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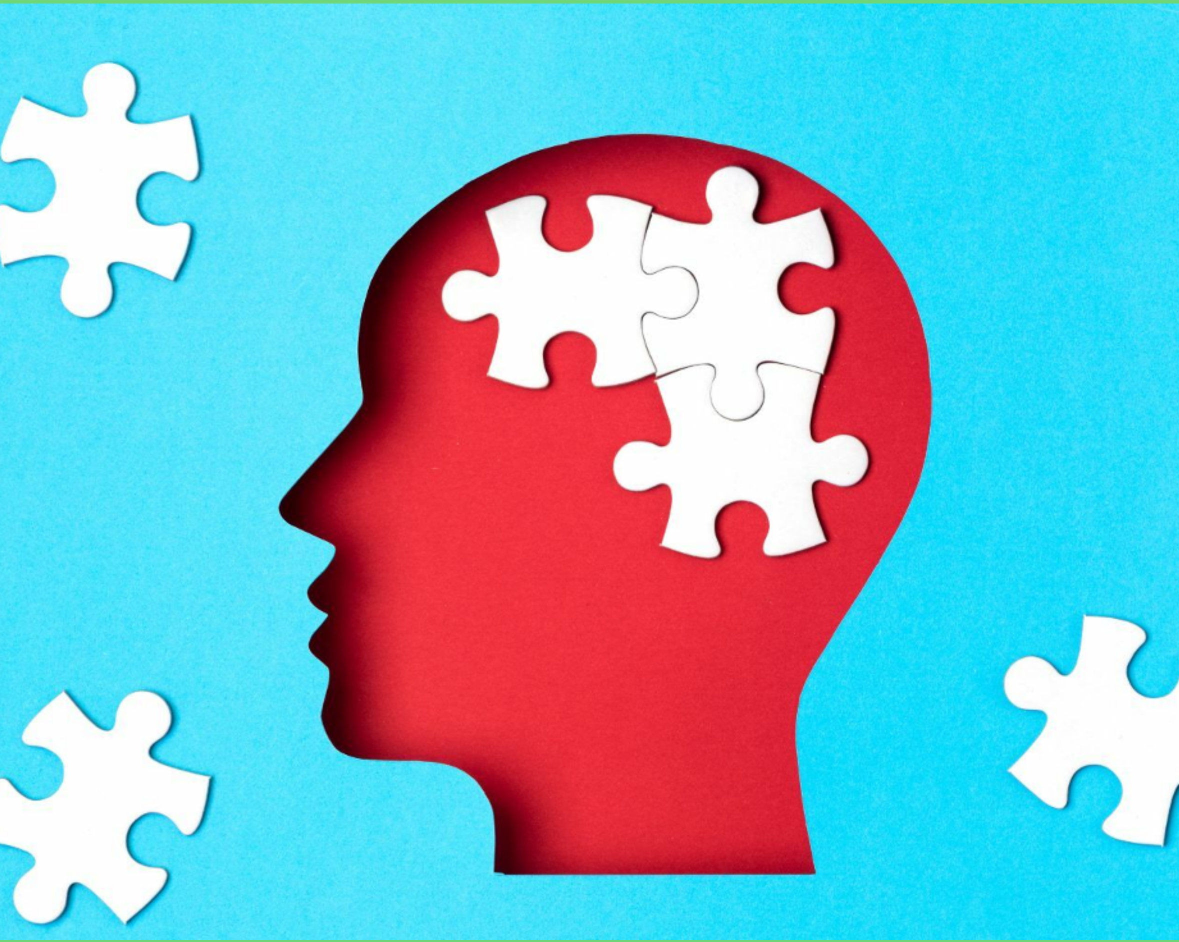

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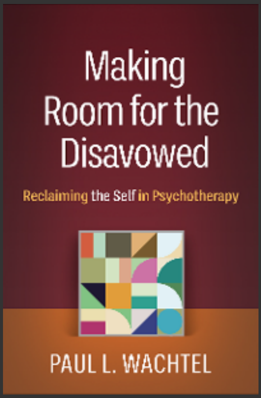

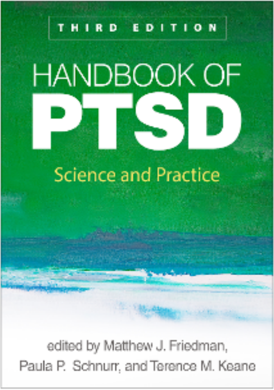

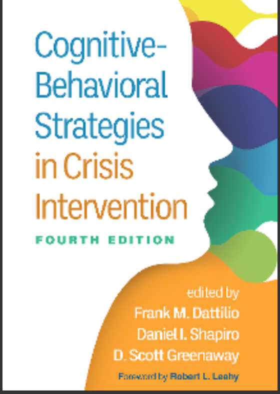

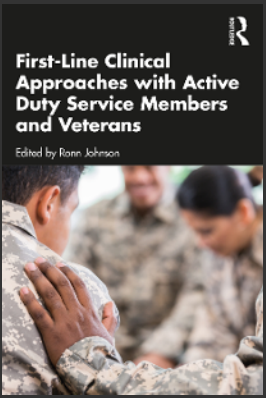

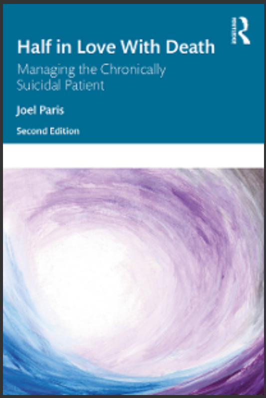

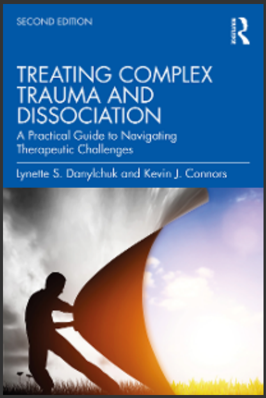

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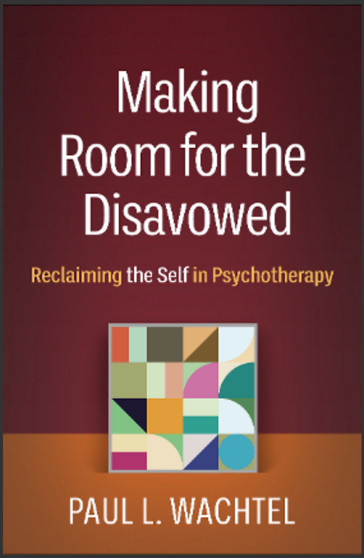
CHAPTER 1

Making Room for Thoughts and Feelings



This chapter is excerpted from

Making Room for the Disavowed

Paul L. Wachtel

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CHAPTER 1

Making Room for Thoughts and Feelings

Attachment, Self-Acceptance, and Emotional Immediacy

Doing psychotherapy is a challenging occupation. Things rarely go as smoothly as manuals or, for that matter, books like this, can seem to imply. Patients sometimes come into sessions and have nothing to say, or they seem to be just telling a story that has nothing to do with the work. Sometimes it feels like they are just "complaining" about what other people are doing, and there is no obvious path into a dialogue that leads in therapeutic directions. Sometimes they seem unable to stay with the topic, especially when it seems we are getting closer to something important. At times, it may feel we are talking about the right things, and even able to stay with them, but the work just doesn't feel alive, or there is little sense of movement. The list of such conundrums is long, and almost every therapist could likely add many further examples. It is easy to call these behaviors "resistance," and sometimes (if resistance is understood in the less adversarial and pejorative way I discuss in Chapter 4) it may well be useful to think about them in this way. But I want in this book to explore ways in which these obstacles to movement and emotional aliveness derive as well from some of the most common assumptions and practices in our field.

My aim is to point to a therapy that is more accepting, more experiential, and more emotionally immediate. In that effort, I draw on developments across the psychodynamic, cognitive-behavioral, humanistic–experiential, and systemic traditions. I seek in doing so to illuminate both the often unappreciated overlaps in their ways of working and the processes they mobilize and, as well, the unique contributions that each offers to the therapist who is open enough to accept their diverse contributions, even when they present themselves in an unfamiliar accent.

My own original training and background was in the psychodynamic tradition, and psychodynamic thought, especially in its newer relational forms, continues to inform and enrich my work to this day. But my psychodynamic sensibility owes as much to Robin Hood as to Freud. I steal riches from other orientations, and I do so openly and brazenly. And, like Robin Hood (at least the Robin Hood of myth), my aim is to give away the fruits of my thieving to those in need—in this case, my patients.

Rather early in my career, I saw important ways in which psychodynamic work and thought could be enhanced by attention to behavioral (Wachtel, 1977a) and systemic (Wachtel & Wachtel, 1986) perspectives and interventions. Subsequently, and increasingly, I have turned as well to the contributions of humanistic and experiential therapists—to the point where it may be most accurate to call my version of psychodynamic thought and practice a "psychodynamic–humanistic–experiential" point of view. This latter direction in the evolution of my thinking and practice was prompted by my concern that it was important that the patient come to *experience* and to *accept* his cast off thoughts and feelings, not just know them or be able to verbalize them.

My interest in the potential of approaches explicitly identified as experiential for this purpose will hardly be surprising to most readers. But many readers may be quite surprised that in seeking a more experiential, less intellectualized therapeutic approach, I also turned early to the methods of behavior therapy. The first thoughts that come to most readers' minds about behavior therapy are not likely to highlight behavior therapy as an approach that enhances the *experiential* quality of the therapy, much less as an approach that could not only be compatible with a psychodynamic way of working but could actually deepen and extend the clinical reach of psychodynamically guided practice. I discuss this experiential contribution of behavior therapy especially in Chapters 7 and 10.

More recently, two other sources have contributed especially prominently to the further evolution of my thinking and to the experience- and acceptance-centered emphasis of this book: attachment theory and what has been called third-wave cognitive-behavioral therapy (CBT). Attachment theory has in some ways been a significant part of my thinking for some time. But in recent years I have reexamined what I view as the most significant contributions of attachment theory to our understanding of personality dynamics (e.g., Wachtel, 2010b, 2017a), and those reconsiderations led to attachment theory playing an even more central role in my thinking and to its being a theoretical cornerstone of this book.

The aspects of attachment research that are likely to be most familiar to readers center on attachment *categories* (secure/insecure, avoidant, anxious–ambivalent, etc.) and on the continuities in attachment status over time or between the attachment status of the parent and that of the child. This is important work, both strongly grounded in research and with significant clinical implications (e.g., Eagle, 2013; Holmes & Slade, 2018; Wallin, 2007). But the emphasis in this book is primarily on the *processes* of attachment rather than the categories. In particular, it is on the ways that adaptation to the emotional signals of the attachment relationship leads to selective access to only a portion of the potential repertoire of thoughts, feelings, and ways of interacting that we might bring to bear in living our lives, and on how the unconscious and automatic self-restrictions this entails affect our further development and interactions with the world.

It will be apparent as I proceed, especially in Chapters 8 and 9, that this process-centered understanding of attachment is not just about infancy and early childhood but is also about how the perceptions (and perceptual restrictions) that are initiated in our early attachment relationships become part of our way of life. In explicating this, I examine how the pattern is extended over time, as our habits and expectations elicit responses from others that tend to perpetuate those very habits and expectations. This is a conception of attachment that is suited not just for therapists whose work centers on tracing the origins and early roots of the patient's difficulties but also for therapists whose work focuses more on how the patient lives in the present.

Third-wave CBT has been an even more recent contribution to my thinking. Like the point of view that is central to this book, third-wave cognitive-behavioral approaches are less focused on *correcting* the patient's thoughts and perceptions than on promoting *acceptance* of them. This is especially true of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2016), but is an important element of all of the perspectives that are part of what has been called the third wave (Hayes et al., 2004). Just how new the third wave is, how much it genuinely differs from what could be called first or second wave approaches, has been a matter of controversy in the cognitive-behavioral community (e.g., Hofmann & Asmundson, 2008). With regard to the issues I discuss in this book, however, it will be apparent that the perspectives generally viewed as part of the third wave have quite different implications from versions of CBT more centered in theories and practices deriving from the work of Beck or Ellis. I especially elaborate on these differences in Chapter 7.

Also central to the point of view guiding the discussions in this book is a strong conviction that to understand human behavior and human experience properly, we must understand them *in context*. This, it may be noted, is also an important foundation of ACT, which is rooted in what Hayes (2013, 2016) calls contextual behavioral science. Contextual thinking is, as well, a quintessential property of the systemic point of view, which is another key foundation of the theoretical synthesis that underlies the approach to therapy discussed in this book. The contexts I consider in the clinical and theoretical discussions that follow range from the immediate interpersonal and relational contexts of the person's life (including, prominently, but not surprisingly, that of the therapeutic relationship), to the contexts of family, school, workplace, and community, to the larger contexts of race, class, ethnicity, and cultural values.

My earliest psychoanalytic grounding was strongly influenced by the culturally infused version of psychoanalytic thought advanced by Erik Erikson (e.g., Erikson, 1950, 1958, 1969/1993), along with the contributions of writers such as Fromm (1941, 1955) and Horney (1937, 1939), and I have been concerned with the intersections of psychoanalytic and psychological thought and larger social and cultural phenomena for many years (e.g., Wachtel, 1983, 1999). In this book, as I have previously (e.g., Wachtel, 2008, 2014a), I ground my analyses in a conception of the *contextual self,* a point of view I employ to represent the simultaneous realities of, on the one hand, our being powerfully shaped by our interactions with others and by social and cultural influences and, on the other, our actively giving meaning to and selecting among those influences, manifesting an individuality that is genuine and meaningful.

Beyond Irrational, Infantile, Dysfunctional: From Uncovering, Correcting, and Pathologizing to Acceptance and Validation

For many years, much of psychotherapeutic practice centered on disabusing people of their illusions or misperceptions. These could be the infantile fantasies and defensive distortions that were long the focus of psychoanalytic work. They could be the irrational or dysfunctional beliefs that were central to the cognitive approaches of Beck and Ellis. They could be the self-deceptions that Fritz Perls relentlessly aimed to strip away in the early years of Gestalt therapy. Or they could be any of a range of other formulations, from still other frameworks, that are clearly intended to more accurately identify the sources of patients' or clients' suffering but that can ironically and unwittingly end up invalidating the patient's experience and contributing to his view of himself as damaged or deficient.

Along with these tendencies, there was a strongly pathocentric emphasis on disorders, deficits, and diagnostic entities. Psychoanalytic patients were viewed as fixated or arrested at early stages of development, looking like adults on the outside but deep down still viewing the world through lenses that were oral, anal, phallic; paranoid, depressive, schizoid; primitive, archaic, preoedipal; the list of terms is long and almost invariably uncomplimentary. From a different theoretical vantage point, behavioral and cognitive-behavioral therapists, after years of criticizing psychoanalysts as rooted in an outdated and inappropriate medical model, embraced with gusto the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), arguing that sorting people into psychiatric diagnoses was essential to any responsible investigation of therapeutic outcome (e.g., Chambless & Hollon, 1998; Chambless & Ollendick, 2001).[1] And across the range of orientations, the codes of the *International Classification of Diseases* (ICD) and the language of Axis I and Axis II, of borderline and narcissistic and comorbidity, became essential to learn not just for psychiatrists but for psychologists, social workers, and other mental health professionals as well.[2]

This book presents a very different vision of what psychotherapy is about and of how to understand the problems people bring to our offices. A central challenge it explores is how to attend seriously to the depth and reality of the problematic patterns of thought, behavior, and emotional meaning-making that bring people to therapy, and yet frame the understanding of those patterns in ways that promote validation and self-acceptance rather than grounding the therapeutic effort in conceptions of the patient as infantile, irrational, or distorting or misperceiving reality.

Making Room for the Full Self

Central to the way the book addresses this challenge—and giving it its very title—is a vision of therapy as a means to *make room* for thoughts, feelings, perceptions, and desires that, over the course of development, the patient has come to experience as dangerous or shameful. Relatedly, the book examines the differences between a making-room-for emphasis and an emphasis on pathology, on identifying errors in the patient's

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[1] For an alternative cognitive-behavioral view, see Barlow et al. (2017); Hayes and Hofmann (2018).

[2] Fashions in these terms keep changing, with some disappearing or falling out of favor and others emerging, but the medicalized and pathocentric structure has persisted.

thinking, and on uncovering what the patient has been *hiding* from himself.

To be sure, it is essential to keep in mind that the patient has come to see us because *something is wrong* in his life. As a consequence, it is essential we look in a clear-eyed way at the contribution to his difficulties or dissatisfactions deriving from how he thinks, interprets experiences, and interacts with others. This means we must also be attentive to how those ways of thinking, interpreting, and behaving must change if he is to live his life more comfortably and satisfyingly.[3] This implies not a single-minded focus on acceptance and validation alone, but a *dialectical* approach—as offered by Linehan (e.g., Heard & Linehan 2019), Bromberg (1993), and a range of other leading thinkers in each of the major orientations in our field—in which the tension between acceptance and change is not only acknowledged but embraced as a core guiding principle. Theoretical purity is the enemy of therapeutic success, and that holds as much for the make-room-for point of view at the heart of this book as it does for any other. When, in the witty words of Larry Beutler (2004), our discourse on therapeutic methods becomes a matter of "dogma eat dogma," it is the patient who is the loser.

Nonetheless, I believe—and it is one of this book's aims to elaborate on the logic and the observations supporting this view—that the most useful grounding for our work resides in thinking of psychotherapy as the effort to make room for thoughts and feelings that have come to be experienced as prohibited and have been excluded not only from the experienced sense of self but from the patient's repertoire of adaptive resources. Having been particularly alerted to this issue in the process of writing this book, I have noticed that when my work with a patient is not going well, reminding myself to refocus my attention on helping the patient *make room* for these excluded thoughts, feelings, and experiences is one of the most useful ways of getting back on track. Although I employ a wide range of other perspectives and ways of working, it is this element of the work that is particularly the focus of this book.

In this regard, it may be worth noting that it was only halfway through the writing of this book that I fully realized it was most fundamentally about "making room." I began with a set of interrelated themes, and the writing of the book was an effort to work out for myself the nature of their linkages and the implications for therapeutic practice. These included the particular take on attachment I mentioned previously

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[3] As I discussed in the Preface, throughout this book, for purposes of clarity I refer to the therapist, when discussing therapists generically rather than referring to a specific person, with the pronouns *she, her,* and *hers* and to the patient generically with *he, his,* and *him*.

(and discuss further later in this chapter and especially in Chapters 8 and 9); concern with making the work more able to promote self-acceptance and not just self-knowledge; related intuitions about how concepts such as interpretation and cognitive restructuring are more antithetical to that spirit of acceptance than is often appreciated; the importance of making the work more experiential and emotionally immediate; the ways that social realities and cultural values impact our patients' sense of possibility in life; and the critical import of grounding the work in the way the person lives in the world, not just what is in his head. As I explored the ways that each of these themes impacted the way I practiced and thought about psychotherapy, I only gradually began to see that the red thread through them all was making room for the thoughts, perceptions, feelings, wishes, and ways of acting that the patient had pushed aside or marginalized. Once I understood in this way what I was really up to, the writing became much easier.

But it is also worth noting that as much as this is a book that particularly highlights the concept of making room for the parts of the self that have been cast aside, I am not introducing one more entry into the endless stream of therapeutic brands that proliferate like viral mutations through the body of our field. This is not a book about MRFT ("make room for" therapy). There is no MRFT manual, and there are no MRFT training institutes, no certification in MRFT. The book is about a *way of thinking* about therapy, not about a *kind* of therapy. Much of what I describe may sound familiar to many readers. It builds on prior work in all of the major orientations in our field. But I believe that if the reader follows the argument and the clinical examples carefully, it is apparent that thinking in terms of making room for what the patient has pushed away or retreated from in himself can give the therapeutic process and the therapeutic interaction a substantially different feeling than much of what is common in contemporary practice.

Early Attachment Experiences and the Shaping of the Self: Learning to Fear Our Thoughts and Feelings

The make-room-for perspective is rooted in a critical implication of the uniquely prolonged vulnerability and dependency that characterizes human infancy and childhood. Because of that dependency, we learn early, as best we can, to be who our key attachment figures *need us* to be—to be the kind of baby and then the kind of child that can elicit whatever nurturance and responsiveness they are capable of offering. To a substantial degree, we learn to bend our thoughts, feelings, desires, perceptions, and very sense of self in directions most likely to elicit attuned responsiveness from our caretakers and to avoid eliciting disapproval, rejection, neglect, or other painful or deleterious responses.[4]

This doesn't always work out so well—that is, alas, why we are a thriving profession. But in small degree or large, almost all of us find a way to gain at least a measure of security via these (mostly unconscious) adaptations. Secure and insecure attachment do not constitute a binary; children or adults who are categorized as securely attached are by no means free of anxiety or self-doubts, and most people characterized as some version of insecurely attached usually can nonetheless establish relationships, hold a job, and generally carry on with their lives (albeit in ways that are likely less satisfying and effective as a consequence of their compromised attachment status). The differences picked up by measures of secure or insecure attachment certainly make a difference in the quality of people's lives in important ways, but the process of trimming the self to fit the needs of the attachment relationship is a human proclivity shared by secure and insecure alike. And even as this effort contributes importantly to whatever degree of attachment security we achieve, we also almost inevitably lose something precious as well. Even those of us who are all in all doing well in life inevitably turn away from certain parts of ourselves in the process of establishing as secure an attachment experience as we are able to in our particular emotional and familial circumstances. As I elaborate throughout this book, a good portion of the difficulties that patients bring to therapists are rooted in the ways that (mostly without awareness) we turn away from ourselves in the pursuit of responsive parental attention and affirmation. In particular, those difficulties are rooted in the ways we become afraid, guilty, or ashamed of thoughts and feelings that are an essential part of our genuine self and a critical resource for full and satisfying living. Attention to how the patient has learned to invalidate his own experiences and to what he has come to feel is most shameful or unacceptable is a central focus of the point of view presented in this book.

Attention to attachment phenomena has been an important focus

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[4] I am not here pointing to a simple conformity or obedience, automatically being exactly the way the parents want us to be. The interplay between needs for autonomy and self-expression and needs for parental approval and responsiveness is complex. But often, even in what looks like rebelling against what the parents seem to want or need, the power of those parental messages is evident. This is often especially the case in adolescence. Adolescents sometimes behave in ways that seem excruciatingly incongruent with how the parents want or need them to be, but at another level they may be seen as expressing a side of the parent that the parent has had difficulty expressing.

across a range of therapeutic orientations, from Susan Johnson's version of emotionally focused couple therapy (e.g., Johnson, 2019), which brings together humanistic–experiential and systemic thinking, to Diana Fosha's accelerated experiential dynamic psychotherapy (AEDP), which draws strongly upon both psychodynamic and experiential perspectives (e.g., Fosha, 2000), to attachment-based family therapy (e.g., Diamond, Diamond, & Levy, 2014), to a wide range of psychodynamic applications of attachment thinking (e.g., Fonagy, 2001; Holmes & Slade, 2018; Wallin, 2007). It has been less broadly influential in the realm of CBT, but important exceptions exist that I discuss further in Chapter 8 (e.g., McBride & Atkinson, 2008). Certainly there is little reason to think of attachment theory as in any way incompatible with a CBT perspective; attachment is a topic about which there is a vast body of systematic and carefully conducted research and thus seems a natural realm to explore by an approach like CBT, which prides itself on being solidly grounded in empirical research. It is also worth noting that Beck directly corresponded with Bowlby, stating explicitly that he saw Bowlby's views as relevant to and in many ways compatible with his own (Rosner, 2012). The attachment relationships of the early years invariably include a complex mix of attunement and misattunement, validation and invalidation. The final result is that some thoughts, feelings, and desires are able to be fully elaborated and represented in consciousness, whereas others are cast into shadow, not necessarily disappearing but rendered less able to be clearly experienced or articulated, less effectively integrated into one's adaptive efforts, and less able to contribute to a sense of vitality and clear direction in living.[5]

The luckiest among us end up born to parents who happen to like best (and be competent at dealing with) what is most characteristic of who we are. But even in this most fortunate state of affairs, this still does not mean they like or love every aspect of us equally. And long before we have learned to speak or to articulate in consciousness what this means or what it feels like, we have begun to learn how to adapt to these (usually unstated and often unacknowledged) parental preferences. We learn to put forward and develop certain of our qualities and to place others deep in the background, less called upon, developed, or experienced; and, over time, we essentially come to *define ourselves* in a way that reflects this self-editing. If not all of us go through life with one hand tied behind our back, all of us have at least a finger or two back there, not fully participating in the task of thriving in life.

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[5] This conception of the influence of attachment experiences intersects in interesting ways with Stern's (1997) concept of unformulated experience.

Therapy Need Not *Focus* on the Past to Address the *Impact* of the Past

What I have just described does not mean that infancy or childhood is destiny, nor does it imply a simplistic determinism in which we simply become what our parents want (or need) us to become. To begin with, often there are *two* parents involved, each of whom may be responsive to different aspects of the child. Even when there is just one, there are often grandparents, aunts, uncles, nannies, and then teachers, playmates, and a host of other figures who can open the field to a wider range of the developing child's inclinations and experiences. Secondly, the perceptions and responses of others are *influences* on our development, they are not irresistible forces before which we are utterly helpless. The growing child's temperament, desires, and ways of making sense of what he or she experiences are themselves shaping forces in the continually evolving interactions that develop between child and parent and child and world. We are not simply putty in the hands of our mothers and fathers.

But the dynamics of self-redaction I have been describing do take their toll, even in the best of upbringings. Much of this book examines the consequences of, in essence, building a life on the foundations of only a part of ourselves, and considers how the range of human interactions we have come to call psychotherapy can contribute to our bringing back into the picture the parts that got cast aside. To understand this impact and work effectively with it in therapy, we must consider not just the early years, when the process was initiated, but the feedback loops through which early patterns are perpetuated over time and the kinds of life experiences that can *disrupt* the pattern and lead to change. This complex amalgam of attention to subjective representations (as in the concept of the internal working model) and, equally and complementarily, attention to the impact of actual life events is the key to effective therapeutic leverage. It is a path as well to rendering the findings and conceptual tools that have accrued from attachment theory and research accessible to cognitive-behavioral, experiential, and systemically oriented therapists, many of whom center their clinical work on addressing the patterns and experiences of their clients as they are manifested in the present rather than focusing much attention on probing their early years.

As I especially elaborate in Chapter 9, current patterns and perceptions cannot be dissolved simply by demonstrating their link to the past, because they are linked not just to what happened years ago but to what happens *every day*. They are part of the patient's *way of life,* tied to the cycles that repeatedly generate actions in response to perceptions and perceptions in response to the consequences of those actions. Much of Part III is concerned with how to work with this challenge clinically. If we are to change those perceptions and expand the possibilities for new actions and new experiences, we must break into that self-perpetuating chain of events as the process is happening. We gain useful *perspective* from looking at the past, but we gain *therapeutic power* from working in the present.

Experience and Emotional Immediacy: Ensuring That the Therapy Is More Than Just Words

Both psychodynamic and cognitive therapy share a common vulnerability—they can sometimes be too intellectual, too "in the head," too purely verbal and insufficiently experiential. Almost all practitioners of either approach would regard such an overintellectualized state of affairs as a miscarriage of their approach; but it is a miscarriage that is not as rare as one might hope. When this happens, the patient can *say* things differently, sometimes even *see* things differently, without *being* different, *living* differently, *feeling* differently.

From a psychoanalytic vantage point, for example, Jacobs (2001), reflecting on many years of clinical experience, has commented:

> Increasingly, I have come to share my patients' view that, as important as it is—and unquestionably, it is of the greatest importance in paving the way for change—understanding the workings of one's mind is not a sufficient analytic goal. Too often in my work, I have witnessed the development of insight that remained just that: insight in a vacuum, insight divorced from action or change, understanding that had little impact on the patient's life or the difficulties that brought him or her to treatment. (p. 154)

Jacobs is clear that he does not mean that analysts must abandon interest in insight or self-understanding per se. While the version of psychoanalytic ideology that for many decades depicted a well-conducted analysis as aiming for change that is generated by "insight alone" or "interpretation alone" was deeply misguided (cf. Abend, 2007; Aron & Harris, 2010; Arlow & Brenner, 1990; Dewald, 1973; Gill, 1954, 1984; Stern et al., 1998), it remains the case that without a clear understanding of our feelings and aspirations, a deeply satisfying way of life is virtually impossible. Moreover, the real danger that the therapy can end up being "mere words" clearly does not mean that we can *abandon* words or verbal exchange in the work. Although I argue in this book for greater emphasis on the role of nonverbal, directly experiential and procedural learning, I have no intention to disparage (or even to play down) the verbal or linguistic dimensions of the therapeutic interaction. Nor, in highlighting the importance of emotional immediacy, do I intend thereby to somehow *replace* words with emotions or new experiences. Indeed, I have written an entire book on the artful use of words and language in therapy (Wachtel, 2011a), and I by no means aim to repudiate that book with the publication of this one.

But more often than one might hope, the words exchanged in the therapeutic dialogue do become *mere* words, and one important aim of this book is to help clarify when and how this occurs and to offer an alternative in which "the talking cure" is more than just talk. I consider throughout this book the ways that viewing the therapeutic task through the lens of making room for the thoughts and feelings that have been cast out of the experienced sense of self aids in generating a therapeutic process that does not remain solely on the verbal or cognitive level. When the main thing the therapist does is *point out* or *interpret* the patient's warded off thoughts and feelings or, as in cognitive therapy, critically examine the premises and assumptions that underlie the patient's thinking, there is not only a risk of sterile intellectualization but a risk as well that the patient will experience himself as getting "caught" doing (or thinking or feeling) something wrong. The make-room-for perspective provides a different set of images and metaphors, pointing to the therapist's *inviting* rather than interpreting the warded off thoughts and feelings. It encourages the patient not just to know or examine the feeling, but to *let it in*.

Inviting in the feeling or desire, embracing or accepting it, does not mean that there are no ways in which it needs to change. Years of being suppressed, unacknowledged, unable to participate in the countless interpersonal learning experiences that enable us to refine the way we express our feelings and desires can lead to their taking forms—a product of their very suppression—that really can create problems in many spheres of living (see especially Chapters 4 and 9). Thus, in order to make room for those cast off or disavowed thoughts, feelings, or self-experiences in an effective and enduring way, it is often necessary to help the patient shape them and express them in a way that does not generate consequences that will drive them back underground. Some therapeutic approaches are more explicit than others about helping the patient with the interpersonal and emotion-regulation skills needed to express effectively the newly emerging repertoire of feelings he is experiencing. But even approaches that in their manifest theoretical rationale eschew explicit advice, coaching, or guided structuring generally find ways to do this, often in implicit fashion. This can occur especially in the mutual interactions of the therapeutic relationship or in the ways that the therapist restates and reframes what she is hearing coming from the patient (Wachtel, 2011a).

Therapeutically useful acceptance is not *bland* acceptance, nor is it *blind* acceptance. The acceptance that contributes to therapeutic change is acceptance that takes account of how the very suppression of the person's conflicted inclinations can lead them to take forms that impede harmonious and satisfying relationships, but that at the same time conveys a fundamentally inviting and affirming attitude toward the patient's efforts to expand the expression of his subjectivity. Here again, in navigating the conflicting perceptions and guidelines the attentive therapist is likely to encounter, a valuable resource is provided by the dialectical formulations of Linehan (1993), Bromberg (1993), and other leading figures in each branch of our field.

But along with the necessity of what one might call sophisticated realism as a grounding element in therapeutically useful acceptance, it remains essential to be clear that the acceptance and the reappropriation of the disavowed thoughts and feelings must be pursued in a manner that is not overly tilted toward the verbal or cognitive realm. The patient must *experience* what he has previous disavowed or cast off, he must *feel* the previously forbidden feeling or wish if he is to genuinely reappropriate it. He must *go there* if he is to believe at more than an intellectual level that it is *safe* to go there; logic alone or verbalized insight alone won't do the job.

The point is well captured by Pascual-Leone and Greenberg's (2007) apt phrase, "the only way out is through." Their use of this phrase derives from their perspective as emotion-focused, experiential therapists, but it reflects a view that, stated differently, has proponents in each of the major orientations in our field. As I discuss at various points in the book, it overlaps conceptually with the foundations of cognitive-behavioral methods emphasizing exposure, as well as efforts to address experiential avoidance in ACT and related ideas and methods in other acceptance- and mindfulness-centered cognitive-behavioral approaches. At the same time, it is a key to understanding why I posit, in my discussion in Part II, an overlap between exposure methods in CBT and the qualities that make for genuinely effective psychodynamic interpretations. And it intersects as well with an important contribution of systemic approaches, which, in promoting new patterns of interaction in the emotional systems that are central to the patient's life, create direct experiences that take the person *through* experiences they have devoted their lives to avoiding. The overlaps and synergies among these various approaches to encouraging the patient to *move into* the experiences he has been avoiding rather than merely talking about them are a central concern of much of the rest of the book.

