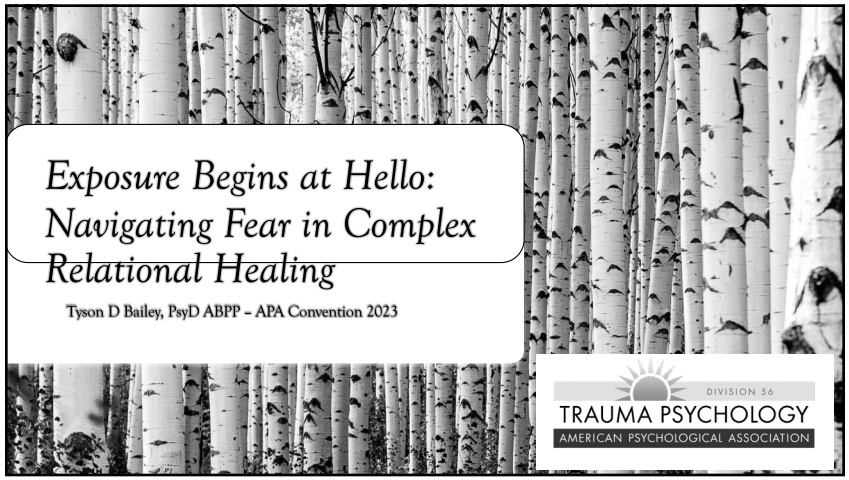

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Gratitude

- It is not possible to thank everyone who has helped shape this presentation; however, there are a few individuals without whom this presentation and my journey as a psychologist would have been very different
  - Laura Brown
  - Bethany Brand
  - Chris Courtois
  - Bill Heusler
  - Michelle Brown
  - Chuck Benincasa
  - The members and EC of Division 56
  - The humans who have bravely shared their lives and wisdom

3

A bit about me

- White, cis, male identified, heterosexual, married, temporarily able-bodied (most days), no known indigenous heritage, spiritual, U.S. born, English speaking, college educated, and middle-upper-middle class (raised and current)
- Partner in a group practice in Washington
- Forensic work primarily includes criminal defense and civil plaintiff
- Associate editor for Psychological Trauma: Theory, Research, Practice, & Policy
- Editor-in-chief for the Journal of Threat Assessment and Management
- Division 56 president in 2021
- Board certified in clinical psychology

4

Plan

- What makes therapy work?
- What is exposure?
- Brief review of treatment for complex trauma
- Bring it all together – Conceptually driven trauma recovery

5

Assumption of Safety

- I think the major difference between a social justice and a white/colonial lens on trauma is the assumption that trauma recovery is the reclamation of safety—that safety is a resource that is simply 'out there' for the taking and all we need to do is work hard enough at therapy.

Kai Cheng Thom

6

Cultural responsiveness

- **Cultural Competence** is the knowledge and understanding of the diverse and complex needs of people from various cultural groups. Cultural competency is a continuum of practice that involves acknowledging cultural differences, identify gaps in treatment, and then tailoring your behavior and the services you provide to meet the needs of all groups by hearing from the groups and involving them in changes and decision-making.
- **Cultural humility** challenges us to learn from those we work with and serve, reserve judgement, and actively bridge cultural divides.

7

Cultural responsiveness

- **Cultural responsiveness** is when services are framed by understanding of culture, cultural competency, and cultural humility creating a cultural responsive foundation for families and communities to be engaged and supported utilizing the strengths of their diversity and cultural dynamics. Culturally responsive programs and services evolve appropriately to engage families and communities in the design, delivery, and evaluation of effective and appropriate services. Think of cultural responsiveness as a tool to ensure the inclusion of various points of views and experiences. It often requires that those in a position of power take stock of their role in society and the advantages that may come with it and encourages the learning and understanding of other groups to foster respect, trust, and inclusion of that understanding in every step of decision-making.

https://cceh.org/cultural-competency/

8

Social location

- Social locations reflect the many intersections of our experience related to race, religion, age, physical size, sexual orientation, social class, and so on. Social location contributes not only to our understanding of the ways in which our major institutions work, but also to our ability to access them. The effect of colonization is such that the social location of someone in the dominant society may be very different from that of an Aboriginal person.

http://web2.uvcs.uvic.ca/courses/csafe/mod2/notes3.html

- The way society, outside of self, perceives you in accordance with your expression, your appearance, and your mannerisms

Rev. Angel Kyodo Williams

9

MindfulDiversity
Belonging together in a complex world

Social Positioning*

The positioning of an individual in a given society. Social positioning influences social status.

- **Dominant group (valued identities)** has the power, makes the rules, and is seen as normal.
- **Non-dominant group (devalued / stigmatized identities)** adapts to the dominant group's values and often feels that their difference is seen as abnormal. Being in a non-dominant group can feel isolating, especially in an environment that doesn't correct for the bias towards the dominant group.

