COMPLEX TRAUMA AND STABILISATION

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Westminster Rough Sleeping Services
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AGENDA

- The Context: Trauma Informed Care & Psychologically Informed Environments
- Historical Context of PTSD
- Developmental Trauma Disorder & Complex Trauma
- Brain Structure & The Infant Brain
- How the Brain responds to Trauma
- Dissociation
- Categories of Trauma
- Phased Model of Treatment
- Affect Regulation Training
THE CONTEXT

- It is now generally accepted that the vast majority of individuals who find themselves using rough sleeping services have significant histories of trauma.
- A number of systemic approaches have been developed here in the U.K. and the U.S.
- Psychologically Informed Environments (PIE) – Johnson and Haigh (2011)
- Pre-Treatment Approach and Housing First – Jay Levy (2013)
- Trauma Informed Care (TIC) – Homeless Link (2015)
- These approaches have in common:
  1. An appreciation of the impact of traumatisation on individuals and systems.
  2. An explicit focus on the psychologies of people using and working within services.
Trauma: A deeply distressing or disturbing experience.

- What kinds of life events can lead to trauma?
Trauma is a pervasive fact of modern life and most of us have been traumatised to some degree at points in our life.
POST TRAUMATIC STRESS DISORDER

• First appeared as a diagnostic construct in the DSM III in 1980.

• In response to a social demand to delineate a syndrome that captured the suffering experienced by many Vietnam combat veterans.

• At this time the U.S. was coping with millions of soldiers returning from war.

• The PTSD field trial (1997) was unable to demonstrate that the diagnosis of PTSD captures the most essential elements of human suffering following trauma.
The main symptoms are:

1. Re-experiencing the event in varying sensory forms, e.g. flashbacks.
2. Avoiding reminders of the trauma.
3. Chronic hyperarousal in the Autonomic Nervous System (ANS), e.g. startled response.

PTSD is first diagnosed when these symptoms last more than a month and are combined with a loss in social functioning, e.g. work, friendships.

PTSD can develop in an individual in response to three types of threat:

1. Incidents that are, or are perceived as, threatening to one’s own life or body integrity;
2. Being a witness to acts of violence to others; or
3. Hearing of violence to or the unexpected or violent death of close associates.

(It can develop in children who have been molested without it being life-threatening)
SOMATIC DISTURBANCE

- Somatic (Bodily) disturbance is at the core of PTSD and can be triggered internally or externally.
- People are plagued by the same frightening body symptoms they experienced during the trauma including:
  - Accelerated heart rate, cold sweating, rapid breathing, heart palpitations, hypervigilance and hyperstartle responses. These can lead to:
  - Sleep disturbances, loss of appetite, sexual dysfunction and difficulties concentrating.
There are four PTSD symptom clusters (rather than three).

Intrusion symptoms which now include dissociative reactions, e.g. flashbacks.

Avoidance symptoms.

Negative alterations in mood and cognitions.

Marked alterations in arousal and reactivity.

This sub-type acknowledges the role of dissociation as the most direct defence against overwhelming traumatic experience.

This is defined primarily by symptoms of:

- Derealisation - feeling as if the world is not real; and
- Depersonalisation - feeling as if oneself is not real.

Essentially these describe elements of the experience of the freeze response.
The PTSD framework does not include the key symptoms and problems of individuals who are exposed to prolonged and repeated trauma such as childhood sexual abuse, domestic violence and political violence.

Complex presentations that arise from severe trauma early in life present very differently.

Research trials on effectiveness of treatments for PTSD keep variables to a minimum, e.g. uncomplicated single-incident traumas.

Severe disorders are not researched adequately because they don’t fit well with research requirements.

It is wrong to generalise findings from these research trials to a very different clinical picture, but sadly this is often the case leading to, at best ineffective and at worst damaging clinical interventions, e.g. Trauma-Focused CBT.

