Phases of trauma treatment

- 1. Symptom reduction and stabilization.
- 2. Reprocessing traumatic memories.
- 3. Personality integration.
“Trauma as a disorder of non-realization.”

• “The core issue of trauma is that survivors have been unable to realize fully what has happened to them and how it affects their lives and who they are...the inability to realize involves many ways of not knowing...chronically traumatized individuals often have difficulties with realization not only in regard to their traumatic experiences, but also daily life...” Van der Hart et al
  – Chronic and automatic avoidance.
Phases of treatment from perspective of overcoming “phobias” that foster avoidance

- Phase one: Symptom reduction and stabilization is about overcoming phobias of attachment and attachment loss.
- Phase two: Reprocessing traumatic memories is about overcoming phobias related to the traumatic memories.
- Phase three: Personality integration involves overcoming phobias of normal, healthy life, health risk taking, change, and intimacy.
Phase one: overcoming attachment related phobias.

• Setting the treatment frame.
  – Set of relational guidelines and beliefs that define the role and degree of involvement of therapist and client in treatment.
  – Provides structure, safety and clarity about expectations for the relationship.
  – Inconsistency, unpredictability, and uncertainty are major threats to survivors.
  – Need security, support, and adaptive limits to feel safe.
Window of affective tolerance

- **Hyper**: Tolerance for high level affects such as fear, anger, as well as positive emotions such as excitement and joy.
  - Expand

- **ANS**: original capacity

- **Hypo**: Tolerance of low level affects including shame, sadness, despair, hopelessness.
  - Expand

**Goals**
1. Raise threshold.
2. Decrease intensity.
3. Quicken return to baseline.
Phase one: overcoming attachment related phobias

• Initial phobia of contact with therapist.
• First obstacle in therapy.
  – Fear of being close to and then losing another human being.
  – Fear of being engulfed by another and losing all autonomy and control.
  – Fear of being ridiculed, rejected, or abandoned in the face of strong needs for support, acceptance and reassurance.
Phase one: overcoming attachment related phobias

- Maladaptive conscious and unconscious “if-then” reflexive beliefs.
  - “If she really knew me then she would despise me.”
- Have never associated human attachment with an internal sense of felt security, but instead it signals emotional and physical pain.
- Conditioned negative self evaluation (shame) inhibits positive connection.
  - “I am inherently weak, flawed, disgusting, and therapist is inherently useless and dangerous.”
Phase one interventions for attachment phobia

- Do not press for attachment, but rather provide consistent and predictable (not constant) availability.
- Gently approach talking about the therapeutic relationship to surface cognitive distortions.
- Empathetic attunement.
  - Consistent empathy with client’s experience of self and others, aimed at decreasing chronic defensive responses.
  - Educate about attachment.
Phase one interventions for attachment phobia

• Recognize and gently challenge reflexive beliefs (conditioned defenses) about attachment.
  – “Getting close always hurts.”
  – “Needing others is pathetic.”
  – “People just want to use you.”

• Use different perspective e.g. “If a child said that, how would you respond?”
  – Utilize basic CBT techniques.
    • Cost-benefit analysis, vertical descent.
Phase one interventions for attachment phobia

• Identify negative evaluative conditioning that provokes client’s fear of rejection, criticism, or humiliation (core beliefs).
  – “I am bad, worthless.”
  – “I am disgusting, stupid, shameful.”
  – Watch for somatic reflections of shame enactments, particularly if you display empathy.
• Withdrawal and self attack or other attack.
Phase one interventions for attachment phobia

- Discuss perceived short-term advantages of minimal attachment, or attachment avoidance in order to empathize with the resistance.
- Gradually suggest long-term difficulties, like loneliness, lack of support, inability to get emotional needs met.
Phase one interventions for attachment phobia

• Discuss the limitations of consistency, predictability, availability, and the fact that therapist make mistakes.

• Discuss client’s fears of being abandoned without offering unrealistic reassurance, or promising to “always be there, never leave etc.”