Group Identity	Dominant / Valued Group	Non-Dominant / Devalued Group
Sex	Male	Female, Intersex
Sexual Orientation	Heterosexual	Gay, lesbian, bisexual, queer, asexual
Gender Identity	Male	Female, transgender, non-conforming, non-binary, agender
Gender Expression	Follows gender norms	Non-conforming, non-binary
Gender Alignment**	Cisgender	Transgender, genderqueer, Two-Spirit, non-conforming
Race	White	Other race, mixed-race
Monoracial/Multi	Monoracial (one race)	Multiracial
Ethnicity	European-American	African-American, Asian-American, Native American, Latin-American, etc.
Education	Bachelor's Degree and higher	High School/Associate's Degree

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Class	Owning class, professional/middle class	Lower middle/working class, low-income/ poverty class
Ability	Abled-bodied, non-disabled	Disabled
Neurodiversity	Neurotypical	Neurodivergent: ADHD, Autism, etc.
Age	Under 40	Over 40
Religion	Catholic / Protestant	Muslim, Buddhist, Jewish, Hindu, Wiccan, Yoruba, atheist, etc.
Relationship Status	Partnered / Married	Single, Poly, non-monogamous
Immigrant Status	Self and parents born in U.S.	Immigrant, or Immigrant parents
First Language	Colonizer (English, Spanish, Portuguese, French, Dutch, etc.)	Colonized / Other (Hmong, Navajo, Punjabi, Nahuatl, Mixtec, Tagalog, etc.)
Childhood Family Environment	Opposite-sex heterosexual parents, nuclear family	Single parent/caregiver, adopted, same-sex parents, divorced parents
Personality	Extravert	Introvert

* This is not a comprehensive list. Dominant and non-dominant status are based on U.S. culture and may vary for some group identities depending on location (e.g. age, civilian/veteran, etc.).
** **Gender Alignment** is a word I created to categorize people whose gender identity is either aligned (cisgender) or not aligned (transgender) with the gender assigned at birth.

Angella Okawa, LMFT #83306 www.mindfuldiversity.com / angella@mindfuldiversity.com (edited 02/03/2021)

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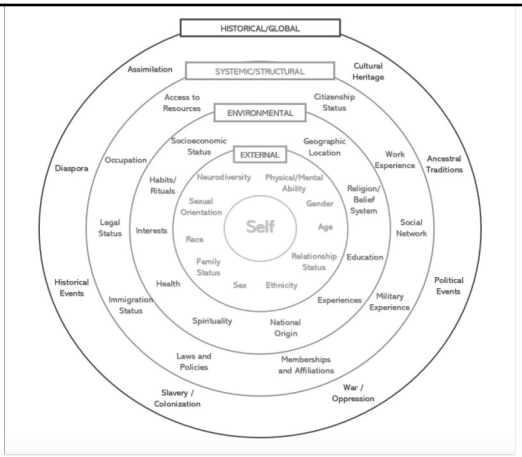

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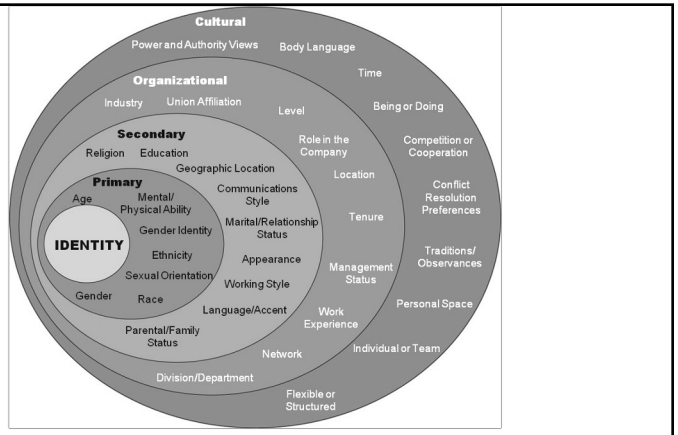

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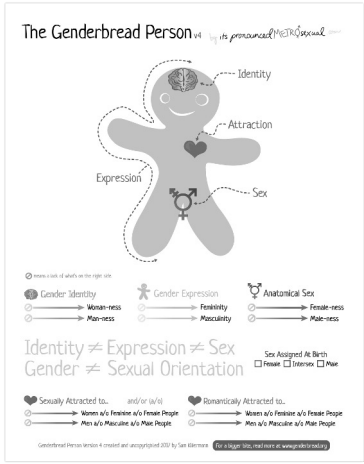

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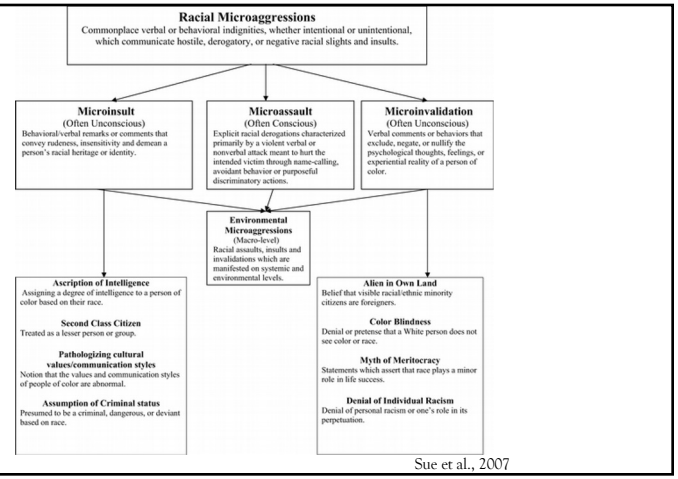

Sue et al., 2007

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What are the Elements of Good Enough Therapy?

