# *Principles of* Trauma Therapy

## A Guide to Symptoms, Evaluation, and Treatment

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- An overall approach that is respectful and positive, and that provides support and validation in the context of a therapeutic relationship
- Psychoeducation on trauma and trauma symptoms
- Some form of stress reduction or affect regulation training
- Cognitive interventions that address harmful or debilitating trauma-related beliefs, assumptions, and perceptions
- Opportunities to develop a coherent narrative about the traumatic event
- Memory processing, usually involving guided self-exposure to trauma memories
- Processing of relational issues in the context of a positive therapeutic relationship
- Exploration activities that increase self-awareness and self-acceptance

Many of these interventions may occur within the same therapy session, and may be hard to distinguish from one another during the treatment process. Nevertheless, they represent, to some extent, separate processes and goals. For this reason, each receives detailed attention in the following chapters. We also include in Part II chapters on the treatment of acute trauma (that is, traumas that have very recently occurred) and the psychopharmacology of posttraumatic states.

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# Central Issues in Trauma Treatment

## A Basic Philosophy of Trauma, Recovery, and Growth

Although much of this book is devoted to the technical aspects of treatment, we start this chapter with philosophical issues associated with trauma therapy. This is because the way in which the clinician views trauma and trauma-related outcomes, and what he or she believes to be the overbridging goals and functions of treatment, have significant effects on the process and outcome of therapy.

Perspectives on trauma and its treatment vary among clinicians, and a variety of clinical models can inform effective psychotherapy. The approach that we advocate in this book emphasizes the probably innate tendency for humans to process trauma-related memories and to move toward more adaptive psychological functioning. As discussed in more detail later in this book (Chapter 8), many of the "reliving" symptoms of posttraumatic stress disorder (PTSD) can be conceptualized as recovery algorithms that humans have evolved over time in response to trauma exposure (Briere, 1996, 2002a; Horowitz, 1978). The intrinsic function of these reliving experiences appears to be to process and integrate upsetting material. This implies that individuals who present with trauma-related symptoms are, in a sense, attempting to "metabolize" or internally resolve distressing thoughts, feelings, and memories. This perspective reframes many posttraumatic symptoms as adaptive

and recovery focused rather than as inherently pathological. It also suggests that therapeutic exposure (see Chapter 8) and other approaches to processing traumatic memories may work by optimizing those activities in which the client is already engaged, as opposed to imposing entirely new or alien techniques. Seen in this light, traumatized individuals are not collections of symptoms, but rather people who, at some level, are attempting to recover—albeit not always successfully.

A second philosophical notion offered in this book is that trauma can result in growth. Like many other therapists who work in this area, we have found that adversity and distress—beyond their capacity to disrupt and injure—often push people to develop in positive ways. As documented by various studies, this may involve new levels of psychological resilience, additional survival skills, greater self-knowledge and self-appreciation, increased empathy, and a more broad and complex view of life in general (for example, O'Leary, 1998; Siegel & Schrimshaw, 2000; Updegraff & Taylor, 2000). The recently widowed person may learn new independence, the survivor of a heart attack may develop a more healthy perspective on life's priorities, and the person exposed to a catastrophic event may learn important things about his or her resilience in the face of tragedy. The implication is not that someone is "lucky" when bad things happen, but, rather, that not all outcomes associated with adversity are inevitably negative. The message is not that one should "look on the bright side," which can easily be seen as dismissive and unempathic. Instead, we suggest that the survivor's life, although perhaps irrevocably changed, is not over, and that future good things are possible.

Of course, some traumatic events are so overwhelming that they make growth extremely difficult; they may involve so much loss that it seems impossible (if not disrespectful) to suggest any eventual positive outcomes to the client. Survivors of chronic traumas such as severe childhood abuse or torture may feel that they have been permanently injured. In other cases, life experiences may have pushed some survivors so far into avoidance and defense that they cannot easily see beyond the immediate goals of pain avoidance and psychological survival. Even in these instances, however, treatment should not necessarily be limited to symptom reduction; it may also include the possibility of new insights and skills. In less tragic circumstances, it may even be possible to suggest that adversity can make the survivor more, as opposed to less.

This philosophy may appear to be a distraction from the technical job of trauma treatment. Clearly, an injured person first needs attention to immediate safety and life support, and help with painful symptoms; it is often only later that the more complicated and subtle aspects of recovery and growth become salient. Yet, ultimately, some of the best interventions in posttraumatic psychological injury are implicitly existential and hopeful. This perspective can also be beneficial for the therapist—the possibility that the client can not only recover, but also may gain in some way from traumatic experience, brings tremendous richness and optimism to the job of helping hurt people.



