Supporting Individuals Healing from Trauma

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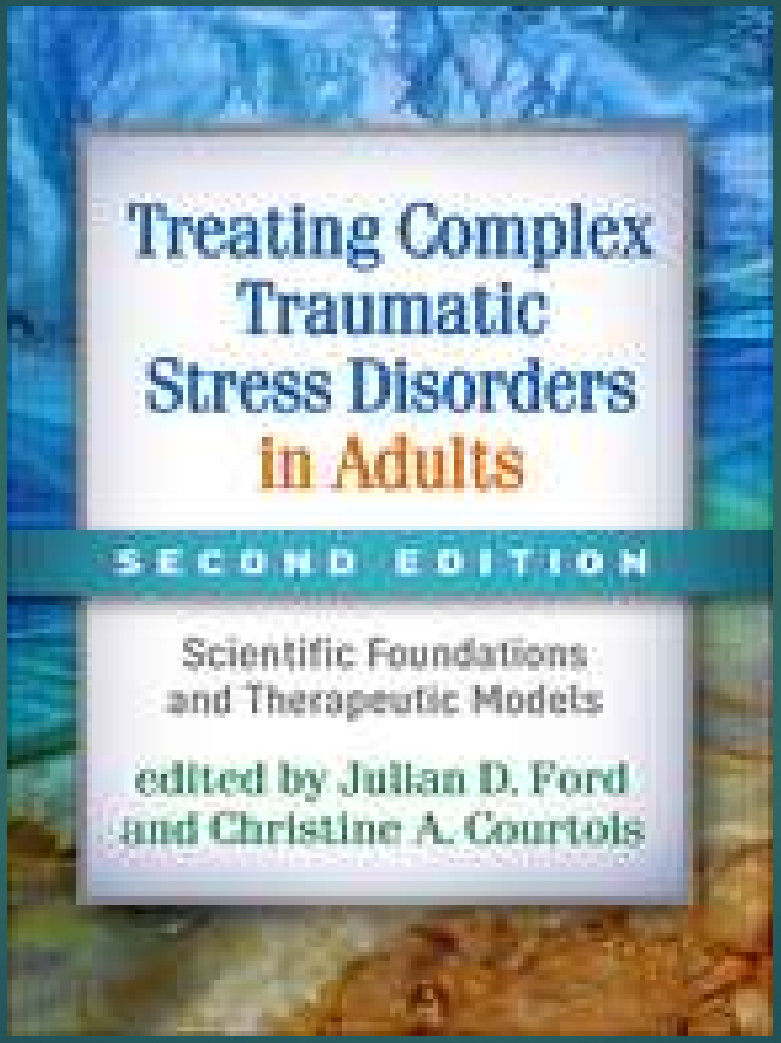

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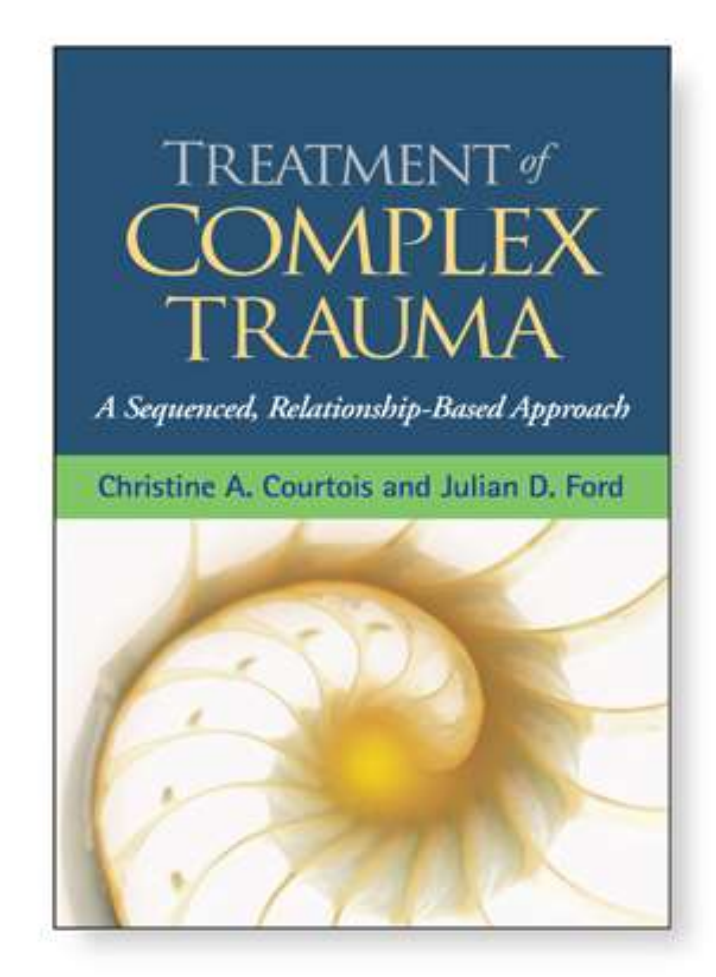


Agenda

- Introduction to Treatment
- TIC: Philosophy, General Guidelines, and Competencies
- Different Types of Trauma and Response
- The Self of the Therapist
- Relational Elements
- Evidence-based and Supported Treatments

Introduction to Treatment

- Treatment of traumatized individuals is not for the faint of heart
  - Traumatized clients are different from those who are not
  - They present unique challenges and opportunities
- They have many posttraumatic and other manifestations
  - Especially the case in survivors of childhood complex trauma
  - There may be a major disconnect between past and present
- Therapists must be aware and prepared to treat them
  - Traumatized clients make up a high percentage of the mental health caseload

Introduction to Treatment

- The contemporary study of trauma and the development of treatment approaches have been ongoing for the past 40 years
- Theoretical models of trauma and treatment have developed
- Philosophy and guidelines for treatment have developed
- Different types of trauma and different approaches to treatment have been identified
- Evidence-based practice has been promoted for all trauma treatment, but not all therapists are in agreement
- The relationship has proven to be is as important as the treatment method

Introduction to Treatment

- Unfortunately, even today, most therapists have not had information about working with trauma as part of their professional training !!!
- This has created a wide disparity between the needs of clients and the capabilities/competencies of therapists
- So, a major need is for ongoing training at different levels of expertise, supervision, and ongoing consultation
  - Emotional health of the therapist is also needed
- Trauma treatment philosophy and competencies have been identified; innovation is ongoing

Trauma-Informed Care

"Trauma-informed services are those that incorporate an understanding of the impact of violence and psychological trauma in the lives of consumers of mental health, healthcare, and social services."

(Clark, Classen, Fourt, & Shetty, 2015)

Trauma-Informed Care

- Focuses on the strong possibility (or even the likelihood) of trauma in the mental health and medical client's background and *as highly pertinent to the client's distress and symptoms*

- Directly acknowledges and is sensitive to trauma-related issues

Trauma-Informed Care

- Major paradigm shift in view of clients and their symptoms/ injuries
  - Views symptoms as coping attempts, skills, and adaptations to injury and not as disorders
    - A much less pathologizing way of viewing symptoms
    - A much more open and understanding perspective

Adapted from Risking Connection**, pp. xiii-xiv**

Trauma-Informed Care

What *happened to you* versus what's *wrong with you*?

(Bloom)

It's *not you*, it's *what happened to you*

(Courtois)

Trauma-Informed Care

- Makes the connection:
  - "Germ theory of trauma" (Bloom)
  - We have a major pathogen in our midst
- TIC offered as a "universal precaution"
  - Applies to all clients and services
  - Across all levels of the organization
  - Basis of good professional practice in general but
  - Especially important for those who have been traumatized

Trauma-Informed Care

- Not a fad
- Not a marketing ploy
  - Totally unethical or advertise and then not use it
- Must be applied and reinforced
- Treaters must be supported in different ways

Guiding Principle of TIC

First, Do No *More* Harm

(Courtois, 2014)

Core Principles of TIC

- **Awareness:** Know the role of trauma
- **Safety:** Ensure physical and emotional safety
- **Trustworthiness**: Maximize trustworthiness, make tasks clear, **maintain clear and appropriate boundaries**
- **Choice:** Respect and prioritize client choice and control. **Individualize** treatment
- **Collaboration:** Collaborate and sharing of power with clients
- **Empowerment:** Prioritize client empowerment and skill-building; enhance motivation

Some Major Assumptions of TIC

- Many symptoms are misguided attempts to regulate emotions
  - Often paradoxical
  - What once worked may stop working and become a problem
- Symptoms and problems are often "secondary elaborations of the untreated original effects of the trauma"—and disconnected from their source
- The relational impact of trauma affects the helping relationship, often making it unstable

Some Major Assumptions (Risking Connection)

