ABUSE RELATED TRAUMA THERAPY

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Why Trauma Therapy?

- Presentations in Practice
- Over-representation of the client group in the trauma statistics
- My own interest

Trauma and Disability

- US studies show up to 83% of the females and 32% of the males who have developmental disabilities are the victims of sexual assault. (Johnson & Sigler 2000).
- US estimates say that 83% of women with a disability will be sexually assaulted in their lifetime. (Stimpson & Best, 1991).
- In NZ, disabled women represent up to 31% of victims of sexual violence.(World Health Organisation, 2009)

Trauma & Disability cont

- One NZ study showed 33 per cent of victims of sexual violence had a disability or impairment (Kingi & Jordan, 2009)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) report states: "Persons with disabilities are up to three times more likely to be victims of physical and sexual abuse and rape, and have less access to physical, psychological and judicial interventions" (McGregor, 2011)
- Services for diverse population groups such as people with disabilities/disabled peoples has been identified as a gap in services in NZ, as have language and cultural barriers, and by the limited availability of appropriate safe places of refuge (McGregor, 2011)

Presentations in Practice

- Children
- Adult women
- Adult men
- Parents – fathers and mothers

Why Intervene?

Some Effects of Early Trauma
(McGregor. 2001)

- Anxiety
- Complex PTSD (CPTSD)
- Dissociation
- Depression
- Eating disorders
- Impaired self-capacities
- Impaired 'self' and 'other' boundaries
- Interpersonal and parenting difficulties
- Memory impairment
- Personality disorders
- Post-traumatic Stress Disorder (PTSD)
- Psychiatric symptoms
- Re-victimisation
- Self-blame
- Self-harm and suicidal behaviour
- Sexual difficulties
- Somatisation and physical effects
- Substance abuse.
- Dissociative Disorders

Six Primary Abuse Effects
(Briere, 2002)

(1) negative preverbal assumptions and relational schemata,

(2) conditioned emotional responses (CERs) to abuse-related stimuli,

(3) implicit/sensory memories of abuse,

(4) narrative/autobiographical memories of maltreatment,

(5) suppressed or "deep" cognitive structures involving abuse-related material, and

(6) inadequately-developed affect regulation skills.

Assessment of Abuse Related Trauma

- In abuse-focused therapy, assessment is an on-going process
- Clients who have suffered prolonged, repeated abuse often appear with disguised presentations and have multiple difficulties that initially may appear unrelated to the abuse.
- Many survivors will be unwilling to disclose much information until they feel they can trust you.
- Survivors dealing with severe dissociation can be most difficult to assess.

Assessment of Abuse Related Trauma

- Presentation symptomatology in terms of personal, social, emotional, behavioural, cognitive, physical
- Psychosocial Assessment
- Developmental History
- TSI2 (Briere, 2010)
- Multidimensional Trauma Recovery and Resiliency Scale MTRR-99 (Harvey et al, 2000)

Assessment & Treatment Planning Process

- Engage client in the process
- Gather information about abuse and its effects
- Assessment
- Collaborate in Treatment Planning

Seven Domains of Therapy Goals
(McGregor, 2001)

1. Self-Esteem: Self-hate, shame and feelings of badness will be replaced with more positive and realistic self-views. Responsibility for the abuse and any shame about adaptations following the trauma will be put into perspective. The survivor will be able to be self-caring.

2. Symptom Mastery: Psychological and psychophysiological symptoms will decrease and be manageable.

3. Affect Tolerance: Emotions will no longer be feared as overwhelming. The survivor will have access to a full range of feelings, which they will be able to name and experience without distress.

4. Memory and Affect are Linked: The survivor will be able to look back over the trauma in the 'here and now' and acknowledge how they felt, without being plunged into feelings of the past

Therapy Goals cont,
(McGregor, 2001)

5. Attachment: Safe relationships will have been developed. Isolation will be replaced by an ability to connect to others. Perceptions of others will become more realistic and less 'black and white'.

6. Meaning: The survivor will have been able to develop views of themselves and the world that are complex. They will be able to incorporate contradictory and ambiguous views of reality. They will have a realistic sense of optimism about the future.

