CONTEXTUAL THERAPY FOR COMPLEX TRAUMATIZATION: BEYOND SYMPTOM REDUCTION

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THE CONTEXTUAL CONCEPTUAL FRAMEWORK

For Understanding Complex Traumatization

The Ten Adverse Childhood Experiences (ACEs)

Before the age of 18, the person was exposed to…

Abuse/Neglect

- Physical abuse
- Emotional abuse
- Sexual abuse
- Physical neglect
- Emotional neglect

General Household Dysfunction

- Intimate partner violence
- Household member alcoholic or drug user
- Household member chronically depressed, mentally ill or suicidal
- Loss of parent due to death, separation or divorce
- Household member in prison

NOTE: ACEs in **red** are traumatic events, but those in **black** are not.

A Dose-Response Relationship

- The more ACEs someone has been exposed to, the greater the risk of each of the psychological, medical and health risk behavior outcomes studied.
- As the ACE score increased, the number of psychological, medical, and health risk behavior outcomes increased.
- On average, the *life expectancy* of an individual with ACE ≥ 4 is *almost 20 years less* than that of someone with ACE = 0.

Impact of the ACEs (*examples*)

Psychological/Behavioral	Health Risk Behaviors	Medical
■ Anxiety	■ High Level of Perceived Stress	■ Heart Disease
■ Depressed Affect	■ Promiscuity	■ Diabetes
■ Hallucinations	■ Severe Obesity	■ High Blood Pressure
■ Sleep Disturbance	■ Intravenous Drug Use	■ COPD
■ Difficulty Controlling Anger	■ Alcohol Abuse	■ Cancer
■ Violent Behavior	■ Current Smoking	■ Hepatitis

ACEs as An Index of Family Functioning

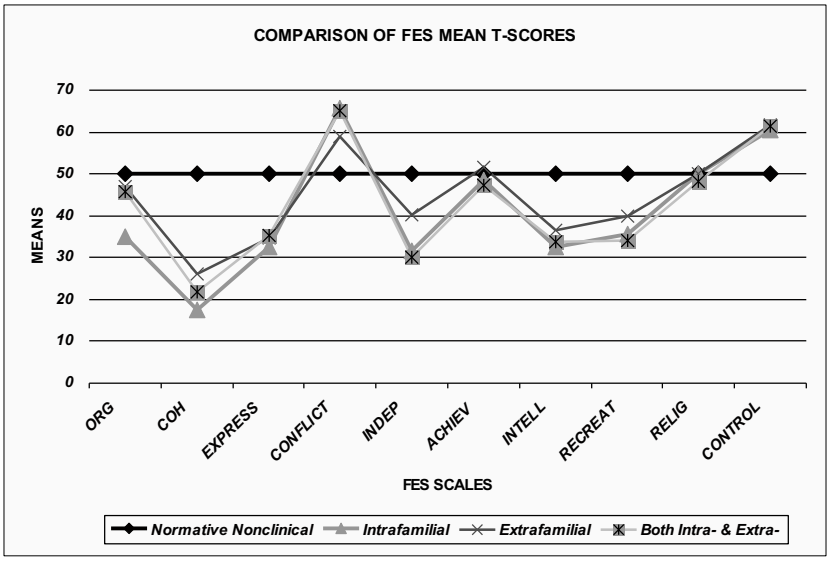
"…. One may miss the forest for the trees if one studies these categories individually. They do not occur in isolation; for instance, a child does not grow up with an alcoholic parent or with domestic violence in an otherwise well-functioning household." (p. 361)

Felitti, V.J. (2002). [The relationship of adverse childhood experiences to adult health: Turning gold into lead.] *Zeitschrift fuer Psychosomatische Medizin und Psychotherapie, 48(4),* 359-369.