- Trauma shapes the survivor's basic beliefs about identity, relationships, world view, & spirituality

- The effects of childhood abuse are important and *can* be addressed within mental health (and substance abuse) treatment and service systems with a trauma framework

pp. 12-15

Some Major Assumptions (Risking Connection)

- A shared trauma perspective fosters collaboration
- A treater offers:
  - Respect
  - Information
  - Connection
  - Hope
- Treaters need the same from one another
- Working with survivor clients affects the person of the helper

Trauma-Informed Care

- Individual respect and regard as a starting point
  - May be difficult for the client to accept
- Founded on acknowledgement and inquiry:
  - asking about signifies importance and ability to talk about rather than deny or avoid
- Founded on **safety:** emotional, relational, physical, environmental
  - Consistency, reliability, and trustworthiness of environment and treaters
  - A safe organized environment w/ no physical threat

Trauma-Informed Care

- Starts with assessment
- Why it is important to ask about trauma
- How to ask and respond to disclosures
- Safety first
- Asking does not ensure accurate response
  - Does not mean the client is a liar or a malingerer
- Violence and risk-assessment with safety planning, as needed
- Assessment is best considered as ongoing
  - Resolution of one issue might open another

Trauma-Informed Care

- Strength and resiliency-based
  - assumes strength and resources
  - builds on what is available
  - assesses motivation
  - gives attention to client goals and resources
  - "resources" the client
  - collaborative and empowering
  - addresses therapy-interfering behavior
- Informed consent and refusal

Trauma-Informed Care

- Psych-education: normalize, validate, educate throughout treatment
  - 1. Psychotherapy process and how to engage; "rules of the road"
  - 2. Trauma and its effects
    - psychological, biological, neurobiological & social effects and development of symptoms
  - 3. The process of change
    - Change is not linear—it is "messy" and recursive
    - Asserts that crises are best managed through development of "feeling and self-management skills"

Trauma-Informed Care

- Create hope
  - Healing is possible
  - Healing is a process
    - Setbacks, crises, lapses or relapses are opportunities for problem-solving and new learning, not failure
    - There is no expectation of perfection
    - Therapist is expected to make mistakes as well

Trauma Informed Care

- The significance of the relationship
  - The treater and relationship as essential to healing
  - The treater will be personally impacted by the trauma work
    - May have own trauma history
    - Even without own history
- Many treaters are traumatized by the system itself (organization, managed care, caseload demands, lack of support, moral injury) and are burned out
  - Trauma-informed model provides them with a new "operating system" and values along with additional training and support

CONSENSUS TREATMENT PRINCIPLES

1. Safety is an essential condition for successful treatment and may take time to develop.

2. Relational attachment and safety in the therapeutic relationship are essential.

3. Treatment must enhance the ability to manage extreme arousal states and tolerate feelings. Somatosensory and affective identification and skill-building in self-regulation are needed.

4. Treatment is strength-based and should enhance the sense of personal control, empowerment, and self-efficacy.

CONSENSUS TREATMENT PRINCIPLES

5. Treatment must enhance the client's ability to approach and master rather than avoid experiences that trigger symptoms. Trauma-focused.

6. Treatment must assist in maintaining an adequate level of functioning consistent with past and current lifestyle. Present-centered.

7. Therapists must be aware of clients' trauma/ transference reactions and effectively manage their own countertrauma/countertransference, VT, and personal health status.

CONSENSUS TREATMENT PRINCIPLES

8. Treatment, like complex trauma, is complex, multimodal, integrative, and individualized. Person-centered.

9. Treatment focuses on desensitization of traumatic memories and associated emotions to enhance personal authority over memory and meaning-making rather than memory retrieval. Resolution results in the lessening of trauma-based symptoms and posttraumatic adversity and decline.

APA Competencies for Trauma Treatment (2014)

- Competencies are defined as knowledge, skills, and attitudes.
- The competencies:

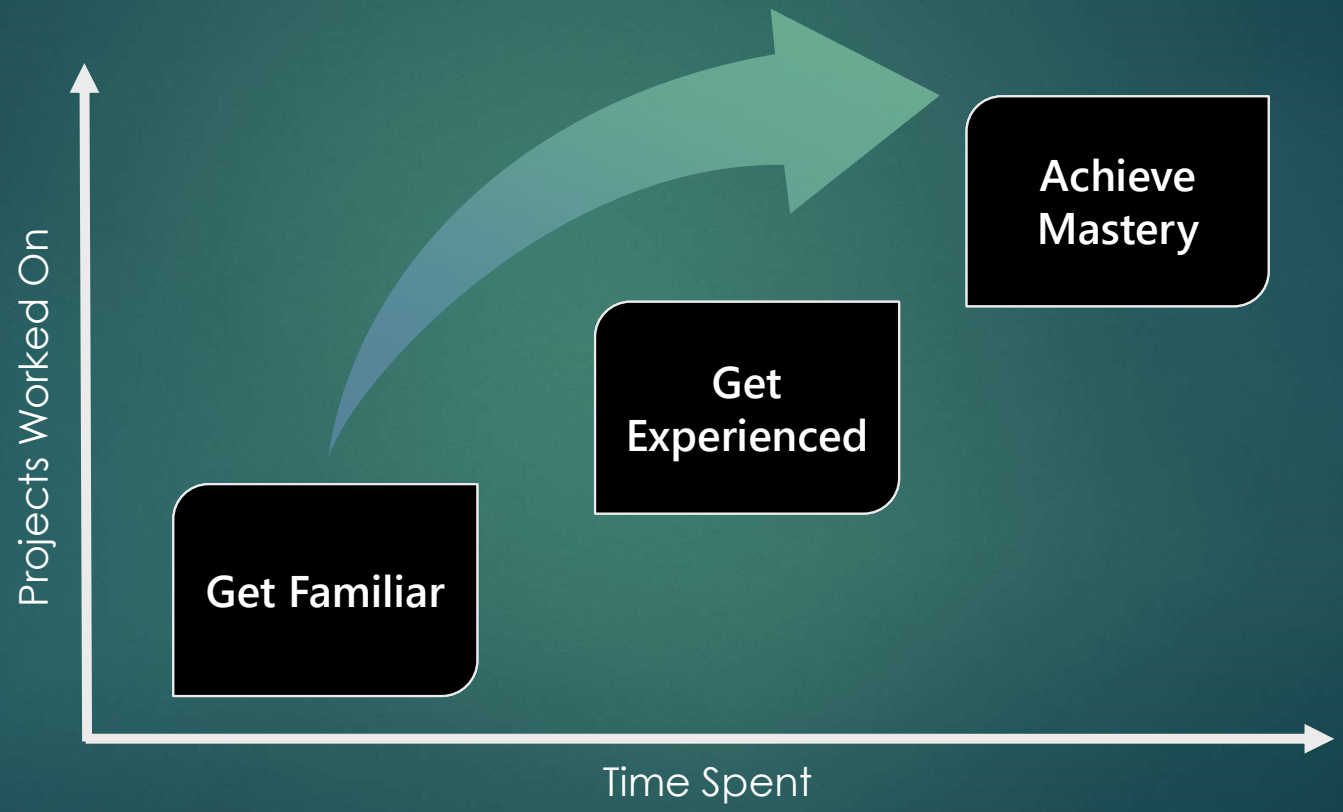
  Are expectations for an entry-level therapist.

  Articulate *minimal* expectations; all trauma therapists practicing at the entry level should be able to demonstrate these core competencies.

  Assume that general competencies for psychotherapy have been achieved.

  Are not specific to any one treatment model.

Working Toward Mastery



Cross-Cutting Trauma-Focused Competencies

1. Demonstrate understanding about trauma reactions and tailor trauma interventions and assessments in ways that honor and account for individual, cultural, community, and organizational diversity.

2. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at time(s) and duration of trauma as well as time of contact.

3. Demonstrate the ability to understand, assess, and tailor interventions and assessments that address the complexities of trauma-related exposure.

4. Demonstrate the ability to appropriately appreciate, assess, and incorporate trauma survivors' strengths, resilience. and potential for growth in all domains. Facilitate shared decision-making whenever appropriate.

Cross-Cutting Trauma-Focused Competencies

- 5.

APA Competencies for Trauma Treatment

- A total of **five broad competencies**, each with a subset of knowledge, attitudes, and skills necessary for achieving proficiency in a given area
  - 1. Knowledge
  - 2. Assessment
  - 3. Trauma-focused psychological interventions
  - 4. Trauma-informed professionalism
  - 5. Trauma-informed relational and systems
- Note: There are now many sub-specialty areas in trauma psychology and treatment that require specialized knowledge
  - Therapists may choose to specialize in one or more area, e.g., sexual assault, disaster response, refugees, combat trauma, human trafficking, etc.