7. Memory: Control over memories will develop to the point that the survivor can choose whether to think about traumatic events or not. They will have come to terms with their memories (or degree of memories) of abusive events.

Mary Harvey et al (2000) adds an eighth dimension – self cohesion

Abuse FocussedTrauma Therapy 3 stage process

- 1. Safety and self-work
- 2. Exploration and integration
- 3. Empowerment and reconnection

Trauma Therapy Process Stage 1

Stage 1 – Safety and self work tasks

- Establish a secure therapeutic relationship
- Build safety and stability
- Psycho-education re abuse and its effects
- Symptom management
- Build Self Capacities
- deal with cognitive distortions including low self-worth and self-blame
- build 'cognitive life rafts'
- help build your client's self-identity
- help your client to identify their 'self' and 'others' boundaries
- help your client to identify and express their feelings and needs
- allow your client to internalise your caring as a way of building self-capacities
- encourage your client to treat themselves with care and respect
- encourage them to develop positive interpersonal relationships and widen social supports.

Clinical Outcomes Stage One

Your client will usually have

:

- gained some safety and stability in their life
- increased their self-confidence and ability to protect themselves from abusive people
- gained some control over the most disturbing symptoms
- increased their self-capacities and firmed their self-identity
- increased their feelings of self-competence and self-esteem
- decreased self-blaming
- learned about bounded relationships
- begun to believe they deserve good things in life and to be treated with respect and consideration.

Trauma Therapy Process Stage 2

Stage 2 - Exploration and Integration

- **"Be careful not to assume your client's readiness to work on traumatic material. Clients who may appear to have good self-capacities may in fact be using dissociation. As therapy progresses, however, their dissociative strategies should reduce. You may then find that your client's self-capacities prove inadequate for further exploration into trauma. If this is the case, return to the predominant focus of self-work."** ***(McGregor, 2001 p. 36)***
- Continue to provide safety
- Paced work, Working within the 'therapeutic window'
- controlled exposure to small aspects of traumatic material, within a safe therapeutic environment
- Systematically approaching and 'reclaiming'
- desensitising painful abuse-related affect
- Emotional and Cognitive Processing
- integrating the desensitised traumatic material and affect
- Building a survivor narrative.

Clinical Outcomes Stage Two

- Desensitize abuse memories
- Reclaim sense of power
- Build a survivor narrative

"Your client should eventually reach a point where they can appreciate that the trauma is in the past; that it affected them in certain ways, but they are able to move on. Until they reach this point, they risk re-enacting the trauma daily in their lives, for example through passivity, depression, interpersonal difficulties and symptoms of PTSD." (McGregor, 2001)

Trauma Therapy Process Stage 3 (McGregor, 2001)

Stage 3 **Empowerment and reconnection**

- consolidate gains
- assess responsibility for the CSA
- orient to 'normal' life
- reconnect with others
- gain empowerment
- prepare to end therapy
- Review and Relapse Prevention

References

- Briere, J. (2002) Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid, & C. Jenny (Eds.). *The APSAC handbook on child maltreatment*, 2nd Edition. Newbury Park, CA: Sage Publications

.

- Briere, J. and Scott, C. (2006*) principles of Trauma Therapy,* Thousand Oaks, CA: Sage.

- Harvey, M.R.,(2000) *Multidimensional Trauma Recovery and Resiliency Scale MTRR-99 Clinical Rating Form,* Harvard Medical School.

- Kingi, and Jordan, J. (2009) *Responding to sexual violence: Pathways to recovery.* Wellington, NZ: NZ Ministry of Womens Affairs.

- McGregor, J. (2011**) *New Zealand Human Rights Commission's Report to the Committee on the Elimination of Discrimination Against Women (CEDAW)***

- ***McGregor, K. (2001) Guidelines for therapists working with adult survivors of child sexual abuse,* Wellington, NZ: Accident Compensation Commission.**

- Stimpson, L., and Best, M. (1991). *Courage Above All: Sexual Assault Against Women with Disabilities*. Toronto: DisAbled Women's Network.

- World Health Organisation (2009) *Promoting Sexual and Reproductive Health for Persons with Disabilities* .WHO/UNFPA .