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Everything Counselors and Supervisors Need to Know About Treating Trauma

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Understanding Trauma: Adaptive and Pathological Responses

Counselors and supervisors working with traumatized individuals need to understand both the emotional/behavioral manifestations of trauma as well as the physical impact of psychological trauma within the body. However, integrating the complex literature into actual practice is difficult. Many authors explain various aspects of the following material in greater detail, but this paper is intended to provide information that is accessible to all counselors working with traumatized clients.

An individual's reaction to emotional trauma is complex and difficult to predict. A person's age, past exposure to trauma, social support, culture, family psychiatric history and general emotional functioning are some of the variables related to individual response to trauma (McFarlane & Yehuda, 1996). In addition, the emotional and physical proximity to actual danger, degree of perceived personal control, the length of exposure to trauma, the reaction of others to the trauma, and the source of the trauma (e.g., natural disaster, abuse from parent, abuse from stranger, random personal violence, combat, terrorist act) also impact an individual's reaction to trauma (McFarlane & de Girolamo, 1996).

Some people demonstrate resiliency, responding to trauma in a flexible and creative manner. In contrast, trauma becomes a negative, central defining moment in the lives of others, marking the start of entrenched emotional distress, maladaptive behavior,

and/or relational dysfunction. Following exposure to a traumatic event, most individuals experience temporary preoccupation and some involuntary intrusive memories. Horowitz (1978) has proposed that in many, the repetitious replaying of the painful memories actually functions to modify the emotional response to the trauma resulting in a gradual increase in tolerance for traumatic content. Whereas with time most people actually heal by integration and acceptance of the traumatic experience through this repetition, others develop the persistent patterns of hyperarousal and avoidance of Posttraumatic Stress Disorder (PTSD). In these individuals, the traumatic memory does not become accepted as part of their past. Instead, each replay of the memory only increases sensitization and distress (van der Kolk & McFarlane, 1996).

Dissociation is another common response to exposure to a traumatic event. "Dissociation is a way of organizing information ...(that) refers to a compartmentalization of experience: Elements of the trauma are not integrated into the unitary whole or integrated sense of self" (van der Kolk, van der Hart, & Marmar, 1996, p. 306). The overwhelming nature of trauma interferes with the integration of the event into conscious memory and identity in many children and adults. These individuals may mentally leave their bodies during a traumatic or threatening event, allowing them to observe the event from a distance and limit their immediate distress and pain.

The Neurobiology of Trauma

Although the body of literature addressing the neurobiological response to trauma is complex and somewhat contradictory, some knowledge is needed to understand and appropriately treat trauma. Exposure to stress or trauma has a dramatic effect on the Autonomic Nervous System (ANS), which is composed of the Sympathetic Nervous System (SNS) and the Parasympathetic Nervous System (PNS). The PNS maintains normal physiological activity when not under stress, decreasing the heart and breathing rate and blood flow to the extremities while decreasing the blood flow to digestive system.

The SNS is adaptive and designed to protect the body when there is a perceived threat to survival or body integrity by activating the fight or flight (or freeze) response. During this response, adrenalin and cortisol levels increase dramatically, producing hyperarousal and hypervigilance while preparing the body to fight or run from danger by constricting blood vessels and pupils, decreasing the blood flow to the digestive system and increasing perspiration, as well as heart and breathing rates. In addition, when it is impossible to overcome or flee, the body freezes by the process of dissociation. In this response, the individual feels numb and disengaged (sometimes fainting) with a perceived suspension of time and derealization, theoretically preparing the body for camouflage, increasing the chance of survival through compliance with prey, and/or creating conditions in which death is not as painful in case the prey does not walk away.

Although the SNS stress response is vital for survival, too much SNS stimulation has deleterious effects on the body. Since the autonomic stress response is triggered similarly by both physical and emotional pain, individuals who continually perceive

danger in their environments will elicit a constant autonomic response of alertness, which ranges from a state of vigilance to terror.