Types of Trauma

- I. Accident/Disaster/"Act of God"
  - Sudden, unexpected, generally one-time or time-limited
  - Chronic illness/disability, time-unlimited
- **II. Interpersonal**
  - Sudden, unexpected, one-time or time-limited (more likely to be a stranger)
  - Anticipated, repeated, chronic (more likely to be known, related)
- III. Identity/gender//ethnicity/sexual orientation
  - Lifelong vulnerability
- IV. Community/group membership
  - Lifelong or episodic vulnerability
- V. Cumulative/continuous/catastrophic

Attachment/Relational Forms of Interpersonal Trauma

- Occurs in attachment relationships with primary caregivers
  - insecurity of response and availability
  - mis-attunement, non-response
  - lack of caring and reflection of self-worth
  - caregiver as the source of *both* fear and comfort
- Includes DV and child abuse of all types
  - often "on top of" attachment insecurity
  - neglect, abandonment, non-protection, non-response, sexual and physical abuse and violence, verbal assault, antipathy, bullying
- Impacts child's development

Dimensions of Interpersonal Trauma

- Relational
  - Disruptions in the sense of safety, security, loyalty, and trust that may block connections and communication in the family of origin and extend to other relationships
- Betrayal trauma
  - involves betrayal of a role or relationship
- Second or institutional injury
  - involves lack of assistance or response and/or insensitivity on the part of those who are supposed to help, intervene, or protect

Complex Trauma

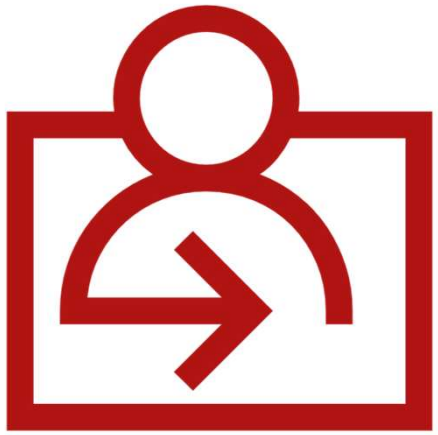
- Interpersonal
  - In attachment/other significant relationships
- Involving all forms of abuse/neglect
- Repeated/chronic
- Layered
- Progressive
- Revictimization
- Continuous/cumulative/catostrophic

Complex Developmental/Dissociative Trauma

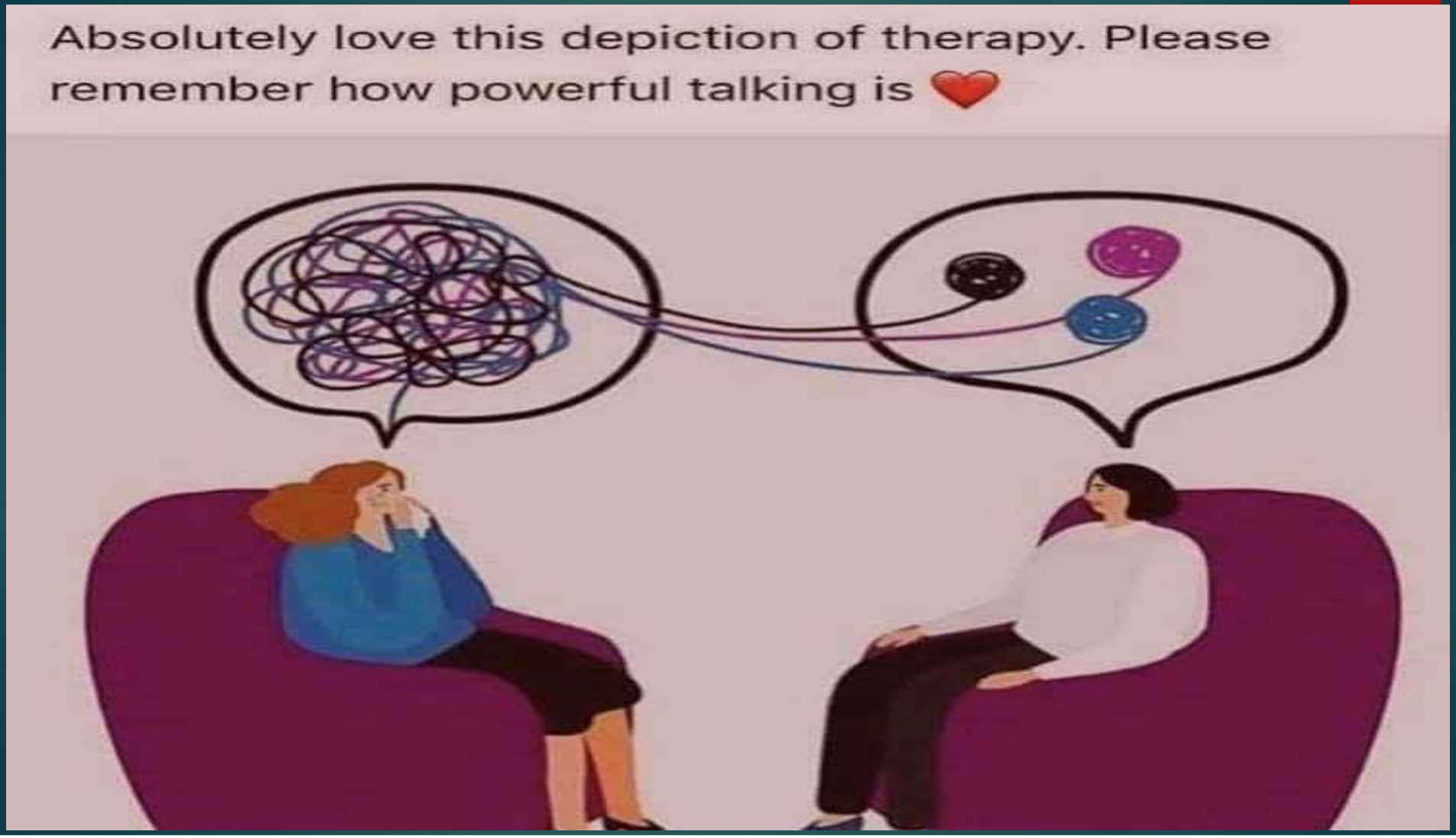
- Associated with chronic, pervasive, cumulative abuse and trauma in childhood, often on a foundation of attachment/relational trauma
  - insecure attachment, *especially disorganized*
- **Severely impacts the developing child**
  - neurophysiology
  - psychophysiology
  - bio-psycho-social maturation & development, including attachment capacity/style & other
- "survival" vs. "learning brain"
  - not associated with intelligence

What Is Complex Trauma?

Relational Healing for Interpersonal Attachment (Relational) Trauma



Effective Treatment Starts with the Therapist


Absolutely love this depiction of therapy. Please remember how powerful talking is ❤️

The Self and Presence of the Therapist

- Must maintain personal and emotional health
- Must have completed own therapeutic work
- Required to be:
  - emotionally regulated
  - physically and emotionally attuned and engaged
  - accepting
  - open and accessible
  - curious and reflective; learning with the client
  - client's "memory trace" and prompt at times
  - playful at times
  - cheerleader/encourager at times
  - source of hope
  - humble and not "authority on high"

Attachment Styles of Client and Therapist

- Therapist must know own attachment style and use it
  - If insecure or disorganized, therapist will have a difficult time not being reactive and staying engaged
  - Work on self to develop "earned secure" style
- Learn client's attachment style to work with it and to "get under it"
- Expect play-out behaviorally and defensively
- Bring it to the client's attention over time

Boundary Issues

- "Risky Business" (Pearlman)
- "Treatment traps," challenges, lapses, and errors
  - how they are handled can be restorative or disastrous/retraumatizing
  - knowing about them can help the therapist get out of them and manage them with less anxiety (Chu, 1988
- Transference, CT and VT issues
- Attachment style and the relational process

Boundary Issues

- Potential for boundary violations (vs. crossings) common with this population (indiscretions, transgressions, and abuse)
- Therapist must try to stay steady state *and* emotionally resonant
  - Mindfulness and awareness
- Avoid dual roles where possible
- Engage in personal therapy as necessary
- Engage in ongoing continuing education, consultation/supervision, peer support

Boundary Issues

- On average, start with tighter boundaries
  - Teach limits and boundaries, "rules of the road"
- Reinforce the right thing!!
- Expect boundary challenges
  - Teach negotiation and collaboration
  - Hold to important boundaries
- *Be conditional about behavior while being unconditional about person*

Boundary Issues

- Progression of boundary violations: e.g., from excessive disclosure to patient as confidante, excessive touch to sexual comforting and contact
- It is **NEVER *OK*** to sexualize the relationship
  - patient may seek to sexualize directly or indirectly
  - therapist may develop sexual feelings
- Guideline: welcome and discuss *when presented by patient*; hold the line, keep your seat, do not touch, DISCUSS. When belongs to the therapist, seek consultation. Only discuss if therapeutically warranted and then, very carefully w/ ownership.

