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# Primer on perspectives and practices of trauma

Trevor P. Haase  
*James Madison University*

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Primer on Perspectives and Practices of Trauma

Trevor Paul Haase

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FACULTY COMMITTEE:

Committee Chair: Debbie Sturm, Ph.D.

Committee Members/Readers:

Lennis Echterling, Ph.D.

Renee Staton, Ph.D.

## **Dedication**

To my immensely supportive wife, Erin, and our new born daughter, Phoebe. Your imminent arrival has been a cherished motivation.

## **Acknowledgements**

This work is the product of countless hours of typing and weekly office visits. The support lent to me by Dr. Sturm and Dr. Echterling is immeasurable. Grounding, centering, new perspectives, and encouragement were in abundance and readily given. I hope my gratitude towards you both is felt. To Dr. Staton, I have the utmost respect for you and feel honored to have you as a part of my committee.

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## **Abstract**

A large majority of the general population has endured at least one traumatic event in their lifetime and many will seek counseling services to process and resolve the impact from the traumatic experience. Counselors and mental health providers will likely encounter trauma survivors in a high frequency in the majority of therapeutic settings. Practicum and internship level counselors are often not prepared for navigating the complexities that arise working with trauma survivors. This paper outlines the various perspectives and practices of the works of Dr. Bessel van der Kolk, Narrative Therapy, and Trauma Focused-Cognitive Behavioral Therapy. These orientations were designed to prepare counseling students to provide services to those seeking resolution to their trauma history. The purpose of this paper is to provide practicum and internship level students with an accessible tool to increase their awareness and understanding of various approaches to working with trauma, and to be able to ethically provide services for a likely client.

## **Introduction**

Each semester, practicum and internship counseling students embark on the beginning of their clinical practice through their placements. These students are exposed to a vast array of different population groups with different needs. Counseling students are given opportunities to utilize their academic training and provide appropriate and adequate services to real-life clients. Practicum and internship allow the counseling students to develop competency under the scrutiny of supervision.

Counselors, in all settings, are likely to be exposed to working with survivors of trauma. Working with this population requires the utilization of strong therapeutic skills, clinical knowledge, and reasoning (Layne et al., 2014). The demand required of new practitioners working with trauma survivors is inevitably going to be a magnitude greater than working with other populations. The foundational skills and functions for new counselors are likely not to be developed in the practicum or beginning stages or their internship courses. Therefore, the goal of this project is to coalesce the current standards-of-practice and leading schools of thought on working with trauma and to develop a primer targeting practicum and internship counseling students. The primer will serve as a tool for new counselors to develop the core competencies expounded upon by Layne et al (2014) in increasing the use of empirically valid methodology, competency in trauma concepts, identifying the objectives of interventions, the practice of acquired knowledge, and utilization of therapeutic skills. The primer will include multiple theoretical orientations and the core beliefs and techniques utilized to provide counseling students with a framework in which they can operate and serve their clients with a trauma background.

## Trauma

### Trauma Definition

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed.) defines trauma, in relation to Posttraumatic Stress Disorder (PTSD), as experiencing an event where a real, or credible threat, to one's life is made, serious injury, or sexual violence is present in the following ways: 1) directly experiencing the traumatic event(s); 2) witnessing, in person, the event(s) as it occurred to others; 3) learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; and, 4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (2014, p. 271).

There is a debate in the literature about what constitutes as a traumatic experience. The definition is important for understanding the connection between event and the diagnosis of PTSD. Briere & Scott have proposed "an event is traumatic if it was extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (2015, p. 10). The difference in definition is important in understanding what trauma is, its impact on an individual, and the best course of treatment in therapy. In addition to the overall definition of trauma, several additional clarifying definitions of trauma exist and are explored in the following sections.

### ***Single-Incident Trauma***

Single incident trauma is the exposure to an isolated form of trauma, often taking the form of a serious accident, unexpected death, or a natural disaster. Single incidents, despite the lack of frequency, may manifest behavioral and biological reactions akin to PTSD diagnostic criteria. The symptomatic experience may be more likely to be connected to reminders of the trauma rather than a continuous pervasiveness (van der Kolk, 2005).

### ***Chronic Trauma***

Chronic trauma is experienced over an extended duration over the course of one's life. Traumas often related to chronic trauma are domestic violence, exposure to war, surgical or medical events, and even occupational risks (Wills, & Schuldberg, 2016). The literature suggests that there is a connection between exposures to multiple traumas and having a higher likelihood of developing more severe symptomology (Cloitre, Cohen, Edelman, & Han, 2001). The impact of trauma may be observed through the symptomology expressed, but also affects neurobiological development. Chronic trauma diminishes one's ability to synthesize sensory, emotional, and cognitive cues in a sensible and adaptive way (Ford, 2005). With increased exposure to trauma, the likelihood of physical and physiological symptomology increases. Chronic trauma is invasive in all domains of life (Anda et al., 2006), and with higher incident rates the likelihood of the development of PTSD increases (Kilpatrick et al., 2013).

