It's Not You, It's What Happened to You:

Complex Trauma and Treatment

By

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Chapter Five
Healing From Trauma

Treatment Foundations

The first four chapters of this book might cause readers to feel overwhelmed and even a bit hopeless about recovering from the effects of trauma. If so, there is no need for despair because, along with all of the other things that have been learned about trauma over the course of the past several decades, a number of treatment methods have been developed, tested, and proven effective. This chapter provides an overview of these methodologies. Before discussing the various approaches to trauma treatment, however, it is useful to understand a few of the underlying principles, including the need for safety, facing vs. avoiding trauma responses, development of the treatment alliance, and facets of posttraumatic healing.

Safety First

It is a given that trauma survivors simply can't heal from past traumas when they are still being traumatized. As such, risk assessment and safety planning are essential foundations of treatment. This "safety first" principle primarily involves an assessment of current risks, along with the development and implementation

of skills that can ensure personal safety in the present. When an individual is actively at risk (i.e., still in an abusive relationship, unable to engage in self-protection, continuing in risk-taking or addictive behaviors), establishing safety may take a great deal of attention and effort.

Generally speaking, safety planning teaches clients to identify cues to danger, to review potential responses, to evaluate alternatives in terms of risks and benefits, and to seek support and take action when appropriate. In other words, safety planning is a process in which clients acquire the skills they need to deal with potentially dangerous and abusive situations and to increasingly keep themselves safe. Applying the safety plan is also a process.

Facing vs. Avoiding

As discussed earlier, many complex trauma survivors use avoidance mechanisms extensively in their attempts to self-regulate and self-soothe their posttraumatic responses. They isolate, they keep secrets, they become people pleasers, they get aggressive, they "numb out" with substances and/or behaviors, they dissociate, they bond with their perpetrators, etc. And while all of these mechanisms can shield trauma survivors from pain, they also prevent the experience, integration, processing, and resolution of traumatic events. In contrast, the core of trauma treatment involves exploring and processing traumatic experiences, memories, and emotions as a way to integrate and resolve them. This means that trauma survivors must engage with traumatic memories rather than avoiding or dissociating from them.

Unsurprisingly, dredging up painful memories can temporarily make symptoms of PTSD, depression, and anxiety worse rather than better and can cause a return to old "tried and true" coping mechanisms. As such, addressing trauma must take place in an environment of safety with a focus on containment and healthy

coping skills, including the ability to regulate emotions and to stay sober while doing so. To this end, clients are taught skills that keep them from dissociating and help them to ground themselves in their bodies and remain "present." The therapist also helps clients separate the past from the present and to understand that remembered trauma is not occurring in the moment, even though flashbacks and other re-experiencing symptoms may make it seem as though it is.

The Treatment Alliance

Therapy for trauma and related symptoms requires an informed therapist with whom a "therapeutic alliance" is formed. My colleague Dr. Sandra Bloom has aptly described the building of a therapeutic alliance as "relational healing for relational injury." Typically this alliance develops over time and is based on the trustworthiness and attunement of the therapist, and the client's understanding that *therapist and client are working together* in his or her best interests. Establishing a therapeutic alliance in this way can help to undo a lifetime of mistrust—a major therapeutic advance in and of itself. It also helps in the shifting of avoidant, preoccupied, or disorganized attachment styles toward "earned secure" attachment.

Importantly, this process extends to not just the therapist but to others in the therapeutic environment, starting with the client's peer support group. Residential treatment settings, group treatment settings, twelve step support groups, and other peer support networks let trauma survivors safely discuss their trauma-related issues with supportive, empathetic, and nonjudgmental others, thereby extending their treatment alliance. These survivors learn that they are not alone in what happened to them and in the feelings and self-perceptions they developed, nor are they alone in the maladaptive coping methods they've relied upon. In time, they learn to give as well as take in group recovery settings, working for the benefit

of all. Often these secondary treatment alliances are incredibly powerful from a healing standpoint.

