Treating Self-Destructive Behaviors in Trauma Survivors: Strategies and Intervention Techniques for Clinicians

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Session One

- Defining traumatic experiences, their meaning and their relationship to loss
- Processing attachment styles and impact on affect regulation and dysregulation
- The challenge of attaching to abusive caretakers
- The optimum window of arousal

Setting the stage

- A strengths-based de-pathologized approach
- Moving away from pathologizing diagnoses
- SDB as creative coping strategy
- Use right brain-based modalities in the work
- SDB serves a function for clients - we need to give them other ways to achieve what it does for them
- Standard safety contracts don't work - we'll explore an effective and creative alternative

defining trauma

- a traumatic event, either witnessed or experienced, representing a fundamental threat to one's physical integrity or survival
- responses can be quite varied including intense fear, anger, anxiety, helplessness, horror, confusion.
- sometimes people have strong emotional reactions and other times they go into an immediate shut down and the emotional responses are less accessible.

the **meaning** of the event may be as important as the actual physical act or trauma and should be explored with the client to process their subjective take on the experience

Come up with a 1 sentence narrative to describe this scene….

when the meaning of the event makes it traumatic

- personalizing the experience: feeling "targeted" or singled out
- feeling responsible for the event: "it's because of me" "it's my fault"
- believing you could have stopped it or prevented it
- believing the world is out to get you: feeling alone
- feeling the trauma has made you "weird" or different
- using it as "evidence" that bad things will keep happening to you or to others

the impact

- depression
- anxiety
- helplessness/hopeless
- isolated/alienated
- intense fear
- rage
- chronic pessimism
- loss of hope/faith/trust
- increased suspicion
- vulnerability to subsequent trauma
- vulnerability to self-harm

when the meaning of the event minimizes the trauma

- believing it wasn't your fault
- seeing the event as arbitrary/coincidental and not about you
- believing there was nothing you could have done to prevent it/stop it from happening
- focusing on the fact that you survived it
- focusing on the help you received from others
- seeing it as an opportunity to connect with others
- using it as an opportunity to personally grow/make a difference in the world

the impact

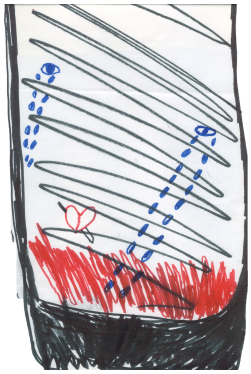
- gratitude
- appreciation
- optimism
- increased sense of faith
- sense of 'renewal' or 'getting a second chance'
- empowerment
- personal growth
- positive change
- social connectedness
- desire to engage in self-care and self-compassion

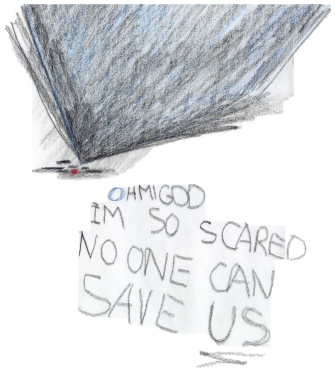
defining trauma

- disempowerment
- activates social engagement response or "fight or flight" response
- activates "last option" of freeze: de-realization/de-personalization/dissociation
- shame/guilt/"badness"/embarrassment
- betrayal
- grief/bereavement

trauma and loss

- a key component is the experience of **loss:**
- boundaries/safety
- trust
- innocence
- protection/comfort
- attachment to loved ones
- possessions
- consistency/predictability/normalcy
- sense of self/body
- control/power
- memories
- faith/hope/spirituality





examples of trauma

- sudden onset of illness/disease
- physical injuries
- medical procedures
- car accident
- physical, sexual, emotional, verbal abuse
- human trafficking
- neglect, abandonment
- death

examples of trauma

- victim of crime/incarceration
- witnessing violence/domestic violence
- victim of natural disaster
- victim of terrorism
- participating in combat/war refuge
- abrupt change in financial status
- profound change in familial dynamics
- the immigration experience

Putting self-destructive behaviors in a developmental context:
To truly understand the dynamics of self-harm, you must connect the behavior to our earliest developmental task…
successfully attaching to our primary caretakers

secure attachments with caregivers allows the child to develop a sense of trust, gain mastery over the environment, and develop the capacity to modulate physiological arousal

(van der Kolk and R. Fisler, 1999)

attachment and affect

- infants can modulate affective arousal, ignoring sensory input and achieving a trance state, by sucking, averting their gaze, or dissociating
- they rely on caretakers to re-balance agitated internal states by soothing, comforting, rocking, feeding, verbally reassuring, singing, etc.

The ability to manage emotional states is contingent upon successful attachment. Affect regulation begins with inter-regulation: soothing, consistent nurturance from caretakers. Through the experience of modeling, neurological imprinting, and learned behavior, this gets introjected by the child and leads to auto-regulation.

Babies and children are all or nothing, like "light switches" in and out of sympathetic and parasympathetic responses.

Over time, they develop the ability to modulate in and out of these states by using facial expressions and safe mutual interactions to emotionally regulate themselves.

It's as if they are "borrowing" the stability of the parent's pre-frontal cortex.

The way we are held and comforted in childhood, sets up certain chemical systems and patterns in our brains. Positive human interactions trigger the brain chemistry in the reward system of our brain. We experience sensations of pleasure, calm, safety, and release hormones that regulate stress.

"the function of a child is to make the people around them deeply engaged with them. It's part of the hard wiring in their brains. The whole front of our brains is about being with other people"
van der kolk 2008

Achieving attachment
Dr. Ann Corwin

- Eye contact: infants seek out faces for emotional comfort and reassurance that they will be fed.
- Touching: safe, appropriate physical touch stabilizes infants, manages their emotions
- Talking: the tone and rhythm of words provides comfort and emotional grounding

mother-child attachment patterns

(Ainsworth, 1978, Main and Solomon, 1986)

- **Free/autonomous:** present, sensitive, aware of child's feelings and needs (SECURE CHILD)
- **Dismissing:** unavailable, disengaged, rejecting (AVOIDANT CHILD)
- **Ambivalent:** fluctuating between inconsistency and enmeshment (ANXIOUS-AMBIVALENT CHILD)
- **Disorganized:** traumatized and grief-stricken, frightened by and frightening to their children (DISORGANIZED CHILD)

