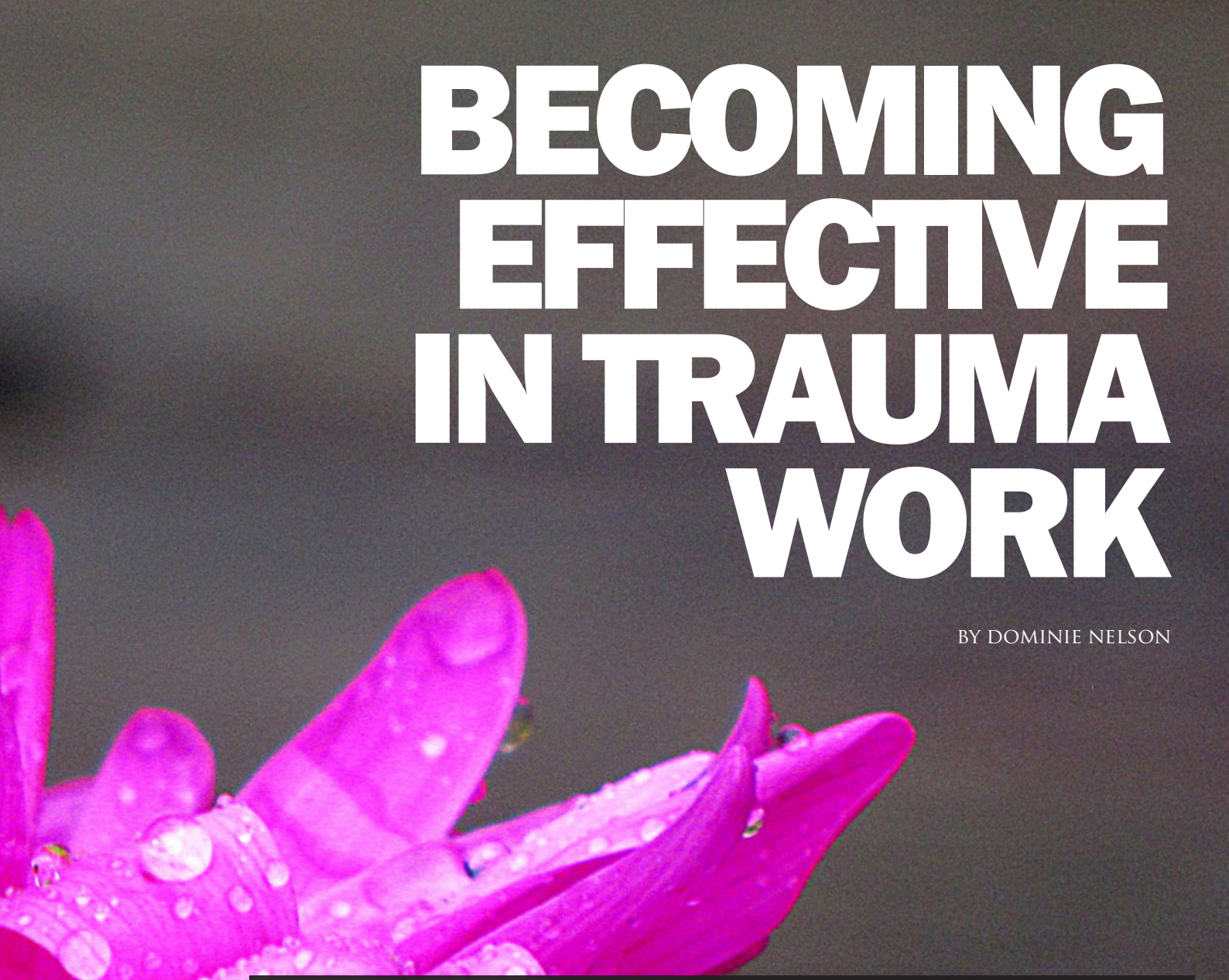
How can we be more effective in providing psychotherapy to victims of trauma?

A brief review of the ASCA guidelines.

