PROGRESSIVE COUNTING

WITHIN A PHASE MODEL OF TRAUMA-INFORMED TREATMENT

RICKY GREENWALD

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ROUTLEDGE

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Clinicians recognize trauma and loss as a prominent source of clients' problems. Progressive counting is a significant advance in trauma treatment because it is about as efficient, effective, and well-tolerated as EMDR while being far simpler for therapists to master and do well. PC's value has already been supported by two open trials and a controlled study. Are you ready to provide therapy that routinely effects profound healing and lasting change? This book will show you how.

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INTRODUCTION

We are always looking for a treatment approach that may be more consistently effective, more efficient, better tolerated by clients, or easier to master. This book offers such an approach, by integrating arguably the four most significant developments in contemporary psychotherapy. First is the increasingly sophisticated appreciation of the role of common factors in contributing to therapy's effectiveness. Second is the developing literature on memory reconsolidation and the specific factor that leads to rapid, dramatic, and durable improvement. Third is the growing awareness of the importance of trauma, along with advances in trauma treatment. Fourth is the move away from specific treatments for each diagnosis, towards a transdiagnostic treatment approach based on underlying factors common across diagnoses.

This book integrates these developments by teaching a coherent, accessible, and replicable treatment approach that can be used effectively with a wide range of clients.

The Four Keys to Effective Psychotherapy

1. The Common Factors

The importance of common factors to therapy's effectiveness has become ever more widely recognized and embraced, as evidenced by the republication of the best-selling *Heart and Soul of Change* (Duncan, Miller, Wampold, & Hubble, 2010). This recent synthesis of the common-factors research emphasized the integration and inextricability of the various factors. That is, you can't just add more empathy or therapeutic alliance to an otherwise non-viable treatment approach and suddenly have a viable treatment. Rather, the common factors are necessarily grounded in a coherent and credible treatment model – itself a common factor – that is embraced by therapist and client. Such a treatment model serves as the foundation for the explanation of the problem, the plans for rectifying the problem, and the hope for success and change. These constitute much of the basis for the therapeutic alliance, the leading predictor of treatment success in this line of research (Norcross, 2010).

Although the present book does not explicitly focus on the common factors, in fact they are being systematically addressed and incorporated. Obtaining regular feedback regarding the client's symptoms and response to treatment – identified as key to consistency in treatment success (Lambert, 2010) – is built into every session. The phase model of trauma-informed treatment is highly credible for addressing a wide range of presenting problems, and is readily embraced by

therapists as well as clients. Client agency, another key predictor of treatment outcome (Bohart & Tallman, 2010), is fundamental to this book's treatment model, and is fostered in many ways. Presenting a convincing rationale for treatment activities, and developing agreement on treatment goals and tasks, are also foundations of this treatment approach.

Unfortunately, research has not yet determined what makes some therapists better than others – more competent, caring, and empathetic. Are these innate qualities, perhaps enhanced via personal therapy and/or supervision, or can caring and empathy be taught? To some extent, these can be taught, or at least intentionally elicited, and that is done here. This book's scripted case formulation intervention – providing the client a trauma-informed explanation of the underlying reasons for the presenting problem – has consistently been found to increase therapist empathy and caring even towards their most challenging clients (Greenwald et al., 2008).

2. Memory Reconsolidation and the Specific Factor

The recent book, *Unlocking the Emotional Brain* (Ecker, Ticic, & Hulley, 2012) explains the recent brain research that definitively maps the deep structure of healing via memory reconsolidation. The authors describe most presenting problems as being driven by schemas or mental models that are locked in the brain as a result of traumatic events (my term, used broadly to include any upsetting events that have not been fully processed or integrated). They characterize most therapy approaches as supportive or *counteractive* in that the focus is to manage or override the mental model, emotional reactivity, and associated symptoms. Such approaches tend to be incremental and subject to relapse because the underlying mental model and emotional reactivity remain. Instead, they recommend a transformative approach – using the brain's ability to reconsolidate memory – to permanently modify the underlying mental model and eliminate the emotional reactivity.

The primary criticism of the common-factors research is that it has relied on statistical analysis of randomized clinical trials. This means that outliers – for example, individual cases in which dramatic and lasting improvement occurred – have been rendered invisible in the group average, rather than specifically studied. On the other hand, process research focusing on individual cases has identified a specific factor that typically quickly leads to large and durable changes: guiding clients to face and process previously avoided emotional experiences (see Ecker et al., 2012).

Guiding the client to face, process, and resolve a trauma memory is arguably the most profound and impactful example of such a treatment activity. Furthermore, a transformative trauma resolution procedure such as progressive counting, featured in the present book, can effect memory reconsolidation at the source of the associated symptom-generating mental model.

This does not mean that the common factors are not important; indeed, these specific treatment activities are unlikely to occur without a treatment approach incorporating the common factors. It is probably most useful to conceptualize the common factors as the necessary foundation for the specific healing activities to be implemented.

3. The Best in Trauma Treatment

In recent years, trauma-focused treatment has seen dramatic advances in methodology and effectiveness. Numerous authoritative literature reviews (e.g., Bisson & Andrew, 2007; Ehlers et al., 2010; National Institute for Clinical Excellence, 2005) have found that (a) trauma-specific

treatments such as prolonged exposure and eye movement desensitization and reprocessing (EMDR) are more effective than so-called non-specific (to trauma) treatments (e.g., eclectic or psychodynamic therapy); and (b) the leading trauma-specific treatments are all equivalent in outcomes. However, recent meta-analyses of direct comparisons of trauma treatments, taking into account more studies than were previously available, have for the first time found a greater effect size and better efficiency for EMDR (Greenwald, McClintock, Siebel, et al., 2013; Ho & Lee, 2012). EMDR is also known for being well-tolerated and therefore applicable to children, those with complex PTSD, and other challenging clients (Greenwald, 2007). Thus EMDR would appear to be the trauma treatment of choice. However, EMDR is difficult to master, requiring two to three times as much training time as other leading trauma treatments and even then with mixed results in terms of therapist competence (Greenwald, 2006b).

