

# Best practice guidelines for working with adults surviving child abuse

ASCA has conducted a review of the literature pertinent to working with adult survivors of childhood trauma and abuse. Empirical studies and clinical guidelines have been considered.

The following principles are important:

1. Provide a safe place for the client
2. Ensure client empowerment and collaboration
3. Communicate and sustain hope and respect
4. Facilitate disclosure without overwhelming the client
5. Be familiar with a number of different therapeutic tools and models
6. Views symptoms as adaptations
7. Have a broad knowledge of trauma theory and provide the client with psycho-education
8. Teach clients adaptive coping strategies (i.e. teach clients self-care, distress tolerance strategies and arousal reduction strategies)
9. Teach clients to monitor their thoughts and responses
10. Teach clients interpersonal and assertiveness skills

## 1. PROVIDE A SAFE PLACE FOR THE CLIENT

It is often only in a perceived safe environment that those who have been exposed to danger can let down their guard and experience the luxury of introspection and connection (Briere & Scott, 2006). Childhood trauma and abuse, at their core, are about being and feeling unsafe. A framework of physical, emotional and psychological safety is vital. Most people who have been abused need to regain their sense of safety (Briere & Scott, 2006).

Building a trusting relationship with someone who have experienced childhood trauma or abuse can be challenging. People who have been repeatedly hurt in interpersonal relationships have acquired a range of ways to guard against future harm. They are often vigilant, cautious, suspicious and/or angry and instinctively hide certain aspects of themselves and may mislead or block helpers from knowing them too soon (Saakvinte et al., 2000). It takes time for survivors to feel safe enough to reveal their feelings honestly in therapy and develop a trusting relationship with the therapist (Harper et al., 2007).

Even though many survivors may want to talk to their therapist about their feelings, their shame as well as fear of the therapist's response stops them from doing so (Harper et al., 2007). Health professionals need to be patient with survivor clients, and willing to wait until the client feels ready to reveal painful material.

Periodically checking with the client about his/her experience of the therapeutic relationship may help the client identify issues of mistrust. It also gives them permission to talk about what might be interfering with his/her ability to honestly express thoughts and feelings (Harper et al., 2007).

Building a trusting relationship between therapist and client is a prerequisite to addressing traumatic memories or applying any technique – even if that takes months or years (Rothschild, 2003). It involves helping the client loosen the defences they have used to cope with their trauma. If the therapy situation does not feel safe, a loosening of defences can lead to decompensation or even increase vulnerability to further harm (Rothschild, 2003).

## 2. ENSURE CLIENT EMPOWERMENT AND COLLABORATION

Saakvinte et al. (2000) stress collaboration and empowerment as key to working effectively with adult survivors. Survivors benefit most when they participate actively in their treatment and have control over decisions that affect them. For many survivors being cooperative and compliant can replicate feelings of being abused.

Interventions are more effective when they are developed collaboratively (Saakvinte et al., 2000). This can be very difficult when working with clients who are at risk of harm, at their own hands or by others, or at risk of harming others. Saakvinte et al. (2000) explain that collaboration requires acknowledging our responsibility to our clients and the power we have in the relationship while deferring to each client's personal expertise and authority.

It is important for the client to take the lead in therapy (Harper et al., 2007). A study by Ullman et al. (2007) with survivors of childhood abuse found that a perception of control over the recovery process was associated with less distress.

Harper et al. (2007) conducted in-depth interviews with 30 survivors of child abuse six months after discharge from an inpatient trauma centre. This study found that therapists who were patient, understanding and respectful of survivors' need for a sense of control in working towards their own solutions were viewed as most helpful. Survivors found it validating when therapists followed the client's direction as opposed to leading them or pressuring them to follow a specific course of action. Maintaining a sense of control over which therapeutic issues were addressed, and when, helped the survivors manage overwhelming feelings better, and was identified as important. Many participants in this study felt it crucial that their therapists allowed them to reach their own solutions in their own time. Some participants found it helpful to be allowed to focus on present day situations; others found it helpful to focus on abuse-related feelings. Participants also appreciated therapists who gave them choices, and who acknowledged participants' insights and ideas about their own recovery. A woman noted with reference to her psychiatrist, "*She always asks me, and gives me a choice; 'Well, do you want to go this way, do you want to go this way?' So, she makes sure that I'm in control of everything*".