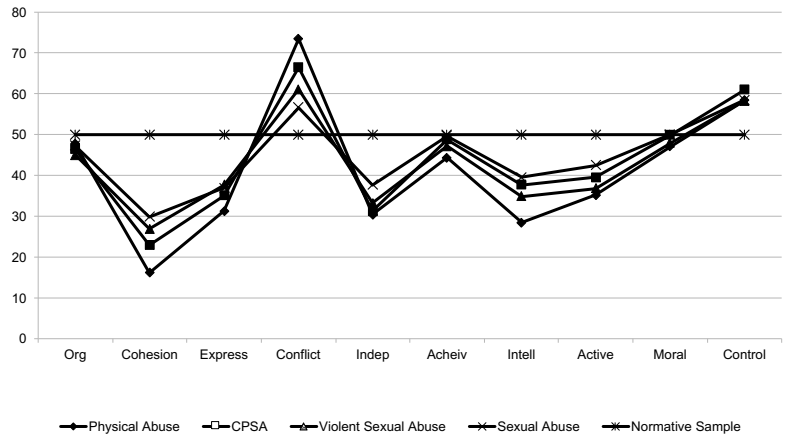
The Context of Childhood Adversity

The point Felitti is making is not merely that impact of the number of individual ACEs in a person's background is additive, or even exponential. The findings of ACEs research not only draw our attention to the harmful influences that were *present* in the households of adults with a high ACEs score; it also points to what was *absent*: an interpersonal environment that contained the resources required to foster development, socialization, and practical skills acquisition learning. In this respect the ACEs are not just detrimental in and of themselves, or cumulatively. They are *indicators* or *markers* of a broader family *context* that is deficient in its capacity to prepare the child to manage the complex challenges of living as an effective, independent, and socially competent adult.

Family Environment of Child Sexual Abuse Survivors in Therapy



Family Environment of Child Sexual and Physical Abuse Survivors in Therapy



Areas of Weakness in Adaptive Functioning Commonly Observed in PCA Survivors

Developmental

- Attachment (disconnected)
- Cognitive (poor reasoning)
- Sensory (unawareness)
- Emotional (alexithymia)
- Impulse Control (rudimentary)

Socialization

- Limited social skills
- Weak grasp of social conventions
- Gaps in knowledge of mainstream culture
- Poor abilities for planning, organization, structure, routine

Practical Knowledge

- Personal hygiene
- Money management
- Obtaining housing
- Securing and maintaining employment

NOTE: These are examples of possible deficiencies. The areas and specific types of weakness in adaptive functioning can vary widely based on the idiosyncratic features of the interpersonal/family context in which each individual was reared.

Conceptual Implications: A Contextual Perspective

- Prolonged Child Abuse (PCA) often occurs in the *context* of growing up in an interpersonally deficient household that fails to adequately foster development, socialization and practical skills acquisition.
- As a consequence, over and above the trauma-related difficulties they exhibit, PCA survivors often manifest a wide range of warps and gaps in development and socialization that impair their ability to attain effective and gratifying adult functioning. This represents an alterative way of conceptualizing Complex PTSD, i.e., traumatization plus gaps and weaknesses in adult living capacities.
- Successful therapy for PCA survivors needs to take into account the interpersonal/development context in which PCA usually occurs by aiming to remediate gaps and warps in development, socialization, and learning in addition to targeting trauma-related symptoms.

Corollaries of a Contextual Framework

- Growing up in a distant or emotionally inconsistent and controlling family fosters affect hunger and unassertiveness, qualities which render PCA survivors prime targets for perpetrators of childhood victimization and later revictimization.
- Many of the difficulties of PCA survivors/clients with Complex PTSD are attributable not only to traumatization, but also to the lack of developmental capacities, socialization and knowledge needed to lead a gratifying adult life.
- Without these capacities, which include self-soothing and other coping skills, trauma-focused exposure is highly likely trigger flashbacks and dissociative episodes and foster deterioration rather than improvement in functioning.