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EBP vs. EST

- "*Evidence-based practice in psychology (EBPP)* is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

(APA, 2006, p. 273)

- Empirically supported treatments are the focus of many research studies to help with specific experiences or states of distress
  - Only one leg of the stool

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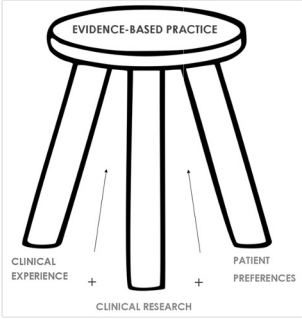
EBP vs. EST



https://guides.americancareercollege.edu/c.php?g=393192&p=2673709

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Psychotherapy Outcome

- Model 1: Percentage of outcome as a function of therapeutic factors
  - Extratherapeutic change
    - Self-change, spontaneous remission, social support, fortuitous events
  - Common factors
    - What works in most therapy, regardless of orientation
    - Relationship is the sine qua non, although other client and therapist factors are present
  - Expectancy/placebo
    - Knowledge of of being treated and belief in the work
  - Techniques

(Norcross & Lambert, 2019)

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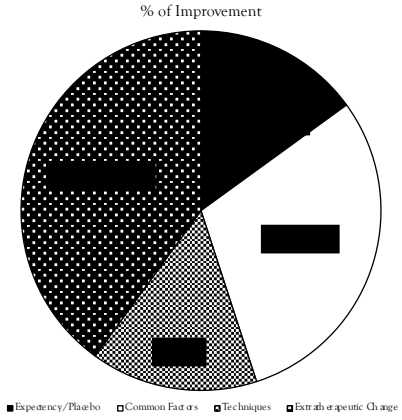

Norcross & Lambert, 2019

20

Psychotherapy Outcome

- Model 2: Considers all outcome variance
  - Unexplained
    - Measurement error, methodology, complexities of human behavior
  - Client
  - Relationship
  - Techniques
  - Therapist variables
  - "In this model, we assume that common factors are spread across the therapeutic factors—some pertain to the patient, some to the therapy method, some to the treatment method, and some to the therapist"

(Norcross & Lambert, 2019, pp. 12-13)

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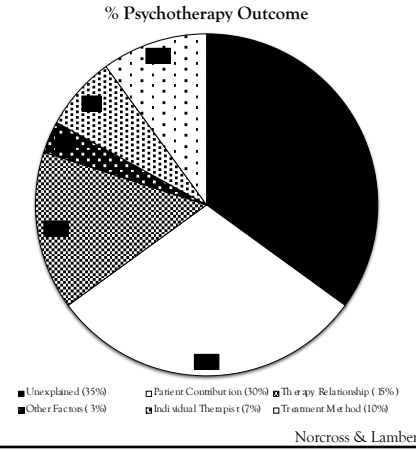

Norcross & Lambert, 2019

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Comparison of Two Models

- First model separates common and specific factors, representing only the explained variance
- Second model explains the total variance and common factors and included across the model

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Self-Reflection

- Please write your thoughts regarding the following questions
  - How do you see the common factors research applying to working with individuals who have experienced trauma?
  - When considering your training, did it focus more on technique or the relationship? How do you think this has affected your work with clients?

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Comparison of Two Models

- Take home points (Norcross & Lambert, 2019, p. 13)
  1. Client variables contribute to a bulk of the variance across both models
  2. The relationship accounts for at least as much as the method
  3. Treatments do matter, particularly for complex cases
  4. Adapting and customizing therapy is critical
  5. Therapists need to consider "multiple factors and their optimal combination, no only one or two of their favorite"

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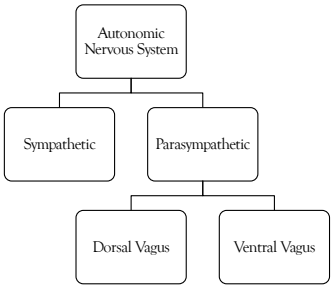
Polyvagal Theory



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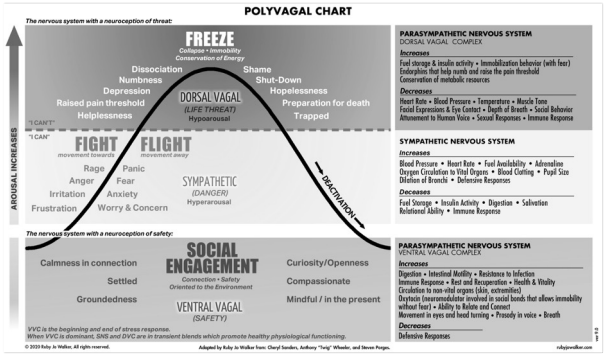
Polyvagal Theory