### ***Complex Trauma***

Complex trauma shares similarities to chronic trauma. Complex trauma is a term that describes a prolonged period of chronic trauma experienced during the developmental stages of childhood. The traumatic events are related to interpersonal experiences (van der Kolk, 2005) and the impact of trauma experienced in early development distinguishes it from chronic trauma. Complex trauma has the potential of extinguishing the essential domains of self-regulation and relational skills. The impact of complex trauma is life-long, but its impact may be mitigated through therapeutic intervention. Complex trauma may be observed in the following eight domains: attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept. The decreased base-line of functioning for these eight domains creates a greater risk of re-victimization and increases the severity of experienced symptomology (Cook et al., 2006). It is noted that there is no current formal Complex Trauma diagnosis in the DSM-5. Proponents of the inclusion of Complex PTSD fear that the lack of a diagnosis and utilizing adjunctive diagnoses does not reflect the severity of the experience of the client. Furthermore, comorbid diagnoses do not effectively communicate the interwoven connection between the complex PTSD and the comorbidities (van der Kolk, 2005).

### **Prevalence**

A 2013 study suggests that the prevalence of at least one exposure to a traumatic experience is 89.7% for the general population (Kilpatrick et al). For those that have experienced a traumatic event, it is more likely that they have experienced multiple traumatic experiences than having a single-incident (Kessler et al., 1995). Despite the

high rate of exposure to trauma only 4% of the population are diagnosed with PTSD. However, those that have experienced multiple, or chronic, traumatic experiences are 12% more likely to manifest PTSD than the general population (Briere, Agee, & Dietrich, 2016).

Finding conclusive information and statistics on trauma related data is a difficult task. The criteria for defining trauma often differ moderately to severely. Not all studies use the DSM-5's criteria for objectively identifying a trauma experience. The research literature related to complex trauma include domains of neglect and emotional abuse as categories of traumatic experiences. The statistical information found weighed heavily in favor of research on children when using the American Psychological Association literature database search tool "APA PsycNET." Despite the difficulty in obtaining accurate statistics on adults the realization that the children that have experienced traumatic experiences age in to adulthood and do not age-out of their symptomology (Yehuda, 2002).

### **Implications of trauma on wellness**

Trauma has the ability to impact both the physical and mental wellbeing of those that have experienced adverse experiences. The literature suggests that there is a correlation between the severity of trauma and increasing number of traumatic experiences to the likelihood of increased severity and pervasiveness of negative symptomology relating to trauma (Briere, Kaltman, & Green, 2008). The effects of trauma are often lifelong and can result in diminishing of numerous neurobiological functions (Lupien, McEwen, Gunnar, & Heim, 2009).

In a 2001 study, researchers observed a strong connection between traumatic experiences during childhood with different impacts on both mental and physical health. Researchers found that those with childhood traumatic experiences had increased risks for liver disease, decreased reproductive health, and a higher risk for mental illness. The research also noted an increase likelihood of smoking, alcohol, and obesity (Edwards et al., 2001).

Along with the impact that trauma has on mental and physical health, trauma may also manifest in a way that disrupts social connectivity. Traumatic experiences decrease the functioning and regulation of the autonomic nervous system (ANS). Trauma survivors often struggle with hyperarousal and hypervigilance that suspends them in a pattern of being on alert. While on alert, the ability to engage in a meaningful relationship is impacted, as they are searching for and responding to perceived threats whether real or created (Geller, & Porges, 2014).

### **Children**

A study in 2015 found that children that have a history of exposure to traumatic events show deficits in emotional regulation when compared to other children without a similar history. The study also found that children that were exposed to conflictual stimuli had a greater amygdala response (Marusak, Martin, Etkin, & Thomason).

Another complication that may result from trauma early in the life span is the impact and disruption of developing secure attachments. Often, children who have experienced trauma develop a disorganized attachment pattern that persists in to

adulthood. The consequences of a disorganized attachment limit possibilities of co-regulation and positive social experiences (Rholes, Paetzold, & Kohn, 2016).

### **Adults**

Adults who have experienced trauma in childhood are at a higher risk of diagnosable mental illnesses than those that do not report any abuse. Approximately 30-40% of individuals that report sexual abuse report a lifetime history of depression. That number is an increase from the 10-20% of individuals that do not report sexual abuse (Molnar, Buka, & Kessler, 2001).

Psychotropic medications are commonly prescribed as an intervention to treat mental illnesses. There is a strong correlation between the numbers of traumatic experiences over a lifetime with the likelihood of utilization of psychotropic medications. This connection suggests a connection between early life experiences to the development of mental illnesses (Anda et al., 2007).