Living-in-the-World: The Inseparable Yin and Yang of Culture and Self and Self and Context

Within the web of reciprocally reinforcing causal forces therapists need to take into account, social and cultural influences must be included as integral and inseparable. Often, in the training of therapists, they are implicitly presented as "additional" factors, addressed in special courses on multiculturalism, diversity, or cultural sensitivity. Such courses can be an enormously valuable contribution to future therapists' educations, but when they are thus isolated, their impact is limited and their very content is misrepresented. Culture is not an "additional" factor in people's psychology; it is not just a "surface" element to be distinguished from the "deep" layers of the psyche that most fundamentally drive our behavior and experience (Wachtel, 2003b, 2008). The values and assumptions of a culture are a prism through which almost every experience is filtered and given meaning.

At the same time, each individual in a culture absorbs that culture differently. This is especially the case in a society in which most people belong simultaneously to many different subcultures, with sometimes one element of the kaleidoscope of possibilities in the foreground of our perceptions and experience, sometimes another.[6]

All of us grow up in the particular (and particularly influential) subculture of the family, shaped by its specific *version* of the culture and its own *position within* the culture. That version and that position include the impact of race, class, ethnicity, region, occupation, and economic status, though here, too, none of these is automatically determinative; the meaning given to each of these elements of identity will be slightly different in each family. In turn, each individual in the family will take a somewhat different meaning from the family's messages, including the ways it reads and selects from the larger culture. These dynamic interplays, rather than either static cultural categories or fixed cultural values or characteristics, are what we need to trace as therapists. In doing so, it is important that we not overindividualize in the sense of underestimating just how powerful a role culture plays in how our patients see and experience the world. It is probably an occupational hazard of therapists to focus on our patients' individual experiences and proclivities in a way that underestimates the impact both of culture and of socioeconomic circumstances. But it is important as well that we not end up dismissing culture in a different way—by making

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[6] See Sen (2006) for an important discussion of the underappreciated *multiplicity* of our identities and cultural affiliations.

it a categorically powerful *external* force. Culture is *in* us. It is part of almost everything we do, every choice we make. As we interact with the world, the world interacts with us. *Who I am* cannot be divorced from *who I am in the world.*

The continuing interaction between the world of culture, society, and relational events and the world of subjective interpretation and experience requires the sensitive therapist to be attentive to a continually changing state of affairs. We observe and work with both stable—sometimes *too* stable—individual tendencies and, at the same time, a constantly changing interactive field. Both the stabilities and the variations are essential to track and work with, as are multiple dimensions of these stabilities and variations. How we *feel* matters; how we *see* or *interpret* or *make sense of* events and interactions matters; what we *do* matters; and the *context* matters. In recent years I have increasingly begun to think in terms of a phrase that I first borrowed (and modified) from the writings of existential and phenomenological writers to capture these complex, multifaceted, and reciprocal connections. The phrase is *living-in-the-world,* and it is designed to highlight the importance of action as well as experience and of awareness that both always occur in relation to some context; that is, the importance not just of what is happening in the person's head but of how he lives in the world. The hyphens connecting the words in the phrase, again borrowed from existential and phenomenological writers, are designed to emphasize the *inseparability* of the actions/experiences and the contexts in which they occur.

I first introduced this phrasing in a discussion of the limits of a purely *representational* psychology, and of the ways in which both psychoanalysis and cognitive therapy often exhibit this representational bias (Wachtel, 2019):

> Discerning people's representations, even in the most accurate and perceptive way, is like looking at a snapshot. It is a picture of what is "there" right now. But life . . . is a *process;* it always occurs *in time,* and it occurs as well *in interaction* with the environment, both the physical environment and the psychological environment. The still photo must be supplemented with a video.
>
> Put differently, the person's representations [must be seen] in the context of his or her *way of life.* And . . . that way of life [must be understood] not just as it is "represented" but as it is *lived.* That is the "video" that gives context and further meaning to the still photo. It is the "video" that shows us how the internal structures and inclinations both respond to *and* create the ongoing events in a continuous fashion; and in the case of psychopathology, how . . . the patient's problematic representations lead to behavior that elicits from others the very reactions that will maintain or exacerbate those representations. (pp. 339–340, italics in original)

Throughout this book, I highlight the necessity for the therapist to keep her eye on both sides of this complex, reciprocally interactive reality. On the one hand, she needs to be keenly attentive to the patient's subjective experience and to the particular ways he gives meaning to events, rather than simply being passively shaped or determined by what is happening. On the other hand, his sense of self and his actions in the world *are* (inevitably and powerfully) impacted by the events he encounters (and participates in) and by the contexts in which his behavior and experience are manifested. Throughout this book, I particularly highlight the ways in which the work is enhanced by attention to the vicious and virtuous circles that characterize so much of our lives and to the concrete reciprocal interactions that create and recreate these circular patterns (see also in this regard Wachtel, 1994, 2008, 2009, 2011a, 2014b). I highlight as well how the therapeutic process must encompass both empathic resonance with the patient's subjective experience and attention to how the ways he interacts in the world contribute to the very experiences he has come to therapy to address.

Psychotherapy as a Complex Amalgam: The Diverse Sources of Therapeutic Gain

This complex matrix of reciprocal causal influences means that the effective practice of psychotherapy requires continual midcourse corrections that test the mettle of any therapist and leave most of us, if we are honest with ourselves, feeling at sea much more often than we hope our patients can notice. In this challenging arena of human interaction, it is enormously helpful to have a broad range of models, principles, and guiding images to draw upon in those far from infrequent moments when (theory or manual notwithstanding) we actually don't know what to do next. Unless I am a particularly inept therapist (a real possibility, I must acknowledge, but one that the reader will surely understand is not my primary working hypothesis), therapeutic work *often* creates moments where the therapist's experience is "give me a tool, *any* tool; give me a way to get past this morass; a way to respond to what the patient has just said that gets us back on track; a way that helps me see *what track we even should be getting back on*."

To be sure, despite this view of therapy as often consisting of uncharted territory, this book aims to provide at least a partial road map through that territory. One primary route I chart, it should already be clear, moves away from an emphasis on uncovering self-deceptions, irrationalities, and dysfunctional beliefs toward greater *acceptance* of the thoughts and feelings that have been cast aside because they have generated anxiety or threatened important attachment relationships, and points toward, that is, an emphasis on *making room for* those thoughts and feelings, on reappropriating them and making them more fully available to the task of living life well. A second key route moves from an emphasis on insight or other primarily cognitive or verbal efforts to a greater focus on the implicit, procedural, and experiential sources of therapeutic change, viewing emotional immediacy and lived experience as core elements of the process.

These, however, are not the only routes, nor are they one-way streets, leading from the "wrong" side of the tracks to the "right" side. The dimensions I am discussing in this book are not binaries that define wholly separate approaches to the therapeutic endeavor. To be sure, it will not be hard to detect that I view some therapeutic approaches as too centered on pathology or too verbal, cognitive, or intellectualized. But it would be a serious misreading to assume that my message is that one end of either continuum is always what should be emphasized. Some patients particularly benefit from a close examination of the implicit assumptions that shape their experience or guide their life choices or from greater insight into the feelings and desires they have obscured from themselves; without that clearer understanding of their underlying thoughts and feelings, even emotionally compelling experiences in the course of the work can lead to only fleeting gains. Likewise, some patients need a particularly clear and forthright focus on how their interpersonal behavior, emotional reactions, and ways of construing events and experiences *get them in trouble,* and a simply *accepting* stance does them a disservice and can replicate parental neglect rather than parental caring. Dialectical behavior therapy (DBT) in particular is noteworthy for providing that kind of "tough love" approach with regard to behaviors and emotional reactions that are highly problematic and require a frank response to that reality. DBT is also, at the same time, noteworthy for coupling that focus on what needs to change with a genuine emphasis on acceptance in a manner that is aptly named dialectical.

My emphasis in this book on acceptance, emotional immediacy, and *making room* for thoughts and feelings will most be of value if its limits are also appreciated. In this age of promoting therapeutic "brands" (see e.g., Rosen & Davison, 2003; Ablon et al., 2006) and allegiance to ever-proliferating acronyms (what I think of as "acronymphomania"), it is especially important both to disembed from that culture of advocacy and self-promotion and to explore the limits of one's favored point of view. Therapy is a complex amalgam; *many* forms of intervention, *many* ways of relating and interacting almost always are part of the process. There is usually much more that is relevant to therapeutic success than is typically highlighted in the literature of any of the current major theoretical orientations (which understandably emphasize those elements that appear unique to that orientation or are primarily emphasized in its conceptual framework).

Almost all treatments for any but the most simple of complaints mobilize a wide range of processes and experiences. These include the experience of being listened to in a respectful, empathic fashion by another person; the experience of being *understood* by the other person, of one's point of view being registered and taken seriously, even when alternatives are also offered; the offering of advice and direction (which happens, whether explicitly or more covertly, in *almost all* therapies, including those that claim to eschew advice or direction); the opportunity to practice new social behaviors and ways of expressing one's feelings to others; opportunities to learn new ways of regulating emotion, including new narratives that change the *meaning* of experiences or introduce new options; clarification of one's values, aims, desires, and phenomenological experience; enabling new ways of understanding the experience of the *other people* with whom one interacts or has a relationship (reflecting the importance of what Fonagy and his colleagues [e.g., Fonagy, Gergely, Jurist, & Target, 2002; Bateman & Fonagy, 2019] call mentalization). All these—and more—are elements frequently (if not always explicitly) part of the overall therapeutic process, contributing to the patient's experience and the prospects for change.

Common Factors or Multiple Pathways to Change?

Some of what I have just depicted overlaps with the point of view generally described as the common factors perspective. But where the common factors approach seeks to reduce the apparent diversity of methods to just a few underlying dimensions, my aim here is to *dive into* that diversity, to point to the *many* things therapists actually do in interacting with their patients. My assumption is that the more methods, metaphors, strategies, and guiding images the therapist has available to guide her response to this constantly shifting landscape, the more likely she is to be able to find a response that meets the challenges the clinical moment presents.

This strategic choice does not constitute a critique of the common factors approach. Common factors theorists and researchers have made enormously valuable contributions to our field, especially in illuminating the ways that advocates often blur the distinction between evidence for the efficacy of their preferred approach and evidence of its superiority to other approaches. (For discussions of the methodological and rhetorical sleights of hand that can lead to confusions between the former and the latter, see Shedler, 2010 and 2020, and Wachtel, 2010a and 2018.) The factors that have emerged from the analyses of common factors theorists—such as the therapeutic alliance, the generation of positive expectations in the client, and the provision of a convincing theoretical rationale for therapy (Wampold & Imel, 2015; Wampold & Ulvenes, 2019)—point to important core elements of therapeutic success, relevant across the boundaries of competing theoretical orientations. But the highly individual and often unpredictable ways in which patients can respond to the therapist's efforts mean that often we need many more images and guides to how to respond to what is happening than are provided by these few rather abstract factors. Different levels of analysis can be of value for different purposes.

Thus, to illustrate, while I am in strong accord with the view that it is critical to therapeutic success to establish a strong therapeutic alliance, it is also important to be clear that such a conceptualization offers rather limited real direction as to how to proceed. There is *an enormous number of ways* to establish an alliance effectively, and those ways will differ quite substantially from patient to patient. One patient will require that the therapist lay back, listen, not try to intervene or offer advice, and will be turned off by the therapist's playing too active a role or by her trying to help the patient "solve" the problem ("Just listen, hear me, understand me, don't try to tell me what to do"). Another may have quite different preferences and expectations. He may be put off and fail to develop trust or confidence in a therapist who "doesn't offer very much" or in a therapy that seems to him "just talk." He may *want* advice, *want* the therapist to take charge, may feel *abandoned* (or even in the hands of an incompetent) if the therapist mostly just listens and refrains from overtly intervening. And, of course, the potential variations go well beyond the simple distinction in the foregoing example. People—and therapeutic interactions—are not just of two types. Establishing (and maintaining) trust, commitment, and shared goals requires a wide range of concrete actions and responses with different patients, or even with the same patient at different points in the work.

Trying to build the therapeutic alliance without considering what *kind* of alliance the patient wants and without attending not only to the patient's general preferences and personal style, but also to the particular issues and life circumstances the patient is facing at any given moment, his present emotional state, and a host of other dynamic elements will leave the therapist with only the roughest outlines of a guide to how to respond to the challenges of the therapeutic moment. The alliance does, in a therapy that is going well, constitute a relatively stable foundation that can be fairly forgiving of errors and oversights. But it is nonetheless the product of—and potentially vulnerable to—a myriad of specific interactional moments that either deepen and consolidate it or impede and attenuate it. The idea of attending to, maintaining, or aiming to strengthen the alliance is a useful conceptual tool in guiding the therapist's efforts, but it is also a rather *abstract* tool, and does not offer much concrete advice to the therapist who is asking herself "What do I do *now*?"[7]

To be sure, the same can be said regarding making room for the patient's cast off or disavowed thoughts and feelings. Precisely *how* to make that room requires much spelling out and close examination, and it is one of the aims of this book to offer a clinically meaningful articulation of the range of ways this conceptualization can guide daily therapeutic work. Of particular importance in these discussions is consideration of how a deep grounding in the patient's subjective experience and subjective frame of reference can be combined with attention to the patient's *actions in the world*—to his ways of interacting with others, the reactions he evokes in them, the ways those reactions feed back to elicit further (often similar) behavior in him, and the ways these sequential and reciprocal elements organize themselves into patterns that frequently are self-perpetuating, eliciting the very responses that keep them going. These interactive and recursive processes bear quite directly on whether feelings and desires that were experienced as threatening can begin to be reintegrated or will continue to be excluded and treated as "non grata."

The complexity and multidimensionality of these patterns requires a similar multidimensionality in the conduct of the therapy. Making room for thoughts and feelings may sound at first like a singular therapeutic strategy, but, as the book proceeds, it will be apparent that as an organizing idea it is germane to a broad range of methods and perspectives while giving a particular cast to each.

Generic Elements in the Work

Still further adding to the complex amalgam that is psychotherapy, and to the sense that more goes on in a typical therapy session than any book (or manual or protocol) can fully capture, is that much of what therapists do or say includes "generic" ways of communicating, ways of interacting

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[7] In contrast, the literature on *ruptures* in the therapeutic alliance and repairs of those ruptures (e.g., Eubanks, Samstag, & Muran, 2023; Muran & Eubanks, 2020; Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 2000), while also strongly grounded in systematic research, offers a much more *clinically applicable* look at these dynamics.

with others that are not only not specific to any particular therapeutic approach but not specific to psychotherapy in general.[8] Rather, they simply reflect how people learn to interact and converse with others in order to make things go relatively smoothly and comfortably. Many things go on in almost every session that were learned not in graduate school but in the ordinary give and take of living and interacting with other people.

These may range from an mm-hmm (that is, a *spontaneous* mm-hmm, not the self-conscious, beard-stroking mm-hmm of a late night movie about psychoanalysis), to a head nod, to a smile, to asking a question, to any of the many other things we say simply to maintain a comfortable flow of the conversation. The proportion of the interaction that constitutes these kinds of generic conversational activities will likely be different in the therapy context than in most conversations, and the differences are probably greater for some orientations than for others. They are also likely to vary from patient to patient and even for the same patient from one session or one interaction to another. But these traces of everyday conversational DNA are a discernable part of the interaction in almost all therapeutic work.

It is important to be clear that these kinds of everyday nonverbal and paraverbal responses are not simply filler; they are an intrinsic part of the process.[9] The well-documented finding (e.g., Wampold & Imel, 2015; Muran & Eubanks, 2020) that some therapists consistently achieve better outcomes than others, quite apart from whatever techniques or theoretical orientation they employ (and in comparison to others who use those same techniques or operate from the same orientation) is likely a product of skill in these everyday aspects of human relating. More generally, for all therapists, these kinds of communications contribute to establishing and maintaining the therapeutic alliance. They are part of the social lubricant that human relatedness depends on. If the therapist is focused exclusively on "the work," little work will be done. If she is too relentlessly "like a therapist," she will be a *poor* therapist. An enormous body of research documents the critical importance of the alliance in

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[8] Here again it should be evident that what I am referring to is not the same as what common factors theorists mean when they refer to nonspecific elements.

[9] They of course *can* be just filler. We all have moments in the session (many, really) where we are uncertain what to say and essentially *punt*, delay, or just "keep something going." Sometimes, this is just to cover up (perhaps even to ourselves) that we *do not* quite know what we are doing at that point, that we are a bit lost. But even here, such behavior on the therapist's part is not necessarily a bad thing or a sign of incompetence. The ability, *during* those moments, to maintain some kind of connectedness, flow, sense of "we are okay" can itself contribute to the therapeutic alliance, and hence to the progress of the work.

contributing to therapeutic success (Norcross & Lambert, 2019; Norcross & Wampold, 2019). But too often, discussions of the alliance treat it primarily in terms of *the proportion of variance* it accounts for. What clinicians really need is examination of *how* the alliance is maintained or strengthened, what they can actually *do* to facilitate this.

Attention to Omissions and Ambiguities

One further element in what I am calling the complex amalgam has to do with attention to ambiguities and omissions in the patient's narrative. One of the most important skills good psychotherapy training hones is the ability to *notice* ambiguities and omissions that might be passed over in most conversation. This is especially important because, as I discuss more in Part II, such ambiguities and unnoticed omissions in people's narratives (and self-narratives) account for a good deal more of the way people retreat from and marginalize thoughts, feelings, and intentions than do the standard "defense mechanisms" that are so prominent in the argot of our field. Here again, we see that a make-room-for perspective is likely to give a different tone to inquiry into these ambiguities and omissions, as it does to most of the therapeutic interaction.

Consider the following simple (but representative) example. A patient, several sessions into the work, says, "My wife and I have had a stressful few years—deaths of parents, losing jobs, four pregnancies, three to term." The death of a parent is obviously a real and important stress, as is losing a job (the latter was the precipitating event that brought this patient into therapy). But what caught my attention, and what I responded to in this instance, was the phrase "four pregnancies, three to term," and, specifically, the way in which "three to term" (I already knew he had three children) was added as an incidental aside. In one sense, he *was* signaling to me that the miscarriage was another of those meaningful stresses of these recent years. But at the same time, he was obscuring and minimizing the significance of this experience (probably to himself as well) by the incidental way he placed it in his narrative. He was, one might say, signaling that this was an area of *conflict,* something *not easy* to talk about.

It is not always clear whether it is a good idea to comment on a mode of narration such as this at any particular point in the process. On some occasions, a comment or question such as "oh, so there was a miscarriage?" or even a further elaboration such as "what was that like for you?" will feel like a lifeline to the patient, an indication that what he thought couldn't be talked about (or perhaps even *thought* about) actually could be. In the terminology of the important work of Weiss and Sampson and their colleagues (e.g., Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986; Silberschatz, 2005), the therapist here may be "passing the patient's test," showing that his fearful expectation that people important to him will always collude in maintaining avoidance of painful or difficult topics need not be the case and that the feelings it raises can be not only shared but borne and worked through.

But with other patients, or at other points in the work, the same comment by the therapist might feel to the patient insensitively intrusive and, perhaps, require the therapist's skill in repairing ruptures in the alliance (Eubanks, Muran, & Safran, 2019; Eubanks, Samstag, & Muran, 2023; Muran & Eubanks, 2020; Safran & Muran, 2000). In these instances, we might say, passing the patient's test could mean understanding that the incidental way he dangles the topic indicates he needs us not to be intrusive, as perhaps his parent was, but rather to be sensitively patient and wait until he is ready before introducing the subject.

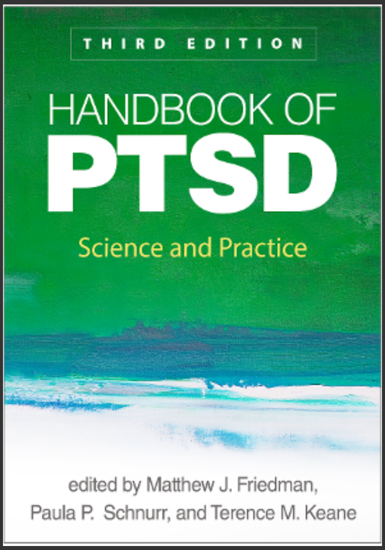
Thus, whether to *say something* about what one has noticed is a judgment call, and we cannot be sure in advance that we are making the right call. If one inclines toward the wait-and-see option as safer and less intrusive, for example, one must recognize that it could *also* trigger a rupture *not* to pick up on the hint. The therapist can potentially fail to pass the patient's test in these instances by confirming the patient's fear that "no one wants to touch those feelings; I better keep them to myself and try to bury them."

But *noticing* what is hinted at but not explicitly stated in the patient's narrative, *noticing* where something seems to be left out or minimized, is important either way. Whether it is talked about now or later—or even never talked about at all as an explicit topic, but rather serves to inform the therapist of a set of issues or sensitivities that form the background for her comments to the patient in a *different* context—it is the ability to *register* such ambiguities, omissions, and circumlocutions that distinguishes the listening and participation of the good therapist from the "mere conversation" it can often resemble.

The skills of the therapist have been described as "listening with the third ear" (Reik, 1949). What Reik was alluding to, and what many therapists aspire to, is an *interpretive* ear, an ear that hears the *hidden meaning* of the unsaid. To be sure, the capacity to hear and understand what is at most only implied is a real asset for a therapist. But accurately reading the meaning of the unsaid is a skill that therapists may believe they have to a much greater degree than they actually do. As in Lake Wobegon, every therapist thinks she is above average. The surer path to therapeutic success, less spectacular or impressive or "magical," but more reliable, more likely to be able to be *counted on* day in and day out, is a different kind of hearing what is unsaid—namely, noticing *that* something was unsaid, that there is an ambiguity or uncertainty or seeming omission in the narrative the patient is presenting to you—or to himself. If we can cultivate our *confusion* or *unclarity,* notice and acknowledge our *not* really understanding what the patient is saying (or, more often, not *fully* understanding), then we are in a much better position to be *reliably* successful.

CHAPTER 2

PTSD from DSM-III to DSM-5



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CHAPTER 1

PTSD from DSM-III to DSM-5

PROGRESS AND CHALLENGES

Matthew J. Friedman, Paula P. Schnurr, and Terence M. Keane

Since prehistoric times, men, women, and children have been exposed to traumatic life events. Indeed, a literary record of the adverse impact of such exposure can be found in the work of poets, dramatists, and novelists such as Homer, Shakespeare, Tolstoy, Dickens, and Remarque, up to and including contemporary authors. Attempts to record and understand such events and their consequences within a scientific or medical context are much more recent, dating back to the mid-19th century. For example, archival compensation and pension data from the U.S. Civil War indicate that high rates of traumatic exposure were associated with high rates of physical and psychological morbidities (Pizarro, Silver, & Prause, 2006). These latter observations generated a number of somatic (e.g., soldier's heart, effort syndrome, shell shock, neurocirculatory asthenia) and psychological (nostalgia, combat fatigue, traumatic neurosis) conceptual models (see McFarlane & Kilpatrick, Chapter 3, and Bryant, Chapter 6, this volume, on the history and psychological models of posttraumatic stress disorder [PTSD], respectively). Reviewing some of the rich clinical (and literary) reports provided prior to 1980, when the diagnosis was formalized (see below), we see that many authors were describing what would now be labeled PTSD. So, what has been gained by this conceptual and diagnostic construct?

The explication and adoption of PTSD as an official diagnosis in the American Psychiatric Association's (APA, 1980) third edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) ushered in a significant paradigm shift in mental health theory and practice. First, it highlighted the etiological importance of traumatic exposure as the precipitant of stress-induced alterations in cognition, emotion, brain function, and behavior. Dissemination of this model provides a coherent context within which practitioners have been able to understand the pathway from traumatic exposure to clinical abnormalities. Second, the PTSD model has stimulated basic research (both human and animal), in which it has been possible to investigate the causal impact of extreme stress on molecular, hormonal, behavioral, and social expression. More recently, investigators began to explore gene–environment interactions and epigenetic expression within this paradigm. Third, as noted earlier, the traumatic stress model has invited the elaboration of therapeutic strategies that have successfully ameliorated PTSD symptoms. Finally, PTSD was a unifying principle at a time when investigators were describing similar symptoms that were specific to different traumatic events, such as child abuse, interpersonal violence, rape, the Holocaust, and Vietnam combat exposure. The important inductive leap of the DSM-III PTSD diagnosis was recognition that the reactions to these different types of events had more commonalities than differences. Subsequent research has shown that the same therapies can be used successfully across different types of traumatic events. All of these extraordinary advances could not have occurred before posttraumatic distress and dysfunction were reconceptualized as PTSD.

It is possible that PTSD would not have been included in DSM-III without strong support from veteran, feminist, and Holocaust survivor advocacy groups. Unlike depression, schizophrenia, and other anxiety disorders, PTSD emerged from converging social movements rather than academic, clinical, or scientific initiatives. As a result, PTSD received an ambivalent, if not hostile, reception in many prominent psychiatric quarters when it was first introduced in 1980. The professional response to this negative reception was an outpouring of research to test the legitimacy of PTSD as a diagnosis. This entire volume documents the current state of the art of such research. Our conclusions are that people who meet PTSD diagnostic criteria exhibit significant differences from nonaffected individuals, as well as from individuals with depression, anxiety disorders, or other psychiatric disorders. Such research spans the spectrum from gene expression to brain imaging to cognitive processing to clinical phenomenology to interpersonal dynamics. Analyses of the PTSD symptom clusters have validated the PTSD construct from DSM-III through DSM-5 (APA, 2013). There can no longer be any doubt about the reliability, validity, and heuristic value of PTSD as a diagnosis.

As detailed in Chapter 2 on the evolution of DSM-5 and in Chapter 3 on the history of trauma-related disorders, the actual term *posttraumatic stress disorder* did not appear in our nosology until 1980. The first *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I; APA, 1952) included “gross stress reaction,” a transient disorder following exposure to civilian catastrophes or military combat. Strangely, at the height of the Vietnam War, DSM-II (APA, 1968) eliminated this category. In 1969, John Talbott, future president of the APA, called for the return of this diagnostic category because there was no current DSM diagnosis that captured the symptoms he had treated as a military psychiatrist in Vietnam (Bloom, 2000).

During the 1970s, several social movements in the United States and around the world converged to bring attention to reactions following interpersonal violence, as well as combat. The women’s movement focused attention on the sexual and physical assault of women as highlighted by the speak-outs and consciousness-raising groups organized by the National Organization for Women. Laws were changed to reflect the understanding that incidents of abuse within the family were crimes and of societal concern, not merely private family matters. Mandatory reporting of child abuse was enacted in all U.S. states. Rape shield laws, marital rape laws, and the legal recognition that rape could happen to boys and men, and not just girls and women, also changed attitudes and services provided. Landmark studies by Burgess and Holmstrom (1973, 1974), Kempe and his colleagues (Gray, Cutler, Dean, & Kempe, 1977; Schmitt & Kempe, 1975), and Walker (1979) resulted in descriptions of the child abuse syndrome, the rape trauma syndrome, and the battered woman syndrome, respectively, and spawned a generation of research on those topics. The descriptions of responses to these forms of interpersonal traumas were much like those being described by the millions of Vietnam veterans who had returned from the war (Figley, 1985; Friedman, 1981). As a result, when the revision of the DSM was considered, reactions to all traumatic events were pooled into one overarching category.

In 1980, DSM-III included PTSD for the first time as an official diagnosis. PTSD was classified as an anxiety disorder that had four criteria: (1) the existence of a recognizable stressor that would evoke distress in nearly anyone; (2) at least one of three types of reexperiencing symptoms; (3) at least one indicator of numbing of responsiveness or reduced involvement in the world; and (4) at least two of an array of other symptoms, including hyperarousal or startle, insomnia, survivor guilt, and cognitive difficulties (see Friedman et al., Chapter 2, this volume, for more details). DSM-III also distinguished acute from delayed onset, depending on whether full symptom expression occurred within or after the first 6 months following exposure to trauma (see Friedman et al., Chapter 2, this volume, on DSM-5 diagnostic criteria for PTSD). Introduction of the diagnosis in DSM-III was followed by a wave of prevalence studies to determine who develops the disorder and under what conditions, along with development of valid and reliable assessment instruments for these criteria. Publications on treatment outcome studies began to appear by the mid- to late 1980s.

On the one hand, clinicians, who had been seeking an appropriate nosological category for psychiatrically incapacitated Holocaust survivors, rape survivors, combat veterans, and other traumatized individuals, were delighted. They finally had a DSM-III diagnosis that validated the unique clinical phenomenology of their patients. Recognition of the deleterious impact of a traumatic event provided a conceptual tool that transformed mental health practice and launched decades of research. For the first time, interest in the effects of trauma did not disappear with the end of a war. On the other hand, the new diagnosis also engendered criticisms, some of which continue to the present (see below).

The next revision, DSM-III-R (APA, 1987), produced the criteria that, for the most part, exist today. Six criteria, labeled A–E, were established: (A) the stressor; (B) reexperiencing symptoms; (C) avoidance/numbing symptoms; (D) arousal symptoms; (E) a duration criterion of 1 month; and (F) significant distress or functional impairment. The stressor criterion continued to define eligible stressors as events "outside the range of usual human experience (i.e., outside the range of such common experiences as simple bereavement, chronic illness, business losses, and marital conflict)" and usually experienced with intense fear, terror, and helplessness (p. 247).

Among the questions addressed by the DSM-IV field trials was whether criterion A, the stressor criterion, should be changed or dropped entirely (Kilpatrick et al., 1998) because after the first wave of PTSD prevalence studies, it had become evident that "outside the range of normal experience" was inaccurate. In fact, most people experience at least one qualifying traumatic event in their lives, and some events, though infrequent in one person's life, are all too common across the population. Researchers asked whether people who experienced other stressful events, such as divorce, loss of a job, or the natural death of a loved one, would also develop PTSD. They found that it made little difference whether the definition of the rates of PTSD was strict or nonrestrictive; few people developed PTSD unless they had experienced an extremely stressful (life-threatening) event. Researchers also found support for including a subjective distress component in criterion A (criterion A2) because of consistent findings that the levels of panic, physiological arousal, and dissociation present at the time of the event were predictors of later PTSD (Kilpatrick et al., 1998; see Friedman et al., Chapter 2, this volume).

DSM-IV was published by the APA in 1994 and was revised slightly in 2000. Several changes in the PTSD diagnosis were formalized, along with the introduction of a new disorder, acute stress disorder (ASD). Despite the PTSD subcommittee's strong interest in moving the disorder out of the anxiety disorders group, the diagnosis remained where it was. Criterion A now had two parts: (1) objective (e.g., exposure to an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others) and (2) subjective (e.g., experiencing intense fear, helplessness, or horror during the event). Other diagnostic alterations are described in Chapter 2 (Friedman et al., this volume).

The bigger development in DSM-IV was the introduction of ASD, which emerged at the recommendation of the DSM-IV Dissociative Disorders Subcommittee, with the observation that people who had dissociative symptoms during or immediately after the traumatic event were most likely to develop PTSD. ASD was also introduced to bridge the diagnostic gap between the occurrence of a traumatic event and 1 month later, when PTSD could first be diagnosed. Criteria for ASD include the same stressor criterion as PTSD, and the presence of reexperiencing, avoidance, and arousal symptoms. DSM-IV's ASD differed significantly from PTSD in its emphasis on dissociative symptoms. Indeed, DSM-IV stipulated that individuals with ASD must exhibit at least three types of dissociative responses (amnesia, depersonalization, derealization, etc.).

PTSD diagnostic criteria were also revised in DSM-5 (see Friedman, Resick, Bryant, & Brewin, 2011; Friedman et al., Chapter 2, this volume, for details). To briefly summarize:

1. PTSD is no longer categorized as an "anxiety disorder" but is now in a new category, "trauma and stressor-related disorders," alongside acute stress disorder, adjustment disorders, and other related diagnoses.
2. The PTSD construct has been expanded to include other clinical phenotypes; in addition to the DSM-III/IV fear-based anxiety disorder, PTSD now includes anhedonic/dysphoric, dissociative, and externalizing phenotypes.
3. The latent structure of PTSD now comprises four (rather than DSM-IV's three) symptom clusters (i.e., intrusion, avoidance, negative mood and cognitions, and arousal and reactivity).
4. DSM-IV's criterion A2 (i.e., responding to the traumatic event with "fear, helplessness of horror") has been eliminated, given the recognition that many other powerful emotions like shame and rage can contribute to development of PTSD.
5. DSM-IV's 17 symptoms have been retained (though sometimes revised or clarified), and three new symptoms have been added.
6. Two new subtypes have been added: a dissociative subtype for people with derealization or depersonalization, along with the full PTSD syndrome and a preschool subtype for children 6 years of age and younger (see Friedman et al., Chapter 2, and DePrince et al., Chapter 8, this volume).

With regard to ASD, it is no longer necessary for traumatized individuals to exhibit any dissociative symptoms. Nine (out of 14) symptoms are needed for the diagnosis (Bryant, Friedman, Spiegel, Ursano, & Strain, 2011). Given recognition that acute posttraumatic reactions may be expressed differently by different people, individuals who meet DSM-5 ASD diagnostic criteria may or may not exhibit dissociative symptoms.

