- An overall approach that is respectful, positive, and compassionate, and that provides support and validation in the context of an empathically attuned 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
- Activities that increase self-awareness and self-acceptance, including opportunities to reflect on one's internal experience and change one's relationship to the effects of one's history

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 more acute trauma presentations and the psychopharmacology of posttraumatic states.

FOUR

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 and, to some extent, theoretical 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.

Intrinsic Processing

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, when possible, to move toward more adaptive psychological functioning. As discussed in more detail in Chapter 8, many of the "reexperiencing" symptoms of posttraumatic stress disorder can be conceptualized as recovery algorithms that humans have evolved over time as a response to trauma exposure (Briere, 1996, 2002b; see also a related perspective by M. J. Horowitz, 1978). The intrinsic function of these reliving experiences appears to be, at least in part, a way to process,

desensitize, and integrate upsetting material. This implies that individuals who present with intrusive 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, to some extent, 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. This view allows the therapist to more clearly understand expressed emotional pain as "just" emotional pain—not as intrinsically negative, nor as a trigger for countertransference, but rather as a process wherein the client can process her or his history and ultimately experience reduced emotional suffering.

A second, related notion offered here 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 help 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-acceptance, a greater sense (and appreciation) of being alive, increased empathy, and a more broad and complex view of life in general (A. Brown, 2009; Joseph & Linley, 2008; V. E. O'Leary, 1998; K. 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, and that the process of surmounting obstacles may lead to increased capacities, and perhaps even greater wisdom. The message is not that one should "look on the bright side," which can easily be seen as dismissive and unempathic, and may support avoidance. 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 traumas such as severe childhood abuse, torture, or disfiguring fire may feel that they have been permanently injured, if not ruined for life. In other cases, life experiences may have pushed some survivors so far into withdrawal 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 be limited to symptom reduction; it may also include the possibility of new awareness, 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 resilient.

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 not only can recover, but also may grow from traumatic experience, brings tremendous richness and optimism to the job of helping hurt people.

Respect, Positive Regard, and Compassion

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 develop beyond it. It is often hard to be in therapy, especially when (as is outlined in the next few 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 harder choice, when the option is available, to directly engage one's memories and their attendant psychological distress and attempt to integrate them into the fabric of one's life. As noted at various points in this book, it may be that the client must engage in some level of avoidance in order to deal with otherwise overwhelmed memories, thoughts, and/or feelings during treatment. These responses are logical, even helpful, and should be understood as such by the clinician. Although sometimes problematic, such "resistance" does not contradict the fact that the client deserves considerable respect for being willing to revisit painful events and

to choose some level of awareness over the apparent (although typically false) benefits of complete 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, imbued with the notion that the client is doing the best he or she can with the circumstances that confront him or her, the therapy process almost always benefits. Although the client may not completely believe the therapist's nonjudgmental, positive appraisal of him or her (in C. R. Rogers's [1957] lexicon, his or her *unconditional positive regard*), visible therapist respect and appreciation assists greatly in establishing a therapeutic rapport, increasing the likelihood that the client will make himself or herself psychologically available to the therapeutic process.

Related to positive regard, but extending beyond it, is the notion of *compassion*. Considered at various points in this book, compassion can be defined as nonjudgmental, nonegocentric awareness and appreciation of the predicament and suffering of another (in this case, the client), with the directly experienced desire to relieve that person's distress and to increase his or her well-being. Compassion involves a positive emotional state in the clinician—unconditional caring that is directed to the client regardless of his or her actual or presumed good or bad qualities (see Briere, 2012a; Germer, 2009; as well as Chapter 10, for discussions of compassion and its various definitions).

Importantly, compassion is not equivalent to pity, which implies a power imbalance and clinician sympathy regarding the diminished state or status of the client. Rather, it reflects the clinician's awareness that he or she and the client share a common human predicament—the impermanence and fragility of life and well-being—and the fact that all humans, including the clinician, will suffer at various points in their lives. It also involves the natural caring feelings that tend to arise when we see, without distortion, the struggle and vulnerability of others.

From this perspective, the clinician communicates nonjudgmental caring in a way that is not clinically detached, pathologizing, or superior. In the presence of such valuation, the traumatized client may be more able to fully inhabit, accept, and process his or her distress, while incorporating a sense of loving acceptance in relationship to another. As we note in Chapters 8 and 9, this positive state may activate attachment-related neurobiological phenomena

that, in turn, serve to countercondition the client's negative emotional responses associated with past relational traumas.

Compassion is probably a normal human state, but it can be further developed in the clinician in various ways. These include clinical training and supervision that emphasizes nonegocentric attention and mindfulness, specific didactic and experiential exercises that teach compassion (Gilbert, 2009), and, for those interested in this path, contemplative activities such as *metta* and mindfulness meditation (for example, Salzberg, 1995).

Hope

Hope is critically important to effective trauma treatment. Repeated experience of painful things (including 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 Pollyanna-ish 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 intrinsic self-healing processes described earlier in this chapter and in Chapter 3. Even more important, having completed trauma-focused treatment is associated with greater symptom reduction than not having done so (see Foa, Keane

Friedman, & Cohen, 2008, for a review of most current therapies and their effectiveness for trauma). 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 (Briere & Lanktree, 2014; 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.

THE PAIN PARADOX

Implicit in various aspects of this discussion is something we can call the *pain paradox.* It is referred to as a paradox because traumatized or otherwise suffering people sometimes inadvertently engage in pain-enhancing or sustaining behaviors while trying to reduce painful or upsetting states. In an effort to remediate distress and suffering, survivors may do things that specifically increase, not decrease, posttraumatic distress, and that often make them more chronic.

The paradox lies in how we are socialized to address emotional pain and discomfort. It is not uncommon to receive advice from friends or others to "just get over it," "put your past behind you," or "snap out of it." Similarly, media advertising campaigns counsel the viewer or listener to take pills for all varieties of discomfort, buy things to feel better, and address self-perceived inadequacies with purportedly ego-boosting products, ranging from make-up to automobiles. The message is often that pain, distress, and dissatisfaction are bad things. Because they are bad, they should be removed, medicated, distracted from, or otherwise avoided. Once a person is no longer in pain, or his or her pain has been numbed, once he or she is not aware of bad feelings, then he or she will feel good and will experience happiness. In this context, in fact, feeling good often arises when one has done things to stop from feeling bad.

However, although a common approach to distress in our culture is to do whatever possible to end it, modern psychology (and, as it turns out, philosophies such as Buddhism) suggests that avoiding unwanted thoughts, feelings, and memories actually increases or sustains pain, symptoms, and distress—whereas directly experiencing and engaging pain ultimately reduces it. For example, numerous studies indicate that those who use drugs or alcohol, dissociate, avoid discussing what has happened to them, and/or engage in other avoidance behaviors such as denial or thought suppression are more likely to develop intrusive and chronic posttraumatic problems and syndromes (Briere, Scott, & Weathers, 2005; Cioffi & Holloway, 1993; D. M. Clark, Ball, & Pape, 1991; Gold & Wegner, 1995; Morina, 2007; Pietrzak, Harpaz-Rotem, & Southwick, 2011). In contrast, those who are able to more directly experience distress, or engage in psychotherapy, mindfulness training, therapeutic exposure, or other ways of accessing traumatic memory, are likely to have improved and experience less chronic outcomes (Foa, Huppert, & Cahill, 2006; Hayes, Strosahl, & Wilson, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Palm & Follette, 2011; B. L. Thompson & Waltz, 2010). As Bobrow (2011) notes, "what we cannot hold, we cannot process. What we cannot process, we cannot transform. What we cannot transform haunts us" (para. 5; also see Bobrow, 2007).

The pain paradox thus suggests that people who have been hurt do best if—to the extent possible—they can stay present in their pain, avoid less, and experience more. From this perspective, pain is not "bad," nor are anxiety or sadness "bad" feelings; in fact, the experience of pain, distress, or even flashbacks may be "good": It represents access to experiences that can be cognitively and emotionally processed and, once addressed, may then lessen or fall away.

Of course, it is easy to say that people in pain should try not to block, suppress, or deny. As noted at various points in this book, trauma-related problems in affect regulation and tolerance, especially in the context of overwhelming memories, and/or a lack of sufficient social support, may mean that the survivor essentially has no choice but to avoid, in order to maintain some degree of internal homeostasis. Asking a homeless war veteran, hospitalized burn victim, or torture survivor to "stay with the pain" can be a harsh, perhaps impossible, request. Yet even the very beleaguered person may have moments when he or she could tolerate more direct access to internal distress, painful memories, or potentially difficult realization. Further, the titrated exposure activities described in Chapter 8 are designed to provide the otherwise avoidant survivor with the opportunity to experience and process small increments of nonoverwhelming traumatic memory. Thus, the suggestion to allow emotional pain rather than

avoid it is a general one—not a demand that the overwhelmed trauma survivor open the floodgates of previously suppressed trauma, but rather an invitation to engage when it is safe and appropriate to do so, and only to the extent possible.

The implications of the pain paradox for trauma therapy are significant. They suggest that approaches that encourage awareness of one's ongoing experience, that allow access to nonoverwhelming amounts of painful memory, and that encourage deeper insight into the basis for ongoing suffering, will be helpful—whereas medications that only numb or mask unwanted emotional states, or therapies that distract, focus merely on support, or even teach avoidance, may be less efficacious.