Reversing the Downward Spiral

My colleague, Dr. Stephanie Covington, has used a downward spiral that increasingly constricts and tightens as a means of depicting what happens to the unrecovered trauma survivor (and addict) in virtually every aspect of his or her life. The result is less and less freedom, less and less power, less and less control. However, with proper treatment and healing an opposite pattern can develop, with the downward spiral reversing and becoming an upward, increasingly open spiral. As trauma survivors move up the spiral of recovery, the loops widen, opening up their minds, their selves, their emotions, their relationships, and their lives. They experience an ever-growing sensation of freedom, power, and control. No longer are they helpless victims. Instead, they are active participants in their own lives, able to affect and even to control potentially negative outcomes in a positive fashion and to engage with others who are trustworthy and reciprocal. In short, as their lives open up, they find that they are no longer ruled by past traumas.

Resilience and Posttraumatic Growth

It may seem contradictory, but the effects of trauma are not always or only negative. In some cases, the traumatized individual "rises to the challenge" and responds with great resiliency and enhanced coping, and feels stronger as a result. Traumatic events and experiences can turn up positives hidden within negatives—silver linings in dark clouds that are sometimes referred to as *posttraumatic growth.* In short, individuals may find meaning in their traumatic experience, leading to increased resilience and/or changed perspectives that lead to personal insight and growth. For example, a cancer survivor might come to appreciate life more, making changes in lifestyle and working much harder to develop meaningful connections. Many trauma survivors are

highly empathetic and spiritual, seemingly miraculous in light of what some of them have endured.

Trauma-Integrated Treatment: Sequenced and Relationship-Based

Trauma-Informed Care

Trauma-Informed Care (TIC) is a philosophy and approach to treatment based on the fact that many (if not most) individuals receiving treatment in the mental health/addiction services system have a history of trauma that relates directly to their present-day distress. For this reason, TIC includes an emphasis on universal screening for trauma at the start of treatment, along with an interweaving of information about trauma and its impact throughout the treatment process.

As opposed to traditional treatment models that focus primarily on symptoms, TIC approaches clients from a position of respect for them as individuals—for their survivor skills, adaptations, personal strengths, and resilience—incorporating a problem solving and skill building approach that emphasizes client control and empowerment. It seeks to reduce the negativity and stigma that often accompanies the treatment of many survivors. Clients are encouraged to actively collaborate on and participate in their treatment as a way to break the pattern of shame and being "done to" (disempowered or victimized) and to establish in its place a pattern of self-efficacy, empowerment, accomplishment, and personal pride. TIC also attends to the client's environment (including personal relationships and home and work life) as part of his or her individualized needs, offering hope for healing and recovery there as well.

Trauma-Focused Treatment

Trauma-Focused Treatment (TFT) is specifically directed at the

resolution of trauma in order to alleviate its symptoms. The difference between TFT and TIC is that TFT is a component of TIC, implemented when trauma is an overriding issue for a particular individual. For instance, nearly all substance abusers have a trauma history, but for some that history is much deeper and more powerful than it is for others. Both sets of addicts need TIC, but only one group requires the extra focus on trauma that TFT provides.

Integrated Trauma-Informed Addiction Treatment

It used to be that trauma survivors who entered treatment for addiction were treated for addiction and addiction only, with trauma put on the back burner until sobriety was firmly established. It was believed that until a person got sober, little else could happen on the therapeutic front. And it is easy to see why this approach was taken. After all, if you assume (as most therapists do) that addictions are a maladaptive attempt to self-soothe and self-medicate, and that the basis of trauma-focused psychotherapy is recognizing, experiencing, and processing past and present emotional discomfort, then logic dictates clients can't grow past their emotional challenges (their trauma) while they are simultaneously self-medicating away the resulting anxiety, emotional instability, and depression they experience.

Over the years, I have developed a sequenced model of treatment for addictions coupled with PTSD and Complex PTSD. Built on the three-stage trauma treatment model proposed by Dr. Judith Herman in 1992 and much earlier by Dr. Pierre Janet, it involves stabilizing the client before addressing traumatic memories in any detail. My updated model, integrating addictions treatment, recognizes the interconnected nature of addictions and unresolved trauma and the fact that they often have a negative synergistic impact. In short, this model proposes that if both conditions are not treated concurrently and clients don't heal from both issues simultaneously, they may not heal from either. This thought is well-

supported by studies showing that addicts with extensive trauma histories have a much harder time maintaining sobriety than addicts without such histories.