In general the lack of acknowledgement of the severe impact of childhood abuse on the developing brain leads to an inadequate provision of services.
Many prominent experts in the understanding and treatment of trauma have proposed alternative criteria and treatment models (ISTSS, Van Der Kolk). These have in common a focus on the neuroscience evidence on adverse experiences. Disorders of Extreme Stress (DESNOS) Complex Trauma Developmental Trauma Disorder (DTD)
COMPLEX PTSD

- PTSD taskforce delineated a syndrome of psychological problems that have been shown to be frequently associated with histories of prolonged and severe interpersonal abuse.
- Called “Complex PTSD” or “Disorders of Extreme Stress Not Otherwise Specified”.

1. Alterations in the regulation of affective impulses, including difficulty with modulation of anger and being self-destructive.
2. Alterations in attention and consciousness leading to amnesia and dissociative episodes and depersonalisation.
3. Alterations in self-perception, such as chronic sense of guilt and responsibility, chronically feeling ashamed.
4. Alterations in relationship to others, such as not being able to trust, not being able to feel intimate with others.
5. Somatisation: the problem of feeling symptoms at a somatic level for which no medical explanations can be found.
6. Alterations in systems of meaning (self, others, sustaining beliefs)
PTSD & COMPLEX PTSD - DIFFERENCES

• Complex PTSD results from the actions of others
• This creates havoc for the soothing affiliative system – cannot be easily accessed
• Tragedy is that people blame themselves and struggle to turn to others for help
• Problem of approach (attachment system) & avoid (threat system)
• Exposure therapies work for fear-based memories but not shame-based memories
• Emotional regulation is key in the treatment of complex trauma:
  • It builds the frontal cortex.
  • It down-regulates the threat system at an internal level.
  • It facilitates Empathy & Mentalisation.
CATEGORIES OF TRAUMA

- Terr (1994) – Type I (Single Incident Trauma) and Type II (repeated traumatisation).
- Rothschild (2000) extended this to include further categories:
  - Type IIA – Individuals with multiple traumas who have relatively stable backgrounds that have built resilience and can separate the individual traumatic events from one another.
  - Type IIB – Individuals who are so overwhelmed with multiple traumas that they are unable to separate one trauma from another.
    - IIB(R) – Someone with a stable background, but with a complexity of traumatic experience that is so overwhelming they can’t maintain resilience (e.g. Holocaust Survivors)
    - IIB(nR) – Someone who has never developed resources for resilience
ACE STUDY - 2014

• ACE: Adverse Childhood Experience
• Participants were recruited to the study between 1995 and 1997 and have been in long-term follow up for health outcomes.
• Demonstrated an association of adverse childhood experiences (ACEs) with health and social problems as an adult.
• A person’s cumulative ACEs score has a strong, graded relationship to numerous health, social, and behavioural problems throughout their lifespan, including substance use disorders.
ACES are Adverse Childhood Experiences

How Prevalent are ACES?

The ACE study* revealed the following estimates:

<table>
<thead>
<tr>
<th>Abuse</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Physical Abuse</td>
<td>28.3%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>20.7%</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>10.6%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Neglect</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Emotional Neglect</td>
<td>14.8%</td>
</tr>
<tr>
<td>Physical Neglect</td>
<td>6.9%</td>
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</tbody>
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What Impact do ACES Have?

As the number of ACES increases, so does the risk for negative health outcomes.

Risk

- 0 ACES
- 1 ACE
- 2 ACES
- 3 ACES
- 4+ ACES

Possible Risk Outcomes:

Behavior

- Physical
- Emotional
- Sexual
- Marital Abuse
- Substance Abuse
- Divorce

- Physical
- Emotional
- Sexual
- Marital Abuse
- Substance Abuse
- Divorce
THREE AFFECT REGULATION SYSTEMS

**Drive, excite, vitality**
- **Incentive/resource-focused**
  - Wanting, pursuing, achieving, consuming
  - Activating

**Content, safe, connected**
- **Non-wanting/Affiliative focused**
  - Safeness-kindness
  - Soothing

**Anger, anxiety, disgust**
- **Threat-focused**
  - Protection and Safety-seeking
  - Activating/inhibiting
COMPLEX TRAUMA = THREAT SYSTEM

- Shame (self-identity)
- Self-criticism
- Self-blame/attributions
- Emotion dysregulation
- Dissociation etc.
- Interpersonal difficulties (attachment)

All also involve threat system activation...
GROUP DISCUSSION

Has anyone had the experience in which, the kinder you are to a person, the more the person becomes distressed?

