30 Years of **Trauma Therapy**

LESSONS LEARNED

HARMONY PLACE MONTEREY

Those Whose Work **Inspired Us…**

John Bowlby, Donald Winnicott, Janet Judith Herman, Mardi Horowitz, Cory Hammond, Bessel Van der Kolk, Laurie Perelman, Christine Courtois, John Briere, Jeffrey Young, Francine Shapiro, Dan Brown, Kathy Steele, Patricia Resick, Edna Foa, James Chu, Janina Fisher, John Watkins, Alan Sroufe, Diana Fosha, Dick Schwartz, Peter Fonagy, Dan Siegel, Laurel Parnell

5 **Treatment Tracks** at Harmony Place Monterey

Trauma and PTSD Treatment	• Run by Dr. Mark Schwartz Sc.D. and Lori Galperin, LCSW
Mental Health, Depression and Bipolar	• Run by Dr. Mark Schwartz Sc.D. and Lori Galperin, LSCW
Eating Disorders	• Run by Samantha Young M.Ed., LPCC
Drug and Alcohol Addiction Treatment	• Run by Leon Larimer Ph.D., FICPP
Sexual Disorders	• Run by Dr. Mark Schwartz Sc.D.

Age at Time of **Forcible Rape**

(Kilpatrick et al, 1992)

Developmental Psychopathology

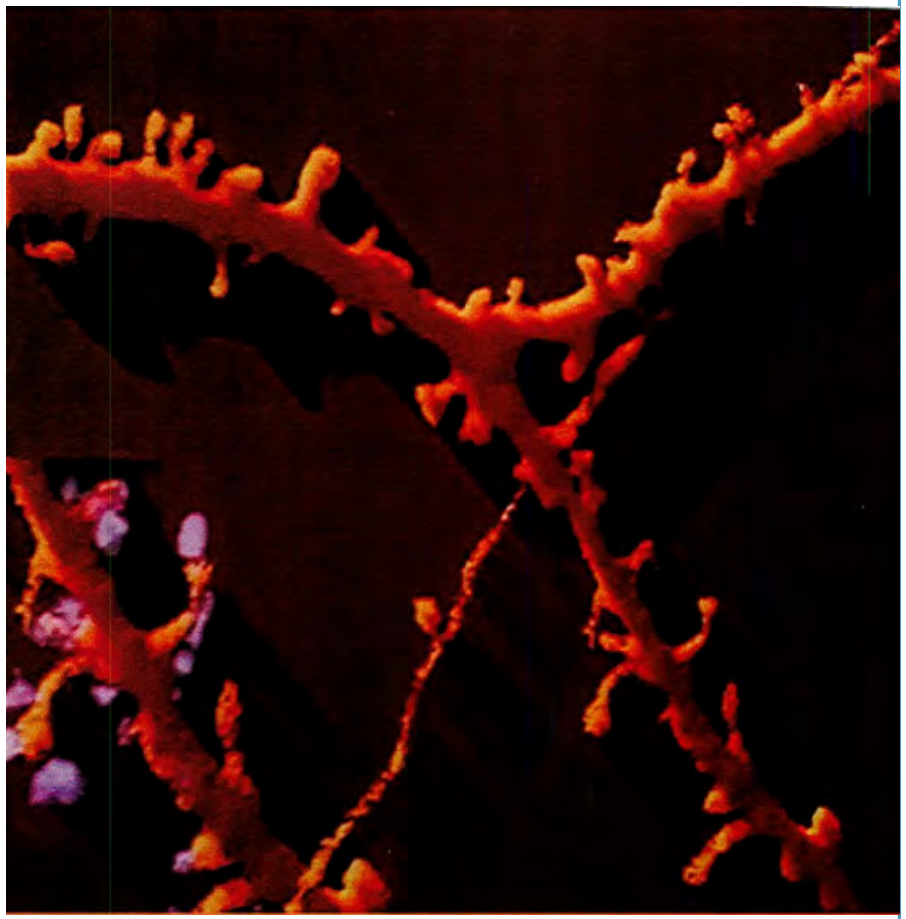
Seeks to Understand the Development Roots of Adult Disorder — experiences that leave individuals vulnerable or buffered with respect to stressful life circumstances and the capacity of individuals to draw strength from available social support

The protrusions seen here are called "memory bumps," "footprints of memory" or technically, dendritic spines.