The stages of Integrated Trauma-Informed Addiction Treatment are as follows:

- **Pretreatment (Assessment):** Assessment usually involves several clinical interviews (at the point of initial contact with the program and at the time of admission with nursing, psychiatry, psychology, counseling, and other program staff). Psychological instruments might also be administered by computer or in written format, some of which might be re-administered later as a way to measure the client's progress. Assessment is wide-ranging, including many questions about trauma and other crises in the family or elsewhere, along with questions about relationships, addictions, and symptoms of trauma such as depression, dissociation, and anxiety. Based on the assessment, an individualized treatment plan is developed.
- **Stage One:** This stage is devoted to detox (as needed), abstinence from addictive substances and/or behaviors, and issues of early sobriety. Emphasis is on safety and crisis management, along with extensive education about addiction and trauma and their interaction. Twelve step and other recovery programs are introduced as they relate to sobriety and overall mental and physical health. Residential treatment settings may incorporate a variety of alternative and complementary modalities (meditation, yoga, neuro and biofeedback, acupuncture, expressive therapies, massage, mindfulness stress reduction, animal-assisted therapies, etc.) Once the basics have been covered and the individual has achieved a fair degree of stability and a decreased risk of relapse, he or she is assessed in terms of the need for Trauma-Focused Treatment (TFT), and a continuing treatment approach is recommended.

- **Stage Two:** This stage is focused on the processing of trauma and its impact through the use of specialized, evidence-based (clinically tested and proven to work) TFT techniques. The goal of this stage is to reintroduce and reintegrate trauma response in doses that are manageable through use of learned coping and emotional modulation skills. The therapist closely monitors the client's responses in order to keep the client in his or her "window of tolerance," helping the client to face and process trauma without becoming overwhelmed. The therapeutic techniques available are first discussed with the client, so that he or she may help to choose one or more that suits his or her specific needs. All of the techniques involve some degree of exposure to what has been avoided/dissociated/suppressed, often resulting in a temporary intensification of distress. Clients are encouraged to discuss their reactions in detail with the therapist, who then offers both emotional support and corrective information when problematic or erroneous interpretations and perceptions are uncovered. Shame, loss, anger, and grief are usually at the forefront during this stage. This emotional and cognitive processing of past traumas and associated memories to the point of changed perceptions and resolution results in the lessening of symptoms and, in turn, an easier time maintaining sobriety and living a more stable and satisfying life.
- **Stage Three:** This stage generally begins after the first 30 to 60 days of treatment (often after an inpatient treatment stay ends). At this point, treatment focuses on the client's newfound ability to make life choices based not on his or her history of trauma and addiction, but on freedom from those bonds and a newly developed sense of self-worth

and personal empowerment. Clients are encouraged to apply their newfound knowledge and skills to a life of sobriety and safety from additional abuse and trauma. Many life changes may be in order during this stage—developing intimacy, recovering from sexual difficulties, improved parenting, developing new relationships and letting old ones go, discussing past abuse and trauma with perpetrators and others, determining whether to initiate a particular course of action (police report, further disclosure, confrontation, lawsuit, etc.), reestablishing a career or resetting a career path, and more. Twelve step programs can be especially useful as a foundation for these efforts.

Although the treatment stages are presented above in linear format, they are actually rather fluid in application, with clients engaging in the different treatment tasks and moving back and forth between the stages as needed. For example, if a client reports feeling unsafe and overwhelmed during the formal trauma processing that takes place in Stage Two, he or she returns to Stage One's safety planning and skill-building to restabilize and practice skills. Once stabilization and skills are reestablished, the trauma exposure work of Stage Two resumes. Throughout the stages there is planning for backslides and relapse, with setbacks treated as problems to be solved rather than personal failures. At all stages, clients are encouraged to take risks with self-exploration in a safe and supportive environment and to engage in new behaviors based on newly acquired perspectives and skills.

If addicted trauma survivors are struggling with core concepts of healing, or they just can't seem to establish a footing in recovery and sobriety, then either intensive outpatient or inpatient residential treatment may be recommended to jump-start the process. These concentrated programs can last as little as a few weeks or as long as several months. In such settings, addicted trauma survivors are

removed from the people, places, and things that initiate or reinforce their trauma and drive their addiction. They are instead surrounded by supportive, empathetic staff members and other patients who are also dealing with painful trauma, deep shame, and debilitating addictions.