• The attachment book – chapter closes on horrible memories, shame and abuse.
• When worker re-opens the attachment book all of these painful feelings & memories are re-opened.
• This activates basic defensive strategies.
• Being extra kind can make it worse
• This helps to explain why clients may in act in counter-intuitive ways.
Kindness, Attachment and Threat

Bowlby: Kindness opens the attachment system and then whatever ever fears, anger or despair is coded there will become available and can be intensely threatening.
WHAT CAN WE LEARN FROM THIS?

• Adapt our approach and response depending on client.
• Adapt our approach and response depending on situation.
• When you are distressed do you always need the same thing from people? (bereavement & work stress)
• This makes our job more difficult.
• We need to use our intuitive wisdom to tell us what people need from us.
• Tone down or tone up – Goldilocks!
Along with disturbances in ability to self-regulate across 5 domains:

1. Difficulties with emotional regulation
2. Disturbances in relational capacities
3. Alterations in attention and consciousness (such as experiencing dissociation or depersonalisation)
4. Somatic distress and disorganisation
5. Changes in belief system.

3 core symptoms:

1. Re-experiencing
2. Avoidance/numbing
3. Hyper-arousal
DIFFICULTIES WITH EMOTIONAL REGULATION

• Aggressive outbursts
• Self-destructive behaviours
• Extreme anxiety
• Extreme agitation
• Inability to tolerate distress
• Rapid fluctuations in mood
• Inability to self-soothe
DISTURBANCES IN RELATIONAL CAPACITIES

- Entrenched feelings of mistrust.
- A sense of isolation and feeling cut off from others.
- Difficulties making or keeping close relationships;
- Getting on with people at work;
- Getting on with friends and family.
- Barriers to engaging with support and healthcare professionals.
ALTERATIONS IN ATTENTION AND CONSCIOUSNESS

- Severe dissociative states
- Auditory flashbacks (e.g. hearing screams of others being tortured)
- Emotional flashbacks (sudden and prolonged regressions to frightening feeling states)
- Somatic flashbacks, e.g. feelings of pain at site of injury, genital pain.
SOMATIC DISTRESS AND DISORGANISATION

- Severe sleep disruption
- Unusual eating patterns
- Chronic body pain
- Headaches & migraines
- Gastro-Intestinal problems
- Non-epileptic seizures
CHANGES IN BELIEF SYSTEM

- Negative self-concept
- Guilt
- Shame
- Overwhelming feelings of defeat and hopelessness.
- Fundamentally changed world views, e.g. losing faith
- Previously being tolerant and becoming racist.
In contrast to traumas such as RTAs and torture, childhood abuse occurs as part of everyday life.

For people abused as children seemingly neutral environmental cues can trigger extreme emotional distress:

- Seemingly innocuous experiences
- ‘Harmless’ sounds
- The way the light comes into a window.
- Particular smells.
- Physical sensations

What are the implications for working with people in a hostel setting?
People with Complex PTSD often engage in coping strategies in an effort to regulate their physiology and emotions:

- Self-harm
- Alcohol and Drug Misuse
- Eating Disorders
- Promiscuity
Complex PTSD is a re-framing of the diagnosis of Borderline Personality Disorder (BPD) (Van Der Kolk)
Up to 70% of those with BPD have co-morbid dissociative disorders (Hull & Corrigan)
BPD is essentially a disorder of childhood abuse and neglect.
Both BPD and Hysteria (the historical precursor of BPD and Complex PTSD) carry much stigma.
Recent research (Cloitre et al, 2014) demonstrates that Complex PTSD is distinguishable from PTSD and BPD.
Researchers who place the traumatic origins of the disorder at the centre of their treatment approach face much opposition.
The study of war, RTAs and other non-interpersonal traumas is considered respectable.
Investigating the darkest side of human nature: our capacity to horribly abuse our own offspring, partners and other family continues to be controversial and avoided.
The most important job our brain is to ensure our survival and to do that it needs to:

1. Generate internal signals about what our bodies need, e.g. food, rest, protection, sex and shelter.
2. Create a map of the world to point us where to go to satisfy those needs.
3. Generate the necessary energy and actions to get us there.
4. Warn us of dangers and opportunities along the way.
5. Adjust our actions based on the requirements of the moment.

