blue knot foundation

National Centre of Excellence
for Complex Trauma

Complementary Guidelines

to *Practice Guidelines for Clinical Treatment of Complex Trauma:*

1 GUIDELINES TO DIFFERENCES BETWEEN THERAPY FOR COMPLEX TRAUMA AND STANDARD COUNSELLING APPROACHES

AND

2 GUIDELINES TO THERAPIST COMPETENCIES FOR WORKING WITH COMPLEX TRAUMA AND DISSOCIATION

(2 sets)

BLUE KNOT FOUNDATION

Dr Cathy Kezelman AM
Pam Stavropoulos PhD

Empowering recovery from complex trauma

Complimentary Guidelines to
Practice Guidelines for Clinical Treatment of Complex Trauma

© 2019 Blue Knot Foundation

Authors: Kezelman C.A., Stavropoulos P.

Dr Cathy Kezelman AM
President – Blue Knot Foundation

Pam Stavropoulos PhD
Head of Research – Blue Knot Foundation

Blue Knot Foundation 2019 Complimentary Guidelines to *Practice Guidelines for Clinical Treatment of Complex Trauma: Authors* Kezelman C.A & Stavropoulos P.A.

www.blueknot.org.au

Blue Knot Helpline 1300 657 380

AUDIENCE: These guidelines are intended for *clinicians* (i.e. counsellors, psychologists, mental health social workers and other mental health professionals) who work in one-to-one therapeutic contexts with clients/patients who experience the impacts of complex trauma. This includes therapists who specialise in this work as well as those who see complex trauma clients as part of their general work.

Disclaimer

This document is a general guide to appropriate practice. The guidelines are designed to provide information to assist decision-making and are based on the best available evidence at the time of development of this publication.

© 2019 Blue Knot Foundation

Contents

Blue knot Foundation **5**

Introduction**:** **7**
Complementary Guidelines to *Practice Guidelines for Clinical Treatment of Complex Trauma*

(1) *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches* 9

(2) *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* 19

Appendices ***29***

(1) *Features of Complex Trauma of which all Therapists and Health Professionals need to be aware* 31

(2) *Self Care for Therapists who work with Complex Trauma Clients* 33

Blue Knot Foundation

Blue Knot Foundation is the Australian National Centre of Excellence for Complex Trauma. It empowers recovery and builds resilience for the more than five million (1 in 4) adult Australians with a lived experience of complex trauma. This includes those experiencing repeated ongoing interpersonal trauma and abuse, often from childhood, as an adult, or both as well as their families and communities.

Formed in 1995, Blue Knot Foundation provides a range of services. These include:

- specialist trauma phone counselling, information, support and referrals including around redress
- educational workshops for survivors and their family members, partners and loved ones
- professional development training for workers, professionals and organisations from diverse sectors
- group supervision
- consultancy
- resources including fact sheets, videos and website information at www.blueknot.org.au
- advocacy
- research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it.

In 2012, Blue Knot Foundation released *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* www.blueknot.org.au/guidelines. These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice. In 2015, Blue Knot Foundation released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by *Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts,* and in 2018 the paper *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance of Trauma* was launched and released. In 2018-19 Blue Knot Foundation released its *Talking about Trauma* series.

In 2019 Blue Knot Foundation released *Practice Guidelines for Clinical Treatment of Complex Trauma*. In addition to this complementary publication, the following will also be released:

- An additional publication on trauma-related dissociation
- Guidelines for Clinical Supervisors of Therapists who work with Complex Trauma

For more information, visit www.blueknot.org.au. If you need help, information, support or referral, call Blue Knot Helpline on 1300 657 380 or email helpline@blueknot.org.au between 9am-5pm Monday to Sunday AEST/ADST.

Introduction: Complementary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma

The 2012 release of *The Last Frontier: Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* by Blue Knot Foundation (then ASCA) was pioneering. These guidelines – updated in 2019 to reflect evolving research and developments[11] - provide recommendations for therapeutically addressing complex, as distinct from single-incident, trauma. The years since 2012 have also highlighted a need to `fill the gaps' with respect to how the principles of therapy for complex trauma differ from those which underpin many counselling modalities. Correspondingly, they have identified the need for skills regarding therapist competencies for working with complex trauma.

The prevalence of complex trauma is increasingly acknowledged in the mental health field. This is confirmed by inclusion of the new diagnosis of Complex PTSD in the *International Classification of Diseases, ICD-11*[2] (although not in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-5).*[3] Increasing numbers of therapists and diverse health professionals from a range of disciplines are receptive to providing therapy to clients with complex trauma histories.

The following Guidelines are designed to help professionals orient to this task by specifying what the work requires and the relevant competencies. As such, they complement and support the *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019). These two sets of complementary guidelines, which also stand in their own right, are:

(1) *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*

and

(2) *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation*

The first - *Guidelines to Differences between Therapy for Complex trauma and Standard Counselling Approaches* - address the ways in which working with clients who experience the impacts of complex trauma require adaptation of counselling principles which are common to a wide range of psychotherapies (i.e. irrespective of the particular modality). This relates not only to the need for all modalities to be trauma-informed. At a more basic level it relates to the `taken for granteds' of what is widely considered to comprise `good' therapy.