In general, concepts such as the pain paradox and intrinsic processing are depathologizing: Painful posttraumatic states such as flashbacks, grief, anxiety, or depression are not necessarily evidence of a disorder, per se. In many cases, they represent a healthy condition: access to immediate awareness, even if that awareness carries with it things that cause distress, make one sad, or bring one fear. As the client is more able to hold, tolerate, and process these states and their etiologies, without unnecessary interference through avoidance, the emotional mechanisms described in Chapter 8 will more easily take place and recovery will be more likely.

CENTRAL TREATMENT PRINCIPLES

Beyond a 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, some are also relevant to other treatment methodologies, including trauma psychopharmacology.

Provide and Ensure Safety

Because trauma is about vulnerability to danger, safety is a critical issue for trauma survivors (Cook et al., 2005; Herman, 1992b; Najavits, 2002). 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 a 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 little 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 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 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 its capacity to be evoked by the present.

Unfortunately, in order to feel safe, not only must there 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). As a result, even a safe therapeutic environment may appear unsafe to some clients. For this reason, among others, treatment may take considerably longer—and call more on the clinician's patience and sustained capacity for caring—than is allowed for by shorter-term therapies. Some multiply traumatized individuals—former child abuse victims, torture survivors, victims of sustained 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 and stability (Courtois, 2010). 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 become more distressed by such activations.

As noted earlier in this chapter, providing 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 exclusive 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 (C. E. 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 significantly reduced or terminated. 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 survivor 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 certain aspects of trauma therapy can be initiated (Cloitre et al., 2010; 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 exposure-based aspects of trauma therapy can be initiated. These include the appropriate use of medication (see Chapter 12), crisis intervention, development of affect tolerance and regulation skills, and, in some cases, simple supportive psychotherapy. In the absence of such pretreatment, activation of trauma-related material not only may result 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 (Briere, 2002b). 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 immediate trauma-specific interventions, as opposed to being worthy targets of treatment. For example, when is posttraumatic stress or anxiety too severe to support therapeutic exposure to traumatic memory, 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, more grounding, skills-development, and/or supportive psychotherapy will be 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 therapeutic exposure. For example, some traumatized individuals with "borderline personality disorder" or low-level chronic psychosis may be sufficiently stable to tolerate trauma treatment, whereas others with less diagnostic severity may not. Clinicians often have appropriate concerns when working with psychotic or personality disorders because such disturbance is 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 appears to be a good working relationship between client and therapist (Courtois & Ford, 2013; Kudler, Krupnick, Blank, Herman, & Horowitz, 2009; 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 (M. J. Lambert & Barley, 2001; Martin et al., 2000; 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 clinician is compassionate and attuned, and the client feels accepted, liked, and taken seriously. Even in short-term, highly structured treatment approaches (for example, some forms of cognitive-behavioral therapy), clients with good 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 even more likely to benefit from a strong therapeutic relationship.

Because trauma therapy often 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 a minimum, a positive therapeutic relationship provides a variety of benefits. These potentially include decreased treatment dropout and more reliable session attendance, less avoidance and greater disclosure of personal material, greater treatment adherence and medication compliance, greater openness to—and acceptance of—therapist suggestions and support, and more capacity to tolerate painful thoughts and feelings during therapeutic exposure to trauma memories (American Psychiatric Association, 2001; Cloitre et al., 2002; Farber & Hall, 2002; A. F. Frank & Gunderson, 1990; Horvath, 2007; McGregor, Thomas, & Read, 2006; Rau & Goldfried, 1994).

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, 2002b). 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, compassion, and empathy from the therapist, they may gradually lose their generalizability to current relationships and become

counterconditioned by positive relational feelings. In this sense, a good therapeutic relationship is not only supportive of effective treatment, but 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 to all mental health clients with similar complaints, 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 et al., 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 (Briere & Lanktree, 2011; Cloitre et al., 2002). We next describe 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; Cloitre et al., 2010; Courtois, 2010).

The affect regulation construct can 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, of 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.

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 8, treatment of those with impaired affect regulation capacities and/or a heavy trauma load should proceed especially 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, 2002b), 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; DePrince, Combs, & Shanahan, 2009; Dutra, Callahan, Forman, Mendelsohn, & Herman, 2008) 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 and that are hard for the survivor to discriminate from current, real-time perceptions. As a result, the adult abuse survivor may experience sudden feelings of abandonment, rejection, or betrayal during psychotherapy and attribute them to the therapist.

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 with 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 no longer evoked in therapy. As noted in Chapter 9, 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, often can be extremely helpful.

Significantly, although the clinician works hard to communicate an absence of criticism or rejection, this does not mean that he or she discourages 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 unduly 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 often 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 both girls and women are especially more likely to be sexually victimized than their male counterparts. In contrast, boys are at greater risk than girls of childhood physical abuse, and boys and men are more likely to experience nonintimate physical assaults than girls and 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, and

across cultures and sexual orientations, 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, whereas men are often more permitted the expression of anger, but may be socially discouraged from communicating "softer" feelings, such as sadness or fear (Cochrane, 2005; Krause, DeRosa, & Roth, 2002; Levant & Pollack, 1995; Renzetti & Curran, 2002). Men and women may also 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; Feuer, Jefferson, & Resick, 2002; 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 also should 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 (or be seen as) latently homosexual (Alaggiaa, 2005)—a response that, in a homophobic culture, may result in compensatory hypermasculinity or overinvolvement in heterosexual activity (Briere, 1996). Conversely, gay or bisexual men who were sexually abused by males as children may incorrectly believe that their sexual orientation somehow caused them to be abused by men, or that their abuse caused them to be paradoxically attracted to men, conclusions that, in many cultures, may 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 or unintentionally seductive (Baugher, Elhai, Monroe, & Gray, 2010; M. R. 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 (Barnett, 2001; L. E. 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 that 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 et al., 2001; Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Carter, 2007). Traumas common among those with lower socioeconomic status, in addition to child abuse, neglect, and exposure to domestic violence (Bergner, Delgado, & Graybill, 1994; Finkelhor, Ormrod, Turner, & Hambry, 2005; Kyriacou et al., 1999; Sedlak & Broadhurst, 1996), are sexual and physical assaults by peers, community violence, shootings, robbery, sexual exploitation through prostitution, trauma associated with refugee status, and loss associated with the murder of a family member or friend (for example, Berthold, 2000; Breslau, Davis, Andreski & Peterson, 1991; Farley, 2003; Giaconia, Reinherz, Silverman, & Pakiz, 1995; Schwab-Stone et al., 1995; Singer et al., 1995).

Social, sexual, and racial discrimination, as well as marginalization of gay, lesbian, bisexual, and transgendered people, also ate likely to have direct negative psychological effects that are, in a sense, posttraumatic (Berg, 2006; Carter & Forsyth, 2010; 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 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). Social marginalization also means that many traumatized people have reduced access to appropriate mental health services (for example, McKay, Lynn, & Bannon, 2005; Perez & Fortuna, 2005; Rayburn et al., 2005). Combined with the discrimination often experienced by other racial/ethnic minority 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.

Refugees

Beyond North America, individuals from certain regions of the world are especially likely to be maltreated. When these people immigrate to North America or other places, they often 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, trafficking, "honor" killings, sexual violence, and extreme ethnic or gender

discrimination (Allden, Poole, Chantavanich, & Ohmar, 1996; Basoglu, 1992; Marsella, Bornemann, Ekblad, & Orley, 1994; K. E. Miller & Rasco, 2004; Steel et al., 2009). The effects of such experiences tend to be especially long-lasting; in one sample of 80 Vietnamese refugees resettled to Norway, the majority still had very high symptom scores on a standardized measure 23 years later (Vaage et al., 2010). The 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 and should not be overlooked (Marsella et al., 1996; Nickerson, Bryant, Silove, & Steel, 2011).

Cultural Variation

Partially because ethnic and racial minorities are more likely to be traumatized, and partially due to the general multicultural mix present in many modern 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 from a person raised in Japan. The Surgeon General's (2001) last report on the cultural aspects of mental health services noted:

> 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.

These wide cultural differences often translate into different trauma presentations and idioms of distress, as described in Chapter 2. In addition, above and beyond their social status in North America, people from the various cultures and subcultures of the world have widely different expectations of how clinical intervention should occur, and of the ways in which clinicians and clients should interact (Marsella et al., 1996; Nader, Dubrow, & Stamm, 1999; Van der Veer, 1995). In one culture, for example, eye contact between clinician and client is a

sign of respect; in another, it may be the complete opposite. Similarly, in some cultures, certain topics (for example, sexual issues, visible loss of dignity) are considered to be more embarrassing or shameful than in others, and thus should be raised only when relevant to treatment, and then with great sensitivity.

Although the focus of this book precludes a detailed discussion of this issue, a central point must be made: Cultural awareness and sensitivity are an important part of any psychotherapeutic process—including trauma therapy. Clinicians who find themselves, for example, regularly working with Cambodian refugees, Hmong clients, or Mexican immigrants have a responsibility to learn the primary rules of clinical engagement with people from these cultures, as well as, if possible, something of their culture, history, and language.