The bumps grow when stimulated by sensory input.

Each spine measures less than 0.25 millionths of a meter.

More than 90% of excitatory synapses terminate on spines. These are actual microphotographs of dendrites places on neutral background. Glutamate receptors are plentiful on the dendritic spines.

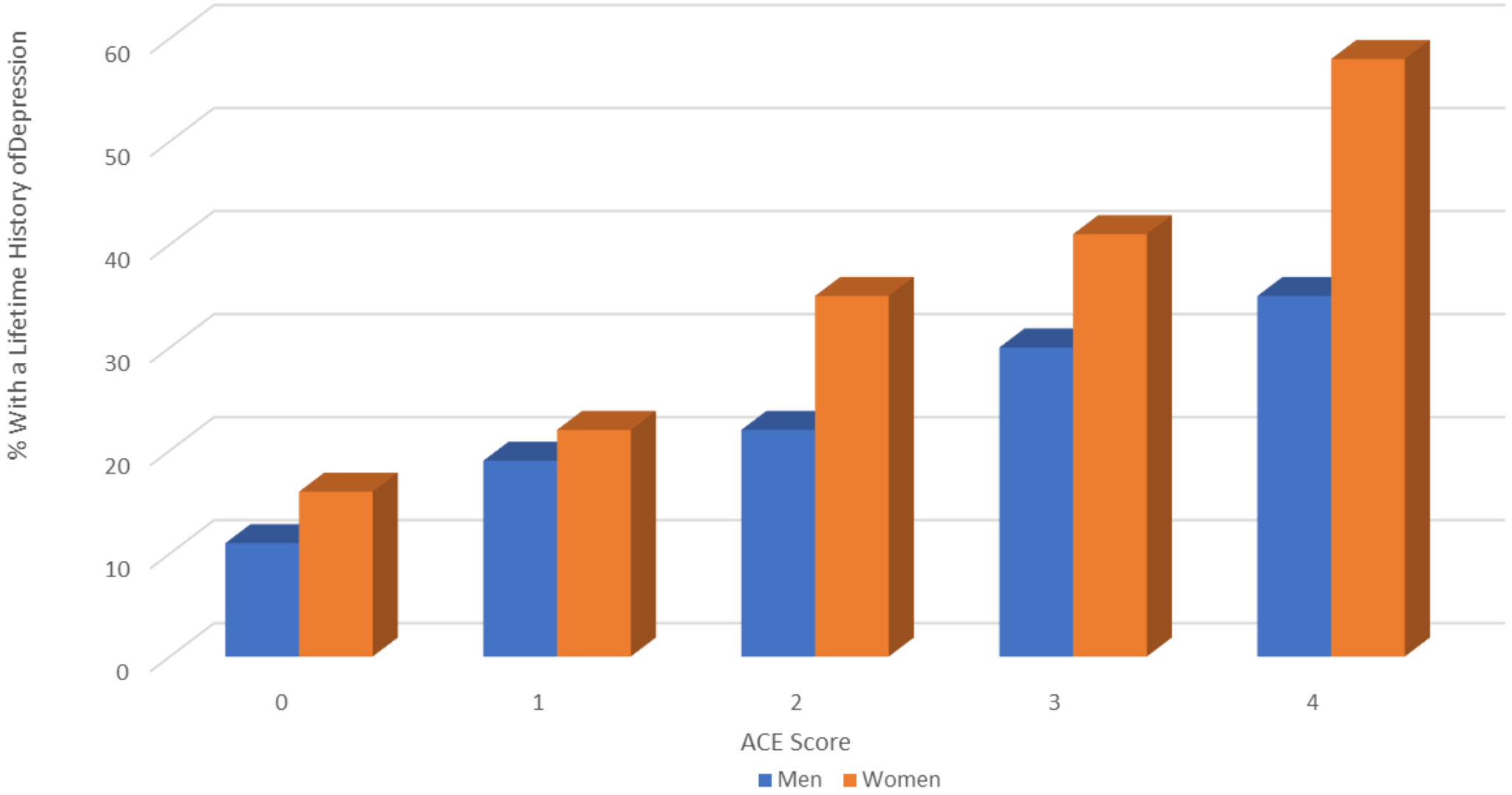


Adverse Childhood Experiences Are Common

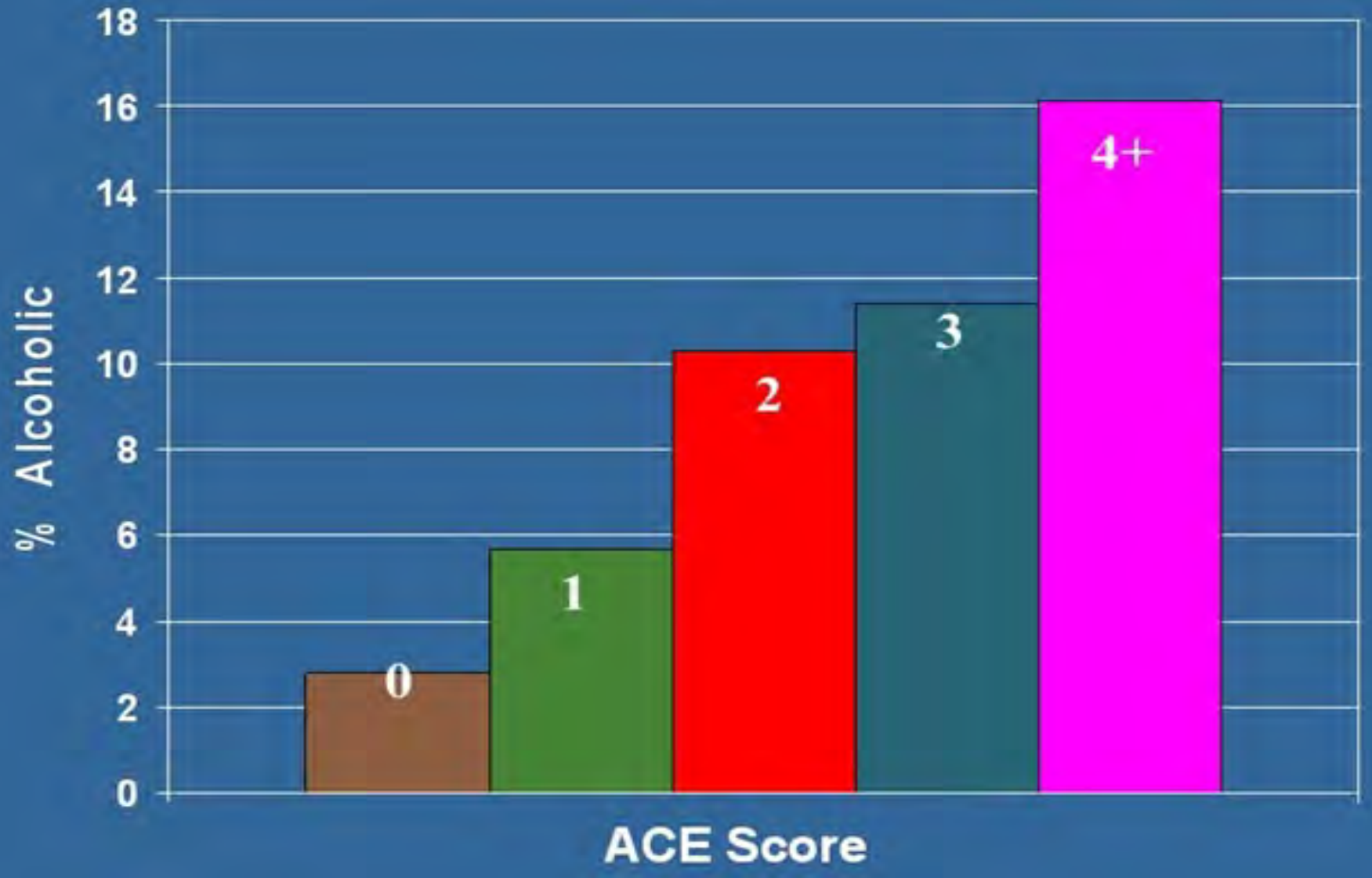
Of the 17,000 HMO Members:

- 1 in 4 were exposed to 2 categories of ACES
- 1 in 16 were exposed to 4 categories
- 22% were sexually abused as children
- 66% of the women experienced abuse, violence or family strife in childhood

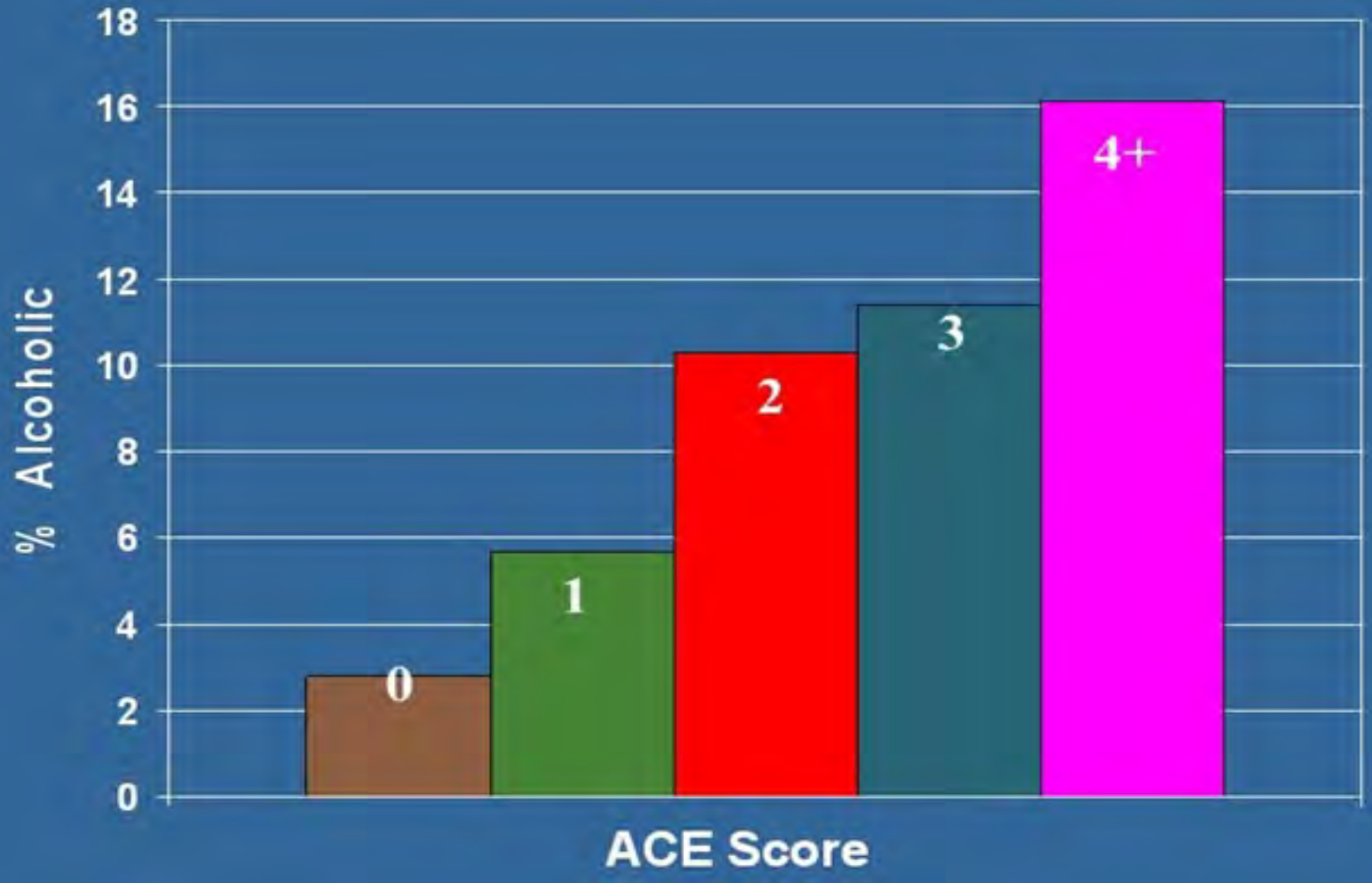
Chldhood Experiences Underlie Chronic Depression