Needless to say, every addicted trauma survivor's treatment arc is different. Each person arrives with specific problematic behaviors and a unique background, so each client needs an approach tailored to his or her particular needs. Some will respond best to individual therapy supplemented by group work. Others will do best in group settings, making little progress one-to-one. Still others will struggle utterly until they are physically and emotionally separated from the people, places, and things that have perpetrated trauma on them or that remind them of their trauma.

Commonly Utilized Treatment Modalities

There are more than 100 types of therapy currently in use. Many are general approaches used for a wide variety of disorders, including trauma-related disorders. Several were developed specifically for the treatment of trauma. Oftentimes both general psychotherapeutic approaches and trauma-specific approaches are coupled with alternative modalities like yoga, meditation, neurofeedback, massage, exercise, acupuncture, nutrition and supplements (as needed), animal-assisted therapy, art therapy, self-defense classes, and more. Psychotherapy may also be supplemented with *psychopharmacotherapy*—the use of medications to alleviate the symptoms of psychological disorders, including addictions. It should be noted that psychopharmacological medications do not cure the underlying disorder. Instead, they lessen the symptoms and their negative impact, sometimes making it easier for clients to tolerate things like re-experiencing trauma in therapy sessions. As such, these medications are best used in conjunction with a psychotherapeutic approach (or multiple approaches).

The choice of treatment modality should always take into account the trauma survivor's beliefs, values, and personal preferences. The most commonly used treatment modalities for trauma and related symptoms are described below. They include:

- **ACT (Acceptance and Commitment Therapy):** ACT is a relatively new form of therapy that enhances the client's acceptance of his or her status, followed up with a commitment to action. ACT involves the application of mindfulness strategies and techniques. It teaches people to notice, accept, and embrace their thoughts, feelings, and memories (rather than trying to control them). Then, based on this, the individual can clarify his or her values and develop an action plan for reasonable and positive change.
- **CBT (Cognitive Behavioral Therapy):** CBT looks at what triggers and reinforces actions related to re-experiencing trauma and/or engaging one's addiction, and identifies ways to short-circuit the process. In other words, CBT teaches clients to stop unwanted thoughts and behaviors by thinking about something else or by engaging in some other, healthier behavior such as cleaning the house, reading a book, attending a twelve step recovery meeting, or talking to a loved one.
- **Couples and Family Therapy:** Family and couples therapy sessions are a routine part of addictions treatment. When chronic attachment trauma is involved, these sessions can be expanded to address that. In such cases, the establishment of safety within the family/relationship is the initial focus, with additional treatment geared toward relational healing and the development of intimacy, parenting skills, and the like.
- **CPT (Cognitive Processing Therapy):** CPT is an adaptation of CBT, conducted in written form. In CPT, clients write out their trauma story, which they then read to the therapist. They go over it carefully so the therapist can provide outside perspective and help to identify any erroneous beliefs or problematic cognitions held by the client. The intent is to short-circuit those beliefs and to replace them with a more realistic assessment of and response to the situation.

- **CR (Cognitive Restructuring):** CR is often used as a part of other therapies, including CBT. CR is a process of learning to identify and dispute maladaptive thoughts and cognitive distortions. This modality uses many strategies, such as guided imagery, thought recording, and Socratic questioning (questioning that is deep, disciplined, systematic, and focused on fundamental issues and problems).
- **DBT (Dialectic Behavior Therapy):** DBT is a behavioral therapy approach based on the belief that behavior change can occur through the acceptance of emotions and consistent practice at managing and regulating them. DBT teaches various methods such as distress tolerance, mindfulness, dialectics (discourse intended to resolve disagreements), emotion regulation, and interpersonal effectiveness. While not specifically developed for trauma treatment, it has widespread applicability.
- **EDP (Experiential Dynamic Psychotherapy):** This is an accelerated from of psychodynamic psychotherapy designed to bring patients directly to the experience of buried feelings, impulses, and emotions, thereby allowing them to understand and overcome their issues.
- **EFTT (Emotion Focused Therapy for Complex Trauma):** EFTT is based on the idea that the therapeutic relationship and the emotional processing of trauma memories are mechanisms of change. Emphasizing access to previously inhibited feelings, the clinician and client work

together to modify maladaptive responses to trauma such as fear, avoidance, and shame. Traumatized clients engage in experiential exercises to simulate confrontation of the perpetrator and change the outcome of the traumatic experience.

