Contextual Therapy for Prolonged Child Sexual Abuse Survivors

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Florida Council Against Sexual Violence
Annual Conference
June 9th, 2010

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The Three Symptom Clusters in PTSD

- **Intrusion** – flashbacks, nightmares, involuntary thoughts, triggering of physiology/cognition
- **Numbing and Avoidance** – shut down, impaired recollection, avoidance of reminders/behavior
- **Arousal** – irritability, hypervigilence, difficulty concentrating, insomnia, exaggerated startle response

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Diagnostic Criteria for Complex PTSD

History of prolonged subjugation resulting in alterations in:

• Affect Regulation (impulsive acting out)
• Consciousness (dissociation)
• Self-Perception (shame, helplessness)
• Perceptions of Perpetrator (preoccupation)
• Relations with Others (isolation, search for rescuer, revictimization)
• Systems of Meaning (hopelessness)
Other Problems Often Associated with a History of Trauma

- Major Depression
- Alcohol and Drug Abuse and Dependency
- Compulsive Behaviors (e.g., sexual, eating, self-injury)
- Dissociative Difficulties (e.g., amnesia, “spaciness”)
- Somatization Disorder
- Borderline Personality Disorder
- Schizophrenia
MMPI-2 Profiles: CSA Survivors in Therapy

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The Trauma Model

• A single or circumscribed traumatic event results in
  PTSD
• Repeated or ongoing traumatic events result in
  Complex PTSD
• In either case, the centerpiece of treatment should be
  Uncovering of / Exposure to Traumatic Material

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The Three-Phase Model of Trauma Treatment

• Phase 1: Safety and Stabilization
• Phase 2: Trauma Processing and Resolution
• Phase 3: Integration and Reconnection

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Family of Origin Environments of PCA Survivors

COMPARISON OF FES MEAN T-SCORES

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“[Various types of adverse childhood experiences] 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)

- Vincent Felitti

The Context of Prolonged Child Abuse

 Survivors of prolonged child abuse in therapy often describe growing up in interpersonal environments which

• were detached or chaotic, with insufficient or unpredictable emotional responsiveness

• lacked adequate structure and guidance regarding instrumental skills and cultural norms

• modeled ineffective, destructive coping strategies

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Two Converging Lines of Causation

Ineffective family environment → Increased vulnerability to abuse → childhood abuse → impaired psychological adjustment in adulthood
Trauma and Interpersonal Context

Trauma *disrupts* existing functioning.

Growing up in an ineffective interpersonal context interferes with basic aspects of functioning developing adequately *in the first place*. 

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It follows that…

no amount of uncovering or processing of traumatic material can be expected to instill capacities that were never developed to begin with – capacities that have always been absent or deficient need to be identified and directly targeted for remediation.

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Routine Daily Stressors and Traumatic Stressors

• Deficits in basic aspects of functioning impair the capacity of PCA survivors to cope with routine daily stressors.

• When confronted in treatment with the extra-ordinary stressor of traumatic material, it is not surprising that PCA survivors often rapidly decompensate rather than improve.
Implications of Contextual Theory for Therapy with PCA Survivors

• PCA survivors need to learn how to cope with the ordinary stressors of daily living (remediate developmental deficits) before they will be equipped to deal with the extraordinary stress aroused by being confronted with traumatic material.

• Work from present (difficulties) to past (origins of difficulties), rather than making past history the centerpiece of therapy.

• Trauma work with PCA survivors should center primarily on processing distortions arising from trauma, secondarily on extensive, explicit processing of traumatic events.
Three Main Components of Contextual Therapy

1. Therapist-Guided Practical Skills Transmission
2. Collaborative Relationship
3. Client-Guided Conceptualization
Collaborative Relationship: Commonly Encountered Challenges in Complex Trauma Survivors

- Distrust
- Dependency
- Disconnection (Dissociation)
- Deficient Acculturation
- Disbelief
- Don’t Deserve
Distrust: Impact on Treatment Alliance and Therapeutic Response

**Impact**
- Fear of self-disclosure –
- Wariness about accepting directives
- Hesitancy to engage emotionally

**Response**
- Validate/accept
- Pace/patience
- Unintrusiveness/respect for autonomy
- Allow client to take lead in processing
Dependency: Impact on Treatment Alliance and Response

**Impact**
- Intense preoccupation with & desire for contact with therapist
- Distraction from therapeutic goals
- Increased fear of abandonment

**Response**
- Provide structure
- Limit extra-session contact
- Balance confrontation with empathy
- Promote social support system

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Disconnection: Impact on Treatment Alliance and Response

**Impact**
- Dissociative symptoms
- Impaired attending
- Poor awareness of feelings
- Tenuous contact with therapist

**Response**
- Monitor client focus
- Maximize in-session presence
- Teach grounding techniques
- Teach sensory & emotional awareness