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Polyvagal Theory

- Notice the experiences that are likely to happen when the dorsal vagal branch is activated
  - Shame, shutdown, hopelessness, etc.
- Imagine the impact of persistent activation in this area on your sense of self and willingness to engage in the world
  - Consider how these experiences are related to willingness to form a relationship, particularly when a power differential is present

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Polyvagal Theory

- **"Co-Regulation:** Polyvagal Theory identifies co-regulation as a *biological imperative*: a need that must be met to sustain life. It is through reciprocal regulation of our autonomic states that we feel safe to move into connection and create trusting relationships." (emphasis added)

  Dana, 2018, p. 4

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Attachment Styles			
	Child	**Adult**	**Behavior**
Organized	Secure	Secure/Autonomous	Quickly comforted; Stranger is not a good substitute for mother; Quickly feels safe enough to play again
	Anxious/Avoidant	Dismissing	Engages with the stranger in nearly the same way as the attachment figure; No reaction to mother returning; Not really interested in interactions
	Anxious/Ambivalent	Preoccupied	Appears stressed about being somewhere unfamiliar, slow to calm down; Seeks proximity, but rejects it once it is achieved
	Disorganized/Cannot Classify	Unresolved/Fearful/Cannot Classify	Controlling-Punitive; Controlling-Caregiving; Behaviorally disorganized

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Trauma

- Lenore Terr (1991) defined the following criteria for trauma exposure:
  - Type I (Single Incident) – One time, short-term, unexpected event
    - MVA, Natural Disaster, Sexual Assault
    - Unlikely to create a prolonged posttraumatic reactions
  - Type II (Repetitive or Complex) – Ongoing trauma (physical, sexual, emotional, attachment) that are the result of intentional acts, or the failure to act appropriately, by another human being
    - Chronic neglect, maltreatment, abuse
    - Highly likely to create long-term, complex posttraumatic reactions, including dissociation

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Trauma

- Terr (1991) differentiated between the surprise of the initial incident and the "...subsequent unfolding of horrors creates a sense of anticipation" that require "Massive attempts to protect the psyche and preserve the self..." (p. 15)

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Type III

- Solomon and Heide (1999) proposed a third, "more extreme" category
  - It results from multiple and pervasive violent events beginning at an early age and continuing for years. Typically, the child was the victim of multiple perpetrators, and one or more are close relatives.
    - (p. 204)

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TABLE 2
LONG-TERM EFFECTS OF TYPES OF TRAUMA

	Type I	*Type II*	*Type III*
Full, detailed memory	X	V	
PTSD symptoms	X	X	X
Denial		V	X
Repression		V	X
Emotional numbing		V	X
Poor self-esteem/self-concept		X	X
Interpersonal distrust		X	X
Superficial relationships		V	X
High anxiety		V	X
Chronic depression	V	V	X
Suicidality		V	X
Feelings of shame	V	X	X
Foreshortened sense of future		V	X
Dependency		X	V
Rage		V	X
Affective dysregulation		V	X
Self-injury		V	X
Eating disturbance		V	X
Substance abuse		V	V
Narcissism		V	X
Impulsivity		V	X
Identity confusion		V	X
Dissociative symptoms		V	X

NOTE: X = typically, V = varies.

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Less Exclusive Definition

- John Briere and Catherine Scott's (2013) definition, which considers any event to be "traumatic if it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (p. 8).
- The authors note that it is important to follow the established diagnostic criteria, particularly in high stakes situations (e.g., forensic)

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Adverse Childhood Experiences Study (ACE)

- Assessed 8 adverse childhood experiences:
  1. Emotional abuse
  2. Physical abuse
  3. Sexual abuse
  4. Witnessing domestic violence (toward female-identified individuals)
  5. Parental marital discord
  6. Growing up with mentally ill parent/caregiver
  7. Substance abuse
  8. Incarcerated household member

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Adverse Childhood Experiences Study (ACE)

- The ACEs work maintains a unique location in the debate about trauma exposure, as it is not tied to a particular diagnostic category.
- Higher ACE scores increase the likelihood of chronic physical (e.g., heart, liver, or lung disease, cancer) and mental (e.g., suicide attempts, substance abuse, depression) health problems (Felitti et al., 1998).
- The findings have been replicated and extended in more recent research, which suggests that PTSD, headaches, autoimmune problems, and sleep disturbances are also among likely outcomes as the number of ACE categories increases (see Kalmakis & Chandler, 2015 for a review).

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Beyond Criterion A

- Trauma is a biopsychosocial/spiritual-existential phenomenon
- Events that are not overtly or easily apparent to observers as life-threatening may be perceived as traumagenic, symbolic and powerful threats to life and safety
- Repeated trauma exposures have results that are different than those of one-time or infrequent trauma exposures, as body/mind/psyche/meaning systems adapt to the content of chronic traumatization. Trauma-informed practice requires a broadened understanding of what can be subjectively traumatic.