Monitor and Control Counteractivation

An additional important concept in trauma-focused therapy is what is commonly referred to as *countertransference* (described as *counteractivation* in self-trauma theory [Briere, 2006]; 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 experiences. In many of these cases, these experiences involve childhood maltreatment, adult traumas, or other upsetting events. Of course, all behavior is influenced by past experience, and not all counteractivation responses are negative (Dalenberg, 2000; Pearlman & Saakvitne, 1995). Even positive countertransference, however, must be monitored by the therapist, since it may produce unhelpful 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 counteractivation 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 experienced a traumatic miscarriage a month ago. Upon hearing her client's excitement about a new pregnancy, she experiences unexpected anger and distress.

- 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 especially manipulative, malingering, 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 counteractivation 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 attempts to avoid discussion of the client's trauma history and 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.

Reducing the Negative Effects of Therapist Counteractivation

As noted earlier, not all counteractivation is necessarily problematic, and, in fact, all therapists experience some level of counteractivation in their work. When it interferes with treatment, however, steps must be taken to reduce its influence.

One of the best preventive measures against countertransference problems is regular consultation with a seasoned clinician who is familiar with trauma issues and, hopefully, the therapist (Briere, 2006; Pearlman & Courtois, 2005). Another option is to form a consultation group with one's peers. However structured, such meetings should allow the clinician to share the burden of his or her daily exposure to others' pain as well as to explore ways in which his or her own issues can negatively affect therapeutic outcome. In many instances, inappropriate identification or misattribution can be prevented or remedied by the consistent availability of an objective consultant who is alert to countertransference issues in general, and the clinician's vulnerabilities in specific.

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

Practice Ethically and Within the Standard of Care

A final topic in this chapter is that of ethical and professional practice. Because the trauma client is often in a vulnerable state, and psychotherapy generally involves a power imbalance between client and therapist, it is very important that the clinician attend to any issues or dynamics that might even remotely result in maltreatment, exploitation, or inadequate care.

In many cases, ethical and risk-reducing activities correspond to what would be good therapeutic practice in any event. For example, honoring the client's boundaries, refraining from any form of exploitation or maltreatment, reporting and (when appropriate) intervening in potential danger to the client and others, and guarding the client's confidentiality all reflect activities that increase safety (Chapter 4), support identity development and functioning (Chapter 9), and/or encourge a positive therapeutic relationship (Chapter 4). Similarly, the therapist should take care to not overdisclose his or her personal history, relationships, preferences, or ideas about things unrelated to the client, as well as constraining the extent to which the client and therapist interact

outside of the treatment. This not only allows him or her to manage the client's trauma activations, but it also addresses professional and ethical issues around dual relationships, clinical boundaries, and professional standards of care. Finally, professional requirements regarding documentation and charting allow the clinician to monitor the client's progress in therapy, such that treatment interventions correctly address the client's current needs, as well as to provide relevant information to other professionals when warranted.

As noted earlier in this chapter, because the form of treatment outlined in this book emphasizes relational connection with—and positive regard toward—the trauma survivor, issues associated with counteractivation are especially salient. For example, although compassion—requiring nonegocentric caring and the need for the therapist to be interpersonally "present"—is an important part of trauma-focused psychotherapy, these issues occasionally can be challenging for the clinician. For example, when are one's caring feelings for the client based on compassion and appreciation of his or her suffering, and when do they potentially represent the clinician's own needs for intimacy or connection, or unprocessed sexual or romantic issues? Similarly, how is the therapist to discriminate understandable anger at the client's trauma perpetrator, or sadness at his or her irrevocable losses, from counteractivation of the clinician's own childhood memories? What is the exact boundary point that must be reinforced when the client requests additional attention, caring, or self-disclosure from the therapist? In some cases, responsivity and slightly increased connection or attunement can be helpful, if it is appropriate to the situation and monitored for counteractivational distortions. In other cases, the therapist's over-response to such demands or requests may reflect co-transferential dynamics and produce problems.

Although this is obviously a complex topic, we offer several suggestions:

- Therapy boundary violations, including voyeurism, emotional gratification, exploitation, dual relationships (inside or outside of the therapy environment), romanticization, or any sexual behavior are unethical and potentially very harmful to the client. If the clinician is concerned that any of these phenomena are occurring, he or she should proceed under the assumption that the concern is valid. Under such circumstances, outside help, consultation, or (in the case of actual and significant behavior) intervention should be sought.

- Authoritarian or overly directive treatment can have negative impacts. A corollary of this is that the therapist should not be definitive when, in fact, the issues are complex; the client is, in some ways, unknowable to the

therapist; and absolute truth is hard to find. Interventions that involve lecturing or heavy-handed declarations of fact are likely to go awry, and may be bad practice. Examples include

- Telling the client that he or she has or has not been abused, despite his or her protestations to the contrary or a lack of evidence one way or the other;
- Making definitive interpretations about the meaning or etiology of the client's current behavior when, in fact, such hypotheses are largely speculative;
- Validating or supporting unfair or prejudicial social messages about sex, race, age, ethnicity, sexual orientation, gender identity, or socioeconomic status;
- Reinforcing dependency or acquiescence in someone who needs to become more entitled, self-referenced, and independent; and
- Making value judgments about things that are best seen nonjudgmentally, such as many forms of "bad" or "immoral" behavior.

• Duty to report trumps confidentiality. If the therapist becomes aware—or has reasonable suspicion—of child, elder, or dependent adult abuse, or of the client's danger to himself or herself or others, the clinician must do whatever is required by law and professional ethics to ensure safety. This may involve the child welfare system, law enforcement, or involuntary hospitalization. Issues in this area are sometimes hard for clinicians to confront, especially when the correct action goes against the wishes of the client. There are no easy answers to the breach of trust that the client may feel in such circumstances. We suggest, however, that clients be informed at the onset of therapy about what the law or professional ethics require the therapist to report or intervene in, so that such actions at a later date are less surprising (see Briere and Lanktree, 2011, for a more detailed discussion of this topic).

• Clinician counteractivational responses are, in our experience, typically triggered ones. If the therapist notes a significant change in his or her internal state or perspective, or intrusive phenomena similar to those outlined for *trigger identification* in Chapters 6 and 7, he or she should entertain a strong hypothesis that such responses are at least partially a function of his or her own history, as opposed to solely client-level stimuli. Although this is not always true—sometimes sudden affective or cognitive shifts reflect insight or compassion—we generally recommend the psychoanalytic dictum that if the therapist suddenly wants to make an exception to the relational rules in therapy, the best advice is not to do so and to reflect on the impetus

• As a correlate to the above, be wary of very strong feelings or reactio during therapy, even if they seem to be about social justice, the client's entitl ments, or things that have been done to him or her. It is entirely appropriate be on the client's "side," even to be his or her advocate, when necessary ar therapeutically appropriate. And social injustice should be confronted whe ever possible. However, if the therapist detects strong anger, outrage, over dentification with the client, or an intrusive need to protect or parent, it is least possible that he or she is being triggered and is responding to his or h own needs rather than those of the client. Such instances violate a significa principle of relational treatment: The central unit of analysis in psychotherap is the client, not the therapist. All of this is difficult to parse in some instance and we do not mean that the therapist should be distant or uninvolved. Rathe we suggest that the attuned and helpful clinician is someone who carefull scrutinizes his or her therapeutic behaviors to make as sure as possible th they are dedicated to the client's safety and well-being, as opposed to reflec ing his or her own history, needs, or inappropriate expectations.

• This work is sometimes very difficult, albeit important and meaningfu As noted earlier, we strongly recommend that the trauma-focused clinician (a well as other helpers) access resources that can provide the support necessar to sustain this process—whether in consultation, supervision, or one's ow psychotherapy. The clinician's willingness to hear painful things, connect wit people who may have difficulty with interpersonal connections, and do thi work rather than something else, is a tremendous gift to the traumatized client But such work should not be done alone.

The reader is referred to the following sources for more detailed informa tion on ethical practice, counteractivation/countertransference issues, an professional standards of care related to trauma treatment: Cloitre et al. (2011); Courtois and Ford (2013); Courtois, Ford, and Cloitre (2009) Dalenberg (2000); Kinsler, Courtois, and Frankel (2009); and Pearlman an Saakvitne (1995).

SUGGESTED READING

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FIVE

PSYCHOEDUCATION

Although much attention is paid in the treatment literature to the cognitive and emotional processing of traumatic memories, psychoeducation is also an important aspect of trauma therapy (Allen, 1991; Flack, Litz, & Keane, 1998; Friedman, 2000a; Najavits, 2002). Many survivors of interpersonal violence were victimized in the context of overwhelming emotion, narrowed or dissociated attention, and, in some cases, a relatively early stage of cognitive development; all of which may have reduced the accuracy and coherence of the survivor's understanding of these traumatic events. In addition, interpersonal violence frequently involves a more powerful figure who justifies his or her aggression by distorting objective reality—for example, by blaming victimization on the victim. These fragmented, incomplete, or inaccurate explanations of traumatic events are often carried by the survivor into adulthood, with predictable negative results.

Therapists can assist in this area by providing, when indicated, accurate information on the nature of trauma and its effects, and by working with the survivor to integrate this new information and its implications into his or her overall perspective. Although often presented relatively early in treatment (for example, Talbot et al., 1998), psychoeducational activities are helpful throughout the therapy process. For example, as the client addresses traumatic material later in treatment, he or she may gain from additional information that normalizes or provides a new perspective on traumatic memory.