Research demonstrates that the presence or absence of dissociative symptoms does not affect the severity, morbidity, or longitudinal course of people with ASD (Bryant, Friedman, Spiegel, Ursino, & Strain., 2011).

We begin this third edition of the *Handbook of PTSD* by briefly reviewing the wealth of scientific information that has accrued since 1980 because of the new conceptual context provided by PTSD. Such research has not only transformed our understanding of how environmental events can alter psychological processes, brain function, and individual behavior, but it has also generated new approaches to clinical treatment. Indeed, the translation of science into practice since DSM-III is the major impact of the PTSD diagnosis. Then we consider questions, controversies, and challenges regarding PTSD.

SCIENTIFIC FINDINGS AND CLINICAL IMPLICATIONS

Epidemiology

When PTSD was first operationalized in DSM-III, a traumatic event was defined as "a catastrophic event beyond the range of normal human experience." Epidemiological surveys conducted since 1980 have shown otherwise. More than half (68.7%) of all American adults are exposed to traumatic stress during their lifetimes (Goldstein et al., 2016). In nations at war or subject to internal conflict, traumatic exposure is much higher (Bromet, Karam, Koenen, & Stein, 2018). Surveys of U.S. military veterans suggest, as might be expected, high rates of exposure to war-zone stress, although prevalence estimates vary in magnitude depending on the specific nature of each war and the war-specific demands of each deployment (Magruder & Yaeger, 2009; Marmar et al., 2015; Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015).

One of the most robust findings in epidemiological research on PTSD is a dose–response relationship between the severity or amount of exposure to trauma and the onset of PTSD (Bromet et al., 2018; see Korte et al., Chapter 4, this volume). This dose–response association has held up whether the traumatic experience has been sexual assault, war-zone exposure, natural disaster, or terrorist attack (see Friedman et al., Chapter 2, on DSM-5, and Korte et al., Chapter 4, on epidemiology, this volume). Within this context, however, in the United States, the toxicity of interpersonal violence, such as that in rape, is much higher than that in other types of traumatic events (e.g., Breslau, 2009; Pietrzak, Goldstein, Southwick, & Grant, 2011; see Korte et al., Chapter 4, this volume). In developing nations, however, natural disasters are much more likely to produce PTSD because of the magnitude of resource loss associated with such exposure (see Korte et al., Chapter 4, and Copeland & McGinnis, Chapter 5, this volume, on the epidemiology of PTSD among adults and children, respectively).

It is also important to recognize that PTSD is not the only clinically significant consequence of traumatic exposure. Other psychiatric consequences include depression, other anxiety disorders, and alcohol or drug abuse/dependency (se Korte et al., Chapter 4, this volume, on epidemiology). Finally, accumulating evidence indicates that when traumatized individuals develop PTSD, they are at greater risk to develop medical illnesses (Schnurr et al., Chapter 25, this volume). The clinical implications of these data are clear. Given that exposure to traumatic experiences occurs in at least half of the U.S. adult population (and much more frequently within nations in conflict), mental health and medical clinicians should always take a trauma history as part of their routine intake. If there is a positive history of such exposure, the next step is to assess for the presence or absence of PTSD (see Livingston et al., Chapter 16, and Briggs et al., Chapter 17, this volume, on assessment of PTSD in adults and children).

Risk Factors

Most people exposed to traumatic stress do not develop persistent PTSD. For example, one study found that even among female victims of rape, the most toxic traumatic experience, 54.1% did not exhibit full PTSD after 1 month, and 78.8 % of female assault survivors did not have PTSD after 3 months (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). This means that most people have sufficient resilience to protect themselves from developing the disorder. Research on risk factors generally divides them into pretraumatic, peritraumatic, and posttraumatic factors (see Korte et al., Chapter 4, this volume, on risk factors). Pretraumatic factors include age, gender, previous trauma history, personal or family psychiatric history, educational level, genotype, and the like (see Korte et al., Chapter 4, on epidemiology, and Averill et al., Chapter 30, this volume, on resilience).

It is not clear why some pretraumatic risk factors are associated with PTSD prevalence. It is easy to understand how something like childhood adversity might increase risk of adult disorder. But, for example, female rather than male gender predicts greater likelihood of developing PTSD following exposure to trauma (e.g., Goldstein et al., 2016; see Korte et al., Chapter 4, this volume). It is possible that this is just due to women's greater likelihood of having experienced the events most likely to be associated with PTSD, such as child sexual abuse, rape, or intimate partner violence (Kessler et al., 2005). However, such apparent gender differences may actually represent more complex phenomena, such as gender differences in how trauma is conceptualized, potential gender-related differences in the PTSD construct itself, the social context in which gender differences are expressed, or the way comorbid disorders contribute to this difference (see Kimerling et al., Chapter 13, this volume, on gender issues in PTSD). Finally, there is evidence that whereas female gender predicts greater risk of PTSD, it may also predict more favorable responsivity to treatment.

With the recent characterization of the human genome, it will not be long before pretraumatic factor research includes genotype assessment. Indeed, recent studies identified a number of candidate genes that are being investigated regarding vulnerability versus resilience to PTSD following exposure to traumatic events. Given that genotype, epigenetic methylation, and gene expression differences likely accompany the development of psychopathologies such as PTSD, research incorporating all three forms of genetic information from the same traumatized individuals is needed (see Bustamante et al., Chapter 11, this volume, on the genetics of PTSD).

Peritraumatic risk factors concern the nature of the traumatic experience itself, as well as one's reaction to it. The dose–response relationship between trauma exposure and PTSD onset, mentioned previously, applies here, so that the severity of traumatic exposure predicts the likelihood of PTSD symptoms. Other peritraumatic risk factors include exposure to atrocities, peritraumatic dissociation, panic attacks, and other emotions (see Korte et al., Chapter 4, this volume).

Social support is a very important protective factor that can protect trauma-exposed individuals from developing PTSD (see Korte et al., Chapter 4, this volume, on epidemiology, and Averill et al., Chapter 30, this volume, on resilience, this volume.) Indeed, social support appears to be such a powerful factor that it has been shown to offset genetic vulnerability among depressed children to adverse life events (Kaufman et al., 2004).

Schnurr, Lunney, and Sengupta (2004) have distinguished between risk factors for the onset of PTSD and those factors that predict maintenance of PTSD. In their study of Vietnam veterans, risk factors for persistence of PTSD emphasized current rather than past factors and included current emotional sustenance, ongoing social support, and recent adverse life events. The clinical significance of these findings is noteworthy. Assessment of risk factors, especially the strength and availability of social support, should be a routine part of any PTSD diagnostic interview. Furthermore, mobilization of social support, whenever possible, should be part of any treatment plan. This applies whether the client has either chronic PTSD or an acute posttraumatic reaction, and whether the clinician is providing treatment within a traditional clinical setting or an early intervention following a mass casualty within a public mental health context (see Morganstein et al., Chapter 31, this volume, on prevention and public health).

Psychological Theory and Practice

PTSD invites explication in terms of classic experimental psychological theory to a far greater degree than any other psychiatric syndrome. It is one of the more interesting and unique disorders as well, inasmuch as researchers, theorists, and clinicians have the rare opportunity to be present at the genesis of a disorder that began at a precise moment in time. Hence, there is a rich conceptual context within which to understand the disorder (see Bryant, Chapter 6, this volume, on psychological models of PTSD). Both conditioning and cognitive models have been proposed. Pavlovian fear conditioning, either as a unitary model (Kolb, 1989) or within the context of Mowrer's two-factor theory (which combined the learning principles of classical and operant conditioning), has influenced research and treatment (Keane & Barlow, 2002; Keane, Zimering, & Caddell, 1985). Such models inspired considerable animal, psychophysiological, and brain-imaging research, in addition to psychological investigations with clinical cohorts. Emotional processing theory (Foa & Kozak, 1986) has also been very influential. This theory proposes that pathological fear structures (i.e., stimulus, response, and meaning propositions; Lang, 1977), activated by trauma exposure, produce cognitive, behavioral, and physiological anxiety. Finally, cognitive models derived from classical cognitive theory (Beck, Rush, Shaw, & Emery, 1979) postulate that it is the interpretation of the traumatic event, rather than the event itself, that precipitates clinical symptoms.

Several cognitive-behavioral therapies (CBTs) are derived from the aforementioned theories and are tested with patients with PTSD. What all CBT approaches have in common is that they elegantly translate theory into practice. The most successful treatments for PTSD are CBT approaches, most notably prolonged exposure, cognitive therapy, cognitive processing therapy, written exposure therapy, and narrative exposure therapy. Several chapters in this volume review the empirical evidence supporting CBT approaches for adults (Galovski et al., Chapter 19), children and adolescents (Cohen & Mannarino, Chapter 20), couples and families (Monson et al., Chapter 21), and in group formats (Beck & Sloan, Chapter 22). Indeed, all clinical practice guidelines for PTSD identify trauma-focused CBT as the treatment of choice (Hamblen et al., 2019).

CBT is also effective in treating acutely traumatized patients with ASD within weeks of exposure to a traumatic event (see Azad et al., Chapter 18, this volume). This approach utilizes briefer versions of the prolonged exposure and cognitive restructuring protocols that have been so effective in treating chronic PTSD. Also, CBT protocols were modified so that they can be delivered through the Internet (see Ruzek, Chapter 28, this volume), or remotely via telehealth or mobile phone applications (see Morland et al., Chapter 29, this volume).

In addition to CBT, eye movement desensitization and reprocessing (EMDR) has emerged as a first-line therapy for PTSD and is recommended as a front-line treatment in several PTSD practice guidelines (Hamblen et al., 2019). Although there are strong disagreements about the mechanism of action for this approach, especially with regard to the importance of eye movements, the evidence regarding EMDR's efficacy is strong enough for it to be classified as a first-line treatment for PTSD in recent clinical practice guidelines (see Galovski et al., Chapter 19, this volume, on psychosocial treatments).

Although such progress is gratifying, it is the case that there is still much work ahead. Almost all randomized clinical trials for PTSD tested only components of CBT or single medications. Such studies suggest that approximately half of all CBT patients achieve full remission of symptoms, leaving another half that experience partial or less improvement after a course of CBT. Clearly, there is room for more research on new treatments and for a better understanding of how to combine medications and/or psychosocial treatments in real-world settings. Also, questions about optimal strategies for specific phasing of treatments may benefit those who typically drop out of therapy early or do not benefit from a standard course of treatment. Indeed, future research will need to investigate systematically which treatment (or combination of treatments) is most effective for which patients with PTSD under what conditions. Finally, it is imperative that we utilize the most advanced technologies for dissemination of evidence-based practices for the treatment of PTSD in clinical settings (see Stirman, Chapter 32, this volume, on implementation of the best clinical practices).

Recent progress has also been made in developing clinical approaches for PTSD among children and adolescents (see Brown et al., Chapter 14, this volume), thanks in part to establishment of the National Child Traumatic Stress Network in the United States. Yet progress with regard to older adults has lagged behind (see Cook & Simiola, Chapter 15, this volume). In short, there is a real need for better understanding of the consequences of traumatic exposure and for developmentally sensitive treatment approaches for people at either end of the developmental lifespan.

Biological Theory and Practice

Thanks to advances in technology and computational science, biological research has progressed beyond animal models and neurohormonal assays to brain imaging, genetic research, and analysis of brain tissue. It is notable that a book on the neurobiology of PTSD, published in 1995 (Friedman, Charney, & Deutch, 1995), had no chapters on brain imaging, genetics, or neuropathology, unlike this volume. The neurocircuitry that processes threatening stimuli centers on the amygdala, with major reciprocal connections to the hypothalamus, hippocampus, locus coeruleus, and raphe nuclei; and mesolimbic, mesocortical, and downstream autonomic systems. Major restraint on the amygdala is ordinarily exercised by the medial prefrontal cortex. In PTSD, amygdala activation is excessive, whereas prefrontal cortical restraint is diminished. Furthermore, great advances have been made in our understanding of neurocircuitry, neuroplasticity, and neuropathology that mediate both posttraumatic psychopathology and recovery from PTSD (see Averill et al., Chapter 9, this volume, on neurocircuitry and neuroplasticity, and Girgenti et al., Chapter 12, on neuropathology and research with postmortem brain tissue).

Many different neurohormones, neurotransmitters, and neuropeptides may also play important roles in this stress-induced fear circuit (see Rasmusson et al., Chapter 10, this volume, on neurobiological alterations associated with PTSD), as do different genes that are expressed or suppressed in PTSD (see Bustamante et al., Chapter 11, this volume, on the genetics of PTSD). Thus, there are many potential opportunities to translate such basic knowledge into pharmacological practice and precision medicine.

At present, only two medications, both selective serotonin reuptake inhibitors (SSRIs), have been approved by the U.S. Food and Drug Administration (FDA) as treatments for PTSD. There is growing research with other medications affecting different mechanisms, but many more randomized clinical trials are needed. Given our growing knowledge in this area and the fact that only 30% of patients receiving SSRIs achieve full remission, there is reason to expect that newer agents will prove more effective in the future (see Davis et al., Chapter 23, this volume).

Another significant translation of science into practice concerns the association between PTSD and physical illness (see Schnurr et al., Chapter 25, this volume). Given the dysregulation of major neurohormonal and immunological systems in individuals with PTSD, it is perhaps not surprising that patients with PTSD are at greater risk for medical illness (Schnurr & Green, 2004) and for increased mortality due to cancer and cardiovascular illness (Boscarino, 2006). Again, as a mark of recent progress, in 1995 such relationships were merely hypothesized (Friedman & Schnurr, 1995). Now there is a compelling and rapidly growing database to verify these hypotheses.

Resilience, Prevention, and Public Health

Two epidemiological findings have profoundly affected our understanding about the risk of exposure to trauma and about the consequences of such exposure. First, as noted earlier (see the section “Epidemiology”), exposure to catastrophic stress is not unusual over a lifetime. Second, most exposed individuals are resilient; they do not develop PTSD or some other disorder in the aftermath of traumatic events. Recent world events have thrust such scientific findings into the context of public policy and public health, including terrorist attacks in New York City, Madrid, Moscow, London, Boston, and elsewhere: the South Asia tsunami of 2005; Hurricane Katrina; the wars in the Middle East and Africa; and many other human-made and natural disasters. The scientific question is, Why are some individuals resilient, while others develop PTSD following such catastrophic stressful experiences? The clinical question is, What can be done to fortify resilience among individuals who might otherwise be vulnerable to PTSD following traumatic exposure? And the public mental health question is, Following mass casualties or large-scale disasters, what can be done to prevent psychiatric morbidity in vulnerable populations?

From a historical perspective, these three questions are remarkable. Only because of recent scientific progress can such questions even be conceptualized. The new interest in resilience is emblematic of both maturity in the field and technological advances. Resilience is a multidimensional construct that includes genetic, neurohormonal, cognitive, personality, and social factors (see Averill et al., Chapter 30, this volume, on resilience). From the clinical and public health perspective, the major question is, Can we teach vulnerable individuals to become more resilient? Our emergent understanding of the multidimensional mechanisms underlying resilience has given the term *stress inoculation* a new meaning in the 21st century. This in turn has raised public policy and public mental health questions about the feasibility of preventing posttraumatic distress and PTSD in the population at large (see Morganstein et al., Chapter 31, this volume, on public health and prevention).

In the United States, the terrorist attacks on September 11, 2001, instigated a national initiative to understand the longitudinal course of psychological distress and psychiatric symptoms following exposure to mass casualties. In this regard, civilian disaster mental health found much in common with military mental health. In both domains, it is recognized that most posttraumatic distress is a normal, transient reaction from which complete recovery can be expected. A significant minority of both civilian and military traumatized individuals, however, do not recover but go on to develop clinical problems that demand professional attention. Thus, several trajectories follow traumatic stress: normal transient distress, early-onset PTSD followed by recovery, or chronic clinical morbidity. On the one hand, the second and third trajectories require treatment by traditional mental health professionals; indeed, evidence-based early interventions have also been developed for acutely traumatized individuals (see Azad, Chapter 18, this volume). On the other hand, the first trajectory, affecting most of the population, demands a public mental health approach that fortifies resilience (see Averill et al., Chapter 30, and Morganstein et al., Chapter 31, this volume, on resilience and prevention, respectively).

The conceptual and clinical advances that have been made in this area during the last decade are very exciting. Future research should produce a wide spectrum of scientific advances that will enhance our understanding of resilience (at genetic, molecular, social, etc., levels), thereby providing needed tools to foster prevention and facilitate recovery at both individual and societal levels.

CRITICISMS OF THE PTSD CONSTRUCT

Criticisms of PTSD as a diagnosis have not abated with the passage of time. Some have probably been exacerbated by concerns about the escalating number of PTSD disability claims recently filed by veterans and civilians (see Friedman et al., Chapter 2, on DSM-5, and Kilpatrick et al., Chapter 27, on forensic issues, this volume). The cross-cultural argument currently rages within the context of natural disasters (e.g., the 2005 South Asian tsunami) or large-scale terrorist attacks (e.g., the bloodshed in Mumbai in 2011) or the endless wars and forced migrations (especially in Africa and the Middle East; see Silove & Klein, Chapter 26, this volume, on culture and trauma). Currently, these arguments also appear within the popular culture, due to mass media's increased attention to ongoing terrorist attacks, natural disasters, wars, and industrial accidents around the world. As a result, scientific debates about PTSD, previously restricted to professionals, have found their way into daily newspapers, popular magazines, radio talk shows, and televised documentaries. Critics of the diagnosis claim that (1) people have always had strong emotional reactions to stressful events, and there is no need to pathologize them; (2) PTSD serves a litigious rather than a clinical purpose; (3) the diagnosis is a European American culture-bound syndrome that has no applicability to posttraumatic reactions within traditional cultures; (4) verbal reports of both traumatic exposure and PTSD symptoms are unreliable; and (5) traumatic memories are not valid. We believe that these criticisms demand a thoughtful and balanced response because they reflect concerns about PTSD that are shared by the professional community and the public alike.

PTSD Needlessly Pathologizes Normal Reactions to Abusive Violence

This criticism asserts that normal reactions to the abnormal conditions of political repression and torture (or interpersonal violence; e.g., domestic violence) should be understood as appropriate coping responses to extremely stressful events. The argument further states that a psychiatric label such as PTSD removes such reactions from their appropriate sociopolitical-historical context and thrusts them into the inappropriate domain of individual psychopathology. We reject this argument because it fails to acknowledge that some people cope successfully with such events and manifest normal distress, whereas others exhibit clinically significant symptoms and subsequently experience disability. This is another area in which both public health and individual psychopathology models are applicable to different segments of a population exposed to the same traumatic stressor (see Averill et al., Chapter 30, and Morganstein et al., Chapter 31, this volume, on resilience and prevention, and public health, respectively).

As we have learned during the post-9/11 era of posttraumatic public mental health, most people exposed to severe stress have sufficient resilience to achieve full recovery. A significant minority, however, develop acute and/or chronic psychiatric disorders, among which PTSD is most prominent. People who meet PTSD diagnostic criteria differ from nonaffected individuals with regard to symptom severity, chronicity, functional impairment, suicidal behavior, and (both psychiatric and medical) comorbidity. The purpose of any medical diagnosis is to inform treatment decisions, not to "pathologize." Therefore, we reiterate that it is beneficial to detect PTSD among people exposed to traumatic stress to provide an effective treatment that may both ameliorate their suffering and mitigate or prevent future adverse consequences.

PTSD Is a Culture-Bound European American Syndrome

The PTSD construct has been criticized from a cross-cultural perspective as an idiosyncratic European American construct that fails to characterize the psychological impact of traumatic exposure in traditional societies. We acknowledge that certain culture-specific idioms of distress around the world may do a better job describing the expression of posttraumatic distress in one ethnocultural context or another. On the other hand, PTSD has been documented throughout the world, and the cross-cultural validity of PTSD has been demonstrated conclusively (Bromet et al., 2018; Hinton & Lewis-Fernández, 2011; see Silov & Klein, Chapter 26, this volume, on culture and PTSD). An important report, with a unique bearing on this issue, compared people from widely different cultures who were exposed to a similar traumatic event. North and colleagues (2005) compared Kenyan survivors of the bombing of the American embassy in Nairobi with American survivors of the bombing of the Federal Building in Oklahoma City. Both events were remarkably similar with respect to death, injury, destruction, and other consequences. Similar, too, was PTSD prevalence among Africans and Americans exposed to these different traumatic events. Furthermore, a recent randomized clinical trial in the Democratic Republic of the Congo demonstrated the cross-cultural utility of the PTSD diagnosis, as well as the generalizability of evidence-based PTSD treatment in a non-Western arena. Female Congolese survivors of sexual violence who received group sessions of cognitive processing therapy exhibited marked reduction of PTSD symptoms and significant improvement in functional status compared to a comparison group that received supportive therapy. This improvement was sustained at the 6-month follow-up assessment (Bass et al., 2013). Finally, the World Mental Health Survey demonstrates that PTSD occurs across the globe in low- as well as high-income countries. Its symptom characteristics, risk factors, clinical course, associated disorders, and disease burden appear to be consistent (although prevalence may vary) from one country to the next (Bromet et al., 2018).

PTSD Primarily Serves a Litigious Rather Than a Clinical Purpose

PTSD has played such a prominent role in disability and legal claims in part because it has been assumed that the traumatic event is causally related to PTSD symptom expression and, hence, functional impairment (see Kilpatrick et al., Chapter 27, this volume, on forensic issues). Although traumatic exposure is a necessary condition for the development of PTSD, it is not a sufficient condition. For example, the event most likely to result in PTSD is rape, yet only a minority of rape victims are diagnosable with PTSD after a few months. Other risk factors play a role in symptom onset and duration, as described earlier in the section on risk factors (see Korte et al., Chapter 4, this volume, on epidemiology). Despite the etiological complexity of PTSD onset, the stressor criterion is fundamental in personal injury litigation, and in compensation and pension disability claims. This is because traumatic exposure establishes liability or responsibility for psychiatric sequelae in a context that puts PTSD in a category by itself with respect to other psychiatric diagnoses.

As noted by Kilpatrick and colleagues (Chapter 27, this volume, on forensic issues), the geometric increase in PTSD claims in civil litigation is due to society's growing recognition that traumatic exposure can have significant and long-lasting consequences. Another important factor driving much of this criticism is the sheer magnitude of money awarded for successful personal injury suits or compensation and pension disability claims.

There is also concern that the stressor (A) criterion has opened the door to frivolous litigation in which PTSD-related damages or disabilities are dubious at best. Although DSM-5 has tightened the definition of a "traumatic event" (see Friedman et al., Chapter 2, this volume), it cannot change the behavior of lawyers seeking to win monetary or other benefits for their clients.

There is a significant difference, however, between challenging the utility of PTSD as a clinical diagnosis and questioning how the diagnosis is applied or misapplied in litigation by attorneys or in disability evaluations by mental health professionals. We believe that minimal standards for such evaluations (e.g., utilizing evidence-based assessment instruments; see Livingston et al., Chapter 16, and Briggs et al., Chapter 17, this volume, on diagnostic assessment in adults and children, respectively) must be developed and enforced. This would ensure that people who have a legitimate claim for a favorable judgment or compensation because of their PTSD are not penalized because of misuse or abuse of this diagnosis in civil litigation or in the disability claims process.

Traumatic Memories Are Not Valid

An important scientific question concerns the validity of traumatic memories. A review of the literature on PTSD-related alterations in cognition and memory (see Brewin

& Vasterling, Chapter 7, and DePrince et al., Chapter 8, this volume, on cognition and memory; and dissociation, respectively) indicates that trauma-related alterations in physiological arousal and information processing may affect how such input is encoded as a memory. Furthermore, the retrieval of such information may be affected by both current emotional state and the presence of PTSD. Such appropriate concerns notwithstanding, when external verification has been possible, it appears that most traumatic memories are appropriate representations of the stressful event in question. A particularly newsworthy manifestation of questions about the accuracy of trauma-related memories was sensationalized in the popular media during the 1990s as "the false-memory syndrome." The issue concerned formerly inaccessible memories of childhood sexual abuse that were later "recovered." Some individuals who recovered such memories went on to sue the alleged perpetrators, thereby transforming a complex, controversial, and relatively obscure scientific and clinical question into a very public debate argued in the courtroom and mass media. It is now well documented that accurate traumatic memories may be lost and later recovered, although it is also clear that some recovered memories are not accurate. The veracity of any specific, recovered memory must be judged on a case-by-case basis (Roth & Friedman, 1998; see Brewin & Vasterling, Chapter 7, this volume, on memory).

Verbal Reports Are Unreliable

A major theme throughout modern psychiatry has been the search for pathophysiological indicators or biomarkers that do not rely on verbal reporting. This is a challenge to assessment of not only PTSD but also all DSM-5 diagnoses. We recognize the importance of this concern but see no reason why it should be cited as a specific problem for PTSD, and not for any other psychiatric diagnosis.

Several laboratory findings hold promise as potential non-self-report assessment protocols for refining diagnostic precision (see Averill et al., Chapter 9; Rasmusson et al., Chapter 10; and Girgenti et al., Chapter 12, this volume, on neurocircuitry and neuroplasticity, neurobiology, and neuropathology, respectively). These findings include psychophysiological assessment with standardized cue presentation or script-driven imagery, the startle response, utilization of pharmacological probes (such as yohimbine or dexamethasone), brain imaging, neurohormonal biomarkers, or alterations in gene expression. At the moment, however, none has sufficient sensitivity or specificity for routine utilization in clinical practice.

In the meantime, we should not overlook the remarkable progress we have made in diagnostic assessment through development of structured clinical interviews and self-report instruments with excellent psychometric properties. In addition to improving diagnostic precision, such instruments have been utilized as dimensional measures to quantify symptom severity and to monitor the effectiveness of therapeutic interventions (see Livingston et al., Chapter 16, and Briggs et al., Chapter 17, this volume, on assessment in adults and children, respectively).

A remarkable study by Dohrenwend and colleagues (2006) demonstrated the high reliability of retrospective self-report data among a representative sample of 260 Vietnam War veterans who participated in the National Vietnam Veterans Readjustment Study (NVVRS). The investigators compared verbal reports of combat exposure recorded by NVVRS investigators with a military-historical measure comprising military personnel files, military archival sources, and historical accounts. Results showed a strong positive relationship between the documented military-historical measure of exposure and the dichotomous verbal report-based assessment of high versus low to moderate war-zone stress previously constructed by NVVRS investigators. In short, this meticulous study indicates that verbal reports are usually quite reliable.

SUMMARY

PTSD has been at the center of multiple controversies. Close examination of these contentious issues indicates that the arguments are generally not about PTSD per se, but about the appropriateness of invoking PTSD within a controversial or adversarial context. Because the issue of causality or etiology is so clearly specified in PTSD, as in few other diagnoses, it will likely continue to be applied or misapplied in clinical, forensic, and disability situations. An important goal is to respect the scientific evidence to ensure appropriate applications in the future. It is also useful to recognize that, as in the recovered memory controversy, such contentious issues spawned important basic and clinical research that has improved mental health assessment and treatment.

Our purpose in this volume is to document how far we have come since DSM-III in 1980, so that we can generate forward momentum in the right directions. Improving our understanding of PTSD so that we can translate the science into better clinical practice is the overarching goal. This book is dedicated to advancing that understanding in order to prevent PTSD in the first place and to optimize assessment and treatment for people who suffer from the disorder and related problems.

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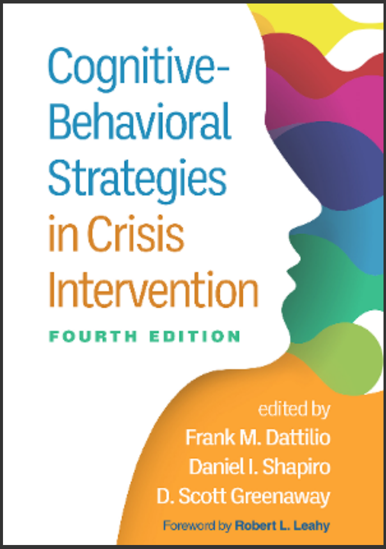
CHAPTER

3

Crisis Intervention

An Overview



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CHAPTER 1

Crisis Intervention
An Overview

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Crisis has been no stranger to civilization since the time humans first roamed the earth. Some of the most intense crises have involved situations from natural disasters, pandemics, and wars, to illicit drug and alcohol abuse, physical and mental illness, suicides, and homicides. While the magnitude and frequency of crisis situations may vary, their occurrence in general remains consistent. If anything has changed over time, it is the perception of crises and with how they are dealt. Because of the soaring number of crisis situations, our world is in need of more effective interventions than ever before.

The term *crisis* generally evokes an image of any one of a number of extreme negative life events. Catastrophic disasters, terrorist attacks, overwhelming lack or manipulation of resources, rapes and other sexual violence, illness, and devastating loss, all by their very nature involve situations of life-threatening proportions. The images and stories of the victims of these terrible crises strike to the core of all of us. Nowhere does this ring truer than when watching the global events involving storms, fires, war-torn nations, abuses of human rights, and recent to the publication of this volume, the effects of a global pandemic, which knocked our world on its side with a worldwide death toll exceeding 15 million and counting (Associated Press, 2022). However, a crisis may also relate to circumstances or experiences that threaten one's home, family, property, health, or sense of well-being. A psychological crisis may involve a loss or threat of a loss or a radical change in one's relationship with oneself or with some significant other (Goldenberg, 1983). For a child, it may involve a sudden relocation of their home to another state and saying goodbye to friends. For an adolescent, it may be the breakup of a romantic relationship or being ostracized by one's peers, cyberbullying, or even an unrelenting condition of acne. What generates, or fuels, a crisis is not simply defined by a particular situation or set of circumstances but rather by the individual's perception of the event and their ability (or inability) to effectively cope with that circumstance. In the same situation, different individuals deal with the potential crisis with varying degrees of competence or success. Simply stated, crisis results when stress and tension in an individual or family's life mount to unusual proportions and take a significantly negative toll on them (Greenstone & Leviton, 1993). Losing one's footing while trying to cope with a major setback leads to a crisis situation. What's more, crises can strike anyone without warning, which makes them all the more emotional.

History of Crisis Intervention

Historically, the concept of crisis intervention for individuals dates to the Lemberger Freiwillige Rettungsgesellschaft (Lemberg Rescue Society) organized in Vienna in the latter part of the 19th century (1883–1906). In 1906, the Anti-Suicide Department of the Salvation Army was organized in London, and the National Save-a-Life League was set up in New York City (Farberow & Schneidman, 1961). Crisis counseling was developed during World War II, when psychologists and psychiatrists, who were working near the battlefield, saw cases of extreme "battle fatigue" (*shell shock* in World War I; *posttraumatic stress disorder* [PTSD] in subsequent wars and conflicts). They found that dealing with the crisis close to the front line rather than being sent back to a rear-area hospital was helpful for some of the war personnel. The intervention that was used at that time took a focused approach. The goal was to return the soldier who suffered stress to active duty as quickly as possible. In fact, this is where group treatment became popular. Because there was such a large number of distressed soldiers, they had to be treated in groups (Dattilio, 1984).

With the opening of the Suicide Prevention Center in Los Angeles in the early 1950s, an intrinsic model for modern-day crisis centers was established and, soon after, similar suicide prevention centers and general crisis intervention hotlines began to emerge around the United States. In large part, these avenues spawned in answer to the general demand of social concern and awareness of the late 1950s and 1960s. This movement became particularly pronounced with the enactment of then-President John F. Kennedy's Community Mental Health Centers Act of 1963, in which crisis units played a major role (Dattilio, 1984). With the innovation of the suicide prevention hotline, crisis intervention hotlines began to diversify and specify their focus. This came about because suicide intervention centers were asked to help people deal with all types of crisis. Out of this need developed hotlines for teens, drug abusers, sexual assault victims, and older adults. The telephone began to be used as a means of maintaining contact and following up with patients discharged from psychiatric facilities. Poison control hotlines were developed, as well as for community rumor control, and general community services. These resources appeared to help callers with problems, such as garbage removal or pest control, low-income housing, voter registration, pollution, and many other types of issues.

Mirroring or serving as a model for similar growth around the world, currently in the United States there are more than 1,400 grassroots crisis centers and crisis units affiliated with the American Association of Suicidology or local community mental health centers. There are also more than 11,000 victim assistance, rape crisis, and child sexual abuse intervention programs, as well as more than 1,000 domestic abuse shelters and hotlines (Yeager & Roberts, 2015). In modern times, Roberts and Camasso (1994) estimated that each year as many as 4.3 million documented calls come into crisis hotlines. Roberts (2005) further projected that if we were to take this figure and broaden it to include all natural and local 24-hour crisis lines, including those for crime victims, survivors of terrorist attacks, victims of domestic violence, sexual assault victims, troubled employees, adolescent runaways, and child abuse victims, as well as the crisis intervention units at mental health centers, the total estimate would be approximately 35–45 million crisis callers per year (p. 11). This does not include the thousands of crisis services available through community hospital emergency rooms or psychiatric emergency service centers.