Ideal would be a trauma treatment as effective, efficient, and well tolerated as EMDR but simpler to master. In the Greenwald, McClintock, Siebel, et al. (2013) meta-analysis, the counting therapies matched EMDR's superior efficiency, though only one study of the counting method (Johnson & Lubin, 2006) and one study of progressive counting (PC; Greenwald, McClintock, & Bailey, in press) were included. PC is based on the counting method but modified for enhanced efficiency and client acceptability. Those clinicians who have used both EMDR and PC generally report their impression that PC is a little faster, a little easier for clients to tolerate, and on occasion less thorough than EMDR. The first controlled study comparing PC to EMDR (Greenwald et al., in press) found no difference between the treatments in effectiveness, efficiency, and client acceptability; however, the power was too low to reliably detect small or modest differences. Time and further research will tell how PC and EMDR compare. Meanwhile, PC appears to be at least in the same league as EMDR, while being far easier and quicker for therapists to master and to do properly. Thus PC is featured in this book.

4. Transdiagnostic Treatment

The medical model has historically been promoted as the foundation of the psychotherapy approach, despite being a poor fit for psychotherapy (Wampold, 2010). In medicine, one can actually provide a specific treatment for a properly diagnosed disorder and thereby effect a cure. However, mental health diagnoses are largely behaviorally defined rather than based on underlying dynamics or etiology, and the evidence for the superiority of a particular treatment for a given diagnosis is dubious (Wampold, 2010). Therefore the common-factors researchers have long been advocating a focus on good therapy applied to a wide range of clients and presenting problems.

More recently the call for transdiagnostic treatment approaches is also coming from the CBT community, which has previously focused on developing diagnosis-specific treatments (Clark & Taylor, 2009). This is because clinicians are unlikely to learn a large number of specific treatments for various diagnoses. Also, whereas specific treatments are typically developed and validated in laboratory studies with individuals who only have the targeted diagnosis without co-morbid conditions, practicing clinicians are unlikely to encounter many such clients. This makes treatment fidelity a problem, in that treatments may have to be substantially altered to work with more complex clients with multiple diagnoses; also, which specific treatment would one select? Furthermore, more symptom features are shared across a wide range of diagnoses than are distinct (Harvey, Watkins, Mansell, & Shafran, 2004). A transdiagnostic treatment approach that addresses these common features, and that can be applied with some flexibility without violating treatment fidelity, would have a greater chance of being learned well and applied in clinical practice

(McHugh, Murray, & Barlow, 2009). In short, a transdiagnostic treatment approach would be quite practical, if it works.

Several transdiagnostic approaches have been developed, typically addressing those mechanisms (e.g., interpretational bias, emotional dysregulation, avoidance, etc.) seen as being key to the maintenance of the presenting problems (Mansell, Harvey, Watkins, & Shafran, 2009). Although some such approaches are promising (e.g., Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010), this focus on mechanisms may to some extent be replicating the field's traditional error of relying on the medical model's diagnosis-centered approach. That is, the same basic mind-set and counteractive approach previously applying treatment to diagnoses are now being applied to mechanisms. But what if these mechanisms, that purportedly serve to maintain symptoms across a range of diagnoses, are actually themselves symptoms of something deeper?

Indeed, these so-called mechanisms are readily recognized as common outcomes of trauma exposure. Trauma, broadly defined to include loss and other significant adverse life experiences, has been implicated as routinely causing or contributing to nearly every type of diagnosis (see Chapter 1). The evidence of trauma being at the root of many problems has been reinforced by trauma treatment outcomes, which consistently feature mitigation or elimination of those symptoms identified as maintenance mechanisms in the transdiagnostic treatment literature (see Chapter 3). The present book utilizes an integrative trauma-informed therapy approach to address this important source of client problems, while also directly addressing symptoms or situations as needed.

Progressive Counting Within a Phase Model of Trauma-Informed Treatment

Trauma resolution methods such as PC are not just for posttraumatic stress disorder anymore. Research continues to implicate trauma as a potential source of most types of emotional or behavioral problems. This does not mean that PC can be used as a stand-alone treatment for every client's presenting problem. It does mean that, within a comprehensive trauma-informed treatment approach, PC can be very helpful for the part of treatment that focuses on resolving the client's trauma memories.

PC is not a replacement for other effective interventions. We still use those too. An anxious client still has to gradually face the challenge in real-life situations. An angry client still has to learn to manage his or her angry reaction and behavior. An oppositional child still needs a parent to set firm limits. These interventions would be included in the comprehensive treatment approach. PC doesn't change this. What PC can change is the strength of the force driving the anxiety, anger, or oppositionality. When a client can face and work through the trauma memory(ies), the underlying mental model is modified, reactivity goes down, and the other interventions have a better chance of being effective.