## Respect and Positive Regard

One of the implications of this philosophy is that the traumatized client should be seen as someone who, despite being confronted with potentially overwhelming psychic pain and disability, is struggling to come to terms with his or her history—and, perhaps, to grow beyond it. It is often hard to be in therapy, especially when (as is outlined in the next chapters) such treatment requires one to feel things that one would rather not feel and think about things that one would rather not consider. The easy choice, in many cases, is to block awareness of the pain and avoid the thought—to "let sleeping dogs lie." It is a braver choice, when the option is available, to confront one's memories and their attendant psychological distress and attempt to integrate them into the fabric of one's life. It may be that—in order to survive pain—the client engages in some level of resistance in order to avoid being exposed to the full experience of relived trauma during treatment. Such a response is logical and should be understood as such by the clinician. It does not take away from the fact that the client deserves considerable respect for being willing to revisit painful events and to choose awareness over the apparent (although typically false) benefits of denial and avoidance.

Continuous appreciation of the client's bravery is a central task for the trauma-specialized clinician—acknowledging the courage associated with the client's mere physical presence during the therapy hour, and taking note of the strength that is required to confront painful memories when avoidance is so obviously the less challenging option. When the therapist can accomplish a respectful and positive attitude, the therapy process almost always benefits. Although the client may not completely believe the therapist's positive appraisal of him or her, visible therapist respect assists greatly in establishing a therapeutic rapport, increasing the likelihood that the client will make him- or herself psychologically available to the therapeutic process.

## Hope

Hope is also intrinsic to effective trauma treatment. Repeated experience of painful things (including painful symptoms) may cause the client to expect continuing despair as an inevitable part of the future. In this light,

part of the task of therapy is to reframe trauma as challenge, pain as (at least in part) awareness and growth, and the future as opportunity. This in no way means that the clinician should be Pollyannaish about the client's experiences and current distress; it is very important that the client's perceptions be acknowledged and understood. However, it is rarely a good idea for the therapist to accept and therefore inadvertently reinforce the helplessness, hopelessness, and demoralization that the client may infer from life experiences; to do so is, to some extent, to share in the client's injury. Instead, the challenge is to acknowledge the sometimes incredible hurt that the client has experienced, while, at the same time, gently suggesting that his or her presence in treatment signals implicit strength, adaptive capacity, and hopefulness for the future.

Instilling hope does not mean that the therapist promises anything. For a variety of reasons (for example, genetic or biological influences, the possibility of premature termination, treatment interference through substance abuse, especially complex and severe symptomatology, new traumas, and so on), not every client experiences complete symptom remission. Because we cannot predict the future, we cannot guarantee that things will go well for any given person. Yet, an overall positive view of the client and his or her future is often justified and helpful. Even when not treated, many of those individuals exposed to major trauma will experience significant symptom reduction over time (Freedman & Shalev, 2000), probably as a function of the innate self-healing processes described in Chapter 3. Even more important, having completed trauma-focused treatment is associated with greater symptom reduction than not having done so (Foa, Keane, & Friedman, 2000). For such reasons, it is generally appropriate to communicate guarded optimism regarding the client's future clinical course and to note signs of improvement whenever they occur.

Ultimately, hope is a powerful antidote to the helplessness and despair associated with many major traumas and losses. Although not typically described as a therapeutic goal, the instillation of hope is a powerful therapeutic action (Meichenbaum, 1994; Najavits, 2002). It takes advantage of the ascribed power and knowledge of the clinician to communicate, with some credibility, that things are likely to get better. The impact of this message for many trauma survivors should not be underestimated.

## Central Treatment Principles

Beyond a general philosophy of trauma and recovery, there are a number of basic principles of effective trauma-focused treatment. Although these



principles apply most directly to psychotherapy, they also are relevant to other treatment methodologies, including psychopharmacology.

### Provide and Ensure Safety

Because trauma is about vulnerability to danger, safety is a critical issue for trauma survivors (Herman, 1992a; Najavits, 2002; Cook et al., 2005). It is often only in perceived safe environments that those who have been exposed to danger can let down their guard and experience the relative luxury of introspection and connection. In therapy, safety involves, at minimum, the absence of physical danger, psychological maltreatment, exploitation, or rejection. Physical safety means that the survivor perceives, and comes to expect, that there is no likelihood of physical or sexual assault at the hands of the clinician or others, and that the building is not likely to collapse or burn during the session. Psychological safety, which is sometimes more difficult to provide, means that the client will not perceive himself or herself to be criticized, humiliated, rejected, dramatically misunderstood, needlessly interrupted, or laughed at during the treatment process, and that psychological boundaries and therapist-client confidentiality will not be violated. It is often only when such conditions are reliably met that the client can begin to reduce his or her defenses and more openly process the thoughts, feelings, and memories associated with traumatic events. In fact, as is discussed in Chapter 8, it is critical that the client experience safety while remembering danger; only under this circumstance will the fear and distress associated with trauma in the past lose the capacity to be evoked by the present.