1 *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

2 'WHO releases new International Classification of Diseases (ICD 11)' 18 June 2018 News Release Geneva http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classification-of-diseases-(icd-11) According to this long awaited diagnosis, `Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse' (Cloitre, Garvert, Brewin et al `Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis', *European Journal* of *Psychotraumatology*, 4, 2013. For detailed discussion of the new diagnosis of CPTSD, see ch 1 in *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

3 The current edition of the DSM (DSM-5, 2013) does, however, include a dissociative subtype of PTSD. For discussion of the dissociative subtype vis a vis the ICD-11 diagnosis of CPTSD, see ch 1 of the updated *Practice Guidelines for Clinical Treatment of Complex Trauma*, ibid.

For example, while most directly associated with `person-centred' approaches and the foundational contributions of Carl Rogers, empathy and `unconditional positive regard' are prioritised in a range of contrasting psychotherapeutic modalities. So, too, is a `strengths-based' orientation, emphasis on `client as expert', and the assumption and celebration of client `resilience'. While valuable in many ways, all such principles need to be considered more carefully in the context of complex trauma rather than being applied automatically.

There is a need for basic counselling principles which have become `articles of faith' to be reappraised for their adequacy with respect to psychotherapy for complex trauma. The new *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches* can be read as either an introduction to, or reminder of, the challenges complex trauma poses to some familiar and cherished norms of the premises of `good therapy'.

The second additional short guidelines – which present therapist competencies for working with complex trauma – can be read as a prelude to the clinical guidelines. The original and updated clinical guidelines convey what therapy for complex trauma clients entails. But they do not specify the attributes and abilities the therapist needs. The *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* rectify this gap.

Effective therapy for complex trauma requires a particular skill set. While several of these skills can be learned and acquired, the requirements of therapists doing this work are substantial. This also means that this work is not for everyone. Yet complex trauma is so prevalent that all clinicians are likely to encounter it in their practice - knowingly or unknowingly and `ready or not'.

This underlines the need for the practice and manner of delivery of all clinicians to be trauma-informed (i.e. the way in which therapy is provided, `over and above' the nature of the clinical treatment). If therapists are unwilling or unable to work with complex trauma clients, it is important to refer their clients to clinicians who have the requisite skills. The new *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* also present a `self-selecting' tool for clinicians to assess their affinity with the requirements of the work. Some may choose not to focus their practice in this area as a result, or may seek additional training.

Clinical supervisors (for whom specific guidelines will be released separately)[4] will also find both sets of complementary guidelines helpful. This is because they assist supervisees to meet and maintain the requisite levels of skill to work clinically with complex trauma clients. The appendices to the following complementary guidelines summarise the features of complex trauma which should inform all varieties of therapy provided to address it. They also present principles and tips to assist the self-care of the therapists doing this work.

4 See *Guidelines for Clinical Supervisors of Therapists who Work with Complex Trauma.*

Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches

`An approach [informed by understanding of adaptations to experience of trauma and abuse] mandates alteration of traditional therapeutic interventions'

(Chu, *Rebuilding Shattered Lives,* 2011:76)

The common features of what is widely regarded as `good' therapy need to be reconsidered in a number of ways when working clinically with complex trauma. Likewise, all modalities need to be trauma-informed and to accord with current clinical and neuroscientific insights in the neurobiology of attachment (see *PRACTICE GUIDELINES FOR CLINICAL TREATMENT OF COMPLEX TRAUMA, 2019)*.

Just as van der Kolk (2006: xxii) *has said that otherwise diverse psychotherapies historically share a lack of awareness of the body, a range of otherwise diverse psychotherapies share common principles which, while largely considered `good practice', need modification for working with the challenges of complex trauma.*

The following principles and recommendations apply to all clinical work – i.e. irrespective of the particular modality – with clients who have experienced complex trauma within interpersonal relationships.

(1) Clients who experience the impacts of complex trauma start at a different point

Their starting point differs from that of clients who do not experience the effects of complex trauma as well as clients who have experienced a `single incident' trauma: `*In contrast to the traumatized person who has experienced a sense of safety and well-being prior to onset of the (single-incident) trauma, the survivor of complex trauma does not start with this advantage*'; (Shapiro, 2010). This has a number of implications for the way in which to conduct the therapy. It also highlights the limits of many standard counselling approaches and also of more specialised modalities which are not trauma-informed.

(2) Impacts of complex trauma can be `hidden' and confused with surface symptoms

Because clients with complex trauma often show a `*bewildering array of clinical presentations*' (Herman, 2009: xiii) many therapists `target symptoms' without realising that they may be generated by underlying trauma. Thus `targeting symptoms' - which is a common feature of many short-term interventions - without this understanding can be problematic in different ways (also see `Features of Complex Trauma' at the end of this document).

(3) Resourcing is more challenging (also see Guideline 7)

Many counselling modalities hold `*the assumptive belief that the patient already has the necessary knowledge internally to heal*', and that it is `*the inability to access that knowledge that has been the problem*' (Schwarz, 2002: 112). With complex trauma, however, the situation is more complicated.

Difficulty with self-regulation is a characteristic feature of complex trauma. This means that it may not only be a matter of *accessing* inner resources, but of *acquiring* and *developing* them. Many complex trauma clients have longstanding self-regulatory deficits which predate their presenting issue/s. But this may not be apparent to the therapist, especially if - as is also common - the client is unable or unwilling to disclose their prior challenges.

This can result in the therapist trying to `elicit' and/or `strengthen' internal resources via interventions and suggestions which are not appropriate for clients whose *capacity* to self-regulate has been disrupted by complex trauma. Also see Guideline 7.