As social animals these all require coordination and collaboration with others.

Trauma has a negative impact on every one of these
1. Social Engagement – calling out for help or support from those around us.

2. Flight or Fight – run to a safe place or fight off the attacker.

3. Freeze or Collapse – organism tries to preserve itself by shutting down.
FREEZE RESPONSE

• If it isn’t possible to fight or flee then freeze is the best chance of survival.
• Predators depend on movement to detect their prey.
• Predators rarely eat dead prey.
• It gives the prey an opportunity to escape when predator drops attention.
• It saves energy and resources.
• It creates a numbing effect – the prey doesn’t feel the pain of being attacked.
The frustrated FIGHT response gets locked into the nervous system as rage.

The frustrated FLIGHT response gets locked in as helplessness.

In animal kingdom creatures quite literally ‘shake off’ the undischarged energy and return to normal functioning.

In humans the neo-cortex overrides the natural instinct and the reptilian part of the brain remains frozen in constant state of terror, rage and helplessness.

Trauma is caused by the frozen residue of energy that has not been resolved and discharged.
THE CORE OF THE TRAUMATIC REACTION

1. Hyperarousal – increased heartbeat and breathing, agitation, difficulty sleeping, tension, jittery muscles, racing thoughts.
2. Constriction – Blood vessels in skin and extremities constrict so more blood is available to the muscles. Attention constricts – hypervigilance.
3. Dissociation – Distortions of time and perception.
4. Helplessness – Inability to access resources.

Experiential exercises
(Peter Levine)

• Hyperarousal & Constriction
• Dissociation
Dissociative Identity Disorder

Daydreaming → Spacing out → Dissociative Identity Disorder

Harmless → Potentially Life-threatening
DISSOCIATIVE DISORDERS

• Dissociative Amnesia – loss of memory for all events over a discreet period.
• Dissociative Fugue – Loss of knowledge of one’s own identity.
• Dissociative Identity Disorder (previously Multiple Personality Disorder) – A person develops a sense of existing as two or more distinct personae.
• Depersonalisation Disorder - Feeling as if oneself is not real.
• Dissociative Disorders not otherwise specified – Those that don’t fully meet requirement of above disorders including Derealisation.

• 11% of general population meet criteria for a Dissociative Disorder.
• 88% of survivors of Childhood Sexual Abuse (CSA) meet the criteria.
Complex PTSD – including dissociative disorders – can have an impact on functioning equivalent, at least, to major psychotic disorders and should be considered a serious mental illness”

Corrigan and Hull (2015)

1. Amnesia
2. Depersonalisation
3. Derealisation
4. Identity Confusion
5. Identity Alteration

• Other common phenomena include ‘hallucinations’, age regression and post-traumatic flashbacks.

5 CORE SYMPTOMS OF DISSOCIATION
DISCONNECTION

• Has anyone had the experience of being told distressing information by a client, where there is little or no associated emotion?
• What could be the reasons for this?
• How should we respond?
RE-ENACTMENT

- The drive to complete and heal trauma is as powerful as the symptoms it creates.
- The (unconscious) urge to resolve trauma through re-enactment can be severe and compulsive.
- People are drawn into situations that replicate the trauma in both obvious and unobvious ways, e.g. sex workers with a history of CSA.
- This is understood as the brain’s attempt to resolve the original trauma by creating a different ending and discharging the frozen energy.
TRAUMA REACTION - SUMMARY

Example: Road Traffic Accident (RTA)