To use PC well, you have to know a lot more than just how to do the PC procedure. You have to know when to do it, and how to get the client to that point. You can't just say, "Hi, I'm Dr. X. Tell me the worst thing that ever happened to you, and now imagine watching it in your mind like a movie . . ." (It doesn't work – I've tried it!) A lot of things have to happen first. For example, many clients would not consider facing the trauma memory unless they really understood how the memory might relate to their current concerns. And some clients who may be willing to try PC are not strong enough yet to tolerate it, and would become emotionally overwhelmed if it were tried too soon.

This doesn't mean that we have to be scared about using PC. It does mean that we should use it responsibly, at the right time and in the right way. It is important to recognize that trauma

resolution is a late-stage activity within a trauma-informed treatment approach. A lot of bases have to be covered first.

Because the trauma treatment movement is relatively new, many mental health professionals still do not have training in using structured trauma treatments such as PC. Even fewer understand what a trauma-informed treatment approach is, or how to do it. The essential skills in PC go far beyond having the client focus on the trauma memory while the therapist counts out loud. The therapist must also know how to conceptualize a case from a trauma perspective and how to sequence interventions within a trauma-informed treatment approach (Greenwald, 2006b). This makes it possible to get clients to, and through, PC.

Overview of the Book

In this book, PC is presented within the framework of a phase model of trauma-informed treatment. This model incorporates other essential treatment elements such as those that have been identified in the respective literatures on common factors, specific factors, memory reconsolidation, and trauma treatment. The treatment model applies to all ages, but some of the component interventions require modification according to the age of the client. The interventions are presented as they apply to adults, with modifications for application to child and/or adolescent treatment noted along the way.

The first two chapters summarize the evidence for trauma as a contributor to a wide range of presenting problems, and on that basis present the trauma-informed treatment approach. The third chapter features a review of research in support of the component interventions (including PC) and of the approach as a whole. The following chapters go through the treatment approach step by step, often including scripts and practice exercises. Then case examples are provided, some focusing on the trauma resolution component and others addressing other aspects of the treatment approach. The final chapter teaches a system for using the trauma treatment framework to problem-solve challenging cases; this can be used for your own cases or for providing supervision or consultation to others. This case consultation system can also be used to retro-fit this book's approach to apply to your work with existing clients.

Appendix A provides a listing of Internet resources on trauma-informed treatment. Appendix B provides copies of some brief, treatment-friendly questionnaires that can be used at the beginning or end of each session to obtain feedback and improve outcomes. Appendix C provides scripts for many of the interventions. The scripts are especially helpful while you're learning and first using the various interventions with clients.

The book's treatment model is taught in part through a story, in which elements of the story correspond to treatment components. The story, alas, uses some gender-role stereotypes. Although I have been writing in a non-sexist style since long before that was considered acceptable, in this case I am sticking with the story as is. It is archetypal, it works, and every time I tried to make it more politically correct, it worked less well. I hope you will be able to take the good from it; and if you want to tell it to your own clients in a different way, of course you are free to do so.

This book does not comprehensively teach every intervention that may be needed for every client problem such as dissociation, self-mutilation, bulimia, etc. You still need to attend to your clients and whatever special issues they may face. Sometimes the approach in this book will be sufficient, and sometimes it will have to be supplemented. For example, the book's self-management interventions may be more than adequate for an angry or aggressive client, but more extensive interventions may be needed for a client who self-harms. For another example, using

the book's scripts may promote the development of a good therapy relationship, but with a client for whom a good relationship feels threatening; you'll have to address that. This book's purpose is not to address every eventuality, but to provide the core of the treatment approach.

In this book the focus is on the individual portion of treatment, even though the individual approach may not always be sufficient to achieve the treatment goals. This emphasis on the individual is not intended to be dismissive of the importance, in some cases, of working with the key people in the client's environment.

Doing What Works

Mental health professionals have been under some pressure to use empirically supported interventions whenever possible, both for ethical and economic reasons. Although the current emphasis on empirically supported treatments has merit, unresolved issues remain. One problem with this trend is that many such methods may be perceived by clinicians as inapplicable to their practice settings. Another problem is that this perception is often correct; empirically supported interventions that were developed in laboratory settings may have limited success in the field.

The present treatment approach offers the prospect of improved outcomes by integrating a series of empirically supported interventions within a comprehensive treatment approach. It incorporates the common factors found to be effective across orientations, as well as the specific healing components inherent in trauma resolution with PC: guiding clients to face previously avoided emotion, and memory reconsolidation. This treatment approach also offers direct application to clinical practice, because (a) it is transdiagnostic, applying to a wide range of clients and presenting problems, and (b) the interventions have already been adapted to practice settings. You won't have to change it or translate to make it work with your clients.

The advantage of using field-tested interventions is that, more often than not, they work. Here's how you can make them work as well as possible for you. First of all, practice using the scripts, *word for word*. The scripts are like sales pitches that have been developed and refined for one purpose: to get the response you are hoping for. I encourage you to practice with the scripts verbatim several times, with colleagues and then with clients, until you have them more or less memorized (it doesn't take long). Over time, as you start changing the words to fit your situation and to suit your personal style, you will notice whether or not you are still getting the responses you want. If you are, carry on; and if not, go back to the script and see if you can identify the difference that makes the difference.

This book teaches a highly structured treatment approach that guides the therapist step by step from beginning to end. This approach entails mastery of a number of complex clinical skills. Those workshop participants who have repeated (e.g., as part of the process of becoming a supervisor) have consistently reported learning a lot more the second and even the third time around. If you are using the book without the benefit of the supervised practice that a training program affords, it is worthwhile to go back to the book repeatedly over time as you gain more practical experience. This will help you to better understand why you are doing what you are doing, and to master the finer points. With practice, study, and experimentation, you should be able to integrate this book's approach with your existing skills for maximum effect.

