A Summary of Self-Trauma Model Applications for Severe Trauma: Treating the Torture Survivor

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John Briere, Ph.D.
Psychological Trauma Program
Keck School of Medicine
University of Southern California

This handout, divided into nine sets of questions and answers, briefly outlines ways in which the Self-Trauma Model can be applied in the treatment of torture survivors and others exposed to severe adult traumas. The reader is referred to Briere (2002) and Briere and Scott (2006) for more detailed information, and additional references are available at *www.johnbriere.com*. Although STM has been used to treat torture effects, it is primarily a way to conceptualize and intervene in any severe trauma. Thus, it should not be seen as a substitute for the torture-specific methodologies you have developed and used in your work. I am honored to join you in this discussion, and have some small experience with torture survivors, but I am not a torture treatment expert.

1) What is the Self-Trauma Model (STM)?

The Self-Trauma Model is an approach to trauma treatment that has evolved over time, first described in 1989 and continuously revised thereafter. Later iterations of STM, for example, have stressed mindfulness and meta-cognitive awareness (defined below). In contrast to some models, this approach focuses not only on the processing of posttraumatic stress, but also on the development or reinstatement of certain "self-capacities:" *identity* (the ability to locate an internal sense of self from which to operate on the world; ideally one that is flexible, as opposed to overly individualistic and unchanging); *affect regulation* (the ability to tolerate and, ultimately, reduce, painful internal states – without resorting to avoidance strategies); and *relatedness* (the capacity to form meaningful, nurturing relationships with others).

This approach suggests that people can be emotionally overwhelmed and symptomatic when trauma-related distress exceeds their relative ability to handle that much distress (i.e., their trauma load exceeds their affect regulation capacity). When overwhelmed, most people will resort to avoidance behaviors, ranging from denial, thought-suppression, and behavioral avoidance, to dissociation, substance abuse, and distracting (but often maladaptive) activities. These responses, although often helpful in the moment, block emotional and cognitive processing of traumatic memories, and thus may lead to chronic posttraumatic outcomes.

Based on exposure and mindfulness theories, it is suggested that recovery will take place to the extent that the traumatized person can experience small increments of non-overwhelming distress in the context of a safe, supportive relationship. Such activities can only occur if the client is able to recall them without being re-traumatized; her or his affect regulation capacity must be sufficient to accommodate the pain associated with greater access to trauma-related material. As a result, the self-trauma model devotes considerable time to teaching the client how to calm himself or herself, using relaxation techniques, grounding procedures, emotional labeling, and mindfulness activities. In cases of severe trauma, affect regulation training may be more important, initially, than therapeutic exposure. However, as noted below, exposure is encouraged, to the extent possible, even relatively early in therapy.

This approach also fosters what Teasdale (1999) has called *meta-cognitive awareness*. In the current context, this means that the client is supported in developing a capacity to view his or her thoughts, feelings, and memories as arising from past experiences (in this case, trauma), as opposed to necessarily representing information on current reality. The ability to discriminate thoughts and memories (based on the past) from current perception (the here-and-now) allows the client to be less reactive when triggered, and to develop a modicum of equanimity. This ability to reflect on one's experience, rather than immediately reacting to it, typically grows over time. It is fostered by discussions of memory and its power, mindfulness training, trigger identification and intervention (see below), and, ultimately, the experience of repeatedly feeling "handle-able" fear and upset in therapy, and coming to realize that such emotions represent the past -- not the present.

Finally, STM interventions are invested in the client's growing *self-reference*. This refers to the individual's ability to consider self-other interactions in terms of what would be best for him or her, as opposed to solely the needs and expectations conveyed (sometimes traumatically) by society or specific perpetrators. This does not mean that the client is encouraged to be selfish or ego-centric, but rather that she has a chance to explore and validate her own entitlements to boundaries, self-determination, wellbeing, and dignity. This serves as an antidote to the *other-directedness* that typically emerges when one is controlled or oppressed from an early age, or massively dominated in adulthood, such that reality comes to be what other people say or want, as opposed to reflecting one's own experience. In treatment, support for self-reference comes from the non-authoritarian manner and demeanor of the therapist, his or her avoidance of excessive interpretations or feedback on "reality," or even excessive advice in situations where it is not necessary. The communication, ideally, is that the client's experience is the important thing; not the therapist's needs, views, or expectations, and that the client may know more about herself and what she needs than she, or others, may realize.