Both lengthy periods of stress or exposure to traumatic events have been found to cause serious damage to an individual's health. The hormones of adrenalin and cortisol, released during stress, bathe the areas of the brain involved in memory and response to stress (Bremner, 2002). Although these hormones mobilize brain systems critical to survival in crisis, excessive or repetitive stress can lead to long-term changes in the brain systems of memory and the stress response in some individuals. For example, researchers have reported that cortisol may cause specific damage in the brain, such as damage in the hippocampus that can impair memory formation (Sapolsky, 1996).

Particularly intense or prolonged trauma exposure can cause individuals to have a more intense physiological response to all stress. Studies have confirmed that when compared to nontraumatized controls, individuals with PTSD respond to reminders of trauma with significant increases in blood pressure, heart rate, and skin conductance (Pitman, Orr, Forgue, de Jong & Claiborn, 1987).

Several other physiological responses have been associated with chronic SNS arousal, including increased irritability in the limbic system, which is generally involved in emotional functioning (Siegel, 2003). This irritability results in stimulation of the fight or flight response by almost any excessive stimulus (e.g., smells, loud noises, flashes of light) in trauma victims (Scaer, 2005). In fact, each recurrent stress only increases sensitivity of the SNS fight or flight response and vulnerability to anxiety and depression.

The specific impact of stress and emotional trauma on the brain is a complex process dependent on many variables, but particularly age and the part of the brain developing at trauma exposure. Brain growth during the first three years of life is dominant in the right hemisphere of the brain, which typically processes nonverbal signals communication, including facial expression of feelings, perception of emotion, and regulation of the autonomic nervous system. Siegel (2003) stated that self-soothing is a critical function of the right hemisphere that can be disrupted by exposure to significant stress and trauma in the first years of life.

As the brain grows and organizes, the higher more complex areas begin to control the more reactive and primitive functioning of the lower parts of the brain, such as the limbic system, in a normal individual. An individual's ability to control their impulses and behavioral response to strong emotions requires modulation (e.g., logical thinking and problem solving before reacting) of the more primitive parts of the brain by the more sophisticated cortex. However, chronic arousal of the SNS fight or flight response can have a negative impact on the development of the higher brain functions (e.g., logic, language, impulse control, planning). Simply, the more sophisticated and complex the survival network becomes, the more difficult it will be for higher cortical functions to subdue it during learning, concentration, and recall (Perry, 2001).

Persistent SNS stimulation also increases the risk that characteristics of the state of arousal become more stable traits. Research suggests that persistent hyperarousal may permanently alter the SNS adrenalin system; whereas, persistent dissociation may alter the opioid (e.g., endorphins – the body's natural morphine) system.

As the physiology of trauma becomes better understood, many of the behavioral manifestations of trauma exposure make even more sense. Due to the perpetual state of arousal and hypervigilance, individuals can struggle with PTSD and other anxiety spectrum disorders. Some traumatized individuals are drawn into substance abuse and self-destructive tension reduction behaviors in an effort to subdue the sympathetic activation. Poor affect regulation and impulsivity are likely related to decreased cortical modulation of the emotional response. Consequently, understanding the biology of trauma helps to inform and guide the treatment process.

Treating Trauma

Early models of treating trauma, typically involved talking about the traumatic event as a central component of treatment. Retelling the trauma was viewed as curative and necessary. Often the goal was to retrieve traumatic memories and review them in counseling session. However, as noted above, more recent research suggests that while some individuals do experience symptom relief after talking about trauma, others respond with an exacerbation of symptoms (van der Kolk & McFarlane, 1996). In fact, exploring traumatic memories can even be damaging to some clients. “A client is most at risk for becoming overwhelmed, possibly retraumatized, as a result of treatment when the therapy process accelerates faster than he (sic) can contain” (Rothschild, 2000, p. 78). As a result, counselors are responsible for managing the intensity of exposure to traumatic materials during the counseling.