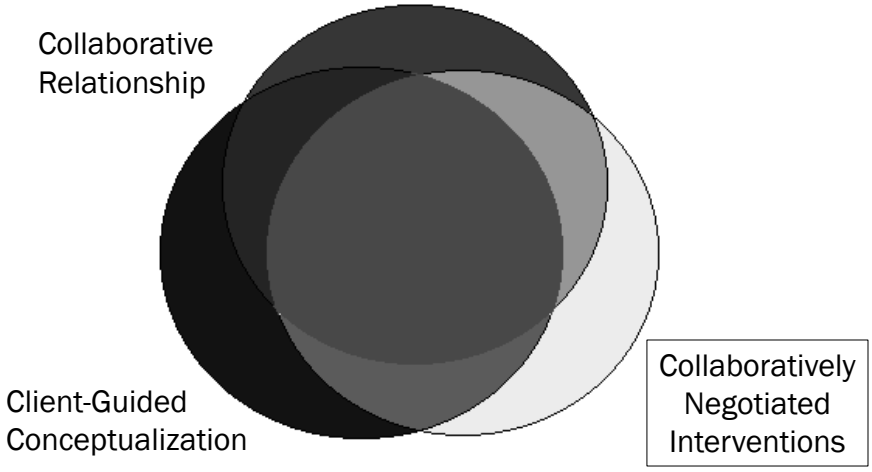
THE CONTEXTUAL TREATMENT MODEL

For Addressing Complex Traumatization

Principles of Contextual Treatment for Complex Traumatization

- Contextual Therapy is *conceptually driven* rather than *intervention driven.* It is guided by applying the Contextual Conceptual Framework to identify and understand the particular constellation and intersection of trauma-related and interpersonal-developmental context-related problems exhibited by each individual client.
- While there are particular interventions routinely drawn upon in Contextual Therapy, interventions may be appropriated from other approaches (e.g., DBT, behavior therapy, exposure) depending on the objective at any given point in treatment.

The Three Core Components of the Contextual Therapy Model



THE CONTEXTUAL TREATMENT MODEL

The Collaborative Relationship Component

Principles of Collaborative Relating

- Due to having grown up in a deficient family context, it is highly unlikely that PCA survivors have ever experienced, or have a clear conceptual model of, a collaborative relationship.
- Instead, PCA survivors often expect betrayal, abandonment and contempt and/or infantilization, indulgence and unconditional praise and acceptance.
- In the course of establishing the collaborative relationship required for a successful therapeutic outcome, the therapist must model the components of this type of relationship and act in a way that resists and contradicts the pull of the challenges listed in the following slide.

Potential Obstacles to Collaborative Relating

Client-Related Challenges	Common Corresponding Countertransference Reactions
■ Dependency	■ Over-Solicitousness/Distancing
■ Distrust	■ Intrusiveness/Impatience
■ Dissociative Spaciness	■ Lack of Focus, Inattentiveness
■ Deficient Enculturation	■ Presuming Intentionality → Anger
■ Disbelief Change is Possible	■ Blaming Client for Failure to Progress
■ Don't Deserve	■ Accusing Client of Self-Sabotage

Modeling Collaborative Relating

- Clarifying Communication: “What do you mean by the term ‘X’?”, “I’m not sure I understand what you mean by ‘Y’.”, “Help me see that the way you do.”
- Goal-Setting: “What will your life be like if we’re wildly successful?”, “What do you want to accomplish (in the entire course of therapy; in today’s session; next)?”
- Seeking Permission and Promoting Consensus: “Which of these things do you want to work on next?”, “Is it ok if we talk about ‘X’ now?”, “Are you ready to work on ‘Y’?”, “Let’s figure out *together* a way to work toward this goal (that feels comfortable to/works best for you).”

THE CONTEXTUAL TREATMENT MODEL

The Client-Guided Conceptualization Component

Rationale for Client-Guided Conceptualization

- On one hand, among the areas of deficiency that are near-universal among PCA survivors are solid reasoning and judgement, sound decision making, and emotional awareness. Without firm capacities in these areas it is almost impossible for survivors to make sense of their painfully chaotic histories and constellation of difficulties.
- On the other hand, PCA survivors are frequently reared in circumstances that leave them indoctrinated with extremely distorted perceptions of themselves.
- Directly challenging the content of survivors' beliefs is unlikely to be successful. The primary strategy in Contextual Therapy is to *guide them through the reasoning process*, and trust survivors to *come to their own conclusions*.