### **Counseling clients with trauma**

The need for counselors with a strong foundation, expertise, and confidence in working with trauma is significant in the field of counseling. However, there is a wide gap between the availability of such professionals and the demand from mental health consumers (Courtois & Gold, 2009). There is difficulty in finding an appropriate theoretical orientation that fits both the authentic self of the clinician and trauma informed practice. While there are more effective treatment models than others, the impact of trauma on each individual is unique and therefore there is not one best model that can be applied to trauma overall. As counselors work to develop the objectives and

treatment plans for working with trauma, they must also be mindful of the complexities that trauma creates in the lives of those impacted. The goals of therapy should integrate the development of coping skills that the client may use outside of session (Bicknell-Hentges, & Lynch, 2009).

Counselors need to practice discretion when working with trauma. Processing may be a central point in counseling and may provide some symptom relief and reduction. However, processing has the same potential to increase symptomatic response and destabilize the clients (van der Kolk, & McFarlane, 1996). The belief that exploring and processing details in traumatic memories will provide therapeutic release may be misguided. If the counselor is not vigilant in managing a session, the chance of de-containment of the trauma is possible. Counselors will benefit from not pushing quicker than the client is ready, from providing a safe stabilized progression, and from avoiding rushing a long process (Rothschild, 2000).

### **Difficulty in Working With Trauma**

Working with survivors of trauma tends to be a complicated and stressful process for new counselors. Creating a relational bond and therapeutic alliance are major predictors for the success of the treatment. The therapeutic alliance trumps any other variable, including treatment modality (Norcross, & Lambert, 2011). Clients that are seeking the services of counselors are likely to have a difficult or tentative experience in developing the therapeutic alliance and bonding with their counselor. This relationship is the foundation and precondition for the exploration and processing of traumatic experiences (Cloitre, Stoval-McClough, Miranda, & Chemtob, 2004).

### **An Abundance of Theories**

There are an abundance of different approaches to working with a person with trauma. A vast number of larger orientations have different models and branches on how to use the core concepts to create a trauma specific orientation. Cognitive Behavior Therapy (CBT) is utilized in Cognitive Processing Therapy and Trauma-Focused CBT in creation of CBT based trauma specific practices. Other orientations have less formal modalities for working with trauma but have been expanded upon to provide insight on how their orientation could encompass trauma work. As in work with the general population, counselors are able to provide services at their own discretion. Integration of multiple different theories may provide a more holistic approach than working from a defined modality based in cognition, affect, or behavior.

### **Trauma and New Counselors**

Given the complexity in identify and utilizing all the different information, modalities, theories, practices, and conceptualizations of trauma work there may be an overwhelming experience for new counselors to weed through the literature available. Despite this daunting task, it is an important part of the education process of counseling students to be equipped and ready for working with trauma. The literature suggests that counselors emerging from their academic programs should have at least an introductory knowledge of the impact of trauma and clinical skills targeting working with this population. The importance of competency in these two realms is due to the universality of trauma and trauma survivors across all settings in the clinical mental health occupation (Layne et al, 2014). Practicum and internship students have shown to be competent and

successful in providing services to trauma survivors with appropriate supervision and commitment to doing the extra work involved in developing their competencies. The level of success can be comparable to those that have practiced in a counseling role for their entire career with the aid of direct supervision (Nyman, Nafziger, & Smith, 2010). That being said, new counselors do experience some specific speedbumps in their training.

### ***Colluding in Avoidance***

New counselors may find themselves treading lightly while working with trauma for a multitude of reasons. Counselors may justify their unwillingness to explore the traumatic experiences in fear of exacerbating symptoms or re-traumatization of the client. Discretion is required to be aware of not colluding with a client's maladaptive pattern in the avoidance of processing and working on their experience (Bernier & Dozier, 2002).

### ***Vicarious Trauma***

Counselors beginning their work with the trauma population would benefit from taking precautionary measures to avoid vicarious trauma - a traumatic response to working with and listening to traumatic experiences in a therapeutic capacity (McCann & Pearlman, 1990). A strong predictor of the impact of vicarious trauma is the hours spent per week exposed to traumatic experiences (Bober, & Regehr, 2006). Self-care appears to have moderate benefits for preventing vicarious trauma (Tippary, White-Kress, & Wilcoxon, 2004).

In a 2009 study by Harrison and Westwood, the importance of providing information on protective practices early in education was highlighted to combat the

impact of vicarious trauma. Practices such as diversifying the role, practicing mindfulness, and active optimism were purposed by the research in the study. The benefits of such practice were observed to decrease the potential impact of vicarious trauma. Protective practices also were observed to help avoid erosion in the services provided. There is an ethical duty to provide the information to counseling students on the host of potential negative consequences of working with trauma.