It is important that therapists recognise the abuse survivor's competence to make decisions and to develop solutions (Harper et al., 2007). It is especially important that therapists do not assume that adults abused as children are fragile; they need to refrain from doing for survivors what survivors can do for themselves (Harper et al., 2007). As child abuse survivors have often been taught to attend exclusively to others while dismissing their own needs, it is important to encourage them to value their own needs, honour their own ideas, and become the directors of their own therapy (Harper et al., 2007).

In a crisis situation, ask the client to work with you to make things safer. If the individual must be contained to achieve safety, encourage his/her help or participation. It is always valuable to say what you are going to do before you act and to ask if a client can do it him/herself. The more you can include a client in the process, the more the process becomes a way of helping a client expand his/ her repertoire of coping skills and increasing his/her sense of personal control over his/her own actions and environment. The more you name what is happening and invite the client's collaboration towards achieving safety, the more you differentiate the present from past abuses of power. After a crisis intervention, there should always be a debriefing with the client to discuss what was helpful and what could have been done differently (Saakvinte et al., 2000).

## 3. COMMUNICATE AND SUSTAIN HOPE AND RESPECT

It is vital to communicate and sustain hope and respect when working with adult survivors of childhood trauma and abuse (Saakvinte et al., 2000).

### 3.1 Respect

The health professional's respect for the client is conveyed in many ways, including:

- Forms of address
- Respect for confidentiality
- Punctuality
- Sensitive use of language
- Admitting when you have made a mistake or feel unsure
- Assuming that the client as well as the health professional have valid points of view (Saakvinte et al., 2000).

### 3.2 Hope

Helping professionals who work with survivors serve as trustees for survivors' future possibilities. In our words, actions, and body language, we communicate hope. While it's important to empathise with the survivor's current hurt and despair, it is important to hold onto visions of the survivor's potential future self (Saakvinte et al., 2000).

Rothschild (2003) stresses the role of 'hope' and the importance of identifying and building on the client's internal and external resources. She explains that it is important to help the client identify the resources he/she already possesses (such as: a sense of humour and defence mechanisms, interpersonal resources such as friendships, family, pets, belief system, etc.).

## 4 FACILITATE DISCLOSURE WITHOUT OVERWHELMING THE CLIENT

### 4.1 To disclose or not to disclose?

Disclosure for survivors of child abuse may bring their abuse story back to the surface, and this can be very overwhelming (Harper, Stalker, Palmer, & Gadbois, 2007). Facing memories and experiencing flashbacks can be painful and/or overwhelming, and can trigger automatic childhood responses such as running away, avoidance or denial (van Loon & Kralik, 2005c). Some professionals who feel there is nothing to be gained by going back over past experiences, nor delving into them. Others believe that disclosure externalises those past experiences, and disentangles the issues they invoke from who the survivor really is, making it possible to separate the survivor from the abuse experiences (van Loon & Kralik, 2005c).

Some survivors find disclosure helpful, others do not. If a survivor does not want to disclose, they may not be ready, or this may not be a necessary part of their 'recovery journey'.

For example, the survivor participants in a study by van Loon & Kralik (2005b) concluded that their needs in respect to disclosure varied. Some survivors found that they did not need to dig too deep because the process of exploring could become re-traumatising. Others explained that it was important to acknowledge that the abuse happened and speak about the aspects of the abuse story that related to the impacts of the abuse, rather than the details of what happened. Survivors should never be 'forced' to disclose their past experiences.

Survivors who participated in a study by Harper et al. (2007) also hold differing experiences. Some found it important to explore the past; others found it helpful to move on from the past and focus on present day issues.

### 4.2 Barriers to disclosure

The survivors in the study by van Loon & Kralik (2005a) noted that they minimised, discounted and ignored the fact they had been sexually abused during childhood, or for most of their lives. The reasons for this varied, but they included shame and embarrassment; fear of retaliation from the perpetrator and concern that they would not be believed. This led to many women discounting their experiences, denying they happened or choosing to block them out.

**Barriers that prevent survivors from seeking help (and inhibit disclosure) include:**

**Coping strategies:**

Many survivors use the protective defences learned in childhood such as denying, minimising, or dissociating to cope with their situation (van Loon & Kralik, 2005a). Complete or partial denial, minimization, and even total repression of the abusive event/s inhibit the survivor's ability to seek and receive help. These strategies keep the survivor from knowing just how terrible things actually are. Changes in the survivor's ability to think clearly are not easily observed when patterns of covering up are ingrained as survival skills (Walker, 1994).