CHAPTER 1

UNDERSTANDING TRAUMA

Why Trauma Matters

If you are working as a therapist, chances are that you are trying to help your clients to do better in some way: get in less trouble, do better at school or work, feel less anxious, angry or sad, get along better with others, reduce self-destructive habits, not hurt people . . . So why not just focus on the problem? Why should we care about trauma?

Following is a partial listing of the kinds of presenting problems (Anda et al., 2006; Fairbank, Putnam, & Harris, 2007; van der Kolk, 2007) that are potentially trauma related:

- disruptive behaviors
- poor frustration tolerance
- depression
- anxiety
- poor concentration
- loss of interest in activities/goals
- "don't care" attitude
- stress
- relationship problems
- anger and volatility
- fighting and aggression
- school/work absences
- substance abuse
- addictions
- criminal behaviors
- noncompliance with medical treatment
- dissociation
- self-destructive and suicidal behaviors
- high-risk behaviors
- medical problems.

This is not to suggest that trauma is the only reason that people have problems. But trauma can find the individual's weak spot. Trauma is a powerful stressor that can either cause new problems, or make pre-existing problems worse. If we try to help people but we don't take trauma into account, we risk ignoring a driving force behind the problems. We risk being less effective.

A Useful Definition of Trauma

Not long ago, trauma was defined as a horrific event "beyond the scope of normal human experience" (American Psychiatric Association, 1980). To qualify as traumatic, an event should be subjectively perceived as threatening to a person's life or physical integrity, and should include a sense of helplessness along with fear, horror, or disgust. Such events might include being in a car accident, house fire, or natural disaster; being raped; or being assaulted. Through research we have learned to identify a wider range of events as being possibly traumatic – for example, witnessing a parent or sibling being beaten; being diagnosed with a life-threatening illness.

The bad news is that traumatic events are not beyond the scope of normal human experience. By the time most individuals become adults, they will have been exposed to one or more traumatic events. This is not just true for those growing up in high-crime urban areas. Even our (presumably) best-protected children experience trauma. For example, a study of second-year college students (modal age of nineteen) found that 84% had already experienced at least one major trauma (Vrana & Lauterbach, 1994). Among disadvantaged populations, very few escape exposure to major trauma events, and multiple or chronic exposures are more common (see Greenwald, 2002b). Trauma during childhood and adolescence is now so common as to be normative. Of course, the longer someone lives, the more opportunity for exposure to trauma. When we are working with a client with any kind of problem, we can't afford to assume that trauma is not a factor.

Although the focus here is on trauma, it is important to note that other adverse life events can have a trauma-like impact. For example, a person's response to a significant loss can be virtually identical to a posttraumatic response, except that following loss, hyperarousal may not be present (Pynoos, 1990). The research on so-called Adjustment Disorder shows that many children and adolescents do not adjust to or recover from a range of adverse events (Newcorn & Strain, 1992) but maintain some symptoms indefinitely. Research with teens (Joseph, Mynard, & Mayall, 2000) as well as adults (Bodkin, Pope, Detke, & Hudson, 2007; Gold, Marx, Soler-Baillo, & Sloan, 2005; Mol et al., 2005; Robinson & Larson, 2010) has shown that distressing life events such as bereavement, divorce, chronic illness, or unemployment tend to lead to equal or greater PTSD symptoms than do those events that have traditionally been defined as traumatic.

When working with a distressed client, we do not ask if the event qualifies as a trauma before offering help. We will offer essentially the same treatment regardless of whether the source of the distress is an earthquake, a sexual assault, or a death in the family. In this book, the term trauma is intended to apply to major trauma as well as loss and other adverse life events, as long as the event has had a trauma-like impact on the client.

This chapter emphasizes childhood (including adolescent) trauma for several reasons. First of all, some therapy clients are children. Second, the rest of the therapy clients were children once, and almost certainly experienced something during their childhood that qualifies as trauma within the broad definition used here. Finally, as will be further explained later, it is likely that adult clients' childhood trauma history is directly relevant to their presenting problems.

What Makes an Event Traumatic?

Not every upsetting event is so intense and overwhelming that it is experienced as traumatic. The biggest factor pushing an event into the traumatic range is, not surprisingly, how bad it is. Several factors determine the severity of the exposure to trauma:

- the severity of the event
- the proximity of the experience
- the personal impact of the event
- the after-event impact (e.g., lifestyle disruption).

Severity of the Event

Some events are clearly worse than others. For example, an open-hand spanking is not as bad as being whipped with a belt, which is not as bad as being beaten to the point of broken bones. In most cases, once the event has been described, its severity is readily apparent. However, individuals with special vulnerabilities may experience certain insults especially severely. For example, an elderly person with fragile bones may be more severely injured than a middle-aged person by the same hard fall. Also, how the event is perceived contributes to its severity. For example, a young child who does not understand the danger she was in may not experience a nearly fatal near-miss event (e.g., almost being hit by a car) as traumatic.

Proximity of the Experience

The more directly the individual is involved in the event, the higher the risk of posttraumatic stress symptoms. For example, in a school shooting, children witnessing the event had the most severe symptoms, followed by children nearby who heard the shots but did not see the event, followed by children farther away who neither saw nor heard (Pynoos et al., 1987). However, even distant exposure can have impact, especially when children can personally relate or feel directly affected in some way. For example, a young boy, whose friend told him that the friend had seen a stranger being beaten on the street, became afraid that if he went outside someone might beat him up too.

