

Stabilisation work in complex trauma counselling

Working effectively with trauma in healthcare settings / 8th March 2018



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What is complex trauma?

- ❖ CPTSD was originally proposed in 1992 by Judith Herman in her book Trauma & Recovery.
- ❖ The most common exemplar is prolonged trauma of an interpersonal nature, particularly child sexual abuse or childhood trauma and neglect more broadly.
- ❖ Courtious (2004) expanded complex trauma experiences to include “other types of catastrophic, deleterious, and entrapping traumatisation occurring in childhood and/or adulthood”.
- ❖ The unique trademark of complex trauma – compromise in the individuals' self-development, which occurs during a critical window of development in childhood, when self-definition and self-regulation are formed (Courtious and Ford, 2009).
- ❖ Herman and others have argued that the diagnosis of PTSD, as it is defined (mostly based on the prototypes of combat, disaster and rape) does not fit accurately enough.
- ❖ The category is not yet adopted by either the American Psychiatric Association's (APA) DSM-V, or in the World Health Organization's (WHO) ICD-10. Current captured under the acronym DESNOS (Disorders of Extreme Stress Not Otherwise Specified).
- ❖ It is proposed for the ICD-11, to be finalized in 2018.

Symptoms of CPTSD

Three core symptoms: (1) re-experiencing, (2) avoidance/numbing (3) hyper-arousal

Along with disturbances in ability to self-regulate across five domains:

1. Difficulties **emotional regulation** including symptoms such as persistent dysphoria, chronic suicidal preoccupation, self injury, explosive or extremely inhibited anger
2. Alterations in **attention** and **consciousness**, including ruminative preoccupation and experiencing dissociation or depersonalisation.
3. Changes in **self-perception/ one's system of meanings**, such as a chronic and pervasive sense of helplessness, paralysis of initiative, shame, guilt, self-blame, a sense of defilement or stigma, and a sense of being completely different from other human beings.
4. Disturbance in **relational capacities**, such as not being able to trust, not being able to feel intimate with others.
5. **Somatic distress** and **disorganisation** accompanied by feelings of terror and confusion.