- **EMDR (Eye Movement Desensitization and Reprocessing):** EMDR is a mind-body treatment where clients bring to mind painful (traumatic) memories and beliefs about themselves while simultaneously paying attention to an outside stimulus (i.e., moving their eyes back and forth or other forms of bilateral stimulation, called dual attentional focus). This begins a process of adaptive emotional processing that helps the client make associations between memories in order to resolve them. The procedure is repeated until the client's level of distress about the inciting event has diminished. This technique, along with PE, has the most evidence of effectiveness in extinguishing symptoms of PTSD.
- **Emotional Freedom Techniques:** These techniques involve tapping energy points on the body, focusing (brainspotting), or counting while the trauma is being recounted. This dual focus is thought to allow processing, although these techniques are yet to be investigated sufficiently and are considered experimental.
- **Gestalt:** This is another action-based treatment. Clients are engaged in dialogues and other activities to help them free up and resolve emotional impasses.
- **Group Therapy:** Trauma often presents challenges that are best dealt with in group settings (rather than in one-on-one therapy). In fact, addicted complex trauma survivors nearly always require external reinforcement and support if they want to permanently change their patterns of emotional dysregulation and problem behaviors. Therapist facilitated groups can help these clients see that their problems are not unique, which goes a long way toward reducing the shame associated with trauma, addiction, and other maladaptive coping behaviors. Group therapy is also the ideal place to confront the denial that is integral to maintaining those maladaptive coping mechanisms (especially addictions). Such confrontations are powerful not only for the person being confronted, but for those doing the confronting. As such, everyone present learns how minimization, justification, and rationalization can lead to revictimization and the continuation of damaging behavior patterns. Group members are also able to learn which interventions and coping mechanisms work best based on other members' experience.
- **Hypnosis:** Hypnosis is used in the treatment of trauma to help clients with relaxation and as a tool for self-management. Hypnosis should *not* be used for memory retrieval.
- **MBSR (Mindfulness-Based Stress Reduction):** MBSR is a mindfulness-based program initially conceived of as a way to help people with physical and/or psychological pain. It utilizes meditation, body awareness, yoga, and similar concepts to induce relaxation, stress reduction, and an improved quality of life.
- **MET (Motivation Enhancement Therapy):** MET involves motivational interviewing designed to engage clients in a path of behavioral change. The goal is helping clients increase their personal motivation and achieve goals they have set for themselves (like sobriety for addicts).
- **NET (Narrative Exposure Therapy):** NET was adapted from CBT and other narrative therapies. It involves creating a narrative of the trauma with the goal of transforming fragments of traumatic experience into a coherent story,

which is repeated and corrected with each session until habituation of the event is experienced, thereby reducing related symptoms.

- **PE (Prolonged Exposure Therapy):** PE involves the intentional re-experiencing of traumatic events (in a safe and supportive environment and with relaxation and other skills in place) through remembering and engaging with, rather than avoiding, traumatic memories. Sometimes this technique is referred to as "flooding." PE involves the client's making an audiotape of his or her experience and listening to it repeatedly until it no longer causes distress. This technique, along with EMDR, has the most evidence of effectiveness in extinguishing symptoms of PTSD. *Graduated Exposure* follows a similar strategy, but it is not as direct and the re-experiencing is more gradual.
- **Psychodrama**: This is a specialized group therapy technique that involves the playing out of family roles or other issues, with clients taking part as protagonists, antagonists, and observers/commentators. This acting out of roles and/or events assists with clarifying and resolving past trauma by allowing clients to experience it from a range of perspectives.
- **Psychodynamic Psychotherapy:** This is a form of "depth psychology," which is what most people think of when they picture psychotherapy. The primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate internal conflict, tension, and emotional discomfort.
- **SE (Somatic Experiencing):** SE attempts to promote awareness of and release of physical tension that remains in the body in the aftermath of trauma. SE recognizes that the survival responses (fight/flight/freeze) are aroused but

are not fully discharged after the traumatic situation has passed, and it finishes the dispersal of the trauma response.