Frightened and frightening caregiving

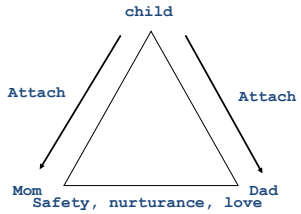
(Janina Fisher, 2010)

FRIGHTENED BEHAVIOR	FRIGHTENING BEHAVIOR
• Backing away • Frightened voice • Dazed expression • Non-responsive • Exaggerated startle • Withdrawn • Avoidant • Anxious	• Looming, attacking postures • Sudden movements • Mocking, teasing • Intrusive • Emotionally reactive • Loud, startling noises • Physically aggressive • Threatening/abusive

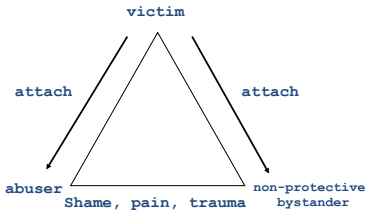
"whether the attachment relationship is consistent or inconsistent, secure or insecure, it provides the context within which the infant develops lifelong tendencies for regulating arousal and affect"

Ogden, Minton and Pain, 2006

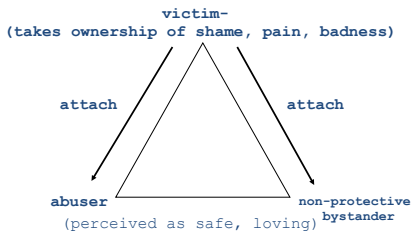
a child's need to attach..

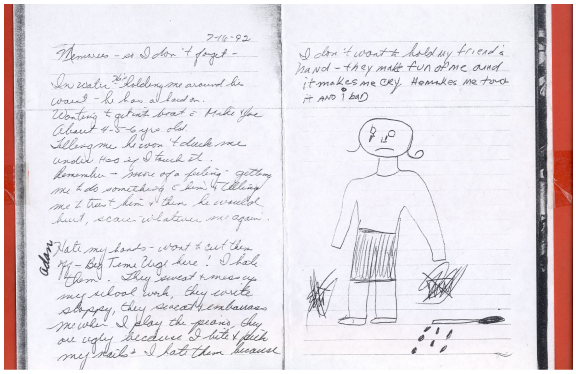


attaching to abusive caretakers



shift the locus of control (Colin Ross)





In The Still Face Experiment, a mother interacts with her child and is then told to freeze. The child tries relentlessly and desperately to re-engage the parent.

6 months later, when children are brought back to the same research environment their cortisol level becomes abnormally high again.

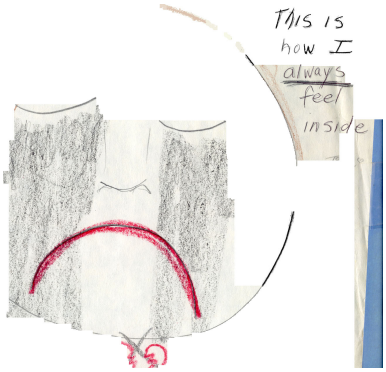
This shows how stressful it is for a child to lose the sense of attachment to a primary caretaker.
And how stimuli that is reminiscent of prior trauma also traumatizes.

Imagine how it feels-and the long term damage that is done- for a child who has a depressed, addicted, emotionally unavailable or traumatized parent.

Children who are not allowed to successfully attach have chemical systems that are abnormal and, as a result, they are in a perpetual state of physiological distress.

When they can't do social engagement for comfort, the next coping response is fight/flight. However children are typically not able to fight back or get away, so they have no choice but to go into a freeze or dissociated state.

The habitual use of a freeze response sets the stage for the dissociation that is needed to engage in self-destructive behaviors in adolescence.



When children have emotionally available and consistent caretakers, they develop secure attachments.

Healthy attachment equals affect regulation (the ability to mange one's emotional states). The lack of good attachment leads to affect dysregulation - which forces the child to turn to dysfunctional self-soothing and coping strategies

affect dysregulation: not in the optimal window of arousal
(Janina Fisher, 2010)

- HYPER-AROUSAL
- Easily triggered
- Psychomotor agitation
- Hyper-vigilant
- Separation anxiety
- Rejection sensitivity
- Emotional overwhelm

- HYPO-AROUSAL
- Flat affect
- Numb, detached
- Passive, submissive
- Victim identity
- Avoidant, withdrawn
- Disconnected from body

Review of Session 1

- We discussed trauma and its connection to attachment that is either secure, or insecure, ambivalent or disorganized
- We then discussed the impact that attachment styles have on affect regulation and dysregulation

Session Two

- We will now add the Developmental challenges, and adolescent stressors that become overwhelming and add to the vulnerability to engage in self-destructive behaviors
- Why clients self-harm
- The meta-communication of self-mutilation, addiction and eating disordered behaviors

the developmental challenges of adolescence

- aside from the first year of life, the most amount of physical/neurological change occurs in adolescence
- puberty is the biological process of turbulent change
- body changes in shape, size, hormonal structure, neurology
- "body betrayal" feel uncomfortable with the changes
- adolescence is from 10-26 years old!
- identity, group affiliation, esteem, and confidence connect to body traits/development
- cultural pressures to look a certain way- can evoke self-loathing (if I hate my body- it resonates to hurt it)

Additional adolescent stressors

Shifting peer allegiances and loyalties
Difficult decisions made without adult input
Cyber-bullying and rumors disseminated on the Internet
Academic pressure to compete, excel and choose school/career paths
Peer pressure to engage in scary and inappropriate behaviors

"tipping point factors"

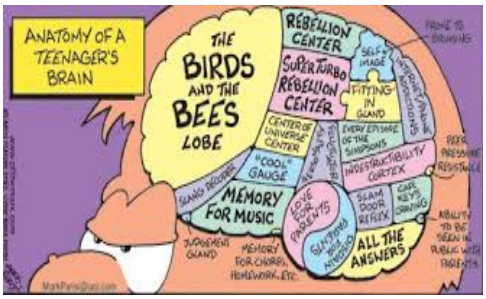
- dysfunctional family dynamics
- poor communication
- parental alcoholism
- parental depression/anxiety
- cyber-bullying
- extensive surgery or hospitalizations
- institutional setting
- parental neglect/ absence
- trauma and abuse

Given the developmental challenges of adolescence, the child is intrinsically hyper-aroused. When you add trauma, neglect, abuse and other intense dysfunctionality to the equation, this can often be the tipping point.

The nervous system becomes overly sensitive to rejection, gets triggered by intimacy, increases in hyper-vigilance and is in a frequent state of overwhelm and stress.