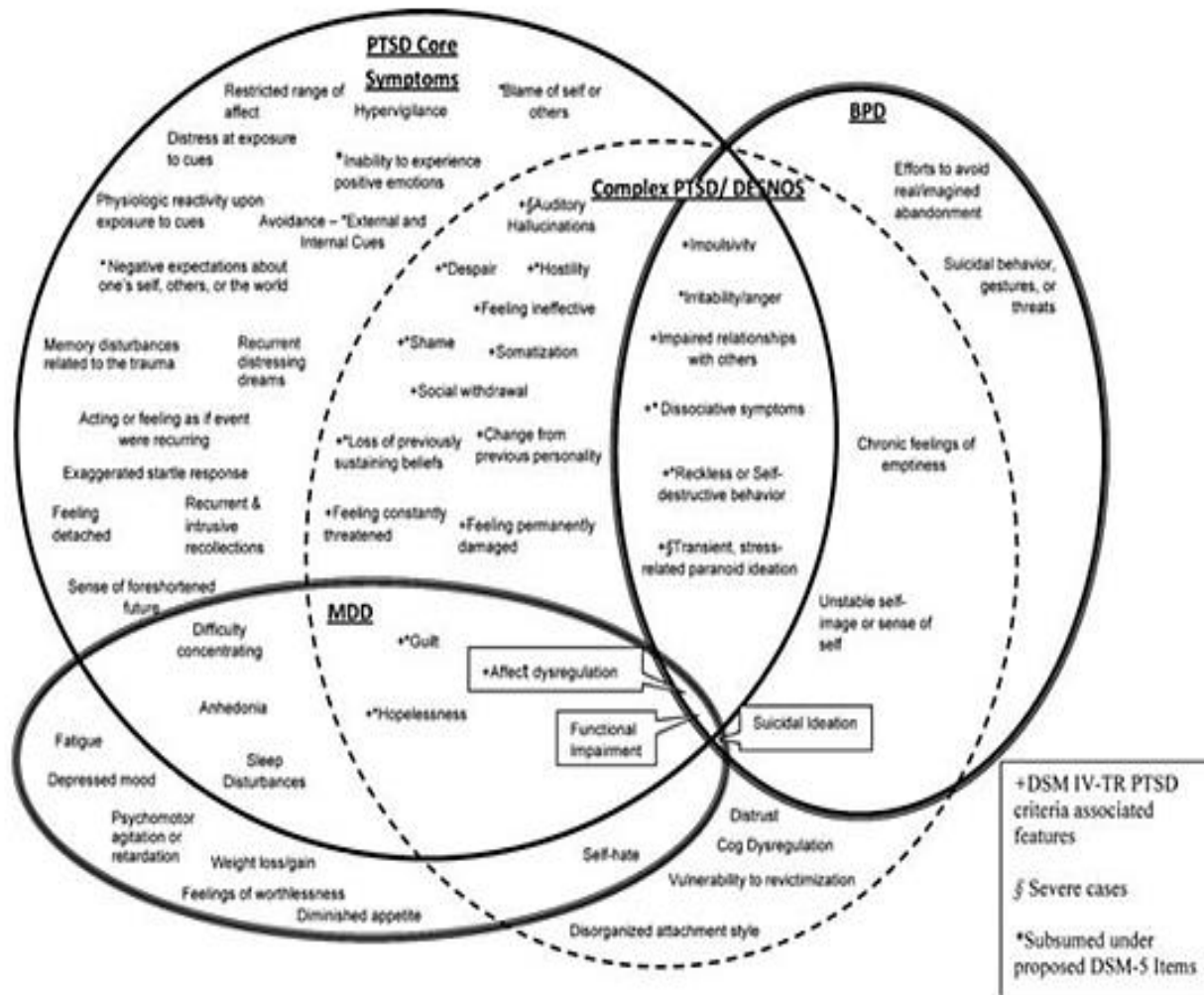


Figure 1. Venn diagram of the overlap between posttraumatic stress disorder (PTSD) core symptoms, PTSD-associated symptoms, disorders of extreme stress not otherwise specified (DESNOS)/complex PTSD, borderline personality disorder (BPD), and major depressive disorder (MDD).

Working with trauma

- ❖ Sharing traumatic experiences can leave individuals vulnerable to becoming dysregulated and at times re-traumatised.
- ❖ It is now the clinical consensus, that all trauma treatment must begin with an emphasis on safety and stabilisation.
- ❖ Babette Rothschild, author of the excellent 'The Body Remembers' (Rothschild 2000) argues that trauma memories should not be addressed before the client is equipped to manage the distress.
- ❖ She uses the analogy of teaching a new driver to be really comfortable with the “braking” system in a car before “accelerating”.
- ❖ If we follow this principle not only will we make trauma therapy safer and easier to control but the individual learns that they can touch just the surface of their experience and then return to a safe and neutral ground.

The challenge of complex trauma

- ❖ **Complex PTSD often creates difficulties with emotional regulation**
- ❖ Aggressive outbursts and self-destructive behaviours
- ❖ Extreme anxiety and agitation
- ❖ Inability to tolerate distress
- ❖ Rapid fluctuations in mood
- ❖ Inability to self-sooth
- ❖ **Complex PTSD creates highly sensitivity to threat**
- ❖ Propensity towards self-shaming/criticism/blame
- ❖ Emotional dysregulation and dissociation
- ❖ Interpersonal difficulties