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What is Complex Trauma? Some Characteristics

- Interpersonal
- Abuse of all types and neglect/non-response
- Repetitive, prolonged, chronic, cumulative
- Often in attachment relationships
  - Dependence/immaturity, accessibility and entrapment
- Often over the course of childhood
  - Layered, cumulative
  - Impacts development
- May be lifelong: same or different perpetrators

(Courtois & Ford, 2013)

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Additional definitions of trauma

- While these will not fit into a formal PTSD diagnosis, understanding these other forms of trauma enhances clinician's understanding of a symptom picture
  - Trauma-informed treatment entails understanding how the individual perceived and responded to events or experiences as traumatic even though not fitting within Criterion A

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Epistemologies of Trauma

- Additive to Criterion A
- Insidious trauma/microaggressions
- Betrayal trauma
- The violation of dominant expectations/just world loss
- Cultural competence includes identifying how social location, heritage, and identities may lead to post-trauma responses to non-Criterion A events

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Trauma- Not Outside the Culturally Aware Range

- Sexual assault occurs in lives of at least 1/3 of women; recent information suggests 1/16 of women define their first sexual experience as nonconsensual
- Sexual and physical abuse and/or neglect occur in lives of 1/3 of children
- Domestic violence occurs in lives of 1/3-1/2 of women in the US
- Discrimination and oppression are daily occurrences in the lives of many people in target groups
- War, genocide, colonization and/or recent family histories of these are common world-wide

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Other Definitions of A Traumatic Stressor

- Expanded view of what constitutes a traumatic stressor
  - Interpersonal betrayal
  - Abuse of power
  - Insidious trauma, "micro-aggressions"
- Expanded view of range of post-traumatic injuries beyond PTSD to CPTS, dissociative responses
- Culturally competent, because takes into account a range of what is experienced as traumatic and a range of responses to trauma

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Insidious Trauma (Root, 1990)

- Uses lives of target group members as basis for paradigm
- Daily experience is replete with sub-threshold traumatic stressors
- Includes "ordinary oppression", daily life experiences of exclusion or low-level maltreatment
- Leads to increased vulnerability over time
- Also referred to as "micro-aggression" (see work of Derald Sue and colleagues)

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Insidious Trauma

- Requires continuous development of coping strategies which may constitute cultural or individual resiliency factors
- When major trauma or tipping point event occurs
  - Previous coping strategies may rigidify, leading to worse outcome with Criterion A events
  - But may also lend some resilience
  - Feminist view of trauma survivor as potentially resilient emerges from this model

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The "Criterion A" of Insidious Trauma

- What constitutes a traumatic stressor may be a sub-threshold event that *represents* threat to safety, or one thing triggering a chain of responses to many similar events
  - E.g., being called derogatory name may open cascade of associations
  - Risk is of person being seen as "personality disordered" or "over-sensitive" rather than insidiously traumatized

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Oppression As Trauma

- Within this definition, various forms of oppression-racism, classism, sexism, heterosexism, etc are defined as traumatic
  - Directly, via hate crimes or discrimination
  - Indirectly, via microaggressions and everyday oppression woven into fabric of society
  - Via exposure to aversive racism, sexism, heterosexism, etc which is difficult to pinpoint, thus crazy-making

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Betrayal Trauma (Freyd, 1996)

- The effects of the violation of human bonds and the effects of loss of important human connections conceptualized as trauma
- Occurs in relational contexts where a person violates role expectations of care and protection

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Criterion A?

- BT frequently is located in acts that are often not painful or life-threatening and frequently do not immediately evoke fear or helplessness, thus failing to meet *DSM* criteria for a traumatic stressor
  - Sexual abuse of child not involving force or threat, exploitation by clergy or therapist

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How This is Trauma

- Betrayal traumas are interpersonal events that may be initially experienced as confusing or distressing, but not as traumatic – often accompanied by "betrayal blindness", in which target of betrayal is unable to see/know what is being done
- What is experienced as threatening to safety is the willingness of the care-giving person to violate their role and betray role, relationship, and victims themselves

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How This is Trauma

- The awareness of the betrayal and threat may come long after the events have occurred
- Cognitive reappraisal of event (see Koss on acquaintance rape) leads to perception of betrayal and trauma
- BT can also involve betrayal by larger systems (institutional betrayal)
  - E.g., FEMA after Katrina
- Institutional cowardice also happens, which can lead to betrayal

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Loss of the Just World

- Janoff-Bulman drew on social psychological constructs to define trauma as the shattering of expectations of the just world
- Three fundamental assumptions:
  - The world is benevolent
  - The world is meaningful
  - The self is worthy
- Members of dominant groups are at greatest risk for being traumatized in this way, as these fundamental assumptions underlie dominant status

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Race-Based Traumatic Stress

- Carter and colleagues (2007 for review) noted that experiencing persistent racism, which must be emotionally painful, sudden, and uncontrollable, creates emotional pain (instead of the threat required by Criterion A)
- The authors emphasize this results in a *psychological injury*, not a specific mental health disorder

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Race-Based Traumatic Stress

- Reactions include:
  - Intrusions (persistent thoughts)
  - Avoidance (push away from events)
  - Arousal (irritability)
  - Symptom clusters
    - Anxiety
    - Anger/Rage
    - Depression
    - Low selfesteem
    - Shame
    - Guilt

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What Do These Other Models Have in Common?