Now add the adolescent brain..

- The adolescent brain is wired for aggression, pleasure seeking, impulsivity, and risk taking
- The adolescent brain responds to emotionally loaded imagery and situations with an intensity far greater than that of young children or adults
- Responds differently to alcohol increasing the likelihood of binge drinking
- Functions responsible for cause and effect thinking, abstract reasoning, planning ahead and impulse control do not fully develop until the 20s



The coping strategies that help younger kids- pacifier, thumb sucking, a blanket and teddy bear, running to a parent for comfort- may feel inappropriate or be unavailable in adolescence, so young teens look for other ways to self-soothe and manage stress... if there are no healthy resources, then increased dissociation and self-destructive behaviors become an option...

the need for dissociation

- mentally escaping what cannot be physically escaped
- a way to survive untenable circumstances
- disown the pain and betrayal of abuse
- a way to still love an abusive caretaker
- highly dissociative teenagers at increased risk for self-harming behaviors

why people engage in self-destructive behaviors

- coping strategy
- establishing control
- making invisible wounds, visible
- opportunity for self-care
- distraction
- avoiding F-O-O issues
- TRS

why people engage in self-destructive behaviors

- re-enactment of revenge
- internalizing rage
- event marker
- self-punishment
- punishing others
- alter communication

why people engage in self-destructive behaviors

- cry for help/attempt to master attachment
- heighten dissociation
- short circuit dissociation
- security/uniqueness
- creating euphoria
- sense of identity
- institutionalization

Connecting self-destructive behaviors to self-soothing, re-enactment, and the meta-communication of a prior pain narrative…

self-destructive behaviors and self-soothing: a vicious cycle

- unresolved trauma/pain leaves survivors vulnerable to "triggers"-which create intrusive thoughts, emotions, and body sensations
- survivor attempts to avoid/escape intense pain and discomfort
- survivor turns to drugs/alcohol/cutting/eating disorders to disown, numb untenable thoughts and feelings and self-soothe
- being drunk/high/dissociative impairs judgment, creates unsafe scenarios, increases likelihood of additional trauma or re-enacts old trauma
- self-harm evokes shame which creates new pain
- perpetuates the need to self-soothe or go numb

Re-thinking eating disorders

- start with a paradigm shift
- eating disorders provide affect regulation for clients who have no other way of self-soothing
- eating disorders are a form of self-injurious behavior
- SIB must be de-pathologized and re-framed as a creative way to provide critical information about unresolved pain, abuse, trauma
- eating disorders offer meta-dialogues designed to express thoughts, untenable affect, needs, and unresolved trauma

Re-thinking eating disorders

- the dynamics of anorexia, bulimia, and binge eating each uniquely re-enact and re-story specific aspects of abuse/trauma
- when working with eating disordered-behavior, assess for, rule out or corroborate history of sexual trauma, physical, and emotional abuse/neglect
- identify connections between the eating disordered behavior and prior abuse/trauma as well as issues with attachment

Re-thinking eating disorders

- during therapy session, take focus off food diaries, caloric intake, weighing, and dieting
- treating eating disorders must include an exploration of these unspoken thoughts, feelings, needs, and memories
- treatment modalities must offer alternative, safer, creative ways to re-enact and resolve prior traumatic experiences
- treatment modalities must also help clients self-soothe in more appropriate ways

"meta-communication"

(Virginia Satyr)

- the expression of thoughts, feelings, and needs
- encoded in non-verbal behaviors
- a form of expression for clients who cannot use their voice
- eating disorders, SIB and addictions articulate unmet needs, unresolved trauma, and untenable affect

"trauma re-enactment syndrome"

(Dusty Miller, Women Who Hurt Themselves, BasicBooks, 1994)

- self-injurious behavior is a re-enactment of prior abuse, using the "body as the battleground"
- the nature of the self-injury is not arbitrary
- eating disorders, addictions and self-mutilation are ways to re-tell and re-story prior sexual/emotional abuse
- these behaviors are often a manifestation of PTSD

Clients often cannot find words for their traumatic experiences- not stored in Broca's area- or there was an injunction against telling from perpetrators' threats, or the abuse occurred when they were pre-verbal. Therefore, clients "show" us their narratives through their behaviors.

binge eating: re-enactment

- sexual trauma
  - specific sexual acts
  - physical pain
  - ambivalence
  - disregard for the body
  - dissociation/numbness
  - secrecy and shame
- emotional "incest"
  - overwhelming nurturance
  - enmeshment
  - no boundaries

Dottie's journal entry

I shove hard to swallow foods into my mouth- it hurts my throat
and I do it until I feel sick to my stomach- a familiar but scary feeling
I want to stop but it's like I'm standing outside of myself and I can't control it
If my kids knew what I was doing they would think that I was so weird and crazy- I need to keep this a secret from them
The only good thing is that when I gain enough weight, my husband loses interest in me and leaves me alone in the middle of the night
Why do I force myself to overeat foods that I like? It makes me hate those foods after a while and that actually feels sad
I spend large parts of the day thinking about my binges.. I guess it's better than thinking about other things
Sometimes it feels good to eat anything I want- mostly I feel like crap and think I deserve to be sick to my stomach

bulimia: re-enactment

- sexual trauma
  - specific sexual acts/consequences
  - physical violence
  - physical pain
  - ambivalence
  - disregard for the body
  - secrecy and shame
  - punishing the body
- verbal/psychological/emotional trauma
  - disgust
  - loss of control
  - ACOA issues

Mary's journal entry

I think that what I do is totally gross- I am totally gross
Eating huge amounts of food hurts my jaw, throat and stomach
Purging with laxatives gives me horrible cramps and although it can feel "freeing" I sometimes feel like I'm being held captive on the toilet (this is upsetting, don't know why)
Some people have one secret, I have a lot of secrets-hiding the food, locking the bedroom door to binge, stuffing my face, stealing laxatives in the pharmacy, hiding out in the bathroom..
I have moments of feeling ok, then I remember what I do at night and realize I'm really a freak
Paying the price for bingeing means starving the next day- successfully starving means the reward of a half gallon of ice cream
When I get mad at myself for doing this, I tell myself that at least I am in control of my body- I decide what goes in it!

anorexia: re-enactment

- emotional/physical neglect/abandonment
  - physical act
  - vulnerability
  - disregard for the body
  - invisibility
  - loss
- sexual trauma
  - dissociation/loss of body ownership
  - secrecy and shame
  - loss of freedom
  - disregard for the body

In addition to re-enacting a prior trauma or pain narrative, eating disordered behaviors are also a way to re-story past experiences.