Unfortunately, in order to feel safe, there must not only be safety; the client must be able to perceive it. This is often a problem because, as noted earlier, trauma exposure can result in hypervigilance; many traumatized people come to expect danger, devote considerable resources to detecting impending harm, and have a tendency to misperceive even safe environments and interactions as potentially dangerous (Janoff-Bulman, 1992; Pearlman & Courtois, 2005). Even a safe therapeutic environment may appear unsafe to some traumatized clients. As a result, therapy may take considerably longer—and call more on the clinician's patience and sustained capacity for caring—than is allowed for by short-term therapies. Some multiply traumatized individuals—former child abuse victims, torture survivors, victims of political oppression, adolescent gang members, "street kids," or battered women, for example—may need to attend therapy sessions for relatively long periods of time before they can fully perceive and accept the fact that they will not be hurt if they become vulnerable in treatment. For such people, interventions such as therapeutic exposure or psychodynamic interpretation may not be appropriate until therapy has

been in place for a long enough time to allow an expectation of safety. Given these concerns, it is obviously important that the therapist be able to determine the client's relative *experience* of therapeutic safety, since many clinical interventions involve the activation and processing of upsetting memory material. To the extent that such memories trigger fear and pain, those who are not aware that they are safe may be more distressed by such activations.

As noted earlier in this chapter, ensuring safety also means working to ensure that the client will be relatively free of danger outside of the therapeutic setting. Highly fearful or endangered survivors are unlikely to have sufficient psychological resources to participate in psychotherapy without being emotionally overwhelmed and/or especially avoidant. The battered woman should be as safe as possible from further battery, and the sexual abuse victim must be out of danger from his or her perpetrator, before psychological processing of symptoms is attempted. Otherwise, the client's life and physical integrity may be risked in the service of symptom relief. Although this may seem an obvious fact, many therapists fall into the trap of attempting to process traumatic memories with acutely traumatized individuals who continue to live in obviously dangerous circumstances.

This does not mean that all psychological interventions are ruled out in work with the still-at-risk—only those having as their primary focus the direct processing of traumatic memories and feelings, or those that prize insight over safety. For example, the acutely battered woman may easily gain from psychoeducational activities or cognitive interventions that provide information on increasing personal safety or that support the often daunting task of leaving an abusive partner (Jordan, Nietzel, Walker, & Logan, 2004). On the other hand, she may be placed at continued risk if the immediate focus of therapy is to emotionally process her last battery experience or to analyze what childhood issues are involved in her attraction to authoritarian men in the first place. Of course, some chronic life-endangering phenomena, such as unsafe sexual practices or intravenous substance abuse, are not threats that can be easily terminated—the individual may need some level of symptom reduction, increased coping, or psychoeducation before these behaviors can be reduced or ended. Nevertheless, when the danger is acute and potentially avoidable, the clinician's first focus must be on ensuring immediate safety.

## Provide and Ensure Stability

*Stability* refers to an ongoing psychological and physical state whereby one is not overwhelmed by disruptive internal or external stimuli. It also implies some degree of capacity to resist the effects of such stimuli in the near future. Stability concerns are highly relevant to work with trauma survivors, since



adverse events are often destabilizing and can produce conditions (for example, chaotic interpersonal or physical environments, posttraumatic stress, depression) that further increase susceptibility to stress. In addition, some trauma-related responses (for example, substance abuse, problematic personality traits, or reactive psychosis) can contribute to unstable lifestyles, such as homelessness, recurrent involvement in chaotic and intense relationships, or chronic self-destructiveness.

### *Life Stability*

*Life stability* refers to generally stable living conditions. For example, those living in extreme poverty, chaotic environments, or chronically risky occupations (for example, prostitution) may have difficulty tolerating the additional distress sometimes activated by trauma therapy. Such conditions may involve hunger, fear, racial or sexual oppression, and the insecurity associated with inadequate or absent housing—none of which support emotional resilience in the face of activated distress. In fact, without sufficient security, food, and shelter, avoidance of traumatic material (for example, through numbing or substance abuse) may appear more useful to the trauma victim than the seemingly counterintuitive notion of reliving painful memories. Trauma therapy is most helpful to those who have the social and physical resources necessary to experience safety and the option of trust. As a result, the first intervention with traumatized people who have few resources is often social casework: arranging adequate and reliable food, shelter, and physical safety.

### *Emotional Stability*

In addition to physical stability, trauma survivors should have some level of psychological homeostasis before formal trauma therapy can be initiated (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005; Herman, 1992a). In general, this means that those with acute psychotic symptoms, high suicidality, extremely high levels of posttraumatic stress, or debilitating anxiety or depression may require other interventions before trauma therapy can be initiated. These include the appropriate use of medication (see Chapter 11), crisis intervention, and, in some cases, supportive psychotherapy. In the absence of such pretreatment, activation of trauma-related material may result not only in an exacerbation of existing symptoms (for example, renewed psychosis or posttraumatic stress) but also may overwhelm the survivor's existing capacity to regulate his or her emotional state, producing new distress and dysfunction. Exacerbated or newly activated symptoms, in turn, may result in increased avoidance behaviors, such as substance abuse or suicidality, as well as increasing the likelihood that the client will drop out of therapy.