(4) Diverse counselling modalities are not sufficiently relational and rest on an `individualist bias'

This may seem strange because it is well-known and widely acknowledged, especially in the counselling field, that we are relational beings. Yet despite this acknowledgment, many modalities and approaches retain an individualist bias:

`Many pressures incline us towards drafting an outline of the client as a private being, as someone who...has more or less stable boundaries, has a more or less internal locus of control...' (Furlong, 2013:69). As Furlong goes on to remark,

`[c]ertain therapeutic traditions acknowledge an explicit relational aspect as a core principle, mindful that the established approaches (CBT, humanistic/third force, psychoanalytic traditions) recognise an autonomous, well-bordered self as the ideal...even if the practitioner has a relational, feminist or post-structural allegiance, the materiality and context of the therapeutic project invites the practitioner to act as if the client is bounded by their skin' (Furlong, ibid).

The principle that `we can only work with the individual in the room' also strengthens the `default' bias of individualism. While the person who attends therapy is the person to whom we directly relate, it is also important – particularly in relation to complex trauma – to attune to the *context/s in which individuals are embedded.*

The legacy of decontextualized individualism is particularly problematic when working with complex trauma clients because:

- Complex trauma *is relational* and often involves a power disparity *(what does `individual responsibility' mean in this context?)*
- Neurobiological deficits inhibit perceptual flexibility *(this makes exercising agency, `choice', and `changing one's perspective' more challenging)*
- Emphasis on individualism (however indirect) risks shaming a client who already feels isolation and self-blame
- The client may have little sense of being an individual with their own `self' *(i.e. the assumption of individuality may not match the client's subjective sense and lived experience)*

(5) Diverse counselling approaches assume a coherent identity and prematurely encourage `I' statements *(i.e. use of the personal pronoun `I' is often premature for complex trauma clients)*

Self-continuity and identity are shaped by experience. In complex trauma, particularly childhood trauma, they are often disrupted:

`The usual motto of `united we stand, divided we fall' is rendered useless. So a new strategy comes into plan. `United we collapse, divided we survive'. The person automatically begins to dissociate aspects of the experience into separate compartments of the mind' (Schwarz, 2002: 100);

`Traditional talking therapy approaches might work with individuals who are less fragmented or traumatised, but it does not work with clients whose habits of self-alienation and self-rejection recreate the rejections and humiliations of childhood' (Fisher, 2017: 63).

It is important for the therapist to pay close attention to non-verbal communication and the body (see next guideline).

(6) Diverse counselling approaches are often insufficiently attuned to non-verbal communication

`The words...may or may not convey significant meaning. The implicit, nonverbal subtext almost always does' (Wallin, 2007:259) Verbal expression is frequently unavailable in relation to complex trauma (Ogden, 2006) and overwhelming experience for which there are 'no words'. This has major implications for `talk therapy' of all kinds:

`When we consciously and deliberately engage in practices that produce physical calmness, we signal the limbic brain that we're safe at a physiological level' (Church, 2015: 49).

Thus somatic awareness and attunement on the part of the therapist when working with complex trauma is essential.

(7) Care is needed with `techniques'

The importance of the relational context in many varieties of psychotherapy (and its particular importance in complex trauma therapy) may mean that the role of `tools and techniques' is unclear. For some therapists and modalities, specific tools are indispensable. Others regard them with ambivalence (as conveyed by the chapter title *`If You Meet the `Tool' on the Road, Leave it! Person-of-the-Therapist Issues'*; Schwarz, 2002: 217).

Yet methods and strategies are needed to assist complex trauma clients to develop their self-regulatory capacity. In a relational context, which is recommended, the benefits of any `tool' are maximised. The application of many tools and techniques can also be individualised. This means that it is not a matter of choosing either `relationship' OR `strategies and techniques', but of how to optimise both.

The stakes of this balance are particularly high and challenging in relation to complex trauma. This is because *many `standard' tools and techniques may be inappropriate and potentially retraumatising* (as per Guideline 3).

For example, `relaxation' exercises may be the opposite of soothing for hypervigilant clients (especially if the term was used as prelude to abuse). Imagery which may be fine for non-traumatised clients may likewise trigger complex trauma clients. And the very invitation to use basic mindfulness to `focus' may be impossible for the dissociated client as mindfulness and dissociation are opposing brain functions (Forner, 2017).

This is not to say that many tools and techniques will necessarily be unhelpful. Rather it is to underline *the great care with which any method and strategy in treatment for complex trauma should be selected, potentially modified, individualised, and applied* (Schwarz, 2002; Porges & Dana, 2018).

(8) `*Focusing on the feeling'* is contra-indicated in the early stages of therapy

The question `*how does that make you feel?'* has become synonymous with `send ups' of psychotherapy. But while the ability to access and express emotion is a goal of therapy, that particular question is contraindicated *if clients are unable to self-soothe and manage their internal states* (which is a task of Phase 1 of effective complex trauma therapy; see clinical guidelines). The familiar question `*How does that make you feel?'* is NOT indicated if clients lack self-regulatory skills.

(9) Empathy is necessary but not sufficient

`Unconditional positive regard' and empathy are widely and rightly endorsed:
`*The therapist uses Carl Rogers trilogy of genuineness, warmth, and unconditional positive regard'* (Schwarz, 2002: 219). But in complex trauma, impairment of self-development may impede the client's ability to respond to these:

> `*pure empathy and a warm therapeutic relationship are not enough, for traumatized people are unable to read or fully receive compassion'* (Levine, 2010: xi).