- A way for the client to "re-claim" power and control-now *they* decide how, where and when the body is hurt
- A way to garner the empathy, attention or support they didn't receive in the past

meta-communication and other addictions

- re-enacting a numb, dissociative state
- "my life was/is out of control"
- re-enacting physical neglect of the body
- re-enacting the de-valuing of self
- re-creating physical/sexual danger
- information about affect dysregulation

meta-communication and other addictions

- re-enacting isolation/lack of attachment
- re-creating feeling of helplessness
- perpetuating family of origin modeling
- re-enacting sense of invisibility/loss
- re-enacting perpetrator's drunken behavior
- perpetuating feeling "like a loser"

meta-communication of self-mutilation

- the body part that is injured and the way in which it is injured often connects to the prior pain narrative
- self-injury may be a way to "punish" the body for its "participation" in sexual abuse (feeling aroused, achieving orgasm, etc)
- "cutting" or "burning" the body may be a metaphor for feeling "cut down or burned" by an abuser's words or behaviors

Treating Self-Destructive Behaviors in Trauma Survivors:
Strategies and Intervention Techniques for Clinicians

Session Three

- We've set the stage regarding trauma, attachment, affect regulation and dysregulation, and the additional developmental stressors of adolescence
- In this session we will be:
  - Incorporating a strengths-based, de-pathologized approach to self-harm
  - Understanding the cycle of self-destructive behaviors and the dynamics that influence the process

the “strengths based” perspective.....

positive ways to view and work with traumatized clients and their “symptoms”

four precepts of a strengths based model

- normalizing
- universalizing
- de-pathologizing
- re-framing

normalizing

- feelings, “symptoms”, thoughts, behavioral choices makes sense, and are inevitable, given what the client has experienced, and given where they’ve come from

“If you look at the behavior (of borderlines) through a traumatic background, it makes perfect sense...If you’ve been.. abused for years, your entire organism and personality has been organized around your trauma.. the way they act is understandable.. they are people trying to survive” (Bessel van der Kolk, 2004)

universalizing

- although every client's story is unique, millions of people have experienced sexual, physical abuse and other forms of traumatic stress
- anyone who is experiencing trauma is hard-wired to go into a fight/flight or freeze response
- unresolved traumatic experience leaves behind tangible cognitive, somatic, and psychological residue
- people who have been traumatized can think, feel, and behave in very similar ways

universalizing

- In 2014, 6 million children were involved in 3.6 million reports to CPS for abuse
- In the U.S. each year as many as 260,00 new cases of sexual abuse are documented
- 79.4% children who die from abuse are under the age of four
- 47.7% children who die from abuse are under the age of one
- 48.5% are male, 51.2% are female
- 45% of the perpetrators are male and 55% are female
- 60-85% of child fatalities due to maltreatment are not recorded as such on death certificates
- 5 kids die everyday as a result of abuse/neglect

The trauma survivor's DSM

- Bad
- Broken
- Damaged
- Dirty
- Weird
- Abnormal
- Crazy
- Stupid

re-framing

- offering a more positive, hopeful way to think about/talk about experiences and symptoms
- working with symptoms as **metaphors** for trauma
- de-coding symptoms as non-verbal forms of **communication** about a pain/trauma narrative
- acknowledging and honoring symptoms as necessary, creative **coping strategies** that ensured client survival

re-framing symptoms

- **symptoms as metaphors**
  - anorexia=feeling invisible, neglected
  - bingeing=needing to create a protective shield
- **symptoms as communication**
  - cutting fingers= these hands participated in sexual behavior and should be punished
  - drinking=my life was/is out of control
- **symptoms as coping strategies**
  - eating, drinking=self-medicate
  - SIB=alleviate anxiety
  - dissociation=avoiding perceived threat

advantages of a strengths based perspective

- eliminates power struggles re: diagnoses
- strengthens the therapeutic alliance
- allows for genuine trust
- infuses the work with hope for client/therapist
- removes the "glass ceiling" that diagnoses impose on progress
- separates you from other helping professionals
- highlights internal resources rather than impediments

advantages of a strengths based perspective

- allows clients to "connect the dots" and make sense out of confusing symptoms
- allows clients to shift from "I'm crazy" to "I've been traumatized"
- helps clients to feel less alone in their experiences
- allows for the "de-coding" of symptoms so deeper healing can occur
- invites curiosity about a trauma/pain narrative

advantages of a strengths based perspective

- allows for alleviation of shame/guilt when symptoms are re-framed as coping strategies
- emphasizes resilience, creativity, intelligence, courage, strength, empowerment, and responsibility
- creates opportunities to explore alternative coping strategies
- invites a solution-focused approach
- teaches client that they are more than their trauma experience
- invites the use of "healthy parts" within the client

Clients "at war" with their bodies

- internally mediated cognitive distortions regarding body shape/size, etc.
- social or familial pressure to adhere to unrealistic cultural "norms" re: weight, appearance
- history of traumatic experiences/sexual abuse evoking feelings of disempowerment, shame, loss of body ownership or control
- false belief that the body "participated" in sexual acts during abuse due to arousal/orgasm
- physical abuse or neglect normalizing a lack of nurturance or self-care

These unresolved experiences and pain narratives can result in an increased vulnerability to engaging in self-destructive acts including: addictions, sexual acting-out, self-mutilation and eating disordered behaviors.

If a client hates his or her body, or tries to disavow a connection to it- then it resonates to hurt the body in some way.