- Loss of safety-relational, physical, spiritual, although not necessarily direct threat to life
- Betrayal of trust
- Existential challenges-what is the meaning of life if trauma has occurred
- Subjective experience: May not be visible to the outside world
- Not necessarily a sudden blow or one-time event, often a process in relational context

55

The Traumagenic Culture

- Culturally aware models of trauma treatment posit that one obstacle to healing is traumagenic culture, in which insidious traumata and oppression become strategies for institutionalizing social inequities
  - Effects of trauma on function of target groups and their members
- Individual change is impeded or difficult when societal and environmental changes do not also occur
- Understanding the continuing effects of a traumagenic environment on the trauma recovery process will be a crucial component of culturally competent trauma treatment

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Not just human design...

- The DSM suggests that traumas of human origin are more traumatizing (due to assumptions of neglect or malice)
- Critical theory in psychology argues that the traumagenic potential of these and similar acts is heightened, not simply, as the *DSM* would suggest, because the trauma is of human design, but also because repeated prior life experiences have lent added stigmatizing meaning to becoming the victim of this type of trauma (e.g., rape)
- Institutionalized trauma (expectable outcomes of oppressive cultural norms) also creates a traumagenic environment
- Traumagenic culture is upheld by myths about trauma which create secondary victimization for many trauma survivors

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Herman's Model (1992)

- Phase 1: Safety and Stabilization
  - Forming the therapeutic relationship
  - Building skills/coping strategies
  - May help with issues of housing, income, etc.
  - Formulating goals for therapy
- Phase 2: Processing and Mourning
  - Introduction of specific trauma resolution techniques (EMDR, narrative writing, CPT, exposure, etc.)
  - Helping the clients grieve losses that have come from the traumatic event(s) in their life

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Herman's Model (1992)

- Phase 3: Reconnecting
  - Discuss vulnerabilities and how to continue to maintain safety
  - Creating a newly defined relationship with oneself, focusing on integrating psychological, somatic, and spiritual aspects of identity
  - Fostering community relationships with others who do not engage in risky behavior
- "Resolution of the trauma is never final; recovery is never complete" (Herman, 1992, p. 211)
  - We often revisit stages as the work goes on or as the client reaches new developmental milestones

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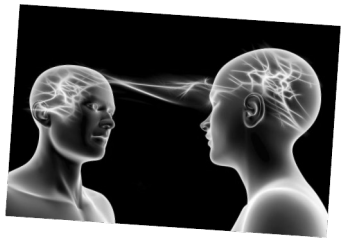

"Don't just do something, sit there"

Laura Brown citing a long line of mentors

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Stephen Finn's Work

- Therapeutic Assessment is a paradigm in which psychological testing is used to help people understand themselves better and find solutions to their persistent problems. Therapeutic Assessment differs from traditional psychological assessment, whose main goal is to diagnose disorders, plan treatments, and evaluate the effectiveness of interventions; Therapeutic Assessment can serve all these purposes as well, but its **primary goal** is to facilitate positive changes in clients.

(Finn, n.d.)

- http://www.therapeuticassessment.com/about.html

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Step 1
Initial Session(s)
⇩
Step 2
Standardized Testing Session(s)
⇩
Step 3
Assessment Intervention Sessions
⇩
Step 4
Summary/Discussion Sessions
⇩
Step 5
Written Feedback is Provided
⇩
Step 6
Follow-up Session(s)

Finn, 2007

63

Therapeutic Assessment (Finn, 2007)

- Initial Session(s)
  - Ask the client what problems they see in their lives and let this be the focus of the assessment process
  - Ask clients what they think the answers will be before doing the testing
  - Some relief may come by helping clients to translate their experience into concrete questions
- Standardized Testing Session(s)
  - Choose the measures that will best answer the questions created in the initial session(s)

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Therapeutic Assessment (Finn, 2007)

- Intervention Session(s)
  - Designed to specifically evoke the "problems-in-living," so they can be "observed, explored, and addressed with various therapeutic interventions" (p. 14).