### **Personal Reflection from a New Counselor**

Through my practicum and internship rotations I developed and fostered a sense of competency and confidence in working in the counseling role. The lack of mastery made the task difficult to practice fully present. I find myself still continually taking mental inventory on my posture, my words, the next question, or the time left in session. At times, I recall a feeling of infinite variables needing to be directed manually and a hope that at some point would feel automatic.

The idea of working with a specific problem only further exacerbated sensed lack of mastery and competency. Working with individuals who have experienced trauma and traumatic experiences feels laden in parallel process. The feelings of being stuck and clueless how to proceed reemerged in the counseling room. My internal questions ran through my head, “What should I be focusing on?” or “What can I provide to be helpful?” I had learned about trauma but I was still unsure how to consolidate these facts and use this knowledge to inform my practice. Through supervision, reading, and practice I began to nurture a sense of comfort in working with trauma in therapeutic role.

### **The Primer Introduction**

The primer provided is written to provide some foundational frameworks for new counselors starting in practicum and internship locations on working with clients who have experienced trauma. It is with hope that the information will provide new counseling students a sense of grounding during their first experiences of working with trauma. The information is non-prescriptive, and may be used wholly or partially at the discretion of the reader. With the primer, counseling students may have a better sense of the manifestations of trauma and common conceptualizations in the mental health community. The primer is not a substitute to supervision or consultation, but may be used in conjunction with the former mentioned practices.

## **Van der Kolk**

### **Overview**

Bessel Van der Kolk, MD at the Trauma Center at Justice Resource Institute, one of the leading pioneers in the Complex PTSD research and psychotherapy world, has developed a guide for assessing and treating complex PTSD (Yehuda, 2002). The information available is useful for conceptualizing and working with all experiences of trauma. While van der Kolk primarily works with complex PTSD, the material he provided may aid new counselors in their journey in developing a framework for working with trauma.

### **Conceptualizing Therapy**

Therapists who work with individuals who have experienced prolonged exposure to trauma need to develop awareness for how trauma is re-enacted in a client's life. Counselors work with their clients to develop knowledge on their internal processes, both emotional and physical reactions. Counselors use this knowledge to give a platform to their clients to begin to process their experiences as well as to avoid participating in a re-enactment of the client's trauma. A sensitivity to treatment is a major factor in presenting a positive treatment experience. Traumatic experiences were often birthed out of interpersonal relationships which makes therapy potentially risky and easily misunderstood due to the interpersonal nature.

Counselors utilizing van der Kolk's model work with clients to develop an awareness of their individual internal and external experience. The work is non-linear and

gives close attention to the clients' responses to treatment and intervention. Re-traumatization is avoided, however, as there is a willingness and appropriate place to invite discomfort in to the session to provide therapeutic opportunities to challenge the patterned impact of trauma.

### **Key Points**

Van der Kolk's work is explained as a "Phase Oriented" treatment. Counselors are encouraged to be mindful of the impact the trauma has manifested in the client. The speed in which treatment is managed is dictated by the pervasiveness of the trauma, the clients' abilities in managing symptoms of PTSD, and an appreciation for maladaptive and adaptive psychic defenses implemented for managing difficult and traumatic memories. The phases that van der Kolk model prescribes are as follows:

#### ***Symptom management***

Phase I revolves around the management of symptoms being experienced by the client. The treatment of symptoms may include behavioral therapies, psychopharmacological interventions, or mindfulness training. The goal is to provide holistic care to the client and improve their general wellness to increase natural ability to manage and cope with PTSD-related symptoms.

Clients develop mastery and internal locus of control by being able to increase their ability to manage and cope during periods of hyperarousal. Counselors work with clients to gain this ability by helping client identify and process uncomfortable physical and affective sensations.

Dialectical Behavior Therapy (DBT) has been suggested by van der Kolk as a treatment modality during phase one of counseling. DBT provides a framework for clients to practice mindfulness with their emotions through a nonjudgmental lens and allows remittance from avoidance of difficult emotions.

### ***Create Narratives***

In Phase II, counselors assist clients in creating a safe and healthy distance from their emotional experience. The process of narrating the internal world fosters the ability to manage intricate representations of what may have felt intangible. The verbalization of the experience provides counselors the ability to identify areas of strength and resiliency as well as accurately validate the sum of the impact of trauma.

### ***Realize Repetitive Patterns***

The work counselors do in Phase III is to help clients identify the repetitive patterns connected to their traumatic experiences. The repetitive patterns are often trauma re-enactments that maintain the client in their trauma narrative. Changing the behaviors of those that trigger the client would not provide long-term relief for the client, but would mask the trauma temporarily.