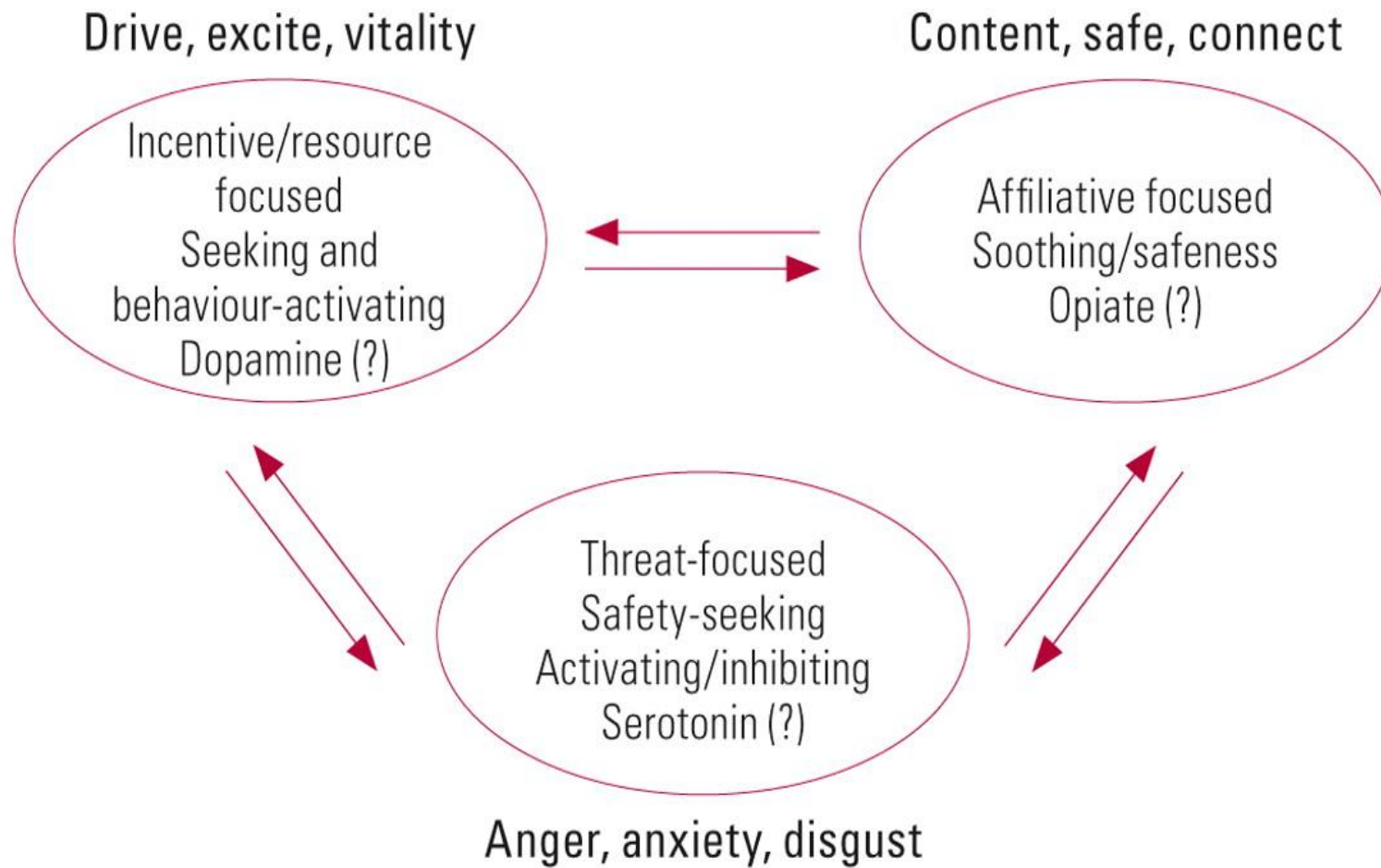


FIG 1 Affect regulation systems. From Gilbert (2005a), with permission of Routledge.