John Briere (1996, Briere & Scott, 2006) extensively studied complex trauma and its treatment – noting that the individual and unique ways that trauma is processed impacts the retelling of traumatic experiences. Briere developed a model for assessing and manipulating the intensity of trauma exposure in individual clients so that the intensity remains within a therapeutic window that does not retraumatize. When individuals are retraumatized in the counseling session, they typically begin to revert back to their original maladaptive response for dealing with the original trauma. Some may dissociate, while others may regress or rely on addictions to deal with the traumatic material.

Adapting Briere's principles, the intensity of in-session trauma exposure can be measured at three different levels. In Level One, the client demonstrates minimal emotional stimulation. The affect being displayed is rather flat. The individual appears somewhat numb with a calm voice tone and nonverbal behavior that do not match the content of the trauma being described.

In Level Two, the individual is demonstrating some affective stimulation, but does not appear overwhelmed or out of control. The nonverbal behavior appropriately matches the traumatic content, but not to the degree that the person appears to be re-experiencing the trauma.

In Level Three, the client is extremely stimulated with the intensity close to the original response to the trauma. It is as if s/he is actually reliving the trauma in the present, even crying uncontrollably, gasping for breath, or displaying younger or

regressed behaviors such as rocking and thumb sucking. Other clients may dissociate during the session or demonstrate an increase in addictive or self-destructive behaviors between sessions. Premature termination and other signs of resistance may occur when clients become overwhelmed with traumatic material.

Using a process not unlike systematic desensitization, the counselor is responsible for managing the level of emotional stimulation in sessions. Without adequate emotional stimulation (i.e., Level One), the client remains within their comfort zone and avoids the affective stimulation necessary to develop an increased tolerance for re-experiencing the traumatic material. However, clients' symptoms typically worsen when they become too emotionally stimulated and overwhelmed during the session (Level Three). As clients gradually learn to think and talk about their trauma without becoming overwhelmed (Level Two), they remain in the therapeutic window. Time spent within the therapeutic window not only gradually increases their tolerance for exposure to the traumatic material, but also facilitates the positive integration of the traumatic memories within their personal history and identity. Such integration allows the repetitious replaying of the painful memories to begin to modify the emotional response to the trauma. Over time, this process begins to replace the persistent patterns of hyperarousal and avoidance with healing integration and acceptance of the traumatic experience.

Counselors must assume responsibility for protecting PTSD clients from retraumatization during treatment. In addition to watching for overstimulation, regression, and dissociation in the sessions, they should check for an increase in out-of-session symptoms or addictive responses.

The goals of trauma treatment should include helping poorly defended clients develop more adequate coping strategies (e.g., relaxation training, stress reduction exercises, cognitive modulation of affect through self-talk) prior to asking them to re-experience the trauma in sessions. Strategies from dialectical behavior therapy (Linehan et al., 1999) such as problem-solving, behavior change and emotional regulation can also be implemented to assist in affect regulation and improving relationship skills.

Counselors can regulate the intensity during sessions in several ways. Intensity can be increased when in Level One by asking: affect questions (i.e., "How were you feeling when...?"); for specific details of the trauma; for them to describe the trauma step-by-step; for visual, kinesthetic, auditory, etc. memories of the event; and what happened to their body. Similarly, counselors can decrease the intensity when in Level Three by: asking content questions not specifically related to trauma (e.g., "How old were you at that time?"); using a hypnotic voice tone to calm; asking the client to stop talking about the trauma and anchor them to the present; repeating and rephrasing what the client has just said; getting client to open eyes and describe the current setting; using relaxation and breathing techniques in session; and asking the client to talk about neutral events in the present not related to the trauma.