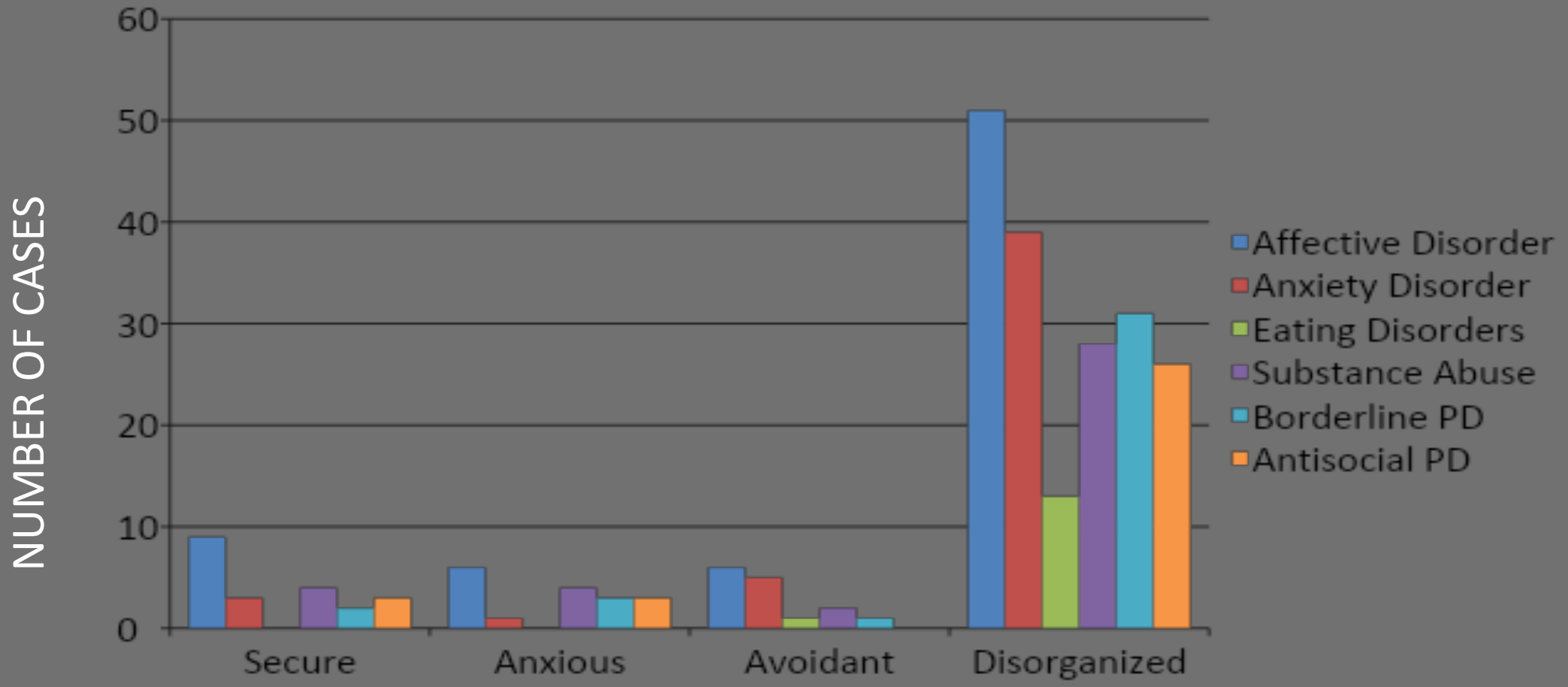
ACE and Adult Alcoholism



Childhood Experiences Underline Suicide



AAI Classification and Psychiatric Diagnoses



Penagy et al., 1995

Clinical Manifestation of Disorganized Attachment

Disorganized Internal World

- Dysregulated psycho-physiological state
- Affect dysregulation (too much or too little)
- Lapses in self-observation or monitoring
- Discontinuous self-states and affect states
- **Cognitive distortion, confusion**

Disorganized Behavior

- Impaired self-agency and goal-oriented behavior
- Inhibition of exploration and play

Clinical Manifestation of Disorganized Attachment cont...

Disorganized Behavior

- Activation of contradictory attachment strategies
- Controlling behaviors
- Submissive or excessive care-taking behavior
- "Stable instability" in relationships
- Defensive aggression and helplessness
- Inability to elicit desired responses from others

Clinical Manifestation – Disorganized Attachment

- Affect Dysregulation
- Lapses in Self-Monitoring
- Discontinuous Self and Mood States
- Dissociated "Parts"
- Impaired Self-Agency and Goal-Directed Behavior
- Inhibited Exploratory Behavior
- Contradictory Attachment Strategies
- Controlling Versus Submissive
- 'Stable instability' in Relationships
- Source of Attachment is also Source of Fear

Re-Framing the Meaning **of Symptoms**

- Start with the assumption that every symptom is a valuable piece of data!
- Use Psycho-educational material to make educated guesses about the meaning of symptoms as a symptom-memory or as a valiant attempt to cope.
- Ask her, "how would this_____ have helped you to survive in an unsafe world?" "How did it help you feel less overwhelmed? Less helpless? More hopeful?
- Look for what the symptom is still trying to accomplish: I.e., chronic suicidal feelings might offer comfort or a "bail-out plan;" cutting might help modulate arousal; social avoidance could be an attempt to avoid "danger"