Phased Treatment Approach



84% of 50 expert clinicians endorsed a phase-based or sequenced approach as first line of treatment for Complex PTSD (Journal of Traumatic Stress, 2011)

Key parts of stabilisation

- ❖ Learning how to regulate arousal and impulses
- ❖ Reflecting on inner experience and patterns of thinking and feeling
- ❖ Knowing how and when to apply the brakes
- ❖ Develop awareness of risk (including how and why individuals put themselves at risk)
- ❖ Practicing adaptive coping strategies for dealing with suicidal and self-harming impulses
- ❖ Discovering how to anticipate stressful or triggering events
- ❖ Learning how to calm body and mind
- ❖ Distinguishing between past and present reality and how to stay “in the present”
- ❖ Recognising and making better use of dissociative abilities

The foundations of stabilisation 1

- ❖ The work of stabilisation begins with creating a 'secure base' and container.
- ❖ Falloot and Harris (2008) propose five essential conditions in creating a secure base in trauma-informed therapy:
 - (1) safety
 - (2) trustworthiness
 - (3) choice
 - (4) collaboration
 - (5) empowerment
- ❖ Clear contracting and transparency about the therapeutic process at the outset of therapy
- ❖ In complex trauma work this may require more structure and feedback than we are used to.
- ❖ Empathic listening, encouraging the client to take a lead, and careful attention to the client's feelings can actually be counterproductive at this stage of therapy

The foundations of stabilisation 2

- ❖ A key part of stabilisation work is psychoeducation.
- ❖ The use of psychoeducation has two purposes at this stage of treatment:
 - (1) it helps the client make sense of symptoms: how to recognise them; how to anticipate them, what they mean and how to manage them
 - (2) it decreases the clients sense of shame, confusion, and a sense of being crazy
- ❖ We want to convey that all symptoms make perfect sense as a response to traumatic experience
- ❖ Each symptom represents either a deeply encoded memory or an attempt to solve a challenge or danger
- ❖ This approach can be empowering because it draws a picture of someone who is smart, creative, and resourceful
- ❖ Each troubling symptom can be re-framed with the appropriate psychoeducational input
- ❖ Stabilisation can minimize mechanisms that contribute to the rupturing of the therapeutic alliance and derailment of treatment.

Using Outcome measures to help clients

- ❖ The DSM Criteria for PTSD can be very helpful because each and every troubling symptom can be reframed with the appropriate psychoeducational input
- ❖ Psychoeducation on symptoms also provide opportunity to talk about the role of questionnaires (e.g. PHQ9, GAD7, IES)
- ❖ Value the time clients spend completing questionnaires and explore how they can be used to monitor and track improvements across the course of therapy