Although psychoeducation is usually provided during ongoing individual treatment, it also can occur in the context of separate, clinician-led support groups, wherein a small number of people with similar trauma histories

compare stories, give each other advice, and discuss interpersonal violence and its effects. An advantage of group interventions is that the survivor can learn from the similar experiences of others; a process that may be more powerful and enduring than when similar material is delivered solely by the therapist. On the other hand, by their very nature, support groups may be less efficient than face-to-face psychotherapy for the client's own processing, integration, and personal application of whatever he or she learns from such information.

HANDOUTS

Whether it occurs in individual therapy or in a guided support group, psychoeducation sometimes includes the use of printed handouts. These materials typically present easily understood information on topics such as the prevalence and impacts of interpersonal violence, common myths about victimization, and social resources available to the survivor.

The therapist should keep at least four issues in mind when deciding what (if any) written material to make available and how it should be used:

1. *The quality of the materials.* Some handouts contain misinformation, may advocate religious or social perspectives that may indirectly blame, proselytize, or exclude, or may be written at a level that is not easily understood by the survivor.
2. *The language of the materials.* For example, a person whose primary language is Spanish may gain little from a pamphlet written in English.
3. *The cultural appropriateness of the information or depictions.* For example, materials may reflect more middle-class concerns, or visual depictions may be limited to Caucasian figures.
4. *The risk of insufficient cognitive-emotional integration.* Merely offering educational materials is not the same as providing effective psychoeducation, especially if the materials are distributed without sufficient discussion or application to the client's own history or current situation.

Most important, handouts should be considered tools in the psychoeducation process, not stand-alone sources of information. The public health literature,

for example, suggests that didactic material alone may not be especially effective in changing the beliefs or behaviors of victimized individuals (Becker, Rankin, & Rickel, 1998; Briere, 2003). Instead, the clinician should ensure that the information is as personally relevant to the survivor as possible, so that whatever is contained in the handout or media is directly applicable to his or her life, and thus has greater implicit meaning.

Client-oriented brochures and information sheets can be obtained from a number of organizations, either via the web or by requesting materials by mail. At the time of this writing, three web sites that include especially useful consumer information are:

International Society for Traumatic Stress Studies
http://www.istss.org/resources/index.htm

Office for Victims of Crime (U.S. Department of Justice)
http://www.ojp.usdoj.gov/ovc/help/welcome.html

David Baldwin's Trauma Pages
http://www.trauma-pages.com/pg4.htm

BOOKS

Clinicians may also refer clients to readily available books that are "survivor-friendly," such as Judith Herman's *Trauma and Recovery* (1992a). Although obviously limited to individuals with adequate reading skills, such books allow clients to "read up" on traumas similar to their own. Other books are specifically written for the survivor or interested layperson (one of the best being Jon Allen's [2005] *Coping With Trauma*) and contain advice as well as information. Some may be too emotionally activating for some survivors with unresolved posttraumatic difficulties, however—at least those individuals early in their recovery or treatment process. Other books may contain erroneous information or suggest self-help strategies that are not, in fact, helpful. For these reasons, we recommend that the clinician personally read any book before recommending it to a client; not only to make sure that it is appropriate to the client's needs and is factually accurate, but to gauge its potential to activate significant posttraumatic distress in those unprepared for such emotional exposure.

VERBAL INFORMATION DURING THERAPY

Although written psychoeducational materials can be helpful, more typically information is provided verbally by the clinician during the ongoing process of psychotherapy. Because the educational process is directly imbedded in the therapeutic context, it is often more directly relevant to the client's experience, and thus more easily integrated into his or her ongoing understanding. (Briere, 2003). Additionally, psychoeducation provided in this manner allows the therapist to more easily monitor the client's responses to the material and to clear up any misunderstandings that might be present. As noted at the end of this chapter, however, over- or misapplication of psychoeducation during treatment can also impede therapy progress; as with many aspects of good therapy, the issue is often the correct balance of content versus process and sufficient attunement to the client's clinical response.

GENERAL FOCUS

Whether through written or verbal means, clinicians in the trauma field often focus on several major topics during psychoeducation. These include:

- *The prevalence of the trauma.* Data on the prevalence of interpersonal violence tends to contradict the common belief that the client was specifically selected by the perpetrator by virtue of weakness, badness, or unconscious provocation, or that the client is virtually alone in having experienced the trauma. For example, knowing that approximately 1 in 5 women in the general population have been raped at some point in their lives, or that 20 percent of men have been sexually abused as children, may be a meaningful antidote to the survivor's fear that he or she alone has experienced such events and that something specific to him or her caused the event to occur.
- *Common myths associated with the trauma.* As noted at various points in this book, interpersonal violence often occurs within a broader social context that, to some extent, blames victims for their experiences and/or supports perpetrators for their behaviors. For example, rape victims are often believed to have been seductive or otherwise to have "asked for" their victimization (Burt, 1980); domestic violence may be justified as appropriate and rightful dominance of wives by husbands (Walker, 1984); and it may be assumed that individuals, in general, frequently lie about having been abused or assaulted in the service of manipulation or retribution. When the client subscribes to these myths, he or she is more likely to, in fact, blame himself or herself for the victimization or explain away the trauma as something not worthy of treatment (Resick & Schnicke, 1993). For this reason, it can be helpful to discuss "rape myths" or "common myths about wife battering" in a way that makes it clear that such beliefs are not accurate.
- *The usual reasons why perpetrators engage in interpersonal violence.* This may include describing the often compulsive, multivictim nature of many perpetrator behaviors, and the psychology driving the perpetrator's actions—including the offender's frequent need for power and dominance in the face of insecurity and feelings of inadequacy. Such information can reduce the client's self-focused explanations for the assault and increase his or her awareness of the perpetrator's dysfunctional or malignant characteristics. This shift in attribution may make self-blame appear less logical to the survivor. In addition, knowledge that the client was "one of many" for the perpetrator may further decrease his or her tendency to take personal responsibility for what was done to him or her.
- *Typical immediate responses to trauma.* Among other victim reactions to adverse events, this may include peritraumatic dissociation (for example, "spacing out," out of body experiences, or experiencing time distortion at the time of the trauma), occasional sexual responses associated with sexual traumas (as opposed to, in many cases, positive psychological feelings), relief at not being injured or killed when others have been, and "Stockholm effects," wherein the victim becomes attached or somehow bonded with the perpetrator. Because these are all relatively normal responses to trauma, despite their apparent negative qualities, the client may eventually experience relief, as well as decreased guilt and self-blame, upon receiving and integrating such information.
- *The lasting posttraumatic responses to victimization.* Information on the commonness and logical nature of posttraumatic stress symptoms (for example, flashbacks, numbing, or hyperarousal responses) and other trauma-related responses (for example, substance abuse, panic attacks, or intimacy fears)—as described in Chapter 2—are an important part of most good trauma therapy. As the client comes to

understand that posttraumatic symptoms are normal (in the sense that such symptoms are logical and relatively common) responses to abnormal or toxic circumstances, he or she is less likely to experience himself or herself as damaged or mentally ill and may feel less out of control. Similarly, it is almost always preferable to view oneself as suffering from a well-understood cluster of typical responses to traumatic events (for example, posttraumatic stress disorder [PTSD]) than it is to see oneself as besieged by a variety of bizarre, unrelated symptoms. In addition, psychoeducation may prepare the client for symptoms that arise in the future. By describing symptoms before they occur, the clinician can provide a sense of predictability. This, in itself, may significantly reduce posttrauma anxiety. And successfully predicting potential symptoms enhances the overall credibility of the therapist especially in terms of his or her nonpathologizing analysis of what symptoms mean and do not mean.

- *Reframing symptoms as trauma processing.* Psychoeducation can involve reframing certain posttraumatic symptoms more positively, even as evidence that recovery is occurring. This is a somewhat more active process than the normalization of symptoms described earlier. Not all symptoms can be reframed, of course, nor should they be. Depression, panic attacks, suicidality, or psychosis, for example, are generally what they appear to be: evidence of psychological disturbance of some form or another. On the other hand, as described in Chapter 8, posttraumatic reliving symptoms are often signs of attempted psychological processing (even when unsuccessful), and posttraumatic avoidance is frequently an adaptive attempt to reduce the overwhelming aspects of reactivated distress. By reframing posttraumatic symptoms as potentially adaptive, the clinician may counter some of the helplessness, perceived loss of control, and stigmatization that often accompanies flashbacks, activated trauma memories, or psychological numbing. In fact, clients who accept the reframing of flashbacks as trauma processing may even come to welcome some reexperiencing responses as evidence of movement toward recovery.
- *Safety plans.* Women who are at risk for ongoing domestic violence may need to learn about "safety plans" that other women have used successfully in similar circumstances. Typically, this involves developing a detailed strategy for exiting the home (for example, prepacked suitcases, escape routes) and finding a new, safer, environment, whether it be a friend's home or a local women's shelter (Jordan, Nietzel, Walker, & Logan, 2004). Other clients may benefit from concrete information on how to access medical or social services, a child protection worker, or police assistance (Briere & Jordan, 2004). The goal of such interventions is to increase the power of victims to ensure their own safety, and thus to decrease not only the likelihood of continued victimization, but also some of the helplessness often associated with exposure to chronic interpersonal violence.

CONSTRAINTS

Despite its generally salutatory effect, psychoeducation can backfire if not carefully adapted for the individual client, or if the conclusions that the client draws from the information are not monitored. For example, while information on the commonness of interpersonal violence may reduce the client's sense of being the only one who has been victimized, it may also reinforce the client's overestimation of the amount of danger in the interpersonal environment, leading to increased fear and avoidance of others. Similarly, too much focus on perpetrator dynamics may reinforce the client's need to excuse his or her perpetrator, and information on standard posttraumatic reactions may inadvertently cause the client to feel disordered or dysfunctional or to take on a trauma "sick-role."