Facilitating Client-Guided Conceptualization

- Client-guided conceptualization is facilitated by a process akin to Socratic questioning, sometimes referred to as Colombo or (Donald) Meichenbaum-style interviewing. However, in contrast to the misconception many people have of Socratic questioning, it is *not designed to lead the recipient to a particular answer*.
- Instead, the therapist helps clients frame their inquiry, identify areas of relevant evidence, and progress through a logical reasoning process by asking them to explain how they arrived at their present beliefs. If their convictions are not based on evidence and logic, at some point they will be unable to support their conclusions and will be motivated to revise them.
- Although PCA survivors are primed to accept what others (including the therapist) tell them, they are more likely to truly absorb and benefit from conclusions they arrive at

Types of Questions Commonly Employed in Client-Guided Conceptualization

(These questions are asked from a "one-down" position, with a tone of humility that conveys that you don't know the answer… *because you <u>don't</u>*.)

- What do you mean by the term 'X'?
- I'm not sure I understand what you're saying.
- How did you come to that conclusion?
- What is your evidence for that?
- Is that a conclusion you came to on your own, or is that something you were told by someone else?
- Could you please explain that?

The Objective of Client-Guided Conceptualization

… is to help clients identify and clarify

- what they think/believe
- what they feel/value/want
- why they do what they do (motivation/learning sets)
- what they have lived through

At the outset of therapy they may not be clear on these areas… but *they* are the only ones who can come to know these things because they are the only ones with direct access to the relevant data. In regard to this territory the therapists can help guide them through the process of arriving at conclusions, but must humbly recognize that it is not effective to prod survivor clients toward particular conclusions.

Where survivor clients *do* need to be provided with answers is in matters of

- fact (e.g., this is how you go about renting an apartment)
- resources for knowledge and skills (e.g., how to use the internet)
- skills (e.g., here are some methods for self-soothing)
- socialization (i.e., these are the conventions that people in this society/culture expect you to follow)

These are areas that people need to learn about.

They can't reasonably be expected to figure them out by relying on logic and reasoning. (Social conventions, for example, are based on historical accident and tradition, not logic.)

THE CONTEXTUAL TREATMENT MODEL

The Collaboratively-Negotiated Intervention Component

Contextual Therapy is a Phase-Oriented Trauma Treatment

- Phase 1: Safety and Stabilization – Especially for PCA survivors, who never established stable adult adjustment, a firm platform of comfortable and effective functioning must be established in the present before there can be a productive confrontation of past trauma.
- Phase 2: Trauma Resolution – Deconditioning the fight-flight-freeze fear response to trauma-related cues via some form of exposure, in this population often graded and titrated.
- Phase 3: Forming a Productive and Gratifying Post-Trauma Adult Life Structure – Progressively evolving the components of daily living, occupational adjustment and social functioning that were never firmly and consistently established.

Prioritized Treatment Goals (Not Lock-Step, Not Rigidly Sequential)

- Reduce Distress – learning and implementing strategies for reducing and eliminating anxiety, depression, and other forms of distress
- Modulate Dissociation – learning techniques for counteracting unwanted, automatic episodes of fogging/spacing out
- Master Adult Living Skills – such as sound reasoning, interpersonal attachment, emotional regulation
- Break Addictive and Compulsive Patterns
- Traumatic Processing – resolving trauma-related reactions via cognitive processing and exposure
- Establish a Stable Adult Life Structure – work, social support network, daily routine, etc.

Principles of Collaboratively-Negotiated Intervention

- Client and therapist figure out together the treatment goals to be achieved, and which goal(s) are a priority to work on at any given point in therapy.
- Drawing on a wide range of interventions, client and therapist figure out together which intervention or set of interventions is most likely to be effective for the client in achieving the goal at hand.
- Client and therapist adapt and modify standard interventions to fit the client's individual needs and maximize effectiveness, sometimes selecting particular standard interventions, sometimes combining aspects of existing interventions, and sometimes creating a novel intervention specifically tailored to the individual client's needs.

The Over-Arching Goals of Contextual Therapy

- Reduce or eliminate distress and response patterns (e.g., traumatization, addictions, compulsions, dissociative reactions) that impair functioning.
- Transmit the weak or absent developmental, socialization, and learning capacities that were never established to begin with.
- Build on these two achievements to help the client form a stable, gratifying, productive life structure.

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QUESTIONS & DISCUSSION