1. The person is initially protected from emotional reaction and even from a clear memory of sense that it really happened.
2. This allows the victim to find a safe place for these altered states to wear off.
3. The body also reacts profoundly in trauma. It tenses in readiness, braces in fear and collapses in helpless terror.
4. When the mind’s protective reaction returns to normal, the body is meant to also.
5. If this restorative process is thwarted then the effects of the trauma become fixated and the person becomes traumatised.
6. Traditionally Psychology approached trauma through the effects on the mind, but more recent approaches (Shapiro, Van Der Kolk, Levine, Rothschild) focus on body.
THE DEVELOPING BRAIN

- At birth a newborn’s brain is the most immature of the organs.
- Like a new computer with a basic operating system ready for development and programming.
- It is highly responsive to external influences.
- The cerebral cortex is the most complex and most flexible and easily influenced structure. The brain stem, the least so.
- The first weeks, months and years are crucial for establishing the foundations of later capacities and talents, as well as deficits.
- How the brain develops is dependent on the infants interactions with the environment.
THE TRIUNE (3 PART) BRAIN

• The brain develops from bottom up.
• The reptilian brain develops in the womb and organises basic life sustaining functions – it is highly sensitive to threat.
• The limbic brain, organised during the first six years of life, is the primary site of complex emotional and social behaviours.
• The pre-frontal cortex develops last, and is also affected by trauma – unable to filter out irrelevant information and goes offline in response to threat.
MIRROR NEURONS

- Like a neural WiFi mirror neurons pick up other people’s movements, emotional states and intentions.
- Attunement and mirroring in the early years with primary caregivers is essential in order for the limbic system and frontal cortex to develop optimally.
- If this doesn’t happen then the infant is likely to experience identity disturbance and difficulties regulating emotion later in life.
- Trauma invariably involves not being seen, not being mirrored and not being taken into account.
ATTACHMENT

• A securely attached child will store an Internal Working Model (IWM) of a responsive, loving and reliable mother and of a self worthy of love and attention.

• An insecurely attached child may store an IWM of an unresponsive, inconsistent or unreliable mother. This selectively influences perception, cognition, motivation and sense of self.

• A healthy attachment between infant and caregiver enables the infant to develop the capacity to self-regulate both positive and negative stimuli.
IMPACT OF ABUSE AND NEGLECT

Disrupted Attachment

Trauma responses

Self-regulation Difficulties

Sensory Processing Differences

Altered neurobiological development
Thalamus: Processes incoming sensory information from environment and body state and passes on the Amygdala to interpret its emotional significance.

Amygdala: If threat is detected it sends messages to the Hypothalamus.

Hypothalamus: Secretes stress hormones to defend against the threat.

Several microseconds later via a second neural pathway:

Thalamus sends message via Hippocampus and Anterior Cingulate to the Frontal Cortex, for a conscious and more refined response.

Hippocampus: Gives a date and time stamp to the experience to make sense of the experience within a personal time line.
There is evidence that early childhood abuse results in an underdeveloped hippocampus.

The amygdala, which is fully formed at birth is unaffected.

There is also evidence of deficits in the medial pre-frontal cortex, which is involved in self-identity and ability to down-regulate threat.

Medial Prefrontal Cortex: Allows people to observe what’s going on, predict what will happen and make a conscious choice and then restore balance.
THALAMUS

• The ‘Gatekeeper’ of the Brain.
• Its job is to direct any ‘visitors’ to the correct part of the brain.
• The ‘visitors’ are sources of information that arrive via our five senses of smell, sight, sound, touch and taste.
• It registers the visitor and then ensures it is sent correctly to the next part of the brain.
• It always sends information to the amygdala first and to the prefrontal cortex a few milliseconds later.
• This explains the common experience of jumping in fear to something in the environment (amygdala response) and then a moment later realising it is safe (prefrontal cortex response).
The ‘smoke detector’ or alarm system of the brain.