Ironically, a therapist's over-reliance on empathy risks shaming the client who may blame her/himself for not being able to respond to it (e.g. `*My therapist is so warm and kind; there must be something wrong with me if I can't respond to them').*

(10) Reconsider the bias against therapist proactivity

Many modalities `take their lead' from the client who they assume will communicate, whether directly or indirectly, where therapy needs to go:
`*Clinicians are trained to rely on clients as the experts on their own internal states, to assume that they are the most credible source of information about both past history and moment to moment awareness'* (Fisher, 2017: 153).

But clients cannot easily communicate the multiple impacts of complex trauma. This means that therapists may need to be proactive on different occasions to minimise the possibility of retraumatisation should the client move out of their `window of tolerance':

`*Many therapists have been carefully trained to avoid directing the treatment for fear that clients will become automatically compliant and lose an opportunity to get `in touch' with an inner sense of direction. But because dissociative fragmentation results in multiple senses of direction and an inhibited prefrontal cortex, because of the risks of retraumatization or stuckness and avoidance, the therapist has to be unafraid to gently direct the focus and pacing of treatment'* (Fisher, 2017: 59-60; Paivio & Pascual-Leone, 2017: 5).

Clearly this involves a `dance' between therapist proactivity where necessary and avoidance of `leading' and `taking over'. But the complex trauma client `*cannot successfully learn the abilities needed without help and direction from the therapist'* (Fisher, 2017: 59).

(11) ‘Strengths-based’ should not be at the expense of recognising difficulties

It is therapeutic to celebrate strengths. This is also a welcome and stark contrast to pathologising orientations regarding what is `wrong' with - rather than what *happened to* - the person. At the same time, it is important not to minimise distressing ongoing difficulties.

One of the `signature features' of complex trauma is an impaired capacity to access internal resources. All therapists – and especially exponents of short-term interventions, strategies and techniques – need to be aware of this. It again underlines the need for a trauma-informed understanding of the psychobiological effects of unresolved overwhelming experience. When a therapist does not understand these impacts, they can unintentionally imply that the client should `put the past behind them' (which is a retraumatising implication that is not uncommon).

As with the irony of therapist over-reliance on empathy (see Guideline 9) excessive focus on strengths at the expense of attuning to difficulties may increase client self-blame for ongoing distressing problems (e.g. *`I should feel/cope better than I do').*

(12) `Will power' and `inner strength' have limits

When there is a superficial understanding of the concept of `resilience', `inner strength' does not apply when a client has not developed the capacity to self-regulate. (Also see Guideline 11 above.) Experience of complex trauma cannot be resolved by `will power' alone (traumatised people cannot simply `move on' as *`the time honoured expression `time heals all wounds' simply does not apply to trauma';* Levine, 2010: 88).

This is important for therapists to understand, because many clients experiencing the impacts of complex trauma can be high-functioning in compartmentalised ways. This means that they may seem `resilient' by external criteria while subjectively experiencing little quality of life.

(13) Emphasis on `independence' (rather than *inter*dependence) can be problematic

Experience of shame about the need for support and inability to `go it alone' is common among survivors of complex trauma. The wider culture often has strong unrealistic notions of `independence' which are reflected in counselling and psychotherapeutic modalities alongside the contrasting emphasis on relationality (see Guideline 4). The apparent inability to be `independent' is also widely regarded as a `personal' deficit. However it is often a legacy of suboptimal early care-giving relationships and other compounding factors.

The capacity to trust and depend on others is a marker of emotional health. It is also disrupted by complex interpersonal trauma. Therapists should emphasise *inter*dependence, rather than unrealistic autonomy, as a therapeutic goal. Thus they should consistently work to assist clients to realise that `relationality rules' and that it can be experienced in healthy ways.

(14) The notion of the `over-functioning' therapist needs to be revisited

Self-regulation is often a primary task of complex trauma therapy. Because complex trauma clients *`cannot successfully learn the abilities needed without help and direction from the therapist'* (Fisher, 2017: 59), more is required of the therapist when working with this client population than is the case when working with others.

Particularly in the first phase of therapy (in which stabilisation and the capacity to self-soothe are key goals; see clinical guidelines) what may be regarded as therapist `over-functioning' in relation to non-traumatised clients is not only appropriate but necessary with respect to clients with complex trauma:

`Trauma clients need more, and hopefully will receive more…The ability to tolerate emotional distress, while offering authentic reassurances and yet still setting necessary limits becomes easier with experience of how and how much that actually helps the person' (Danylchuk & Connors, 2017: 169). Also see next guideline.

(15) Revisiting boundaries

Paying attention to boundaries so they are neither `too rigid' nor `too relaxed' is a staple and `sacred cow' of psychotherapy of all kinds. Yet *`[t]esting boundaries is part of the therapy process'* (Ross & Halpern, 2009: 82). Many complex trauma clients (i.e. for whom therapy is `a confrontational, challenging, and frightening journey') are likely to test boundaries frequently: *`[i]f there is no transference or boundary testing then the real work of therapy has not yet begun'* (Ross & Halpern, ibid).

In light of the self-regulatory difficulties of this cohort, and consistent with the previous guideline, the therapeutic boundaries for complex trauma can be more challenging for both parties and also need to be more flexible. This may necessitate therapeutic contact 'outside hours', which is rarely required for clients who are able to self-regulate:

`When working with Complex PTSD, therapists may find themselves having to spend additional time on communication with the client between sessions in order to facilitate emotional regulation and support in navigating any life-interfering activation that occurs as a result of therapeutic processing' (Schwarz, Corrigan et al, 2017: 203).