2) STM seems to especially address child abuse effects. Can it be used for adults exposed to severe traumas -- for example, torture survivors?

Yes. Although STM was initially developed in the context of treating adults severely abused or neglected in childhood, it is used much more broadly as a therapeutic approach to severe and complex adult traumas. The central issue involves the balance between negative internal states and the individual's capacity to regulate those states. Because childhood abuse and neglect are potent sources of impaired affect regulation capacity, interventions like the current one have been useful in work with child abuse survivors. However, there is another major way in which emotional distress can exceed affect regulation capacity: adult traumas can be so severe that they overwhelm even "normal" or typically adequate affect regulation. Torture survivors often represent this latter group: they may have developed an otherwise effective affect regulation repertoire in childhood, but the intensity of their adult trauma and violation may overwhelm this capacity. In especially unfortunate instances, there may be both childhood maltreatment and adult torture experiences, potentially leading to very complex adult mental health outcomes.

3) Are flashbacks, nightmares, intrusive thoughts, and "re-enactment" behaviors examples of psychopathology or potentially something more positive?

This is an area in which STM departs from classical medical model approaches to posttraumatic disturbance. It extrapolates from a variety of sources to suggest that the intrusive reexperiencing "symptoms" of PTSD, such as flashbacks and nightmares, represent the mind's evolutionarily-derived attempt to process traumatic memories by selectively allowing them to be triggered in relatively safe environments (Briere & Scott, 2006). Thus, although many torture survivors and

others may be plagued by unremitting flashback, nightmares, and intrusive memories of their trauma, this model suggests that these responses are not evidence of psychopathology, but instead the mind's/brain's attempt to engage in systematic desensitization. From this perspective, for example, a person whose memories of torture are triggered by aspects of his or her current environment is not showing evidence of a disorder, but rather is attempting to extinguish or habituate painful emotional memories by reexperiencing them in a safe context where they are not reinforced by continuing danger.

In optimal circumstances, this means that the "reexperiencing symptoms of PTSD" will eventually result in decreased emotional distress, as painful memories are regularly triggered in safe environments and slowly desensitized. Unfortunately, because some memories are so intense, and the client may have insufficient affect regulation capacities, reexperiencing does not always "work:" instead, flashbacks and triggered memories can be experienced as overwhelming, motivating avoidance responses (e.g., dissociation) that reduce acute distress but undercut processing. In other words, because posttraumatic memories can only be processed when the individual feels the associated emotional distress, avoidance strategies block desensitization by not allowing painful emotions to be activated and go unreinforced.

This does not mean that the therapist makes experience-remote statements to the client such as "your horrible flashbacks are great news: it means you are trying to process!" On the other hand, this perspective can be communicated in a more gentle and gradual manner, wherein the therapist does not pathologize reexperiencing, and finds ways to help the client see that he or she is engaging in a natural healing response – even if it doesn't seem that way. Further, STM counsels the clinician that sustained and chronic flashbacks, nightmares, reenactments, etc., may be evidence that the client is involved in high levels of avoidance, in order to maintain equilibrium – arising from insufficient affect regulation capacities and/or memories are so distressing that any affect regulation repertoire would be insufficient. In such cases, the therapist might teach additional affect regulation skills, work to desensitize memories with careful, titrated exposure activities, and perhaps work on trigger identification issues (described below). Importantly, in such instances, the therapist is not treating the client for the intrusive symptoms of PTSD; he or she is helping the client to do what he or she is already trying to do: process painful memories.

4) Why is the therapeutic relationship so important for survivors of severe trauma? What is the role of compassion?