We will explore a treatment approach that helps clients understand the cyclical and chronic nature of their behaviors. This "cycle of self-destructive behaviors" teaches clients about the "domino effect" of triggering and the subsequent cognitive and affective manifestations that lead them to an act of self-harm.

case study: Karen (16 years old)

- family system:
- 18 year old bother: "troubled", violent
- mom: violent, alcoholic, abusive parents; mother died when she was 14; history of alcoholism, untreated depression, enmeshed/disengaged with her children
- dad: beaten by father, rigid, religious family;enables mom's drinking; problems with anger; violent towards son; demands academic/athletic perfection from Karen

Karen (continued)

- super-achiever, "star" athlete, honor roll student
- dissociative, depressed, emotionally detached, sarcastic, condescendingly compliant
- cuts fingers/inner thigh (9 years old)
- hospitalized 3x for anorexia; hates her body; distorted body image
- leaves house at night to "hang with friends"; "experiments" with alcohol (black-outs); shoplifting; sexual promiscuity; witnesses friends having sex

Karen's traumatic experiences

- alcoholic, emotionally unavailable mother
- enabling, co-dependent, rigid ,violent, father
- dysfunctional family dynamics: communication; boundaries; roles; violence
- sexually abused by cousin (9 years old)
- verbally/psychologically abused by brother
- sexual abuse repeatedly attempted by brother
- unsafe environmental/peer scenarios
- traumatic hospitalizations
- dissociative sexual encounters

the cycle of self-injury

(adapted from Dr. Tracey Alderman)

- **triggering event**
- **negative cognitions<< >>negative affect**
- **unbearable tension and anxiety**
- **dissociation<< >>analgesia**
- **self-harming behavior**
- **positive outcomes**
- **negative outcomes**
- **emotional vulnerability**

the triggering event

- objectively painful or subjectively distorted
- perceived as threatening
- extreme over-arousal to minor emotional and stressors and sensory experiences that connect to prior trauma/pain
- connects to feelings of rejection, abandonment, abuse, neglect, separation, loss, disapproval, disappointment

Karen's triggering events

- smelling alcohol on someone's breath
- hearing dad fight with her brother
- feeling rejected by her boyfriend
- being yelled at by her coach for not performing well
- trying on jeans and feeling the tightness around her stomach
- being alone in the house at night
- getting less than an "A" on a school paper
- a guy trying to kiss her on a date

negative cognitions

- cognitive distortions including:
  - dichotomous thinking
  - minimization and magnification
  - over-generalizations
  - emotional reasoning

Karen's negative cognitions

- "Things will never get better in my house"
- "I am worthless"
- "I always screw up"
- "I am unlovable"
- "My body is fat and ugly"
- "Whatever I do, it's never good enough"
- "I'll never feel safe in the world"

negative affect

- in response to negative cognitions or the trigger itself
- anger
- depression/sadness/despair
- inadequacy/worthlessness
- helplessness/disempowerment
- loss/isolation/rejection
- embarrassment, betrayal

Karen's negative affects

- rage
- depression, despair, loss
- inadequacy, disempowerment,
- isolation, rejection
- embarrassment
- betrayal

unbearable tension and anxiety

- unable to regulate, control, stabilize or manage negative thoughts and feelings
- negativity becomes overwhelming and untenable
- lacking appropriate coping strategies and self-soothing techniques

Karen's unbearable tension and anxiety

- headache
- stomach upset
- pounding chest
- feel like I can't catch my breath
- drowning in my feelings
- feel like I'm going crazy
- thought racing

dissociation and analgesia

- intense anxiety can alter consciousness
- coping mechanism
  - reduces tension and creates protective detachment
- subjective numbness
- loss of time, unaware of environment
- detached from body, no sense of physical pain

Karen's dissociation and analgesia

- black cloud envelops me
- get tunnel vision
- numbness, detached from my body
- lose sense of time, don't know where I am
- pain-free

self-harming behavior

- dissociation/analgesia create opportunity for self-harm
- pain is not experienced during the act
- de-personalization, de-realization
- extent to which body is harmed may not be within conscious control

Karen's self-harming behaviors

- cuts inner right thigh
- scratches her face
- cuts left palm
- engages in unsafe sex
- restricts caloric intake/ignores hunger
- exercises obsessively
- leaves house in middle of the night/drinks
- shoplifts

positive outcomes

- release of endorphins
- alleviation of anxiety/tension
- elimination of negative thoughts
- re-grounding
- reintegration
- re-connection to the body

Karen's positive outcomes

- "I feel better"
- no more tension in my body
- elimination of negative thoughts
- feel re-connected to myself
- feel back in control
- gets parental attention

negative outcomes

- shame, guilt and depression
- loss of control
- self-hatred
- feelings of failure, inadequacy
- fear of disapproval
- perpetuation of victim role

Karen's negative outcomes

- feel guilty, weird, and depressed
- loss of control when I don't remember hurting myself
- self-hatred
- feel like I screwed up again
- fear of disapproval (parents, coach, friends)
- always feel like a victim

emotional vulnerability

- negative outcomes create vulnerability to next triggering event
- benign encounters distorted and perceived as threatening
- feeds back into beginning of sib cycle

Karen's emotional vulnerability

- "I'm on the defensive, waiting for the next bad thing to happen"
- "Feel weird and different"
- teased for being overly sensitive
- react instantly if parents "look at me the wrong way"
- "Think that people have a hidden agenda when they talk to me"
- don't trust anyone

The goal in treatment is to work with the behavior rather than trying to extinguish it as quickly as possible.

What does that evoke in the clinician? How do we navigate pressure from family members and loved ones to "cure" the problem?

Can you let go of controlling the pace of treatment and recovery?

Treating Self-Destructive Behaviors in Trauma Survivors: Strategies and Intervention Techniques for Clinicians

Session Four

- In the last session we identified the cycle of self-harm
- Now we will look at ways to creatively treat self-destructive behaviors through "intervention sites" designed to reduce and eventually extinguish the behaviors
  - Addressing triggers, cognitive distortions, and negative affect
    - using journaling, somatic resourcing, cognitive re-framing, art, visualization and guided imagery techniques to enhance safety, containment and grounding for traumatized clients

Focusing on Treatment

The strategies we employ gives clients other creative ways to accomplish what the self-destructive behavior appears to give them (in the short-term). These strategies will yield more lasting results, and do not evoke the powerlessness, shame and guilt that often accompany their self-destructive acts.

the opportunity to intervene

- TRIGGERING EVENT:
  - process context: environment, interactions
  - identify internal and external triggers
  - create "escape clauses" to address potential triggers
  - permission to avoid triggers
  - sensorimotor strategies

the opportunity to intervene

- TRIGGERING EVENT:
- Journaling with **REACTS**
- **R:** relationship dynamics (who was with me? what happened?)
- **E:** emotions
- **A:** awareness of five senses
- **C:** context (date, time, location)
- **T:** thoughts
- **S:** somatic experiences (on the body)

My self destructive act: drinking to the point of getting drunk and being hung over
R: (relationship dynamics) - I was with my five-year-old daughter. I was trying to get her to go to sleep and she wouldn't stay in her bed.
E: (emotions) - I was feeling overwhelmed and inadequate as a parent, and really angry at my daughter. Then I felt guilty for feeling angry so I wanted to numb myself from those feelings.
A: (awareness of 5 senses) - I heard my daughter crying in her room. I saw myself as a little girl, crying.
C: (context) - It was 8:00pm. I was sitting alone in my bedroom. I was triggered by her crying and triggered by feeling helpless and alone in the house.
T: (thoughts) - "You know if you drink, the pain will go away." "But if you drink and your daughter needs you in the middle of the night, you might not be able to get up for her." "You see, you really are a bad parent and don't know what you are doing."
S: (somatic) - A lot of tension in my arms, light-headed, stomach is in knots.