Note that this also presumes and requires the therapist to engage in ongoing reflective practice, self-care, and regular trauma-informed clinical supervision.

References

Danylchuk, L.S. & Connors, K.J. (2017) *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges.* New York, Routledge.

Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation.* Routledge, New York.

Forner, C.A. (2017*) Dissociation, Mindfulness and Creative Meditations: Trauma Informed Practice to Facilitate Growth*. New York, Routledge.

Furlong, M. (2013) `Calling the client as a relational being', *Psychotherapy in Australia* (Vol.19, No.3), p.68-75.

Herman, J. (2009) `Foreword', Courtois, C.A. & Ford, J.D., ed. *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide*. New York, The Guilford Press, pp. xiii-xviii.

Levine, P. (2010) *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness* Berkeley: North Atlantic Books.

Ogden, P., Minton & Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. New York, Norton.

Paivio, S.C. & Pascual-Leone (2017) *Emotion-Focused Therapy for Complex Trauma: An Integrative Approach* Washington DC, American Psychological Association.

Porges, S. & Dana, D. (2018) *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies.* New York: Norton).

Ross, C.A. & Halpern, N. (2009) *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* Richardson, TXL Manitou Communications.

Schwarz, L., Corrigan, F. et al (2017) *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma.* New York, Routledge.

Schwarz, R. (2002) *Tools for Transforming Trauma.* New York, Routledge.

Shapiro, R. (2010) *The Trauma Treatment Handbook: Protocols Across the Spectrum*. New York, Norton.

Wallin, D.J. (2007) *Attachment in Psychotherapy*. New York, The Guilford Press.

Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation

`[M]any patients have been retraumatized by [clinicians] who had inadequate understanding and skills to treat complex trauma-related problems'.

(van der Hart et al, 2006)

`One doesn't need to be a specialist. One just needs to gather some special knowledge and add it to the important basics without which no special knowledge is particularly useful' (Chefetz, 2015: viii).

Effective therapy for complex trauma requires a particular skill set. While several of these skills can be learned and acquired, the requirements of therapists doing this work are substantial. This also means that this work is not for everyone. Yet complex trauma is so prevalent that all clinicians are likely to encounter it in their practice - knowingly or unknowingly and `ready or not'.

This underlines the need for the practice and manner of delivery of all clinicians to be trauma-informed (i.e. in the way therapy is offered; `over and above' the nature of the clinical treatment). If therapists choose not to work with complex trauma clients, or are unable or unwilling to do so for whatever reason, it is important to refer these clients to a therapist who has the requisite skills. Thus the following *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* not only present the skills which are required. They also serve as a `self-selecting' tool for clinicians to assess their affinity with the requirements of the work. On this basis therapists may choose not to focus their practice in this area and/or to seek additional training.

(1) Identify the components and requirements of the work

> *`There is a lot to learn to become a competent trauma therapist…It is not something that fits in a semester or two of instruction'*
> (Danylchuk & Connors, 2017: 167).

The educational challenge of becoming a competent complex trauma therapist is fundamental. This is because many 'psy' curricula do not focus on working with trauma, much less complex trauma. Working effectively with complex trauma requires greater knowledge and skills than are apparent in standard counselling modalities. This also applies to specialised approaches and methods which are not trauma-informed (also see *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches).*

Practising and aspiring complex trauma therapists should attune to the following areas of focus which are addressed in the subsequent guidelines:

- the variegated and often structurally dissociated internal world of the client (i.e. divisions of the personality generated by early life trauma; van der Hart, Nijenhuis & Steele, 2006; note that not all clients who experience the impacts of complex trauma are structurally dissociated)
- the several roles and functions the therapist of complex trauma is required to undertake *(which differ in significant ways from what clinicians may be familiar with and expect)*
- the particular challenges of therapy for complex trauma and dissociation (*which include actively and often painstakingly helping the client to develop healthy self-regulatory capacity, managing strong transference-countertransference dynamics,* and *recognising and addressing `the interpersonalisation of dissociation' via enactments in the therapy room* [Stern, 2010])
- the need for the therapist to be highly attuned to their own functioning, self-knowledge and self-care
- related to the above, the nature and particular dynamics of the therapeutic relationship

(2) Attune to the diversity of the client's internal world which, if structurally or otherwise divided, challenges the way in which we engage `the whole person'

Many complex trauma clients may have diverse, trauma-generated, and unintegrated internal states with varying degrees of consciousness for one another. This challenges the extent to which many complex trauma clients experience themselves as a `whole person'. It also challenges the extent to which therapists can experience them in this way as well:

`Attempts to process [client responses] as if they were those of a whole integrated individual are usually frustrating at best. Therapists often find themselves dismissing such clients as `resistant', `unmotivated', or `guarded', without realising that they have been stymied by a series of parts whose job it is to distance in relationships, avoid the trauma, and detach emotionally' (Fisher, 2017: 111);

`The challenges of utilizing any treatment approach effectively become greater when amnesic barriers and/or intense conflicts between parts create an inability for the whole person or system to work with the therapist, much less work with itself'; Fisher, 2017: 156).

(3) Orient to `parts' language and work

Unintegrated `parts' of the personality challenge the therapeutic benefits of unqualified use of the personal pronoun `I' (Fisher, 2017). This also highlights the potential need for dedicated `parts' work.