Personal Impact

Something that happens to the individual or to someone he cares about is likely to have a greater impact than something that happens to a stranger. Children take it very personally when a parent or sibling is victimized or hurt. On the other hand, it is important not to underestimate the impact that an apparently distant event can have on a child.

- A 10-year-old boy's classmate drowned during a school outing. He did not even like the drowned girl, but felt guilty that he had not been friendlier toward her and irrationally blamed himself for her death.
- A 9-year-old girl's best friend's father died of cancer. She became obsessed with the fear that her own parents might have cancer.

After-Event Impact

This critical element of severity of exposure is often overlooked. Imagine that two identical bombs are dropped. One explodes and makes a crater in the ground. The other explodes somewhere else

and also makes a similar crater in the ground, but then some nearby buildings collapse into the second crater. Although both bombs had the same strength, the second bomb has had more impact and thus can be considered more severe. Life experiences can be like this too. A traumatic event is more than just the single terrible moment.

- A 24-year-old woman is in a car accident. After the crash, she does not know for a few minutes whether her sister (the driver) is dead or alive. In the hospital, she has to wait by herself in a small room for almost an hour. They cut off and discard the bloody jacket she is wearing, to tend her wounds; her boyfriend gave her this jacket and she treasures it. She is left with a scar on her lower arm and feels that she can no longer wear short sleeve shirts or bathing suits.
- A 4-year-old boy's father dies unexpectedly. His mother becomes depressed and withdrawn. Spring comes around and his father is not there to teach him how to catch a baseball, with the glove he'd already gotten for Christmas. Father's Day comes. His birthday. His first day of school. (This goes on indefinitely, as major losses can have fresh impact at every developmental milestone.)
- A 50-year-old man hurts his back in a work accident when a heavy object fell on him. He is unable to return to work and has to live on disability payments, reducing his income substantially. He feels frequent back pain, which makes it hard to get a good night's sleep. Because of his pain, lack of sleep, loss of income, and inability to work, he becomes irritable. This makes it harder to get along with his wife, and they start snapping at each other and keeping their distance more than before.

In other words, it's not just the event itself but the circumstances surrounding and following the event that may make it traumatic rather than merely upsetting. Personality, social support, and other factors (discussed later in this chapter) also help to determine whether an individual can handle an event or will be overwhelmed.

The "Trauma Wall"

A popular saying is that "What doesn't kill you makes you stronger," or, less colloquially, that we grow from adversity. Although this certainly can be true, it is not always the case. Sometimes what doesn't kill you may still hurt you or cause damage. So how does this work – why does it go one way rather than the other?

Here a food analogy is helpful. Usually, we chew food, swallow it, and digest it. It becomes part of our nutrition, something we can grow from. Ideally, we do something similar with an upsetting experience. Kübler-Ross (1969) described a similar process in the stages of processing grief.

For example, let's say your dog dies. Maybe you don't think about it or process it every minute of the day, but now and then you do think about it, remember different aspects: how frisky she was when you first got her, how she liked to have her belly scratched, how badly you feel about having let her out the day she got hit by a car. You remember, you talk to others, you take a walk, you write, you cry, you laugh. Little by little – or bite by bite – the hurt becomes smaller as more gets processed, integrated, *digested*. When an upsetting experience is digested, it becomes your nutrition, something you grow from. Then it becomes part of long-term memory, part of the past. It is not as fresh or upsetting anymore. Along with the emotional processing, we have organized the elements of the experience into a coherent story, including a perspective that allows us to move on. For example, you might say to yourself, "Well, she loved to play outside. I guess there was

always the risk of an accident, but she would have been miserable tied up," and "She was a great dog. I'll always love her."

However, sometimes upsetting experiences do not get processed in this ideal way. Sometimes it's just too much to face, to take bites out of. Maybe the event was too upsetting and overwhelming; maybe you try to talk about it and are punished for that (perhaps by parents getting upset or peers rejecting); maybe just when you are ready to take a bite out of this upsetting memory, another one comes along. It can be so difficult to face this upsetting memory, to tolerate it, that many people try to push it aside, push it behind a wall. That brings quick relief, so the strategy is experienced as helpful. Unfortunately, it provides only a temporary solution.

Here the food analogy does not quite match what happens with trauma memories. If you have eaten some food that is bad for you or poisonous, you will probably be able to get rid of it somehow. Maybe you'll be shaky or sick for a little while, but it'll be gone from your system. Unfortunately, with an upsetting experience, you can't just reject it and flush it down the toilet. The only way out is to go through – through the memory processing system into long-term memory. Until the memory is processed, or digested, it stays behind the wall.

Although the wall may provide some relief, this system has problems. First, the memory stays fresh and keeps its power indefinitely, until it is digested. I have worked with people months, years, and even decades after the trauma, and the quality of the undigested memory is the same. When asked to concentrate on the memory, they say things like, "It's so vivid it's like it just happened yesterday," or, even more telling, "I'm there."

Also, although the memory retains its freshness and power, it is still behind the wall, so we can't get at it with the rest of our psychological resources the way we can with processed memories. This means that the memory, or parts of the memory, can negatively influence us and we may feel helpless to stop it. For example, many rape victims will say, "I know in my head that it wasn't my fault, that I didn't do anything wrong, that I didn't deserve that. But I can't help feeling ashamed, dirty, to blame." In other words, the healthy part that knows better can't manage to influence the powerful beliefs and feelings that are shielded behind the wall.