BECOMING EFFECTIVE IN TRAUMA WORK

BY DOMINIE NELSON



INTRODUCTION

The body of knowledge connected to the recognition and understanding of the impact of Complex Trauma continues to increase in light of research and a growing body of evidence emerging from clinical practice. The ASCA guidelines are intended to facilitate adjustments in the clinical approach to treatment in order to foster improved outcomes. As culture and service delivery play a role in recovery, the guidelines consider the potential impact of current systems of care on client outcomes. The guidelines, the first in Australia, have been developed in collaboration with consumers, carers, academics, researchers and clinicians and constitute a 'living document' as knowledge continues to grow.

DEFINITIONS

Simple Trauma: an event evoking fear, horror and helplessness for example a natural disaster, traumatic accident, being the victim of or witnessing assault, abuse or violence.

Post Traumatic Stress Disorder (PTSD): where a traumatic wound occasions hyper vigilance, fragmentary intrusions of memory and avoidance as a mechanism of management of consequent hyper arousal more than one month after the traumatic event occurred.

Complex Trauma: Trauma taking place within relationship and involving recurring events which are cumulative and repetitive, such as familial violence or sexual abuse. When abuse occurs over a period of time, the child's normal development is affected. The saying 'as the twig is bent so the tree grows' conveys something of the long term effects of prolonged interpersonal abuse. The term 'developmental trauma' has been used in the literature to communicate the impact on the

child of abuse throughout a period of the lifespan. Likewise 'betrayal trauma' captures the essence of the cumulative impact of intentional, premeditated and multiple abusive episodes which may occur over many years and involve a care giver from whom the child may ordinarily expect protection. The term 'complex trauma' intends to convey a more accurate impression of the consequences of multiple traumatic stressor exposures and experiences, along with severe disturbances in primary caregiving relationships'.[1]

Best Practice: Trauma informed practice and service delivery includes adopting, adapting or developing a treatment frame which provides a comprehensive and phased approach to trauma work, the focus of which is integration. The trauma-informed practitioner will possess an overall understanding of the effects and implications of trauma, be conversant with the separate and yet overlapping phases of trauma processing[2], and have knowledge of neuroscience and the purpose and value of integrative treatment[3]. Optimally therapists will be conversant with a range of theories and understand the value of the different theories to an integrated treatment approach. Within this understanding the uniqueness of the individual (both client and counsellor) together with well-boundaried yet flexible treatment is acknowledged. At all times the relationship between counsellor and client is central being both the vehicle and means of recovery and the crucible in which transformation and change occurs.

UNDERSTANDING THE IMPACT OF COMPLEX TRAUMA:

Understanding the multiple effects of trauma must include acknowledging the interplay between relational risk, profound and significant neurological changes and intrapersonal effects including differences in the way the individual views themselves from those who have not encountered betrayal and attachment disruption. Trauma responses were initially adaptive or helpful for survival or attachment in the traumatic environment but now interfere with life and relationships. Symptoms can be understood as coping mechanisms that have become unhelpful or have outlived their usefulness. The best that a child can do, for example to manage intense emotions is different to the range of options an adult can access. A child's primary focus may be on maintaining attachment to the perpetrator (if a caregiver), an adult is no longer dependent in the same way and survival does not depend on caregivers. The survivor of complex trauma is likely to have an attachment style that is insecure rather than secure. The therapeutic relationship provides opportunity for clients to learn secure attachment and therefore adjust from ambivalent, avoidant or disorganized attachment to earned-secure.

WE WORK WITH INDIVIDUALS:

Expect to work with a variety of client responses including a sense of shame which may not be readily apparent. Shame is generated through a shift in understanding which may be deliberately fostered by perpetrator or caregivers, so that the abuse becomes not what was done to me but about my wrongness, badness, fault or culpability. Shame grows when the client develops a sense of stigma – often involving shame about coping mechanisms or inability to understand or regulate emotions. Shame creates a sense of isolation; clients may be unable to draw upon relationships to regain self-integrity.[4] Shame affects culture and therefore the ways in which we interact. [5]