- It checks incoming information from the body and outside environment for potential threats.
- If it detects a threat it will give us bursts of feelings like anxiety or anger to alert us to take action to protect ourselves.
- It sends messages to activate the Fight, Flight, Freeze response.
- It works on a “better safe than sorry” principle and so can create a stress reaction even if there is no real danger.
- People who have experienced trauma in their backgrounds often have an over-sensitive or ‘trigger happy’ amygdala. This kept them safe at the time but causes problems later because the brain and body stay on high alert unnecessarily.
PREFRONTAL CORTEX

- This allows us to form thoughts and to develop language.
- It is responsible for rational thinking, planning, imagination, self-awareness and self-identity.
- It is built by our early relationships and our early environment.
- It is able to reflect on our internal experience and is sometimes called ‘The Watchtower’ of the brain.
- It receives threat messages a few milliseconds later than amygdala and can make a more rational decision about whether the threat is real or not.
- Once it is clear there is no threat it sends soothing and calming chemical messages to the amygdala and other parts of the brain.
HYPOTHALAMUS

• The ‘Pharmacy’ of the brain prescribing and producing the hormones required for any given scenario.
• Is activated by the amygdala in response to perceived threat.
• Secretes stress hormones to defend against threat, e.g. adrenalin, noradrenalin and cortisol.
• These hormones prepare the body for Fight, Flight or Freeze responses
• It also governs physiological functions such as temperature regulation, thirst, hunger, sleep, mood, sex drive, and the release of other hormones within the body.
The hippocampus is like a filing clerk, noting the time and place of events.

It puts a date and time stamp on our memories.

It can cross refer the event to previous memories to help decide whether the incoming information is a threat or not.

Highly stressful and traumatic events can stop the hippocampus from working properly and so these events don’t get a date and time stamp, which can lead to PTSD symptoms.

There is evidence that people who experience significant trauma growing up have an under-developed hippocampus, which makes it more difficult for them to store memory and make sense of their experiences.
Individuals with PTSD cannot make sense of their symptoms in the context of the events they have endured. They are plagued by state-dependent triggers and their traumatic experiences float in time without an end or a place in history.

### CATEGORIES OF MEMORY (ROTHSCHILD, 2000)

<table>
<thead>
<tr>
<th></th>
<th>Explicit (Declarative)</th>
<th>Implicit (Non-declarative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process</strong></td>
<td>Conscious</td>
<td>Unconscious</td>
</tr>
<tr>
<td><strong>Information types</strong></td>
<td>Cognitive, facts, mind, verbal/semantic, description of operations and procedures.</td>
<td>Emotional, conditioning, body, sensory, automatic skills, automatic procedures</td>
</tr>
<tr>
<td><strong>Mediating Limbic Structure</strong></td>
<td>Hippocampus</td>
<td>Amygdala</td>
</tr>
<tr>
<td><strong>Maturity</strong></td>
<td>Around 3 years</td>
<td>From birth</td>
</tr>
<tr>
<td><strong>Activity during traumatic event and/or flashback</strong></td>
<td>Suppressed</td>
<td>Activated</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Constructs narrative</td>
<td>Speechless</td>
</tr>
</tbody>
</table>

- Explicit (Declarative) refers to conscious, cognitive processes that involve verbal/semantic information and procedures.
- Implicit (Non-declarative) refers to unconscious, emotional processes that involve automatic skills and procedures.
Group Discussion

1. What are the prevailing attitudes to dealing with trauma in our society?

2. Are these helpful?

3. What can we do to change attitudes?
GOALS OF TRAUMA THERAPY

1. Emotional and Physical Stabilisation
2. Development of resources to cope with the consequences of early trauma.
3. Development of resources to cope with everyday life.
4. Uniting implicit and explicit memories into a comprehensive narrative of the events and aftermath of the traumatic incident (including making sense of body sensations).
5. To eliminate symptoms of ANS hyperarousal in connection with those memories.
6. To relegate the trauma to the past: “It is over. That was a long time ago. I survived”.