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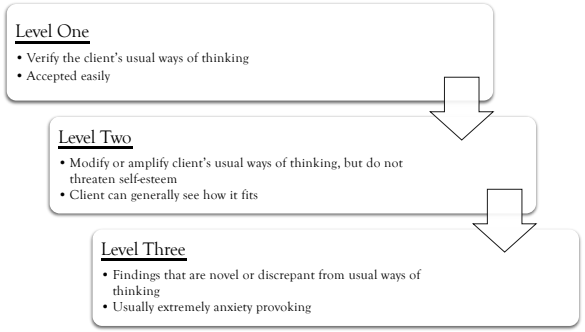
Summary/Discussion Session



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Therapeutic Assessment (Finn, 2007)

- Follow-Up Sessions
  - Often happens 2-3 months after the feedback session
  - Discuss any developments or difficulties the client is noticing
- Therapeutic Assessment can be done with your therapy clients!
  - Rorschach with couples

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Screening Measure

- Is used for the early identification of individuals at potentially high risk for a specific condition or disorder
- Can indicate a need for further evaluation or preliminary intervention
- Is generally brief and narrow in scope
- May be administered as part of a routine clinical visit

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Screening Measure

- Is used to monitor treatment progress, outcome, or change in symptoms over time
- May be administered by clinicians, support staff with appropriate training, an electronic device (such as a computer), or self-administered
- Support staff follow an established protocol for scoring with a pre-established cut-off score and guidelines for individuals that score positive.
- ***Is neither definitively diagnostic nor a definitive indication of a specific condition or disorder***
  - https://www.apaservices.org/practice/reimbursement/billing/assessment-screening

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Assessment Measures

- Provides a more complete clinical picture of an individual
- Is comprehensive in focusing on the individual's functioning across multiple domains
- Can aid diagnosis and/or treatment planning in a culturally competent manner
- Can identify psychological problems and conditions, indicate their severity, and provide treatment recommendations
- Integrates results from multiple psychological tests, clinical interviews, behavioral observations, clinical record reviews, and collateral information

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Assessment Measures

- May include screening measures that are used in conjunction with other information from the assessment, providing a broader context for interpreting the results
- May use screening results to determine the choice of instruments for an assessment
- May cover domains of functioning, such as memory and language, visual and verbal problem solving, executive functioning, adaptive functioning, psychological status, capacity for self-care, relevant psychosocial history, and others needed to respond to the referral questions

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Example

- The PTSD Checklist
  - Fantastic screening measure that provides indications of *probable* PTSD over the past month
  - Can be used to report a likelihood of posttraumatic symptoms (PTS); however, not PTSD without further corroboration
  - Walks through the exact criteria, so face validity is an issue in high stakes settings (e.g., forensic)

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Measures

- Events
  - Interview questions
  - Childhood Trauma Questionnaire
  - Life Events Checklist
  - Combat Exposure Scale
  - Adverse Childhood Experiences
  - Trauma History Screen (Asks for the # of times)
  - Trauma History Questionnaire (Asks for frequency and age)
  - Life-Stressor Checklist-Revised

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Measures

- Screening
  - Dissociative Experiences Scale
  - PTSD Checklist
  - Dissociative Subtype of PTSD Scale
  - Posttraumatic Diagnostic Scale
  - Somatoform Dissociation Questionnaire

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Measures

- Assessment
  - Trauma Symptom Inventory
  - Inventory of Altered Self-Capacities
  - PAI and MMPI (know the research on how to interpret these measures)
  - Trauma Symptom Checklist for Children
  - Trauma Symptom Checklist for Young Children
  - Multidimensional Inventory of Dissociation
  - Multiscale Dissociation Inventory
  - Detailed Assessment of Posttraumatic Stress

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Interviews

- Clinician Administered PSTD Scale
- Structured Interview for Disorders of Extreme Stress
- Dissociative Disorders Interview Schedule
- Structured Clinical Interview of DSM Disorders
- Structured Interview of Reported Symptoms (know the trauma research)
- Office Mental Status Exam for Dissociation

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Feigning

- Various validity scales
  - You must know the research, even on the trauma-specific measures
- Structured Inventory of Malingered Symptomatology
  - Screening measure
  - Watch for Bethany Brand's research with this measure
  - Short answer: Do not use this test with complex trauma clients
- Structured Interview of Reported Symptoms
  - Know about the Trauma Index
- Test of Memory Malingering
  - Individuals with high levels of dissociation unlikely to fail this test

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Summary

- Ensure you are aware of the trauma-specific measures that are available
- Do not go beyond the data you have
  - If a measure says it indicates probable PTSD, then that is all you can say
- Single incident is not the same as repeated trauma and the effects are significantly different
- It is critical to understand how complex posttraumatic presentations show up on measures

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Summary

- If you do a lot of clinical assessment, knowing Stephen Finn's therapeutic assessment model can be very helpful
- Most of the common measures are not for individuals who have one or more marginalized identities

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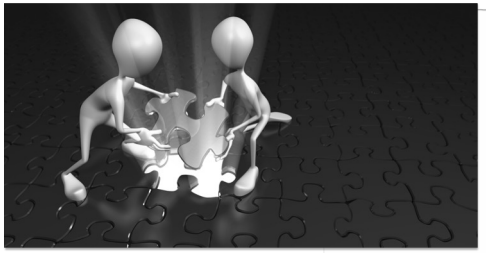

The assessment process is collaborative, just like therapy. Completing assessments using this format is another examples of how culturally competent, empowerment oriented therapeutic interventions are completed.