### ***Making Connections***

In exploration of the repetitive patterns, clients begin to link their internal experiences to their maladaptive behaviors. Clients are able to acknowledge and make sense of their patterns as responses to their unresolved trauma. Counselors may find it helpful to explore and process the internal sensation that is fueling the repetitive pattern. Common behaviors clients may include present risky sex, disordered eating, gambling, or

self-inflicted violence. Connecting the internal state to the behavior may prove to be fertile ground for processing an unresolved experience.

### ***Identify and Processing Traumatic Memory***

Phase V of the phase orientated treatment consists of the deconditioning of the responses created through traumatic experiences. Counselors facilitate space for clients to experience their traumatic experiences in a way that challenges the sensations and allows for the client to experience this new information to perturb their pattern. The power, valence, and rigidity of the traumatic experience is reduced with the ability to feel safe (Rothbaum, & Foa, 1996).

Van der Kolk is a proponent of the use of Eye Movement Desensitization and Reprocessing (EMDR) for processing trauma in this phase of treatment. EMDR is used to increase the aware of the “exceptions” of positives experiences that are hidden, and dampened in the lives of those that have experienced chronic and complex trauma. This is aligned with the phase of treatment in decreasing the conditioned responses manifested from traumatic experiences. Van der Kolk notes the benefits of EMDR in avoidance of flooding a client and risking re-traumatization while processing trauma. Van der Kolk’s work in this phase is the intentionality to acknowledging and honoring the traumatic experiences, and pervasiveness of all domains of life, but should concentrate the work around bringing the client into the present and beginning to extinguish the cues that trigger clients in to the past.

### ***Learn interpersonal Connections***

Phase VI works with interpersonal connections and the development of resiliency in relationships. Past relationships may have been filled with ambiguous boundaries and may have been fertile ground for trauma re-enactment. Counselors are able to continue their work with clients by improving relationships through the continued fostering of adaptive coping skills and corrective emotional experiences. The new relationships provide experiences that continue to disrupt the rigid boundaries created to cope with what felt like danger in all interpersonal relationships.

### **Additional Resource**

*The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* is van der Kolk's 2014 published book. The book is the collection of the leading work on theory, research, and practice for understanding trauma. The synthesis of literature compiled in the book provides readers with a holistic approach to working with survivors of traumatic experiences, especially those who present with complex traumatic stories.

## **Narrative Therapy**

### **Overview**

The manifestation of Narrative Therapy came through the collaboration of Michael White and David Epston (1991). White (2004, 2005) applied narrative therapy to working with survivors of trauma to as a way to validate and explore the impact of trauma through the shift in narrative a trauma creates in one's life. White suggested that through the use of narrative therapy clients could begin to see past the impact of trauma and begin to draw in positive experiences and details to challenge the central theme in the client's life narrative (2004).

The work of narrative therapists is to work with their clients to examine and deconstruct the story that has been organically developed through the life experiences. Clients in Narrative Therapy are conceptualized as having created their life's narrative to help them understand and navigate the world. The narrative, in essence, is how they cope. This narrative is the main source from which one builds the foundation for all interpersonal and intrapersonal reasoning.

Traumatic experiences are seen as having the ability to disinhibit one's capability to construct an adaptive life narrative. The narrative created following trauma often lacks positivity, optimism, and pro-social beliefs. The narratives that manifest become more centered on lacking safety, and are threatening in nature. The ability to integrate former and current positive experiences to one's narration is diminished. Anxiety and distress are common symptoms that reflect the emotions of a narration formed out of trauma.

Working on trauma through a narrative therapy orientation gives clients the ability to deconstruct the narration that trauma has had on their lives. Therapists and clients can begin to see the influence of trauma on the how the client shapes their world view, and how this narrative directly and indirectly influences their current state. Clients may begin to recognize the incongruence between their narrative and positive experiences that have gone unaccommodated.

(Erbes, Stillman, Wieling, Bera, & Leskela, 2014).

### **Key Points**

Along with colleagues, Erbes' (2014) study on the use of narrative therapy with the trauma survivor population limited sessions to three focal points. Clients were able to explore and process the contradictions to their trauma narrative, process how they have responded to a trauma experience, or directly process the traumatic experience. John Stillman, LICSW, (2010) expounded on Narrative Therapy as having seven core principles that dictate the work a Narrative Therapist should utilize to inform their practice. The same principles can be applied to the use of narrative therapy when working with survivors of trauma to rewrite their narrative. The principles are not prescriptive and should be held with sensitivity to cultural influences. The seven core principles of narrative therapy are Deconstruction (Personal, and Societal), Identity Proclamation, Intentionality, Narrative Metaphor, Personal Agency, Positioning (De-centered, and Externalization), and Subordinate Story Development (Absent but Implicit, and Reposition).

### ***Deconstruction: Personal Day-to-Day***

The routines that people entrench themselves are often the byproduct of their narrative. Even in difficult and maladaptive patterns the ongoing daily schedule can be difficult to break when unexamined. Therapists and clients can examine the reasons behind why the client's life is structured in the manner that it is. The exploration and examination provides insight for the client to be in a position to begin to author a new narrative that provides them an opportunity to actualize the life they have envisioned themselves leading (Stillman, 2010).