Furthermore, the memories stored behind the wall are not content to stay there. They are always waiting for a chance to come out, go through the system to be digested, and become part of the past. It is as if the memory is seeing its chance and saying, "Me too! Can I finally be treated like a normal memory and get processed already?" When this happens, we say that the memory was *triggered* or activated by a reminder, something thematically related. Another way of explaining this is that the stuff piled up behind the wall is like a *sore spot*, and when some kind of reminder hits that sore spot, the reaction is stronger than others might expect. This is because the person is not just reacting to what's happening right now; the old stuff is kicking in, too.

- Most of us who drive are at least a little nervous about driving. This is reasonable and inspires us to put on our seat belts and watch out for bad drivers. However, we are still able to enjoy conversations with our passengers, listen to the radio, and think about where we are going. Now think about the woman who experienced a car accident because she couldn't stop on a snowy road. Afterward, whenever she got into the driver's seat, she had the usual amount of nervousness, plus all the extra fear from behind the wall. You've probably seen people like her on the road, clutching the wheel and gritting their teeth as if they are expecting an accident to occur at any second. On rainy or snowy days, so much of the fear piled on that she could not manage to drive herself to work.
- Most of us, when accidentally bumped in the hallway, will be slightly irritated, perhaps make a comment, but forget about it five minutes later. Now think about the 12-year-old boy who

has been routinely physically abused at home. Behind the wall is piled-up fear of being attacked, a sense of helplessness, and rage. When he is bumped in the hallway, the sore-spot reaction from the stuff piled up behind the wall is so strong that he believes he is being attacked. Naturally, being angry and not wanting to feel helpless anymore, he defends himself. When he is sent to the assistant principal's office for "punching a peer with no provocation," he insists that the other student started it.

- A young woman had been disciplined in a harsh and scary manner in her own childhood: her mother would yell at her, and then sometimes slap her or throw something at her. Now she is a mother herself. When her 3-year-old yells and cries, it hits her sore spot (yelling was always a danger signal for her) and she becomes paralyzed: first she freezes in her tracks, then starts crying. She doesn't know why this happens, and otherwise handles her child pretty well.

Note that it is not necessary to be aware that an unprocessed memory is being triggered for it to be happening. Sometimes the person will be acutely aware of it, as unwanted images from the memory itself come back. For example, one 13-year-old girl said, "Every time my boyfriend tries to kiss me, I freak out. I see the face of that guy who messed with me when I was little." However, often the person is unaware of the impact of the behind-the-wall memory and just subjectively experiences a strong reaction to the present situation. For example, a sixth-grade boy who has experienced several events involving helplessness may give up too quickly when he does not immediately grasp how to do his math homework. He may say, "It's too hard – I can't do it" when he probably could do it with a little effort – if he weren't overwhelmed by the sore-spot helplessness from behind the wall.

We all understand this phenomenon. We understand that people have their wounds, their sensitive areas, their sore spots. We say, "Don't mention John around her, unless you want her to start crying," or "Don't joke like that with him – he'll go ballistic." What we mean is that there are unprocessed memories piled up behind the wall that can get triggered by thematically related events in the present. We understand that people can be more reactive than the current situation warrants when something hits their sore spot. This is one of the consequences of carrying trauma memories that are not fully processed.

Resiliency and Vulnerability

Beyond the objective severity of the event itself, several factors contribute to determining whether a given upsetting experience is ultimately processed or pushed behind the wall.

Social Support

The choice to face and digest an upsetting event versus pushing it behind the wall occurs in a social context. Children may not want to talk about upsetting thoughts and feelings around their peers for fear of being rejected and isolated. At home, children may not want to worry their parents or other family members. When a parent says, "Don't talk about that. It'll only upset you!" the child learns, "Wow – this is so bad and scary that even Mom/Dad can't handle it!" So unless children are in an accepting and supportive environment, they may be getting messages that do not provide support for talking about the trauma and that discourage processing.

Temperament

Pain threshold is a familiar concept that can be applied to emotional pain as well. People are unique in the ways they experience events. The same event with the same severity will bother one person more than another. Extending an earlier analogy, two identical bombs might make different size craters for each person. Furthermore, even if the same size bomb is making the same size crater for two people, it might bother one person more than the other. For example, on a 0–10 scale of severity of emotional upset, two people might each report the same event as being a 6. However, one person might experience that 6 as no big deal, and the other might find it intolerable. Obviously, the more difficulty a person has with tolerating pain, the more tempted that person will be to push the memory behind the wall.

New and/or Repeated Insult/Wound

Suppose a child has experienced a minor everyday type of upsetting event, such as a peer insult or a school-related frustration. She is on track to digest it and is just getting ready to take a bite when some new stressor comes along . . . and then another, and another, and another. Eventually so many of these small events pile up that the pile is experienced as "too much" and pushed behind the wall. This pileup of minor events commonly occurs in children who have an untreated learning disability or attention deficit/hyperactivity disorder (ADHD); children who are bullied; and children who are subject to neglect or emotional abuse.

You might have noticed that we just expanded our definition of trauma. If it's behind the wall, it counts. If it's behind the wall, it's creating sore-spot reactivity, whether the sore spot comes from one big event or a hundred smaller ones.