Ultimately, psychoeducation should not occur in a vacuum. Information is often helpful, and may be antidotal to distorted beliefs and maladaptive responses, but it must occur in the context of ongoing therapeutic discussion and evaluation (Najavits, 2002). Specifically, the clinician should attend carefully to how clients integrate new information into their worldviews and how they apply such information in their daily lives. Simply teaching (let alone lecturing) clients about what to do or not do, or suggesting how they should think about trauma and its effects, is rarely helpful in and of itself (Neuner, Schauer, Klaschik, Karunakara, & Ebert, 2004). Instead, psychoeducation is most useful when it is integrated into the ongoing therapeutic process.

SUGGESTED READING

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SIX

DISTRESS REDUCTION AND AFFECT REGULATION TRAINING

As described in Chapter 2, treatment-seeking trauma survivors often experience chronic levels of anxiety, dysphoria, and posttraumatic arousal. Many also describe extremely negative emotional responses to trauma-related stimuli and memories—feeling states that are easily triggered and hard to accommodate internally. When faced with overwhelming arousal, distress, and/or emotionally laden memories, the survivor is often forced to rely on emotional avoidance strategies such as dissociation, substance abuse, or external tension reduction activities. Unfortunately, as described in Chapter 8, excessive avoidance often inhibits psychological recovery from the effects of traumatic events. In the worst case, the need to avoid additional posttraumatic distress may lead the hyperaroused or emotionally dysregulated client to avoid trauma-related material during therapy, or to drop out of treatment altogether. As well, emotional states that are aversive enough to overwhelm available affect regulation resources may negatively affect the client's perception of the treatment process and the psychotherapist.

This chapter describes two sets of interventions: those intended to reduce acute, destabilizing emotions and symptoms that emerge during the treatment process, and those focused on the client's more general capacity to regulate negative emotional states. This material is presented early in the treatment part of the book because, in some cases, high anxiety and/or low affect regulation capacity should be addressed before more classic trauma therapy (for example,

emotional processing) can be fully accomplished (Chu, 2011; Cloitre et al., 2011; Courtois, 2010; Ford et al., 2005). The interventions outlined here can be used at any point during therapy, however. For example, although the relaxation techniques described in this chapter may be initiated early in treatment, these and other approaches to affect regulation may be relevant whenever the survivor experiences escalating or intrusive negative internal states. In addition, the intrinsic development of affect regulation skills usually occurs in the context of repeated exposure to—and processing of—trauma-related emotions, a phenomenon that progressively unfolds as treatment continues.

The techniques presented here are variously described in the trauma and anxiety literature as forms of "grounding," relaxation training, cognitive therapy, stress inoculation, meditation, and anxiety management. However labeled, these approaches all focus on the client's increased capacity to tolerate and down-regulate painful emotional states, both during treatment and in his or her ongoing life.

DEALING WITH ACUTE INTRUSION: GROUNDING

Although much of this chapter is devoted to increasing trauma survivors' affect regulation skills, there are occasions when the clinician may have to intervene more directly in a client's emotional dysregulation. For example, in response to some triggering stimulus or memory, the client may experience sudden panic, flashbacks, intrusive negative thoughts, dissociative states, or even transient psychotic symptoms during therapy. These internal processes can be frightening—if not destabilizing—to the client and can diminish his or her moment-to-moment psychological contact with the therapist. At such times, it may be necessary to refocus the survivor's attention onto the immediate therapeutic environment (with its implicit safety and predictability) and the therapist-client connection.

This intervention, often referred to as *grounding,* can be quite helpful in acute situations. It is also, however, by its very nature, potentially disruptive to the treatment process. Grounding techniques tend to alter the immediate narrative/relational stream of psychotherapy, and run the risk of implying that something is going awry, such that a sudden, "emergency" procedure is required. For this reason, grounding should only be used when clearly indicated, should be adjusted to the minimal level necessary to reduce the client's internal escalation, and should be framed in such a way that it does not

stigmatize the client or overdramatize the experience. In some cases, other therapeutic interventions may be just as effective, such as gently moving the client's narrative into more cognitive or less emotionally intense aspects of whatever is under discussion (see Chapter 8), or by engaging in some other intervention that does not involve an obvious change in focus.

If, despite these concerns, grounding is indicated (that is, the client is acutely overwhelmed by intrusive symptoms or escalating trauma memories, and psychological contact with the therapist is diminishing), we suggest the following general steps.

1. *Attempt to focus the client's attention onto the therapist and therapy,* as opposed to whatever internal processes are occurring. This may involve—to the extent that it does not trigger the client—shifting one's chair slightly closer to him or her, unobtrusively moving into his or her visual field, or slightly changing one's voice so that it compels more attention. This does not mean, of course, that the therapist yells at the client or behaves in an unduly intrusive manner. In addition, it usually does not suggest that one should touch the client, since physical contact can intensify the client's fear or sense of invasion, or trigger memories. Whether to touch or not is contingent on the specifics of the situation, including, for example, the nature of the trauma and whether the therapist is well known to the client and trusted by him or her.

2. *Ask the client to* briefly *describe his or her internal experience.* For example, "Susan, is something going on/upsetting you/happening right now?" If the client is clearly frightened or responding to distressing internal stimuli, but can't or won't describe them, go to Step 3. If the client is able to talk about the internal experience, however, it is often helpful for him or her to generally label or broadly describe it. This does not mean the survivor should necessarily go into great detail—detailed description of the flashback or memory may increase its intensity, thereby reinforcing the response rather than lessening it.

3. *Orient the client to the immediate, external environment.* This often involves two, related messages: (a) that the client is safe and is not, in fact, in danger, and (b) that he or she is *here* (in the room, in the session, with the therapist) and *now* (not in the past, undergoing the trauma). In some cases, the client can be oriented by reassuring statements, typically using the client's name as an additional orienting device (for example,

"Susan, you're okay. You're here in the room with me. You're safe."). In other, more extreme cases, grounding may involve asking the client to describe the room or other aspects of the immediate environment (for example, "Susan, let's try to bring you back to the room, okay? Where are we?/What time is it?/Can you describe the room?"). The client might be asked to focus his or her attention on the feeling of the chair or couch underneath him or her, or of his or her feet on the floor. However accomplished, the client's reorientation to the here and now may occur relatively quickly (for example, in a few seconds) or may take longer (for example, a number of minutes).

4. *If indicated, focus on breathing or other methods of relaxation.* This is an example of when breath or relaxation training (as described later in this chapter) can be especially helpful. Take the client through the relaxation or breathing exercise for as long as is necessary (typically for several minutes or longer), reminding the client of his or her safety and presence in the here-and-now.

5. Repeat Step 2, and assess the client's ability and willingness to return to the therapeutic process. Repeat Steps 3 and 4 as needed.

If it is possible for therapy to return to its earlier focus, normalize the traumatic intrusion (for example, as a not-unexpected part of trauma processing) and the grounding activity (for example, as a simple procedure for focusing attention away from intrusive events), and continue trauma treatment. It is important that the client's temporary reexperiencing or symptom exacerbation be neither stigmatized nor given greater meaning than appropriate. The overall message should be that trauma processing sometimes involves the intrusion of (and distraction by) potentially upsetting memories, thoughts, and/or feelings, but that such events are part of the healing process, as opposed to evidence of psychopathology or loss of control.

INTERVENING IN CHRONIC AFFECT DYSREGULATION

In contrast to grounding, which addresses relatively acute emotional intrusions or activations, this section describes psychological interventions in the sustained hyperarousal and anxiety experienced by many survivors of major, chronic trauma.

Medication

When dysphoria or posttraumatic arousal is of sufficient intensity that it interferes with treatment and recovery, psychoactive medications may be indicated. As described in Chapter 12, pharmacologic agents that target anxiety and/or hyperarousal, or stabilize mood, sometimes may be helpful in reducing such symptoms during trauma-focused psychotherapy. As also noted, however, such medications are not a cure-all for dysregulated emotional states; their efficacy is variable from case to case and may be counterindicated in some instances because of significant side effects. Often, the best approach to high pretreatment arousal and anxiety is to use psychiatric medication, if necessary, but also to apply psychological interventions that reduce anxiety and increase affect regulation skills, as described in this chapter.

Relaxation and Breath Control

One of the most basic forms of arousal reduction during therapy is learned relaxation. Strategically induced relaxation can facilitate the processing of traumatic material during the therapy session by reducing the client's overall level of anxiety. Reduced anxiety during trauma processing both lessens the likelihood the client will feel overwhelmed by trauma-related distress and probably serves to countercondition traumatic material, as described in Chapter 8. In addition, relaxation can be used by the survivor outside of treatment as a way to reduce the effects of triggered traumatic memories. For individuals with especially easily activated anxiety or intrusive reexperiencing, the benefits of calling upon an internal relaxation mechanism cannot be overstated.

There are two general approaches to relaxation training, *breath training* and *progressive relaxation,* both of which are described only briefly here. For more detailed information, the reader should consult the Suggested Reading list at the end of this chapter.