Table 1: Regulating Intensity

Increase Anchor in trauma	Ask affect questions Ask for specific details of trauma, step-by-step Ask for sensory (visual, kinesthetic, auditory, olfactory) memories of the event Ask about their fears Ask what happened to their body
Decrease Anchor in the present	Ask content questions not related to trauma Use calming voice tone Stop client from talking and anchor in the present Repeat and rephrase what the client has just said Get client to open eyes and describe the current setting Use relaxation and breathing techniques in the session Ask the client about activities before and after present session or other events not related to the trauma

Treating trauma is a very fluid process. Given the many variables related to the impact of trauma, traumatized individuals are extremely diverse. Consequently, counselors need to be active, vigilant, and directive in managing the degree of client emotional stimulation. If, initially the client moves immediately from Level One to Level Three, the counselor must improve coping and only briefly touch traumatic material without overwhelming the client. The process is parallel to the use of systematic desensitization in the treatment of other anxiety disorders. As the client is able to tolerate processing more traumatic in-session content, other traditional cognitive behavioral (e.g., challenging distorted beliefs, implementing behavioral change, setting up contingency programs) and dialectical behavior therapy strategies can then be utilized to address symptoms such as anxiety, depression, and self-destructive or addictive behaviors.

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Handout 1: Treating Trauma in Children and Adolescents

The age and developmental level of the client dictates an appropriate treatment protocol. Treatment of the very young or severely delayed (without clear traumatic memories) primarily focuses on teaching self-calming/relaxation strategies; identification of triggers by adults; reassurance and protection from affective stimulation.

Children in later preschool and early elementary years with more clearly identifiable affective response to traumatic memories typically involves nonverbal modalities of treatment (art and play), which allow the child to express feelings and experiences that they cannot verbalize; teaching self-calming and relaxation techniques; allowing the child to test the loyalty of relationship with therapist (this challenging, but repetitive testing is a way of working through the trauma). Verbal young children may talk about the trauma utilizing the therapeutic window as long as they are not pressured to talk. All children need reassurance of safety. Even verbal children may talk more while playing or with the use of puppets, dolls, or stuffed animals. As a result, it is important to provide appropriate toys that will allow the reenactment of trauma as well as other age appropriate play materials.

Children typically need help in learning to identify their emotions and level of stimulation. Parents or other adults can assist in identifying triggers. Family therapy and parent training can be used to guide adults in minimizing affective stimulation, trauma triggers, and escalating responses. Teach the adults to recognize when the child is triggered, then assist in calming and wait to address behaviors when the child is able to make use of the feedback. The counselor can set up behavioral plans that set small goals that successively approximate target goals. An important aspect of treatment is to help adults understand the child's behavior so that it is not taken personally or viewed as defiance. Adults may need to be reminded to affirm regularly (catch them doing something positive frequently).

Trauma in adolescents is related to an increased risk of delinquency, substance abuse, high risk behaviors, poor school performance, dropping out of school, and sexual promiscuity (Perry, 2001; Schore, 1996). Adolescents often resist therapy and try to avoid any discussion of trauma. They may view counseling (or psychotropic medication) as one more stigma that means they are not normal.

The normally heightened narcissism of adolescence is often accentuated in individuals with a history of trauma and disrupted attachments. Unfortunately, this narcissism not only results in an undeveloped empathy response in some, but also contributes to a sense of entitlement and a tendency to blame others, rather than taking responsibility for personal choices. Consequently, narcissism can impede emotional maturation as well as social and skill development that results from learning from one's mistakes and gaining an understanding of the reciprocity required in interpersonal relationships. Such individuals also are likely to over-react to any perceived injustice, since they tend to rigidly view context solely from their own perspective.

As with all other aspects of trauma previously discussed, there is significant variability in an adolescent's response to trauma. While some harbor great resentment and

blame for their predicament, other traumatized adolescents may internalize too much of the blame projected onto them by abusive and/or neglectful caregivers. They may try to maintain an idealized view of their family or perpetrators, while believing that they somehow deserved maltreatment. As one youth explained, “But every time he beat me, I had done something wrong.”

Since distrust is a common reaction to trauma, counselors have to recognize how it can interfere with a youth's ability to make use of services that are provided. General distrust is compounded by the tendency to perceive adults and others as either all good or all bad (i.e., splitting). The consistent expectation that trust will be betrayed can create a pattern in which individuals can be idealized when the youth is getting everything they want, but then quickly shift to be seen as completely untrustworthy following even the slightest disappointment. Given that any trust produces anxiety considering the risk of being hurt, a youth may prefer to maintain the safer and less anxiety-producing expectation of distrust.