It is not always easy to determine when symptoms are too intense to warrant trauma-specific interventions as opposed to being worthy targets of treatment. For example, when is posttraumatic stress or anxiety too severe to support cognitive-behavioral therapy, and when are these symptoms in the range that would be appropriate for such treatment? Specific assessment approaches that may shed some light on these issues were presented in Chapter 3. Most generally, the issue is whether the symptoms in question have significantly reduced the client's capacity to "handle" or regulate the almost inevitable upsurge of emotion that follows therapeutic exposure to unresolved trauma memories. If the increased activation is not overwhelming, classic trauma treatment is usually indicated. If the response to treatment would be to become flooded with negative affects, pretreatment (or solely supportive psychotherapy) is required until greater psychological stability is present.

Interestingly, some forms of disorder traditionally assumed to be synonymous with psychological instability may not always be contraindications for trauma therapy. For example, some traumatized individuals with borderline personality disorder or low-level chronic psychosis may be sufficiently stable to tolerate classic trauma treatment, whereas others with less diagnostic severity may not. Clinicians often have concerns when working with psychotic or Axis II disturbance because such disturbances are frequently associated with affect regulation problems and more extreme dysphoria. However, the critical issue is less the type of disorder, per se, than the client's relative capacity to tolerate the emotions associated with exposure to traumatic memories.

## Maintain a Positive and Consistent Therapeutic Relationship

One of the most important components of successful trauma therapy is a good working relationship between client and therapist (Pearlman & Courtois, 2005). In fact, a number of studies indicate that therapeutic outcome is best predicted by the quality of the treatment relationship, as opposed to the specific techniques used (Lambert & Bergin, 1994; Orlinski, Grawe, & Parks, 1994). Although some therapeutic approaches stress relationship dynamics more than others, it is probably true that all forms of trauma therapy work better if the client feels accepted, liked, and taken seriously. Even in short-term, highly structured treatment approaches (for example, some forms of cognitive-behavioral or pharmacologic therapies), clients with good working relationships with their helpers are more likely to persevere in treatment, adhere to whatever regimen is in place, and, as a result, experience a more positive clinical outcome (Rau & Goldfried, 1994). Longer-term and more interpersonal treatment approaches, in which relational issues are more



prominent, are probably even more likely to benefit from a strong therapeutic relationship.

Because trauma therapy almost always involves revisiting and processing painful memories, as well as potentially reactivating feelings of danger and vulnerability, successful treatment is especially contingent on therapeutic support and connection. Distant, uninvolved, or emotionally disconnected client-therapist relationships are, in our experience, quite often associated with less positive therapeutic outcomes (see Dalenberg 2000, for an empirically based discussion of this issue). At minimum, a positive therapeutic relationship provides a variety of benefits. These potentially include:

- Decreased treatment drop-out and more reliable session attendance (Rau & Goldfried, 1994)
- Less avoidance and greater disclosure of personal material (Farber & Hall, 2002)
- Greater treatment adherence and medication compliance (Frank & Gunderson, 1990)
- Greater openness to—and acceptance of—therapist interpretations, suggestions, and support (Horvath & Luborsky, 1993)
- More capacity to tolerate painful thoughts and feelings during therapeutic exposure to trauma memories (American Psychiatric Association, 2001)

In addition to supporting effective treatment, the therapeutic relationship is more likely to be helpful to the extent that it both (1) gently triggers memories and schemas associated with prior relational traumas, and (2) provides the opportunity to process these activations in the context of therapeutic caring, safety, and support (Briere, 2002a). As is described in more detail in Chapter 9, even the most benign client-therapist relationship may trigger at least some rejection or abandonment fears, misperception of danger, or authority issues in survivors of extended or severe trauma. When these intrusions occur at the same time that the client is feeling respect, caring, and empathy from the therapist, they may gradually lose their generalizability to current relationships and become counterconditioned by current, positive relational feelings. In this sense, a good therapeutic relationship is not only supportive of effective treatment, it is virtually integral to the resolution of major relational traumas.