### **Deconstruction: Societal and Cultural**

Narrative Therapists can aid their clients in identifying and processing the societal and cultural norms that are in effect for the client. The influence from society and culture has the possibility of compounding and impacting the way one responds to a traumatic experience and may dictate the narrative on how one responds to their trauma. To examine the influence and untangle a personal response from expectations may allow one to begin to adopt, change, or deflect the system's expectations that may not fit with their experience. The narrative of following these expectations may provide relief and space for the client to process their experience in their own authentic way (Stillman, 2010).

### ***Identity Proclamation***

Interpersonal relationships are a key component to the development of one's identity. In narrative therapy a client is able to explore their relationships and the influence their relationships have on their narrative. The feedback loops received by the different relationships help reaffirm or challenge the current narration. Therapists may help shine light on these relationships and the bonds that tie the narrative to the client.

Clients are able to engage in a deliberate way of maintaining their narrative through interpersonal relationships. The process of this deliberate way of shaping their narrative provides a stronger sense of (Stillman, 2010).

### ***Intentionality***

In the wake of trauma the sense of intentionality may become a casualty. The identities and narration clients hold may suffer from a lack of intentionality. Narrative therapists believe that identities are established through relationships and experiences. When one experiences a trauma, their intentionality is often decreased and their narrative becomes overwhelmed by the trauma. Therapists facilitate the challenging of the “problem stories” by finding the exceptions and highlighting the core personality of the client (Stillman, 2010).

### ***Narrative Metaphor***

Clients are encouraged to identify and develop metaphors to describe their experience and narrative. The application of metaphors in session allows for the client to create a cumulative representation of their story. This strategy also helps form a story that is digestible and less threatening for the client to process. This approach provides a sense of safety when working with trauma and could potentially reduce the risk of triggering emotional flooding. The metaphor can be repackaged and provide more meaning and utilization of resiliencies (Stillman, 2010).

### ***Personal Agency***

Narrative therapists respect the autonomy of their clients. The client is the one that identifies and names the problem with their narrative and expresses their own goal

for what they would want their narrative to represent. The therapist serves the client by highlighting and providing feedback based on the tracking done in session. Clients are to use the therapist's feedback in a way that helps them consolidate their ever-shaping narrative (Stillman, 2010).

***Positioning: De-centered, but Influential***

The therapist takes a position of a non-expert in the client's life and allows the client to lead and be the master of their domain. The therapist maintains a close enough position in the relationship to be influential and provide feedback, but only offers it as a curiosity or wondering. The goal of probing and questioning a client is to highlight the struggle and impact the negative experience that is creating problems in the client's life (Stillman, 2010).

***Positioning: Externalization***

The problem that a client is facing is to be externalized from the client. The therapist allows the client to change their perspective and relationship to their problem. Narrative therapists put a great emphasis on the belief that the client is not the problem, but rather the problem is defined externally as the core issue. The externalization of this core issue gives space for the counselor to facilitate a shift in therapeutic goals. No longer does a counselor need to change the person at their core, but now is able to work in an alliance with the client to work directly at the true core of the issue (Stillman, 2010).

***Subordinate Story Development: Absent but Implicit***

When the narrative of a client is saturated with a problem they are often unable to identify or name the subordinate story. This is where the story of resiliency and growth

lies hidden. The problem is inherently a problem due to the understanding that there is a more authentic or accurate way of life that is not being actualized. Narrative therapists help clients develop the subordinate story through exploration of the hindrances that block this narrative (Stillman, 2010).

***Subordinate Story Development: Repositioning***

In the Subordinate Story Development, Narrative therapists work with clients to identify and reposition the exceptions in their negative narrative. This includes those exceptions that stood out and helped or times when their experience was different, even if only slightly. This route allows for clients to see possibilities and attach to an experience that is closer to the narrative that they are developing with their therapist (Stillman, 2010).

**Additional Resource**

“Playful Approaches to Serious Problems: Narrative Therapy with Children and their Families” (1997) is a book written for the use of narrative therapy with children. Authors Freeman, Epston, and Lobvits condense narrative therapy in to a digestible format for children to respond to with more ease. The book provides counselors with activities, and techniques to use with their adolescent clients.

## **Trauma Focused-Cognitive Behavioral Therapy**

### **Overview**

Trauma Focused-Cognitive Behavior Therapy (TF-CBT) was created through the work of Judith Cohen, Esther Deblinger, and Anthony Mannarino (2006). Despite being a Cognitive Behavioral Therapy based modality, TF-CBT integrates material from other disciplines, such as family-systems, humanistic, and attachment orientations. TF-CBT was originally developed with the intention of working with children who have experienced sexual abuse. More recently, TF-CBT has been applied to working with all forms of traumatic experiences. While the original intent was to apply this program to children, research has shown TF-CBT to be an effective treatment for adults who have experienced trauma (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013).