In 2005, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) and Vibrant Emotional Health (formerly the Mental Health Association of New York City) teamed up to launch the 988 Suicide and Crisis Lifeline (formerly the National Suicide Prevention Lifeline) with over 200 accredited crisis centers responding to callers dialing 988, and since July 2022, all landlines and cell phones in the United States have been able to access this service. Other countries (e.g., England, Australia, and Canada) have followed suit. In its first 5 months, the 988 Lifeline received over 1.7 million calls, texts, and chats, and since its inception, over 2.1 million individuals have used the 988 Lifeline, with the number of users increasing steadily each year. Specific data on usage and outcomes are limited but can be accessed through the 988 Lifeline website (*988lifeline.org*).

These numbers have increased since the first global health crisis of the 21st century and the first pandemic in generations to affect all countries in the world with the onset of COVID-19 in 2020. Like other recent epidemics (e.g., SARS, AIDS), this major physical health threat also fueled a widespread mental and behavioral health crisis, but this time causing a significant impact on the well-being of people, systems, and resources in every nation. Droves of frontline health workers became so physically and emotionally overwhelmed that they flooded crisis centers and mental health professionals (Nelson & Kaminsky, 2020). Supply chains were disrupted, and public health practices led to loss of livelihoods throughout the world, disproportionately affecting the already disadvantaged. As a result, on October 5, 2020, President Donald Trump signed Executive Order 13594, saving lives through increased support for mental and behavioral health needs. This support was designed to prevent the tragedy of suicide, to help end the opioid crisis in the United States, and to improve mental and behavioral health systems in general (Substance Abuse and Mental Health Service Administration, 2020).

Crisis Theory

Crisis intervention, based on crisis theory, is one of the most widely used types of brief treatment employed by mental health professionals working in community settings (Ell, 1996). Burgess and Roberts (2005) and Burgess and Holstrom (1974) posit that crisis results when homeostasis is disrupted—that is, when the individual's balance, however precarious or firm it might be, is thrown off, and the individual is no longer able to cope with the situation effectively. The result would be that the individual would then manifest a number of symptoms that become the clinical markers for the crisis response, often warranting crisis intervention. In general, crisis intervention is aimed at a psychological resolution of an immediate crisis in an individual's life and restoring them to at least the precrisis level of functioning (Aguilera, 1990). Rosenbaum and Calhoun (1977) regard a crisis as involving some precipitating event that is time limited and that disrupts the individual's usual coping and problem-solving capabilities. Slaiku (1990) offers a definition that synthesizes the definitions of crisis as "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome" (p. 15). This definition focuses on several specific areas. The first part of the definition addresses the "temporary" nature of crisis situations. For most individuals, crises are immediate, transient, and temporary. For other individuals, however, the temporary nature of crisis may lead to years of upset. Their life crises may become part of a posttraumatic stress that is long-term and chronic. Other individuals have a predisposition to view certain stimuli as dangerous and thereby damaging. They may see many circumstances as crisis laden. For these individuals, there is no one crisis but a series of "brush fires" that continue to strain their coping ability throughout life.

The second part of the definition addresses the individual's response of feeling upset. The term *upset* can be broadened to include the most common responses to crisis: those of anxiety and depression. In more severe reactions, the individual may also be disorganized. This disorganization may involve confusion and decreased problem-solving ability. In its severest form, it might include brief reactive psychoses or delirium. The disorganization may be cognitive (e.g., mental confusion), behavioral (e.g., acting in random or uncharacteristic ways), or emotional (e.g., being emotionally labile). The individual's inability to cope, the focus of the next part of the definition, revolves more specifically around the issue of problem-solving ability. If an individual's balance is disrupted and some form of anxiety results, the individual's cognitive flexibility decreases, problem-solving ability suffers, and avoidance or denial may be used as a coping strategy. By using the common or traditional techniques for personal coping, many individuals find themselves overwhelmed. Their customary methods of problem solving are not adequate to the present task requirements (Roberts, 2000).

The final part of the definition involves the potential for rather weighty consequences. Loss of health, property, or loved ones and death are well within the definition of weighty consequences that could lead to radically positive or negative outcomes. Negative outcomes would include loss of self-esteem, loss of esteem of others, or, in cultural contexts, loss of "face." Slaiku (1990) suggests the possibility that the crisis situation could also lead to powerful positive outcomes, including the opportunity for new experiences, starting over, or gaining new skills, behaviors, and even insights, including the appreciation of our human vulnerability to life's perils.

While the concept of crisis may be viewed in various ways, Yeager and Roberts (2015, p. 13) nicely emphasize it as a turning point in a person's life.

A classic example is evident in some recent crises in the years prior to publication of this volume: civil war in Syria, school and mass shootings in the United States, the invasion of Ukraine by the Russian Federation, and the AIDS epidemic, as well as the COVID-19 global pandemic. In the United States, the events of 9/11 and Hurricane Katrina also serve as exemplars. All of these events produced weighty consequences, including loss of life, health, and property, not to mention an increased vulnerability to life's perils. In fact, the events of 9/11 alone represented the largest loss of life of U.S. citizens in 1 day in its nation's history (Roberts, 2005). Untold lives have been lost in Syria and Ukraine, and by the worldwide pandemic that began in 2020.

Those responding to crisis learned a powerful lesson from all of these events, particularly those involved in large-scale crises: that one must be prepared for life-threatening events at any time, and that, as human beings, we are, by nature, always vulnerable to unanticipated crisis.

Usually, when individuals are in a crisis situation and their present resources are not adequate to the task, they call on little-used reserves of personal fortitude and spirit to carry them through. They may also call on infrequently practiced skills to help them prevail. Or, if they have the added advantage of a family or social/community network on which they might rely for assistance, support, or encouragement, they use that network as an expanded resource. In addition, they may search for or create temporary systems of support to assist them through the crisis period. With an extensive repertoire of coping strategies and the techniques to implement the strategies, a supportive family system, an active cultural or religious community, good friends, or a therapist on whom to call, potential life crises can be more easily weathered.

Why a particular situation or event is moved to a level of a crisis at one time and not another is a central issue underlying the treatment of the individual who ends up in crisis. The strategies and techniques for intervening in crisis situations are the focus of this volume. Our goal in this chapter is to provide a theoretical and conceptual basis, as well as a rationale for a cognitive-behavioral format for the delivery of crisis intervention services.

Erikson's (1950) psychosocial theory of development was formulated as a "crisis theory" based on the concept that crises are not necessarily negative life occurrences that injure or destroy the individual but rather serve as points of growth. This growth can add to individuals' strength, provide them with a coping repertoire, and help them to succeed in every area of life. Erikson further believed that the lack of resolution of these crises could lead to a poor coping style. This theory would obviously be opposed by some victims of crisis in the short term. Most individuals who are the victims of disaster or violent attacks fail to see Erikson's crisis concept. It is a concept that is likely to be accepted only years after the crisis event has occurred.

Erikson's (1950) model states that throughout their lifetime, an individual encounters a number of predictable life crises (Erikson identified eight). By the nature and degree of resolution or nonresolution of these crises, the individual grows and develops in a particular direction. This growth and development lead to the conceptualization of an idiosyncratic life view and its attendant behaviors, cognitions, and emotions. Individually, and in combination, the eight crises subsume virtually every possible life schema. Overall, the resolution or nonresolution of the life crises determines the development of the individual's personal, family, cultural, gender, and age-related schema (Freeman, 1993). This schema then becomes a template for that individual's behavior. Erikson viewed the initial resolution of these crises as amenable to change throughout life, inasmuch as all eight crises are concurrent rather than sequential (aging, death, illness, etc.). A particular crisis may be more prevalent at a particular point in life (i.e., crises do not start and end during a particular developmental period). This fact then presents a much more optimistic view for ongoing crisis resolution. If an individual has not managed to successfully cope with a particular crisis or resolve it in a positive manner, they have other opportunities to resolve it throughout life.

To put this model in terms of cognitive-behavioral therapy (CBT), by understanding the particular types of behaviors that emerge from the resolution or nonresolution of these life crises, the therapist can understand the individual's coping style and strategies. Understanding of the individual's schemata sets the stage for tailoring interventions more effectively to help individuals and families resolve or cope with present life crises. The first major therapeutic task is discerning and manifesting a particular schema that then allows therapists to work with their patients to examine (1) the schema, (2) the advantages and disadvantages of maintaining it, and (3) methods for disputing and/or altering it. This schematic focus is central to the cognitive-behavioral approach to crisis intervention.

Schemata

Schemata are hypothesized structures that guide and organize the processing of information and the understanding of life experience. Beck (1967, 1976) has suggested that schemata are the cognitive substrate that generates the various cognitive distortions often observed in patients. These schemata serve to increase or decrease the individual's vulnerability to various situations. These schemata or basic rules of life begin to form as a force in cognition and behavior from the earliest points in life and are well ingrained by the middle childhood years. They involve the accumulation of the individual's learning and experience within the family group; religious group; ethnic, gender, or regional subgroup; and broader society. The particular extent or effect that a given schema has on an individual's life depends on (1) how strongly that schema is held; (2) how essential the individual sees that schema to their safety, well-being, or existence; (3) the individual's previous learning vis-à-vis the importance and essential nature of a particular schema; (4) how early a particular schema was internalized; and (5) how powerfully, and by whom, the schema was reinforced.

Schemata can be active or dormant, with the more active schemata serving as the rules that govern day-to-day behavior. The dormant schemata are called into play to control behavior in times of stress. The schemata may be either compelling or noncompelling. The more compelling the schemata, the more likely it is that the individual or family will respond to the schemata. A good example of this is the work of social psychologist Paul Slovic, who has studied "psychic numbing" in people with regard to observing the plight of others with mass murder and/or genocide (Slovic et al., 2013). Much of this boils down to the schema that people maintain regarding moral judgment.

Schemata are in a constant state of change and evolution. Environmental data and experience are taken in by individuals only as they are able to fit them into their already-learned structures, which have been built by their own subjective experience. If new learning doesn't fit into the existing structure, an individual may be able to build a new structure in order to assimilate the new view or information. And, some individuals may be better at this than others. The self-schemata then become selective as the individual may ignore environmental stimuli that doesn't fit into their preconceived notions. There is an active and evolutionary process by which all perceptions and cognitive structures are applied to new functions (*assimilation*) while revised cognitive structures are developed to serve old functions in new situations (*accommodation*). Some individuals persist in utilizing old structures without assimilating them to the new circumstances in which they are involved—they use them in toto without measuring fit or appropriateness. They may further fail to accommodate or build new structures.

Schemata are cognitive structures that can be described in great detail. We can also deduce them from behavior or automatic thoughts. The behavioral component involves the manner in which the belief system governs the individual's responses to a particular stimulus or set of stimuli. In seeking to alter a particular schema that has endured for a long time, the professional must help the individual deal with the belief from as many different perspectives as possible. A pure cognitive strategy would leave the behavioral and affective untouched. The pure affective strategy is similarly limited, and, of course, the strict behavioral approach is limited by its disregard for cognitive-affective elements. In many cases, we find that an individual's particular schemata are consensually validated.

The cognitive-behavioral approach initially involves an intrapsychic focus on the individual's automatic thoughts and schemata. This part of the therapeutic work deals with the individual's belief systems; assumptions about self, world, experience, and the future; and general perceptions. A second focus of the therapy is interpersonal and deals with the individual's style of relating to others.

The third focus of the therapy is external, and it involves understanding how different ways of responding associate with changes in emotions and thoughts. With this assessment and, ideally awareness, then changing behaviors may affect a more productive coping style. This external focus involves learning new behaviors/responses, trying the new behaviors, evaluating the result of the new behaviors, and developing and using available resources. People typically do the best they can to cope but might use coping strategies that inadvertently maintain their distress or rely on strategies that do not actually lead to better outcomes for them.

The particular attributes of cognitive therapy make it ideal for crisis intervention work. The eight specific attributes involve the *activity* of the model. This part of the model invites the patient to become an active player in their therapy, helping to restore a sense of control over their life.

The *directiveness* of the model is important because it encourages the therapist to be an active guide, directing the therapy. The therapist's job is more than restatement and reformulation. The therapist shares hypotheses; utilizes guided discovery; encourages the patient; serves as a resource person; acts as a case manager, and in certain cases, advocates for the patient. The therapist helps the client become more aware of each element of the model, when possible, and points out when they think additional strategies seem warranted.

The *structure of the therapy* calls for the establishment of a discrete problem list that helps both patient and therapist clarify where the therapy is going and evaluate how the therapy is progressing. This structure is essential for the patient in crisis and commensurate with most models of crisis intervention (Greenstone & Leviton, 1993; Yeager & Roberts, 2015).

The content and the direction of the therapy are established early in the collaboration. Having established and agreed on a problem list and focus for therapy, the therapist and patient structure the individual sessions through agenda setting and homework.

Agenda setting provides for maximum success in the limited time available during a typical therapy session. Rather than having the therapy session wander and meander, the therapist can work with the patient to set an agenda for the session, which helps to focus the therapy work and makes better use of time, energy, and available skills. Agenda setting at the beginning of the session allows both patient and therapist to place issues of concern on the agenda for the day. Accomplishing the items on the agenda requires that the therapist be skilled at setting priorities and pacing the session, taking into account the needs of the patient. This is a skill refined through practice and experience. However, even seasoned therapists may feel tense and anxious and exhibit a loss of effectiveness when they are first learning how to pace a session that is built around a collaborative agenda. This is a natural part of adjusting to the patients' needs and establishing a footing in treatment.

The *short-term nature of the therapy* is a fourth element in crisis intervention. Research protocols for testing the efficacy of cognitive therapy generally involve 12–20 sessions over a period of no more than 20 weeks, whereas the treatment of a crisis situation may need to be more rapid but not necessarily limited to 20 weeks. For certain patients the length of therapy may be six sessions; for other patients, 50 sessions. The length of the therapy and the frequency and length of the sessions are all negotiable.

There is also some discussion in the professional literature about the pros and cons of early intervention techniques (Brom & Kleber, 1989; Foa et al., 1995; Schützwohl, 2000; Dattilio & Freeman, 2007). This aspect is something that therapists need to consider seriously in regard to the effectiveness of any intervention.

In addition to the aforementioned, the problems being addressed, the skills of the patient and the therapist, the time available for therapy, and financial resources all have the potential to dictate the parameters of treatment.

Another salient aspect, which has long been the backbone of CBT, is the development of *collaboration* (Beck et al., 1979). The therapist and patient must work together as a team. The collaboration is not always 50:50 but may, with the crisis patient, be 70:30 or 90:10, with the therapist providing most of the energy or work within the session or in the therapy more generally. The more stressed the patient is, the less energy they may have available to use during the course of therapy. The therapeutic focus would be to help such patients make maximum use of their energy and build greater energy resources and then to shift the ratio into a better proportion later in therapy to support maintenance and independence.

A sixth issue is that the cognitive therapy model is a *dynamic* model of therapy. The dynamic cognitive approach to therapy promotes rapid self-disclosure of individual cognitions in order to increase understanding through enhanced knowledge and an understanding of thoughts, beliefs, and attitudes. Early schemata develop and are modified within the family group, and cognitive therapy with families can provide a context for observing these schemata in operation (see Dattilio, 2010).

Also, cognitive therapy is a *psychoeducational* model of therapy. It is a skill-building or coping, model of therapy as opposed to a cure model. Patients in cognitive therapy ideally gain skills to cope more effectively with their own thoughts and behaviors that may be dysfunctional. Rather than cure, the cognitive therapist helps the patient to acquire a range of coping strategies for present and future exigencies of life.

Finally, the cognitive therapy model is a *social/interpersonal* model. We do not exist in social vacuums. The relationships of the individual to their significant others, friends, and work colleagues are all schematically based and are essential foci for the therapy. If the individual is isolated, there may be great gaps in their resource network.

Clearly, if one does not have external resources and few internal resources on which to rely, a crisis will result. In some cases, individuals have what objectively appears to be a wealth of support, but the support is not accepted by the individual or is perceived by the hopeless individual as not sufficient or available. In Edwin Arlington Robinson's (1897) poem "Richard Cory," Cory was seen to have everything. He was wealthy, handsome, well dressed, and sophisticated. Despite all these apparent resources, however, "one calm summer night, [Richard Cory] went home and put a bullet through his head" (as cited in Scheick, 2007).

Highlighting the importance of understanding the individual's schemata, available resources, and belief in those resources, we can look at the Social Readjustment Rating Scale (Holmes & Rahe, 1967). In this scale, the death of a spouse is rated number 1. It is seen as the most powerful stressor and the standard against which all other life stressors are measured. The death of a close family member is rated as 5 on the scale, and the death of a friend as 7. If the spouse was much loved, it is easily understandable as to why it is perceived as a situation of the highest stress. In the case of an embittered and estranged couple, the death of a spouse may be a solution to long-term stress, bringing with it relief and even financial security. Or, in the case of a loved spouse with a terminal illness and intractable pain, the eventual death of that spouse, family member, or friend may be prayed for out of love and caring. The eventual death may be a great relief because of the peace and surcease the death will bring to the terminally ill individual. In such cases, then, the rating level on the Social Readjustment Rating Scale would be lower.

Slaiku (1990) states, "Short-term, time-limited therapy is the treatment of choice in crisis situations" (p. 98). In this respect, the active, directive, goal-oriented, structured, collaborative, and problem-solving nature of cognitive therapy makes it the ideal crisis intervention treatment model. The immediate goals of cognitive-behavioral strategies in crisis intervention are threefold: (1) evaluating and assessing the immediacy of the crisis situation; (2) assessing the individual's coping repertoire to deal with the crisis; and (3) generating options of thought/perception, emotion, and behavior. Some individuals have a skill deficit in problem solving. This requires the direct teaching of better problem-solving skills. Other individuals have the problem-solving strategies and techniques available but see their ability as far less than it is. A more behavioral approach is necessary in the former situation, whereas a more cognitive approach is called for in the latter.

Using Slaiku's (1990) definition, described earlier, there are several possible points of intervention. The initial point of intervention is the recognition that the situation that brings on the upset and disorganization is *temporary*. This implies that by seeing the situation with a long-term focus it may be possible to "wait it out"—for example, patients with panic have difficulty seeing the long view because the immediacy of the physiological symptoms and the misinterpretation of danger draws their focus to the "here and now" (see Dattilio & Kendall, 2007). The idea of waiting out the bodily response and not responding by running is somehow viewed by the patient with panic as impossible. Working with the patient to develop the long-term view may help to decrease the crisis perception. The perception of immediate danger and the need to avoid it cause patients with panic to act in self-defeating ways in the ideal interest of saving their life.

A second point of intervention involves the *upset*. Clearly, if the situation were not as upsetting, there would be no crisis. The upset is caused by a perception that can be questioned or challenged—for example, a businessman reported being in crisis over the economic downturn and the possible loss of his business. He reported that every time he thought of losing his business he would then extend the thought to losing everything. He would picture losing his home, his car, his wife, his children, his self-respect, and the respect of others. He would, in his view, be living on a hot-air vent in the street, housed in a large cardboard carton. His upset came not simply from the reality of his business difficulties but rather from his catastrophic style of thinking.

The third point of intervention relates to the *disorganization*. If the individual's thoughts, actions, and emotions are confused and disorganized, the clear therapeutic strategy is to offer some structure and a format for problem solving. The therapist must recognize that confusion and disorganization are common themes for virtually all psychological problems. Patients' complaints that they "need to get their life/head/marriage together" are quite common. For patients seeing themselves in crisis, this collection of parts or pieces may be more emergent. The cognitive therapy model is especially helpful with the patient who is disorganized—for example, a woman who was sexually assaulted while on a date saw her only avenue of action being to flee her job and school program. She was overwhelmed by the thoughts, images, and feelings related to the rape. She was further confused by the contradictory advice and information offered by others, which was compounded by legal issues and threats. She described her reaction as running off in 10 directions simultaneously. No direction gave her answers or peace.

Each of us uses a fairly limited repertoire of techniques for coping with life. Our day-to-day life is rather familiar and comfortable. We can expect certain consequences when we act in particular ways. If, for example, an individual begins her morning commute at 6:30 A.M., she will likely experience little traffic. If, however, she leaves at 8:00 A.M., she may be in the middle of a traffic jam. She then knows that she has to leave earlier to avoid the "crisis" of the morning rush. If she lives in an area that experiences heavy winter snow, she considers driving in snow to be part of the risk or price to pay for living in that area. Ideally, she has coped by having snow tires, sand in the trunk, a shovel, cold-weather gear, a blanket, and flares. If there is snow in an area, and the people living there are not prepared for it, even a coating of snow becomes a crisis of major proportions.

A final point of intervention is to help the individual *reduce the potential for a radical outcome*. If the outcome were uncomfortable rather than catastrophic, the crisis potential would be significantly reduced.

Assessment

As in any other circumstance, assessment is crucial during crisis situations, particularly because the given situation may be critical at the time and require an almost immediate response. What makes assessment difficult is that it must be conducted almost three times as quickly as in the normal course of treatment and, in some cases, under difficult circumstances. When a crisis situation presents itself with little or no opportunity to implement formal assessment inventories or questionnaires, a paradigm is recommended for quick structured interviewing. Greenstone and Leviton (1993) recommend adhering to the following steps:

1. *Immediacy*. Intervention usually begins at the moment the intervener encounters the individual in crisis. The intervener must immediately attempt to size up the situation, alleviate anxiety, prevent further disorientation, and ensure that sufferers do not harm themselves or cause harm to others.

2. *Taking control*. Here it is important for the therapist to be clear about what and whom they are attempting to control. The purpose of assuming control is not to conquer or overwhelm the victim but to help reorder the chaos that exists in the sufferer's world at the moment of the crisis. The one conducting the crisis intervention provides the needed structure until the victim(s) is (are) able to regain control. Consequently, it is important to enter the crisis scene cautiously.

Approaching the crisis situation slowly and carefully can prevent unnecessary grief and give the professional time to mentally absorb what they are encountering. It is important for the professional intervening to make every attempt to remain stable, supportive, and able to establish a structured environment. This may involve using personal presence, including strength control, and making every effort to have a calming effect on the crisis situation and exercising some emotional control over the victim. Research usually indicates that victims respond to structure and those who represent it, if they sense genuineness and sincerity by the professional conducting the interview.

3. *Assessment.* Intervening usually involves making a quick, on-the-spot evaluation. This means attempting to understand how and why the individual got into a crisis situation at this particular time and which specific problem is of immediate concern. Assessment also involves the use of management and identifying any variables that would hinder the problem management process. This is particularly true of those individuals who have experienced multiple crisis situations or traumas. For this reason, a new diagnosis, "complex posttraumatic stress disorder," has been adopted in *International Classifications of Diseases, 11th Edition* (ICD-11; Maercker et al., 2022). Individuals with complex PTSD typically have sustained multiple exposures to traumas, such as childhood abuse and other traumatic incidences that may lead to their condition being more refractory and resistant to treatment interventions.

The bottom line consists of how the intervener can be most effective in the least amount of time. Consequently, lengthy histories are forfeited in favor of focusing on the assessment of the present crisis and the events that occurred within the immediate hours surrounding the crisis—more specifically, pinpointing the precipitating events.

A number of inventories have been designed for use in crisis situations, although, unfortunately, there is a surprising lack of standardized instruments with strong psychometric properties available to mental health practitioners engaged in crisis work.

One assessment measure that has been designed to provide a rapid assessment for measuring perceived psychological trauma and perceived problems in coping efficacy is the Crisis State Assessment Scale (Lewis, 2002). This scale is still in the process of validation but it offers constructs mentioned earlier and is used to predict or indicate the magnitude of a crisis state. This assessment measure may be helpful initially in order to aid in the direction of future treatment.

Another inventory is the modified version of the Structured Clinical Interview Schedule for DSM-5 (QuickSCID-5). This is an abridged version of the Structured Clinical Interview Schedule that allows the intervener to provide a more expedient method of assessment in crisis situations (First & Williams, 2021). In addition, there are other scales, such as the American Academy of Crisis Interveners Lethality Scale (Greenstone & Leviton, 1993, pp. 19–20). This scale allows an individual to quickly assess criteria in a crisis situation by summing up the scores and matching the total with the criteria.

4. *Decide how to handle the situation after the assessment.* This essentially involves using the material that was gathered during the assessment stage and deciding on an avenue for intervention. It may also involve exploring the possible options available to the individual in crisis and either handling the situation at the moment or referring it out as needed.

We suggest two additional steps, as follows:

5. *Develop a crisis implementation plan.* Once you have chosen an action, you will need a plan for real-time implementation. Often a crisis or safety plan is written out in a step-by-step manner or key steps and reminders are put on a coping card. These are then shared with important support people so that what is developed in the ideal setting of the therapy room can be put into action in the not-so-ideal crisis situation.

6. *Evaluate and follow up.* Discuss how the plan did and make changes to make it better or more flexible for future crises. Ideally you have a measurable outcome in

mind, planned before implementing your plan, like reduction of anxiety or completion of a task.

The reader is referred to the individual chapters of this book for more detail on various assessment tools for particular crisis situations.

Treatment

Obviously, models of brief psychotherapy have been the treatment of choice in crisis settings. There are several models of brief psychotherapy—however, they all have the common goal of removing and alleviating specific symptoms in a timely fashion. The intervention may lead to some personality reconstruction but this is not considered a primary goal (Aguilera, 1990).

The focused cognitive therapy approach to crisis intervention has five stages: The first stage is the development of a relationship with the patient and a building of rapport. This also follows in line with the cognitive model's notion of collaboration (Kazantzis et al., 2017). The patient must feel comfortable enough to allow a free flow of information about the crisis in which they are currently involved. The therapist's behavior is instrumental in developing this rapport. The therapist has to be able to convey a nonjudgmental attitude to the patient and a feeling of interest and concern in the patient's problem. In a more serious crisis, levels of trust tend to develop more easily—thus, the patient may have already assumed a certain level of trust in meeting with the therapist. Therefore, to some degree rapport will not be as difficult to develop; however, in a less serious crisis, deliberate attempts on the therapist's part to build rapport is especially important because it may be more difficult to develop.

The second stage is the initial evaluation of the severity of the crisis situation. Such an evaluation allows the therapist to get some idea of the immediate physical danger to the patient. It might also offer some idea as to the type of schemata held by the person with whom the therapist is dealing. The therapist must determine which course of action to take. Finally, the therapist must assist the patient in identifying the specific problem they are experiencing. Often the patients' confusion and disorganization render them unable to define their problem. The therapist must make every effort to help individuals focus on the specific areas creating problems as opposed to attempting to deal with the vagaries of "depression," "anxiety," or "communication problems." It is important, however, not to focus on one specific problem too early in the contact because there is a chance the therapist could be overlooking other significant problems. Developing a problem list ensures a more specific focus within the broader context.

Once the problems are identified, the third stage involves helping the patient assess and mobilize their strengths and resources. This may be in the form of identifying friends in the immediate vicinity who could help, as well as various internal strengths and resources the person in crisis is likely to overlook. It is extremely useful to have the cognitive and behavioral resources menu handy and available.

In the fourth stage, the therapist and patient must work jointly to develop a positive plan of action (collaboration and problem solving). An essential aspect of this collaboration includes eliciting the patient's commitment to the plan of action. At this point, the technique of problem solving is especially applicable. If the nature of the crisis is such that problem solving is not an appropriate mechanism, the last stage becomes necessary.

A resource that may be called into play at this point is the therapist as advocate for the patient. In such cases, the therapist may need to become more demonstrative in aiding the patient in making a decision.

The fifth stage involves testing ideas and new behaviors. How well the new coping techniques work can be evaluated and the strategies revised accordingly.

Patients in Crisis

The therapist who deals with patients in crisis is under a special pressure. Burnout occurs rather frequently. There is often no place for therapists to vent their own frustrations and upset, which may create a perception of crisis for the therapist. The notion of "therapist heal thyself" is easier said than done. Crisis workers may need peer supervision or some outlet for the pressure of working with patients in crisis. The reader is referred to Dattilio (Chapter 21, this volume) for a more elaborate discussion of this topic.

The crisis intervention work often represents the only link that individuals in crisis believe they have. Even when there is not a life-or-death outcome, the patient's perception is often that in some vague way their very existence is being threatened. When the individual is experiencing a peak in their emotional distress, the therapeutic environment can be seen as the only tie, however tenuous, to survival. For the patient accustomed to the idea of receiving help, the decision to seek professional help is less frightening. Too often, patients do not seek help until the problems have reached crisis proportions. For the more dependent patient, help seeking may in fact be overdeveloped as a coping strategy (Beck et al., 1990). Such patients see every problem as a potential crisis—therefore, they frequently seek help and need support. Conversely, the more autonomous patient may avoid seeking help, believing that they have all the answers themself, viewing the patient role as something to be ashamed of, or even fearing ridicule or criticism from the therapist.

Given the need for rather rapid conceptualization and intervention, we divide patients in crisis into the following five general categories:

1. *The adolescent style.* Such patients may or may not be chronologically adolescent. They are generally experiencing some major life changes having to do with self-image. They are extremely reluctant to show any signs that might suggest dependency, vulnerability, weakness, or lack of self-confidence. For this reason, any request for help may be perceived by these patients as threatening to their self-image. Typical schemata for these individuals revolve around issues of loss, dependence, and fear.

2. *The isolate.* Such individuals are typically distressed to the point of lacking all motivation to make social contact. Their crises revolve around social interactions or the lack of social involvement. Their main problems include their frequent lack of social skills, fear of rejection, passivity, and apathy. Their schemata often dictate that unless they receive absolute guarantees of recognition or support, they refuse to become socially involved.

3. *The desperate individual.* Such patients exemplify for many what crisis intervention is all about. They experience some sudden psychological shock and are in desperate

need of some type of immediate help. This shock may come from an environmental disaster or a psychological loss. As a result of this shock, desperate individuals most likely have lost contact with reality or this contact is extremely shaky. The therapist may represent their final link to reality. Often, the mere sound of a caring, concerned voice is enough to begin bringing these patients back from a state of despair—for example, a therapist reported meeting with a woman patient who was in crisis. He extended the session to double its time to help her move away from her determination of suicide. At some point in the session the patient asked for a cigarette. The therapist did not smoke but offered to use some of their session time to go for a walk together and continue their work while examining whether this healthy coping strategy might take her thoughts of suicide from a 10/10 in severity to something lower. Following a walk through a nice area near the therapist's office the client reported a significant drop to 5/10. When he believed that the patient was able to weather the crisis, he ended the session and set another appointment time for the following day. When the patient came in the next day, she was calmer and less confused. When the therapist asked her about her reaction to the previous day's session, she replied, "I don't remember anything that we talked about. All I remember is that you took the time to go for a walk with me."

4. *The one-shot crisis contact.* Such individuals are typically relatively normal and emotionally stable. Although the crises experienced by such people vary, there are specific reasons they call for therapy. They come to therapy to get help to deal with the specific crisis situation. They perceive themselves as mainly seeking someone to help them through some current situation. For this reason, a brief cognitive approach is especially well suited. This individual is simply looking for some immediate advice or someone to act as a sounding board to advise them on alternatives to the plans of action the individual may have already developed.

5. *The chronic patient.* Such patients seek therapy for one thing or another in a long history of brush fires, sometimes termed the *crisis of the week* [COW]. Therapy means that they will be able to call at any time, and that whenever they call they will be able to find someone to listen to them and help them through the COW. COWs are also effective strategies for avoiding deeper work or tackling bigger projects. We are reminded of the Confucian idea that if we give a person a fish, he can eat for a day but if we teach him to fish, he can feed himself for life. For this type of patient, long histories of therapeutic contact have taught them that they do not need to learn to cope. They can come to therapy and have the therapist do their coping for them.

The use of cognitive therapy techniques in crisis intervention offers advantages both to patients in their ability to receive help and to therapists in their ability to offer help. The patient often feels powerless to change their circumstances or is unmotivated to problem solve and reason through a solution. By working collaboratively and actively to identify cognitive distortions and automatic thoughts and to suggest alternatives, the therapist can provide such patients with some hope for resolving their seemingly insoluble difficulties.

CBT is attractive "because most of the concepts of cognitive and behavior therapy are consistent with commonly shared notions of human nature, the neophyte therapist can readily assimilate them" (Beck, 1976, p. 318). The theories of CBT are easily delineated, and, most important, the link between theory and practice is clear. By virtue of its ease of learning, cognitive and behavior therapy techniques also make crisis intervention work much more satisfying for the therapist.

Issues in Crisis Intervention

Confidentiality

The issue of confidentiality is a sensitive one: knowing when to maintain confidentiality and when it is essential to break confidentiality are very important issues (see Barnett, Chapter 2, this volume, for an expanded discussion). Although confidentiality relies in large part on clinical judgment and accurate assessment of the severity of the situation, there is a general set of ethical standards. A life-threatening situation is one in which the patient is in danger of bodily injury or death. Once the therapist has established that there is a life-threatening situation, the therapist is no longer ethically bound to confidentiality and may have to exercise certain options—for example, if there is a crisis or emergency (e.g., homicide or suicide), the therapist may need to involve the police or insist that the patient offer the name of the spouse, friend, roommate, parent, or significant other who can be an available resource if assistance is necessary. The individual in crisis can enlist the support of these resources throughout the treatment process.