Personal solutions to the many dilemmas created for the complex trauma client convert over time into adult health problems. [6]Trauma changes the brain and reduces the capacity to integrate information and to manage emotions. In addition, trauma affects the capacity of the brain to learn and make sense of information by disrupting neurological links and affecting the brain itself. The psychobiology of trauma is explained in terms of brain impact and neurotransmitter process. Survival is given priority over learning. [7] Unresolved trauma becomes "a central reality around which profound neurobiological adaptations occur". [8]

SAFETY AND TRUST:

The importance of safety cannot be overstated, working with complex trauma means attending to matters of external safety, interpersonal safety and internal safety as the client encounters multiple triggers during all phases of treatment. Without safety therapy cannot proceed effectively. Since survivors have had trust betrayed, boundaries violated and have often been rendered voiceless and powerless, safety as a concept and reality must be taught, modeled and experienced multiple times before it is understood and incorporated into daily practice. For example, some survivors may have at best a rudimentary awareness of interpersonal safety, their sense of 'normal' having been severely compromised. [9] Clients may be in ongoing abusive, manipulative or violent relationships. There may be children currently at risk in unsafe home environments. External safety and stabilization is therefore an essential early phase of counselling. [10] Attention

1 ASCA guidelines p.47

2 ASCA p. 70. For an example of a phased treatment approach see Ross and Halpern (2009).

3 References useful for an understanding of an integrative approach and the findings from neuroscience are included in the bibliography.

4 Brene Brown's publications on fear, shame and vulnerability explain the concept of shame, and explain some processes for building shame resilience.

5 The extent to which shame constitutes part of the national identity of Australians, and the many ways in which this affects social policy and institutions is an interesting question to ponder.

6 ACE, the Adverse Childhood Experiences scale is a longitudinal study which indicates that adverse circumstances in childhood and the personal solutions individuals develop as coping mechanisms contribute significantly to mental health problems over the lifespan.

7 The Learning Brain (or see bibliography for relevant literature).

8 ASCA Guidelines p.xxxi.

9 Ursula Benstead's "The Shark Cage" metaphor provides a useful conceptualization of safety in relationships.

10 Maslow's Heirarchy of Needs indicates the essential nature of safety prior to undertaking other tasks.

must be paid to secure and safe housing, sufficient income to provide food and other daily essentials and physical health is also important. A multi-disciplinary team provides essential support for the survivor.

Internal safety means the survivor has sufficient resources to manage emotional triggering when it occurs. Briere [11]refers to "titrating exposure", meaning ensuring the survivor is not overwhelmed by exposure to traumatic triggers or reminders. Early focus may include work on the skills of emotional regulation.[12]Exposing clients to emotions without sufficient means of regulation overwhelms coping capacity or evokes past (unhelpful) ways of coping. Complex trauma inevitably overrides the interpersonal boundaries of the survivor and much time and emphasis is directed to the issue of sound boundaries.[13] In working with client physical and emotional safety, consider the following questions:

WHAT MIGHT SAFETY LOOK LIKE FROM THIS CLIENT'S PERSPECTIVE?

Does this client have responsibility for minor children who may be at risk?[14]

What are the priorities?
What are the risk factors for this client?
Who can help support this client?
What can you see that this client cannot?
How can you communicate interpersonal safety to this client?
What strengths, assets or resources does this client have and how can these be used?

Be conversant with all aspects of safety and explore issues of safety with your client, updating information as required. Anticipate stressful times and regularly update positive coping strategies including where possible social and multi-disciplinary supports.

BEST PRACTICE: RESPONSIBLE ECLECTICISM:

A 'responsibly eclectic' approach to working with survivors of Complex Trauma is suggested in light of the multiple needs of survivors. Attachment, emotional education and regulation, family systems, body work, and theories encouraging artistic expression can all be helpful. Fundamental to successful outcomes is the necessity of facilitating whole-brain integration, therefore a working knowledge of neuroscience as a basis for integrative work is justifiable. As the final stage of counselling includes grieving losses a working knowledge of grief and loss can be helpful.