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Exposure Therapy

- "In this form of therapy, psychologists create a safe environment in which to "expose" individuals to the things they fear and avoid. The exposure to the feared objects, activities, or situations in a safe environment helps reduce fear and decrease avoidance."
  - APA & Division 12, 2017 - https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy

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Variations

- In vivo
- Imaginal
- Virtual Reality
- Interoceptive

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Likely Mechanisms

- **Habituation:** Over time, people find that their reactions to feared objects or situations decrease.
- **Extinction:** Exposure can help weaken previously-learned associations between feared objects, activities, or situations and bad outcomes.
- **Self-efficacy:** Exposure can help show the client that he/she is capable of confronting his/her fears and can manage the feelings of anxiety.
- **Emotional processing:** During exposure, the client can learn to attach new, more realistic beliefs about feared objects, activities, or situations; and can become more comfortable with the experience of fear.
  - APA & Division 12, 2017 - https://www.apa.org/ptsd-guideline/patients-and-families/exposure-therapy

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Exposure

- External (e.g., spiders, heights, snakes)
- Internal (e.g., somatic sensation, cognitive memory)
- Both

- Important to note that memories can be explicit or implicit
  - Significantly more likelihood of implicit memory encoding with early, repeated trauma

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Pain Paradox

- Although not all trauma resolution methods require facing the memory, many do involve facing something that is painful/scary/activating (e.g., memories, body sensations, relationships)
- John Briere has talked about the "pain paradox" in therapy
- We have a natural tendency to move away from pain
- Therapists essentially ask clients to stop doing what the experience as a natural survival mechanism
- Not only do we ask people to hang out with their pain, we actually encourage them to *lean in to it*!

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De Jongh et al. (2016)

- "For patients with more cPTSD presentations, the recommendation for an initial stabilization phase has the potential to result in a delay or restriction of access to effective trauma-focused treatments." (De Jongh et al, 2016, p. 367).
  - Most of the clients cited had a history of childhood sexual abuse; however, CPTSD was not assessed or verified in the sample
  - Although those with a history of CSA *may* end up qualifying for a diagnosis of CPTSD, there is no guarantee
  - Continues to perpetuate the idea that diagnosis is the most important factor to consider

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Summary

- Facing something we are afraid of is the crux of exposure work, regardless of the technical aspect that is utilized
- The feared experience/stimulus can be internal, external, or both
- Can reach the level of fear of connection to self and others
  - Very common for individuals with a history of Type II and Type III trauma

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When Connection is Key and Terrifying

Bringing the Research Together and Honoring those who have Bravely Shared Their Stories

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Phase 1.5

- Focuses on the consistent integration of concepts, skills, and experiences found in Herman's (1992) model of trauma recovery
- Recognizing that the genuine offer of a caring interpersonal connection is one of the most terrifying experiences
  - Each part of the process, from the formation to the rupture/repair process is an opportunity to help the client's brain learn and integrate new information
  - Conceptually driven and technically agnostic

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Phase 1.5

- "With trauma survivors, the therapeutic alliance cannot be taken for granted but must be painstakingly built." (Herman, 1998, p. S145).
- Examples of exposure
  - The therapist remembering a comment the client made when they experienced it as "no big deal"
  - Validating the underlying emotions
  - Each and every step toward the formation of the therapeutic alliance
  - The rupture/repair process
  - Maintaining an open, empathic stance when clients discuss a moment of disappointment

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Phase 1.5

- This process often moves between graduated exposure and flooding
  - Does not require a rupture for flooding to happen, although interpersonal disruptions are certainly one form

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Phase 1.5

- Recognizes that clients who have experienced Type II and Type III trauma are likely to experience these events from a place of dorsal vagal activation, rather than ventral vagal
- "Safety" is a complex idea that many clients have not ever experienced; talking about and challenging the assumption of safe is a critical and terrifying prospect for many humans taking risks in the therapeutic space

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Summary

- The relationship continues to be one of the more important contributors to therapeutic outcome
- Honoring and cultivating the relationship is a terrifying experience for many clients who have experienced Type II and Type III trauma
- Trauma is an etiology, not a diagnosis

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Summary

- Tallying the number of endorsed symptoms is not sufficient for a diagnosis of Complex PTSD
- A history of a particular type of trauma is insufficient to establish a CPTSD diagnosis, or any other for that matter
- Many clients who I have worked with would not show up for a research study, ever.
  - The power dynamics and risk for harm are considered too great, regardless of the potential benefit

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Summary

- The relationship is critical
  - While some people with organized attachment (secure, ambivalent, anxious) may need less time to form a relationship, those with disorganized attachment styles are likely to have significant difficulties establishing a working alliance
- When considering concept over technique, exposure is part of treatment from the first time a client walks into the office
- The available data does not support valuing technique over the relationship

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Summary

- This model is not necessary for every client and any framing of the triphasic model as delaying necessary care or harmful is of significant concern
- When we understand the mechanisms of this work and value the human relationship over the technique, complex relational healing will happen

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