Cognitive Functioning

We use the term *cognitive functioning* to include intelligence; ability to comprehend and process information; and ability to understand both practical and abstract concepts of crisis, illness, injury, and health. The disorganization of the patient at the point of crisis may thus alter the therapeutic approach.

If, for example, patients or family members do not have a sufficient fund of knowledge to understand the nature of the present trauma, care must be taken to ensure that explanations are made in the simplest terms. Jargon, complex medical explanations, shorthand descriptions, or abstract concepts may be acknowledged as understood while actually leaving the patient and family puzzled by the events, treatment, and sequelae of the trauma (or treatment).

If the family is non-English speaking, it is essential that explanations be offered in their primary language. Regardless of language, care must be taken to work with the crisis within the context of a family's cultural values. Trauma service interpreters must be trained in addressing the practical and emotional needs of the patients and families and be able to translate the psychological concepts of the therapist into clear and digestible ideas that the patient can understand (Dattilio, 1999).

Mourning

Any loss has the effect of reducing one's ability to cope. The sequelae of an emergency may be the permanent loss of a family member through death or the temporary loss of a family member who is hospitalized. In addition, the result of the crisis might be the loss of a cognitive faculty, physical skill or ability, body parts, or intellectual or physical prowess.

The therapist must recognize and deal directly with losses, both real and imagined. In some cases, family members may refuse to recognize the loss. The therapist must walk the line between maintaining hope and facing reality, encouraging the search for treatment options while evaluating the potential for success, and preparing for the worst while hoping for the best.

The mourning process must be identified for the patient. Patients must be helped to accept that any loss must be mourned and that the mourning process is normal, natural, and necessary. Often, follow-up treatment is especially important because the initial loss and mourning will be followed by another mourning process that might begin long after the immediate crisis. There is, in many cases, a "sleeper effect" in which the full effect of the loss does not become clear until the patient or significant other is gone.

Premorbid Personality, Lifestyle, and Interests

The particular interpersonal style, life choices, or intrapsychic conflicts can often provide a context for understanding the patient's or spouse's reaction to the crisis. In many cases, the dependent individual reacts to the trauma by seeking help, reassurance, or comfort. The more autonomous individual may be resistant to help, refuse treatment, and generally avoid therapy with statements such as "I'll be OK," "Just leave me (us) alone," and "I (we) can do it myself (ourselves)." In other cases, the premorbid personality style may not be a good predictor of the emotional reaction to the trauma—for example, under stress the "strong, silent type" becomes helpless and dependent, whereas the weak and helpless individual shows an internal strength and fortitude that may carry an entire family throughout the crisis. This can be explained by the existence of dormant schemata (Freeman, 1993; Freeman & Leaf, 1989) that become active under the stress of the trauma. When the stress of the trauma is removed, however, the individual may return to their previous style of functioning.

Discrepancy between Actual and Perceived Difficulty in Coping

As much as possible, it is important to make clear the discrepancy between actual and predicted ability to cope with problems effectively. It is essential for the patient to be realistic in terms of expectations for coping, recovery, and survival.

Reinforce Even Small Therapeutic Gains

A frequent concomitant of crisis is depression. The negative view of self ("I am unable to cope"), the world, and experience ("It's unfair; why has this happened to me?"), and the negative view of the future ("I will always be this way; I will die alone and unwanted") are the progenitors of depressive affect (Beck et al., 1979; Freeman et al., 1990). The patient's awareness of depressive symptomatology moderates the therapeutic strategy to identify the areas of greatest difficulty and focus rather quickly on these issues. Any small gain or improvement in dealing with the crisis must be identified and reinforced. Such reinforcement can lift the patient's mood. It is necessary to socialize patients to the cognitive model and help them to begin identifying automatic thoughts and schemata.

Emphasize the Collaborative Therapeutic Relationship

The therapist must be seen as a warm, supportive, competent, reasonable individual and must work toward building and maintaining the working alliance. Given the nature of crises, the relationship must be built immediately. Empathy is the most important element; when a patient is in crisis, sympathy is likely to have a negative effect on the overall therapeutic work. There are probably many other people in the patient's world who offer sympathy. The patient needs someone who can enter their internal reality and then offer support and strategies for effective coping.

Barriers to Patient Empowerment

Empowerment is essential in treating patients in crisis. Patients must be helped to recognize their right and ability to be empowered. The goal of empowerment may be limited by the manner in which it is presented, by its implementation, or by misunderstanding the idea or model.

By definition, empowerment implies that one person or agency gives, offers, provides, or allows another person or agency to have or assume power. This definition assumes that the power giver has it within their purview to give or allow power. It further implies that the receiver is willing to assume the proffered power. The power may be related to work or taking charge of one's life or one's surroundings. Given the admirable goal, demonstrated potential, and egalitarian focus, empowerment may be doomed to fail for a variety of reasons. The ability to facilitate change in oneself and/or one's family group is critical to the development of empowerment. Too often self-change is impeded by repetitive, stylistic errors in personal information processing. Simply put, we can make errors in judgment, computation, reasoning, or perception. There are many examples of individuals who are smart, educated, talented, perceptive, and competent but who continue to repeat the same mistakes and find themselves in subsequent crises. Their mistake-making style becomes idiosyncratic and may cause them difficulties at work, at home, in relationships, or within themselves. It is important to help individuals to identify their particular schematic style and then to develop strategies to overcome impediments to change. Impediments to change include lack of practice in new behavior, environmental stressors interfering with change, personal ideas about ability to change oneself or family, personal ideas about consequence of change to self or group, group or family ideas about the need to avoid change, secondary gain from maintaining the status quo in spite of cost, lack of motivation, rigidity, some types of compensatory strategies (e.g., avoidance, "fear of fear," dependent interpersonal style), and vague or unrealistic goals. In therapy, if the goals are not agreed on, patient frustration will result.

Threshold and Vulnerability

The ability to cope with a stressor and whether the same stressors precipitate a crisis depend on the individual's threshold for response. In different situations, the individual's threshold will be very different. A surgeon working in a critical care setting is able to deal with medical emergencies with competence and skill. Once past the doors of the operating room, they may be unable to cope with the normal exigencies of life.

If we picture coping ability on a scale of 0–100, we can literally map an individual's normal threshold for coping. If, for example, the normal stress of life is 60 and one's threshold is 75, there is a cushion of 15 to accommodate extraordinary stress. If, due to higher than normal stress, the stress of life increases to 80, the individual would be overwhelmed and have difficulty coping. If, however, the stressors of life remain the same but one's threshold decreases, the individual will likewise be overwhelmed.

Vulnerability factors lower one's threshold. These are circumstances, situations, or deficits that have the effect of decreasing the patient's ability to cope effectively with life stressors or to see available options.

The following list gives examples of such factors (Freeman & Simon, 1989):

1. *Acute illness.* This may span the range from a severe and debilitating illness to more transient illnesses, such as headaches, viral infections, and so on.
2. *Chronic illness.* When the health problem is chronic, there can be an acute exacerbation of suicidal thinking.
3. *Deterioration of health.* There may be a loss of activity due to aging.
4. *Hunger.* During times of food deprivation, the individual is often more vulnerable to a variety of stimuli. Recent studies have linked a depressive diagnosis to those with an eating disorder.
5. *Anger.* When individuals are angry, they can lose appropriate problem-solving ability. They may also lose impulse control or overrespond to stimuli that they are usually able to ignore.
6. *Fatigue.* In a similar fashion, fatigue decreases both problem-solving ability and impulse control.
7. *Loneliness.* Positive social connections and feeling like we belong are high on the list of human needs to maintain a sense of well-being. When individuals see themselves as isolated, leaving this unhappy world may seem to be a reasonable option.
8. *Major life loss.* Following the loss of a significant other through death, divorce, or separation, individuals often see themselves as having reduced options. They lose interest in what happens to them.
9. *Poor problem-solving ability.* Certain individuals may have impaired problem-solving ability. This deficit may not be obvious until the individual is placed in situations of great stress. The ability to deal with minor problems is a poor indicator of the individual's ability to deal with a crisis.
10. *Substance abuse.* The abuse of many substances can cause two types of problems: acute, in which the patient's judgment is compromised during periods of intoxication, and more chronic, in which judgment may be impaired more generally. Such problems increase suicidality.
11. *Chronic pain.* Chronic pain may cause the individual to view suicide as a method for ending the pain.
12. *Poor impulse control.* Certain patients have poor impulse control because of organic (hyperactivity) or functional problems. Patients with bipolar illness; psychosis; attention-deficit/hyperactivity disorder (ADHD); autism spectrum disorder; or borderline, antisocial, or histrionic personality disorders may all have impulse control deficits.
13. *New life circumstances.* Changing jobs, marital status, homes, or family status are all stressors that are considered vulnerability factors.

These factors can, alone or in combination, increase the patient's suicidal thinking or actions, lower threshold for anxiety stimuli, or increase the patient's vulnerability to depressogenic thoughts and situations (Freeman & Simon, 1989). The vulnerability factors can have a summation effect—that is, when several vulnerability factors operate at the same time, they may continue to lower one's threshold—for example, if an individual who has a history of effective coping (threshold = 90, life stress = 60) suddenly loses the ability to cope and ends up in crisis, the family is often surprised. They may disregard the fact that the individual has had a stroke (–10), his wife has a broken leg (–7), his son is getting divorced (–6), his daughter has lost her job (–5), his oldest grandchild is having difficulty in school (–5), and his pet dog has been hit by a car (–4). His threshold is now 54, low enough to have him respond to normal life stress as if it were a crisis. Rather than thinking in terms of the sequence of losses, families may respond by thinking that the patient has dealt with similar problems in the past, so it is unclear why at this point he is having such a negative response.

Assessment of vulnerability factors may help to explain the ability to deal with crises and to predict the possibility of withdrawal, suicidal ideation, depression, or anxiety.

In the following chapters, the authors present situations and disorders that commonly lead patients into crisis. Each chapter presents a case example and provides related statistical information and prevalence rates, as well as common theories and models that apply to each scenario. The authors then lay out relevant and up-to-date cognitive-behavioral strategies that have been supported by the body of research in the respective areas. It is hoped that readers will use this information as an invaluable resource when taking on patients in crisis, and that they will feel more confident in helping their patients recover from the crises in which they find themselves.

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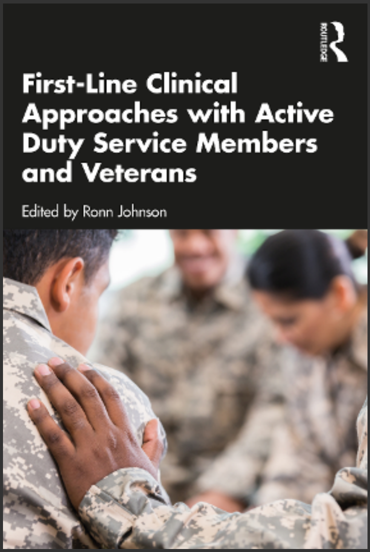
CHAPTER

4

Evidence-Based Practices for Psychotherapy



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5

Evidence-Based Practices for Psychotherapy with Active-Duty Service Members and Veterans

Maria C. Crouch, Jennifer M. Loya, and Joan M. Cook

Number and Proportion of Diverse Active-Duty Service Members and Veterans

Racial and ethnic minorities compose approximately 31% of the 1.3 million active-duty service members (ADSM), 26% of the 0.8 million selected reserve personnel (Department of Defense, 2019) and 25% of the over 20 million total veteran population (National Center for Veterans Analysis and Statistics, 2018). Of ADSMs, 17% are Black (n = 227,736), 5% are Asian (n = 62,110), 3% are multiracial (n = 39,596), 1% are Native Hawaiian or Pacific Islander (n = 15,319), 1% are American Indian and Alaska Native (n = 14,627), and 4% identify as "other" (n = 54,376). Almost 53% of those who listed race as "other" reported being Hispanic, and overall, almost 17% of ADSMs reported being Hispanic, with 18% of White ADSMs reporting Hispanic heritage (n = 167,666). Reserve member representation by race is comparable.

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The proportion of racial and ethnic minorities are expected to increase to approximately 35% of ADSM and veterans by 2040 (National Center for Veterans Analysis and Statistics, 2018). When comparing the percentage of ADSMs to the civilian population, racially and ethnically diverse ADSMs are slightly more represented than among civilians, whereas White ADSMs representation is proportional to the general population, and Asian ADSMs are slightly less represented compared to civilians. However, Department of Defense (2020) data indicated that both active and reserve Black, Asian, and Hispanic officers are unrepresented in contrast to White members. When comparisons were made among enlisted members and across paygrades, it was found that Black, Indigenous, and People of Color (BIPOC) representation decreased as leadership roles/pay grades increased.

Of the veteran population, 15% are Black (n = 2.5 million), 10% are Hispanic (n = 1.6 million), 3% are multiracial (n = 457,555), 2% are Asian (n = 360,479), 2% identify as "other" (n = 297,514), 1% are American Indian/Alaska Native (n = 166,263), and less than 1% are Native Hawaiian or Pacific Islander (n = 47,099). Notably, American Indian/Alaska Native ADSMs and veterans have the highest rates of service per capita than any other racial group (Goss et al., 2017).

Rates of Trauma, PTSD, and Mental Health Service Utilization in BIPOC

The research on trauma, posttraumatic stress disorder (PTSD), and mental health service utilization and outcome in ADSMs and veterans from BIPOC populations have several limitations that should be noted upfront. Most relied on retrospective reports of traumatic stress and PTSD. While some research comes from large-scale representative samples, the majority rely on convenience or clinical samples from single site specialty clinics, or the use of Department of Veterans Affairs (VA) health-care records. In addition, this research largely compares either Black individuals to White individuals or places all BIPOC individuals in a non-White category. These caveats are important to interpreting the current literature, as well as highlighting areas and subpopulations in need of further investigation, and what is needed to improve clinical practice for all ADSMs and veteran members of BIPOC populations. For example, American Indian/Alaska Native veterans have high rates of PTSD, lower quality of life and more health disparities than non-Native veterans, and notable historical and contemporary traumas in addition to combat and combat exposure (Goss et al., 2017, 2019; Hansford & Jobson, 2022). Moreover, American Indian/Alaska Native members are rarely examined as a distinct group when examining PTSD treatment outcome in ASMD and veterans.

In general, there have been reports of elevated prevalence rates of trauma, PTSD, and other mental health issues (e.g., major depressive disorder) for some BIPOC veteran and service member populations compared to White counterparts (Chen et al., 2015; Loo, n.d.; Nichter et al., 2020). Such factors that have been found to contribute to the development of PTSD among ADSMs and veterans include (1) the extent to which they were exposed to combat, (2) firing a weapon during war-zone exposure, (3) witnessing injuries that threaten life or the death of another person, and (4) the degree to which one receives social support after traumatic exposure (Chen et al., 2015). However, in addition to service-related PTSD risk factors, BIPOC ADSMs and veterans are also exposed to other forms of trauma that contribute to PTSD prevalence and severity, particularly race-related stressors. While beyond the scope of this chapter, it is important to note that extrapolating broader understandings of the research examining PTSD among BIPOC individuals can be difficult, given the varied approach to ethnoracial differences, such as the way data is collected and interpreted (e.g., grouping BIPOC individuals in a non-White category), ethnic variations and power differentials in the researcher-participant dynamic (e.g., BIPOC participants might be less likely to engage with White researchers/providers), measurement equivalence (e.g., tests are often not normed on racial groups outside of the dominant group), and an emphasis on combat-related predictors of trauma and a de-emphasis on race-related stressors.

Data on the impact of ethnoracial differences in treatment of PTSD is mixed. For example, in a subsample of male theater veterans ($N = 248$) from the National Vietnam Veterans Readjustment Study, Black ($n = 70$) and Hispanic ($n = 84$) veterans report greater exposure to war-related traumatic stress and were more likely to develop incident PTSD compared to White counterparts ($n = 94$; Dohrenwend et al., 2008). In a large population-based cohort of 20,563 veterans who served during the Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) era (13,162 OEF/OIF veterans and 7,401 veterans who served during the OEF/OIF era but were not deployed to those conflicts), there was increased risk of a positive screen for PTSD among Black veterans compared to other racial groups (Dursa et al., 2014). Relatedly, in a sample of active-duty male military personnel seeking treatment for PTSD, Hispanic/Latino/x and Black ADSMs reported greater PTSD symptoms compared to non-Hispanic White ADSMs (Kaczkurkin et al., 2016).

In a sample of 9,420 veterans recently separated from the military (White $n = 6{,}222$; Black $n = 1{,}027$; Hispanic/Latinx $n = 1{,}313$; Asian, Native Hawaiian, or Pacific Islander $n = 420$; multiracial $n = 438$), McClendon et al. (2019) examined patterns and correlates of PTSD screening across race/ethnicity and gender. Rates of positive PTSD screens were highest among Black veterans (36.3%), followed by multiracial (35.7%), Hispanic/Latino (30.6%), and White (22.5%) veterans. While not included in the analyses due to low sample size, American Indian/Alaska Native (43.3%) veterans did screen positive for PTSD at a higher rate than other groups. Regarding the intersectionality of race/ethnicity and gender, multiracial female (48.1%) and Black male (37.9%) veterans had the highest rates of positive PTSD screens. Additionally, Asian, Native Hawaiian, or Pacific Islander male veterans (19.8%) had the lowest rates of positive PTSD screens. Furthermore, Black, Hispanic/Latina/x, and multiracial female veterans had significantly higher odds of positive PTSD screens than White female veterans. However, gender differences did emerge for multiracial women veterans. While controlling for other variables (e.g., trauma exposure, social support) impacting positive PTSD screens partially or fully accounted for the elevation among Black and Hispanic/Latina/x veterans but remained the same for multiracial veterans.

The empirical literature on PTSD treatment outcomes (not solely focused on evidence-based psychotherapies or predating their wide dissemination and implementation) for veterans from racial minority backgrounds has been limited, and the findings are somewhat varied. Many studies have found that, generally, race and ethnicity were not related to changes in PTSD symptoms or to treatment response. In a study of VA residential PTSD programming among 65 Vietnam veterans (85% White; other races were not reported), race was not a significant predictor of treatment response (Johnson & Lubin, 1997). However, in a more recent, national sample of over 2,000 veterans undergoing PTSD residential treatment, Sripada et al. (2020a) found four latent classes of PTSD symptoms: a low-symptom class, a moderate-symptom class with high reexperiencing, a moderate-symptom class with high emotional numbing, and a high-symptom class. Symptom classes differed by race/ethnicity, with non-White veterans more likely to be in the moderate class with high reexperiencing symptoms.

Mental health treatment initiation and response are varied for BIPOC veterans. In one study among veterans who served in Iraq and Afghanistan (Koo et al., 2016), Asian/Pacific Islander women and Black men were more likely to screen positive for PTSD at treatment initiation compared to other racial groups. Hispanic men were also more likely to screen for PTSD. In addition, symptom cluster differences were significant among racial/ethnic groupings by gender, which have important implications for screening and treatment and the salience of incorporating culture and gender. For example, Hispanic women were more likely to report emotional numbing, which has been salient in prior research but has not been examined by gender.

Maguen et al. (2014) conducted a large retrospective analysis of VA health care records of nearly 40,000 Iraq and Afghanistan veterans who initiated mental health treatment within one year of post-deployment PTSD diagnosis. Women had significantly more PTSD symptoms improve posttreatment compared to men, which is important given that women—in general, among the civilian population—are at a greater risk of PTSD. Black veterans were also less likely to have symptoms improve compared to White counterparts, regardless of time-to-treat. Also, those who had a negative screen at treatment follow-up were more likely to be White. Moreover, ethnoracial and/or gender differences in treatment initiation and response could also be explained by social norms (e.g., acceptability of emotional expression for women) and cultural norms (e.g., disclosure of trauma histories and associated symptoms, help-seeking behaviors).

Using national VA health care records, Hebenstreit et al. (2015) found that race/ethnicity were significantly associated with female Iraq and Afghanistan veterans' completion of minimally adequate care (i.e., at least nine mental health outpatient visits within a 15-week period or at least 12 consecutive weeks of medication use) for PTSD. Namely, Black and Hispanic women were less likely to engage with and complete care. In addition, in a sample of veterans who were receiving VA outpatient PTSD services, those from non-White populations were less likely to achieve improved PTSD symptoms; perhaps due to higher rates of attrition, lower levels of ethnic matching of patients and providers, and no adaptation in the interventions (e.g., change in intervention intensity, change in modality; Sripada et al., 2017). These findings suggest a need to reduce delays in initiating mental health care as well as targeted efforts to improve PTSD treatment outcomes among BIPOC populations.

Using national cohort data of VA patients who were recently diagnosed with PTSD, Black and Latina/o/x veterans were less likely to receive an adequate trial of pharmacotherapy, and Black veterans were less likely to receive a minimal trial of any treatment in the six months after diagnosis (Spoont et al., 2015). Importantly, these differences were not due to differences by group, cultural variables, or their access to care, thus indicating that there is a treatment disparity for these groups (Spoont et al., 2009). Further, research (Spoont et al., 2009, 2015, 2017) has demonstrated that Black veterans with PTSD are less likely to receive any therapy overall, individual therapy (as opposed to group treatment), minimally adequate dose of treatment, or medication trial, as well as have significantly longer wait times for treatment and are less likely to complete PTSD treatment (Castro et al., 2015; Eliacin et al., 2018; Rosenheck et al., 1995; Saha et al., 2008; Spoont et al., 2017).

In a study of 232 veterans from Iraq and Afghanistan who were receiving treatment at a VA PTSD clinic within the first year of return from deployment, engagement in psychotherapy, pharmacotherapy, or both was not associated with differences in race/ethnicity (Haller et al., 2016). However, it has been demonstrated that Black and Hispanic veterans experienced increased discrimination and trauma exposure while deployed in Iraq and Afghanistan, which likely contributes to increased negative mental health outcomes (Muralidharan et al., 2016). This was particularly salient for women of color in contrast to White women. Considerations of gender differences in addition to racial differences is integral to culturally relevant PTSD treatment for ADSMs and veterans.

Evidence-Based Psychotherapies (EBPs) for PTSD

There are numerous guidelines for the treatment of PTSD (Hamblen et al., 2019). The majority converge to designate several psychotherapies as evidence based (EBPs). For example, the Guideline Development Panel for the Treatment of PTSD in Adults, American Psychological Association (2019) strongly recommended prolonged exposure (PE; Foa et al., 2019) and cognitive processing therapy (CPT; Resick et al., 2016), as well as conditionally recommended brief eclectic psychotherapy for PTSD (BEPP; Gersons et al., 2015), eye movement desensitization and reprocessing (EMDR; Shapiro, 2017) and narrative exposure therapy (NET; Schauer et al., 2011). All these treatments are trauma-focused, meaning they involve the processing of traumatic material.

Over the past two decades, the VA has invested significant resources to provide their mental health workforce with training, supervision, staffing, and implementation support in sixteen EBPs (Karlin & Cross, 2014). Beginning in 2006 and 2007, this unprecedented national training initiative included two EBPs for PTSD: PE and CPT. Numerous efforts were made to assist in the training and implementation of these two EBPs (Karlin et al., 2010), including policy changes mandating their availability at all VA facilities (Department of Veterans Affairs, 2008), designation of local EBP coordinators (or champions) at each medical center, and a PTSD mentor program to help PTSD clinic managers make organizational changes to increase the likelihood that the EBPs would be implemented (Bernardy et al., 2011). For the purpose of this chapter, we primarily focus on PE and CPT. In addition to the numerous randomized controlled trials (RCTs) examining PE and CPT among civilians, RCTs examining PE and CPT have been conducted with veteran samples (for review, see Schnurr et al., 2022; Steenkamp & Litz, 2013).

Prolonged Exposure (PE)

In brief, PE is an eight- to 15-session manualized individual therapy with four primary components: (1) psychoeducation about trauma, (2) breathing training, (3) in vivo exposure (hierarchy of avoided trauma-related situations and stimuli and then hierarchical exposure to these safe but avoided situations and stimuli), and (4) imaginal exposure (verbal retelling of the most distressing trauma). In a review of 38 RCTs of PE, inclusion of ethnoracial minorities, other than Black participants, was low (Benuto et al., 2020). In an examination of the influence of ethnicity on the effectiveness of cognitive behavioral treatment for PTSD, particularly PE, in 95 female civilians of sexual and non-sexual assault, there were no differences in treatment efficacy or dropout between Black (n = 35) and White participants (n = 60; Zoellner et al., 1999). Additionally, in a RCT with 173 civilians, there were clinically equivalent PTSD outcomes for Black (n = 43) and White participants (n = 130) in both PE and the pharmacotherapy (sertraline) conditions. However, Black participants attended fewer sessions in PE and sertraline than White participants (Kline et al., 2020).

One study (Ghafoori & Khoo, 2020) conducted among a community-based sample of low-income, diverse patients seeking mental health treatment for traumatic stress found ethnoracial differences in probable PTSD and related symptomology after treatment (e.g., the sixth week of PE). The White group had a higher likelihood of probable PTSD compared to the Latinx group at six weeks into treatment. The White group also had a higher likelihood of probable anxiety compared to the Black, Hispanic/Latina/o/x, and "Other" groupings, and probable depression in contrast to the "Other" grouping. It is critical to observe that this research (as does a vast majority) uses White participants as the reference group. While this is a common practice, it is, arguably at best, reifying the normalcy of whiteness and, at worst, perpetuating racism (Johfre & Freese, 2021). Additionally, due to small sample sizes, many researchers often organize racial/ethnic groups into an "other" category.

Namely, the aforementioned study (Ghafoori & Khoo, 2020) grouped American Indian/Alaska Native, "mixed race ethnicity," Asian, and "other" into an overarching "Other" racial category. In contrast, a growing number of studies exclude racial/ethnic groups from analyses when participant numbers are too small for meaningful group comparisons. For example, several strategies include counting American Indian/Alaska Native peoples as an analytic group regardless of other races reported; collecting data about Tribal affiliation and disaggregate data based on Tribe; and considering effect sizes or at a minimum descriptive reporting what is known about the sample (Crouch & Andrew, 2022). Nevertheless, understanding racial and ethnic differences and responses in the early stages of treatment are integral to tailoring trauma treatment for BIPOC ADSMs and veterans.

Cognitive Processing Therapy (CPT)

CPT is a 12-session manualized treatment focusing on the relationship between unhealthy and distorted thinking patterns related to trauma by teaching new and adaptive ways of thinking. CPT can be delivered in group, individual, or combined formats. In a meta-analysis of the effectiveness of CPT for treating PTSD (Asmundson et al., 2019), the number of studies conducted among ethnoracial minorities, other than the Black population, was low. In an examination of the influence of race on CPT treatment in 308 female civilians with interpersonal violence-related PTSD, there were no differences in treatment outcomes between Black and White participants. However, Black participants were significantly less likely to complete treatment compared to White participants (Lester et al., 2010).

A study by Schulz et al. (2006) demonstrated the effectiveness of CPT in a population of individuals of foreign-born refugees (i.e., Afghanistan, Yugoslavia, Bosnia- Herzegovina) who resettled in the U.S. Most treatments were done at the participants' homes due to poverty and lack of resources or the nature of the trauma (e.g., fears related to being in public). CPT adapted for a naturalistic setting with the use of an interpreter within a refugee population was found to be equally effective as the results from RCTs. Also, length of sessions was not as important as alleviation of symptoms and the educational and skill building processes of CPT. In other words, some participants needed more than 12, and some needed less than 12 sessions. CPT has been found to be an adaptable and efficacious method for PTSD treatment with the general population, veterans, refugees, and other groups.

Effect of Race, Ethnicity, and Culture on EBP Treatment Outcomes in ADSMs and Veterans

Research on race, ethnicity, and culture is integral to understanding and improving EBP treatment outcomes for underserved groups; however, this type of research is limited in ADSMs and veterans. Among 134 service members who completed PE or CPT at a military outpatient clinic (reportedly, 55.7% White, 20.9% Black, 19.0% Hispanic, and 3.8% Asian), ethnicity was not related to symptom change in PTSD (Aronson et al., 2018). In a sample of 259 veterans who received CPT in an outpatient clinic (reportedly, 87.6% White, 6.5% Hispanic, and 3.5% Black), there were no demographics, including race, that were associated with change in PTSD symptoms or explained variance in treatment response (Roberge et al., 2019). Similarly, in a retrospective chart review evaluating the effectiveness of PE and CPT in one VA specialty clinic, there were no significant differences in outcome between Hispanic and White veterans (Jeffreys et al., 2014).

Additionally, in an evaluation of a manualized group therapy in a 10-week, VA combat-related program conducted with 450 veterans (61.8% non-Hispanic Black; the rest were non-Hispanic White), PTSD symptom reduction occurred irrespective of race (Coleman et al., 2018). Using the same sample of veterans, another paper reported that racial and ethnic make-up of groups was also not related to outcomes (Cusack et al., 2019). Importantly, however, improvement was a function of educational attainment, emphasizing that socioeconomic factors can contribute to social equity, quality of life, and treatment effectiveness.

In a small RCT for military sexual trauma-related PTSD among female veterans, there were no differences between Black and White veterans in change in PTSD symptoms over the course of CPT (Holliday et al., 2017). In addition, there were no differences based on race in the number of sessions attended and rates of early termination. However, in a clinical sample of veterans with PTSD who received CPT through an outpatient VA program, ethnicity was one of the variables that influenced the trajectory of PTSD symptom reductions during treatment (Schumm et al., 2013). Across three latent symptom classes, with class one being the most severe PTSD and depression symptoms and class three being the least severe, it was found that the largest proportion of minority individuals (36%) comprised class one. Class one had the most severe self-reported symptoms pre- and posttreatment and exhibited the least improvement. It has been posited that PTSD symptoms are exacerbated by racism and discrimination, and treatment and therapeutic alliance is impacted by limited availability of ethnic matching of provider and patient among ethnoracial minority groups.

Other treatment outcomes, such as suicidal ideation, have also been examined. For example, in a study of 303 veterans (64.4% White, 26.1% Black, 0.3% Asian, 3.0% Hispanic/Latina/o/x, 1.0% American Indian/Alaska Native, and 2.3% "other") who received CPT in a VA residential PTSD treatment program, suicidal ideation significantly decreased over the course of treatment, and this change did not differ based on race/ethnicity (Stayton et al., 2019). It is important to note, though, that for the purpose of multilevel modeling, race/ethnicity were condensed to White and non-White.

Comparatively, other studies have found differences in treatment outcomes between racial/ethnic groups. For example, Maguen et al. (2019) conducted an examination of factors related to initiation and completion of EBPs for PTSD, namely PE and CPT, over a 15-year period in over 260,000 Iraq and Afghanistan War veterans. Whereas 22.8% of the veterans with PTSD receiving mental health care initiated an EBP, less than 10% completed treatment; specifically, 1.9% completed PE, and 7.4% completed CPT. In examining race/ethnicity, veterans who completed PE were more likely to be Black than any other race (e.g., White, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander). It was also found that Black veterans were also more likely to receive PE sooner. While more research is needed to understand this finding, other research (Jeffreys et al., 2014) has found that Black veterans receiving PE had significant improvement in PTSD symptoms in contrast to other racial groups.

Additionally, in a national sample of 2,715 veterans (66.1% White, 25.9% Black, 2.1% American Indian/Alaskan, 2.2% Asian/Pacific Islander, and 3.7% "other"/of an unknown race; furthermore, 8.9% identified as Hispanic) engaged in VA residential PTSD treatment across the U.S., identifying as Black was one of the predictors of poor treatment response (Sripada et al., 2019). Also, using national data from VA PTSD residential treatment programs, Gross et al. (2021) examined symptom outcome differences between Black ($n = 834$) and White ($n = 2{,}036$) veterans. Black veterans experienced less PTSD symptom reduction during treatment and increased depressive symptom recurrence following discharge. In a large sample of VA patients across treatment setting (e.g., specialty clinics, outpatient) diagnosed with PTSD who were undergoing PE or CPT, White veterans were more likely to experience meaningful change (i.e., at least 50% reduction in PTSD symptoms) within the first eight sessions and subsequently (Sripada et al., 2020b). This suggests that BIPOC populations may need to have treatment enhanced or adapted to achieve meaningful change.

Treatment-Seeking, Access, Barriers, Preferences, Engagement, and Retention

While most of the research indicates that treatment outcomes for a range of mental health conditions do not differ by race or ethnicity, there are important mental health treatment disparities in racial and ethnic minority military service members and veterans (Goetter & Blackburn, 2019; Gross et al., 2021). This is consistent with research conducted on civilians, indicating that racial and ethnic minorities have lower rates of access and perceive more barriers to mental health treatment than non-minorities (Goetter & Blackburn, 2019).