Progressive Relaxation

This technique involves clenching and then releasing muscles, sequentially from head to toe, until the entire body reaches a relaxed state (Jacobson, 1938; Rimm & Masters, 1979). As clients practice progressive relaxation on a regular basis, most are eventually able to enter a relaxed state relatively quickly, if not

automatically. Some practitioners begin each session with relaxation exercises; others teach it initially in treatment, then utilize it only when specifically indicated, for example, when discussion of traumatic material results in a high state of anxiety. Two points should be made about the use of relaxation training in the treatment of posttraumatic stress: (1) use of this technique alone (that is, in the absence of coexisting trauma-processing activities) is unlikely to significantly reduce trauma-related symptoms, per se (Rothbaum, Meadows, Resick, & Foy, 2000), and (2) clinical experience suggests that a minority of traumatized individuals may have unexpected anxious or dissociative reactions to induced relaxation (for example, Allen, 2001; Fitzgerald & Gonzalez, 1994) or may not be able to successfully self-induce a relaxed state. Those who are chronically flooded with flashbacks and other reexperiencing symptoms may be less likely to gain from relaxation training (S. Taylor, 2003). In our experience, progressive relaxation can be quite helpful, when indicated, but the client should be monitored for possible, seemingly paradoxical, increases in anxiety or arousal during this procedure.

Mindfulness-based Breath Training

Although progressive relaxation is successfully used by some clinicians, our preference—all other things being equal—is to teach breathing techniques. When stressed, many people breathe in a more shallow manner, hyperventilate, or, in some cases, temporarily stop breathing altogether. Teaching the client "how to breathe" during stress can help restore more normal respiration, and thus adequate oxygenation of the brain. Equally important, as the client learns to breathe in ways that are more efficient and more aligned with normal, nonstressed inhalation and exhalation, there is usually a calming effect on the autonomic nervous system.

Breath training generally involves guided breathing exercises that teach the client to be more aware of his or her breathing—especially the ways in which it is inadvertently constrained by tension and adaptation to trauma—and to adjust his or her musculature, posture, and thinking so that more effective and calming respiration can occur (Best & Ribbe, 1995). There are a number of manuals that include information on breath training during trauma treatment (for example, Foa & Rothbaum, 1998; Rimm & Masters, 1979).

One simple breath training protocol, offered here, is Mindfulness-based Breath Training (MBBT)[1]. This exercise is very similar to the protocol

[1]A version of this protocol has been adapted for the treatment of acute burn survivors (Briere & Semple, 2013).

presented in the earlier second edition of this book, except that it includes reference to mindful attention and slightly changed breath instruction.

First:

1. Explain to the client that learning to pay attention to breathing, and learning to breathe more slowly and deeply, can both help with relaxation and be useful for managing anxiety and, when relevant, pain. Note that when a person gets anxious or feels panic, one of the first things that happens is that his or her breathing becomes shallow and rapid. When we slow down fearful breathing, fear, itself, may slowly decrease.

Then:

2. Have the client rest in a comfortable position. This will typically involve sitting in a chair with his/her spine relatively straight, shoulders relaxed, hands on lap, and legs together with feet flat on the floor.

3. Go through the following sequence with the client -- the whole process should take about 10 to 15 minutes.

   a. If the client is comfortable with closing his or her eyes, ask him or her to do so. Some trauma survivors will feel more anxious with their eyes closed, and will want to keep them open. This is entirely acceptable.

   b. Ask the client to try to pay attention "just to breathing" while doing this exercise. If his or her mind wanders (e.g., thinking about the trauma, the future, or about an argument with someone) or he or she is distracted by physical pain, the client should gently try to bring his or her attention back to the immediate experience of breathing. Note that the client is not trying to suppress these distractions, but instead is only returning his or her attention to the breath. It may be helpful to suggest the image of breathing in peace and strength, and breathing out tension.

   c. Ask the client to begin breathing through the nose, paying attention to the breath coming in and going out. Ask him or her to pay attention to how long each inhalation and exhalation lasts, without trying to speed up or slow down his/her breaths. Do this for 3 breath cycles (sets of inhalation and exhalation).

d. Instruct the client to start breathing more into his or her abdomen. This means that the belly should visibly rise and fall with each breath. It may be helpful to invite the client to place a hand on his or her abdomen so he or she can feel it rise with more diaphragmatic breathing. This sort of breathing should feel different from normal breathing, and the client should notice that each breath is deeper than normal. Ask the client to imagine that each time he or she breathes in, air is flowing in to fill up the abdomen and then lungs. It goes into the belly first, and then rises up to fill in the top of the chest cavity. In the same way, when breathing out, the breath first leaves the abdomen, and then the chest. Some clients find it helpful to imagine the breath coming in and out like a wave. Do this for another 2 or 3 breath cycles..

e. Explain that once the client is breathing more deeply and fully into the belly and chest, the next step is to slow the breath down. Ask him/her to slowly count to *three* with each inhalation, pause, then count to *four* for each exhalation – in for three counts, pause, then out for four counts. Remind the client that exhalation should take a little longer than inhalation. At the end of both inhalation and exhalation, the client should pause, and only beginning inhaling or exhaling again when he/she begins to feel the need to do so. The actual speed of the counting is up to the client, although it should be slower than usual. The client may need to experiment with the appropriate speed of breathing[2]. Once he or she has found the right speed, he or she should continue for 2 additional breath cycles.

f. Remind the client to focus his or her mind on counting during breathing, and to redirect his/her attention to counting whenever he or she gets distracted by pain or a thought, feeling, or memory. Encourage the client to focus his or her attention on the current moment, on counting within the breath, not on memories of the past or worry about the future, breathing in strength and peace, breathing out tension. Suggest that if the client does not recall what number he or she was on when he or she lost track, he or she should start again with "1" at the next inhalation. Note that is normal to loss track of counting, and that doing so is not "bad," but that he or she is learning to let go of these distractions; to stay in the present moment, while relaxing and breathing. The object is only to note that his or her attention has wandered away and to return attention to counting within the breath. The clinician should emphasize that it is not "bad" or "wrong" to get distracted by thoughts or feelings of pain in the body. Rather, it is important to just note that one's mind has wandered away, and then just to redirect attention to counting the breath.

[2]With ongoing practice, some clients find that their breath slows further over time.

4. At this point, have the client practice counting within breaths for another 5 minutes or so. Once 5 minutes have passed, invite the client to open his or her eyes (if they were closed), and come back to the room. Discuss with the client what his or her feelings and thoughts were during the exercise, and any problems that arose. Validate and support the client's willingness to do the exercise, and normalize any wandering of thoughts or distractions (e.g., "that's just what the mind does")—while at the same time encouraging the client to continue focusing on counting the breath and nothing else.

5. Ask the client to practice the breath counting part of this exercise by him- or herself for 5 to 10 minutes a day. He or she should choose a specific time (e.g., in the morning or evening), and make this exercise a regular part of his or her daily routine. Suggest he or she glance at a watch or clock when he or she thinks 5–10 minutes has passed, but not to look at the clock/watch too often. If the client does not have a watch, and no clock is available, he or she can just guess when 5–10 minutes has passed, and stop then. Appendix 2 contains a handout that the client can use to remind him- or herself of the steps of MBBT.

Eventually, the client can extend this exercise to additional times in the day as well, for example, during stressful situations or medical procedures, when in physical pain, or whenever he or she feels anxious. Importantly, MBBT is especially helpful in deescalating triggered negative emotional states during titrated exposure. For this reason, the clinician may choose to begin and/or end exposure sessions with MBBT, and use it midsession whenever therapeutic exposure is associated with destabilization or momentarily overwhelming emotional stress.

After the first 1 or 2 sessions, inquire as to whether doing the exercise has yielded any benefits for the client, including decreased anxiety, pain reduction, or a greater ability to relax. If not, normalize the situation, stating that MBBT sometimes takes a while to work. If it is proving helpful, note and praise any progress.

It should be reiterated that although relaxation training of whatever type is often a helpful component of trauma therapy, it is not always necessary or indicated. Some clients are neither so hyperaroused nor so anxious that they require special intervention in this area. Other clients (and therapists) find relaxation training too mechanistic, or a distraction from the relational process of psychotherapy. Like some other techniques presented in this book, relaxation training is an option, not a requirement, for trauma treatment.

MEDITATION AND YOGA

Another approach to affect de-escalation and regulation involves (1) dispassionately noting negative, repetitive, and habitual thoughts and feelings, and then moving one's attention toward certain, other processes (for example, the breath), and/or (2) engaging in activities (for example, specific movements or physical positions) that produce positive states and preclude or lessen negative ones. The former is often referred to as *mindfulness meditation*, whereas the latter is best represented by *yoga*. Both approaches recently have been embraced as methods not only of affect regulation, but also potentially as interventions for trauma-related distress. Although these methodologies will be reviewed briefly below, the reader is referred to Briere (2012a); Emerson and Hopper (in press; 2011); Waelde (2004), and Chapter 10 for more detailed discussion.