Attachment Status

Some preliminary research suggests that attachment status can, to some extent, predict the child's preferred coping style (Howard & Medway, 2004; Solomon & Siegel, 2003). This also makes sense. How do you become someone with a secure attachment? You do this by having a *good-enough mother* (Winnicott, 1965). This parent figure actually doesn't need to be a mother, but he or she does need to be good enough! When you have a good-enough mother, you learn, through repeated experiences over time, that if you're cold, soon you'll get warm again; if you're hungry, soon you'll get fed; and if you get so angry that you want to kill, your mother will survive and so will you; she will not retaliate or reject you. In other words, in the process of developing a secure attachment, children learn that although they may not like to feel bad, they can handle it and things will come out okay.

When securely attached children have to deal with an upsetting event, they have an experience base and coping style that favors facing it and getting through it. Incidentally, children with secure attachment are also more likely to have good social support, because they are probably still in the family in which the attachment was formed, and because they are more capable of forming other supportive relationships.

On the other hand, how do you form anxious, insecure, avoidant, or disorganized attachment? You do so by having a (subjectively experienced) not-good-enough mother, or a good-enough-sometimes-but-not-other-times mother. Children with problematic attachments have learned,

through repeated experiences over time, that feeling bad can be disastrous and overwhelming. If you are cold, you might get warm, or you might stay cold and miserable. If you are hungry, you might get fed, or you might just get hungrier. If you get so angry that you want to kill, you might get rejected or attacked. In other words, in the process of developing a problematic attachment, children learn that feeling bad is a danger sign, to be avoided if possible.

When such children have to deal with an upsetting event, they have an experience base and coping style that favors trying to push it out of the way, to get rid of the threat. Those with insecure attachment also have more difficulty resolving trauma even with treatment (Stalker, Gebotys, & Harper, 2005).

The more severely problematic type of attachment status is known as failed attachment or reactive attachment disorder. Unattached children may experience trauma in a qualitatively different way than other children do; they also have some unique ways of responding to various interventions. The treatment of those with the most severe attachment problems is beyond the scope of this book. The treatment approach presented in this book is still necessary in their treatment, but it is not sufficient; an additional specialized treatment component is needed.

Safety and Attachment

There are also other consequences of traumatization. In Erikson's (1963) developmental theory, the first stage of development is trust versus mistrust. With a good-enough mother, the infant learns through repeated experience that he or she will be taken care of, that the world is a safe place. Trauma can alter that perspective, reverse that lesson (Solomon & Siegel, 2003).

We have understood this since the beginning of the modern era of trauma study. In the World War I literature on posttraumatic stress disorder (PTSD, which was called *shell shock* then), it was reported that soldiers under bomb attack would frequently call out either for God or their mothers. What is the significance of this? The first promise was being broken: "The world is actually not a safe place. I am not being protected. Mother, God, you lied to me."

Attachment and safety are inherently related, and when children feel unsafe they seek the comfort and protection of their primary attachment figures. The toddler at the zoo is not frightened by the tiger; he is safe with his mother. However, trauma can disrupt attachment, in part because the attachment figures have, by definition, failed to protect and an unimaginably bad thing happened.

Some individuals may react to this trauma-related attachment challenge by withdrawing, giving up on the attachment; some may become clingy or regressive to further activate the attachment figure's protection. Others seek out new attachment figures who are perceived as more likely to protect. For example, although there are practical reasons for affiliating with street gangs, the explanations teens offer are revealing: "We watch each other's backs," and "This is my family."

Survival Orientation

When children are exposed to trauma, they learn that parents and others cannot be relied upon for protection; they learn that bad things can happen. They then make a profound shift in their worldviews, in their orientations to daily living. Instead of focusing on normal concerns and activities, the primary focus becomes keeping the bad thing (or other bad things) from happening again. When we say someone has "lost her childhood," this is what we mean. The child exchanges

the healthy (if naive) optimism for a survival orientation. A similar effect can occur even in adulthood. When trauma exposure challenges the individual's former view of a benign world, the same kind of over-focus on survival can result (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988).

Posttraumatic Symptoms

Many posttraumatic stress symptoms can be understood by taking into account the sore-spot reactivity and the survival orientation. Remember that posttraumatic stress symptoms are not limited to those with PTSD. In fact, PTSD is a relatively infrequent outcome of traumatization even when clinically significant trauma-related symptoms and impairment are present (e.g., Giaconia et al., 1995). The following symptoms are commonly found among trauma-exposed individuals (Shalev, Yehuda, & McFarlane, 2000) with a wide range of presenting problems.

Reexperiencing

Reexperiencing refers to instances in which the memory itself recurs or intrudes into awareness. The individual might complain that he thinks of the memory "all the time" or that it comes to mind at random moments, without warning. However, on analysis, it generally turns out that such intrusions occur when they have been triggered by something in the present. Most people find these intrusions disturbing and disruptive. Flashbacks are an extreme and relatively rare reexperiencing symptom; nightmares and waking memories or images are much more common.

Avoidance

Avoidance relates to both the sore-spot reactivity and to the survival orientation, the wish to keep any more bad things from happening. For example, a woman might avoid driving down a certain street where she had been in an accident, both to avoid a recurrence of the accident and to avoid being reminded of the memory. Avoidance can have significant impact on many areas of life:

- A 16-year-old boy, whose best friend had abandoned him during a street fight, says, "I don't have friends, only associates. Friends let you down." He is avoiding the possibility of being let down again by not trusting anyone anymore.
- A 28-year-old war veteran with exposure to multiple traumas has stopped attending his night school classes, is not doing much in the way looking for a job, and is having unprotected sex. He says, "What does it matter? Nothing's going to work out for me anyway. Why bother making the effort?" He is avoiding the possibility of feeling disappointed again by not getting his hopes up, not setting goals for himself, and not planning for the future (the technical term for this is *pessimistic future*).
- A 9-year-old girl, who had been hit by a car while on her bicycle, has quit her soccer team. She says, "I just don't feel like going anymore." In fact, she's not going anywhere except school and home, because she doesn't feel safe anywhere else. She's learned that bad things can happen out in the world, and she doesn't want any more bad things to happen to her.