• Do not create your own expection that you can “make up” for the attachment loss the client has suffered.
Phase one interventions for attachment phobia

• Survivor, phobic of attachment loss and abandonment, will maximize actions that pull for inappropriate dependence and enmeshment.
  – Attachment distress involves panic, and survivor may exhibit excessive focus on internal distress states, with frantic pursuit of relief.
  – Maladaptive dependency needs will lead to more desperation and hopelessness.

• Goal at this point is to learn to appropriately rely on therapist, but to develop more of own adaptive strategies.
Phase one: overcoming phobia of “mental actions”

- Janet labeled what we feel, think, wish, need, sense, as “mental actions” because they play an essential role in adaptive functioning and guide behavior.
- Adaptive actions are predicated on our capacity to perceive mental actions accurately.
- Survivors persistently avoid or strongly inhibit mental actions thus eliminating sources of information.
- Develop strategies to avoid trauma associated mental actions, and develop substitute beliefs to perpetuate that avoidance, such as “feelings are bad,” “I am weak,” etc.
Phase one: overcoming phobia of mental actions

• Working with trauma derived mental actions must be preceded by client learning to:
  – Use the therapeutic relationship as a regulator of affect.
  – Development of client’s own regulatory skills and resources.
  – Gradual exposure to the avoided adaptive mental actions, with regulation of anxiety, and prevention of avoidant or substitute mental actions.
• Staying in window of tolerance and using reflective skills.
Phase one: overcoming phobia of mental actions

• Psychoeducation and skills training.
  – breathing, calm scene, techniques for regulating affect.
  – basic trauma information, particularly working with trauma responses and “window of tolerance.”
  – orienting and defensive responses.
  – develop capacity for “theory of mind” by drawing attention to inner experience in moment, labeling it, observing it and understanding it.
  – start with current life related responses.
Overcoming phobia of mental actions

• References for stabilization skills.
  – Treating Survivors of Childhood Abuse, Cloitre, Cohen, Koenen.
  – Seeking Safety, Najavits.
  – Inner Strengths, Frederick and McNeal.
  – Affect Regulation Toolbox, Daitch.
  – Treating Traumatic Stress in Children And Adolescents: How to Foster Resilience though Attachment, Self-Regulation, and Competency. Blaustein and Kinniburgh
Phase one: overcoming phobia of mental actions

- Psychoeducation
  - Develop capacity to symbolize.
    - often cannot tell the difference between feeling, fantasy, and actual behavior.
      - e.g. believe anger inevitably leads to uncontrollable rage.
    - educate that mental actions do not always end in behavioral actions.
    - *teach “reflexive verses reflective actions.”*
    - slow, descriptive language of current internal experiences.
  - mindfulness.
Phase one: overcoming phobia of mental actions

- Phobia of affect.
  - “Vehement” (Janet) emotions are not intense feelings but rather substitute actions that maintain the phobia of mental actions.
    - Overwhelming, reflexive, automatic, and often without language.
    - Typically involve inaccurate perceptions of present and catastrophic predictions of the future.
    - No reflection on what is being experienced internally or externally.
      - Often labeled “abreactions”
Phase one: overcoming phobia of mental actions

• Phobia of affect.
  – Adaptive feelings, even when intense, involve self-reflection about what is being experienced and why, and include relatively accurate perceptions and predictions based on the present. Lead to adaptive actions, and support relatively accurate accounts of internal and external experience.
Phase one: overcoming phobia of mental actions

- Phobia of affect.
  - First step in transforming “veheement” emotions is to interrupt and not encourage continued expression.
  - Slow down, become aware of current surroundings, stay in relational contact, breathe, focus on physical sensations.
  - Bring into current awareness.
  - Essential for therapist to know difference between adaptive and vehement emotions.
    - Window of tolerance.
Phase one: overcoming phobia of mental actions

• Interventions for phobia of all emotions consists of slowing down physiological hyperarousal, ground client in the present, encourage reflective awareness in order to prevent maladaptive behavioral actions.