The treatment for Complex PTSD emphasises, not only the reduction of core PTSD symptoms, but equally the development, restoration and strengthening of the person's capacity for self-regulation, self-efficacy and interpersonal, social and environmental functioning (Traumatic Stress Clinic, Camden, 2013).
84% of 50 expert clinicians endorsed a phased-based or sequenced approach as first line of treatment for Complex PTSD (Journal of Traumatic Stress, 2011).
Stabilisation – Ensuring the person has sufficient security in their daily life and basic needs are met, e.g. food, shelter, physical health. Clients might need help with legal, financial and housing issues.

Psycho-education – It is important to normalise the symptoms and problems a person is experiencing. This might include identifying triggers of flashbacks and explaining why this happens to the traumatised brain.

Symptom management – This encourages self-efficacy, mastery and control over distressing symptoms and could include managing dissociation, discrimination training, relaxation or self-soothing, dealing with flashbacks and nightmares and emotional regulation training.
DEALING WITH DISCLOSURES

• What might be tricky if we get people to talk about their experiences?

• Analogy – If someone broke their ankle most of us would know to elevate the leg and apply ice. However, if someone with complex cardiac problems, was having a heart attack we would want to refer them to specialist.

• We don’t expect you to be able to treat trauma.

• We do want you to be able to help people manage their emotions and distress better.

• We do want you to be able to help people be better prepared for accessing trauma services.
## A CAUTIONARY TALE

<table>
<thead>
<tr>
<th>What should we be doing?</th>
<th>What shouldn’t we be doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validating the person for sharing their thoughts and feelings.</td>
<td>Shutting the person down abruptly.</td>
</tr>
<tr>
<td>Empathise with the pain and suffering with compassion and warmth.</td>
<td>Appear shocked or disgusted.</td>
</tr>
<tr>
<td>Suggesting grounding and emotional regulation techniques.</td>
<td>Eliciting gratuitous detail (avoid urge to be voyeuristic).</td>
</tr>
<tr>
<td>Providing information on pathways into trauma treatment services in the Borough.</td>
<td>Telling people to “get it all out”. Emotional discharge is often not the best thing for people experiencing the impact of complex trauma.</td>
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</tbody>
</table>
PHASES 2 AND 3

Phase 2

• Processing of traumatic memories
• Exposure based treatments, e.g.
• Trauma-Focused CBT
• Eye Movement Desensitisation and Reprocessing Therapy (EMDR)
• Narrative Exposure Therapy (NET)
• Body-Focused Therapies

Phase 3

• Integrating back into the community
• Resuming (or starting) everyday activities – relationships, work and family.
• Facilitating access to language skills, education and employment.
• Focus on principles of Post-Traumatic Growth: Relating to Others; New Possibilities; Personal Strength; Spiritual Change and Appreciation for Life.
Before commencing any kind of trauma therapy we need to be sure that the client knows how to put on the brakes.

Managing physiology – breathing and muscles.

Grounding Techniques.

Ability to manage emotions.

Establish safety for the client in and outside of the group context.

Phase 1 is essential.
BASIC PSYCHOEDUCATION

- Prefrontal Cortex (Attention and Anxiety Inhibition)
- Hippocampus (Autobiographical Memory)
- Amygdala (Anxiety and Fear Memory)
**FELT SENSE EXERCISE**

- Feel the way that your body makes contact with the surface that is supporting you.
- Sense into your skin and notice the way your clothes feel.
- Sense underneath your skin – what sensations are there?
- Now, gently remembering these sensations, how do you know that you feel comfortable?
- What physical sensations contribute to the overall feeling of comfort?
- Does becoming more aware of these sensations make you feel more or less comfortable?
- Does this change over time?
- Sit for a moment and enjoy the felt sense of feeling comfortable.
BREATHING & MUSCLE RELAXATION

- Amygdala activation
- Tense muscles
- Progressive Muscle Relaxation

- Amygdala activation
- Rapid Breathing
- Soothing Rhythm Breathing
DEVELOP MINDFUL AWARENESS

- Strengthening the medial prefrontal cortex, or in other words our ‘observing self’.
- This skill is sometimes called mindfulness or non-judgemental awareness.
- Using the observing self we can ‘feel’ and label emotions from a neutral perspective, e.g. “I notice that I have strong feelings of anger” or “I notice there is a slight sense of anxiety”.