11 John Briere, Essentials of Trauma Counselling

12 Marsha Linehan,

13 ASCA Guidelines p.xii.

14 The concept of intergenerational trauma provides new thinking on the risks of trauma to a family system.

ILLUSTRATING BEST PRACTICE: TINA, A CASE STUDY:

Tina is a single woman aged 40 working as an optical technician. The third child and only daughter of a semi-professional married couple, Tina describes her family as having traditional values, and her parents as being distant as a couple but seeming satisfied with their marriage. Growing up Tina felt a sense of isolation, describing her parents as "preferring my brothers". Tina's mother returned to work when Tina commenced schooling; both parents worked long hours but expressed confidence that Tina would be ok at home without their presence as long as she was" a good girl" for her brothers. Tina left home at 18 to attend university and has supported herself since that time. She sees her family at Christmas, but describes her relationship with them as "superficial".

From the age of four Tina recalls times when her brothers experimented sexually with her. By the age of six the experimentation included several of her brothers' friends. Tina describes vivid memories of being restrained and used sexually. She has memories of "the big boys" hurting and tormenting her. Tina recollects seeing her brothers and her father viewing pornography on the home computer. She also recalls parties held at her parents' home, and remembers times when someone would enter her room pull down the bedclothes and climb into bed with her. She doesn't know when that happened, and thinks it may have happened "a few times". When she tried to tell her mother about what was happening her mother's response was to criticize her daughter for "being rude and untruthful", and to emphasize that "good girls didn't lead boys on". Her father's constant advice was to 'toughen up princess'. Tina did not feel it advisable to tell him what was happening to her.

Tina has come to counselling to manage anxiety which began following a minor medical procedure requiring anaesthesia. She has difficulty sleeping and soothes herself by taking warm baths, sometimes four or five times a night. She has recently spent over a thousand dollars installing extra locks on her doors and windows, and can only sleep at night with the light on.

SAFETY

From the start I experienced Tina [15]as a polite and articulate client who was explicit about what she felt would help. Very much in control of her therapy, she developed little rituals around entry, seating, lighting and the order of business for the session, which followed an unvarying pattern week by week. A small deviation from routine would bring reactions of impatience, frustration and at times anger and accusation. After one session when I had attempted to bring something to Tina's attention, she stopped, frozen, and in a 'little girl' voice, asked if she could 'go home now, please'.

Safety for Tina revolved around consistency and control. Small

15 Details have been changed to protect client confidentiality.

deviations from what was familiar overloaded her already hyper-aroused system and caused the outbursts which brought me back into (her) line. Until sufficient internal safety was developed, controlling her environment was the best she could do to manage emotionally. Using observation and taking what I observed during sessions into supervision helped me to recognize that for Tina, safety was a vital issue. Although familiar with many details of what had occurred during the abuse, she could not tolerate in the earlier stages of therapy any question or comment that might draw attention to something not yet fully in awareness. I also recognized that the stronger responses (anger, blaming) happened when Tina perceived our relationship was under threat. This happened most frequently when I expressed an idea that was not congruent with her perspective, or when I made a suggestion about the session that took us away from the familiar routine. Thus for many sessions psychoeducation, questions or altering the order or time frame of a session was out of the question.

My personal dictum of 'do no harm' became the mantra by which I sustained myself, and therapy seemed stalled and had seemed so from the first few sessions. As session followed session however I noticed that Tina made fewer negative attributions about my behavior and became more able to tolerate minor disruptions to routine. As she became more settled and began to manage the hyper arousal she could tolerate and receive information into her system. Safety was her priority and needed to be mine and I communicated interpersonal safety by accepting her need for control and remaining supportive, consistent, emotionally validating and available. I still think it would have been helpful for Tina to learn to stop and breathe (intervention to manage arousal) but this suggestion compromised safety for Tina. We did it her way.