- One it is clear what the symptom is trying to accomplish, then therapist and patient can look for other ways to accomplish the same goals in a context that describes the patient as an ingenious and resourceful survivor, rather than as a damaged victim.

"Trauma Survivors Have Symptoms Instead of Memories"

(Harvey, 1990)

- Chronic over-activation of the adrenaline stress-response system
- Chronic states of fear and dread
- Heightened fears of abandonment
- "Disorganized Attachment"
- Hypervigilance: Constant "looking over one's shoulder"
- Attention becomes narrowly focused on potential threat
- Overwhelming affect and arousal
- Difficulties with "stimulus discrimination"
- Impairments in self-care and self-compassion
- Distorted cognitive schemas
- Trauma results in an increased risk of victimization

Scanning

- And as I count back now from age 7 to 6, you'll be able to begin to move back safely and comfortably through the years, and now, from age 6 to 5, (just continue back and allow your mind to begin to scan, much like the tuner on a radio dial, and as you do, just look for any strong signal indicating some significant event.
- Continuing back from age 5 to 4, back through more and more years, allowing your mind to continue to scan through the years, simply looking for any particularly strong signal, then age 4 to 3, and as your mind moves toward a particularly strong signal indicating some significant event, you'll be able to focus in and talk about where you are and what's happening. You'll be able to stay with that event as long as you want, and then, move on to the next strong signal.
- And now, from age 3 to 2 (pause) and 2 (short pause) to age 1. Just allow your mind to move toward some significant event and as you focus in, just talk about where you are and what you're aware of.