Boundary Issues

- Rescuing-revictimization "syndrome"
  - "vicarious indulgence" as a treatment trap, especially for novice therapists and those with a strong need to caretake or who are enticed by the client
  - may give client permission to overstep boundaries, ask for and expect too much
  - may then lead to resentment/rage on the part of the therapist and abrupt, hostile termination for which the client is blamed (triple bind)
  - may relate to malpractice suits, in some cases (see BPD literature)

The Importance of Relational Repair

- Consistent, reliable relationship, *not perfect!*
- Accepting: non-punitive, non-judgmental
- Encourage collaboration, curiosity
- Encourage reflection and reflective functioning
- Therapist self-disclosure about feelings *in the moment* (Dalenberg research)
  - especially anger
- Therapist owns mistakes and apologizes
  - negotiates relational breach and repairs
  - may be the most significant moments in treatment

Classic Treatment Traps (Chu, 1988)

- Often based on client "resistance"
- Traumatic transference and resistance due to history, family dynamics
- Therapist often "buys in" due to naivete or inexperience
- Experienced therapists can also get caught
- Countertransference at play
- Dissociation and repression can make communication difficult

Classic Treatment Traps (Chu, 1988)

- 1. Trust
- 2. Distance
- 3. Boundaries
- 4. Limits
- 5. Responsibility
- 6. Control
- 7. Denial
- 8. Projection
- 9. Idealization
- 10. Motivation

Assessment Before Treatment

- Comprehensive psychosocial assessment to start
  - Ask about trauma and crises as part of normal questioning
  - Asking does not mean that response will be accurate—serve as benchmark
- Symptoms make up diagnostic criteria for different disorders--used for diagnostic and treatment planning purposes
  - Co-occurring and co-morbid issues and disorders
- But, trauma-informed therapist understands that they often signify more
- Symptoms are more than symptoms

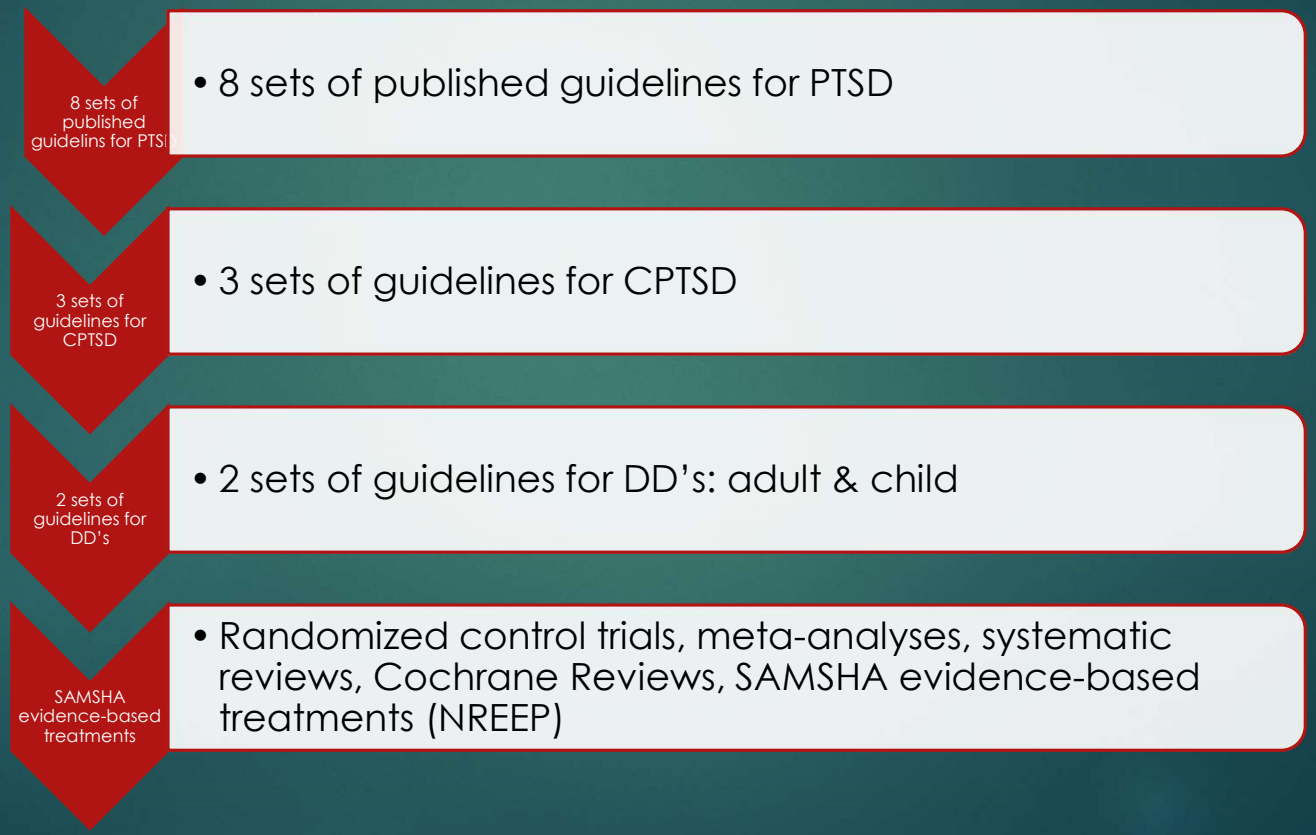
Evidence-Based Practice

- Best research evidence
- Clinical expertise
- Patient values, identity, context

American Psychological Association Council of Representatives Statement,

August 2005

Treatment Guidelines and Evidence-Based Methods and Organizations



Trauma-focused treatments
or
Present-centered/skills-based treatments???
or
Person-centered treatment ??

All of the above ???

"Alphabet Soup" of Techniques and Approaches

Effective Treatments for Classic PTSD*

- Psychopharmacology: 3 classes: SSRI/SNRI, anxiety, sleep
- Prolonged Exposure (PE/EX)
- Cognitive Processing Therapy (CPT)
- Cognitive-Behavior Therapy (CBT-mixed)
- Narrative Exposure Therapy (NET)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Interpersonal Psychotherapy (IPT)
- Brief Eclectic Psychotherapy (BEP)
- Present-Centered Therapy (PCT)
- Psych-education & other supportive interventions

*Few studies have evaluated using a combination of these approaches although combination treatment commonly used and may have advantages

Complex Trauma Treatment

- "Not trauma alone" (Gold, 2000)
- Multi-theoretical and multi-systemic
- Integrative
- Addresses attachment/relationship issues in addition to life issues and trauma symptoms and processing of traumatic material
- Takes context into consideration
- Intensity is titrated to client
- Relational approach

Complex Trauma Treatment

- PTSD symptoms, plus:
- Problems with affect regulation
  - may rely on maladaptive behavior, substances, risk-taking and other problems with safety
- Dissociation
- Negative self-concept/SHAME & SELF-LOATHING
- Problems in relationships
  - revictimization/re-enactments
  - needy but mistrustful; fearful-avoidant, disorganized
- Problems functioning?
- Physical/medical concerns
- Other…

Complex Trauma Treatment

- Recent focus on:
  - Dissociation/dysregulation/self/ego states
  - Somatosensory approaches: SE, SPI
  - Interpersonal neurobiology
    - Attachment-based approaches
    - Affect-based approaches
    - Right brain to right brain
  - Cognitive approaches
  - Hybrid adaptations

Complex Trauma Treatment

- Experiential
- Expressive (art, music, dance, drama)
- Neurofeedback
- Meditative/mindfulness/yoga
- Spiritual approaches
- Energy approaches
- Acupuncture
- Animal-assisted therapy
- Additional medications

Recommended Treatments for Complex PTSD

(ISTSS Complex Trauma Task Force Survey Results, JTS, 2011)

- Sequenced or phased
- Customized: interventions tailored to specific goals, symptoms, client preferences
- "First line" approaches:
  - Emotional regulation
  - Narration of trauma memory
  - Cognitive re-structuring
  - Anxiety and stress management
  - Interpersonal/attachment

Recommended Treatments for Complex PTSD

- "Second line"
  - Meditation/mindfulness
- Course and duration of treatment unclear

Effective Treatments for CPTSD

- PE
- CPT
- CBT-mixed
- EMDR, applied by stage
- IPT
- BEP
- NET
- Psych-education and supportive interventions
- Psychopharmacology

Effective Treatments for CPTSD

- EFT: Emotionally Focused Treatment (Greenberg; Johnson; for couples)
- ART: Accelerated Resolution Therapy
- RP: Relational Psychodynamic and Attachment-Based Dynamic (Davanloo, Abbas, Fosha, Schore, Siegel)
  - Intensive, Accelerated, Short- or Long-Term
- IFS: Internal Family System (Schwartz)
- Some group models:
  - Classen et al.; Wright
  - Lubin & Johnson
  - Herman et al.