### **Conceptualizing Therapy**

TF-CBT includes several components of therapeutic practice to address the widespread impact that trauma may create in an individual's life. Due to the component nature of TF-CBT, therapists are able to identify the needs of their client and develop a treatment plan targeting areas of need to the different components of TF-CBT. The component-based model allows for a short term of treatment with benefits being maintained at least a year after treatment ends (Cohen, Mannarino, & Knudsen, 2005).

### **Management of Therapy**

Counselors working from a TF-CBT orientation manage treatment by addressing the impact of trauma on several domains. Counselors help their clients identify and

process the following domains: 1) affective regulation through addressing the symptoms that arise following a traumatic experience; 2) behavioral modification through the exploration of avoidance of triggers, the addressing of self-inflicted violence, and other maladaptive coping mechanisms; 3) biological wellness is monitored, and addressed in areas such as sleep and physiological symptomology; 4) cognitive processing of rumination, dissociative symptom, negative trauma-related beliefs, and memories; and 5) social reintegration through addressing the impact of trauma on interpersonal connections, and isolative behaviors (Cohen, & Mannarino, 2015).

### **Core Principles**

There are four core principles of TF-CBT counseling. First, TF-CBT is a phase, and component based treatment. There are three phases in TF-CBT The Stabilization phase, Trauma Narrative and Processing phase, and Integration and Consolidation Phase. The components of TF-CBT are Psychoeducation, Parental Skills, Relaxation, Affective Expression, Cognitive Coping, Trauma Narration, In Vivo Mastery, Conjoint parental and child sessions, and Enhancing Future Safety and Development. The second core phase involves component order and proportionality of phases. Components are to be followed in sequential order with little to no deviation. The phases of treatment are to be proportionate to the others. TF-CBT treatment last, on average, between 12-15 sessions. Each phase should last be between 4 and 5 sessions. The third component dictates that gradual exposure is adjusted at the discretion of the counselor. Counselors encourage parents, and clients to use the adaptive skills that have been taught. The fourth and final component involves integration of parents or guardians. Counselors split sessions

between parents, and children to provide a supportive foundation for the children to use outside of treatment. Counselors may also hold a conjoint session between the client, and the parent (Cohen, & Mannarino, 2015).

### **Key Points**

TF-CBT is governed by core principals of practice that are understood in the acronym of PRACTICE.

- P) Psychoeducation is a valuable tool for both the client, and the parental figure to normalize response, and better understood the impact of trauma.
- P) Parental skills are central to the successful outcome of treatment for the child.
- R) Relaxation skills are developed to stabilized, and improve adaptive coping skills.
- A) Affective expression is encouraged as a way to improve coping, and processing.
- C) Cognitive coping allows counselors, and parents to help children link the relationship between their thoughts, beliefs, emotions, and behaviors and identify ways to modify these connections in more adaptive manners.
- T) Trauma narration is important for the development of a cohesive story and understanding of the trauma and its impact on the client's life.
- I) In vivo mastery is utilized to recondition traumatic fears in non-threatening situations and environments.
- C) Conjoint child and parent sessions are beneficial for the child and parent to develop an alliance.

E) Enhancing future safety and development addresses any deficits that child may have developed as a response to their trauma. This benefits clients to maintain gains following termination from services.

(Cohen & Mannarino, 2015)

## **Phases**

### ***Stabilization***

The Stabilization Phase is the first stage of treatment in TF-CBT. During the Stabilization Phase counselors integrate the first five components in to the work done with the client, and the parental figures. Psychoeducation is provided to give the consumers a framework to understand trauma, and trauma responses in greater detail, and to normalize the experience. The hope is that a shift may happen for both parental figures, and clients perspective, and begins to nurture strength and hope.

Parental Skills is the second component utilized during the Stabilization Phase. Counselors provide the parents with more skills to effectively help parents co-regulate with their children. Counselor encourages parents to maintain the understanding of the impact of trauma that may create a disturbance in behavior in the client. Counselors also explore with the parents ways to highlight the positive experiences, and strength displayed by the child.

Relaxation is the third component in the Stabilization Phase. Relaxation skills are introduced and implemented by the counselor to both child, and parent. Counselors highlight the need for the skills to tend to neurobiological changes that maintain trauma

responses. Relaxation skills are encouraged to be used during hyperarousal and other distressing moments, as well during a neutral or positive state.

The fourth component used in the stabilization phase is Affective Expression. During this phase counselors work with clients to develop strong skills to identify, and express their emotions. Trauma often has the impact to limit the ability to competently verbalize emotions. During this phase counselors work to foster safety in the expression of the client's negative emotions. Parents are encouraged to find ways to contain, and attune to their child's emotions.