ATTACHMENT

Although Tina arrived with the intelligence, aplomb and need for respect of an adult woman, she quickly demonstrated unmet needs of a much younger life stage. This was presented together with an adequate emotional vocabulary and sensory awareness paired with little emotional control. I found it an intriguing if somewhat confusing combination which presented challenges in working with Tina. Together we explored ways of meeting her needs that did not compromise my ethical and professional principles. A courageous and determined woman Tina went full tilt into processing the horrors of her childhood. My job became one of helping her to titrate or slow down exposure to the memories and to provide comfort and support when her desire to push on overcame her ability to regulate. At times of external stress we increased therapy sessions until she learned that she could set boundaries with work, relationships and with herself.

Tina learned as we worked the quality and skills of self compassion. A significant accelerator of both stress and shame was her perception of herself as being capable of being all things to all people and of managing a considerable workload on top of the hard work of therapy. While I believe that therapy should never so destabilize a client that daily life becomes difficult, Tina's strength and drive to recover made it necessary to slow her down, gently and consistently. As she learned to 'apply the brakes' in her external life she was more able to tolerate a slower processing pace in therapy. As well as providing a safe place, I became Tina's emotional coach as she slowly became aware of a range of emotions underlying the fear and shame that had become very familiar to her.

Attachment theory understands that there is no such thing as a child in isolation – there is always a mother and a child. Working with Tina and acting as a 'good enough' parent caused me to confront fears and feelings within myself – fears of inadequacy and doing harm, ("if I was any good as a therapist she'd be better by now") feelings of anger when I perceived I was being controlled by her, feelings of frustration and impatience at the slow pace of therapy ("if she'd only listen, we'd make better progress"). Through relationship God grows both of His children, not just the one who comes for therapy.

NEUROSCIENCE: DISSOCIATION

Tina's intriguing blend of ability and disability in the emotional realm is best understood through the lens of neuroscience. One of Tina's defenses had been dissociation, whereby the normally integrated processes of thinking, feeling and being had been disrupted by the painful, ongoing and traumatic abuse suffered throughout her childhood. Dissociation has been termed "the escape when there is no escape", Tina had literally "escaped" internally and separated the pain, emotions and memories. When reminders of the abuse "popped up" in daily life unintegrated sensory experience intruded. These experiences resulted in a flood of emotion which had little connection to immediate events. There were many triggers in our relationship as well as those related more specifically to the abuse. If I appeared offhand or dismissive of her experience Tina would react with anger disconnected from the source of the feeling – her mother's dismissive responses. If I appeared critical of her, memories of her father would be evoked. And of course there were the mistakes I made along the way, for which I learned to offer a sincere apology, and from which she learned that therapists are not perfect.

PUTTING IT TOGETHER:

The counselling relationship provides a new experience of attachment for the client. Attachment involves the provision of a safe and secure space for processing past and present experience and is significant in emotional management. Attachment and emotional regulation begins early in the counselling process and requires ongoing attention as counselling unfolds. The clinician becomes an attachment figure offering security and safety through attentiveness, empathy and attunement. Secure attachment forms a basis for emotional regulation, of great relevance when the processing of memories (suggested as the second stage of trauma work) commences. Emotional intelligence which encompasses abilities to attune to, name and thoughtfully respond to emotional signals within the body is fostered within the attachment relationship which provides opportunity for

corrective experience and learning. Survivors of complex trauma may have a limited capacity to 'name and tame' feelings as a result of inadequate attachment to parents or parent figures. The separation of somatic, mental and emotional experience (emotional dissociation) occurs to the extent that no sense can be made of emotions which are reacted rather than responded to. As counselling unfolds, a team approach may be needed to meet the diverse range of needs of the trauma survivor. Therapies which facilitate whole-brain integration can be added over time. Counselling for complex trauma requires time as the problems and survival solutions generated by the survivor remit slowly, with patience, time and care.

Dominie Nelson. Clinical counsellor. Goodwood, SA. Editor, Counselling Connections Across Australia. Dominie is a clinical counsellor in private practice and works from Life Design Counselling in Goodwood, South Australia. To balance her professional life, Dominie lectures in Adolescent Wellbeing at Tabor Adelaide where she also supervises counsellors in the Post Graduate program. She also lectures in Trauma, Grief and Loss in the postgraduate program (also at Tabor Adelaide). In her personal life Dominie enjoys travel, bush walking, family and friendships.

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