## Tailor the Therapy to the Client

Although a review of some currently available treatment manuals might suggest that clinical interventions are applied more or less equally and in similar ways to all mental health clients, this is almost never the case in actual

clinical practice. In fact, the highly structured, sometimes manualized nature of some empirically validated therapies more directly reflects the requirements of treatment outcome research (that is, the need for treatment to be highly similar and equally applied for each client in a given study) than any clinically based intent to provide equivalent interventions for all presenting clients (Westen, Novotny, & Thompson-Brenner, 2004). In the real world of clinical practice, clients vary significantly with regard to their presenting issues, comorbid symptoms, and the extent to which they can utilize and tolerate psychological interventions. For this reason, therapy is likely to be most effective when it is tailored to the specific characteristics and concerns of the individual person (Cloitre, Koenen, Cohen, & Han, 2002). We describe next several of the more important individual variables that should be taken into account when providing mental health interventions, including trauma therapy.

### *Affect Regulation and Memory Intensity Issues*

As noted previously, *affect regulation* refers to an individual's relative capacity to tolerate and internally reduce painful emotional states. People with limited affect regulation abilities are more likely to be overwhelmed and destabilized by negative emotional experiences—both those associated with current negative events and those triggered by painful memories. Since trauma therapy often involves activating and processing traumatic memories, individuals with less ability to internally regulate painful states are more likely to become highly distressed, if not emotionally overwhelmed, during treatment (Cloitre et al., 2002).

The idea of "affect regulation" is likely to be oversimplified, however. For example, some people are better at tolerating or regulating one type of feeling (for example, anxiety) than another (for example, anger), despite the common implication that any given person has a generalized capacity to regulate emotions. As well, some people's emotional responses may be more intense than others', as a function of having been exposed to more painful experiences. In this regard, it may take more affect regulation capacity to down-regulate emotions associated with some very painful memories (for example, prolonged torture) than those associated with less intense memories (for example, of an automobile accident). It is rarely enough to decide that someone has "affect regulation difficulties" without also determining the affective load that requires regulating (Briere, in press).

Variability in affect regulation capacity—and the severity of the memory-triggered affect to be regulated—has significant clinical implications. Most generally, individuals with impaired affect regulation—especially in the context of easily triggered, highly painful memories—are more likely to experience



overwhelming emotionality when exposed to upsetting memories during treatment, and to respond with increased avoidance, including "resistance" and/or dissociation. Such responses, in turn, reduce the client's exposure to traumatic material and to the healing aspects of the therapeutic relationship. As described in Chapter 7, treatment of those with impaired affect regulation capacities and/or a heavy trauma load should proceed carefully, such that traumatic memories are activated and processed in smaller increments than otherwise might be necessary. Often described as "titrated exposure" or "working within the therapeutic window" (Briere, 1996, 2002a), this usually involves adjusting treatment so that trauma processing that occurs within a given session does not exceed the capacities of the survivor to tolerate that level of distress—while, at the same time, providing as much processing as can reasonably occur (see Chapter 8). In individuals with substantially reduced affect regulation capacities (and/or especially distressing memories), this level of exposure and processing may be quite limited at any given moment. Nevertheless, over time, even seemingly small amounts of trauma processing tend to add up, ultimately leading to potentially significant symptom relief and greater emotional capacity without the negative side effect of overwhelming affect.

### *Preponderant Schemas*

As noted in Chapter 2, trauma exposure often has effects on cognition. Depending on the type of trauma and when in development it occurred, this may include easily triggered perceptions of oneself as inadequate, bad, or helpless, expectations of others as dangerous, rejecting, or unloving, and a view of the future as hopeless. Such distortions inevitably affect the client's perception of the therapist and of therapy. For example, the survivor may expect the therapist to be critical, unloving, or even hostile or abusive.

Early child abuse and neglect may result in latent gestalts of preverbal negative cognitions (Baldwin, Fehr, Keedian, Seidel, & Thompson, 1993) and feelings that are easily evoked by reminiscent stimuli in the immediate interpersonal environment. These relational schemas, when triggered, may result in sudden, intense thoughts and feelings that were initially encoded during childhood maltreatment. As a result, the adult abuse survivor may experience sudden feelings of abandonment, rejection, or betrayal during psychotherapy.

Because the cognitive effects of trauma vary from client to client, as a function of the individual's specific history, therapy must be adjusted to take into account each client's preponderant schemas of self and others (Pearlman & Courtois, 2005). In general, this means that the clinician should do as much as possible to (1) respond in ways that specifically do not reinforce the client's

negative expectations, and (2) avoid (to the extent possible) triggering underlying cognitive-emotional gestalts related to broader themes such as interpersonal danger or rejection. The individual with a tendency to view important interpersonal figures with distrust, for example, may require a therapist who is especially supportive and validating and who is careful not to trigger too many relational memories of maltreatment. This does not simply involve statements to the client that he or she is safe or positively valued—more important, the therapist should act and respond in such a manner that safety and caring is demonstrated and can be inferred. Because the distrustful client will be predisposed to miss such signs, and perhaps even actively misinterpret them, therapeutic interventions must be even more explicit and obvious in these areas than is the case for those without (or less of) this cognitive set.