As a review of the treatment outcome literature reveals, the most powerful components of a given treatment appear to be the quality of the therapeutic relationship and the attunement and compassion evidenced by the therapist. This is especially true for severe traumas such as torture, where distrust is understandably high, alienation and marginalization from post-immigration society is common, and where the client may be easily overwhelmed by memories in the absence of visible, reliable support and caring. Regarding the latter, the client gains from the opportunity to disclose horrendous things to someone who is empathically attuned and responsive, but is not shocked or overwhelmed by what he or she hears. The importance of a positive, engaged, and safe therapeutic relationship cannot be overstated in work with torture survivors and other victims of severe trauma. In fact, in the absence of such a relationship, the client may drop out of therapy or, if she remains in treatment, may not be willing to "let her guard down" sufficiently to process significant aspects of her victimization. This need for a sustained, supportive client-therapist relationship before memory processing can occur may be one reason why shorter-term, less relationship-based clinical interventions seem to have reduced benefits for torture survivors.

Recent work suggests that compassion – the capacity to be nonjudgmentally aware and appreciative of the predicament and suffering of others (and oneself), with a desire to relieve that

suffering – can be especially critical to improvement for those who have been repeatedly maltreated by others. Therapeutic compassion generally involves feelings of unconditional warmth, kindness, and caring towards the client; the experience of which is emotionally, and perhaps even neurobiologically, salutary for both client and therapist (Gilbert, 2009). Fortunately, it appears that compassion can be learned and amplified in the therapist, perhaps especially in the context of mindfulness skill development.

5) How does one increase distress tolerance and affect regulation capacity?

Interventions that increase affect regulation capacity are generally quite helpful for torture survivors and other victims of abuse or violence. Among the skills taught or encouraged during therapy are relaxation, grounding, decatastrophizing, and meta-cognitive awareness.

Although some clinicians teach progressive relaxation to trauma survivors with success, breath training is also effective in this area, and often is learned more quickly. As outlined in various sources, this methodology teaches the client to slow down and deepen her breathing, typically using counting (e.g., 1, 2, 3 on inhalation, and 3, 2, 1 on exhalation) and visual imagery of one's belly filling with air first, followed by one's lung, and then the reverse). Often, relaxation is taught in the first session or two, and practiced when necessary at the beginning of subsequent sessions. Daily practice at home is encouraged, if the home environment is sufficiently safe. It should be noted, however, that some small proportion of individuals may develop paradoxical anxiety when engaging in these techniques – probably because relaxation may be perceived as letting down one's guard and reducing hypervigilance, thereby increasing feelings of vulnerability. In many cases, this reaction can be discussed and normalized, and the client will be able to re-approach relaxation in small increments until it is tolerated and helpful. In a few instances, however, the client and therapist may decide to forego this exercise.

Grounding involves directing the client's attention away from escalating internal states (e.g., overwhelming memories, flashback "storms," panic, dissociative episodes) by having her focus on external stimuli such as her bodily position in a chair, the feeling of her feet on the floor, description of pictures on walls, recitation of the date and, perhaps, location of the therapy office, and sometimes guided movement, such as shifting her weight from one foot to the other, slowly raising her arms up and down, or slowly walking around the room. Some clinicians also suggest that the client make eye contact with him or her, although this is often contraindicated since it may signal aggression or challenge to the client. Similarly, some therapists touch clients as a way to ground them, but this is often problematic because it can trigger flashbacks or memories of violation or intrusion. Grounding activities are typically invoked when the client is feeling overwhelmed and out of control during therapy, but can also be used outside of treatment when she or he is feeling especially triggered, distressed or dissociated.

Decatastrophizing involves some level of interruption or recontextualization of clients' intrusive negative cognitions such as "I'm going to die," "I'm losing control," "he is going to rape me," or "they are out to get me." Such thoughts are often initially developed during abuse, torture, or other interpersonal violence, and can be triggered later by stressful stimuli in the current environment. When this occurs, the client typically has contextually out-of-proportion negative emotional reactions (e.g., terror, self-hatred, fury) that may be further destabilizing. Intervention in such responses often involves identification and discussion of these thoughts (e.g., "Did you have a thought just before you felt so scared?", "where do you think that thought came from?", and "what you were saying to yourself – do you think it was correct?"). Meta-cognitive awareness may be facilitated by working with the survivor to learn how to witness and understand such triggered thoughts as merely memories, "tapes, " "the past," or other phenomena that, although entirely understandable, do not necessarily represent the present, and thus are not "real" in terms of their

affect-stimulating qualities. Two additional interventions, mindfulness training and trigger identification are also used to decrease emotional reactivity, and are discussed separately below.