Utilising the language of parts (as in *`a part of me'* feels this way rather than *`I'* feel this way; Fisher, 2017: 119) often resonates with the client (for whom referring to *`parts of the personality' or `parts of yourself'* is usually *`an apt description of their subjective experience'*; van der Hart, et al, 2006: 4). It also renders an intrinsically challenging therapeutic process less volatile (also see Guideline 7).

Orienting to working with `parts' is a sound foundation for working both with structurally dissociated clients (i.e. whose early life trauma generated divisions of the personality) and clients for whom internal diversity is not chronic and is less severe. This is because it represents a natural extension of much client work more generally.

Ego-state therapy, which has various expressions, can be correspondingly helpful at a broad level in this regard.[5] Internal Family Systems (IFS; Schwartz, 1995), one of the most well-known and widely practised ego-state psychotherapies, can serve as an important conduit to learning the necessary skills.

As Fisher (2017: 8) notes, `IFS is a parts therapy' which `teaches therapists to become fluent in speaking the language of parts'. It also helps therapists to attune to their own internal diversity, in that *`[n]ot only are they asked to speak the language with their clients, but they are also expected to become mindful of their own parts'* (Fisher, ibid). Note, however, that `standard' ego state therapies are not necessarily attuned to the challenges of working with dissociative clients, and that the ego states of structural dissociation and DID[6] differ from those of clients who are not structurally dissociated (Kluft, 2006; Van der Hart et al, 2006).

5 A helpful introductory text in this context (because written by a clinician skilled in working with trauma which is not standard in presentation of ego-state therapy approaches) is Robin Shapiro, *Easy Ego State Interventions: Strategies for Working with Parts* (Norton, New York, 2016). For a contemporary ego-state approach to treatment of clients who struggle with the impacts of childhood trauma, see Shirley Jean Schmidt, *The Developmental Needs Meeting Strategy* (DNMS): *An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* (DNMS Institute, Texas, 2009. www.dnmsinstitute.com Note that the `classic' contemporary text for understanding and working with dissociative parts of the personality is not an `ego-state therapy' approach; i.e. Onno Van der Hart, Ellert Nijenhuis, & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).

6 Note that treatment of DID should not be attempted by therapists who lack the necessary skills and experience and requires adherence to specific treatment guidelines http://www.isst-d.org/downloads/guidelines_revised2011.pdf

(4) Recognise the several roles and functions required of the therapist

Clients who experience the impacts of complex trauma and dissociation generally show `disconnects' between different registers of functioning (e.g. as per the `BASK' model of *behaviour, affect, sensation*, and *knowledge*; Braun, 1988). This means that `ordinary expectable linkage may not occur' (Chefetz, 2015: 25). It also means that more is required of the therapist, and that *`the therapist must listen, speak, and conduct the treatment somewhat differently than he or she otherwise would in treating more integrated clients whose early lives did not require splitting and self-alienation'* (Fisher, 2017: 116).

In her significantly titled chapter `Changing Roles for Client and Therapist', Janina Fisher (2017: 42-64) delineates what she regards as the several additional roles required of therapists who treat clients experiencing the impacts of complex trauma and structural dissociation. These include therapist as *neurobiological regulator* (i.e. when the client cannot perform this vital task for themselves), therapist as *educator,* and therapist as *director, coach, and pace setter* (in that clients *`cannot successfully learn the abilities needed without help and direction from the therapist'* (Fisher, 2017: 59).

These additional roles - which extend far beyond those prescribed in traditional therapist trainings - may be somewhat disconcerting for many counsellors and psychologists. But the need for the complex trauma therapist to be more proactive (see *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*) should be borne in mind.

Importantly, Fisher is not the only complex trauma clinician to assert that the therapist needs to act as `Auxiliary Cortex' (Fisher, 2017: 51). Pat Ogden, Kekuni Minton and Clare Pain (2006: 206, ref Diamond et al, 1963) similarly contend that *`[a]s the therapy gets underway, the therapist becomes an interactive psychobiological regulator for the client's dysregulated nervous system'.* Diamond's conceptualisation of the therapist as an `auxiliary cortex' is referenced and endorsed in the classic text *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Van der Hart et al, 2006).

The rationale for this (and indeed for the other roles Fisher delineates, ibid) is that in the initial stages of therapy, and potentially for a considerable period of time, the complex trauma client generally lacks self-regulatory skills. As s/he becomes better able to tolerate and regulate sensations, emotions, and thoughts via the sustaining supportive role of the therapist, the clinician ceases to act as an *`auxiliary cortex'* as this function becomes decreasingly necessary.

Clearly this and the other therapist roles described above can challenge standard critiques of the `over-functioning' therapist (see *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*). (see Guideline 14 in *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*)

(5) (Re)Consider Boundaries

The above raises the perennial topic of boundaries, which in light of the additional and more extensive capacities in which the therapist is required to act, are somewhat different in psychotherapy for complex trauma. One example of this, as noted in the *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*, is that *`therapists may find themselves having to spend additional time on communication with the client between sessions in order to facilitate emotional regulation and support in navigating any life-interfering activation that occurs as a result of therapeutic processing'* (Schwarz, Corrigan et al, 2017: 203).

This is only one of many ways in which boundaries are more complicated and `look different' in complex trauma therapy. For example, coexistence of unintegrated and potentially competing client states, in combination with the requirement of the therapist to carefully monitor client safety, means that boundaries `*paradoxically necessitate both more stringent AND more flexible decision-making on the part of the therapist than with the average client'* (Schwarz, Corrigan et al, ibid: 209).