Meditation

Meditation represents a broad category of inwardly directed practices, typically involving sitting or lying in a specific position, or walking in a certain way, while focusing on one's breath or some other internal sensation or process. In most instances, the meditator learns to maintain this attention for relatively long periods of time, noting inevitable distracting thoughts and feelings without judgment, then returning to his or her ongoing focus of

attention. As described in Chapter 10, a number of studies indicate that meditation has positive effects on both physical and psychological well-being, generally by reducing stress, increasing equanimity, and, sometimes, prompting existential insights about the basis of suffering. Among the positive impacts noted in the literature are improved blood pressure and other cardiovascular functions, and reduced psychological or physiological problems, ranging from fibromyalgia and chronic pain to anxiety, depression, substance abuse, eating disorders, aggression, and posttraumatic distress (Bormann, Liu, Thorp, & Lang, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Rosenthal, Grosswald, Ross, & Rosenthal, 2011; T. L. Simpson et al., 2007; see, also, Chapter 10). Although it is not entirely clear exactly how meditation impacts stress, it seems likely that it decreases arousal of the autonomic nervous system, reduces preoccupation with negative or upsetting thoughts, lessens psychological reactivity, and broadens psychological perspective. For these and related reasons, meditation is increasingly suggested by clinicians—empirically oriented and otherwise—for those suffering from trauma-related symptoms, although not without some cautions and contraindications, as described in Chapter 10.

Yoga

Like meditation, yoga is a contemplative exercise that, over time, appears to improve psychological and physical functioning (Emerson & Hopper, 2011). Involving careful stretching, and specific movements, postures, and positions in specific sequences, it also includes attention to breath, meditation, relaxation, diet, and a specific philosophical perspective. Yoga not only appears to calm the mind, but it also may increase physical strength, flexibility, and capacity, with associated reductions in psychophysiological stress (R. P. Brown & Gerbarg, 2009; Harvard Mental Health Letter, 2009). Recent research suggests that regular involvement in yoga practice may be associated with improvements in posttraumatic stress, anxiety, and depression (R. P. Brown & Gerbarg, 2009; Descilo et al., 2009; Janakiramaiah et al., 2000), although some studies have significant methodological flaws.

Obviously, meditation and/or yoga is not for everyone, and many trauma survivors do not begin such practices solely as a method of stress reduction or affect regulation. However, many trauma-exposed people find themselves drawn to such contemplative practices and gain significantly from them.

Increasing General Affect Regulation Capacity

Above and beyond immediate methods of distress reduction, such as grounding, relaxation, and meditation or yoga, there are a number of suggestions in the literature for increasing the general affect regulation abilities of trauma clients. All are focused on increasing the survivor's overall capacity to tolerate and down-regulate negative feeling states, thereby reducing the likelihood that he or she will be overwhelmed by activated emotionality. In some cases, such affect regulation "training" may be necessary before any significant memory processing can be accomplished (Cloitre et al., 2011; Courtois, 2010).

Identifying and Discriminating Emotions

One of the most important components of successful affect regulation is the ability to correctly perceive and label emotions as they are experienced (Linehan, 1993a). Many survivors of early, chronic trauma have trouble knowing exactly what they feel when activated into an emotional state, beyond, perhaps, a sense of feeling "bad" or "upset" (Briere, 1996; Luterek, Orsillo, & Marx, 2005). In a similar vein, some individuals may not be able to accurately differentiate feelings of anger, for example, from anxiety or sadness. Although this sometimes reflects dissociative disconnection from emotion, in other cases it appears to represent a basic inability to "know about" one's emotions. As a result, the survivor may perceive his or her internal state as consisting of chaotic, intense, but undifferentiated emotionality that is not logical or predictable. For example, the survivor triggered into a seemingly undifferentiated negative emotional state will not be able to say, "I am anxious," let alone infer that "I am anxious because I feel threatened." Instead, the experience may be of overwhelming and unexplainable negative emotion that comes "out of the blue."

The clinician can assist the client in this area by regularly facilitating exploration and discussion of the client's emotional experience. Often, the client will become more able to identify feelings just by being asked about them on an ongoing basis. On other occasions, the therapist can encourage the client to do "emotional detective work," involving attempts to hypothesize an experienced emotional state based on the events surrounding it (for example, the client guessing that a feeling is anxiety because it follows a frightening stimulus, or anger because it is associated with resentful cognitions or angry behaviors). Affect identification and discrimination sometimes can be fostered by the therapist's direct feedback, such as "It looks like you're feeling angry. Are you?" or "You look scared." This option should be approached with care, however. There is a certain risk of labeling a client's affect as feeling *A* when, in fact, the client is experiencing feeling *B*—thereby fostering confusion rather than effective emotional identification. For this reason, we recommend that, in all but the most obvious instances, the therapist facilitate the client's exploration and hypothesis testing of his or her feeling state, rather than telling the client what he or she is feeling. The critical issue here is not, in most cases, whether the client (or therapist) correctly identifies a particular emotional state, but rather that the client explores and attempts to label his or her feelings on a regular basis. In our experience, the more this is done as a general part of therapy, the better the survivor eventually becomes at accurate feeling identification and discrimination.

Identifying and Countering Thoughts That Antecede Intrusive Emotions

It is not only feelings that should be identified—in many cases, it is also thoughts. This is most relevant when a given cognition triggers a strong emotional reaction, but the thought is somehow unknown to the survivor. As suggested by some clinicians (for example, Cloitre et al., 2002; Linehan, 1993a), affect regulation capacities often can be improved by encouraging the client to identify and counter the cognitions that exacerbate or trigger trauma-related emotions. Beyond the more general cognitive interventions described in Chapter 7, this involves the client monitoring whatever thoughts mediate between a triggered traumatic memory and a subsequent negative emotional reaction. For example, upon having child abuse memories triggered by an authority figure, the survivor may have the unconscious or partially suppressed thought, "He is going to hurt me," and may then react with extreme anxiety or distress. Or the survivor of sexual abuse might think, "She wants to have sex with me," when interacting with an older woman, and then may experience revulsion, rage, or terror. In such cases, although the memory itself is likely to produce negative emotionality (conditioned emotional responses, or CERs; see Chapter 8), the associated cognitions often exacerbate these responses to produce more extreme emotional states. In other instances, thoughts may be less directly trauma related, yet still increase the intensity of the client's emotional response. For example, in a stressful situation the client may have thoughts such as "I'm out of control" or "I'm making a fool of myself" that produce panic or fears of being overwhelmed or inundated.

Unfortunately, because triggered thoughts may be out of superficial awareness, their role in subsequent emotionality may not be observed by the survivor (Beck, 1995). As the client is made more aware of the cognitive antecedents to overwhelming emotionality, he or she can learn to lessen the impact of such thoughts. In many cases, this is done by explicitly disagreeing with the cognition (for example, "Nobody's out to get me," or "I can handle this"), or merely by labeling such cognitions as "old tapes" rather than accurate perceptions (Briere, 1996; see also Chapter 10). In this regard, one of the benefits of what is referred to as *insight* in psychodynamic therapy is often the self-developed realization that one is acting in a certain way by virtue of erroneous, "old" (for example, trauma- or abuse-related) beliefs or perceptions—an understanding that often reduces the power of those cognitions to produce distress or motivate dysfunctional behavior (see Chapter 7).

When the thoughts that underlie extremely powerful and overwhelming emotional states are triggered by trauma-related memories, the therapist can focus on these intermediate responses by asking questions such as "What happened just before you got scared/angry/upset?" or "Did you have a thought or memory?" If the client reports that, for example, a given strong emotion was triggered by a trauma memory, the therapist may ask him or her to describe the memory (if that is tolerable) and to discuss what thoughts the memory triggered. Ultimately, this may involve exploration and discussion of four separate phenomena:

1. The environmental stimulus that triggered the memory (for example, one's lover's angry expression)
2. The memory itself (for example, of maltreatment by an angry parent)
3. The current thought associated with the memory (for example, "He/She hates me," "I must have done something wrong," or "He/She is blaming me for something I didn't do")
4. The current feeling (for example, anger or fear)

These triggered, often catastrophizing cognitions (that is, expectations or assumptions of extremely negative outcomes) can then be discussed as to their relevance to the current situation. In such instances, the client is generally asked to explore the accuracy of such thoughts, their possible etiology (often involving childhood abuse, neglect, or other maltreatment), and what he or she could do to address such thoughts (for example, remind himself or herself that the thought is not accurate or that it is "just my childhood talking"). As the client becomes better able to identify these cognitions, place them in some realistic context, and counter them with other, more positive thoughts, he or she often develops greater capacity to forestall extreme emotional reactivity, and thereby better regulate the emotional experience.

Trigger Awareness and Intervention

There is another cognitive intervention that can help the survivor maintain emotional equilibrium in his or her daily life: The clinician can help the survivor learn to identify and address triggers in the environment that activate intrusive negative feelings. Although, as noted in Chapter 2, activated memories of trauma are not intrinsically negative phenomena, they can motivate behaviors that—although sometimes effective in reducing triggered distress—may be maladaptive or even self-destructive in contexts where attention and adaptive strategies would be more helpful. Successful trigger identification can facilitate a greater sense of control and better interpersonal functioning by allowing the client to alter situations in which these triggers might occur and problem-solve emerging negative states before they produce behavioral problems. Ultimately, as noted later, trigger interventions help increase affect regulation and tolerance.

Trigger identification and intervention is generally learned as a regular component of therapy, so that it can be called upon later when the survivor encounters a trigger in his or her environment. Importantly, it is often hard to figure out exactly what to do when one has been triggered; it is better to have previously identified the trigger (among others), its etiology, and its solutions, in the context of therapeutic guidance and support.