6) What is titrated exposure and how is it applied to survivors who are easily overwhelmed by memories?

Therapeutic exposure is often described as a procedure wherein the client is exposed to a traumatic memory, typically by talking about it, and, when the associated emotions and thoughts are activated, the client is encouraged to "stay in the feeling" until the distress decreases. Cognitive effects often arise from this process, as well, as the client comes to understand that triggered trauma-related emotions do not lead to any actual negative outcome (e.g., dying of fear, becoming psychotic, being victimized again), and thus are decatastrophized. As the client is repeatedly exposed to the trauma memory, eventually his or her emotional responses fade (habituate) and his or her catastrophizing cognitions abate. Importantly, in the most common form of this technique, *prolonged exposure* (Foa & Rothbaum, 1998), the survivor is asked to focus on a specific event (e.g., a single instance of rape) for relatively long periods of time, and is redirected to this memory whenever she or he appears to be avoiding it by switching topics or declining further discussion.

Aspects of this approach are used in the Self-Trauma Model, but with some significant differences. Most importantly, STM uses *titrated*, not prolonged exposure. Victims of extreme trauma, most certainly torture survivors, may either have reduced affect regulation capacities or, typically, especially powerful trauma memories, such that ongoing, full exposure to them may be destabilizing and possibly even detrimental. Instead, STM counsels titrating (adjusting) exposure to the level that can be accommodated by the survivor, sometimes referred to as "working within the therapeutic window." Many torture victims, for example, cannot tolerate more than a very small amount of even tangential exposure to a trauma memory early in therapy – to try to prolong this exposure would be unhelpful, at minimum. Instead, discussion of "hot" memories (those that produce great emotional distress) should begin only when the client is ready, and should proceed slowly, without many details, until he or she is able to accommodate more intense and specific memories. As small amounts of trauma-related emotional states are carefully activated, but not reinforced (due to the safety of the session), these conditioned emotional states slowly become extinguished. Once parts of the memory lose their ability to activate distress, additional memory can be addressed in the same manner.

In this way, the emotional pain associated with traumatic events is slowly metabolized in the context of non-overwhelming, safe, and empathically-attuned discussions of the past. Further, when the client appears to be engaging in avoidance, his or her wishes are implicitly honored, on the assumption that he or she is titrating her own exposure in order to maintain homeostasis. Also, because STM supports the processing of any traumatic memories that arise in treatment (not just a single one set at the beginning of treatment), the client's change of subject may not be treated as avoidance at all, but rather as a choice to process a different memory or address a different issue.

In many cases, contrary to the principles of short-term therapy and the demands of managed care systems, this process of slowly recalling and discussing traumatic events, always balanced by what the survivor can tolerate and accommodate, may extend treatment to many months, or even years in some cases. Given the years of terror, pain, and oppression many people have experienced, it should not be surprising that this is true.

7) What is mindfulness and how can it be helpful in trauma therapy?

Mindfulness can be defined as the acquired ability to experience the here-and-now, with acceptance and nonjudgment, and without being distracted by the past or future. When developing

mindfulness, the individual learns to observe the constantly emerging and changing nature of his or her thoughts, feeling, and memories, and comes to see these phenomena as transient products of the mind --as neither good nor bad, but rather the logical results of consciousness and memory.

Trauma survivors can be taught mindfulness through didactic interventions (see, for example, Linehan's [1993] Dialectical Behavior Therapy), by reading books on the topic, or in the context of meditation (for example, Kabat-Zinn's Mindfulness-Based Stress Reduction [Kabat-Zinn et al.,1986]). Although sometimes initially alien to individuals who seek traditional Western psychotherapy, mindfulness allows the client to be less emotionally attached and involved in triggered experiences, by encouraging meta-cognitive awareness of the process. Further, because mindfulness can help the traumatized person stay more present during distress, it, by definition, reduces avoidance of distress and thereby fosters emotional processing.