- A 35-year-old single woman with a childhood history of sexual abuse victimization overeats (and is significantly overweight) and wears baggy clothes. She is making an effort to be unattractive in the hope of avoiding future sexual assaults.

Hyperarousal and Hypervigilance

Many trauma-exposed people are in a constant state of alert, on the lookout for possible signs of danger. When people are primed to expect the worst, they can be jumpy when startled or threatened. The problem is, when you think you're a nail, everything looks like a hammer. Many traumatized individuals will interpret neutral or ambiguous social cues as being threatening (the technical term for this is *hostile attribution bias*; see Dodge & Coie, 1987). For example, a man may notice someone looking his way and assume that the other person is showing disrespect and trying to start a fight. Of course, this kind of assumption leads to problems!

Numbness

Many traumatized individuals find themselves numb or unable to feel certain (or most) emotions. This may be a *freeze* response to being overwhelmed or it may be a special kind of avoidance. Some people will say, for example, "I can't let myself feel anything or I'll feel everything; it'll all come back. And that's too much," or, "I'm afraid that if I start crying, I'll never stop." The numbness solution is to block it all out and feel little or nothing.

Substance Abuse and Other Distraction Strategies

Many traumatized individuals are unable to effect that numbness and so seek activities that will help them "forget about" the memory or related affect. For example, some people become thrill seekers, troublemakers, or workaholics to stay busy and distracted with attention-compelling activities. Many turn to substance abuse to keep the trauma memories away, if only for a while. One young man who had been brutally assaulted said, "I think about it every night. It keeps me awake for hours. I have to catch a buzz [smoke marijuana] to get myself to sleep." Trauma has been implicated in substance abuse (Ouimette & Brown, 2003; Steward, 1996) as well as other addictions (e.g., Scherrer et al., 2007).

Affect Dysregulation

The technical term for sore-spot reactivity is *affect dysregulation*. We should not use this (or any multi-syllabic technical) term with our clients, but it's important to understand it. Breaking it down, affect is emotion, and dysregulation means unregulated, out of control, or volatile. Emotions may become out of control when traumatized individuals react very strongly to minor stressors because they are already sensitized. This in-the-moment reaction, perhaps of anger, fear, sadness, shame, or helplessness, can be very intense and uncomfortable, even intolerable. The fear of these reactions drives many of the avoidance behaviors.

Also, people who react very strongly to minor stressors are at a high risk of impulsive acting out behavior (van der Kolk et al., 1996). The impulsive acting out provides quick relief from the intolerable feeling, but often leads to other problems. Trauma has been implicated in violence/aggression (Widom, 1989), sexual offending (Ward & Siegert, 2002), and antisocial/criminal behavior (Ford, 2002; Greenwald, 2002b).

Posttraumatic Symptoms Over Time

Unfortunately, people don't just get over their traumatization. The memory (and associated symptoms) doesn't just fade away with time. It stays fresh as long as it's behind the wall. It stays fresh until it's digested. But what does it take for digestion to be possible? What needs to happen?

Going back to the food analogy, suppose you've just had a nice lunch and you're back at work. Someone bursts into your office and announces that there's a bomb in the building, so you have to rush out and go somewhere else. Your nervous system shifts from parasympathetic to sympathetic, and blood leaves the stomach to supply the brain, arms, and legs. This allows you to escape and survive. Twenty minutes later you hear an announcement that the whole thing was a hoax; there's no bomb. You go back to work and gradually your nervous system shifts back to parasympathetic. The blood goes back to your stomach, and you can proceed with digestion.

This return to relaxation does not happen with posttraumatic stress symptoms because the symptoms are self-perpetuating. The perceived need for survival mode is repeatedly reinforced, with no shift to safety and relaxation, no opportunity for digestion:

- A man who had been robbed on a certain street walks the long way home from work to avoid going down that street. He may say to himself every day that he does this, "Phew! I just escaped getting mugged again."
- A girl who was raped by the babysitter – who is now in jail – is bullied by her big brother in minor ways on a daily basis. She learns, over and over again, that males who are bigger and more powerful than she is can have their way with her. Her psychological truth is that she is in constant danger.
- A previously victimized teenaged boy believes that he is being stared at by a peer and interprets this as a hostile affront. If he
    - quickly leaves the situation, he may say to himself, "Phew! I got away! I'm glad I've stayed so alert."
    - challenges the peer, who then backs down, he may say to himself, "I defended myself well. You have to do that or they'll walk all over you."
    - challenges the peer, who responds by fighting, he may say to himself, "I was right: he was hostile."

Regardless of specific outcome, these posttraumatic symptoms serve to reinforce the perception that the world is still dangerous. Every avoidant behavior – such as walking the long way around – only provides relief from fear, and reinforces the perceived need for avoidance. The defensive-intent aggressive behaviors also are self-reinforcing: by forcing the other's withdrawal or hostility, the perceived need for the defensiveness is confirmed. Since traumatized individuals may tend to be hypervigilant and to over-interpret neutral cues, these types of situations may occur frequently. As long as the individuals remain in survival mode, they do not feel safe and are not prepared to relax or to digest their trauma memories.