Effective Treatments for CPTSD

- Treatment packages:
  - EFTT: Emotionally Focused Trauma Treatment (Paivio & Pascal-Leone) (Paivio & Angus)
  - ITCT: Integrated Treatment for Complex Trauma (Lanktree & Briere)
  - IRRT: Imaginal Restructuring and Reprocessing (Smucker & Dancu)
  - STAIR: Skills Training in Affect and Interpersonal Regulation (Cloitre, Cohen, & Koenen)
  - TARGET: Trauma Affect Regulation (Ford)

"Hybrid" and Adapted Models for Complex Trauma

- Seeking Safety (Najavits): addictions
- ATRIUM (Miller): addictions
- SAFE Alternatives (Conterio & Lader): self-injury
- TREM (Harris): SMI
- DBT & ACT (adapted) (Linehan; Hayes): skill development and mindfulness
- Many models, topics, and workbooks…

Dissociation-Specific Treatments

- Three phase model for DID: (Brand et al.)
  - With hierarchy of tasks/skills

Four Emerging Techniques Supported in Recent Review

- Moderate evidence for:
  - Acupuncture
  - Emotional freedom techniques
  - Mantra based meditation (MBM)
  - Yoga
- All mind-body; mechanism of action unknown

Treatment

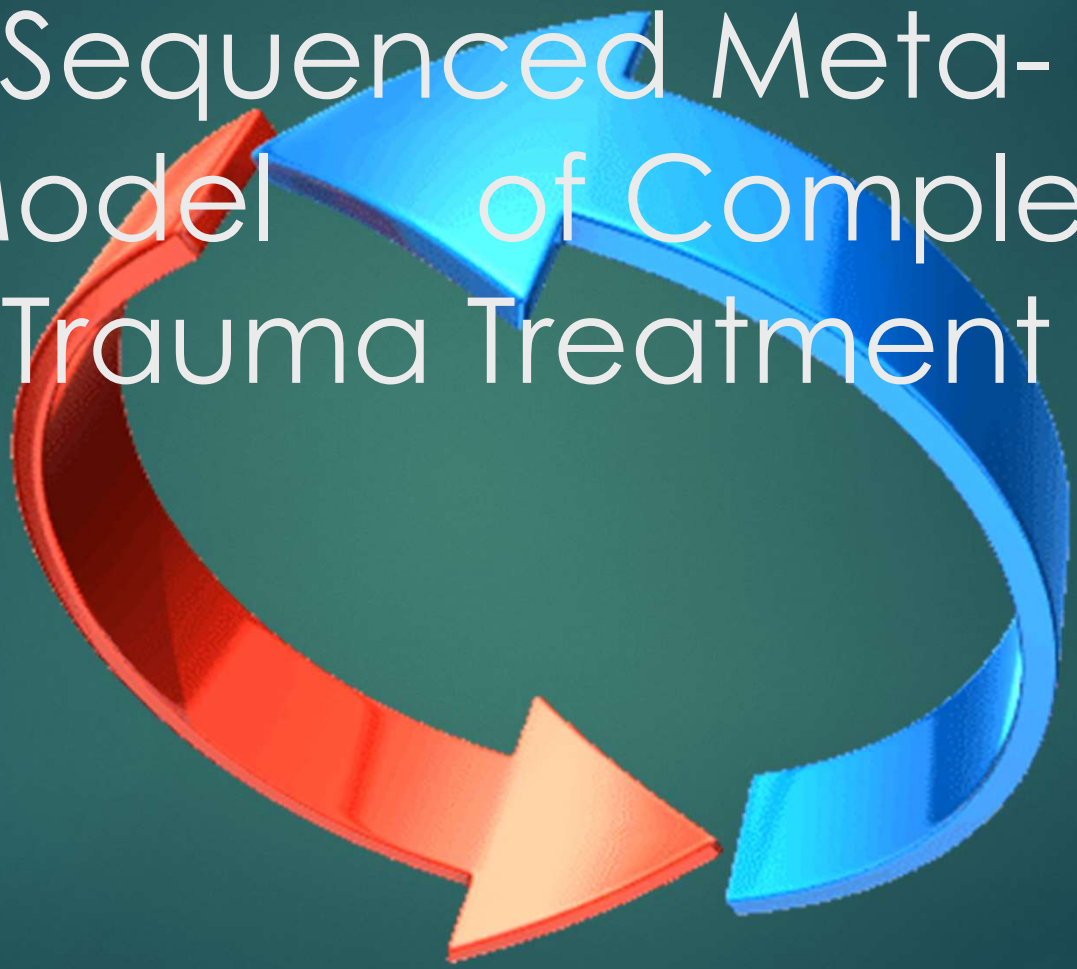
Like Posttraumatic Disorders, comprehensive treatment must be

BIO-
PSYCHO-
SOCIAL/SPIRITUAL
&
Culture and Gender Sensitive

The Questions Are:

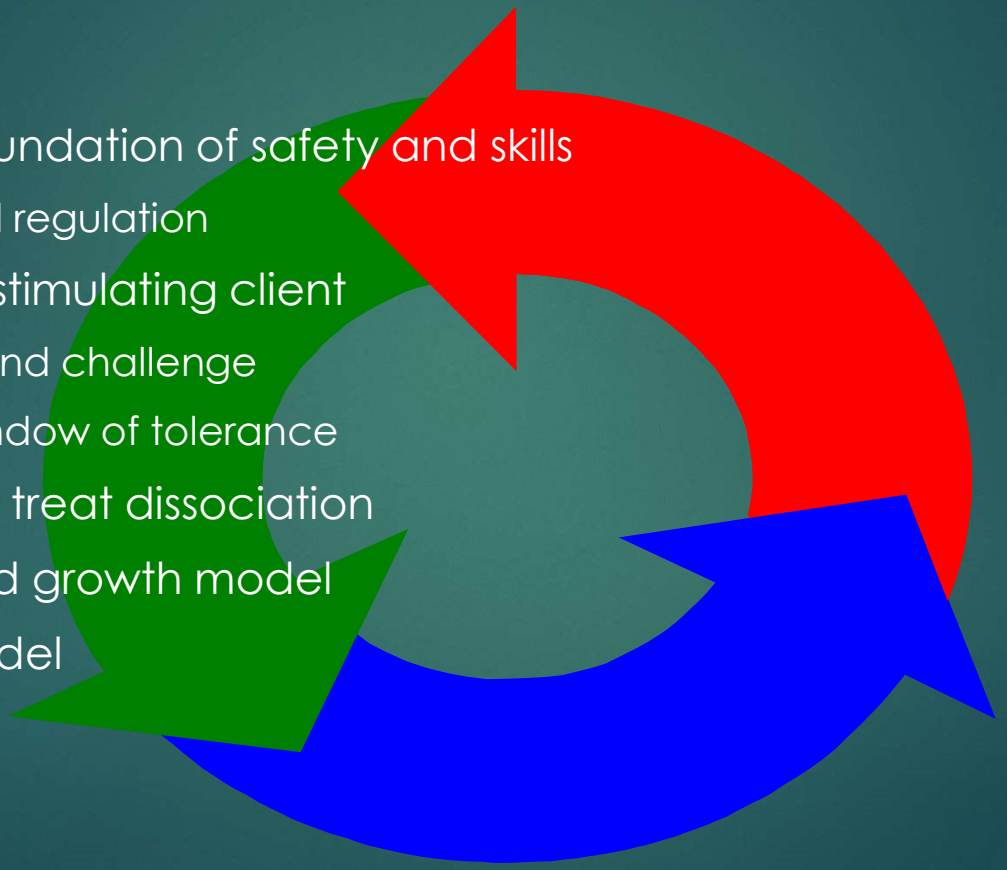
Client Goals, Preferences? What to Offer *and When?* Shared Decision-Making re: Goals, Techniques and Timing