- **SIT (Stress Inoculation Training):** SIT teaches clients ways to address stress and improve resilience. As coping increases, the trauma symptoms may be modified and desensitized.
- **SP (Somatosensory Psychotherapy):** SP is an integrative experiential technique focusing on physical responses to trauma. Clients are encouraged to focus on and learn about their physical responses, and to work with them as a way of understanding and completing the trauma response. This approach puts a less than normal emphasis on talk therapy.

Emotion/Affect Regulation

Regardless of the treatment modality, recovering from trauma is a process of learning to recognize and accept emotions as they happen, to face and integrate them, and to modulate responses. In other words, when triggered by a memory of past trauma, survivors learn to recognize that they are feeling some very powerful emotions, to assess the reality of their situation (to understand that they are reacting to the past rather than an actual threat in the present), and to modulate what they are feeling and how they react (the process of desensitization). This therapeutic work is supported by other strategies such as asking others for support and advice, problem solving, getting regular sleep and nutrition, exercising, and engaging in formalized relaxation through guided imagery, meditation, biofeedback, and the like. Ideally, when trauma survivors become proficient in the various forms of self-regulation, they are able to easily and naturally turn to them in times of distress. Of

course, this is not as easy as it sounds. In fact, it takes a great deal of effort and practice. But over time this work is well worth the effort.

- **External Support:** Healthy people rely on attachment relationships for emotional regulation and useful advice. This is an unnatural act for most trauma survivors new to recovery. However, over time, usually starting in therapy, survivors are able to build trust with supportive and empathetic people.
- **Problem Solving:** In addition to response modulation, trauma survivors must learn to problem solve. Simply regulating emotions will not help with avoiding further traumatization. Instead, trauma survivors must learn to be assertive about their needs, boundaries, and rights.
- **Sleep:** Chronic stress and anxiety are exhausting. Even if a trauma survivor is just sitting around, the constant fear of what might happen is utterly draining. Healthy sleep is the best medicine for this type of stress. Most trauma survivors are advised to go to bed and to wake up at the same times every day (eight hours apart) as a way to establish a regular, healthy pattern of sleeping. Sleep strategies (also called "sleep hygiene") are often taught in recovery programs.
- **Nutrition:** Just as healthy sleep patterns are essential to health, so are healthy eating patterns and proper nutrition.
- **Exercise:** Numerous studies have shown that exercise is a great way to relieve stress and depression. Trauma survivors should approach exercise with caution, however, as sometimes an increased heart-rate, sweating, and the like can trigger flashbacks. As such, aerobic exercise is not recommended for all trauma survivors, nor is meditation or yoga. In some cases, modified versions of these techniques may prove helpful.

- **Formalized Relaxation:** Yoga, meditation, visualization, breath-work, biofeedback, and other relaxation techniques can be especially useful, helping trauma survivors to both relax and to ground themselves in the moment. These too must be tailored to the individual's needs and abilities.
- **Abstinence/Moderation with Substances:** Even trauma survivors who are not also addicts need to be careful with addictive substances, including cigarettes. Cigarettes, alcohol, and illicit drugs can all be harmful to the body, causing problems that may increase stress levels. Furthermore, many addictive substances lead to poor decision-making, which can also increase stress levels.

Developing Newer and Healthier Relationship Patterns

As mentioned throughout this book, healthy relationships interrupt the cycle of trauma. In fact, complex trauma survivors can learn to spin this destructive cycle in the opposite direction. Just as unhealthy models of relating are learned and repeated, healthy models of attachment can be learned and practiced. Over time, complex trauma survivors can drastically improve both their self-worth and the quality of their interactions with others. Primarily this involves the development of a wide-ranging and consistently supportive network of people. Individuals comprising this network may include social contacts, work and school relationships, professional relationships, friendships, romantic and sexual relationships, and family relationships.

- **Social Contacts** are relationships built on circumstance. They are built on small-talk. Although they are not emotionally intimate, they are important because they foster a sense of belonging and community.