Somatic resourcing
(Pat Ogden 2011)

- Taking a breath
- Expanding the chest
- Re-aligning the spine
- Pressing both feet into the floor
- Standing up
- Pushing away
- Thumb hold
- Body hug

Navigating triggers

- Prepare ahead of time
- Shorten the duration
- Meet in a more neutral place
- Bring a friend
- Just say no!

the opportunity to intervene

- NEGATIVE COGNITIONS:
- teach re-framing and positive self-talk:
- write most common negative cognitions on a card; under each one, three times bigger in brighter color, write the re-frame
- paint roller visualization

I am bad.
What was done to me was bad, there is nothing wrong with me.

I should have done something to stop the abuse.
I was a child. There was nothing I could have done. I'm proud I survived.

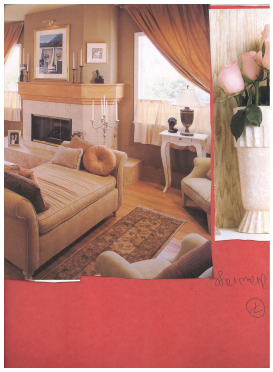
I am trapped and helpless.
Those feelings are emotional flashbacks. In the present, I have choices and power.

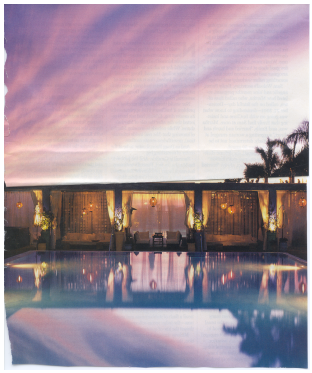
the opportunity to intervene

- NEGATIVE AFFECT:
- visualization of real/imagined "safe place"
- using "safe space in front of closed eyes"
- visualization of inner protector
- teach containment: visualization, drawing, writing, collage
- use mirror neurons
- assess for medication

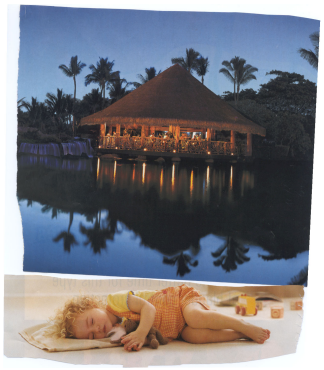
safety

- clients often need to be convinced of the value of incorporating a sense of safety into treatment, as feeling safe may not be normalized for them in their daily lives
- clients often want to move ahead before safety is established, unconsciously re-enacting a lack of safety in the past
- use others words that represent "safe": quiet, calm, peaceful, still






Always
with You
Bless Our Home



"containment strategies"

- reassures clients and therapists that "emotional and cognitive flooding" will not occur
- helps clients feel a greater sense of control over their trauma material
- strengthens a sense of boundaries
- introduces notion of "working through" without being re-traumatized
- increases clients' abilities to return to the "outside world" after session and function appropriately

containment

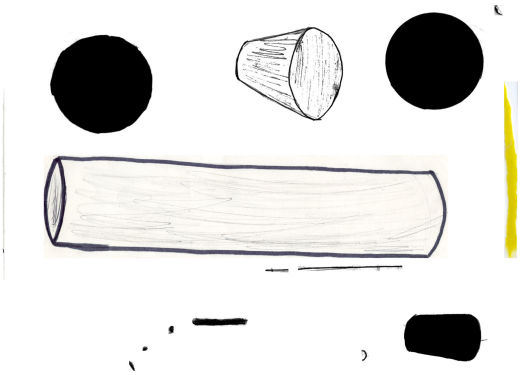
- turning affect/trauma material into colors and shapes
- putting the color/shape into another internal container
- checking for an inner sense of safety
- adding additional layers of containment, if necessary

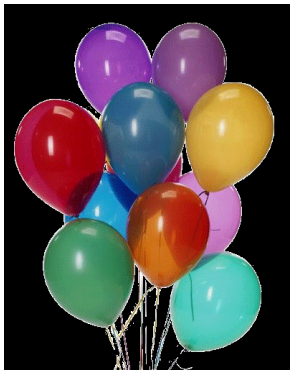
Karen's containment

- emotion to be contained: rage
- shape and color: large, bright orange sun with red spikes, three feet around
- container: large asbestos box (dark wood, green carvings of the sun on the outside)
- additional container: fireproof blanket over box (made from scratchy gray wool with red stripes)
- shiny gold chains and black ropes to hold blanket down
- additional container: shimmering silver angel wings over box
- now it feels completely contained

containment

- making a collage or drawing internal "containers" to store affect and trauma material
- writing down untenable emotion or trauma memory and storing the paper in an actual container (a purse, a box, an envelope, a tupperware container, a drawer with a lock on it, etc.)
- using sand trays





Mirror neurons
(van der Kolk 2007)

- when young, immobilized monkeys watched a researcher move his left arm to put food in the cage, the SAME parts of THEIR brains lit up- as if they were engaging in the action themselves
- clients can experience the effects of self-soothing by mirroring the self-soothing gestures of the therapist which will activate their brains in positive ways
- stroking, floating, gestures for inhale/exhale

Assessing for medication

- Many clients experience difficulties with concentration, focusing, memory, integration, distorted or hopeless cognitions, or lack the physical and mental energy it takes to work in therapy and follow through with homework assignments.
- This may be because they are compromised by depression, anxiety, overwhelming triggering, trauma, or sleep issues.

Assessing for medication

- Medication re-balances those disturbances and creates a "safety net" so clients can comfortably and more effectively address their issues, sleep properly, and better manage their emotions.
- Rather seeing the taking of medication as a "weakness" we need to re-frame it a proactive behavior that is a sign of strength because it is an act of self-care.