• Provide opportunity for client to have inner experiences within context of secure attachment relationship (disparity).

• Focus on physical sensation and verbal description to regulate arousal tolerance.
Phase one: overcoming phobia of mental actions

• Working with shame responses.
  – Create awareness of shame responses and associations it is connected to.
  – Often includes a sense of internal collapse, inhibition, shrinking, hiding, gaze aversion, and sensations similar to freezing and submission.
    • usually automatic and unconscious.
  – Will involve self attack from internal voices, or other attack.
  – Lack language to talk about it.
  – Will impede progress until worked with.
Phase one: overcoming phobia of mental actions

• Overcoming phobia of thoughts.
  – Assign too much reality to thoughts, and subsequently fear they will act on what they think.
  – Must help client accept all thoughts as just that, and realize they are just part of self, not necessarily leading to action.
  – Often reflect distortions and biases related to trauma related core negative beliefs.
    • Need to gently challenge distortions.
Phase one: overcoming phobia of mental actions

• Working with phobia of needs.
  – Usually severly afraid or ashamed of own human needs for contact, caring, love, because these needs were never met adequately, or led to humiliation and abuse.
  – Psycyo-education about basic needs of all humans, to rest, play, work, love, be loved, receive support, empathy, compassion and caring.
    • Would you teach a child to be ashamed or her needs?
Phase one: overcoming phobia of mental actions

• Working with phobia of one’s body.
  – Particularly issues of shame, disgust, related to physical, sexual abuse or humiliation.
  – Phobia based on such substitute beliefs as “my body is disgusting, weak, defective.”
    • Punish it, numb out, push it to breaking point, neglect it and bodily signals.
  – Can involve disgust and shame with appearance, or aspects of body appearance.
  – Process automatic thoughts, beliefs, and how they reflect distortions.
Interventions for overcoming phobias of mental actions  (Van der Hart et al)

• Encourage client to become aware of avoidance strategies without acting on them: switching, numbing, inhibitory affects such as shame, as well as vehement emotions.
  – Focus on noticing how a particular mental action inhibits or activates certain behavioral actions.

• Identify activating affects such as excitement or joy which client has phobic response to.
  – Encourage experiencing positive mental actions being expressed without avoidance or hyperarousal.
Interventions for overcoming phobias of mental actions

• Support mindfulness so client’s mental actions in the moment can be explored and experienced safely.
• Model awareness and verbal sharing of mental actions.
• Begin graduated exposure with minor, everyday affects.
• Encourage client to experience emotions for very short periods of time and explore the experience of the affect e.g. “What is it like for you to stay with that sadness for just a bit?”
Phase two: Overcoming phobia of traumatic memory

• “Janet stated that memory ‘...is an action: essentially, it is the action of telling a story.’...not only is the subject often incapable of making the recital that we speak of as memory, but he remains confronted by a difficult situation in which he has not been able to play a satisfactory part, one to which his adaptation had been imperfect, so that he continues to make efforts at adaptation.”
  - The Dissociative Mind, Howell, E. Howell
  - DSM “reexperiencing” can be seen as attempt at natural integration of traumatic experiences,
Phase two: Stages of treating traumatic memory

1. Preparation.

Keep client well oriented, grounded and connected to you in the present.

Frame the actual memory as having a beginning, middle and end.

Therapist should know the “worse part” or “pathogenic kernel,” as well as core negative belief about self based on the traumatic experience.
Phase two: Stages of treating traumatic memory

2. **Guided synthesis**

Avoided aspects of the traumatic memory are evoked and shared.

- Exposure is guided by client’s capacity to keep intensity within tolerable levels.
  