It is important to note here that tailoring one's treatment approach to a given person's major cognitive issues does not mean that these distortions or disruptive schemas are not evoked in therapy. No matter how hard the clinician tries, the survivor who has been substantially maltreated in the past is likely to view some of the therapist's behaviors as punitive, critical, or abusive, and thus issues in this area almost unavoidably become a topic of discussion during therapy. However, because the therapist is working hard to minimize the extent of these misattributions and triggered schemas, whatever emerges over time in therapy is likely to be less intense and more easily demonstrable as contextually inaccurate. The repetitive experience of fearing that one's therapist is cold and rejecting, for example, and yet finding, over time, that these perceptions are manifestly untrue is often extremely helpful.

Significantly, although the clinician works hard to communicate an absence of criticism or rejection, this does not mean that he or she does not support the client's discussion and processing of these perceptions and feelings as they relate to subtle client-therapist dynamics or to others in the client's environment. Ultimately, the goal is to make treatment possible for those who are especially sensitive and suspicious of the vulnerability, connection, and intimacy that are part of the normal operating conditions of treatment. Knowledge that client X has "abandonment issues," client Y tends to perceive caring as intrusive or sexual in nature, or that client Z responds to authority figures with expectations of hostility or domination can allow the therapist to adjust his or her approach so that it does not unnecessarily trigger these issues and thereby interfere with the process of treatment.

## Take Gender Issues Into Account

Although there is little doubt that men and women undergo many of the same traumatic events and suffer in many of the same ways, it is also clear that (1) some traumas are more common in one sex than the other, and



(2) sex role socialization affects how such injuries are experienced and expressed. These differences, in turn, have significant impacts on the content and process of trauma-focused therapy.

As noted in Chapter 1, women are more at risk for victimization in close relationships than are men, and are especially more likely to be sexually victimized. In contrast, boys are at greater risk than girls of childhood physical abuse, and men are more likely to experience nonintimate physical assaults than women. In addition to trauma exposure differences, men and women tend to experience, communicate, and process the distress associated with traumatic events in different ways. Although there is major variation among people within each sex, women are generally socialized to express more directly certain feelings, such as fear or sadness, but are taught to dampen or avoid others, such as anger (Renzetti & Curran, 2002). Men, on the other hand, are often more permitted the expression of anger, but may be socially discouraged from communicating "softer" feelings, such as sadness or fear (Cochrane, 2005). Men and women also may differ in how they act upon feelings and needs. Men are to some extent taught to externalize or cognitively suppress unpleasant feelings, and to act on the environment in order to reduce pain or distress, whereas women are generally socialized to express their distress to trusted others, and are, overall, less prone to externalizing their pain through acting on the environment (Bem, 1976; Briere, 1996; Renzetti & Curran, 2002). These sex-role-related differences in symptom expression and behavioral response often manifest themselves during trauma-focused psychotherapy. All things being equal, for example, male trauma survivors in treatment may be more prone to expressions of anger—or to denying posttraumatic distress entirely—than female survivors, whereas traumatized women may be more open to emotional expression, especially of feelings of sadness, fear, or helplessness.

Given these sociocultural influences, the therapist should be alert to ways in which trauma survivors express or inhibit their emotional reactions based on sex-role-based expectations. Often, this will involve supporting the client to express the full range of feelings and thoughts associated with a traumatic event, as opposed to only those considered socially appropriate to his or her gender. In fact, to the extent that (as described in Chapter 8) feelings and thoughts are more easily processed when fully expressed during treatment, unaddressed sex role constraints are likely to inhibit full psychological recovery.

The therapist should also be aware of sex differences in how trauma is cognitively processed. Because boys and men are often socialized to present themselves as strong and able to defend themselves, victimization may be more of a sex role violation for them than it is for girls and women (Mendelsohn & Sewell, 2004). Such social expectations can result in different responses to

trauma. Victimized men, for example, may struggle with feelings of inadequacy, shame, and low self-esteem associated with the social implication that an inability to fight off maltreatment reflects lesser masculinity or competence (Mendel, 1995). In addition, many sexually assaulted or abused males have sexual orientation concerns related to their trauma. In the case of childhood sexual abuse, for example, heterosexual boys and men may fear that molestation by another male has caused them to be latently homosexual—a response that, in a homophobic culture, may result in compensatory hypermasculinity or overinvolvement in heterosexual activity (Briere, 1996). Conversely, homosexual men who were sexually abused by males as children may believe that their sexual orientation somehow caused them to be abused by men, or that their abuse caused them to be homosexual, conclusions that can lead to feelings of guilt, shame, and self-hatred (Briere, 1996).