Another consideration when working with traumatized adolescents is that avoidance, denial, rationalization, and distraction are often preferred strategies for dealing with negative affect. Not only do these defense mechanisms naturally lead to treatment resistance, but all also interfere with the ability to mature in dealing appropriately with negative emotions and stimulation. Consequently, counselors of these adolescents need to build a strong therapeutic alliance prior to directly addressing trauma. Initially, adolescents may be more open to discuss “normal” developmental concerns such as peer relationships, clothing and music, future aspirations, or other personal interests of the client. Some willingly engage in therapy that is addressing social skills that help them be more successful with their peers. Many, and particularly male, adolescents may be more open to side-to-side rather than face-to-face conversations. They may be more apt to talking while engaging in other activities (walking, shooting hoops, playing cards, etc.).

Through these less stigmatized and stimulating conversations, the counselor basically proves their consistency and commitment and earns the trust and respect needed to enter into more threatening topics. Counselors need to be watchful of trying to move too quickly because of external pressures by individuals or systems with limited understanding of the appropriate pacing. Many counselors have been confronted with questions such as, “Haven't you started dealing with his sexual abuse yet?”

Once there is an adequate therapeutic alliance, the counselor can begin to transition into more direct discussion of trauma, by first identifying any issues related to the trauma that are causing current distress such as: rage, depression or despair, anxiety or terror. Through the identification of triggers and teaching strategies for calming, self-soothing, and affect regulation, conversations about the origins of the triggers flow more naturally. The counselor can then begin to explore the client's view of self and address distortions, including helping them to normalize and become less reactive to disappointment and small injustices.

While techniques from both traditional cognitive behavior and dialectical behavior therapy can be integrated into treatment, counselors working with children and adolescents must always collaborate with parents/caregivers, legal systems, teachers,

physicians, psychiatrists for comprehensive and coordinated care. Counselors are often required to advocate for often misunderstood traumatized youth. Adults may benefit from help in identifying the emotional obstacles that may be interfering with a youth utilizing services rather than blaming the youth (e.g., “Well, we gave him all these opportunities, but he just did not take advantage of them”). Parents and professionals alike need to be reminded that services are useless to an individual unless they can make use of them. As a result, the goal is to facilitate that process rather than blame the victim.

Counselors and others working with traumatized youth need to recognize that the therapeutic alliance is very fragile and fluid and can be damaged by revealing too much, too fast or out-of-session losses or disappointments. They must continually assess the therapeutic relationship, focusing only on repairing ruptures in the alliance until repaired. This creates an interesting rhythm and “dance” when working with adolescents. Resistance represents the degree to which the counselor or some aspect of the situation is perceived as a threat. Counselors dealing with resistance need to try to name and address the threat. Despite the seeming urgency, treatment cannot move forward until the resistance is managed. This is a continual, evolving process that remains alive during treatment. It often helps counselors to remember that maintaining trust is the most fundamental and central therapeutic work for the individuals who have been traumatized.

Counselors must remain sensitive to the present condition of the therapeutic alliance and not over-respond to the goals that other adults have set or to reports of behavior problems. However, it is admittedly a delicate balance to not collude with the client to avoid the key issues and yet not try to force the youth to talk. Similarly, working with youth presents unique challenges to issues of confidentiality. It is critical to talk with the youth and adults about how confidentiality will be addressed, making sure everyone understands how “secrets” will be handled and clarifying the limits to confidentiality at the beginning of treatment.

Given the tendency of traumatized individuals to resist counseling and project distrust, counselors must carefully monitor their own countertransference and emotional stimulation. As some abused youth attempt to test trust and commitment, they can displace their anger onto the counselor trying to help them. Counselors working with this population can expect some well-placed verbal “hits below the belt.” Working with traumatized populations increases the stress on the counselor and leaves him or her vulnerable to compassion fatigue and burn out.