  - Within window of tolerance.
- Often paced with relaxation and calm sequences.
- Asking for more detail deepens, paced with slowing down and appropriate distancing.
- Deconditioning the responses to the memory.
Phase two: Stages of treating traumatic memory

• 2. Guided synthesis: “pathogenic kernels”
  – Substitute beliefs must be addressed e.g. idealizing of perpetrator/caretaker and devaluation or blame of self (“My father loved me, I seduced him; I was bad, deserved it, I am stupid, incompetent, a coward”).
  – Client is tormented with these messages.
  – Therapist should indirectly challenge: “How is it at that age, that you were such a bad child? What child deserves to be treated that way, ever?”

• Help client form more adaptive beliefs.
• Your presence and responsiveness provides behavioral disparity needed to decondition the responses.
Phase two: Stages of treating traumatic memory

• 2. Guided synthesis: pathogenic kernels.
  • Most substitute beliefs are out of conscious awareness.
    – Often were statements by perpetrators during abuse, operate like malignant hypnotic suggestions, resistant to cognitive challenges alone.
      • Made when survivor was in extreme state of arousal or dissociated, (restricted field of consciousness) with no possibility of realizing they are not true in the present.
  • Guided synthesis of these statements with related affect and sensorimotor components enables client to overcome their influence.
Phase two: Stages of treating traumatic memory

- Guided synthesis: dominant trauma related affects.
  - Intense feelings of worthlessness, shame, humiliation and hopelessness related to trauma that have become pervasive and generalized.
  - Need to be reassOCIated with the trauma and processed.
    - Usually connected to core negative beliefs about self.
      - “lies” about self.
Phase two: Stages of treating traumatic memory

• Guided synthesis: trauma related submission.
  – Memory may involve having engaged in animal defenses such as total submission, fainting, or “playing dead” due to intense dorsal vagal response.
  – Will enact in reprocessing allowing “completion of the action”, in imagination and somatosensory system.
    • Leads to relief and reprocessing most malignant belief about self due to the original submission.
    • Changes how memory is encoded.
Phase two: Overcoming phobia of traumatic memory

- Guided synthesis: modulated and controlled exposure to the traumatic memory.
  - Client actively helped by therapist to remain present while simultaneously synthesizing the previously dissociated actions and contents of the traumatic memory.
  - Stitching together the cognitive, affective, sensorimotor, and behavioral components of the memory while remaining connected to the therapist, and capable of reflective responding.
Phase two: Overcoming phobia of traumatic memory

• “Guided realization:” Ongoing process of helping client to realize his/her history, grieve the inherent losses, and move toward higher levels of integration.

• With adequate synthesis, the memory no longer operates at an intrusive sensorimotor level, but synthesis alone is inadequate.

• Trauma memory must become autobiographical memory by being realized.
  – “This happened to me.” “That little boy was me.”
  – No longer triggers phobic avoidance.
Phase two: Overcoming phobia of traumatic memory

- Realization includes realizing what can now be different in the present.
  - “I don’t have to be afraid anymore.” “Don’t have to worry about making some one angry.”
- Makes an accounting of present that was shaped by past, but no longer dictated by it.
- Changes how client acts in the present.
- Encourage new thoughts, feelings, perceptions, motor actions.
Phase two: Overcoming phobia of traumatic memory

• “The patient must know how to associate the [traumatic] happening with other events of his life, how to give its place in that life history with each of us is perpetually building up and which for each of us is an essential element of our personality. A situation has not been satisfactorily liquidated, has not been fully assimilated, until we have achieved, not merely an outward reaction through our movements, but also an inward reaction through the words we address to ourselves, through the organization of the recital of the events to others and to ourselves, and through the putting of this recital in its place as one of the chapters of our personal history.” Janet
Phase three: integration

Let go of long held core negative beliefs.

- Previously unresolved substitute beliefs will emerge, such as “I am incapable of having an intimate relationship.” “Nothing good will ever really happen for me.”