Another coping strategy commonly used by survivors of childhood abuse is 'pleasing and compliant behaviour'. Survivors of childhood abuse learn to anticipate the emotional reactions of another person to their behaviour. They have learned that pleasing the abuser is one way to reduce the amount of abuse. Preventing the abuser from seeing how emotionally upset they are (sometimes because the abuse will be worse if they show their feelings) is a coping strategy. This need to please and to follow directions may be carried over into the therapist's office. Such clients want to be liked and to please, feeling that the therapist will protect them if they are ingratiating. It is important to understand the significance of this behaviour and to respond sensitively, respectfully, and helpfully (Walker, 1994).

**Self blame**

Self-blame is another common sequela of abuse. The survivor holds her/himself accountable for the victimization: If she/he had not done something wrong, then the abuse would not have occurred. This attribution helps the survivor retain the illusion that she/he has power and control over not being hurt again (Walker, 1994).

**Shame and guilt**

Shame and guilt are common sequelae of abuse. Shame and/or guilt can make it difficult for the survivor to seek or to accept help. Shame is the internal feeling that comes from being exposed and vulnerable, whereas guilt is an externally imposed feeling that comes from believing that something wrong was done (Walker, 1994). Survivors of child abuse may experience guilt because they may have been blamed for the abuse. Survivors of childhood abuse may even think they 'asked for it', 'invited it' or 'deserved it' (van Loon & Kralik, 2005a). Survivors may be experiencing hurt, embarrassment and shame over what happened, so it seems easier to remain silent about the incident (van Loon & Kralik, 2005a).

**The ability to hide one's true feelings**

Most treatment approaches are highly dependent on cognitive understanding and insight into one's thought processes, affective responses, and behaviour. Many women have learned how to hide their true thoughts and feelings from scrutiny, allowing only those consistent with mainstream culture to be viewed by others. This ability to hide one's real thoughts and feelings is frequently enhanced by the impact of abuse. After all, safety from further abuse may seemingly depend on the ability to keep the abuse secret, sometimes even from oneself (Walker, 1994).

**Fear of punishment from the perpetrator**

Perpetrators may actively and aggressively attempt to block the survivor's access to any help (Walker, 1994). Fear of the perpetrator's threats, punishment, rejection, negative reactions, being treated differently, upsetting parents or breaking up the **family also inhibit access to help (van Loon & Kralik, 2005a).**

#### **Fear of the therapist's response**

Many survivors fear that no one will believe them, that their account of the abuse will be dismissed as a fabrication, an exaggeration, or an attempt to evade the true work of psychotherapy (Walker, 1994).

#### **Confusion**

Survivors may feel especially confused if some aspects of the abuse felt enjoyable, exciting and sensually stimulating. In addition, possible mixed emotions of love for the perpetrator and hate for what they have done may also inhibit access to help (van Loon & Kralik, 2005a).

#### **Difficulties putting trauma into words**

The relationship between the difficulties expressing traumatic events in language experienced by some survivors of childhood abuse and the brain's neural connections has been explored by a number of researchers (for example, MacKay, 2008). Research shows that a less developed trauma narrative hinders recovery from trauma (Amir, Stafford, Freshman, & Foa, 1998). During states of high arousal (such as danger) the area of our brain responsible for speech becomes inhibited, which results in a diminished capacity for language in certain situations (Cozolino, 2008). This is a high price for humans to pay for being afraid. Putting our feelings into words and constructing narratives of our experiences contribute invaluablely to emotional regulation, the integration of neural networks of emotion and cognition, and the experience of a coherent sense of self (Cozolino, 2008).

#### **Fear of being ridiculed or not believed**

Many adult survivors of child sexual assault speak of their experiences of being blamed, ridiculed, or shunned, when they tried to disclose (van Loon & Kralik, 2005a).

### **4.3 Responding appropriately and safely to disclosure**

A primary goal of self-trauma therapy is to avoid overwhelming the client, while at the same time facilitating exposure to traumatic material so it can be desensitised and integrated (Briere, 2004). Effective therapeutic responses occur on a continuum, between interventions devoted to a greater awareness of potentially threatening, but therapeutically important material (exposure), and those that support and solidify previous progress (consolidation). Consolidation is concerned with safety and involves activities that reduce arousal and ground the client in the here and now (Briere, 2004).