Abreaction with **Sexual Abuse Survivors**

(Hunter, 1991)

Abreaction is revivification of past memory with release of bound emotion and recovery of repressed or dissociated aspects of a remembered event.

Abreaction provides a psychic reworking of the trauma that identifies, releases, and assimilates unresolved aspects of the abuse, allowing resolution and integration on both psychological and physiological levels.

Why **do Clients Want** "A Witness?"

- A cornerstone of trauma treatment for decades has been the telling of the story to "a witness." But telling "what happened" is not just driven by the need to be "witnessed."
- Human beings want to be heard when they are frightened distressed, angry, hurt, or lonely because they want someone to "**do something"** to shift their state.
- The animal defense of a "cry for help" is an instinctive response for children and other venerable beings. Therefore, "**wanting to be heard**" in the treatment of trauma **is a feeling memory of the longing to be helped**, not just a longing to be acknowledged.

Information Reprocessing Model

- When information is not processed adequately, intrusive recollections, flashbacks, and nightmares are likely to occur.
- These Intrusive symptoms are associated with strong affective responses, which then lead to escape and avoidance behavior, such as avoiding situations that remind her of the event.

"Talking About" versus "Processing" Memory

- "**Talking about what happened**" (i.e., accessing narrative memory) **does not process or metabolize the memories.** What it does is establishes a context for the symptoms, validates the suffering, and increases self-compassion
- And because **narrative re-telling** activates implicit memories (emotions, body sensations, autonomic arousal), it **risks autonomic dysregulation** and **re-traumatization.**
- "**Processing**" **memories refers to interventions that transform or digest the experience** in some way and **do not always include attention to the narrative.** In processing, we seek interventions that promote a sense of mastery, even if they elicit strong emotions.

Trauma Resolution — **How Trauma Gets Played Out,** Day After Day

(Resick, 1996)

1. How am I avoiding remembering?
2. How am I avoiding feeling?
3. How am I avoiding talking about it?
4. How am I minimizing?
5. How am I avoiding focusing on enjoying parts of life?
6. How am I avoiding noticing triggers that cause me to hurt self?
7. How am I avoiding dealing with current life stressors?
8. How am I still protecting those who hurt me?
9. How am I avoiding being close to others?
10. What secrets have I not yet discussed?
11. How am I fighting my therapist and not working my program?

Examples of **Stuck Points**

- If I had done my job better, then other people would have survived. (assimilated)
- Other people were killed because I messed up. (assimilated)
- Because I did not tell anyone, I am to blame for the abuse. (assimilated)
- Because I did not fight against my attacker, the abuse is my fault. (assimilated)
- I should have known he would hurt me. (assimilated)
- It is my fault the accident happened. (assimilated)
- If I had been paying attention, no one would have died. (assimilated)
- If I hadn't been drinking, it would not have happened. (assimilated)
- I don't deserve to live when other people lost their lives. (assimilated)
- If I let other people get close to me, I'll get hurt again. (assimilated)

Examples of **Stuck Points** cont.

- Expressing any emotion means I will lose control of myself. (assimilated)
- I must be on guard at all times. (assimilated)
- I should be able to protect others. (over-accommodated)
- I must control everything that happens to me. (over-accommodated)
- Mistakes are intolerable and cause serious harm or death. (over-accommodated)
- No one can understand me. (over-accommodated)
- If I let myself think about what has happened, I will never get it out of my mind. (over-accommodated)
- I must respond to all threats with force. (over-accommodated)
- I will go to Hell because of the things I have done. (over-accommodated)
- I am unlovable. (over-accommodated)

Integration versus **Dissociation**

Pathological Dissociation, which can most often be traced to Disorganized Attachment in infancy, represents a profound distortion of core self-processes, such that development progresses towards greater complexity, without complementing integration. The result can be internalizing a sense of defectiveness, self-criticism, and hostility to protect the idealized image of the caregiver. When dissociation prevails, there is fragmentation of self.