**Mindfulness

Means paying attention in a particular way, on purpose, in the present moment non-judgmentally.**

Jon Kabat-Zinn
1. Focus your attention on the most intense emotion you are feeling at the time.

2. Label the emotion as best you can (anger, anxiety, happiness, sadness, boredom etc.)

3. Rate the intensity of the feeling on a scale of 0-10 (with 0 being the least intense and 10 being the most intense).

4. Identify where you feel the emotion in your body, e.g. head, chest, stomach.

Labelling our emotions makes connections between the parts of the brain related to emotion and those that are responsible for our thoughts and awareness.

By understanding what the emotion is and what it is trying to communicate we can then make decisions about what we could do to accept or modify the emotion.
Acceptance and Tolerance **does not** mean…

- You have to like or enjoy the emotion you are trying to accept.
- You have to accept everything always.
- You accept the situation that triggered the negative emotion.
- You give up and stop fighting to improve the situation.

Acceptance and Tolerance **does** mean…

- I intentionally permit negative emotions to be present for the amount of time necessary for them to change since fighting against emotions is likely to make them even stronger.
This discrimination method can help with both PTSD and other disorders where there are problems with unwanted triggering of intrusive memories.

Usually the similarities between “now” and “then” are sensory features that are in fact harmless and coincidental.

The differences are typically between key aspects of safety and danger.

Noting and focusing on the differences helps settle associated emotions.

It can be very helpful to look for situations that trigger intrusions and then carefully note the similarities & the differences between “now” & “then”.

This helps progressively reduce triggering of intrusive memories.
## DISCRIMINATION TRAINING

<table>
<thead>
<tr>
<th></th>
<th>NOW</th>
<th>THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Similarities</strong></td>
<td>Heart racing</td>
<td>Heart racing</td>
</tr>
<tr>
<td></td>
<td>Feel afraid</td>
<td>Feel afraid</td>
</tr>
<tr>
<td></td>
<td>Boss angry with me</td>
<td>Mother angry with me</td>
</tr>
<tr>
<td><strong>Differences</strong></td>
<td>My boss isn’t going to hit me</td>
<td>Violence was common</td>
</tr>
<tr>
<td></td>
<td>I’m an adult and have choices</td>
<td>I was a child and had little choice</td>
</tr>
<tr>
<td></td>
<td>I can leave the situation</td>
<td>I was trapped in the situation</td>
</tr>
</tbody>
</table>
This is an approach based on distraction with aims to help you ‘switch off’ distressing memories or bring yourself back to the present moment by directing your attention elsewhere.

- Develop a grounding image.
- Develop a ‘bridging image’.
- Using a ‘grounding object’.
- Develop a grounding phrase.
- Refocusing your attention.
FOUR ELEMENTS GROUNDING TECHNIQUE

• Taken from Francine Shapiro EMDR trauma approach
• Brings person back to present moment
• Implicit message of safety to the brain
• Links with person’s core element
Experiential Exercise: Compassion and Loving Kindness.

- Soothing Rhythm Breathing
- Creating a safe place
- Building a compassionate image
- Using compassion perspective to acknowledge suffering.
- Build courage and motivation to make changes.
- The group uses compassion perspective to help each other.
- Leading to compassionate self-support.

COMPASSIONATE SELF-SUPPORT
SUMMARY OF PHASE 1 INTERVENTIONS

- Brain psychoeducation
- Awareness of felt sense
- Breathing and muscle relaxation
- Mindful awareness
- Labelling emotions
- Understanding & accepting emotions
- Discriminating between past & present
- Grounding techniques
- Compassionate self-support
POST-TRAUMATIC GROWTH

• Very few people would choose to go through the painful experiences they have had in life.
• However, many people who have experienced a lot of trauma and difficulty say they have grown in some ways as a result of those experiences.
• There seem to be five broad areas in which people report positive changes.


• Relating to others
• New possibilities
• Personal strength
• Spiritual change
• Appreciation for life.
QUESTIONS OR COMMENTS