Sequenced Meta-Model of Complex Trauma Treatment

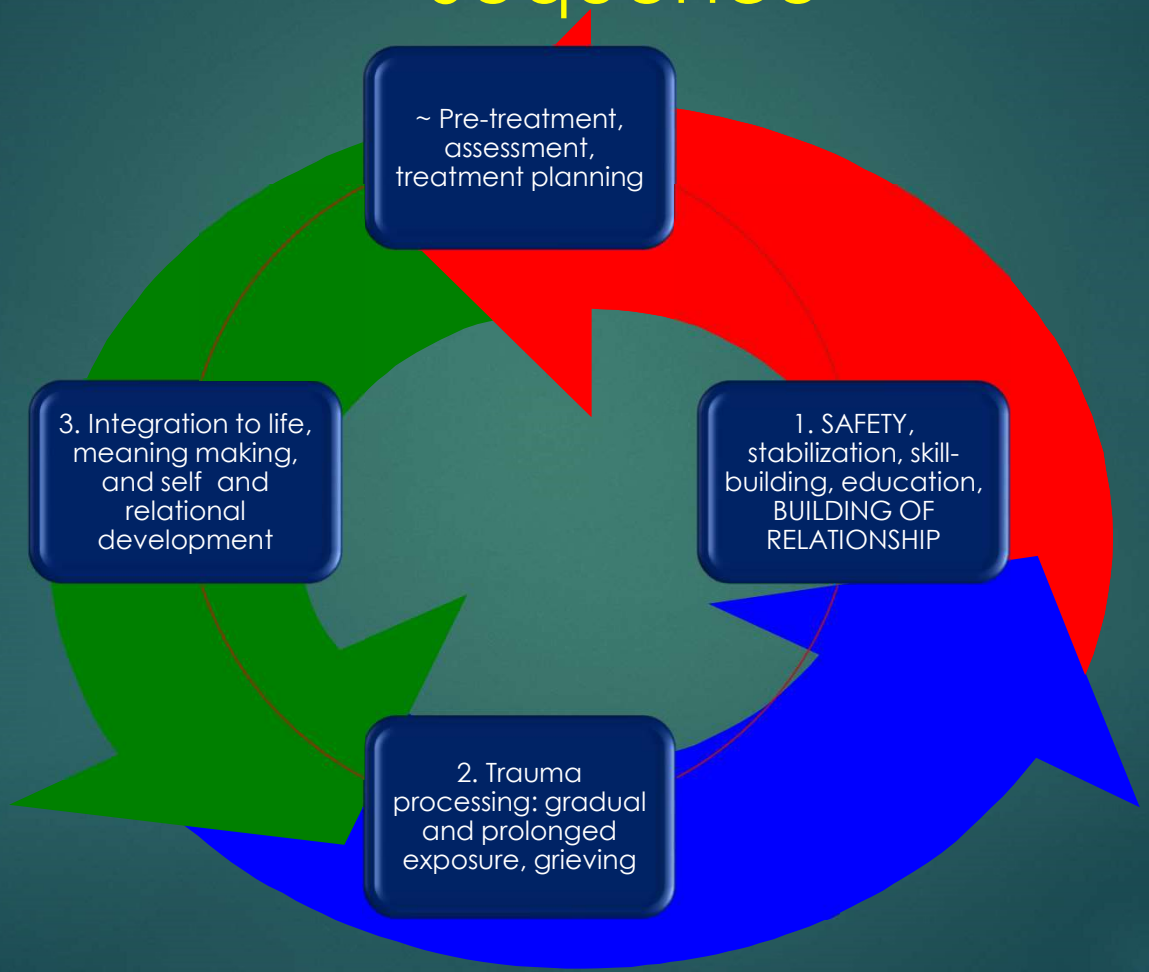


Rationale for Sequencing

- Create a foundation of safety and skills
  - Emotional regulation
- Avoid over-stimulating client
  - Support and challenge
  - Within window of tolerance
- Identify and treat dissociation
- Change and growth model
- Relapse model



Complex Trauma Treatment Sequence



Pre-treatment Stage: Assessment and Contracting

- Assessment and contracting *before* decisions about treatment
- Follow normal intake procedures, complete a *comprehensive* psychosocial evaluation
  - inquire broadly about a range of symptoms
  - inquire about DV, all forms of abuse/trauma/crises
  - follow up with specialized and/or collateral assessment
- Specialized instrument are now available
- Take time to assess and assimilate information

- Inquire about ongoing/pending/considered legal action

Pre-treatment Stage: Assessment and Contracting

Educate about treatment frame issues

- consider a policies and procedures statement and
- a signed treatment contract

Consider consultations, as indicated

- medical, psychiatric, neurological
- second opinions re: diagnosis & tx recommendations

Develop a treatment plan

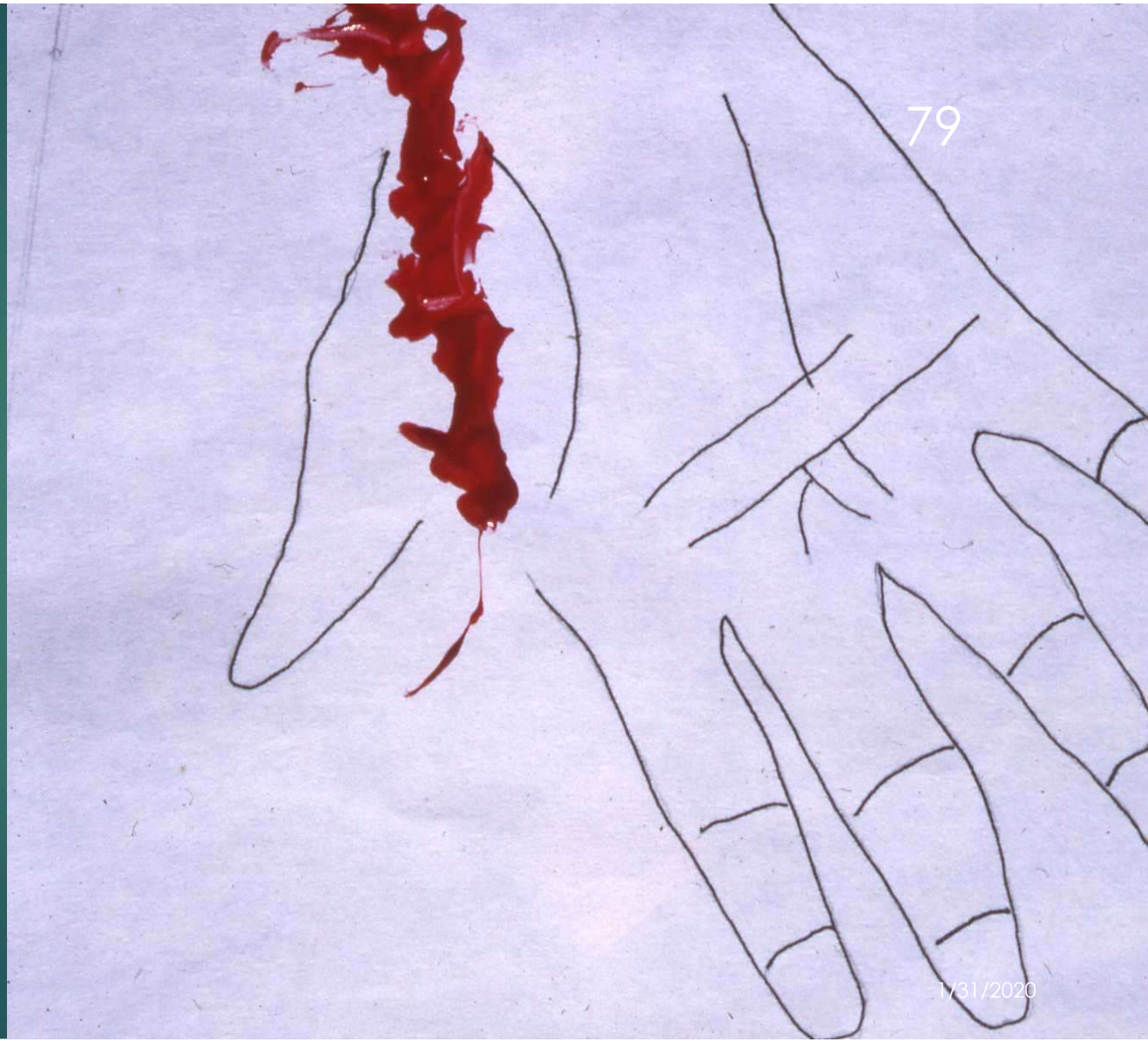
- according to needs and goals, motivation
- according to resources (personal & financial)
- collaborate and share

Assessment

- Symptoms as communication
- Talking without telling

Assessment

SYMPTOMS AS COPING



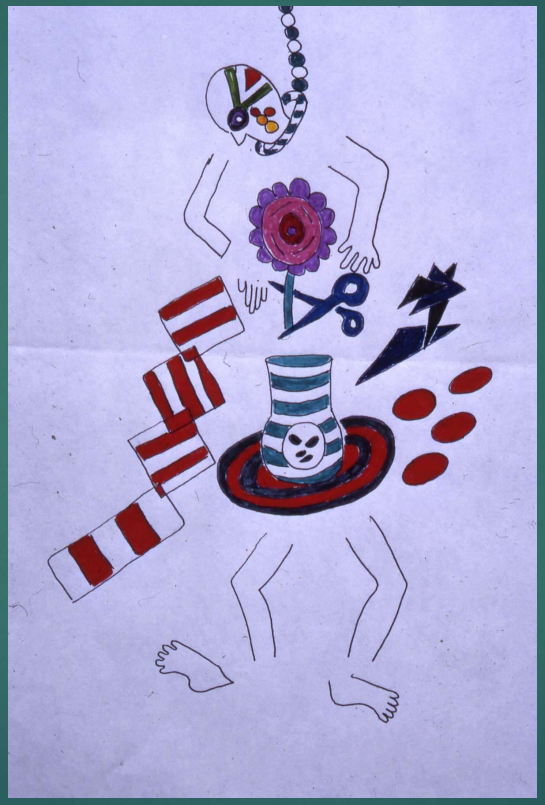
Assessment

Meaning of a symptom

Assessment

Meaning of a symptom

Don't ignore a picture like this!!