Sex role expectations also affect, to some extent, how traumatized women view their victimization. Women who have been sexually assaulted may believe that they in some way enticed their perpetrators into raping them—a concern that reflects the traditional stereotype of females as sexual objects who are intentionally seductive (Burt, 1980). Similarly, women battered or otherwise abused by their partners may believe that their supposed lack of subservience or failure to perform as an adequate mate means that they deserved to be maltreated (Walker, 1984).

Given these gender-specific influences on trauma-related cognitions, the clinician is likely to be more helpful if he or she closely attends to concerns about unacceptability, self-blame, low self-esteem, shame, and sexual orientation as they are expressed in survivors' cognitive reactions to trauma. Traumatized men may require additional reassurance that they are not less masculine (regardless of sexual orientation) by virtue of having been victimized, and may gain from interventions that support the full range of emotional and cognitive expression without fear of stigmatization. Especially relevant, in this regard, is the need for many victimized men to process feelings of shame associated with viewing themselves as deviant and socially unacceptable. Women survivors, on the other hand, may gain especially from interventions that support self-determination and help them to reject feelings of responsibility for their abuse, including the unwarranted notion that they somehow sought out or otherwise deserved maltreatment.

## Be Aware of—and Sensitive to—Sociocultural Issues

### *Social Maltreatment*

One of the more overlooked issues in the treatment of trauma survivors is that people with lesser social status are more likely than others to be victimized



(Bassuk, Dawson, Perloff, & Weinreb, 2001; Breslau, Wilcox, Storr, Lucia, & Anthony, 2004). Social, sexual, and racial discrimination often have negative psychological effects that are, in a sense, posttraumatic (Loo et al., 2001; Root, 1996), and typically are associated with environmental conditions in which further trauma is common (Breslau et al., 1998; North, Smith, & Spitznager, 1994; Sells, Rowe, Fisk, & Davidson, 2003). Some groups in North America suffer from multigenerational trauma, including African Americans, whose ancestors were often held in slavery (Mattis, Bell, Jagers, & Jenkins, 1999), and American Indians who, as a group, have experienced extended maltreatment and cultural near-annihilation (Duran & Duran, 1995; Manson et al., 1996). Combined with the discrimination and marginalization often experienced by other non-Caucasian racial/ethnic groups, and the relatively dangerous living environments in which many are forced to live, social inequality provides a vast depot of trauma and trauma impacts in North America.

Beyond North America, individuals from some regions of the world are especially likely to be maltreated. When some of these people immigrate (or escape) to North America, they carry with them the trauma experienced in their countries of origin. Mental health centers specializing in refugee or immigrant issues regularly deal with the effects of holocausts or mass murder (for example, "ethnic cleansing"), political imprisonment, war, extended torture, "honor" killings, sexual violence, and extreme ethnic or gender discrimination (Basoglu, 1992; Marsella, Bornemann, Ekblad, & Orley, 1994; Miller & Rasco, 2004). This concatenation of social adversity and ethnic variation means that cultural and historical issues are often highly relevant to the process and content of trauma-focused psychotherapy.

### *Cultural Variation*

Partially because ethnic and racial minorities are more likely to be traumatized, and partially due to the general multicultural mix present in North American and European societies, individuals presenting for trauma services are likely to reflect a wide range of cultures and ethnic groups. Such cultural differences are not merely a function of race: people of low socioeconomic status often have different worldviews and experiences than those of the same race or ethnicity who have more economic and social opportunities. Similarly, merely knowing that someone is, for example, "African American," "Hispanic," "Asian," or "American Indian" says little about his or her cultural context. An individual from Vietnam, for example, may be quite different in perspective, language, and emotional style than a person from Japan. The 1999 Surgeon General's report on the cultural aspects of mental health services notes that:

> Asian Americans and Pacific Islanders . . . include 43 ethnic groups speaking over 100 languages and dialects. For American Indians and Alaska Natives, the Bureau of Indian Affairs currently recognizes 561 tribes. African Americans are also becoming more diverse, especially with the influx of refugees and immigrants from many countries of Africa and the Caribbean. (U.S. Surgeon General, 1999)

These wide cultural differences often translate into different trauma pre-entations and idioms of distress, as described in Chapter 2. In addition, ıbove and beyond their social status in North America, people from the var-ous cultures and subcultures of the world have widely different expectations of how clinical intervention should occur, and of the ways in which clinicians ınd clients should interact (Marsella et al., 1996). In one culture, for exam-ple, eye contact between clinician and client is a sign of respect; in another, it nay be the complete opposite. Similarly, in some cultures, certain topics (for :xample, sexual issues, visible loss of dignity) are considered to be more :mbarrassing or shameful than in others, and thus should be raised only when elevant to treatment, and then with great sensitivity.

Although the focus of this book precludes a detailed discussion of this ssue, a central point must be made: cultural awareness and sensitivity are ın important part of any psychotherapeutic process—including trauma ther-ıpy. Clinicians who find themselves, for example, regularly working with Cambodian refugees, Hmong clients, or Mexican immigrants have a respon-ibility to learn the primary "rules" of clinical engagement with people from :hese counties, as well as, if possible, something of their culture, history, and anguage.