***Vulnerability to* dissociative coping mechanisms** is more likely in the absence of experiences of reliable support and self-efficacy. Dissociative processes interfere with the formation of a personal narrative and verbal exchange, undermining the integration of traumatic events with other experiences.

If ego states are split off, projected, rejected, indulged or otherwise unassimilated, they become black holes that absorb fear and create the defensive posture of the isolated self, unable to make satisfying contact with one's self or others. When split-off ego states are made conscious, accepted and tolerated, and then integrated, the self can be at one, and compassion can be released.

Schema of **Self**

He emphasized the value of the alternative, psychological approach, which explains post-traumatic symptomatology as a consequence of the shattering of schemata concerning the self and the world.

Trauma disrupts the meaningful organization of like experience, thereby exerting a debilitating effect on self-perception and the ability to face the future.

(Shay, 1995)

Self-Healing

The therapist is no longer the “healer” but more the “mid-wife,” facilitating the birth of that which already exists inside the client, waiting to be born.

Parts

- Sub-personalities are aspects of our personality that interact internally in patterns that are similar to the ways that people interact in human systems.
- **We all have parts** (think of your playful part, your organized part, shy part etc..)
- All parts are valuable and have good intentions. Even though the behaviors might appear to be destructive, they are intended to protect the individual.
- In response to life experiences, parts can become extreme and destructive, obscuring the leadership of the Self.
- People who have undergone severe trauma typically have more discrete, polarized parts.

Burdens

The concept of "burdens" is brilliant in its widespread application. It side-steps the need to compare or count symptoms to diagnose, and postulates instead, more of a "no one escapes unscathed" framework.

Thus, "burdens" can encompass beliefs, feelings, and the energetic residue of events and experiences that overwhelmed the internal and/or externally accessible resources of the organism and its attachment environment at the time, thereby, creating constraint.

Techniques and **Processes** Involved in **Trauma Work**

- Writing a trauma narrative
- Drawing the trauma
- Sharing the trauma narrative and moving toward — drawing in — supportive people
- Challenging cognitive distortions
- Challenging shame and embarrassment
- Desensitization techniques
- Eye Movement Desensitization and Reprocessing (EMDR)
- Exposure — expressive therapies; anger work
- Personification and confrontation
- Explore pre-morbid history and functioning
- Acceptance and "coming to terms" with existential issues

Therapy involves helping the client reclaim the parts of self that were sacrificed to gain safety. In therapy, we create a context and relationship where pain, anger, and difficulty can be safely acknowledged, while maintaining a connection.

Model of Treatment

1. Stabilize dissociation: safety, grounding, containment skills.
2. Stabilizing out-of-control behavior and affect. Create balanced lifestyle. Regulate eating, sleeping, and exercise.
3. Affect regulation tools.
4. Therapy-interfering behavior, relationships-interfering behavior, life-interfering behavior.

Model of **Treatment** cont...

5. Contextualize and examine developmental events, family of origin, original attributions. Redefine symptoms as survival and coping strategies.
6. Challenge cognitive distortions.
7. Identify disowned parts of self: body, gender, sex, child, etc. Build self-empathy and self-acceptance.
8. Target specific, remembered traumatic events or key episodes creating core schema.

Model of **Treatment** cont...

9. Affect bridges, cognitive bridges, move back from identified symptoms and toward the symptom's origins.
10. Reliving around specific events, exposure and information reprocessing, mastery and completion.
11. Identifying stuck points and therapy-interfering behavior, denial and minimization.
12. Integrative internal work.
13. Expressive therapies for cognitive-affective mastery and schema change.

Model of **Treatment** cont...

14. Use therapeutic relationships for corrective experience, transference, and counter-transference to help client look at current manifestations in a non-shaming manner.
15. Establishing new skills missed developmentally, including skills for intimacy, social interaction, learning, self-definition, self-esteem, mastery through rehearsal.
16. Bring unconscious reenactments into consciousness, confronting directly those who victimized or injured.
17. Work with relations and repair sexual arousal and sexual behavior.

30 Years of Trauma Therapy

LESSONS LEARNED

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