Early Stage: Safety, Skill-building, Self-management, Alliance-building

Stage measured in mastery of skills and healing tasks, not time!

Therefore, often a problem for patient and for managed care; however, good stage 1 work often saves time in the long run

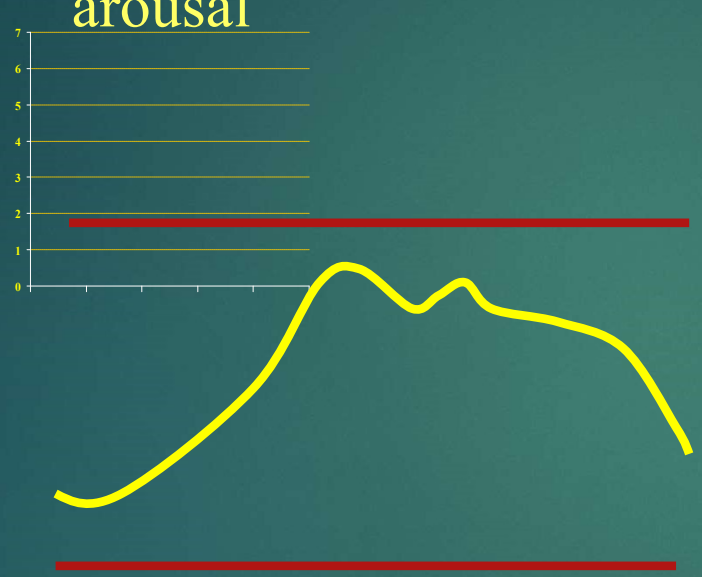
Early Stage: Psychological Components

- Therapeutic alliance and collaboration as essential but take time
  - Mistrust issues
- Safety as essential, not to be ignored
  - Safety from self and others
  - Detox/abstinence/harm reduction: early recovery
  - Life stabilization
  - Safety planning: collaborative problem-solving vs. time-limited contracting
    - involves a hierarchy of interventions and actions, internal and external and the agree-upon use of supports including voluntary hospitalization, if indicated
    - ***expect and plan for relapses***

Early Stage: Psychological Components

- Attachment style/personality and related issues
- Affect
  - Identify emotions
  - Learn to tolerate
  - Learn they are fluid
  - Learn to regulate
  - Open window of tolerance but don't exceed it
  - If exceeded, dial back!!!

Window of Tolerance: Dominate Physiological Systems



Danger zone: dominance of sympathetic nervous system

Safety zone / window of tolerance: dominance of ventral vagal system

Insufficient level of arousal zone: dominance of dorsal vagal system

Van der Hart, Nijenhuis, & Steele, 2000/ den Boer & Nijenhuis, 2006

Early Stage: Psychological Components

- Grounding and stabilization skills for numbing and/or re-experiencing symptoms
- Reduce and manage hyper-arousal
- Identifying/undoing cognitive errors & distortions
- Identify and challenge dissociation: teach management
- Education and collaboration
- Life skills
  - assertiveness, problem-solving, decision-making, organization, finances

Work With The Dissociative Process

- Be actively engaged and observant
  - recognize it, don't ignore
  - ask about, comment on
  - watch for subtle "soft" signs
- Teach recognition of dissociative process/triggers
  - strategic avoidance
- Teach grounding
- Differentiate past from present
- Strengthen ego functions
  - "childmind/childthink" vs. adult self
  - adult self in charge
  - self-nurturing
  - reality testing

Work With The Dissociative Process

- Teach affect identification/modulation
- Separate feeling from taking action
- Teach alternative behaviors/ways to cope
- Utilize dissociation and "trance logic" in the interest of the patient
- "Nudge" patient to face what has been/is being avoided
  - interpretation and empathic confrontation
  - graduated exposure and processing
- Encourage unfreezing, becoming more real
  - physical and emotional
- Have limits, model being real

Grounding Skills

- Remove triggers
- Reorient to the present
  - directive voice, bring patient back
  - stress safety, soothing, comfort, what is known
- Self-awareness
  - ask for adult self-state (in DID/DDNOS)
  - talk to the whole person
- Body awareness:
  - eyes open and focused, increase brightness
  - tactile sensations, use of touch
  - breathing

Middle stage: Trauma processing, de-conditioning, resolution

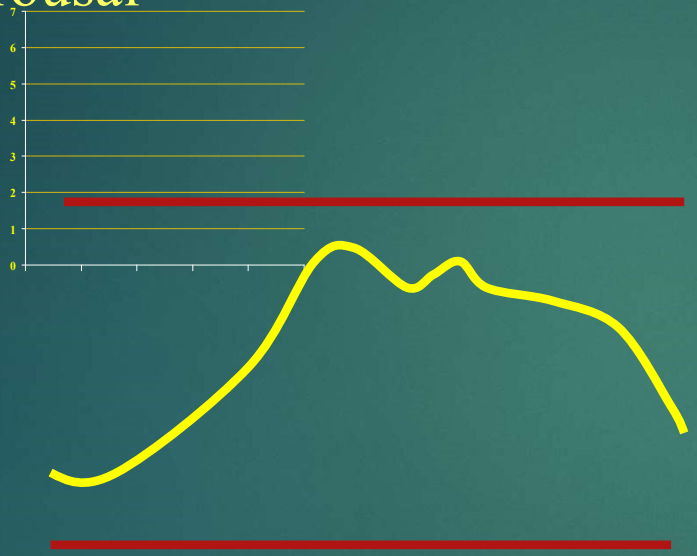
- When to move forward
- What does trauma/emotional processing mean?
  - Is it always necessary?
- Motivation enhancement
- Relapse planning
- Titration

Middle stage: Trauma processing, de-conditioning, resolution

- Revisiting and reworking the trauma
  - in the interest of resolution, not to retraumatize
  - only after stabilization skills have been learned--even with careful pacing, work is destabilizing
  - plan for possible relapse
- Graduated exposure and de-conditioning
  - careful processing of traumatic memories and emotions to de-condition them, allow integration
  - work from least to the most painful of the traumas
  - gradual, approach-avoid, controlled uncovering
  - geared to the "therapeutic window" or "affect edge"
  - with therapist's support & empathy

Window of Tolerance: Dominate physiological systems

arousal



time / exposure

Danger zone: dominance of sympathetic nervous system

Safety zone / window of tolerance: dominance of ventral vagal system

insufficient level of arousal zone: dominance of dorsal vagal system

Van der Hart, Nijenhuis, & Steele, 2000/ den Boer & Nijenhuis, 2006

Middle stage: Trauma processing, de-conditioning, resolution

- Expression of emotion and resolution of core issues/affect/cognitive distortions/schema
  - guilt, shame
  - responsibility, self-blame
  - fear, terror
  - mistrust, ambivalent attachment, and individuation
  - rage: safe expression and channeling
- Griefwork and mourning
  - past and present issues
  - foster self-compassion and self-forgiveness
- Careful attention to body reactions/responses as part of the processing

Middle stage: Trauma processing, de-conditioning, resolution

- Creating a narrative over time
  - increased understanding and resolution
  - Coherence of narrative and new meaning
- Behavioral changes indicative of resolution
- When processing is complete and memory is de-conditioned, symptoms often cease and anguish fades as trauma is integrated with other aspects of life
  - increased control & authority over memories, self
  - greater affect range and tolerance
  - improved self-esteem and capacity for attachment
  - lessening or cessation of symptoms
  - new meaning