## Monitor and Control Countertransference

A last general topic of this chapter is what is commonly referred to as *countertransference* (also described as *counteractivation* in self-trauma theory [Briere, 2005]; see Chapter 8). Although this phenomenon has many different definitions, we use it here to refer to occasions when the therapist responds to the client with cognitive-emotional processes (for example, expectations, beliefs, or emotions) that are strongly influenced by prior personal experi-ences. In many of these cases, these experiences involve childhood maltreat-ment, adult traumas, or other upsetting events. Of course, all behavior is influenced by past experience, and not all countertransference responses are negative (Dalenberg, 2000; Pearlman & Saakvitne, 1995). Even positive countertransference, however, must be monitored by the therapist, since it may produce unwanted responses such as idealization of the client, the need



to normalize what are actually problematic client behaviors or symptoms, or even sexual or romantic feelings. Ultimately, the concern is that counter-transference can interfere with treatment by leading to either (1) a deleterious clinical experience for the client or (2) processes that disrupt the treatment process.

For example,

- Therapist A was raised by a critical, psychologically punitive parent. She now finds that she tends to experience angry or guilty feelings when her client complains about any aspect of the therapy.
- Clinician B was sexually assaulted slightly more than a year ago. Now—upon hearing a client's disclosure of sexual abuse—she experiences powerful feelings of fear and revulsion.
- Therapist C, who is dealing with a recent traumatic death of a loved one, finds that he is prone to feelings of extreme sadness and emptiness while treating a client whose son was killed in a fire.
- Clinician D grew up in a violent, chaotic family atmosphere, where safety and predictability were rarely in evidence; her supervisor notices that she has a strong need to control the process of therapy and tends to see certain clients as manipulative, inappropriately challenging, or engaging in therapeutic "resistance."
- As a child, Clinician E was often protected by a supportive aunt when his mother would go into angry, abusive tirades. He is now treating an older, kindly woman whom he has a difficult time seeing as psychologically disabled, despite her obvious symptomatology.

An additional form of countertransference involves therapist denial or cognitive avoidance of certain subjects or themes during the treatment process. A clinician who tends to avoid thinking about unresolved traumatic material in his or her own life may unconsciously work to prevent the client from exploring his or her own trauma-related memories and feelings. In such instances, the clinician may even become resentful of the client for restimulating his or her own avoided memories or feelings, or may reinterpret appropriate client attempts to confront the past as hysteria, self-indulgence, or attention seeking.

The primary manifestations of an unconscious desire to distance oneself from the client's distress are (1) attempts to avoid discussion of the client's trauma history and (2) a generally decreased emotional attunement to the client. In each instance, the underlying strategy is the same: reduced therapeutic contact as a way to reduce the likelihood of triggered emotional pain. When this response is especially powerful, the clinician may slow or neutralize therapy by decreasing the client's exposure to traumatic material to such a point that it is not processed. At the same time, therapist distance or lack of attunement may activate client abandonment issues, further impeding treatment.

Obviously, given the client's need for safety, stability, boundaries, positive egard, and connection, therapist countertransference can be problematic. 'he trauma survivor, who inherently relies on the therapist for objective data nd relatively uncontaminated responses, may be triggered or misdirected by he intrusion of the clinician's trauma history.

### *Reducing the Negative Effects of Therapist Countertransference*

As noted earlier, not all countertransference is necessarily problematic, nd, in fact, all therapists experience some level of countertransference in ıeir work. When countertransference interferes with treatment, however, teps must be taken to reduce its influence.

Generally, one of the best preventive measures against countertransference roblems is regular consultation with a seasoned clinician who is familiar vith trauma issues and, hopefully, the therapist (Pearlman & Courtois, 005). Another option is to form a consultation group with one's peers. Iowever they are structured, such meetings should allow the clinician to ıare the burden of his or her daily exposure to others' pain, as well as to xplore ways in which his or her own issues can negatively affect therapeutic utcome. In many instances, inappropriate identification or misattribution an be prevented or remedied by the consistent availability of an objective onsultant who is alert to countertransference issues in general, and the clin-ian's vulnerabilities in specific.

An additional intervention, for clinicians who acknowledge the impacts of auma in their own lives, is psychotherapy. It is an ironic fact that, at least ı some environments, clinicians endorse the power of psychological treat-ıent for others yet eschew it for themselves as somehow shameful or unlikely ) help. This double standard is unfortunate, since having experienced psy-ıotherapy is usually a good thing for therapists. Therapy is not only likely ) reduce the clinician's trauma-related difficulties; it can also increase the chness of his or her appreciation for human complexity, and can dramat-ally decrease the intrusion of his or her issues into the therapeutic process.

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