- **Work and School Relationships** resemble social contacts, but they are confined to very specific circumstances. It is not unusual for work and school relationships to become more important over time, developing into friendships or even romantic interactions.
- **Professional Relationships** may not seem overly important in terms of attachment, but this is actually not the case. The boundaries and contractual nature of these interactions (such as in a therapist-client relationship) can provide safety and reliability, which is very useful in terms of helping traumatized people learn the basics of secure attachment. Mentoring is often a significant component of these relationships.
- **Friendships** usually start out as social contacts or work and school contacts, but based on shared interests and life circumstances they become more important over time. Friendships are relatively unthreatening in nature, and they typically entail little conflict. As such, like professional relationships, they are a great way for traumatized people to learn the basics of secure attachment.
- **Romantic and Sexual Relationships** are, essentially, friendships taken to the level of love and sexual activity. Romantic relationships are "primary" attachment relationships that are every bit as important as family relationships, though sometimes in different ways. Because intimacy requires two people to become heavily involved in each other's lives, there needs to be a great deal of give and take. As such, a secure attachment pattern (where neither person "needs" to isolate, be dependent, or exert control) is imperative to long-term success.
- **Family Relationships** can include family of origin, in-laws, and even "family of choice." Sadly, most people who were traumatized to the point of developing non-secure styles of attachment and unhealthy relationship patterns got that way thanks to their families. This does not, however, mean that these relationships are doomed. In fact, complex trauma survivors often, over time and with a great deal of hard work in treatment, learn to forgive those who were neglectful and/or abusive, understanding that those individuals were damaged by their own traumas and were doing the best they could at the time.

Through a considerable amount of hard work in these various domains of relationships, even the most traumatized of people can learn, over time, to interact in healthier ways, breaking old patterns of relating, developing self-worth, and eventually implementing more secure forms of attachment.

Life After Trauma

There is no absolute "cure" for trauma and no "one size fits all" approach to healing. What treatment and recovery do is provide trauma survivors with skills and tools that can reduce trauma's power. In all likelihood, unwanted memories of past traumas will persist to some degree or will recur occasionally even after extensive treatment, but they will not be as triggering and debilitating. Instead, they will become more like memories of normal events. Similarly, trauma survivors (especially the addicted ones) nearly always experience the pull of their unhealthy coping mechanisms, even after years of recovery, but with support and attention to applying learned methods of coping with triggers and emotions the survivor can prevail.

Interestingly, the skills that are learned early in recovery typically become a trauma survivor's go-to coping mechanisms. A lot of people recovering from trauma feel as if their healthy coping

mechanisms should "evolve" and become more sophisticated over time. And to a certain extent this does happen. But when the chips are down, when the survivor is hit with a powerful trigger out of the blue, it is almost always the basic skills that save the day.

It is important to point out that recovery from trauma does not happen in a vacuum. Simply put, a large part of recovery is dependent on relationships with other people who are also in recovery. These individuals can be found in therapy settings and various support groups, including twelve step groups (especially if the survivor is simultaneously recovering from addiction). Many trauma survivors also remain in individual, one-to-one therapy, as this venue tends to provide a more directed approach to dealing with the emotions that past traumas continually bring up. Whatever the setting, it helps to have empathetic others who can and will provide support in times of distress and need. The good news is that over time and with the support and guidance of knowledgeable, nonjudgmental, supportive others, any trauma survivor can overcome the debilitating effects of pretty much anything he or she has experienced.

It is my hope that this book supports your understanding of the trauma that has happened to you and the process of recovering from it. As you learn to separate yourself from what happened to you, you will simultaneously find your "self" and increase your self-esteem. As this happens, you will be able to develop affirming and loving relationships as never before. Yes, recovering from trauma takes willingness and a great deal of courage, but the time and effort you put into this process is incredibly worthwhile.

Resource Guide

Finding a Trauma-Informed Therapist

As mentioned several times throughout this book, many psychotherapists are not trained to assess and treat complex trauma in their clients. As such, the link between past trauma and current mental health issues is often either not acknowledged or inadequately addressed. This situation is gradually improving, but traumatized individuals still run the risk of not getting a therapist who fully understands trauma, traumatic reactions, and specialized treatment. The good news is that first-rate trauma treatment is available if you find the right clinician. Psychotherapist referrals for trauma treatment can be obtained through numerous sources, including:

- American Psychological Association, locator.apa.org/
- Anxiety and Depression Association of America, www.adaa.org/netforum/findatherapist
- International Society for the Study of Trauma and Dissociation, www.isst-d.org
- International Society for Traumatic Stress Studies, www.istss.org/source/cliniciandirectory/
- Sidran Institute: Traumatic Stress Education & Advocacy Help Desk, www.sidran.org
- State and local psychological, social work. and counseling associations, looking under trauma specialization