Middle stage: Trauma processing, de-conditioning, resolution

- Collateral work
  - w/ cautions, preparation, training
    - with current family/significant others: often desirable at different stages of the treatment process
    - with family of origin/abusive others
      - mediation model: third reality (Barrett)
      - re-connection in some cases
      - alienation in others
      - the issue of forgiveness
  - Reporting and civil or criminal action

Late stage: Self and Relational Development

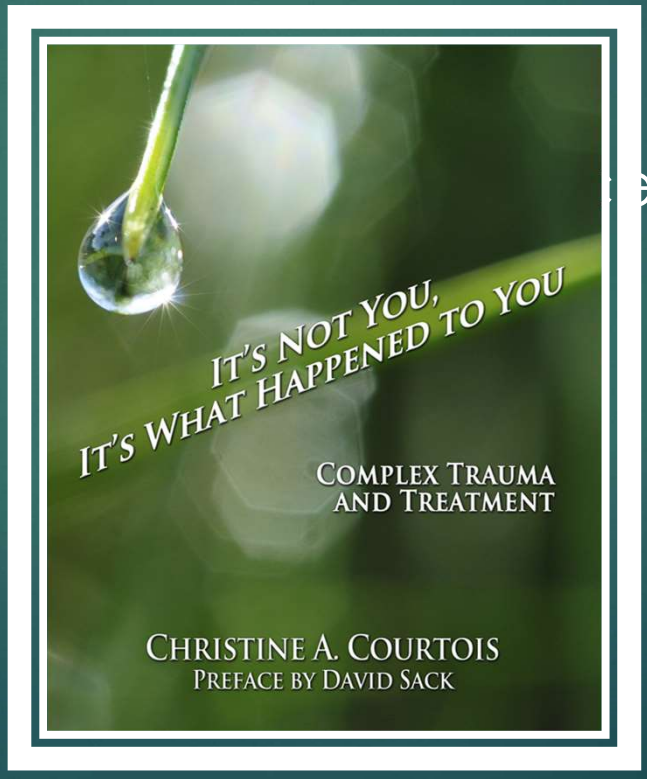
- Treatment trajectories: not everyone heals the same way and to the same degree
- Development and connection with new sense of self
- Existential crises and spirituality
- Ongoing meaning-making
  - may involve a survivor mission
- Current life stage issues
- Remission of symptoms?

Late Stage: Self and Relational Development

- Continued development of connection with others/restitutive relationships
  - intimacy
  - sexuality
  - family of origin: nuclear and extended
  - children and parenting
  - friendships
  - colleagues
- Career/vocational issues, as applicable
- Other: cyclical decompensation?

Published, October 2014

- *It's Not You, It's What Happened to You*
  - http://www.amazon.com/dp/B00OF2ADL0



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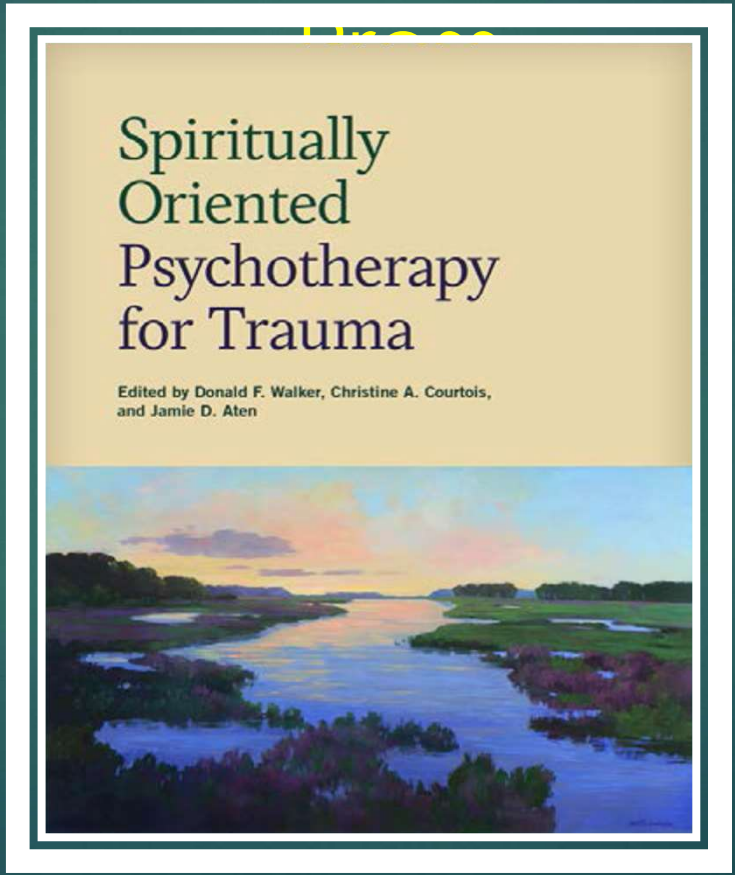

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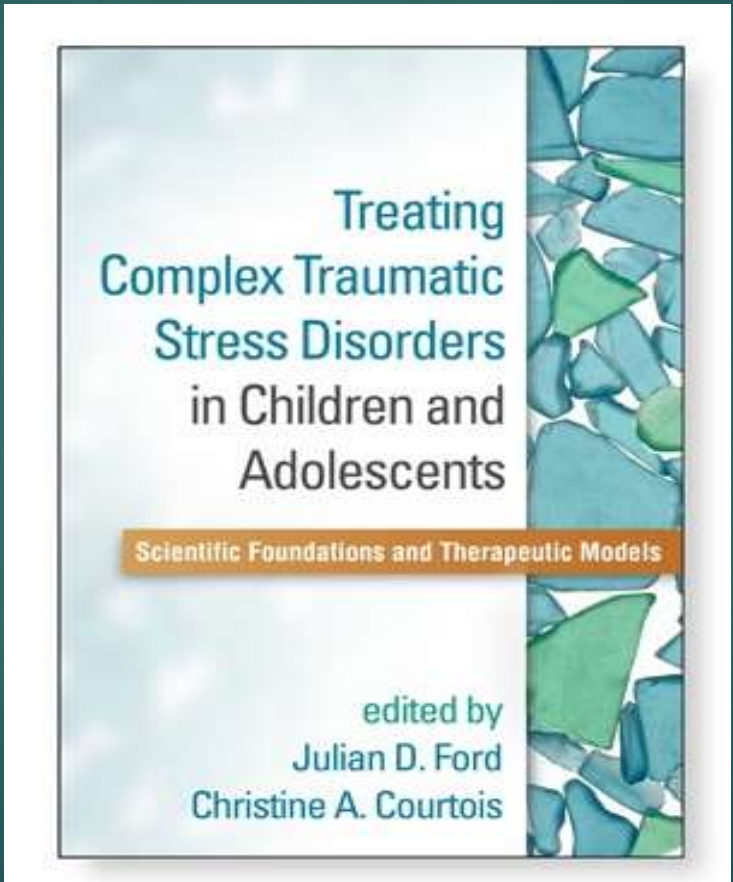

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Available Treatment Guidelines for "Classic" PTSD

- Journal of Clinical Psychiatry (2000)
- ISTSS Guidelines (Foa, Friedman, & Keane, 2000, 2011, 2018/in press)
- American Psychiatric Association (2003)
- Clinical Efficiency Support Team (CREST, Northern Ireland, 2003)
- Veterans' Administration (US DoD/VA, 2004, 2017)
- National Institute of Clinical Excellence (NICE, UK, 2005, 2017)
- Australian Phoenix Centre for Posttraumatic Mental Health (2007, 2017)
- American Psychological Association (2017)

Treatment Recommendations and Guidelines for Complex PTSD

- Courtois, 1999
- CREST, 2003
- Courtois, Ford, & Cloitre, 2009
- Australian Guidelines (Keselman & Stavropolous; , 2012; Blue Knot Foundation, 2019)
- ISTSS complex trauma expert consensus survey, Cloitre et al., 2011, *JTS*; Cloitre et al., 2012--available at ISTSS.org)
- Joint APA Division 56 and ISSTD guidelines (forthcoming)

Other Relevant Treatment Guidelines

- Dissociative Disorders
  - Adult (ISST-D, 1994, 1997, 2005, 2011)
  - Children (ISSD, 2001)
- Delayed memory issues
  - Courtois (1999; Mollon, 2004)

Resources

- ISTSS.org
  - Complex trauma treatment guidelines, 2012
- ISST-D.org
  - look for 9 month-long courses on the treatment of DD's--various locations internationally, nationally, and on-line beginning Sept-Oct
- NCPTSD.va.gov (info and links)
- NCTSN.org (child resources)
- Sidran.org (books and tapes)
- APA Div. 56: Psychological Trauma (traumadivision@apa.org)
- Child Trauma Academy.org

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