Note that while the latter point is made in relation to therapy for the most severe form of structural dissociation, it also applies to less severe forms of dissociation and to therapy for complex trauma per se. Also note that because negotiating boundaries is correspondingly more challenging in this context, the therapist needs to engage in ongoing trauma-informed clinical supervision and pay careful attention to their own self-care.

(6) Expect strong intersubjective and transference and countertransference dynamics

The shame, secrecy, and vulnerability characteristic of complex trauma, and the salience of nonverbal and unconscious processes, mean that powerful emotions are often `beneath the surface' in therapy. This is also and especially when the client cannot articulate them in words. The client's desire for, as well as fear of, contact can evoke and embody strong feelings *in the therapist*. This means that the therapist needs to track their own process in interacting with the client, which raises particular challenges in the context of complex trauma (see below).

(7) Expect enactments in the therapy room

The enactment of unspoken, dissociated, and therefore unassimilated experience is a well-known feature of trauma: `*[b]ecause…dissociated affective memories have not been symbolized, they can only be enacted'* (Wallin, 2007: 105). As Fisher points out, it is helpful for the therapist to consider the question `*[i]s there a pattern in the client's life that might be telling a story of unresolved trauma being re-enacted at an implicit level?'* (Fisher, 2017: 118).

Yet enactments occur not only in the client's external life but also *in the therapy room*. The inevitable activation of attachment dynamics means that *interpersonalisation of dissociation* in the form of enactments (Stern, 2010; Bromberg, 1998, 2011) is common in therapy for complex trauma. As the therapist is necessarily a participant in these enactments, which can ignite their own unconscious processes, issues of `the person of the therapist' (see next guideline) are critical to how enactments are addressed.

(8) `Person of the therapist' issues are high stakes in therapy for complex trauma

> `The first person to feel the effects of things not working well is the client' (Danylchuk & Connors, 2017: 172).

The ability of the therapist (i.e. as well as the client) to `stay present' can be very demanding of the clinician. This is because the therapist is a witness to the traumatic material at the same time as they monitor client safety: *`Being present and real is very powerful, and often very difficult'* (Danylchuk & Connors, 2017: 171). The exacting nature of the work also highlights the need *`to continue to tend to one's own psyche while working in this field'* (ibid: 167).

Experienced complex trauma clinicians recommend prior personal therapy, ongoing reflective practice and trauma-informed clinical supervision:
`As therapists, our egos and performance anxiety can be as significant an obstacle to trauma work as that of the protective nature of the [client's internal] system itself…The therapist's attunement to themselves as well as their client will allow for the most appropriate choices in the course of treatment, and it is there that the therapist's willingness to engage in their own personal healing work is imperative' (Schwarz, Corrigan et al, 2017: 226-227).

(9) The nature of the work involves all aspects of self

`Knowing one's own history and emotional vulnerabilities is essential for staying in this field in a way that supports the health of both therapist and client' (Danylchuk & Connors, 2017: 168);

Witnessing the impacts of complex trauma in turn impacts the therapist. But the challenge of the work can also activate self-protective responses and the therapist may be unaware of these. This speaks to the importance of ongoing self-work as well as all facets of self-care:

`It is not a problem for the therapy if the therapist's affect is aroused. Without affect, how can a therapist empathize? …. The issue becomes whether or not the feelings overwhelm the therapist or force the therapist to psychologically leave the room' (Schwarz, 2002: 219)

The greater our self-knowledge in relation to our own history and coping strategies around intense emotion, the more attuned and effective the therapy. Unconscious self-protective strategies utilised by therapists include covert distancing, and attempts to `contain' the client which may stem from our own difficulty in containing what they evoke in us. Projection and over-identification can also occur on the part of *the therapist,* regardless of whether or not they have a trauma history.

For discussion of these issues in the context of complex trauma, see `The Trauma Therapist' (Part 4 in Danylchuk & Connors, 2017: 163-177). A helpful guide to self-care is provided by Coleman, Chouliara & Currie (2018); also see `Self-Care for Therapists who Work with Complex Trauma' at the end of this document.

(10) `VT goes with the territory' (Ross & Halpern, 2009:224)

Awareness of this challenging reality likewise speaks to the high stakes of therapist well-being. Vicarious trauma (`VT') is a risk that is inherent in exposure to traumatic material over time. This is independent of our more particular countertransference responses which may also be complicating and compounding (e.g. `traumatic countertransference'): `*neither clients nor negligent helpers are responsible for VT. Rather, it is an occupational hazard, a cost of doing the work*' (Pearlman & Caringi, 2009:205).

The challenge, then, is one of recognition and management. `*The warning signs of VT are clear `when you are attuned to them'* (Ross & Halpern, 2009:223). But recognising the warning signs of VT can itself be challenging, especially as therapists can unconsciously minimize their own needs (a `professional liability' of the helping professions; see `Self-Care for Therapists who Work with Complex Trauma' at the end of this document). Note that ongoing trauma-informed clinical supervision is helpful with this. Also note that institutional and policy dimensions are critical mediating factors (Pearlman & Caringi, ibid).

When the risks of the work are attended to appropriately, the rewards of helping clients to recover from their devastating experiences can be profound.

References

Benjamin, R., Haliburn, J. et al. (2019) *Humanising Mental Health Care in Australia: A Guide to Trauma-Informed Approaches* London: Routledge.