Treating Self-Destructive Behaviors in Trauma Survivors:
Strategies and Intervention Techniques for Clinicians

Session Five

- Addressing tension and anxiety, and dissociation using breath work, pacing, flashback halting protocols
- Working with CARESS as an alternative to standard safety contracts
- Addressing positive and negative outcomes and emotional vulnerability

the opportunity to intervene:

- UNBEARABLE TENSION AND ANXIETY
- slow, deep breathing with exhale to activate parasympathetic system
- rhythmic breathing with counting as an anchor (through the nose)
- exercise
- pacing

Breath work

- Triangle breath: inhale-3, hold-3, exhale-3
- Inhale 3, exhale 3 (no retention)
- Inhale-3, hold-3, exhale-5: add words
- Stair step breath: short inhales, long, slow exhale (good for anxiety)

30 minutes of brisk walking 3X a week changes brain chemistry, evokes a greater sense of calm and increases positive cognitions

pacing with "scaling"

- create a subjective template from 0-10
- 0= feeling totally neutral, not disturbed by emotion/memory at all
- 10= completely overwhelmed by the emotion/memory
- ask client to identify the thoughts, feelings, body sensations that accompany 0-10
- agree to "put on the brakes" when a client reaches a "5" (or whatever number begins to feel unmanageable for them)

the opportunity to intervene

- DISSOCIATION AND ANALGESIA
  - use DES to assess for dissociation
  - connect dissociation to triggers-introduce "choice"
  - flashback halting protocols
  - offer re-grounding techniques: ice, cold water, changing environment, petting a dog/cat, movement, aromatherapy, jewelry
  - Visualization of "hand warming"
  - assess for DID

Ericksonian flashback halting technique

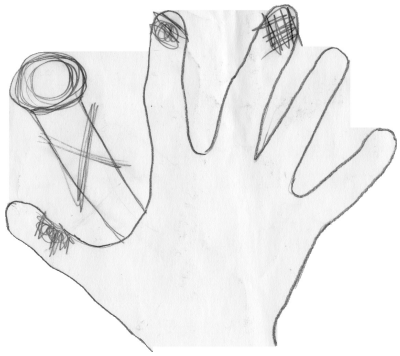
(Milton Erickson)

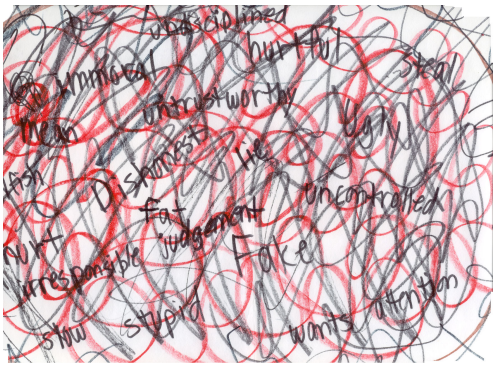
- client assumes comfortable upright position, both feet planted on the floor
- identifies, out loud, five things they **see** in the room, five things they **hear**, and five things they **feel**
- repeat pattern, identifying **four** of each, then **three, two,** and **one**
- helps shift awareness from senses associated with flashback to present-focused senses

Hand warming exercise to promote grounding and self-soothing

The opportunity to intervene:

- SELF-DESTRUCTIVE BEHAVIORS
- Using C.A.R.E.S.S- set a timer at 10 minute intervals, make a box with all items inside
- **C**ommunicate **A**lternatively
  - Journal, draw, collage, clay, poetry, tape recorder
- **R**elease **E**ndorphins
  - Physical activity, hugging, laughter
- **S**elf-**S**oothe
  - Warm bath, singing, meditation, music (*before* I self-harm)




Disgusting
hurtful
Steal
untrustworthy
Ugly
Dishonest
Liar
uncontrolled
Fake
irresponsible
stupid
wants attention

The opportunity to intervene:

POSITIVE OUTCOMES:

- process reinforcing outcomes
- explore alternative ways to achieve same end
- explain the role of endorphins
- offer alternative ways to release endorphins
- ask, "If you accomplished hurting yourself, how you were hoping to feel?" "How else can you achieve that?"

The opportunity to intervene:

NEGATIVE OUTCOMES :

- address shame and guilt
- explore ways to reinstate control
- re-frame "failure" as opportunity to learn
- identify the smallest success in breaking cycle
- reassure client re: therapist disapproval
- address victimization vs empowerment

The opportunity to intervene:

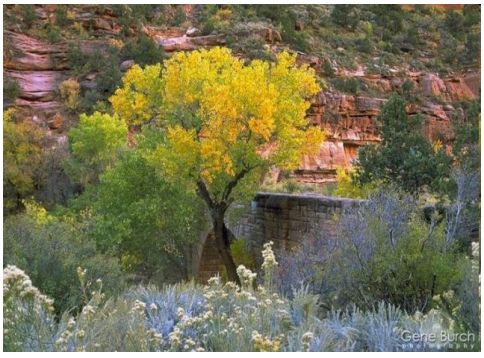
EMOTIONAL VULNERABILITY

- address boundaries and limit-setting
- strengthen verbal and non-verbal assertiveness
- strengthen external network of support
- hand on belly/heart with figure 8 rock for comfort
- use "remembered resource"

Visualize someone from your past or present, alive or deceased, who truly believed in you and loved you. Imagine you are sitting together in a safe, comfortable place.

What compassionate, non-judgmental concerns would they express about your self-harm?

Write yourself a letter of hope from that resource.



Treating Self-Destructive Behaviors in Trauma Survivors:
Strategies and Intervention Techniques for Clinicians

Session Six

- Processing clinical pitfalls
- Counter-transferential responses and the need for self-care when working with this population
- Addressing vicarious traumatization

clinical pitfalls

- focusing exclusively on clients' safety without attending to our own
- working without supervision, support
- making the treatment agenda about our own need to "fix or change" the client
- keeping the agenda rigid and fixed
- becoming angry, anxious or judgmental, rather than operating from our most compassionate Self
- feeling emotions for our clients

clinical pitfalls

- feeling responsible for relapses, cancelations or clients dropping out of treatment
- engaging in power struggles by demanding that clients sign safety contracts and threatening to terminate treatment when they relapse
- fostering co-dependency
- going to trauma retrieval before establishing safety, containment and proper pacing

clinical pitfalls

- showing these clients "special treatment"- running over session, not collecting debt, becoming available after hours, etc.
- not recognizing our own personal triggers
- engaging in too much self-disclosure or allowing the "spotlight" to stay on us during session
- not adequately de-stressing after session, not doing enough self-care

counter-transference

- be clear about your agenda
- be aware of emotional triggers
- maintain healthy boundaries
- understand the impact that self-destructive behaviors have on you
- use self-protective strategies in session
- be aware of your verbal and non-verbal communication in session

our efficacy as professionals is contingent upon the extent to which we take care of ourselves as people

the challenge involves helping others...