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Deficient Acculturation: Impact on Treatment Alliance and Response

**Impact**
- Lack of models for cooperation
- Socially inappropriate behavior
- Likelihood of miscommunication/misunderstandings

**Response**
- Avoid assuming malicious intent
- Watch for areas of deficiency
- Distinguish “right” from “appropriate”
- Teach missing information/skills
Disbelief: Impact on Treatment
Alliance and Response

**Impact**
- Assumes change is not possible
- Convinced basic flaws preclude “normal” functioning
- Sees therapy as a means of relief and venting

**Response**
- Identify and challenge belief that change is not possible
- Orient treatment toward goal attainment
- Avoid reinforcing agendas antithetical to goal attainment

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Don’t Deserve: Impact on Treatment Alliance and Response

**Impact**
- Habitual and severe self-criticism
- Intense fear of improved quality of life
- Impulsively dismantles progress

**Response**
- Foster recognition of habitual self-criticism and fear of improvement
- Teach strategies for challenging negativity
- Help client be alert to and resist temptation to undo progress

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Reasons for Client to Guide Conceptual Exploration

• Client is the sole legitimate authority about the data of which case conceptualization is comprised: lived experience
• Client is ultimately the only one who can know what is the case
• Client is primed to believe you, even if you are wrong
• Even if you are right, conclusions that come from you are less likely to lead to be therapeutic

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Therapist’s Role in Case Conceptualization

• Guide the process of reasoning and judgment rather than the content or conclusions
• Focus on logical deduction and evidence rather than on a particular outcome
• Guide questioning through formulation of tentative hypotheses that are continually open to rejection or modification as new information is generated
Socratic Questioning, Meichenbaum / Columbo Style Interviewing

• Approach your questioning with the stance that *you don’t know* (you *don’t*)
• Be willing to be educated by the client – have her / him *explain* rationale for beliefs to *you*
• Take a *one-down* position, e.g.:
  • I don’t understand
  • Please explain that to me

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Therapist-Guided Practical Skills Acquisition

Prioritized Treatment Goals:
• Security*
• Focus*
• Critical Judgment & Reasoning
• Breaking Maladaptive Patterns
• Trauma Processing/Resolution*
• Living Well

* - covered in today’s training

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Top-Priority Treatment Goal: **Security**

Little else can be accomplished when distress is elevated:

- Distress disrupts concentration; cognitive interventions will be of limited value while distress is elevated
- Chronic distress often engenders hopelessness, depression, suicidal ideation
- High levels of distress trigger a wide range of symptoms and difficulties

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Typical Difficulties Exacerbated by Distress:

- panic attacks, flashbacks, nightmares, obsessions
- dissociative amnesia, switching, depersonalization
- self-mutilation, suicidal gestures
- bingeing, purging, food restriction
- addictive and compulsive behaviors
- rage reactions, verbal outbursts, physical violence

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Distress: Baseline and Threshold

• The most effective target of distress reduction is not momentary fluctuations in distress, but the *baseline* level of distress.

• There is a *threshold* of distress which, when passed, greatly increases the likelihood that other symptoms will be triggered.

• The lower baseline distress is, the less likely it is that momentary increases in distress level will *cross the threshold* to trigger other symptoms.
The Importance of Rationale

• Without a clearly explained rationale, the client will not understand the purpose of interventions and will therefore not be motivated to implement them.
• Encouraging clients to carry out interventions without providing a rationale exacerbates both mistrust and dependency.
• The rationale ties the interventions to both the relationship and conceptualization components of treatment.
Practice Record Sheet: Rationale

- Distress is a central problem that triggers other problems.
- Chronically elevated distress levels are attributable to sensitization of the flight-fight-freeze ("Emergency Alert") response due to ongoing trauma.
- Regular and repeated practice of distress reduction methods will decondition the Emergency Alert response and therefore lower baseline distress.

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Practice Record Sheet:
Essential Principles

• There is a *wide range* of techniques that are effective in reducing distress.
• There are wide *individual differences* in response to various distress reduction techniques.
• The particular technique used is much less important than that whatever technique is employed is practiced on a *regular basis*.
• Consistent practice is much more effective in both the long run and short run than “as needed” practice.
• It is important that the technique used be as *self-directed* as possible.

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## Varieties of Relaxation Techniques

<table>
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<th>Class</th>
<th>Example</th>
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<tbody>
<tr>
<td>Imagery:</td>
<td>Safe Place</td>
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<tr>
<td>Breathing:</td>
<td>Diaphragmatic Breathing</td>
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<td>Somatic:</td>
<td>Modified Progressive Muscle Relaxation</td>
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<td>Hypnosis:</td>
<td>Self-Hypnosis</td>
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**Instructions**: Use the scale pictured below to show, from 0 (completely calm) to 10 (the most nervous you’ve ever felt) how you are feeling. In the “before” column, write down a number from 0 to 10 showing how you are feeling before you practice the exercise. Then do the exercise for several minutes, and write down in the “after” column where the number is when you are done.