Koo et al. (2015) examined the health-care utilization rates (i.e., primary care, mental health outpatient, emergency services) of 309,050 Afghanistan and Iraq veterans who had a least one psychiatric diagnosis and received care between 2001 and 2012. When looking at minority groupings collapsed and in comparison to White veterans, there were no significant differences. However, when the minority groupings were categorized separately (i.e., Black, Hispanic/Latinx, Asian/Pacific Islander, American Indian, multiracial), differences emerged. It was found that minority groups were admitted to inpatient care significantly less, with Black and Hispanic men the most affected. Notably, Asian/Pacific Islander veterans utilize emergency services less frequently. Additionally, whereas women utilized mental health outpatient services more than men, American Indian and Hispanic women underutilized this service. Furthermore, understanding access, utilization, and barriers at the intersection of diverse ethnoracial ADSMs and veteran groups is salient to creating culturally relevant care, mitigating barriers, and increasing engagement and retention. Moreover, the study methods highlight the importance of viewing ethnoracial groups as distinct cultural communities, avoiding overgeneralizing and perpetuating biases, and acquiring a nuanced and accurate understanding of treatment utilization of ethnoracial groups.

One way to increase engagement and outcomes might be to address racism. Racism is built on beliefs that one group of people is superior to another group (or groups) based on biological characteristics (e.g., color of skin, hair texture, and facial features). Due to White supremacy—the core of racism that indicates that White people are better than BIPOC people—White, as well as light-skinned people who may "pass" (or appear) as White, are given unearned privileges solely due to their race (Singh, 2019). To target racism, treatment providers should take an equitable approach to provide treatment for BIPOC populations. In other words, treatment should be provided for, as well as offered to, people who identify as Black, Hispanic, Asian/Pacific Islander, American Indian/Alaska Native, or multiracial when needed.

Moreover, treatment needs reciprocity, whereby relationships are forged by acknowledging power dynamics, understanding and discussing sociopolitical oppressions, giving attention to culture as a key aspect of treatment, and prioritizing the cultural/ethnoracial matching of provider and patient (see Goodman & Gorski, 2014).

Ways to Engage BIPOC ADSMs and Veterans in Mental Health Treatment

One of the most important and yet widely overlooked aspects of EBPs for treating PTSD among BIPOC is the role of the therapist. In an examination of the effect of clinician-veteran pairing in the treatment of PTSD, Black veterans had higher rates of early termination and received fewer psychotherapy sessions when treated by White providers (Rosenheck et al., 1995). This could be due to several variables, including social attitudes, racial discrimination, and internalized oppression. For example, one study (Eliacin et al., 2018) observed that Black veterans attune to cues in the treatment setting (e.g., culturally competent care, diversity, and inclusivity) with the lack thereof signaling the presence of racial biases. Black veterans reported perceiving more racial bias in treatment settings when there was little to no Black representation in visual arts displayed in clinical settings and fewer BIPOC providers. These perceptions are compounded by societal discriminatory views and assumptions based on race and personal moralized attributes (e.g., higher frequency of incarceration) that were upheld by health-care providers. Furthermore, discriminatory provider views are associated with poor treatment engagement and retention. However, there is a noteworthy disconnect between BIPOC patient perceptions and those of health care providers.

Recent survey research (Eliacin et al., 2019) with providers across three VA medical centers found that workforce diversity was viewed as not important to health-care equity within the treatment setting. Despite this belief, a systematic review (Hall et al., 2015) of 15 studies indicated that almost all providers given implicit association tests for implicit biases rated White patients more positively than people of color. However, even though there is a BIPOC preference for same-race providers, the broad mental health workforce in the VA and the Department of Defense and civilian sectors (e.g., psychologists, psychiatrists, social workers, marriage and family counselors) are predominately White.

In one study (Laska et al., 2013) concerning the evaluation of therapeutic skills, it was found that expert-level supervisor therapists were able to accurately identify successful therapists through interpersonal and supervisory interactions outside of the therapy room. Supervisors, without watching therapist sessions, were able to accurately rate therapist effectiveness as it correlated to therapeutic outcomes. Supervisors' ratings of successful therapists were deduced to the following four themes: (1) *reducing avoidance*: therapists were able to address client avoidance and be directive while also considering contextual client factors, (2) *language used in supervision*: therapists were able to receive feedback, be honest about their mistakes, and had high levels of self-awareness, (3) *flexible interpersonal style*: therapists were able to be open to flexing schedules and accommodate clients where they are and within their culture, and (4) *strong therapeutic alliance*: therapists were able to go beyond being supportive and were able to be a balanced mix of genuine, firm, and warm. The clients in the study were veterans from diverse wars, of different ages, and came from different backgrounds; however, salient therapist factors coupled with the use of EBP for PTSD were the keys to positive client outcomes.

Another way to expand care broadly, quickly, and effectively to underserved, underrepresented, and hard to access groups, such as individuals who are BIPOC, is through telehealth. Telehealth delivery is a feasible option to traditional office-based treatment overcoming several barriers and expanding access to care. An ethnically diverse sample of veterans with PTSD were asked to identify their modality preference for receiving PE (Ridings et al., 2019). There was no clear preference for one modality (i.e., home-based telehealth, office-based telehealth, or in-home-in-person), and each modality was preferred by at least a quarter of all veterans. In response to the COVID-19 pandemic, the VA rapidly implemented teletherapy for mental health services due to prior efforts and rollouts of this modality (Zhang et al., 2022). Teletherapy provided for continuity of care for severely mentally ill veterans and mitigated suicide attempt, overdose, and PTSD symptomology. A systematic review (Turgoose et al., 2018) of teletherapy for PTSD treatment (predominantly PE) among veterans observed that telehealth delivery was effective in decreasing PTSD symptomology, the therapeutic process was equal to in-person services or enhanced (e.g., satisfaction ratings), was cost-effective, and inevitably increased access.

Some BIPOC populations may prefer telehealth. For example, American Indian/Alaska Native veterans live in rural areas at a higher rate than all other veteran groups. In order to meet this gap, American Indian Telemental Health Clinics were developed over a 14-year period to facilitate accessible, person-centered, culturally congruent care for this population. Technology is used for mental and physical health care, cultural facilitation (including Native values, family, Indigenous healers, and related spiritual concepts), and care and benefit coordination to increase engagement and retention. The cornerstone of respect is used to build and increase provider-patient alliances, attend to past hurts and distrust with the Western medical system and U.S. government, and increase culture within treatments to address the whole person (mind, body, spirit) within the sociopolitical and historical context. Furthermore, successfully identifying relevant benefits/services and feeling more connected with one's provider and peers within the VA system are associated with a decrease in PTSD symptoms.

Future Directions for Research and Practice

There are several major limitations that need to be addressed to improve the research base as well as clinical practice, including inclusion and attention to psychiatric comorbidities, more nuanced breakdown of BIPOC populations, and the importance of intersectionality. Most research on ethnoracial differences among ADSMs and veterans, as well as civilians with PTSD, does not address comorbid psychiatric disorders, including substance use disorders (SUD). In a small RCT for 79 treatment-seeking veterans with SUDs and co-occurring PTSD, Black participants reported greater decreases in substance use during treatment, but greater increases during follow-up (Brown et al., 2020). Regarding PTSD symptoms, Black veterans reported higher PTSD severity than White counterparts at baseline; however, there were no significant differences in diagnostic remission for PTSD at the end of treatment. This study highlights the nuanced and potentially interactive nature of trauma and co-occurring issues that, when considered together, could lead to fuller case conceptualizations. A systematic approach and understanding of contextual factors contributing to symptoms, and targeted treatment that considers the interconnectivity in comorbid symptom changes, could contribute to more positive outcomes.

As stated earlier, most of the empirical literature focuses on treatment utilization and outcome differences between Black versus White participants, or by placing all individuals from BIPOC populations in one comparison condition. Doing this obfuscates any potential differences that may be there. With many racial and ethnic minorities in the military and veteran population, their unique trauma histories, additional stressors associated with racism and discrimination, clinical presentations, health concomitants and treatment needs, and preferences are imperative to document and address. Moreover, it is equally important that research includes BIPOC voices in the development, design, and interpretation of results as much as BIPOC communities need to be represented within treatment groups (Bharat et al., 2021).

Taken further, most of the studies that examine predictors or moderators of treatment outcome seem to examine the individual effects of sociodemographic categories (e.g., race/ethnicity, age, disability status, socioeconomic status, sexual orientation, and gender) as opposed to their intersectionality. An intersectional lens might yield more nuanced understanding and substantive findings. To provide quality mental health care to military and veteran populations, there should be a competent incorporation of culture. This might include religious and spiritual beliefs, acculturation, ethnic identity, cultural attitudes, and folk healing (Goss et al., 2017; Tseng & Streltzer, 2001) as well as competence in military or warrior culture (Zwiebach et al., 2019). Thus, cultural adaptations and treatment that considers the whole person within their context and culture are necessary for adequate and relevant PTSD treatment among BIPOC ADSMs and veterans.

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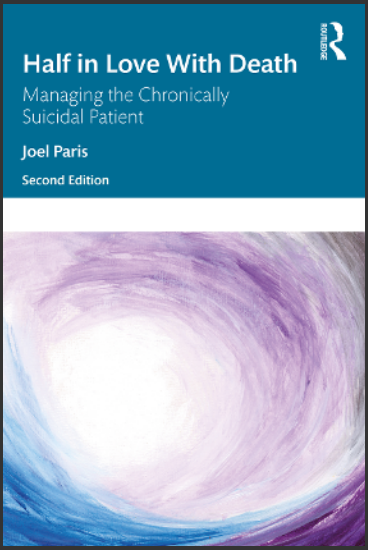
CHAPTER

5

Myths of Suicide Prevention



Half in Love With Death

Managing the Chronically Suicidal Patient

Joel Paris

Second Edition

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Half in Love with Death

Joel Paris

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Chapter 3

Myths of Suicide Prevention

Predicting and Preventing Suicide

To prevent suicide, it must first be predictable. Let us review what we do and do not know about prediction. Over 20 years ago, an expert in suicidology (Goldney, 2000, p. 485) stated: "the sobering reality is that there has not been any research which has indicated that suicide can be predicted or prevented in any individual." That conclusion still holds today. A more recent review (Zalsman et al., 2016) concluded: "In the quest for effective suicide prevention initiatives, no single strategy clearly stands above the others. Combinations of evidence-based strategies at the individual level and the population level should be assessed with robust research designs."

Clinicians have been trained to identify patients who have risk factors associated with fatal outcomes. But, as we have seen, since these clinical algorithms cannot predict *which* patients will eventually die by their own hand, we cannot use that information to save lives. The problem is that whether we attempt to predict suicide from ideation, from attempts, or from other risk factors, we are faced with a very large number of *false positives.* It is worth emphasizing one more time that you cannot predict a rare outcome from a set of common clinical features.

As longitudinal research shows, no combination of risk factors predicts suicide in large samples of patients admitted to hospitals with suicidality (Pokorny, 1983; Goldstein et al., 1991). Moreover, whatever the short-term effects of admission to hospital, they do not prevent suicide. Thus, Haglund et al. (2019) reported that many suicidal patients can die shortly after discharge from hospital wards.

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Some people find all this unpredictability to be depressing, but I find it liberating. Most of the patients I see have chronic suicidal ideation and a history of attempts, but they do not benefit from visits to emergency rooms (ERs) or admissions to hospital wards.

Yet psychiatrists in training are still being taught to use standard algorithms to make decisions for patients who come to ERs and who have been thinking about or threatening suicide. The result is a massive waste of scarce resources.

There are several reasons for the continued failure of models that claim to evaluate risk. First and foremost, suicidal ideation and attempts are poor predictors of fatality, which only occurs in a small minority of patients we see. Another is that clinicians are most likely to treat patients who have made attempts that are not life-endangering and who are signaling a need for help. Finally, the majority of deaths by suicide occur at the first attempt, are not necessarily preceded by attempts, and do not present to clinical settings. In a classical study of fatal outcomes (Maris, 1981), the overall rate of suicide at first attempt was 75%, with 88% of deaths over the age of 45 being first attempts. The National Violent Death Reporting System, using a sample of 73,490, found that 79% died on the first attempt and were mostly men using firearms or hanging (Jordan and McNiel, 2020).

Clinical cases with suicidality are a different population and require a different perspective. As discussed in Chapters 1 and 2, long-term follow-up of patients who presented with attempts in an ER found that only 3% eventually died by suicide (Hawton, Zahl, Weatherall, 2003; Zahl and Hawton, 2004). These are the patients we can often treat successfully and who do not benefit much, if at all, from an overnight stay or a hospital admission.

Yet some experts insist on a hopeful attitude about the overall risk for suicide. In a review published in a leading medical journal, Mann et al. (2005, p. 2065) claimed: Suicide prevention is possible because up to 83% of suicides have contact with a primary care physician within a year of their death and up to 66% within a month. This view would suggest we need to encourage screening of depressed patients by primary care physicians and better treatment of major depression. But these conclusions go far beyond the available evidence and have not been confirmed by research. First of all, depression screening mostly picks up mild cases that are not at risk for suicide (Thombs and Ziegelstein, 2014). Second, psychological autopsy studies have not shown that visits to physicians in those contemplating suicide involved any discussion of depression (Robins, 1981).

Thus, we do not know how to make predictions about suicide risk, even though researchers have long tried to do so. While measures of intent can be statistically associated with eventual fatality (SuominenIsometsa, Haukka, Lonnqvist, 2004; Harriss et al., 2005), they are never strong enough to usefully predict an outcome in individual patients. There is, of course, a greater likelihood of a fatal outcome after life-threatening attempts. Beautrais (2003) followed up a sample of 302 patients with medically severe attempts, and the rate of death by suicide after 5 years was as high as 6.7%. In another study (Gibb et al., 2005), the suicide rate on 10-year follow-up for patients hospitalized for serious attempts was 4.6%.

Overall, between 3% and 7% of all attempters can be expected to eventually kill themselves, and higher rates are associated with more severe and/or repetitive attempts. Even so, the great majority of these patients will never die by suicide.

Another factor that has been studied as a predictor is diagnosis. Several severe mental disorders carry a risk for suicide. Schizophrenia, melancholic depression, bipolar illness, and alcoholism all have suicide rates around 10% (Inskip et al., 1998), and borderline personality disorder (BPD) also carries a risk between 5% and 10% (Paris, 2020a). But once again, diagnosis only identifies populations at risk and cannot be used to predict outcomes in individual patients.

Research has also been conducted on suicide prevention programs in high-risk populations. For example, some studies have focused on occupations known to have a particular risk for suicide, such as soldiers and military veterans (Pruitt et al., 2019). The American military funded one of the largest projects ever conducted, the Study to Assess Risk and Resilience in Service Members—Longitudinal Study (*STARRS-LS*; Ursano et al., 2020). But while this data illuminates some of the risks, it does not support an effective program for prevention.

We need to restrain hopes and accept facts. By and large, we lack evidence-based data to guide *any* program for suicide prevention. However, we do help suicidal patients to stop making attempts. Thus, in treatment-seeking patients, there is good evidence that psychotherapy can reduce repetitions of suicide attempts (to be discussed in Chapter 7). What we do not know is whether therapy for chronically suicidal patients actually prevents that population from fatal outcomes.

In summary, *treatments* for suicidal patients have never been shown to reduce the risk of fatality with any consistency. We have much better evidence that *population-based interventions* can be effective in reducing the suicide rates.

Population-Based Interventions

Restricting Access to Means

Restricting access to means is the most important way to lower the suicide rates. This strategy has repeatedly been shown to be effective (Jenkins and Singh, 2000; Turecki and Brent, 2016). The suicide rates have long been known to be increased by the ownership of guns (Miller et al., 2007), even when firearms are not in regular use. Unfortunately, in some countries, particularly the USA, guns are part of the culture and are widely available. This is most likely the main reason for a higher rate of suicide in that country.

Other means for suicide can also be more easily controlled. One of the most striking reductions of the suicide rates occurred when the UK changed the content of natural gas provided to homes to reduce the content of toxic fumes (Kreitman, 1976). As for overdoses, Hawton, Harriss et al. (2003) reported that simply reducing the size of packages of pain medication is associated with lower suicide rates. All these findings support the conclusion that the most convincing evidence that suicide can be prevented comes from a population-based strategy (Kapur and Goldney, 2019).

Education of Gatekeepers

This option has been widely studied, but it is difficult to determine whether it is effective. For example, primary care physicians may miss observations that suggest a patient is considering suicide. For this reason, it has been proposed that education might help these practitioners to identify clinical depression, which would, in turn, allow treatment (Andersen et al., 2000). However controlled trials of these procedures are lacking to show that they actually prevent suicide (Zalsman et al., 2016). Again, the fact that depressed patients visit physicians does not mean that they discuss suicidal ideation.

A related type of program involves educating "gatekeepers," nonprofessionals who are in contact with potentially suicidal individuals and who are in a position to direct them to treatment. One study applied this method to a large number of soldiers in the American Air Force (Knox et al., 2003) and reported a 33% reduction in suicide over 2 years. But in the absence of, or controlled, trials, this finding is not solid enough for clinical application (Isaac et al., 2019).

Suicide Hot Lines, Close Follow-up, and Media Coverage

"Hot-line" services for suicidal patients have been adopted in many countries. The USA has recently created a 988-line, open 24/7, for this service. But while phone calls may be supportive in the short term, they have not been shown to have any effect on the suicide rates. A group called the Samaritans pioneered this approach in the UK in the 1950s, but a study comparing locations where the program was active to those where they were not reported no differences in the suicide rates (Jennings et al., 1978). Most of the people who call these lines have suicidal ideation and need someone to talk to.

A rather different approach is to encourage professionals to maintain contact with high-risk patients. Motto and Bostrom (2001) studied a large group of patients who had been hospitalized for suicidality but who refused clinical follow-up after discharge. The authors conducted a randomized controlled trial in which the "treatment" consisted only of sending patients a letter four times a year indicating that the team was interested in their progress. Compared to a control group who did not receive such letters, this simple intervention reduced fatalities over 2 years. However, the effect was rather small (21 suicides in the controls and 15 in the contacted group), and the study has never been replicated.

It has long been thought that media coverage of fatalities can produce a social contagion that increases the suicide rates, and that restricting reporting reduces these "copy-cat" deaths (Sisask and Värnik, 2012). This is why many jurisdictions have policies that discourage or ban media reports of suicide. There is, in fact, good evidence supporting this practice (Turecki et al., 2019). (Where I live, when underground train lines stop running, I usually wonder whether there has been a suicide on the tracks that will never be made public).

Also, restriction of access to suicide at a particular site (such as a bridge) can be designed to reduce fatalities (Mann et al., 2005). This kind of intervention targets those who are ambivalent about suicide or who may make attempts on impulse. Seiden (1978) interviewed 29 survivors of jumps from the Golden Gate Bridge in California, who all reported that they regretted their actions before hitting the water. The question remains as to whether those who are strongly bent on suicide will find other means or other bridges.

The Importance of an Evidence Base for Prevention

Prevention of illness is highly valued in medicine. Since almost everyone who dies by suicide suffers from a mental disorder, one would think that clinical interventions, such as treatment for depression, should be an effective method of prevention. But the evidence does not support that expectation. As we have seen, population-based strategies, particularly reduced access, do make a difference. This conclusion could change in the future. But keep in mind that suicide has existed in every society as long as historical records have been kept. Prevalence fluctuates over time but is never absent. That is why good intentions are not sufficient to establish the usefulness of prevention.

Instead, prevention programs, like any other form of health-care practice, need to be evidence based. While several countries have developed national strategies for suicide prevention, clinical trials need to be carried out on these programs. We should not routinely offer interventions without first obtaining data showing that we can predict and prevent suicide.

Demonstrating a causal relationship between interventions and outcomes ideally requires prospective data in randomized controlled trials. However, that kind of research is quite expensive and would be even more costly if applied to the community instead of clinical samples. Clearly, since death by suicide is a rare event, large cohorts would be needed. But there is another obstacle: ethics committees will be hesitant about supporting clinical trials on suicidal patients. Some may even argue that withholding interventions for this population is not ethical. But if we do not know whether an intervention we are not providing would have made a difference, could it be unethical to *fail* to carry out research that could answer these questions?

I have been working with chronically suicidal patients for decades. While it is my impression that mental health professionals save lives in individual cases, I cannot be sure. But if we make our goal a reduction of non-fatal suicidal behavior, we have good evidence that treating patients who make attempts can be successful (see review in Turecki et al., 2019).

But clinical practice does not address the needs of most people who decide to kill themselves and who are not in treatment.

Suicide is an emotional issue. Death by one's own hand is almost always a tragedy. Yet it is not possible to know whether any individual patient would actually have died without interventions. Empirical evidence on the prediction and prevention of suicide suggests that clinical impressions about prevention are insufficient for any conclusion and do not reflect clinical reality.

The fact is that most mental health clinicians will have suicides in patients over a lifetime of practice (Chemtob et al., 1988a, 1988b). If they have not, one might ask what kind of practice they are conducting and whether they have been avoiding treating sick people. Forty years ago, we invited the well-known suicidologist Terry Maltsberger to visit our department. As it happened, a young man with schizophrenia died by leaping from a window on the in-patient unit a few days before our visitor arrived. But when we presented the case to Dr. Maltsberger, his comment was that any good unit is bound to have suicides, and if they never have them, the higher security required interferes with therapy.

If you actively choose, as I do, to treat suicidal patients preferentially, you are sure to lose some. Our research group (Paris and Zweig-Frank, 2001) as well as others (Stone, 1990) have reported that about 10% of patients under care for BPD eventually die by suicide, usually after a series of unsuccessful therapies. But that also means that 90% eventually choose to go on living. That is the good news, and it is very good news indeed.

These conclusions should not in any way lead to a dismissal of a patient's wish to die or to justify a laissez faire attitude. Suicidality always has to be taken seriously, mainly because it reflects psychological pain. Thus, suicidal thoughts and actions both communicate profound suffering and hopelessness. This is a message that has to be received, understood, and acknowledged.

Hospitalization and the Illusion of Safety

Chronic suicidality takes a toll on clinicians. Half a century ago, Maltsberger and Buie (1974) described how suicidal threats can wear down therapists to the point that they emotionally withdraw from these patients. There is another, even more frequent, scenario that can be damaging in a different way. Anxiety about losing a patient to suicide often leads to the decision to send patients to hospital every time they threaten to end their lives.

Our assumptions behind the practice of hospitalizing chronically suicidal patients are wrong on several counts. First, is it true that patients are likely to commit suicide if sent home (and will not do so if admitted to a hospital ward)? No one has ever shown this to be the case. As we have seen, predicting fatality from ideation or attempts is virtually impossible. When a patient is admitted to hospital (and leaves with reduced suicidality), therapists may get the impression that they have carried out a life-saving intervention. But an acute crisis is rarely the scenario for suicide. More die at home out of sheer hopelessness. If patients had not been admitted, we do not know what would have happened: the vast majority who are ambivalent about dying would most probably have not taken their life.

Second, in what way is a hospital environment truly “safe”? Admitting patients is often rationalized on the grounds that we must ensure “safety.” But there is no such thing as a safe place for patients who are seriously suicidal. In order to physically prevent suicide in a hospital environment, nursing procedures have to become extreme. Patients may be put on a suicide watch, with someone hired to sit with them 24 hours a day. Even so, some have been known to kill themselves on hospital wards in spite of all these precautions. This is particularly likely to happen in psychotic patients with schizophrenia or severe mood disorders.

Third, the hospital environment can be toxic for chronically suicidal patients. Understanding this problem requires therapists to embrace a paradox. Some people with chronic suicidality are actually pleased to be in a ward. And when beds are short, some will be held over in the ER in rather uncomfortable circumstances. Even so, we can often see such patients happily chatting with others who are more or less in the same boat. The point here is that the environment of a hospital ward, however unappealing to us, can be less lonely than a patient’s own apartment.

It has sometimes been suggested that patients in a crisis need to be in hospital for a “respite.” But we do not know whether admissions on such a basis are truly therapeutic, either in the short run or the long run. When a patient is discharged, the situation can go rather quickly back to “square one.” And a reinforcement pattern has been set up that often leads to further hospitalizations. Linehan (1993), a behaviorally trained researcher, suggested wryly that if a patient must be hospitalized, the environment should be as *unpleasant* as possible.

Moreover, there are reports in the literature of patients worsening in response to hospitalization. The scenario has been called "malignant regression" (Dawson and MacMillan, 1993). This concept describes a sequence in which some patients become *more* suicidal (not less) in the hospital. To consider one example, wrist cutting can escalate in a ward in spite of precautions. While nursing procedures involve removing sharp objects from the patient's possession, it is almost impossible to prevent this behavior entirely. One can even see overdoses, particularly on open wards where there is no realistic way to prevent patients from walking across the street to buy over-the-counter medication at a pharmacy.

What is the explanation for malignant regression? Simply put, suicidal behavior can be *reinforced* on hospital wards. If we apply classical behavioral principles, the more pleasant the environment in the hospital, the higher the risk that suicidality will continue or even increase—at least in some patients. One of the main reasons for this reinforcement mechanism is that the more suicidal patients are, the more time and attention they are given by staff.

For patients with poor social supports, a week in a ward, or even a night in an ER, offers some kind of connection. In this way, a ward can be a site for attachments. Chronically suicidal patients may talk to nurses and students who may take a special interest in them and/or form relationships with other patients, usually those with similar problems. I have even heard patients claim they are "making friends" on the ward. If the hospital environment is sufficiently reinforcing, patients may understandably be afraid of discharge, with its inevitable return to a lonely and difficult life on the outside. To avoid this feared outcome, their suicidality may escalate. Where there is no limit on length of stay, these patients may end up spending months (or even years) on hospital wards. I have heard some experts suggest that staff shortages and managed care could actually be good for chronically suicidal patients.

Thus, what appears to be a safe environment may not be safe in the long run. Hospitalization is a two-edged sword. It sometimes creates an environment that reinforces the very behaviors that therapy is trying to extinguish. Most clinicians will recognize a scenario in which patients escalate suicidal or self-harming behaviors in the hospital.

A patient who recovered from BPD (Williams, 1998) published a brief article in *Psychiatric Services* based on her experiences as a consumer. Williams described how repetitive hospital admissions made her worse: Do not hospitalize a person with BPD for more than 48 hours.

My self-destructive episodes—one leading right into another—came out only after my first and subsequent hospital admissions, after I learned the system was usually obligated to respond. Williams went on to say,

> When you as a service provider do not give the expected response to these threats, you'll be accused of not caring. What you are really doing is being cruel to be kind. When my doctor wouldn't hospitalize me, I accused him of not caring if I lived or died. He replied, referring to a cycle of repeated hospitalizations, 'That's not life. And he was 100 percent right!'
>
> (Williams, 1998, p. 174)

I agree with her views and have said so at many conferences and symposia. It can be difficult, however, to convince clinical staff that hospitalization is unnecessary and unproductive. After all, this is how they practice. Many will point to a recent or not so recent suicide as a warning, even if they cannot show that such outcomes could have been prevented.

Reassuringly, most experts on the treatment of personality disorders agree with my point of view. I include Linehan (1993), Kernberg (1987a, 1987b), and Livesley (2003) on this list. The late John Gunderson (2003) also believed that hospitalization is usually unhelpful for chronically suicidal patients but was reluctant to refuse admission to patients who insisted on it. His concern was that even when hospitalization is predictably ineffective, refusing it can lead to a power struggle. In a book on BPD, Gunderson and Links (2008) proposed a paradoxical intervention in which a therapist agrees to hospitalize the patient for suicidality, while letting them know that doing so will not be helpful (with the hope that the patient will then elect to decline the offer). My experience is different: if patients are not admitted after a few tries in the ER, they stop insisting on that option.

Several BPD experts (e.g., Gunderson and Links, 2008; Kernberg, 1987a, 1987b) also recommend that therapists tell patients that in the long run, they cannot take responsibility for their survival. They also advise therapists to inform the family of the situation and the rationale for avoiding hospitalizations. (Ways of involving families in the treatment plan will be discussed in Chapter 11.)

In spite of a lack of evidence, some experts continue to advocate hospitalization for most patients who threaten suicide. Over two decades, this conclusion was promoted by the American Psychiatric Association

Guidelines for the treatment of BPD (Oldham et al., 2001). I regret that this report did not consider the absence of evidence for its position. (And 20 years later, the guideline has never been revised.) The problem with clinical guidelines is that its conclusions are usually based on expert consensus rather than hard data. The absence of controlled trials to support hospitalization should put those of us to oppose it in a reasonably strong position. Peter Tyrer (2002), a British researcher on personality disorders, described the American Psychiatric Association guidelines for the treatment of BPD, which recommend hospital admission, as "a bridge too far," i.e., going far beyond empirical evidence while justifying clinical tradition.

To assess the value of hospitalization, we need to go back to basics. The standard approach to evaluating suicidality in clinical practice consists of eliciting suicidal ideation and documenting risk factors that may predict a fatal outcome. If the risk is seen as high, the patient is sent to hospital. But these procedures, even if been useful in acute suicidality associated with a severe episode of depression, have never been tested for chronic suicidality.

In short, hospital admission for chronically suicidal patients can help therapists feel better for a while but do little for patients. The underlying principle seems to be what might be called *the rule of fear*. Patients are admitted because their therapists are afraid they will kill themselves. The question of whether hospitalization actually saves lives or changes the course of illness is an empirical question that is not addressed.

Moreover, hospitalization is expensive. Scarce and valuable resources could be better used to carry out specific treatment plans that can be only provided in a hospital setting and that are supported by empirical evidence. And beds are short these days. For example, in acutely psychotic patients, the rationale for admission is clear. We have treatments for psychosis that work within a short time. Nor would anyone doubt the importance of hospitalizing suicidal patients with a classic melancholic or psychotic depression. In such cases, the efficacy of treatments, ranging from higher dose antidepressants to electroconvulsive therapy, is well established, and we often see results within days. It makes sense to bring patients into the hospital to carry out these interventions, and I would not disagree with instituting suicide precautions to make sure the patient does not die before the treatment takes effect.

Acutely depressed patients with suicidality can benefit from a restrictive hospital environment. But in patients with chronic suicidality, that approach fails because the underlying problem is not likely to be resolved in a short time, and success requires outpatient therapy. Nor can hospitalization be justified if, as is the case for mental disorders such as schizophrenia and bipolar illness, it provides an opportunity to administer effective pharmacotherapy. As Chapter 8 will show, medications for chronically suicidal patients have not been shown to yield the specific effects of drugs used for schizophrenia or severe depression and can only sometimes reduce distress on a short-term basis. In any case, pharmacological interventions do not require a hospital setting for their administration.

Is hospitalization *ever* useful in chronic suicidality? To answer that question, we should consider the most common reasons why patients with BPD are hospitalized (Hull et al., 1996). These include psychotic episodes, serious suicide attempts, suicidal threats, and self-harm. It is logical to admit a patient for treatment of a brief psychosis. I would also support the admission of a patient after a life-threatening suicide attempt. Even if no active treatment is conducted in hospital, a brief admission can provide an opportunity to assess precipitating factors and review treatment plans. But the most frequent scenarios (suicidal threats, minor overdoses, and self-harm) are unlikely to benefit from admission, and treatment for these symptoms can be provided in outpatient treatment. When admitted, chronically suicidal patients simply sit on the ward, being monitored and observed. The problem is that clinicians may be afraid to discharge them.

Links and Kolla (2005) argued in favor of retaining an option for hospitalization on the grounds that life crises can represent a scenario that he terms "acute on chronic suicidality," i.e., an acute episode raising the immediate risk in a patient over a baseline of chronic suicidality. However, Links offered no empirically supported way to separate these phenomena. Since chronically suicidal patients have frequent "acute on chronic" episodes, Links' proposal would lead directly and inevitably to repetitive hospitalizations.

We also need to take into consideration the negative effects of hospitalization. Marsha Linehan once suggested at a conference that the best thing that ever happened to patients with BPD is managed care in the USA, since it prevents psychiatrists from prescribing longer treatments that are bad for them. Linehan (1993), applying the principles of behavioral psychology, discouraged admission for patients with BPD, tolerating at most an overnight hold. A brief stay in an ER is less regressive than a full admission, and since beds are scarce, holding patients overnight in the ER is the preferred alternative.

Even so, overnight holds have their own problems. Most patients agree readily to go home in the morning, but some will not. The outcome may depend on emergency psychiatrists who do morning rounds on patients held over from the night before. Patients who give "the wrong answer" about suicide tend to be kept. These physicians need to be fairly tough—if they are not, the patient may have to "go upstairs."

In a recent incident at one of the hospitals at my university, two experienced emergency psychiatrists, both of whom understood chronic suicidality and personality disorders, went on vacation during the same week. When they returned, the ER was full of chronically suicidal patients who had been there for several days, admitted and held by replacement physicians who had less experience with this population. These psychiatrists had simply passed on the decision, with predictable results.