while maintaining good boundaries and staying mindful of our own needs and feelings

the challenges of our work

- exposed to difficult/ toxic material
- confronted with raw, intense emotions
- bear witness to acts that are senseless/unjust committed by perpetrators and by the client on themselves
- personally triggered
- uphold confidentiality/can't process or release what we witness
- navigating many resources and helping professionals - not everyone has the same agenda

the challenges of our work

- boundaries get tested by clients, colleagues, bosses, agencies, family members
- overworked/underpaid-not paid
- vague job description/changing job description
- unreasonable expectations
- not adequately supported

risk factors

- repeated exposure to stories and images of trauma or pain
- high degree of traumatic intensity paired with significant loss in therapist's life
- degree of "empathic sensitivity" to the suffering of others
- a context of personal stressful events preceding the "witnessing' of the trauma

risk factors

- general ability or inability to cope with emotionally challenging situations
- the intrinsically positive or negative world view held by the helping professional
- the extent to which the helping professional's own unresolved emotional issues resonate with or relate to the client's suffering and experience

Common manifestations of counter-transference (Wilson and Lindy)

- four possible "reactive modes"
  - empathic disequilibrium
  - empathic withdrawal
  - empathic enmeshment
  - empathic repression

empathic disequilibrium

- therapist feels uncertainty, vulnerability
- unable to modulate/contain own affect
- manifests as self-blame
- "where am I going wrong as a therapist?"
- requires client to provide reassurance or comfort
- leads to role reversal

empathic withdrawal

- therapist exudes a blank screen façade
- doesn't use the therapeutic alliance to foster connectedness
- maintains distance
- documents therapy process, doesn't actually help the client
- re-loads rather than listens
- uses intellectualization
- ends session prematurely

empathic enmeshment

- over-identification with client
- loss of appropriate boundaries
- over-involvement
- reciprocal dependency
- shifts from “helping’ to ‘peer”or“parental” role

empathic repression

- rationalizes, minimizes or denies traumatic or emotionally-charged material
- refuses to explore emotionally-charged issues
- distances from client to avoid content
- therapist guides treatment goals/agenda and conversation to avoid upsetting material

counter-transferential issues

- therapist guilt
- therapist rage/sadness
- turning client into a victim
- turning client into a hero
- desire to re-parent
- desire to be best therapist
- sexualizing the client
- inability to relinquish control
- boundaries

therapist guilt

- contrasting own childhood experiences
- inability to "make it all better"
- triggered by own unresolved trauma
- triggered by own historical disempowerment

therapist rage and sadness

- client's trauma stories evoke our own feelings
- outraged by abusive caretakers
- feel emotions **for** the client
- response to client's distorted views about our intentions/interventions

turning the client into a victim

- "tunnel vision" focus on trauma
- see client as fragile, helpless, powerless
- inadvertently foster dependency
- inadvertently disempower client

turning client into a hero

- excessive focus on “bravery” discounts pain
- excessive focus on “surviving” discounts traumatization/ dysfunctional coping
- unfair expectations set client up to fail
- lack of containment/affect management sets client up for flooding

desire to re-parent

- traumatized clients invite re-parenting
- therapist over-compensates
- client’s self-esteem becomes contingent upon therapist approval
- not helping client shift from external to internal resources/validation
- boundaries get blurred

desire to be best therapist

- client reinforcement for being ONLY person who listens/cares
- history of negative therapy experiences
- client builds therapist up-to knock her down
- sets therapist up for failure/sabotages relationship
- resist temptation to buy into praise

sexualizing the client

- "privileged voyeurism" (Christine Courtois)
- seeing the client as only a sexual being
- using a sexual relationship to "repair" trauma
- responding to client's seductive behaviors
- exploiting client's vulnerability
- fueling therapist's ego

inability to relinquish control

- therapist wants more power/unequal relationship
- triggered by family-of-origin control issues
- not trusting client's ability to engage in self-determinism
- well intentioned helping becomes enabling
- inappropriate desire to "protect" client from their own actions

boundaries

- trauma survivors can be needier than other clients
- place unreasonable demands on therapist
- challenge therapist's comfort level with intimacy
- the "special client" - treating survivors differently
- re-enactment of inappropriate family-of-origin boundaries

taking care of ourselves;
addressing vicarious traumatization

- limit exposure to traumatic material
- peer consultation
- supervision
- exercise
- eat properly
- get enough sleep
- delegate and ask for help
- serenity prayer

taking care of ourselves;
addressing vicarious traumatization

- find counter-balances to trauma
- stress management
- humor
- hobbies/ vacations
- connect with others
- express emotions
- spiritual life
- therapy for support/ resolve personal trauma

In summary:
moving clients beyond the trauma

- re-frame their "difficult" or "resistant" behaviors as trauma based, so you can shift from anger and frustration to empathy, and they can feel less "crazy"
- make the environment where you meet with the client as physically "safe" as possible
- be consistent and predictable to avoid triggering
- Help clients distinguish between "then" (when they were unsafe) and "now" (when they have some choices and are safer)
- bear witness to pain so it can be healed
- strengthen external network of support
- strengthen socialization/communication skills

moving clients beyond the trauma

- find ways to empower clients by encouraging input and delegating doable tasks for them
- teach strategies to stay grounded, enhance safety and containment
- remind clients of their resiliency and strengths
- use the therapeutic relationship to create healthy attachment and affect regulation
- de-pathologize their symptoms as creative coping strategies - "it makes sense"
- don't evoke power struggles with safety contracts- use CARESS instead

moving clients beyond the trauma

- remind clients that they are not alone in their experience
- normalize their thoughts, feelings, and testing behaviors
- encourage clients to incorporate spirituality in their healing process
- help clients identify the things in their life that are within their control
- re-frame "they are bad" as "something bad happened to them"

From Karen's Journal:

"for the first time in my life, I'm actually thinking that it's possible to be happy and get better, even if my parents and my brother never get **their** acts together"

"even though I'm not ready to totally give up certain negative behaviors, it's kinda cool to know that there's other, healthier stuff I could do instead..if I wanted to"

The caterpillar MUST struggle within its cocoon, in order to transform itself into a butterfly....