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<th>Calm</th>
<th>Anxiety</th>
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<td>9</td>
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<th><strong>AWAKENING</strong> (0-10)</th>
<th><strong>MIDDAY</strong> (0-10)</th>
<th><strong>BEDTIME</strong> (0-10)</th>
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<td>DAY/DATE</td>
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Tapping Existing Resources

• Construct a list *in session with the client of enjoyable activities* that are *not destructive*
• Examples of items on the list include going for a walk, reading, calling a friend, etc.
• Have the client write the list on a business card or small piece of paper that can be carried in a pocket, wallet, or purse
• When distress is high, client can pull out list to identify what activity on the list she or he can do to distract/soothe her/himself
Major Dissociative Symptoms

- “spacing out”
- depersonalization
- derealization
- amnesia
- identity fragmentation
The Dissociative Continuum

“normal”

depersonalization

amnesia

dissociative identity disorder

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Dissociation as Disconnection in Three Major Spheres

Dissociation can take the form of detachment from

- **Interpersonal** relationships - attachment, intimacy
- **External** stimuli - the here and now: “spacing out,” flashbacks
- **Internal** experience - sensations, emotions, thoughts: automaticity, alexithymia, thought insertion

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The Psychological Birth of the Severely Dissociative Client

palpable sense of the client’s “presence in the present” – being here for the first time

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Training in Grounding Techniques

• Teach client to attend to and stay focused on here and now via:
  • motor activity
  • tactile connection to surroundings
  • visual connection to surroundings
  • temporal connection to surroundings
  • breathing connection to inner experience
  • visceral connection to inner experience
Learning to Disrupt Dissociative Episodes

- Identify triggers / early warning signs
- Employ relaxation technique / grounding techniques as early in the process as possible
- Practice regularly
- Disruption of dissociative episodes occurs progressively earlier in the sequence of events and progressively more automatically

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Processing and Resolving Adverse Impact of Trauma

Two aspects of trauma processing:
• Cognitive – the distorted beliefs about self-others-world that are derived from traumatic experience
  • Not usually triggering - can be addressed from the beginning of therapy
• Narrative – the moment-by-moment content of what occurred
  • Can be triggering - proceed with caution
Indicators of Readiness for Productive Narrative Processing

- Client is stable – crises are few and far between, distress is down
- Client has demonstrated ability to modulate affect, stay focused (not dissociate) when under stress
- Containment of addictive-compulsive acting out is not a major problem
- Client and therapist agree trauma processing is likely to be productive

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Indicators that Trauma Processing is Needed

• Intrusive symptoms (flashbacks, nightmares, physiological triggering) persist
• Aspects of the traumatic events continue to feel unresolved
• Client and therapist deduce that persisting difficulties (e.g. with sex, anger, self-esteem) are related to content of trauma
Methods for Facilitating Trauma Processing

• Prolonged Exposure (PE; Edna Foa)
• Eye Movement Desensitization and Reprocessing (EMDR; Francine Shapiro)
• Traumatic Incident Reduction (TIR; Frank Gerbode)
Prolonged Exposure (PE)

- Systematic, repeated, detailed description of the trauma narrative guided by the therapist; listening to audiotape of the narrative daily; *in vivo* exposure

- Primary Reference:
Eye Movement Desensitization and Reprocessing (EMDR)

• Assessment and targeting of trauma-related cognitive distortions and desensitization to trauma cues via “bi-lateral stimulation”

• Primary reference:

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Traumatic Incident Reduction (TIR)

• Each traumatic incident processed until resolved in a single session via repeatedly alternating between silently imaging it and describing it aloud to therapist without any questioning or prompting

• Primary reference:
The Capstone Treatment Goal: Living Well

- Application of the skills that have been developed to establishment of a fulfilling and effective life structure regarding, e.g.:
  - employment, education, career, income
  - love, relationships, friends
  - family, parenting
  - money management, financial decision-making

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Contextual Therapy: Single Case Outcome

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“To really be home means to be emotionally present and engaged.”

- Jonathan Shay, M.D.

Odysseus in America: Combat Trauma and the Trials of Homecoming

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Remember: Meaning Depends on Context

"I'm not spinning—I'm contextualizing."
Trauma Specialization: Professional Society Memberships

- American Psychological Association Division 56: Trauma Psychology www.apatraumadivision.org
- International Society for the Study of Trauma and Dissociation (mainly clinical) www.isst-d.org
- International Society for Traumatic Stress Studies (mainly research) www.istss.org

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