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Handout 2: Compassion Fatigue (Secondary Traumatization)

Compassion is defined as a feeling of deep sympathy for another's suffering or misfortune. Compassion Stress is the feeling of tension or demand associated with feelings of compassion. Compassion Fatigue progresses from Compassion Stress and is an overwhelming state of tension and preoccupation with the cumulative trauma experienced by and reported by clients within the child welfare, juvenile justice, and other related mental health professionals. This type of fatigue results in symptoms of distress not unlike the clients who experienced the trauma firsthand.

Compassion Fatigue differs from burnout. Burnout emerges gradually and generally involves a state of dissatisfaction with one's position related to work environment factors, career choices and goals, and level of job satisfaction. Compassion Fatigue may be a component of burnout, but is essentially a secondary traumatic stress reaction and vicarious traumatization. The process of Compassion Fatigue is directly connected to client's misfortune or abuse as it is experienced by the professional. The professional's own life experiences, including coping strategies and perceptions of life impact the way a client's trauma affects the professional. Compassion Fatigue has a faster onset of symptoms and faster recovery than professional burnout.

Professionals are affected by hearing or reading histories of trauma and/or abuse. They may actually observe the physical scars of abuse. As a client talks about the trauma that s/he has experienced, internal images are created within the professional's mind and can stimulate intense feelings of compassion which can result in vicarious experiences of the actual trauma.

Little research is available regarding who is more vulnerable to developing symptoms of compassion fatigue. There is also limited understanding of how compassion stress develops into compassion fatigue. However, professionals who have poor boundaries (resulting in a lack of differentiation between self and others), have unresolved traumatic experiences in their own lives; and may be exhausted from the demands of their work combined with other stress are likely candidates. In addition, professionals who are driven to rescue clients or whose self-worth is tied to being liked by their clients may become more susceptible after feeling defeated and discouraged when they cannot maintain these goals.

Professionals who are working trauma victims may begin to experience within themselves symptoms similar to those reported by traumatized clients. It is as if they are prone to being infected with the stress reactions of their clients. They may begin to respond and cope in ways that are at times similar to the reactions of their clients to trauma. Working to help their clients recover and heal from trauma or abuse can create stress and tax the coping system of the professional.

Vicarious traumatization is the process whereby the experience of listening, observing, interaction and being exposed to traumatic material impacts an individual. Professionals working with trauma victims become both the witness and at times participant to the reenactment of trauma. As a result, professionals, like their clients,

develop styles and ways of coping to protect themselves from repeated exposures to traumatic material. For example, numbness may set in after hearing stories of trauma.

The hallmark side effect of vicarious traumatization is the intrusion of the client's violent imagery into the professional's thoughts. These images can last longer than the contact with the client. They can interfere with the enjoyment and pleasure, even sexual functioning of the professional. When clients talk about abandonment issues and these are issues which may touch on the professional's personal experience, the professional may experience intense feelings related to the conversation. However, professionals who do not have a history of trauma are not immune to experiencing these symptoms since they may have a less developed protective response to trauma which could make them even more vulnerable to reactions to traumatic material.

Recommendations for Coping With and Managing Compassion Fatigue

Professionals working with trauma victims need to tend to their own self-care. They should examine within themselves any unresolved trauma issues of their own. It is also critical that they develop an understanding of the characteristics of their client population. Victims of trauma and abandonment are often slow to trust and resistant to treatment. The perceptions of clients exposed to severe or repeated trauma may be tainted in a manner that can distort reality in a way that even the helping professionals can be viewed by clients as abusive.

Professionals should also be alert to the symptoms of compassion fatigue. They need to be aware of their feelings and mood states and recognize when additional support or relief may be needed. Support can come in the form of talking to fellow professionals as well as looking for suggestions, advice, and/or consultations from their professional team. Working in isolation tends to increase the risks of such symptoms and is contraindicated when working with this population.

Professionals should also set realistic goals and boundaries in their work. Additional training and education can be obtained to remain current on the evolving literature related to understanding and treating trauma. Such professional development can also stimulate new ideas and interests in their professional growth.