Bromberg, P. (2011) *Awakening the Dreamer: Clinical Journeys* New York: Routledge.

Bromberg, P. M. [1998] (2001) *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* New York: Psychology Press.

Chefetz, R. A. (2015) *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real*. Norton, New York.

Coleman, A.M., Chouliara, Z. et al (2018) `Working in the Field of Complex Psychological Trauma: A Framework for Personal and Professional Growth, Training, and Supervision' *Journal of Interpersonal Violence* 1 –25

https://rke.abertay.ac.uk/en/publications/working-in-the-field-of-complex-psychological-trauma-a-framework-

Danylchuk, L.S. & Connors, K.J. (2017) *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges.* New York, Routledge.

Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation.* Routledge, New York.

Kluft, R.P. (2006) `Dealing with Alters: A Pragmatic Clinical Perspective', *Psychiatric Clinics of North America* (29), pp.281-304.

Ogden, P., Minton & Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. New York, Norton.

Ross, C.A. & Halpern, N. (2009) *Trauma Model Therapy: A Treatment Approach for Trauma, Dissociation and Complex Comorbidity* Richardson, TXL Manitou Communications.

Schmidt, S.J. (2009) *The Developmental Needs Meeting Strategy (DNMS): An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* (DNMS Institute, Texas www.dnmsinstitute.com

Schwarz, L., Corrigan, F. et al (2017) *The Comprehensive Resource Model: Effective therapeutic techniques for the healing of complex trauma.* New York, Routledge.

Schwarz, R. (2002) *Tools for Transforming Trauma.* New York, Routledge.

Shapiro, R. (2016) *Easy Ego State Interventions: Strategies for Working with Parts* New York, Norton.

Stern, D. (2010) *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment* New York Routledge.

Van der Hart, O., Nijenhuis, E. & Steele, K. (2006) *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* New York: Norton.

Wallin, D.J. (2007) *Attachment in Psychotherapy*. New York, The Guilford Press.

APPENDICES

(1) Features of Complex Trauma of which all Therapists and Health Professionals need to be aware

Lack of a prior `felt sense' of safety

Impaired capacity to self-regulate is a hallmark of childhood trauma
(Courtois & Ford, 2009).

Thus advice to focus on a safe/calming image or feeling may be destabilising (and even the invitation to `focus' per se; see final point below)

Pervasive sense of shame

A `core affect' of complex trauma, shame presents `*not only as an acute emotional state',* but as `*a more fundamental and enduring aspect of…personality structure';*
(Frewen & Lanius, 2015:206)

Thus `*exposure-based therapies may not be the treatment of choice'* (ibid: 207).

`Symptoms' are the outgrowth of coping strategies which were initially protective

`The problem is the solution'; (ACE Study, 1998; 2010; Ecker, 2018); `resilient strategies and maladaptive coping skills' may be `interlaced and occur simultaneously';
(Bloom & Farragher, 2011:16).

Thus `targeting symptoms'- common to many short-term interventions- may be problematic in the absence of practitioner knowledge of possible underlying trauma

High levels of dissociation

`Most people with complex PTSD have experienced chronic interpersonal traumatization as children' and `have severe dissociative symptoms';
(Van der Hart et al, 2006: 112).

Often undetected by clinicians, dissociation (not being psychologically present) impedes the client's ability to focus. Thus mindfulness exercises may be inappropriate and destabilising in the early stages of therapy as mindfulness and dissociation are rival brain activities
(Forner, 2017).

(2) Self Care for Therapists who work with Complex Trauma

`[T]he first line of care should be for the care-givers'
(Rothschild, 2011:134)

`...self-care is an ethical imperative for all therapists but especially for those working with complex trauma'
(Pearlman & Caringi, 2009:216; original emphasis)

The above quotes highlight the importance of practitioner well-being. *The risk of vicarious traumatization is especially high in complex trauma treatment* (Coleman, Chouliara & Currie, 2018). Hence *`[t]he need for good practice guidelines on self-care internationally (ibid).*

It is important to look after and maintain your own wellness and energy levels for you as well as your clients. The following basic points, questions, and tips can help safeguard your well-being:

DIMENSIONS OF WELL BEING:

- Physical
- Emotional
- Organisational *(policies and health of the service in which you work if not in private practice)*
- Consultation with colleagues
- Regular trauma-informed clinical supervision
- Structural and systemic support
- R&R *(is time for rest and relaxation factored into your weekly schedule?)*
- Ability to track your responses *(attune to your body and to somatic cues which may challenge the rationalisation that you `feel fine' and can `carry on' without regular breaks)*
- Your capacity to find meaning *(important when ministering to human distress)*

QUESTIONS TO CONSIDER:

- How do you currently care for yourself in light of the work that you do?
- Do you have a `wellness plan' to which you regularly refer?
- Are there dimensions of self-care that remain in need of addressing?
- To what extent do you track your own (as well as client) responses? *(does consultation with colleagues help you with aspects of this?)*
- Are your attitudes and assumptions to your work and life protective of your own health? *(if not, how can you begin to address this?)*
- From where do you derive your sense of meaning? *(which is critical both to your own well-being and to effective practice)*

For training to help safeguard you against the risks of Vicarious Trauma see https://www.blueknot.org.au/Training-Services/Training-for-your-organisation/Vicarious-Trauma

National Centre of Excellence
for Complex Trauma

Complementary Guidelines
to *Practice Guidelines for Clinical Treatment of Complex Trauma*