/nr.6.2.102e.
25. Lindenfeld G, Rozelle G, Soutar R, Hummer J, Sutherland M. Post-traumatic stress remediated: a study of eight combat veterans. *New Mind Journal*. Published 2019. Accessed August 25, 2026. *New Mind Journal*
26. Lindenfeld G, Miller JC, Hummer J. RESET therapy and stellate ganglion block—common mechanisms in PTSD remediation. *J Psychiatry Psychol Res*. Published 2019. Accessed August 25, 2026. *SCITECH*
27. Lindenfeld GL, Hummer JT, Billiot K. Anger and aggression: a new beginning? *Fam Court Rev*. 2021;59(1):161-170. doi:10.1111/fcre.12538.
28. Pew Research Center. Mobile fact sheet. Published 2025. Accessed August 25, 2026. *Pew Research Center*
29. National Institute of Mental Health. Technology and the future of mental health treatment. Published 2024. Accessed August 25, 2026. *NIMH*
30. Therman W. Noninvasive neurotherapeutic treatment of neurodegeneration: integrating photobiomodulation and neurofeedback training. In: Hamblin MR, ed. *Photobiomodulation in the Brain*. Elsevier; 2019. doi:10.1016/B978-0-12-815305-5.00032-4.
31. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *Am J Prev Med*. 1998;14(4):245-258. PubMed
32. Centers for Disease Control and Prevention. Adverse childhood experiences (ACEs). Published 2026. Accessed August 25, 2026. *CDC*
33. Smith BW, Dalen J, Wiggins K, Tooley E, Christopher P, Bernard J. The brief resilience scale: assessing the ability to bounce back. *Int J Behav Med*. 2008;15(3):194-200. doi:10.1080/10705500802222972. *Springer Nature*
34. Wang YP, Gorenstein C. Psychometric properties of the Beck Depression Inventory-II: a comprehensive review. *Braz J Psychiatry*. 2013;35:416-431. *Brazilian Journal of Psychiatry*
35. Beck AT, Epstein N, Brown G, Steer RA. Beck Anxiety Inventory. *J Consult Clin Psychol*. 1988;56(6):893-897. doi:10.1037/t02025-000.
36. Blake DD, Weathers FW, Nagy LM, et al. The development of a clinician-administered PTSD scale. *J Trauma Stress*. 1995;8(1):75-90.
37. McDonald SD, Calhoun PS. The diagnostic accuracy of the PTSD checklist: a critical review. *Clin Psychol Rev*. 2010;30(8):976-987. doi:10.1016/j.cpr.2010.06.012.
38. Faithly RH, Dubner R. Reliability and validity of verbal descriptor scales of painfulness. *Pain*. 1987;29(2):175-185.