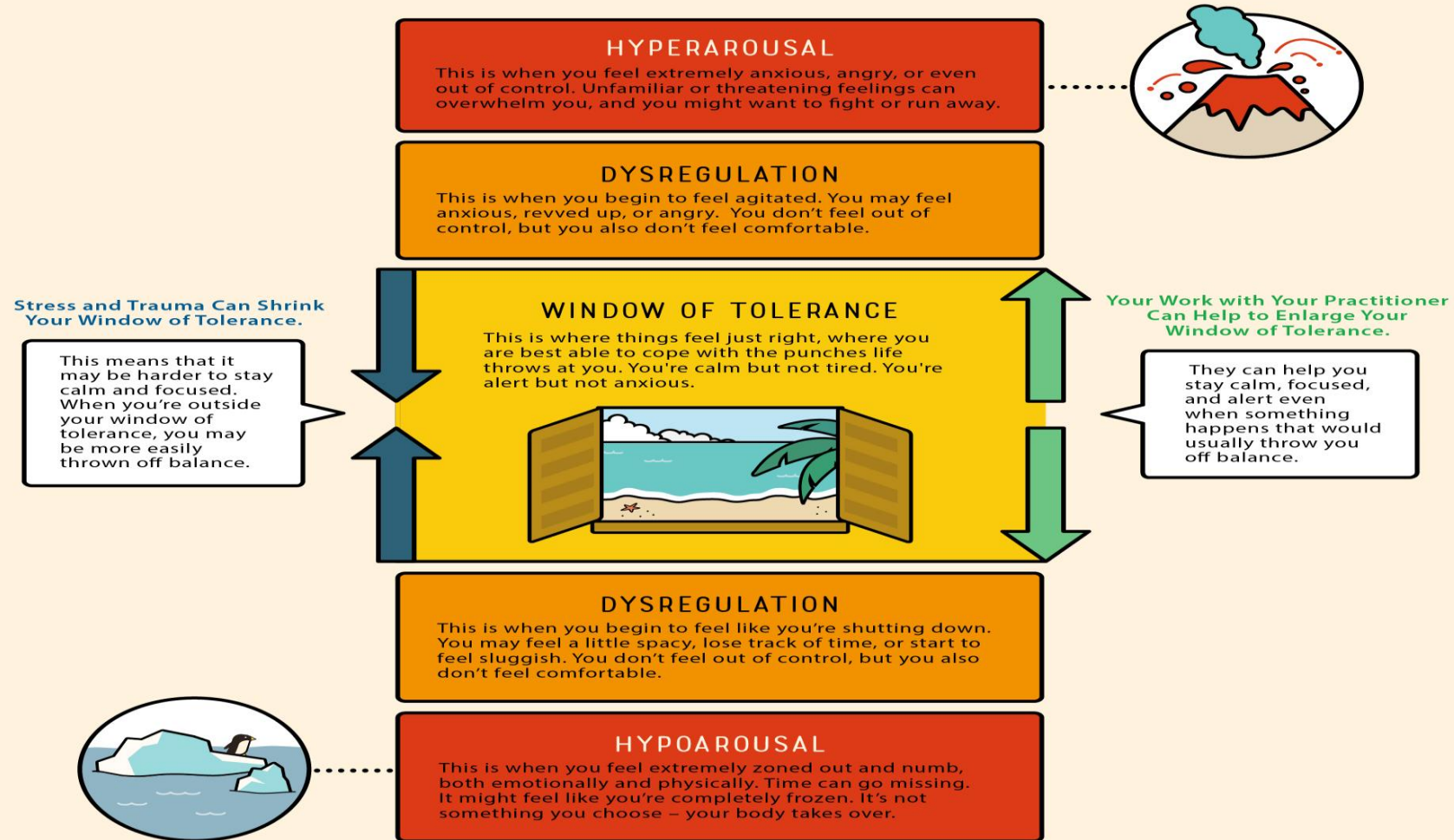
Emotional awareness and regulation

- ❖ Learning to become aware of and validate emotions
- ❖ Labelling feelings, triggers, cognitions and typical coping responses
- ❖ Emotion regulations skills are built and capitalize on healthy coping strategies clients bring into treatment
- ❖ “Three channels of distress” (physiological/somatic, cognitive and behavioural) useful sense-making model
- ❖ Resistance toward experiencing feelings at all and/or experiencing positive emotions
- ❖ Psychoeducation on role of emotions in interpersonal functioning and decision making
- ❖ Sensitivity required but important step in becoming ‘unstuck’ and moving towards emotionally engage living

Pay attention to how clients puts themselves at risk and why

- ❖ Many traumatised clients put themselves at risk in a number of ways for a number of reasons
- ❖ Habituated to danger
- ❖ Attachment cry
- ❖ Habitual dissociation in the face of threat
- ❖ It is important that we openly talk about safety and contract
- ❖ This can be surprising, disconcerting and confusing for clients
- ❖ Facilitate thinking about dis/advantages of un/safe behaviours
- ❖ Discuss levels of safety net
- ❖ Develop a safe plan as a reference point
- ❖ Therapist should not take responsibility for client safety but help build awareness

How Trauma Can Affect Your Window of Tolerance



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Making sense of dissociation