Cognitive Processing is the final component of the Stabilization Phase. Counselors help clients track their process through identifying and connecting the client's thoughts, feelings, and behaviors. Counselors explore the negative or maladaptive beliefs and cognitions that the client holds and explores the integration of adaptive and positive beliefs. Counselors work with the parents in the same manner. (Cohen & Mannarino, 2015)

### ***Trauma Narrative and Processing Phase***

Trauma Narration is the only component of the Trauma Narrative and Processing phase. Counselors have their client explore their traumatic experience in greater detail. The counselor maintains the clients awareness and focus on sensations, feelings, emotions, and behaviors during the time of the traumatic experience. Counselors encourage the client to explore and process in as great of detail as possible as to not avoid and further condition the client's response. The exploration of these memories allows

counselors to help the client identify the faulty, and maladaptive beliefs that arise through the impact of their trauma story (Cohen & Mannarin, 2015).

During the Trauma Narrative phase the counselor continues to meet with the parental figures. The counselor shares the client's developing trauma narrative to give a better understanding of their child's trauma story. This provides opportunities for the counselor to work on the parental figures' cognitions that have hindered the child's treatment. A 2016 study found that a major predictor in the success of treatment is the response of the parental figures during this stage. Parents unable to or avoidant of the details during the sharing of the client's trauma narrative decreased the benefits of TF-CBT (Yasinski et al).

### ***Integration and Consolidation Phase***

In Vivo Mastery is the first step of the Integration and Consolidation phase. The phase is optional and is used at the discretion and clinical judgement of the counselor. In Vivo Mastery is practiced when the client is experiencing a severe reaction to objective nonthreatening scenarios. In Vivo mastery practices a form of systemic desensitization through the development of a hierarchy of distressing scenarios. These scenarios start from a minor discomfort and ascending towards the most distressing scenario. The skills taught during the stabilization phase are encouraged to be utilized.

The second component used during this phase is the conjoint child-parent sessions. During the first session of conjoint session the child tells the parental figures their trauma narrative. The parents will have already been exposed to this narrative in previous individual sessions. Counselors may facilitate an open dialogue between the

child and parents to maintain a positive experience for the child and solidify their trust in the process.

The final component of this phase is Enhancing Safety. The counselor continues to facilitate a dialogue between the parents in the child on topics of maintaining the child's sense of safety that is often lost through traumatic experiences. Counselors may help guide the process to develop a plan for preserving the safety of all members of the family. Through this phase the counselor aims to foster an internalized sense of safety in the client.

### **Additional Resources**

“How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)” published by The National Child Traumatic Stress Network in 2002 is a guide book on the implementation of TF-CBT in therapy. Counselors may review the guide book for a more in depth understanding of TF-CBT and to practice TF-CBT with fidelity to its program.

The Medical University of South Carolina (MUSC) has a web-based program for TF-CBT. MUSC provides free training, and resources for practitioners of TF-CBT and for new counselors interested in becoming a competent TF-CBT provider. The MUSC website allows counselors to learn TF-CBT at their own pace through a regimented program.

## **Additional Resources for Treatment**

### **Yoga**

Yoga has been demonstrated to be an effective adjunctive treatment to psychotherapy for PTSD (van der Kolk et al., 2014). The experience of attunement to internal sensations in the practice of Yoga is believed to globalize to people for a better awareness of one's physiological experience. Yoga practitioners are drawn to the attention of the sensation and rather than avoid the sensation they foster their resiliency through bringing their attention to the sensation (Holzel, 2011). Benefits may be observable in as little as ten sessions (van der Kolk et al., 2014).

### **C.A.R.E.S.S. Model**

Clients diagnosed with PTSD are at a higher risk of engaging in suicide or other self-destructive harming behaviors (Nepon, Belik, Bolton, & Sareen, 2010). The CARESS (Ferentz, 2002) model developed by Lisa Ferentz, LCSW is a tool for counselors to introduce to their clients to decrease maladaptive coping mechanisms. The model aims to provide a healthy alternative to achieving the positive impact clients get through self-harm. Each phase during the CARESS model should last approximately 10-15 minutes and should be followed in order.

C.A.) Communicate Alternatively the internalized sensations and processes that are encouraging the client to self-harm. Activities to address this may be, but are not limited to, creating a collage of thoughts and feelings or writing about engaging in the self-destructive behavior.

R.E.) Release Endorphins that would be released if the client did engage in a self-harming behavior. Clients may find moderate exercise, or listening to a comedy album as alternative means for the release of endorphins.

S.S.) Self-Soothing behaviors promote self-initiative behaviors for treatment.

Clients may find a warm blanket, petting an animal, or scented candles as ways to self-soothe

(Ferentz, 2002).

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