While I do not favor a policy of holding over patients with chronic suicidality more than overnight, I cannot *prove* that I am right. I have not carried out a controlled trial (nor is it likely that anyone ever will). But I am not convinced of the necessity of this practice, for any reason other than reducing the anxiety of the physician on call. I worked for 25 years in the ER of a busy general hospital and almost never admitted anyone for suicidality. Sometimes patients left the ER in a rage, warning me, "you will hear about this in the newspaper." But it *never* happened that patients went home and kill themselves. Nor have I ever heard of this occurring when anyone else was on call. (As we will see later in this book, chronically suicidal patients carry out these intentions when they feel hopeless and disengaged, not when they are angry at the system.)

Hospitalization can also make patients worse by cutting them off from their social and occupational networks. Ironically, this may be why restrictions on hospitalization of psychiatric patients (based on the policies of Health Maintenance Organizations in the USA, as well as major reductions in overall hospital beds in Canada and other countries) may have benefited this population. And if, as so often happens, a patient becomes suicidal again shortly after discharge, little is accomplished. It is not unusual for chronically suicidal patients to have a return of ideation when they have to re-enter the outside world. In this context, using a hospital ward as an asylum provides no framework for addressing the problems that make patients suicidal in the first place.

Clinicians should be particularly concerned about longer admissions. The longer hospitalization continues, the more likely it is that the patient will not be able to return to work or maintain links with other stabilizing influences in their outside life. Even today, some patients can spend weeks on a hospital ward without active treatment. What leads to these lengthy admissions is the rule of fear, in which patients are not seen as "dischargeable" as long as they continue to threaten suicide. In one case on which I was consulted, a patient had spent *3 years* in a unit designed for acute care. Every time discharge was brought up, the patient would announce that she would throw herself in front of a subway train. Yet when this patient eventually left, she never chose to die by suicide.

Another problem is that once hospitalization occurs, admissions tend to be repetitive. Some patients fall into cycles in which they are in and out of hospitals for years. In the days of paper records, charts containing several volumes could barely be lifted.

Reviewing the various scenarios described in Chapter 1 under the broad term "suicidality" helps us to understand why hospital admission does not address the problems of chronically suicidal patients. Suicidal threats should never be dismissed, as they communicate a state of severe distress that therapists need to acknowledge and deal with. But by themselves, they do not constitute a sufficient reason for hospitalization.

Similarly, while suicide attempts are one of the main reasons why patients are admitted to hospital, there is no evidence that this approach provides effective treatment or prevention. One needs to consider the nature of the suicidal act. Some suicidal gestures consist only of self-harm. Many overdoses consist of impulsive actions related to interpersonal crises, associated with low levels of intent. In contrast, overdoses that are potentially lethal or that land the patient in an intensive care unit are different. I accept these actions as one of the few justifications for hospital admission.

Ultimately, the problem with hospitalization is that it interferes with the main treatment for chronic suicidality, i.e., outpatient psychotherapy. It may not be possible to carry out effective management in these patients when frequent and repetitive hospitalizations interrupt the course of therapy. This point is well made in a classic article by Schwartz et al. (1974, p. 204), who were the first to point out that chronic suicidality is a unique clinical problem and that interventions appropriate for acute suicidality may be inappropriate or even counterproductive in this group.

"The management of the person for whom suicidality has become a way of life requires a willingness to take risks and an acceptance of the fact that one cannot prevent all suicides. Those are two qualities which not all therapists have. Once one has concluded that the only way to strive toward the ultimate reduction of lethality is to accept the risk of suicide in the interim, one next needs to determine to what degree the patient and the other people important in the patient's life are ready to accept those risks and to share the responsibility for treatment."

In this light, therapists who treat this population benefit from having certain personal characteristics. If they want to help these patients, they need to give up the idea of being a savior. One can remain optimistic without being omnipotent. One may not be able to treat these patients unless one accepts taking what one expert (Maltsberger, 1994a, 1994b) called a "calculated risk." Maltsberger agreed that repetitive admissions are not helpful and concluded that one cannot treat chronically suicidal patients without accepting some risk of fatality. This paradox lies at the center of the problem.

Hospitalization is not the only alternative when outpatient management is unable to handle suicidal crises. When therapy spirals out of control and the clinician needs the help of a specialized team, partial hospitalization can be useful. Unlike full admission, day treatment has been empirically demonstrated to be effective in cohorts of patients with BPD (Piper et al., 1991; Bateman and Fonagy, 1999).

One reason why partial hospitalization is useful is that it provides a highly structured program. Patients with BPD typically show increased pathology in an unstructured environment (Gunderson and Links, 2008). In this respect, day hospitals contrast with the environment of a ward, where there are large amounts of unstructured time, and where "acting out" may increase on evening shifts when there are no activities at all. In a partial hospital program, where activities are scheduled every hour, little time remains to slash one's wrists. Regression is further limited by the fact that the patient goes home at night. Given that there is no evidence that full hospitalization prevents suicide completion, suicidal risk is not a contraindication for day hospital treatment.

Thus, unlike full hospitalization, day treatment is a better choice for this population. These programs combine many types of intervention, including individual therapy, group therapy, family therapy, occupational therapy, and psychopharmacology.

Time is another factor in partial hospitalization. The day programs examined in the randomized controlled trials quote above lasted at least 6 months. Over this period, improvement could occur through the therapeutic effects of a milieu and/or social and occupational rehabilitation. However, these longer (and more expensive) stays may not be necessary; no one has compared them to briefer periods of treatment. One of the day hospitals in the university where I work long had an 8-week program, a rule that motivates patients to change, and I was rarely disappointed with the results.

Unfortunately, many treatment centers have unreasonable waiting lists or entirely lack day treatment programs. Even when access is possible, it is rare that one can rapidly get patients from the clinic or the ER into partial hospitalization and avoid a wait of several weeks. This is unfortunate, given the fact that this option has been around for a long time; the first day hospital in North America opened in Montreal in 1944. Mental health services can become dependent on hospital beds, whether they were useful or not. Whereas everyone complains about closed beds, few lobby for the opening of day treatment centers.

Accepting Calculated Risks

Most chronically suicidal patients are followed up in outpatient therapy. If they hope to address the root causes of suicidality, therapists must accept some degree of risk. There is also evidence that outpatient treatment works for suicidality. Studies of several psychotherapeutic methods, including dialectical behavior therapy (DBT; Linehan, 1993) and mentalization-based treatment (MBT; Bateman and Fonagy, 2004), have shown that they are effective in reducing both self-harm and suicide attempts, without any time in hospital. What we lack is follow-up data to determine whether completed suicides are less likely in patients treated with these methods.

The management of chronic suicidality requires a unique set of principles. Unlike patients with psychosis or melancholia, patients with personality disorders who are chronically suicidal rarely commit suicide while in hospital. Although some completions can occur soon after discharge, most patients can be expected to remain alive but chronically suicidal. Treatment will take time, and we have no strategies that provide a "quick fix" for the problem.

Kernberg (1984) argued that chronic suicidality requires patience and tolerance and suggested that therapists need to maintain the frame of therapy by not going out of their way to "prevent" suicide at all costs. Kernberg stated (1984, p. 261) that he might tell a patient "that he would feel sad but not responsible if the patient killed himself," would avoid unusual measures to prevent completion, and would routinely inform the family of his management plan. This rationale is similar to that of Rachlin (1984), who pointed out that attempts to save lives in suicidal patients tend to deprive patients of their quality of life.

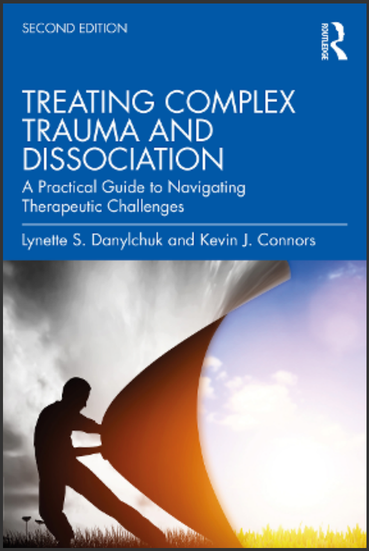
Another crucial point is that it is difficult to conduct effective treatment in an atmosphere of constant turmoil. For this reason, an excessive focus on suicide prevention prevents us from doing our job. When clinicians spend too much time worrying about suicide completion, problem-solving takes a back seat. And when clinicians feel forced to do almost *anything* to prevent suicide completion, the therapeutic relationship becomes characterized by "coercive bondage" (Hendin, 1981) in which the patient controls the behavior of the therapist, and the quality of the patient's life becomes compromised by overzealous concern.

Even if we cannot prevent patients from dying by suicide, we need not accept an attitude of therapeutic nihilism. Most of the patients we see who are considering suicide will not kill themselves. And most can benefit from treatment. Once we move beyond trying to prevent suicide, we can be liberated to accomplish more with chronically suicidal patients.

CHAPTER

6

Overview of the Three Stage Phasic Model of Treatment and Tasks of Each Stage



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5 Overview of the Three Stage Phasic Model of Treatment and Tasks of Each Stage

Working with complex trauma and dissociative clients is analogous to an old vaudeville style of performance—plate spinning. The performer would have a row of thin vertical wooden dowels, each approximately five feet tall. The performer would place a dinner plate on the first dowel and start spinning the plate. When the spinning of the plate achieved a fast enough pace, the plate would remain balanced on the pole and the performer would start the next plate spinning on the next pole. After getting two or three plates rotating rapidly on their respective poles, the performer would return to the first pole and gently shake it in a circular manner to keep the plate spinning at the proper speed. From there the performer might add another plate or two to the growing row of precariously spinning platters. Then the performer would quickly dash up and down the line to shake a few sticks less a plate should slow below the critical speed to maintain its balance. Alternating between launching new plates and maintaining the currently spinning ones, the performer would attend to the row of whirling china until every dowel was topped.

Similarly, while we talk of treatment being a three stage phasic process, the client never stops working on the tasks of Stage One even as they move onto addressing the tasks of Stage Two. When the client has progressed to meeting Stage Three goals, they will often find that they are moving back down the line to address Stage One or Stage Two tasks. Describing trauma treatment as a non-linear process does not do justice to the intricate dance of responding to the complexities of the needs and emerging issues of trauma clients.

Trauma treatment is thought to be best done in stages, starting with safety and stability, moving through remembrance and mourning, and ending with the integration of the trauma and a realization of the authentic self in the world (Herman, 1997). In reality, those "stages" are more like aspects of the process that may need to be dealt with at any time during treatment. As much as possible, it's best to focus on stability at the beginning, to help the client calm down and create as firm a foundation as possible from which to do the deeper work of intentionally facing the trauma. Also, in working with safety and stabilization, the client learns skills that help with the processing of the traumatic material, making that aspect of therapy move more quickly and effectively. The maxim that "the slower you go, the faster you get there"

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(Kluft, 1993) is based on the experience that the skills learned in what is traditionally thought of as the first stage of therapy enable the client to move through the second stage much more easily, with less disruption in all areas of life, and a greater sense of mastery while moving through the effects of the trauma. Without the safety and stabilization skills, therapy can be destabilizing and potentially re-traumatizing. The third aspect of therapy, integration of the trauma and authentic expression of self, emerges to some extent periodically throughout therapy as people work through issues and take growth steps forward, and becomes the natural focus towards the end of therapy.

It is not uncommon for people to come in for help when they are in a crisis. It is often imperative that the therapist deal with that crisis immediately. When that's the situation, the skills and knowledge normally taught in the first stage of therapy need to be taught simultaneously, while dealing with the crisis. Simple grounding tools, some cognitive-behavior skills, psycho-education, and pacing can all be done in the midst of working through a crisis. It's preferable to have these skills prior to dealing with overwhelming emotions and a disrupted life, but it's still essential and very helpful to learn the skills as part of bringing down the overwhelm, and the more those skills are taught, the more empowered the person will be to continue in his or her process.

There is a sense of these aspects of therapy being interwoven. The stability provides the space and ability to face the trauma, and facing the trauma allows for it to become part of a coherent narrative, and, appropriately, in the past. Having worked through a trauma, the person is often open to acknowledging and facing whatever other traumas may have occurred in their life. Thus, people who have complex traumas may find themselves automatically wanting or needing to heal other traumas once they've felt the relief of healing and integrating one.

In dissociative systems, a trauma processed by one part of the person will need to be acknowledged and integrated into the whole system. Sometimes that happens easily, with different parts of the person witnessing the work and following the process with some co-consciousness. In those cases, dissociated parts may actually support or assist in working things through. In more severely split systems, there may be amnesia or an emotional barrier between the part in therapy and the rest of the system, resulting in a more prolonged therapy as the parts become known, and the person is guided through the therapy necessary for a dissociative system to become co-conscious, cooperative, and eventually as integrated as possible.

With dissociative clients, the aspects of therapy are often all happening simultaneously. Even then, however, it's helpful to emphasize stability first, and the other aspects of therapy afterwards. There may be times when parts of a system emerge in a flashback, or come forth believing that the only way to do trauma work is to recreate the feeling of the original ordeal. When these things happen, another part of the person may step in to put on the emotional brakes. Stopping the process can happen by stating the need to slow down directly, or indirectly, by coming too late to an appointment, or skipping sessions. It can also happen with protective alters coming out in session and telling the therapist to stop, sometimes rationally, and sometimes with panic or anger. In other people, a self-helper part or function may step in and let the therapist know it's important to stop. There are many ways for the person to self-regulate when the therapy is going too fast or too intensely. It's helpful in those times to thank the part of the person who slowed or stopped the therapy, and come up with a signal for that part to indicate to the therapist whenever things are not ok inside. This builds a collaborative feeling and helps keep the therapy within the client's overall window of tolerance.

While trauma treatment is described as a three stage model, this presents a false sense of it being a linear process. Trauma treatment is non-linear. Each stage builds upon the previous ones. Return to the image of trauma therapy being like a performer spinning plates on sticks. In order to keep all the plates from crashing, he'll need to give each a push in turn according to the needs of the moment to keep it all going.

Stage One: Safety and Stabilization: Finding a Place to Stand—Setting Up the Context of Therapy, Boundaries, Expectations, Contracts

"The value of a treatment method is inextricably bound to the relational context in which it is applied" (Norcross, 2011).

Other than the client's personal resources and honest and authentic motivation to change, the most significant factor predicting growth and healing is the strength and quality of the therapeutic relationship. This therapeutic alliance is created through a consistent practice of key principles. Foremost is the therapist having excellent interpersonal skills and engaging the client in a welcoming fashion. To be met with empathically attuned, non-judgmental, open curiosity is to create a profound sense of acceptance. When clients feel that the therapist genuinely cares and wants to work with them, they are more open to engaging and feeling empowered to engage.

To create the therapeutic alliance is to create an attachment, a dyadic bond. In this case, the attachment evolves out of a process of reciprocal engaging behaviors between therapist and client, where each recognizes, elicits, and responds to the other in a mutually attuned, ongoing process. The therapist does this to the best of his, her, or their ability, modeling it while also teaching the client about healthy attachment and how this is fundamental to healthy relationships.

The initial task in creating the safety and stability to support the work of trauma recovery is to define the therapeutic relationship as a safe environment in which to meet and to explore problematic feelings, memories, and relationships. Defining the relationship as "safe" is only the first step in a process that will, hopefully, provide sufficient experiences of safety for the client to begin to actually know that the relationship is safe. Survivors are often very familiar with people being warm and kind at the beginning of a relationship, and then using the closeness that develops to harm the client. This is a way in which people are "groomed" to be abused, and therapists need to know that experience is behind a lot of survivors' hesitancy in trusting people who call themselves "safe". Many therapists who work with severely traumatized people have learned to not use the word "safe" without checking to see what that means to the client. Often, the therapist and client choose other words to describe the experience of not being in imminent danger.

The creation of a safe place (or "*danger-free zone*") starts at the first moment of contact and is a collaborative process with the client engaged as a partner in defining the goals of treatment and understanding and setting the guidelines for engagement. The therapist works with the client to specify what healthy therapeutic boundaries will be and how to talk about any difficulties that may emerge for either the therapist or the client during therapy. Carol Mayhew (Connors & Mayhew, 2006) described the purpose of boundaries as creating a "negotiation space" in which it was safe to talk. She noted that good boundaries are consistent and predictable; neither too rigid nor too fluid. As in all human relationships, empathetic flexibility in response to shifting needs and situations needs to be balanced with a desire for stability and certainty. From the beginning, clients should be empowered to express their expectations and needs. Together, therapist and client define and refine the boundaries and expectations as the therapeutic process continues.

People who are coming to heal complex trauma or dissociative issues frequently have great difficulty stating what they need in a way that works. In traumatic situations, their needs didn't matter, and they had no voice in what was happening. In therapy, both of those things are addressed immediately at the onset of the therapeutic process. The client and therapist collaborate as much as possible. The rules they both need to be aware of and adhere to are spelled out clearly. Most therapists include those in their original therapy contract, including rules about confidentiality and the laws that dictate when the therapist must share information about the client. Also included in most therapy contracts is information about the availability of the therapist, payment policies, office or agency policies, HIPAA compliance forms, and, hopefully, information about the therapist's professional will, a document that lets the client know what will happen to the therapy and the client's records if the therapist becomes disabled or dies (Frankel, 2015).

What also should be conveyed at the beginning of therapy is that issues between the therapist and client need to be addressed in the therapy as soon as possible from the time they become known by either person. This places the relationship between therapist and client on the table as something to be discussed whenever necessary and gives the therapist the opportunity to share the importance of this with the client. Unresolved issues can derail the therapy, while issues identified and worked through can add immeasurably to the success of the therapy.

The more severe the abuse, the more the client's boundaries are impacted, and the more often boundaries will need to be discussed, and sometimes slightly altered. In most cases, the boundaries may need to be stretched to accommodate the level of distress and need in the client. In some cases, however, a therapist may make the boundaries more rigid, in an attempt to contain the desperation and need of the client. A survey done by Adah Sachs (2013) compared the boundaries that practitioners kept with clients who suffered Dissociative Disorders (DD) to their boundary practice with all of their other clients. Boundaries were deemed modified when professionals treated their dissociative clients differently than their other clients. The results showed a marked tendency for the modification of professional boundaries when treating people with DDs (Sachs, 2013, p.159). These results appeared to be independent of country or profession but were more pronounced among the more experienced professionals.

For instance, weekly sessions may periodically become bi-weekly sessions, or even daily sessions to work through acute crises and prevent the need for hospitalization. After the crisis has passed, however, the frequency of sessions would diminish, moving back to the norm for that person and therapist. Personal and agency policies may dictate what level of care is possible, and the limitations of the provider need to be clearly stated at the beginning of therapy.

Creating Safety

Safety in sessions includes both emotional and physical safety for both client and therapist. "Do no harm" is a rule everyone needs to follow to the best of his or her ability. With some clients, that may be very difficult. Self-harm and other unhealthy or dangerous behaviors may be the only way the client knows how to handle certain problems, and it may take a while to learn skills that eliminate the hurtful behavior. It takes time to extricate oneself from addictions, and to learn to deal with emotions in non-reactive ways. The therapy will need to involve both harm-reduction strategies and limits for the kinds of behavior that would sabotage treatment.

While most therapists clearly state that it is not acceptable to harm anyone in session, they also normally state that the client may not destroy the office property. Ironically, some clients will intentionally break something in the office in order to be sent away, having no other means of letting the therapist know that they cannot stay in therapy any longer. It is helpful to let the client know that when therapy becomes too difficult, it's acceptable, and a good idea, to tell the therapist. The pace of the work can be slowed down or the direction of the work can be changed to help the client continue with a process that feels productive and not overwhelming.

An important aspect of establishing safety within the therapeutic relationship involves stressing a sense of "I–Thou" mutuality, a deep respect for one another. Too often expectations are simply handed down for how the client is to behave in therapy, and what he or she can, and cannot do. This can be perceived as another set of rules to follow (and challenge) as passed down by yet another authority figure. A more collaborative approach is to have expectations emerge out of a respectful conversation, apply to both client and therapist, and become a behavioral contract between the two people, setting things up to go as well as both people can imagine. As the therapy progresses, expectations may change, and both people can initiate conversations about the need for change and how they can manage that in a mutually satisfying manner.

Clarifying these expectations becomes an embodiment of two people respecting each other, respecting the valuable work they are doing together, and ultimately respecting themselves.

In order to work on difficult material there needs to be an atmosphere of profound respect and safety between therapist and client. This is embodied in the following expectations:

The client will not break any of the therapist's property.
The client will not break the therapist's furniture or otherwise mess up the therapist's office.
The client will not hurt other people.
Clients will not hurt themselves.
And Safety Rule Number One, the Client will not hurt <Insert name of therapist here>.

The therapist goes on to say that this set of expectations is a mutual process and that:

The therapist will not break any of the client's property.
The therapist will not hurt other people.
The therapist will not hurt their own self.
And Safety Rule Number One, the therapist will not hurt <Insert name of client here>.

Creating Stability: Collaboration, Communication, Comforting, and Containment

Creating a context of safety and stability involves creating collaboration, communication, comfort, and containment. These are vital in setting up an environment in which complex trauma clients can heal, and the need for these things is even more pronounced for the dissociative client. Each one of these begins with the first contact between therapist and client, with the therapist continually modeling collaborative communication which is both comforting and containing. Mary Jo Barrett from the Center for Contextual Change describes therapy as "a collaborative process at the very onset and throughout". That therapist and client work together to establish goals, framework and a collaborative relationship (Barrett & Fish, 2014).

Collaboration and Communication

With dissociative clients, that first contact may be repeated with different parts of the person, greeting and connecting with each part genuinely and with respect, no matter what their initial presentation. For the therapist, to continue to keep the whole person in mind is critical. Whether the person is dealing with a single trauma with a sense of self as "before and after", or a lifetime of trauma resulting in no consistent sense of self, the client is still one person, and the therapist needs to keep that reality in mind.

Within the client, the challenge is to come together, retrieving or creating a unified sense of self. Doing that requires learning how to communicate and collaborate within the self. In order to do that, the person needs to be in an environment that allows the client to relax defenses enough to work on difficult material. The presence of the therapist witnessing the client's journey is also essential. Trauma often feels extremely lonely and isolating, so to have a person who sees, hears, understands, and cares, makes a big difference in the client's experience of healing.

The genuine connection with a safe and caring person provides the context in which healing can happen. According to Porges' Polyvagal Theory, sociality is the core process underlying mental and physical health (Porges, 2021). The creation of a safe relationship allows the client's automatic defense mechanisms to relax over time.

In the early part of therapy, there needs to be an openness to allow the client to express the disconnect within, and their genuine reactions to that. Being able to discuss the client's experience from within that framework and to acknowledge and validate their experience without judging or requiring them to accept or acknowledge other parts is an initial step in creating a safe means of communicating in general.

It's common for people to want to distance themselves from their trauma, wishing it could just go away. They may do that through denial, or self-loathing. Some people attempt to rid themselves from their pasts with drugs or alcohol, self-harm, and any other way they can find that might work to relieve their agony and despair. They often hate and fear their vulnerability. In the beginning, it is more helpful to listen to how the person feels and try to understand why he, she, or they would feel like that than to begin to try to change that feeling. Hearing the motivation behind the avoidance helps put both therapist and client in a position to learn how best to build a bridge between internal splits.

To create collaboration within any divided system requires communication between the splits, whether it's a split between traumatic experience and consciousness, or splits within the self. In the case of a complex PTSD client with limited dissociative defenses, this might be creating a sense of awareness between the person's conscious desire to heal and the blocks inside that make that healing difficult. For example, the most difficult part of the trauma may have been the feeling of powerlessness. If that can be named, and that feeling is then validated; it becomes easier to address. No one likes feeling powerless.

Noticing patterns of avoidance or distraction is helpful when done with compassion. Many survivors automatically feel exposed and shamed when their defenses become conscious, as if they were flaws instead of protections. There's also the potential for shame when the traumatic material begins to surface. Accordingly, comforting and containment skills need to be modeled and taught all through the process of healing.

Splits in consciousness protect the person from flooding with intolerable affect and knowledge. They also help keep irreconcilable experiences separate. They protect the person from the annihilation of being betrayed and alone in the face of the abuse. It is common to hear the survivor of abuse describe shock when the abuse begins, the desperate feeling that carries the message and experience of, "this can't be happening, this can't be happening to me, this is not happening to me, I'm not here, I'm up on the ceiling (out the window, etc.), and it's happening to him/her/them down there". When the abuse is followed by denial, with family or others acting as if it didn't happen, the split becomes more profound. The person may have a surreal feeling, losing the sense of confidence in their own reality, increasing the sense of disconnect inside and out.

Having grown up in dysfunctional households, coping with multiple conflicting demands of disorganized caregivers, or reeling from several tours of duty in war zones, the complex PTSD client is ill equipped to manage the challenge of holding two or more conflicting feelings at the same time. They tend to have a narrow Window of Tolerance, and need to learn how to deal with their intense emotions one step at a time. Having someone present and witnessing the person helps to ground the person in the reality of what they had to endure.

Validating the client's feelings and subjective sense of the experience is not the same as validating or confirming the client's history. The therapist is seldom in a position to do that, and that is not the point of listening and witnessing. The point is to hear the person's experience, what impact it had, and then work together to heal from that impact. This is a slow and gentle process of moving from respecting the splits of consciousness that were necessary to survive to supporting the survivor's ability to tolerate and explore a widening circle of conflicting yet related thoughts, feelings, and perceptions.

For the client with more elaborate dissociative parts, this initially appears as a form of "shuttle diplomacy" where the therapist speaks with different self-states, listening to each one as they emerge. At the opportune moment, the therapist begins to help the client become aware of and share alternate points of view held by different aspects of the self and gently assesses the client's (and the separate self-states') readiness to explore and acknowledge those varying ideas and feelings. Gradually, the need for separateness softens. It is no longer necessary to not know what is known, and the person learns to hold conflicting feelings, such as both loving and hating their abuser.

Involving the different aspects of self in discussion takes a great deal of sensitivity and tact. The complex PTSD client may be more comfortable talking about their rage than the terror or shame that was part of the trauma. In dissociative systems, DID or OSDD, some of the aspects of self are often kept "out of the loop" to prevent them from being overwhelmed by the traumatic material or intensity of the conflict. Often those are the aspects of the self that are the ANP or the "host". Carefully engaging that part of self in the process is essential, so the therapist needs to be mindful of situations where one or more parts of the self may affect the pace of therapy in a way that could be harmful to the whole person. Engaging those self-states in a discussion, those who may want to push the pace of the therapy, or those who may block it by "holding the secrets", allows more of the person to be included in the discussion of the purpose and process of the therapy. The conversations with the therapist provide a model and a valuable experience in creating positive communication patterns within a dissociative system which help to build a collaborative internal community.

Bearing in mind that the self-states are dissociated parts of a whole, moving from externalized, concrete means of communication to internalized states of knowing one's self is another important goal. Mid-steps along the way include shifting from externalized communication through the therapist or through tangible means such as written expression to internal forms of communication, such as internal cell phones or imagery of meeting spaces and group discussions. Later in the process the therapist can ask the client to "ask inside" or to "listen intuitively", or move to a place where the ANP can imagine what the EP might be feeling. For the client without such a delineated dissociative system, one might ask if the client can name the feelings that are most difficult to face, and explore why they are so difficult.

Double Binds

One of the common difficulties for traumatized people to face is having been put in a double bind. A double bind exists when two options are offered and neither one is acceptable. People remain stuck in double-binds because to accept one side is to lose the reality of the other, and yet both exist. For example, children may need to lose themselves to remain attached to an abusing parent. If they step back in order to preserve themselves, they are abandoned by their parent. It's a lose-lose situation. Each side of the conflict is held separate and in a state of tension with respect to the other sides of the conflict. To acknowledge both sides is to risk being overwhelmed and to feel "crazy".

Gregory Bateson (Bateson et al. 1956) described this as the classic "Double-Bind Theory". Acknowledging one side apparently requires denying the other.

Yet neither can be denied and neither can be wholly accepted. To complete the trap, the client cannot leave (escape) the conflict; nor can the client talk about or observe the conflict as a whole.

The double bind may also be presented as the illusion of choice. In this situation, the person is told he or she can choose between two or more options. However, all options are horrible, and there is no option to say “no”. This is another form of a no-win situation. To be forced to make what appears to be a choice but isn’t, results in the client taking on a responsibility for something they have no authority or responsibility for. The abuser who says or implies that the victim, “made him do it” puts the victim in this no-win situation. To acknowledge one’s own personal power would be to agree that the abuser was powerless to resist, and to acknowledge that it was the abuser who really had the power is to confront the feeling of powerlessness. Often victims take on the pseudo-responsibility rather than be left with the reality of their own powerlessness to stop the abuse.

For the DID client, each side of the conflict is manifested as a separate self-state, such as a part who loves the abuser, and another part who hates the abuser. The different self-states can neither acknowledge one another nor cooperate without risking the overwhelm of the whole internal community. In highly conflicted “systems”, the self-states seem at war with each other and threaten the community or other self-states should they acknowledge an opposing view. There may be alters who feel attached to the parent, and other alters who have disengaged from the parent to preserve the self. The two alters (or sets of alters) typically stay very distant to each other and may even “hate” each other—which helps to keep them apart so they can continue to manage an untenable situation.

Collaboration among the different and divergent parts of self is critical to moving forward. When the person is in a state of internal conflict, the experience is like a civil war. Lincoln’s quote about “a house divided cannot stand” rings true here.

Gaining awareness of and sufficient access to these self-states or differing aspects of the client allows the therapist to begin to work through the careful process of educating and normalizing the richness of human experience and emotional responses. Children growing up in “good enough” households learn that they can hold these different feelings; that they can be mad at Mom for setting a limit while still loving and being loved by Mom. They learn that they can like their best friend Tommy while being hurt that Tommy outscored them playing pinball.

Learning to respect the different self-states and their contradictory roles is another aspect of building a sense of collaboration. People learn to respect the need to have another part of self (or self-state) hold some of the crushing load. Analogies that seem useful include references to team sports where each player has a specific job to do. Similarly, describing orchestras or choral groups where each musician plays or sings a different part to create a total experience more beautiful than any individual element.

Comforting

There is tremendous loss and pain in facing the horrors of abuse, the devastating sense of betrayal or abandonment. People need respite, shelter from the storm, in order to be able to recover enough to be able to face what happened to them. Sadly, for many people, there was little comfort to be found in their early lives, little chance to have experienced being cared for by another. When abused, they often had no one to turn to for help, having to carry the trauma alone. In a dysfunctional family, children may be abused by the parent they would normally go to for help. That parent may be alternately abusive and nurturing. Unable to predict which presentation of the parent will greet them at the door, a caring mom or an abusive mother, a molesting dad or a playful father, or any number of paradoxical presentations, the child may feel that it is not safe to seek help from others, and will learn other ways to try to comfort the self. Rocking, head-banging, regression, trancing out, or dissociative shifts to alternative ways of being are some of the ways people try to comfort themselves when comfort from others is not available.

As these children grow, they lack experiences of healthy ways to soothe or nurture themselves. Worse, they may not even be able to identify soothing activities. In addition, the perception of soothing activities they do have has been influenced and informed by the behavior of the dysfunctional family. As a result, they may have learned to use harmful means to try to calm themselves, like alcohol, drugs, risky or painful sex.

Being traumatized increases the need for comfort by others and the ability to actively soothe the self. As both of those sources of help are compromised or absent for some people who have been chronically traumatized, the needs of the traumatized person frequently exceed the resources available, both internally and externally. When that happens, caring friends may become frustrated and burned out, leaving our clients dropping into despair.

To further complicate matters, for clients with Dissociative Identity Disorder and/or strong internal conflicts, there may be multiple conflicting ways that they identify as nurturance; some which may be helpful, and some that are not. Compulsive activities, self-harm, avoidance, and dissociation are some of the ways people attempt to self soothe. In people with DID, some parts of the self may be capable of healthy self-soothing, or asking for comfort from others. Other parts of the self may block or react destructively against the vulnerability inherent in asking for help and support. Others may engage in a myriad of self-harming behaviors as a means to turn emotional or relational pain into physical pain or trigger an endorphin enhanced dissociative episode. (Other reasons and uses of self-harm behaviors will be discussed in Chapter 9.) All of these options may be cycling through simultaneously.

Every person and every dissociative internal structure is different, so care must be given to not make assumptions. The careful therapist needs to check in and ask about the person's self-soothing behaviors.

Comforting (and containment) work best when the dissociative person has developed internal collaboration. For people with complex PTSD, a different kind of collaboration needs to develop, involving a willingness to deal with the trauma and sufficient skills to tolerate the intense experience of working things through.

Without internal methods of communication and a respectful, collaborative approach, the client will remain locked in an intrapsychic civil war. For the complex PTSD client without the pronounced dissociative defenses, this manifests as being frozen between two mutually exclusive ways of being, shut down to the trauma or overwhelmed by it.

Containment

Dissociation at any level, from depersonalization, derealization, dissociative trance states, or dissociative amnesia to polyfragmented Dissociative Identity Disorder can be seen as a means to keep the client from becoming overpowered by the effects of the abuse. As with other intrapsychic defenses, these methods are limited in effectiveness, and ultimately fail to prevent the person from escaping the torment of their internal war.