As described by one survivor, the development of intervention strategies prior to being triggered is like creating a "message in a bottle": preplanning about what to do when triggered (the "message") can be developed for later use (placed in a "bottle") and called upon once the individual is triggered (the bottle "floats" to the triggered circumstance, allowing a more measured and thought-out approach to what otherwise might be a crisis situation).[3]

[3]Another, more structured version of trigger identification and intervention, specifically targeted at adolescents and young adults, involving a "trigger grid" worksheet, can be found in Briere and Lanktree (2011) and at http://johnbriere.com.

In this regard, trigger identification can be taught as a series of tasks:

1. *Identify a given thought, feeling, or intrusive sensation as posttraumatic.* This is relatively easy in some cases. For example, it may not be difficult to recognize an intrusive sensory flashback of a gunshot as trauma related. In others, however, the reexperiencing may be more subtle, such as feelings of anger or fear, or intrusive feelings of helplessness that emerge during relational interaction. Typical questions the client can learn to ask himself or herself include the following:
   - Does this thought/feeling/sensation "make sense" in terms of what is happening around me right now?
   - Are these thoughts or feelings too intense, based on the current context?
   - Does this thought or feeling carry with it memories of a past trauma?
   - Am I experiencing any unexpected alteration in awareness (for example, depersonalization or derealization) as these thoughts/feelings/sensations occur?
   - Is this a situation in which I usually get triggered?
2. *Evaluate stimuli present in the immediate environment, and identify which are trauma reminiscent* (that is, "find the trigger"). This typically involves a certain level of detective work, as the client learns to objectively evaluate the environment to see what might be trauma reminiscent, and thus potentially a trigger. Examples of triggers the client might learn to recognize, depending on his or her trauma history, include these:
   - Interpersonal conflict
   - Criticism or rejection
   - Sexual situations or stimuli
   - Interactions with an authority figure
   - People with physical or psychological characteristics that are in some way similar to the client's past perpetrator(s)
   - Boundary violations
   - Sirens, helicopters, gunshots
   - The sound of crying

In some cases, the trigger will be obvious and easily recognized. In others, the client may have to work hard to identify what may be triggering him or her.

3. *Employ an adaptive strategy.* This usually involves some version of "improving the moment" (Linehan, 1993a, p. 148), whereby the survivor reduces the likelihood of an extreme emotional response. Examples include the following:
   - Intentional behavioral avoidance or "time outs" during especially stressful moments (for example, leaving a party when others become intoxicated, intentionally minimizing arguments with authority figures, learning how to discourage unwanted flirtatious behavior from others)
   - Analyzing the triggering stimulus or situation until a greater understanding changes one's perception and thus terminates the trigger (for example, carefully examining the behavior of an individual who is triggering posttraumatic fear, and eventually becoming more aware of the fact that he or she is not acting in a threatening manner; or coming to understand that a given individual's seemingly dismissive style does not indicate a desire to reject or ignore as much as it does interpersonal awkwardness)
   - Increasing support systems (for example, bringing a friend to a party where one might feel threatened, or calling a friend to "debrief" an upsetting situation)
   - Positive self-talk (for example, working out beforehand what to say to oneself when triggered, such as "I am safe," "I don't have to do anything I don't want to do," or "This is just my past talking, this isn't really what I think it is")
   - Relaxation induction or breath control, as described earlier in this chapter
   - Strategic distraction, such as starting a conversation with a safe person, reading a book, or going for a walk, as a way to pulling attention away from escalating internal responses such as panic, flashbacks, or catastrophizing cognitions
   - Delaying tension reduction behaviors (TRBs; see Chapter 2) and "urge surfing" (see Chapter 10). These strategies can be especially helpful for the triggered survivor, and thus are described in detail next.

Delaying Tension Reduction Behavior

Triggered phenomena can be reduced by intentionally forestalling TRBs until they become less probable or lose some of their power. In general, this involves encouraging the client to "hold off," as long as possible, on behaviors that he or she normally would use to reduce distress when triggered (for example, self-mutilation, impulsive sexual behavior, or binging/purging) and then, if the behavior must be engaged in, doing so to the minimal extent possible (Briere & Lanktree, 2011).

There are probably at least two important aspects of this strategy. First, many survivors learn that their TRB responses are to some extent reflexive: Given sufficient attention and thought, such behaviors could be delayed or avoided without too much difficulty. For example, a person whose immediate response upon being triggered into a negative state is to self-injure might discover that, in fact, the upsetting feeling was ultimately tolerable, and that his or her threshold for self-mutilation was, in that instance, unnecessarily low. Second, as noted by Marlatt and Gordon (1985) and others, many triggered emotional states that otherwise would motivate a TRB or episode of substance abuse have a relatively short half-life: If the individual can sit out the activated emotional state, it will often pass in a matter of minutes, thereby obviating the need for maladaptive behavior.

Urge Surfing

Regarding the limits of activated distress, the client may be taught to "urge surf" (Bowen, Chawla, & Marlatt, 2011), as described in greater detail in Chapter 10. When triggered into a state in which a TRB is likely (for example, rage associated with a memory of childhood abuse), the client can attempt to enter a mindful perspective (as presented in Chapter 10) and then, rather than act, "ride out" or "surf" the emotion and associated urge to tension reduce, until it peaks and then fades away. Notably, in both delaying and urge surfing, the survivor does not try to suppress triggered thoughts or feelings, but rather changes his or her relationship to them.

Although the therapist should take a clear stand on the harmfulness of most TRB responses to triggering, and work with the client to terminate or at least decrease their frequency and injuriousness, he or she should not appear to judge the client regarding TRBs: Value judgments about the wrongness or immorality of a given behavior—other than activities that harm others—are rarely helpful. Such statements not only increase guilt and shame, but they often "drive the therapy underground" by forcing the client to keep things (in this case, continued tension reduction) from the therapist.

Because TRBs ultimately serve to reduce distress, client attempts to delay their use (or "surf" them) provide opportunities to develop affect tolerance. For example, in the delay approach, if a survivor is able to try to not binge eat or act on a sexual compulsion following a triggering situation, if only for a few minutes beyond when he or she would otherwise engage in such activity, two things may happen:

1. The client may be exposed to a brief period of sustained (but temporarily manageable) distress, during which time he or she can learn a small amount of distress tolerance.
2. The impulse to engage in the TRB may fade, because the emotionality associated with the urge to engage in the TRB often lessens if not immediately acted upon.

With continued practice, the period between the initial triggered experience and the actual TRB may be lengthened, the TRB itself may be decreased in severity, and affect tolerance may be increased. An added benefit of this approach is that the goal of decreasing (and then ending) TRBs is seen as not stopping "bad" behavior, but rather as a way for the client to learn affect regulation and to get his or her behavior under greater personal control.

Importantly, inherent in either of these approaches is the possibility that it will not be entirely successful. It is an unavoidable fact of clinical life that tension reduction and other avoidance behaviors are survival based and are therefore not easily given up by the client. Nevertheless, by empowering the survivor to engage ("allow") the aversive state and consciously attempt to change his or her normal response to it, the circumstance is also changed and new behavior is often possible.

Affect Regulation Learning During Trauma Processing

In addition to the above, it appears that affect regulation and tolerance can be learned implicitly during the ongoing process of longer-term, exposure-based trauma therapy. Because, as discussed in later chapters, trauma-focused interventions involve the repeated activation, processing, and resolution of distressing but nonoverwhelming distress, such treatment slowly teaches the

survivor to become more "at home" with some level of painful emotional experience and to develop whatever skills are necessary to deescalate moderate levels of emotional arousal. As the client repetitively experiences titrated (that is, not overwhelming or destabilizing) levels of distress during exposure to trauma memories (Chapter 8), he or she may slowly develop the ability to self-soothe, reframe upsetting thoughts, and call upon relational support. In addition, by working with the client to deescalate distress associated with activated CERs, the therapist often models affect regulation strategies, especially those involving normalization, soothing, and validation. However developed, this growing ability to move in and out of strong affective states, in turn, fosters an increased sense of emotional control and reduced fear of negative affect.

SUGGESTED READING

Bowen, S., Chawla, N., & Marlatt, G. A. (2011). *Mindfulness-based relapse prevention for addictive behaviors: A clinician's guide.* New York, NY: Guilford.

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Jacobson, E. (1938). *Progressive relaxation.* Chicago, IL: University of Chicago Press.

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SEVEN

COGNITIVE INTERVENTIONS

As noted in Chapter 2, trauma survivors—especially victims of interpersonal violence—are prone to self-blame, guilt, shame, low self-esteem, overestimation of danger, and other negative beliefs and perceptions. The rape victim may believe she somehow "asked for it" or otherwise caused herself to be assaulted, and the battered woman may assume that she deserved to be beaten. Individuals who have been repeatedly exposed to situations in which they were helpless to escape or otherwise reduce their trauma exposure often develop a sense of having little power to affect future potentially negative events. Some survivors view their posttraumatic symptoms as evidence of being defective or "crazy." Victims of sexual trauma often feel ashamed and isolated by their experiences.

In general, cognitive therapy of posttraumatic disturbance involves the guided reconsideration of negative perceptions and beliefs about self, others, and the environment that arose from the trauma. As these negative assumptions are reevaluated, a more affirming and empowering model of self and others frequently takes its place. At the same time, the client may develop a more detailed and coherent understanding of the traumatic event, a process that is associated with clinical improvement (Foa, Molnar, & Cashman, 1995).

COGNITIVE PROCESSING

In most cases, trauma-related cognitive disturbance is addressed through detailed verbal exploration of the traumatic event and its surrounding