Some interesting work is being done on teaching meditation to trauma survivors, although little has been published to date. As the client learns how to meditate, she practices observing her thoughts and feelings without becoming too psychologically invested in them. In the process of learning to watch these products of the mind -- neither judging nor suppressing them, nor giving them more attention than necessary – the individual may become more cognitively and emotionally centered, thereby experiencing some level of equanimity. It should be noted, however, that the use of meditation with survivors of torture and other severe traumas can be complex. Survivors who are especially besieged by trauma memories may find that they are unable to meditate, or that meditation is associated with increased awareness of intrusive thoughts, feelings, and memories. Further, as mentioned earlier for relaxation, some individuals may experience increased anxiety upon "letting go" of hypervigilance or bodily tension. For these reasons, the clinician and survivor should make joint decisions about the use of meditation, and it should never be imposed on the client without his or her informed consent.

More generally, STM teaches mindfulness through the therapist's overall demeanor and approach to the client. As the therapist conveys compassion, nonjudgment, and moment-by-moment attunement to the client's experience, while at the same time highlighting the difference between activated historical phenomena and the here-and-now, the client is likely to develop a changed relationship to triggered memories and their associated emotional states.

8) What is trigger identification and intervention?

Trigger identification and intervention is a cognitive, affect regulation, and indirect mindfulness technique that is especially helpful for individuals whose traumatic memories are highly triggerable and whose responses are often intense. The best coverage of this intervention is in Briere and Lanktree's (2008) treatment guide for inner city, repeatedly traumatized adolescents. Obviously, such youth are not the only ones suffering this difficulty; torture survivors, combat veterans, victims of sexual assault, and those exposed to prolonged childhood abuse and neglect are all examples of groups that can gain from trigger work.

The underlying basis for trigger identification is the tendency for survivors of extreme or early trauma to be repeatedly triggered by stimuli in their current environment, and, once triggered, to respond as if the event is occurring in the here-and-now (referred to as a "source attribution error" in STM). If the survivor can learn to identify when she is being triggered, however, she can label it as such -- at which point "the facts have changed" and her emotional and behavioral response may change as well. For example, upon being confronted by police, a person who flashes back to a previous torture experience might easily feel terror and try to escape, or seek to protect himself in some way that could be misinterpreted authorities. If, however, this man can recognize that he is being triggered, and is able to tell himself that he is just remembering – not accurately perceiving an impending attack – he may feel less acute fear, and may not engage in behaviors that were

appropriate in the past but unhelpful in the present. Similarly, a person triggered into a rageful state by a minor interpersonal incident might respond differently if she knew she was reexperiencing the past, as opposed to experiencing a major injustice in the present.

Trigger interventions usually involve discussions between client and therapist in the context of a series of questions. These include some version of the following, each of which may be written down by the client on a "Trigger Grid" (Briere & Lanktree, 2008):

What does it mean to be triggered?

Have you ever been triggered? If so, when? What are your triggers?

When you are triggered, what do you usually feel or think? What do you do?

How do you know it when you are triggered?

If you discover you have been triggered, what could you say to yourself? What could you do?

These and related questions are updated throughout therapy, especially after the client has experienced new triggering events. The function of this process is to help the client realize how much of his or her ongoing experience, upsetting times, and perhaps "acting-out" behaviors are triggered phenomena, that, once recognized as such, can be viewed differently and responded to more accurately.

Conclusion

This handout describes some of the central components and perspectives of the Self-Trauma Model as it relates to torture treatment. It is insufficient to fully explain the model, however. In addition, this overview did not address the many socio-cultural issues addressed by STM, especially in the treatment of refugees and individuals in currently oppressive and marginalizing social contexts (Briere & Scott, 2006; Briere & Lanktree, 2008). The reader is referred to broader descriptions of STM for these and other details, as well as workshop conducted on this approach.

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