- ❖ Outside flashbacks, it is important to understand the processes underpinning dissociative symptoms
- ❖ Dissociation remains ill-defined and embraces a collection of differing presentations related to the idea of dis-associating from information processing
- ❖ Providing information on the basis of dissociation helps clients who cannot otherwise understand their experience
- ❖ A spectrum of dissociation from non-pathological level through to highly dysfunctional states
- ❖ Defensive mechanism decreasing the awareness of the impact of trauma so that can better functioning in the short-term?
- ❖ Peri-traumatic dissociation is a compensatory mechanism to marked physiological arousal?
- ❖ 2 important distinctions - Detachment and Compartmentalization
- ❖ Within Compartmentalization we see Absorption e.g. a form of 'tuning-in' to a limited aspect of experience and a 'tuning-out' phenomenon that would include post-traumatic amnesias, and traumatic memories that lack emotion
- ❖ Compartmentalization can incorporate the two e.g. in DID we see tuning in to parts of self while detaching from other aspects of self and in flashbacks we often see acute 'tuning in' to one aspect of an experience whilst being temporarily detached
- ❖ The models indicate necessary changes – if a client is detaching too much, we need to help them 'tune in'; if they are 'tuning in' excessively, then we need to learn to decentre, re-focus , or review
- ❖ This is crucial to flashback management

Know when to apply the brakes

- ❖ Knowing when to apply the brakes minimizes the risk of client's feeling dysregulated
- ❖ Handled with sensitivity so that client's never feel disrespected or misinterpret pacing as a minimisation of their feelings and experience
- ❖ Pacing allows tracking and monitoring of intensity of emotions
- ❖ Process of temporarily slowing down allows to move forward because works stays safe and manageable
- ❖ Identify what takes the client out of the window of tolerance
- ❖ What does it feel like to be hyperaroused? What sensations are there in the body? What thoughts go through your mind? What feelings do you have?
- ❖ Similarly , what does it feels like to be hyperaroused?
- ❖ Dysregulation leading to hyperarousal – edgy, anxious, revved up or angry?
- ❖ Hyperarousal - pale, breathing fast, diluted pupils, shaking, looking on edge, aroused sympathetic nervous system.
- ❖ Dysregulation leading to hypo arousal – brain shutting down, feeling spaced out, flat, sluggish?
- ❖ Hypoarousal – not present, numb, feeling frozen, disconnected

Knowing how to apply the brakes

- ❖ Use a framework for measuring intensity of feelings
- ❖ SUDS (Subjective Units of Distress Scale) 0-100 scale
- ❖ Metaphor of emotional thermometer - does not regulate automatically so need to learn how to regulate 'manually'
- ❖ Taught to breathe in quality or state of mind they need e.g. "I breathe in safety" or "I breathe in calm" and to breathe out affect that is overwhelming "I breathe out pain" or "I breathe out fear"
- ❖ Important caveat: breathing techniques can be contraindicated as can raise hypervigilance and escalate anxiety
- ❖ Individuals vulnerable to danger, need guidance which emphasize relaxation is not incompatible with alertness, such as "I breathe in alertness" or "I calm my body and alert my mind"
- ❖ Look for signs of stress hormones reducing
- ❖ Does attention to body sensations increase distress? Directly engage cortex using 'dual awareness'.
- ❖ Can you see me? How clearly? 25% 75% 50%? What colour is hair? Good or bad hair day? How fully present in body? 50% 25% 75%? Experiment with sensory modalities.
- ❖ Important caveat: therapy sessions rarely useful if client is less than 60% present in their bodies

Interpersonal challenges

- ❖ The concept of interpersonal schemas important to understanding clients “working models of relating” (Bowlby, 1969)
- ❖ Interpersonal schemas of clients may reflect themes of abuse, invalidation, abandonment, rejection or neglect, manipulation, coercion and control
- ❖ Interpersonal challenges present both in-session and between-sessions
- ❖ Attachment system likely to be activated
- ❖ Hypervigilant to threat and moving back and forth between proximity seeking and distancing
- ❖ Not actively working with ‘beliefs’ or ‘schemas’ during stabilisation but awareness is key
- ❖ Use of supervision to reflect and unpack transference and counter-transference

Final thoughts

- ❖ Stabilization is prerequisite for working through trauma
- ❖ Emotional regulation skills are learned in the context of a safe, boundaried, therapeutic relationship
- ❖ Build on and capitalize on health coping strategies
- ❖ It is best to adopt cautious approach
- ❖ Develop a clear roadmap for the work
- ❖ Work on the basis of marginal gains
- ❖ Stabilization may be the central focus of the work

Thank you for listening!

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