The "Good News" is that dissociation works and the survivor need not fully feel the abuse or know the trauma. The "Bad News" is that dissociation works and the survivor cannot learn, grow, or develop a sense of self.

Developing skills to contain the intensity of the emotional storm and cognitive maelstrom is essential to facilitate the process of keeping our clients in the here and now and able to develop critical coping skills and insights into their behaviors, reactions and recovery.

Specific containment strategies will be discussed in a later chapter. The key point here is the need for our clients to address this crucial task as an integral part of the healing process. Furthermore, these skills are interconnected and interdependent. Without a sense of collaboration, the disparate self-states will not communicate nor engage in proactive self-soothing behaviors. Without developing containment skills and adaptive comforting strategies, the client needs to rely on on-going forms of divisive defenses.

Suggestions

Have clients make a list of self-soothing behaviors, things they can do when alone. Add to the list as new things are discovered.

Have clients make a list of how they can be comforted by others. Include the names and contact information for those people who have demonstrated that they can help the client calm down, feel safe, and regain equilibrium.

Have clients get different magazines or pictures from the internet and make a collage of comforting objects and activities.

To work with resistance to self-soothing or being comforted by others, it can be helpful to have the person write, draw, or simply share the possible negative consequences of self-soothing behavior. Actually being kind to oneself, or accepting kindness from another can be painful. People connect with the pain of the absence of that kindness in their personal history. Grief and upset may emerge when true comfort is given and received. The realization that the abuse was as bad as it was, and the lack of concern and care by others can be very difficult to face.

One process that can help discover and potentially widen the client's range of acceptable experience, is to engage in internal dialogues. Similar to the famous empty chair technique of Fritz Perls (Perls, Hefferline, & Goodman, 1951), having the client manifest the different sides of the dialogue (or multilogue as the case may be) allows for the therapist and client to follow and process the discussion together. The empty chair technique involves imagining another person, or a part of the self, on an empty chair, and having an imaginary dialogue with that person or part. Talking and listening to another part of the self externalizes an internal dynamic and helps the person learn more about what's going on inside.

A useful intervention for clients who are unable to identify positive nurturing behaviors, is to create a collage of what they perceive as positive images. The instruction is to find a variety of different magazines covering a variety of interests. Without judging or evaluating, select and clip out any image that gives the client a warm (perhaps wistful) feeling, or ones that the client wishes to experience. The client is encouraged to assemble these apparently random pictures on one or more sheets of paper (perhaps a different sheet of paper for different parts of the self-system) and bring them into session for discussion.

In the follow-up therapy session, client and clinician explore what themes might emerge, why certain items seem as possible or desirable nurturing experiences, and how they could be experienced. Internal conflicts are examined and potential compromise solutions are offered for consideration.

Other strategies include a letter writing campaign or a form of serial journaling. Make a list (sometimes with the assistance of the therapist and/or friends) of things that are normally perceived as healthy ways to self-soothe or be comforted by others. Then choose one each day (or at whatever interval sounds possible) and practice doing that one thing.

Stage 2: Remembrance and Mourning: Facing What Happened

The traditional second stage of therapy is focused on addressing the trauma, and the impact of the trauma on all aspects of the client's life. The skills learned in the first stage of therapy come into play in this stage—the ability to be consciously connected to knowing and feeling what has happened in a way that allows the trauma to be acknowledged, tolerated, and disempowered. Intense emotions surface, and the person has the ability to work through them for the amount of time that is tolerable. The window of tolerance has grown large enough to incorporate the person's experience, and the work of facing the trauma, grieving the losses, acknowledging parts of self that were unavailable or inaccessible, and finding a way to create some meaning out of the tragedy make up the work of this stage.

Remembering and mourning any trauma is difficult. For single traumas, there is a "before" and "after", marking whatever changes within the person and how the person relates to the world. Trauma shatters a person's worldview, and that can be a shift in how the world is experienced, or a devastating rupture leaving the person struggling to find a completely new way of being in order to survive.

When there have been multiple traumas, the second stage of therapy is more complicated. Trauma needs to be faced and dealt with, but with multiple traumas, the person needs most to deal with the common themes of the traumas, such as powerlessness and shame. For some people whose lives have been defined by on-going trauma, it's not possible, or advisable, to try to deal with each traumatic event. Some specific trauma memories may serve as representative of many others; containing behavior and effects common to a lot of the traumatic events in the person's life. Those traumas, when dealt with effectively, carry over into the others, spreading the healing through to those traumas that were similar.

Trauma clients do not need to recall and process every bad thing that ever happened to them. To attempt that would overwhelm both client and therapist. The key is to address pivotal points that speak for many parts, reflecting the core themes of the abuse. The goal is closer to consciousness raising, achieving a "critical mass" that in turn triggers a paradigm shift in the client's understanding of him, her, or themself. The need to address every traumatic incident is based on a fear of not doing therapy "right", of avoiding a mistake and then being punished.

Knowing the history of the person is critical to planning the second stage of therapy. Too often, therapy begins with an insufficient knowledge of the client, and working on the known traumas may activate those that were not identified and overwhelm the person. When that happens, the therapy needs to shift back to emphasizing stability and safety, giving the person time to become calm enough to feel more in charge of the process and less at the mercy of it. The emergence of old coping mechanisms may indicate that therapy is moving too fast for the person, and newly acquired skills are not strong enough to handle the emotional impact of the work. Slowing down is often a good idea. It allows both client and therapist to take stock, revisit the treatment plan, and make any revisions that both feels would be helpful.

Work in Stage Two can be very intense. Trauma treatment triggers trauma (Connors & Mayhew, 2006). This is a challenge for both the client and the therapist. Not many therapists have been trained to deal with intense emotions, like shame, rage, grief, and terror. In Stage Two of the therapy, those are the emotions that emerge when the trauma is faced directly. In dealing with such powerful emotions, it becomes important for the therapist to understand an inverse relationship; with increased affective arousal comes decreased cognitive functioning. Additionally, as dissociative defenses are dropped, there is often an increase in PTSD symptomatology. Failure to titrate these effects frequently undermines therapeutic success.

The therapist must resist the tendency to turn therapy into an ordeal. Trauma is subjectively experienced as if there is no beginning, middle, or end. There is only the never-ending now of terror and pain. Learning to pace oneself is part of healing from the effects of trauma.

Traumatized people have suffered great losses, of many kinds. Some of the impact of trauma can be restored, such as healthy self-esteem. Other things are gone forever, such as the assumption that all people can be trusted. When the trauma comes with betrayal, relationships may be permanently damaged or lost.

A fundamental reality to trauma treatment is that we are not changing history. Therapy cannot undo what has been done. The goal is integration of disowned and dissociated aspects of self and one's experience. Therapy is not exorcism. Rather we are helping our clients deal with what was and grieving what was not.

In processing memories, a growing awareness of what feels bad and scary is necessary and ultimately helpful. Connecting with the past yields vital information about what was learned and what was missing. Clients will then have the opportunity to choose whether or not to hold onto the lessons of the past and what they need to learn (healthy attachment, relationship skills, self-care, etc.) in order to move forward.

The trauma itself may be extremely difficult to share, and to hear. Both the client and the therapist may want to save the other from the devastating reality of what happened. Some clients have felt that telling their truth would contaminate whoever listened. Because so many people may have recoiled and left when the client tried to share previously, there will need to be reassurances given that are followed up with the behavior of listening, staying present and continuing to see the client with respect and compassion. Some therapists may have difficulty hearing their clients' traumatic memories, wanting to save the client from the intensity of what already happened. Even if that is not stated, the client will pick it up and have more difficulty sharing.

A core theme throughout this discussion of trauma treatment is the importance of the authenticity of the therapist and the strength of the therapeutic alliance. As the client is recounting their experiences, in the depth of the pain and torment, the therapist cannot remain the neutral blank screen. Silence is the hallmark of the uncaring other, the enabling parent. An attuned therapist needs to demonstrate and express appropriate levels of compassion and a sense of moral outrage regarding the abuse.

Memories are best dealt with in small amounts. Attempting to process an entire traumatic event at once can easily push people past their ability to assimilate what happened and the impact it left. Taking the time to step into the memory and back out, with resources available to handle each section of the trauma, allows people to move through it step by step; seeing, feeling, understanding, and moving past each section.

There are many techniques that can help in this process. Dr. Kluft writes about his fragmented abreaction technique, using hypnosis to help the client tap into memories and come back out successfully (Kluft, 2013). Catherine Fine and Amy Berkowitz (2001) developed a very effective Wreathing Protocol, using hypnosis and EMDR. Anabel Gonzalez,Dolores Mosquera and Miriam Morrison (2012) have also studied complex trauma and dissociative difficulties and found ways to use EMDR effectively, advising therapists to start with the least upsetting event rather than most upsetting when the client has a long history of abuse and has dissociative issues. Pat Ogden, Kekuni Minton, and Clare Pain (2006) have worked to help people process traumatic memories using somatic techniques. Rich Chefetz (2015), and Elizabeth Howell (2011), work successfully using psychoanalysis. There are many ways to help clients through this stage. The more ways the therapist learns, the better able they will be to match the technique to the client. All of the people just mentioned have a great amount of experience and training, and are able to use many different techniques. Each one will automatically use the approach that will best meet the needs of the client. That is the hallmark of a master clinician.

An important caveat: specialized techniques, specific schools of thought or treatment methodologies are tools, not panaceas. They must all be used with wisdom and caution reflecting the therapist's best clinical judgment based on the unique and individualized needs of the person sitting before them. Many specialized techniques can work well with severely traumatized people, but they must be used with the awareness and cooperation of the client's internal "community". Severely traumatized people are avoiding their pain for good reasons. The desire to be "fixed" quickly and without pain or discomfort can cause therapists and clients to use a technique too often or too soon with tragic results.

As Phil Kinsler has stated, "Any intervention can be harmful if you don't know your client" (Kinsler, 2018). This is particularly important for therapists working with people who are dissociative. People with Dissociative Identity Disorder have adapted to living in situations where they need to not know their own experiences. Those experiences are too traumatic and they lack the safety and supportive relationships that could help them heal. They don't fully know themselves, and, therefore, the therapist can't fully know them, either. The focus of therapy is to help clients get to know themselves safely, in the context of a healthy, supportive relationship. The therapeutic relationship is known to be the most significant factor in healing (Norcross & Lambert, 2014). Trauma that happens within a relationship, from people within a family or close to the person in some way, has a more severe impact, adding betrayal and damage to significant relationships to whatever trauma has occurred. In these cases, which includes many of the people with dissociative disorders, the importance of a solid therapeutic relationship becomes crucial. The traumatized person needs to both deal with the trauma and have the experience of a genuine, healthy, supportive relationship. This is not, and can't be, a "quick fix", and it's not uncommon for premature use of techniques to plunge people into their trauma beyond their capacity to cope. Therapy needs to stay in step with the person's ability to manage the facts and the affect around what happened to them. Every therapy needs to be personalized, designed to work with the whole individual, including any and all self-states known and potentially not yet known.

Most clients have their own way of doing the work of Stage Two. The therapist's job is to make sure the process is fundamentally healthy and allow for individual differences in how it's done. This continues to be a collaborative process, with client and therapist working together to create the best healing path for this particular person. Some things for the therapist to notice is whether clients tend to stand too far back from emotions and experiences or tend to jump in over their head and feel that the process won't work without a crisis. The former is on the avoidant end of the scale, and the latter is on the ordeal end. Somewhere in the middle is the balance point, where the trauma is addressed at a manageable level, within the client's Window of Tolerance.

If there's a difference between the client's ability to tolerate affect and the therapist's ability, that will need to be addressed. The therapist can explore with clients what they can tolerate. The therapist may need to seek supervision or consultation to deal with their personal discomfort with the client's way of working. There are a few ways this can turn out. In some cases, the client may be a bit too avoidant, or trying too hard. In other cases, the client's process may trigger the therapist in ways that make it hard for him or her to remain in a therapeutic position with the client. In the former, the therapist can focus on helping the client find ways to face what happened and move through it successfully. In the latter, the therapist will need to do whatever is necessary to take care of personal issues so they do not impede the client's progress.

One of the advantages for the therapist of working with trauma survivors is that they are continually pushed to deal with their own issues in order to be available to their clients. In doing their own work, therapists also gain insight into how it feels to work on internal issues, and they tend to improve as therapists.

When intense traumatic events are confronted, people may react with the emotion that was not accessible during the event, or they may react with the realization of the effect of the trauma on their lives. They may sob, rage, or shake while speaking. In some cases, the reality of their loss may result in keening, a delayed response to their loss. The therapist needs to be able to gauge whether the client is staying with the window of tolerance or not. In stage two, the client may be able to express this level of intensity and remain in their window of tolerance. They are using the skills learned in stage one. If the client is going over the line, outside their window of tolerance, the therapist will need to gently interrupt the process and help the client calm down enough to continue. Affect tolerance, pacing, self-soothing skills, and the ability to be comforted by others are extremely important during this stage of therapy.

Unbridled expression of emotion without attached context and meaning is unhealthy and retraumatizing. Recounting an experience without the attendant affect remains disconnected and dissociated. An essential element of Stage Two work is to assemble all the dissociated parts of traumatic memories into a coherent and understandable narrative that can be integrated into the client's personal history and on-going sense of self.

Also, during this stage, the client is confronted with the imperfections of memory. It's very difficult to know some of what happened and not all of it. The therapist needs to help the client let the unknown be unknown until it becomes clear from within. In most cases, enough of the memory comes back to be able to make sense of the client's symptoms. However, it's not necessary for the memory to be complete for the person to heal. It's not the details of the memory that are important, it's the effect of whatever happened on the person. So, whether the memory can become clear or not, the client can still heal. Even without details, the impact of the trauma remains, and that's the focus of the therapy.

What does it mean to process a memory? As mentioned above; one essential element of memory work is to assemble all the dissociated parts of traumatic memories into a coherent and understandable narrative. Integrating this more complete understanding of the traumatic event into the client's personal history and on-going sense of self is a second and equally essential aspect of processing the trauma.

There are several steps in the process. In the beginning, the memory may emerge in many ways, as images, sensations, feelings, or knowledge. These fragments may have been part of the person's life for a long time, or may be relatively new. There is usually something familiar about what comes up, and it's helpful to notice that. Sometimes, what was originally breaking through in flashbacks in the first stage of therapy now comes out in more accessible form.

Thinking back to the models of dissociation and how traumatized people block or avoid awareness of different elements of the trauma experience, the need to assemble the previously dissociated components of the event becomes clear. In exploring the event, there are a few guidelines to facilitate a careful unfolding of the dissociated material.

Let the client choose which events to focus on. Use the present to tap into the past. Be attuned to recurrent themes that confound the client's life in the present. Explore the historical aspects of on-going relational conflicts by asking if specific behavioral patterns seem familiar and when or how they were treated in a similar fashion. All of these opportunities provide a doorway into the client's trauma history.

Asking non-leading questions is essential to helping the narrative unfold. Experienced clinicians will have a sense of what might have happened based on their experience and understanding of how trauma impacts people. However, they weren't there and it is the task of the client to piece their history together. An important skill for therapists to model at this juncture is the ability to tolerate ambiguity and uncertainty.

As the client recounts their story, there is often a profound need for them to be believed. The elegant and careful dance of the therapist is to acknowledge the client is reporting their history as they believe it to be at this point in time without validating what the therapist has no means of authenticating. It is important not to get caught up in the details and lose sight of the experience of loss, abandonment, and betrayal.

Often the initial experience of trauma is a repetitive loop of a portion of the event. The goal is to develop a coherent narrative, identifying a context and a frame of reference for making sense of disparate images, feelings, and sensations. Allow for non-linear processing by asking, "What happened before that?" as well as "What happened next?" Ask if other parts of self can contribute to filling in gaps. Move forward and backwards to complete the beginning, middle, and end.

If the client is not at risk of decompensating, it is helpful to have him, her, or them explore whatever has surfaced, paying neutral attention to it, noticing it, jotting it down or sharing it. Let the client talk about it. As the person talks about the piece of memory, monitor their emotional state. Notice the things that seem to be easy to relate, and those that are difficult. Also, notice if there are gaps in the memory, parts that seem to be completely missing, like the awareness of entering a room, and then leaving it feeling devastated, but no memory of what may have happened in the room. Start with what is known and let the person reflect on it. Having distance from the event, and a lot more emotional skills, telling the narrative may be a completely new experience, with insights coming out spontaneously.

In exploring the recalled event, the purpose is to empower the person to examine the beliefs that arose from this and similar experiences. What did this teach them (or more accurately, what did this teach the child that underwent the trauma) about themselves, others, and the world? To facilitate pacing, periodically step out of the recalling to identify and acknowledge dysfunctional and manipulative tactics of the perpetrators, missed opportunities, and distorted beliefs that were either imposed by the abusers or developed by the child as a magical means to try to avoid further abuse. This is a key opportunity to develop the client's ability to question and view experiences from alternative perspectives.

Another way to deal with complex traumatic experiences is to take one feeling common to most and deal with that. For instance, a person may talk about the experiences of being tricked, or betrayed, noticing how that felt and how it impacted their ability to trust others. Or, they may look at the fear they carry, all the reasons for it, and begin to be compassionate to themselves rather than put themselves down for not being brave enough.

When the memory is extremely horrific, leave the worst parts for last. The person will need to confront the trauma, know it, feel it, be able to talk about it in an integrated manner, and then be able to leave the office fully capable of getting home safely. That means that the trauma will take many sessions of work, keeping the amount of emotional material limited at each session.

It is helpful to prepare for what may be an intense session. Without preparation, the most intense parts of the work may come too close to the end of therapy, leaving the person at a vulnerable place when it's time to go. If the session is planned, the client and therapist can move into the work early in the session and allow sufficient time to come back to the present in a grounded way before leaving. It can also be helpful to have a support person available to help the client before and after therapy. This could be the client's friend, roommate, spouse, etc., anyone available who is stable and cares.

Sometimes, Stage Two includes sessions with a little or a lot of abreaction. An abreaction is an outpouring of emotion, the expression of intense feelings that were not able to be expressed at the time of the trauma. For example, a woman who saw her father killed in a car accident froze at that time, and years later, in telling the story of that event, began to wail with grief. She was strong enough for that to happen, so the therapist supported her, and the client was finally able to grieve the loss of her father.

Abreactions can be very helpful, as long as they can be in line with the person's healing. When they are, they come out as a natural part of the process. In the example above, the woman was talking about her father, and herself at the time of the accident. She had a coherent memory, just a lack of emotion, and that felt odd to her since the time of her father's death. This was a single, devastating trauma. Her life changed from that point on. Still, she had spent most of her childhood with two parents who loved her and took good care of her. When she began to keen and wail, the therapist was not concerned about her being unable to return to a stable place. The release of emotion felt "right", as if the missing piece had been found.

It's more challenging with people whose trauma has been on-going. Allowing those people to freely release intense emotions may not be a good idea. Each of their traumas may contain emotions that pop up in other traumas, creating a connection through the similarity of extreme emotional states. To drop into one of those emotional states may take the person on a wild ride through many memories of trauma and become too much to take in and work with successfully. In those cases, the portion of the memory needs to be limited to the amount of energy and time the person and the therapist have to address the emotions that emerge. Techniques such as hypnosis, EMDR, TIR, and others, can help the therapist focus the client on small enough portions of the trauma to ensure success in moving through and coming to a better place. That place is known by the feeling of being present and relatively calm while also being aware of the trauma and the impact of it on the person's life.

As mentioned previously, developing a coherent narrative is important. Understanding how those events impacted the person's life is equally important. As client's come to recognize the depth and extent of what has happened to them, they begin to truly count the cost. With that comes intense grief and a host of existential questions.

The intensity of the grief cannot be adequately expressed in words. The therapist's ability to sit with and bear witness to the client's pain will be tested.

Clients are highly attuned to the therapist's reactions and responses and will stop themselves rather than push the therapist too far.

We help our clients move forward by acknowledging their pain and helping them see that the grief, as all powerful emotions, comes in waves. We remind them to look for relief between the waves, reassuring them that the pain will not go on forever. It is important to help our clients to learn to accept support and to care for themselves. Appropriate self-soothing skills developed in stage one work will be called upon. Comforting that should have occurred when they were younger can happen now.

Frequently, clients ask to understand why this happened to them. Why were they targeted for the abuse? What is inherently so wrong, so bad, about them that people would treat them in such horrific ways? Understanding the dynamics of abusers can shed some light onto this difficult area.

Recognizing that perpetrators are often narcissistic and unable to truly care for or about another person is an important realization. Seeing that a narcissistic abuser does not hold anyone as an equal or a peer deserving of respect; that other people are reduced to the status of an audience or a prop may be helpful.

Another avenue to understanding why abuse can happen over and over from multiple perpetrators is to see the client, their family of origin, and many of the others they interacted with as members of a highly specific and exclusive subculture. Within that subculture people were assigned very defined and limiting roles. It may prove useful to examine the roles of other family members within that same subculture. Of specific interest to dissociative clients is to examine if their internal "system" reflects these same roles.

It is important that the therapist both normalize the early childhood reactions and learned behaviors while encouraging change. Examine how the initial set of responses made sense in the "war zone" that was their childhood home life. Validate the intent and attempt to seek safety and develop some degree of mastery and control in an otherwise unmanageable and unpredictable environment.

While acknowledging how the trauma and abuse impaired developmental growth as a child, stress the need for change as an adult. Key questions focus on the emerging authentic self. As the client can see the attempts to manipulate and limit their expression of self, so can the client let go of false "selves" maintained to appease the abusers. This stage is ripe with opportunities to find unique strengths buried among the ruins. What did the client foster to better survive—keen observational skills, adaptability, compassion?

With dissociative people and others who have long lasting abuse, it may be helpful to take one section of those traumas and work with that, such as the moment of realization that it's going to happen again, or the feeling of relief or abandonment when left alone at the end. Some people may choose to start with noticing how they managed to survive, by leaving their body, shutting down in some way, or, with dissociative people, switching into another part of the self. Noticing the patterns that contributed to survival can help the person appreciate their spontaneous survival mechanisms and notice inner strengths that kept them alive.

Stage 3: Integration and Reconnection

The third stage of therapy involves the integration of the trauma, with the growing sense of being able to be present and authentic, in touch with what happened, but no longer controlled by it. As one person said, “I am no longer my past”. People often experience a burst of post-traumatic growth, finding meaning in their suffering that allows them to move forward, frequently involving ways to transform their trauma by helping others or by finding themselves at a new level of compassion and maturity.

Stage Three is often given too little notice in the literature of working with trauma survivors. This is unfortunate because it is the stage in which the trauma is integrated in such a way that the survivor knows and feels it to be past and is focused on living his, her, or their present and future life without the trauma being a necessary focal point requiring time and energy and influencing identity. Learning to live consciously in the world beyond the trauma challenges the person to evolve, in consciousness, relationships, and meaning. With the trauma having left center stage, all aspects of life shift, and the person now has the ability to have some conscious effect on how those shifts happen.

When a person has had many traumatic experiences, healing has probably taken a long time, and the last stage of therapy becomes a marker for a life transition. They take what they have learned about themselves and the world and put their energy into living in the present and being able to envision a future.

The identity of the person changes. For people with complex trauma and PTSD, they move out from under those labels. Their experiences have impacted them, but they have moved through the experiences enough to have them become part of their past and not something controlling their present lives. Generally speaking, their need to protect themselves, the constant vigilance associated with unresolved trauma, softens and they become more comfortable being closer to other people, more vulnerable. Intimate relationships gain in importance and begin to grow. Old relationships built on the connection through trauma tend to fade unless the other person has also grown.

For people who have integrated from being dissociative, there’s an entirely new experience of being a whole self. Those people speak of the need to adjust to the quiet inside, the absence of internal companions. They may feel unusually lonely and realize how much they need to develop relationships with others outside of themselves. Without internal companions, the person may feel very vulnerable in the world, and it takes time to adjust to that new reality. Dissociative defenses are gone, and the person is steadily confronted with being present and dealing with others outside the self. Internally, normal emotional conflicts are all in one place, not divided into separate parts of the self, so the person can feel positive and negative emotions at the same time and needs to learn how to work with that kind of ambiguity. As a result, the manner in which the person makes decisions changes. They tend to move away from either/or responses and be able to consider the mix of variables that normally appear in significant decisions.

The person's relationships change. Some relationships may change for the better, becoming richer, and more intimate. Other relationships may fall by the wayside, with the gulf between people widening to the point of no longer being able to sustain a connection. Survivors often find each other and cling to each other, having no one else who can see them and comprehend their pain. When one person has grown and is no longer trapped in pain or fear, the connection dissipates.

In the third stage of therapy, people grapple with how to deal with the relationships that have been changed in the process of their healing; which ones will continue, and which ones show no hope of becoming healthy. The relationships that are lost need to be grieved. The ones that continue may need to be nurtured to become what they are possible of becoming. Old relational patterns emerge and new ones are practiced. Roles are examined, and consciously evaluated.

In dealing with abuse, relationships of all kinds are impacted. For example, it's not unusual for people dealing with incestuous abuse to be targeted by the family when they first speak up. Families often flee from the truth, blaming the victim and even defending the perpetrator. When survivors continue to hold onto the truth and heal, they may become the turning point for their entire family. Some family members may ostracize them, but others may see the truth that is finally being told and move towards the survivor. In telling the truth, the survivor is actually behaving as a very loyal family member, speaking a truth the family needs to hear in order to heal. They are seldom recognized in that manner, however, and are frequently labeled "disloyal", the opposite of what they actually are. In the third stage of therapy, the person may need to grieve the loss of the fantasized family, and consider what kinds of relationships might be possible with different family members. The third stage also includes forgiveness (forgiveness "in" —see Chapter 10), and the realization of what would be necessary for any kind of reconciliation in the future.

Often people experience post traumatic growth in meaning and spirituality. Post traumatic growth includes moving beyond the trauma in a way that uses the experience to deepen one's understanding of life, and that often includes an enriched spirituality. People glean meaning out of the trauma, learning to notice and appreciate life, love, kindness, and connection—all the things that were threatened or destroyed in the trauma. They are also often stronger for having survived and confronted their abuse.

For people who have complex trauma and dissociative issues, therapy may have been a part of their lives for years. The third stage of therapy includes ending therapy, something some people may have never thought would happen. Coming to the end of her process, one client and her therapist went over all the goals she had for therapy, those she came in with and those she added as she got into her process. Jointly, she and her therapist checked off all the goals. They had covered them all, and the person was doing well in her life. When it became evident to both that the therapy was done, the client said, "You mean I don't have to be in therapy forever?" The therapist assured her that she didn't, that she had done what she came to do. She could return at any time if she needed to, but she was able to deal with her life on her own now. The client had learned skills that allowed her to address her issues on her own. She had the internal resources she had discovered and learned in therapy, and those were serving her well. Face alight with joy, the client left the office for the last time.

Not all therapy ends that well. Sometimes, for many reasons, people never get to the third stage, or never get to complete it. People move, lose their insurance, become ill or in other ways unable to continue. Therapists also move, retire, become ill or disabled and may not be available to the client for the last stage of therapy.

When the client leaves, if there is time it's helpful to summarize the therapy as much as possible. That includes the reason the person came in, what was covered in therapy, and what still needs to be addressed. The client may need to return to his or her source of insurance to find another therapist, or the therapist may need to give the person referrals. Either way, letting the client know how to proceed to get back into therapy if he or she chooses to do so is an important part of the process of ending.

Some clients leave not out of external necessity but for other reasons, such as fear of facing the enormity of their own trauma, or fear of becoming attached to the therapist. Some may leave in order to maintain a feeling of control, a flight into health, or the need to take a break. Not everyone leaves for the same reason, and it is helpful if the client is able to share the reason with the therapist. That may not be possible, either because the departure is too swift, or because the client may not know why he or she is leaving or may not want to share that information with the therapist.

When the therapist needs to leave, it's helpful to let the client know as soon as possible. Moving, or retiring usually allows plenty of time to gather what is needed together to end as well as possible. Sometimes, however, the therapist leaves because of sudden illness, disability, or death. In these cases, having a professional will can make all the difference for the client and his or her ability to deal with the loss of the therapist and connect with a new therapist. A professional will includes a designated professional to call the clients, notify them of the loss of their therapist, and give them the referral that the therapist had written down for them. Records are then transferred to the new therapist. (Frankel, 2015)

Complicating Factors: Heads up—The Person You Will Be Treating Comes With More Than You Know

Dr. Rick Kluft:

> Good and knowledgeable clinicians are driven by the need to address what is there. Mediocre clinicians are driven by the need to find their models and theories confirmed in what they observe and do. Thereby

> they sacrifice reality testing for statistical significance. They get reliability and lose ecological validity.
>
> (Kluft, personal communication, 2015)

When working with complex trauma and dissociative issues, the three stages of therapy are more intense and complicated. Simple models and single theories seldom fit. The more the therapist can learn about trauma and dissociation, and the individual person coming for help, the more likely the therapy will succeed. Every trauma is different, and every person is different, so formulaic approaches rarely work. The most influential part of the therapy will be the relationship between the therapist and the client. It is within the relationship that the therapist gets to know the client at a level deep enough to determine which therapeutic tools may be helpful. It is also the presence and reality of the relationship that gives the client an experience of being seen and attuned to that facilitates healing beyond techniques and tools. A conscious therapeutic relationship is intensely respectful, continually bringing a sense of dignity into the process.

The necessity is to have a different relational experience from which to learn a different perception, one that is healthier, based on safety and trust. A lot of therapy tends to be top down—attempting to shift a person's way of perceiving and believing, without necessarily exploring the client's experience. With trauma survivors, a typical top-down approach is to ask them to have a thought or belief that would be healthier than the one they currently hold. However, since there is no experience to support that thought or belief, it has no foundation inside and will not stand up to real situations or emotions. A bottom up approach uses the new experiences in a healthy therapeutic relationship to allow the person to have a new experience. For example - asking a person to imagine a safe place inside when there has never been a safe place in his or her life is a top-down approach that often fails with survivors of severe trauma. For them, there's no reference point for what "safe" feels like. So, the therapist needs to work from the bottom up, providing a safe enough relationship from which the client can learn the feeling of safety. Milton Erickson described therapeutic interventions that allowed the client to imagine the therapist's voice going with them into emotionally charged situations (Rosen, 1982). The therapist's voice would connect with a new feeling, one of safety, that the client could then incorporate and practice.

The stages of therapy may not be clearly defined and in perfect sequence, but the relationship can remain consistent throughout the process. The therapist moves in concert with the client to create safety, process trauma, integrate and understand the past and be open to the future, moving back and forth through these tasks to help the client continue to move forward at an optimal pace. It's never a completely smooth process, with misattuned moments, ruptures, and repairs being both challenging and offering some of the greatest opportunities for growth. Working together with a competent and compassionate professional can make healing from complex trauma and dissociative issues happen at a deep level, giving the person experiences of a genuinely caring relationship that he or she may never have known to be possible.

Complex Trauma Disorder is a cluster of different and divergent symptoms and defenses that are manifested in ways that exacerbate and aggravate each other. This is one reason why the stages of therapy need to cycle back and forth so often. On-going trauma causes systemic breakdowns and distortions across multiple developmental dimensions. Key lessons and critical tasks are not taught or worse, deliberately filled with misinformation or patterns that work against the person. While therapy is progressing, time is taken to learn lessons and tasks missed while focusing on survival. Working in relational skills, boundary setting, self-care, autonomy, affective regulation and expression may reveal the distortions learned in dysfunctional settings. Emotional needs may be expressed through a variety of direct and indirect means, some appropriate, and some not. All of this comes out in therapy, and the damage that has been done becomes evident over time in many areas. Knowing the areas impacted by trauma helps the therapist set up the context for therapy and create treatment plans that can address these developmental issues. While there may be common patterns and issues, each client is unique. The more therapists learn about the client in front of them, the better they will be able to create therapeutic experiences.

In clients who have dissociative issues, there may be many different levels of development that manifest during the therapy. Childlike states may emerge in session along with very sophisticated adult states, demonstrating the absence and presence of developmental steps in an unintegrated manner. Knowing that there's an internal variation in the person's ability to respond means that the therapist cannot assume mental or emotional consistency and will need to learn to work with the person knowing that interventions may be "heard" by any or all aspects of the person. The technique of "talking through" (Caul, 1978) is based on the awareness that the person may have few or many aspects of the self that are attending to what is being said so the message needs to be given in a way that is appropriate for the whole system. The language may vary between talking to the part of the person currently presenting and the whole person, parts known and unknown. The intention is to consistently use inclusive and integrative language to invite the whole person into therapy. It is very similar to working with a family in therapy—whatever is said to one person, is heard by all. When this inclusive communication is not done well, the result may be more entrenched internal divisions. One of the worst things a therapist can do is label parts of the person as good parts or bad parts, and attempt to rid the person of the bad parts of self. All the parts of the person belong, although some behaviors may be harmful and those behaviors do need to be addressed in whatever state they emerge. As fragmented as clients may be, they are still one embodied person and need to know and include and integrate as many aspects of self as possible to become whole.