• Need to assess and review basic assumptions about safety, meaning, aloneness, causation, loss of control, power, trust, intimacy, autonomy and interdependence.
Phase three: integration

• Overcoming phobia of normal life.
  – Learning to live a life relatively free of traumatic intrusion and chaos.
  – Life has been organized around restriction, avoidance, and denial.
  – Normal life requires adaptation to complex, difficult and conflicting situations.
    • Requires high integrative capacity, flexibly, and reflective capacity.
Phase three: integration

• Overcoming phobia of normal life.
  – Must learn to deal with routines, monotony, and difference between interest and obsessing, a constricted life and adaptive stability, rigidity and healthy routines.
  – Balance of work, play, rest, relationships.
  – Continued realization that life is not fair, sometimes fraught with loss, pain, disappointment, and difficult experiences.
Phase three: integration

• Adaptive grieving of losses.
  – May initially involve period of traumatic rage and anger in which survivor is not ready to accept losses and remains phobic of grief and sadness.
  – Physiologically grief mimics sensations of trauma such as anxiety, anger, dread, despair, guilt and shame.
    • “No one ever told me grief felt so much like fear.” C.S. Lewis
  – Must eventually accept losses, experience pain, grief, disappointment, and adjust to life in the present.
Phase three: integration

• Adaptive grieving.
  – Accompanied by strong awareness of the present, ability to self soothe, to receive comfort from others, and become satisfied with new gains in life and connection with others.
  – Capable of self compassion.
  – Adjust to life after losses, and redirect emotional energy toward the real present.
Phase three: integration

• Grieving.
  – Therapist’s role is to empathetically bear witness to survivor’s pain, helping client stay present, and connected.
  – Explore resistances to moving through the sadness and grief, and associated substitute beliefs such as “I can’t tolerate the sadness.” “I will never get over it.” “It is just self pity.” “It makes me a weak person.”
  – Facilitate gradual exposure to the feelings of sadness, and adaptive actions.
Phase three: integration

• Overcoming phobia of healthy risk taking.
  – Change usually perceived as a severe threat.
  – Have learned to avoid uncertainty and anxiety inherent in change by developing reflexive patterns of inhibition, self sabotage, and avoidance.
  – Must explore resistance and substitute belief, such as change is dangerous, intolerable, or irrevocable.
  • Evoke action system of exploration, excitement, curiosity.
Phase three: integration

• Overcoming phobia of intimacy.
  – Intimacy requires the integration of many action systems, including attachment, exploration (curiosity), play, sociability, physical and emotional self care (energy regulation), and healthy caretaking.
  – Involves emotional, physical (non-sexual), and sexual components.
  – Involves whole self.
Phase three: integration

• Overcoming phobia of intimacy.
  – Must help client explore distorted or negative beliefs and pathogenic kernel statements regarding intimacy.
    • Explore beliefs about closeness, emotional vulnerability with others, sexual relationships.
    • Begin to empathetically challenge beliefs, particularly reflexive beliefs involving negative conditioning.
    • Conditioned responses can be proven false through exposure, and by being responded to with support rather than humiliation and abandonment.
Phase three: integration

- Overcoming phobia of intimacy.
  - Help client examine quality of current relationships and develop conflict resolution skills, empathy, and reflective rather than reflexive responses to others.
    - Let high maintenance relationships go.
    - Set flexible but stable limits and boundaries, and adaptive responses to other’s boundary setting.
      - Concept of mutuality in relationships.
    - Intimacy requires adaptive dependency and autonomy (not merging or caretaking)
Phase three: integration

• Overcoming phobia of intimacy.
  – Intimacy and the body.
    • Focus on physical self care and enjoyment of the body, as well as gradual increase in intimate physical interactions with loving partner.
    • Body has been source of distress, shame and other negative experiences.
    • Intimacy triggers attachment phobia, reflexive beliefs and conditioned stimuli related to negative evaluations of body, sex, pleasure, touch, needs, and desire.
    • Must slowly create new associations about touch, control, pleasure, and vulnerability in the context of safe relationships.