#### **'Active listening skills'**

Most survivors of abuse find talking, in general, cathartic and talking about the pain caused by their abuse history useful in particular. Therapists who listen to the survivor, ask clarifying questions, name the survivor's experiences, and do not overly challenge what the survivor says, help the survivor make the most progress. Once the relationship

is well-established, it may be appropriate to offer interpretations, but until then, it is most therapeutic to point out contradictions but not offer opinions as to their possible psychological origins. Active, direct participation in validating the survivor's perceptions, feelings, and experiences, in addition to acknowledging the information being shared, and checking to make sure it is appropriately understood, are all important parts of treatment. Often, simply repeating what the survivor has said out loud helps to validate her/his thoughts and feelings in ways that they have never been validated before. Simple but powerful, this may be the best approach a therapist can take even if the survivor is not ready to deal with other issues at that time (Walker, 1994, van Loon & Kralik, 2005a).

In addition, research shows that 'ignoring the disclosure' or 'rushing them' is experienced as particularly harmful by survivors of child abuse (Josephson & Fong-Beyette, 1987). Elie Wiesel a Holocaust Survivor is quoted as saying "What hurts the victim most is not the cruelty of the oppressor, but the silence of the bystander". This is also true for the survivor of childhood abuse who discloses and is met with silence, or tells and is not believed, or tells and sees no further supportive action as a result of disclosing (cited in van Loon & Kralik, 2005a).

## 5 BE FAMILIAR WITH A NUMBER OF DIFFERENT THERAPEUTIC TOOLS AND MODELS

It is important to adapt the therapy to the client, rather than expecting the client to adapt to therapy. This requires the therapist to be familiar with several theories and treatment models (Rothschild, 2003). Rothschild (2003) explains that competition regarding the superiority of one method or model over another is fierce in trauma therapy. This trend puts clients in a difficult position: Should they prioritize choosing a method or is it more important to find a practitioner who is a good fit? Too many trauma therapists offer only one technique and this limitation can compromise client commitment when that particular method fails. It is important for therapists to be trained in several treatment modalities so that treatment plans can be tailored to the needs and tastes of the client

## 6 VIEW SYMPTOMS AS ADAPTATIONS

It is important to view the client's current behaviour in light of their abuse history. The essence of a trauma model is recognition of the trauma in relation to the current behaviour, and recognition of trauma symptoms. It is important to focus on encouraging a change in how the client interprets his/her symptoms and maladaptive behaviours (Harper et al., 2007). It is the health professional's responsibility to reframe the client's responses to the abuse. It is important to understand that the coping strategies survivors used as a child were functional for the child-victim dealing with the abuse, but may not be helpful in present life situations. Reframing feelings and behaviour as coping strategies that were adaptive to surviving past abuse can be the beginning of positive change. A study by Harper et al. (2007) showed that survivors find it helpful when professionals help them see the connection between their current symptoms and behaviour, and their history of abuse (Harper et al., 2007). Participants emphasized that it was very

helpful to their recovery process when therapists assisted them to understand their feelings and coping strategies in the context of their specific abuse history (Harper et al., 2007).

## 7 HAVE A BROAD KNOWLEDGE OF TRAUMA THEORY (BOTH THE PSYCHOLOGY AND PHYSIOLOGY OF TRAUMA) AND PROVIDE THE CLIENT WITH PSYCHO-EDUCATION

### Psycho-education

In the literature, much attention is paid to the cognitive and emotional processing of traumatic memories. Psycho-education is an important aspect of trauma therapy (Briere & Scott, 2006). Health professionals can assist survivors by providing accurate information about the nature of trauma and its effects, and by working with the survivor to integrate this new information and its implications into his/ her overall perspective (Briere & Scott, 2006).

Rothschild (2003) explains that by understanding how the brain and body process, remember, as well as perpetuate traumatic events, the client learns how to regulate affect and pain.

Survivors of childhood abuse find it helpful when their therapists help them relate their intense feelings and maladaptive coping strategies to the trauma. Survivors who participated in the study by Harper et al. (2007) emphasized that it is very helpful when their therapists were knowledgeable about PTSD and trauma-focused treatment. Participants appreciated when their therapists researched new information and techniques, and informed them accordingly. It is important, therefore, that professionals understand the psychological effects of trauma.

### Self-help

To figure out the best way for clients to use reading materials, talk with them about their individual learning styles. What have they read already? How did the reading affect them? Encourage them to notice their reactions, thoughts, and feelings, and to stop reading if they feel distressed or overstimulated. Give clients the opportunity to talk with you about what they have read and their response to the material.

## 8 TEACH CLIENTS ADAPTIVE COPING STRATEGIES

Even though childhood coping mechanisms were functional at the time of the abuse, many are no longer constructive in present life situations. Therefore, it is important to teach survivors of child abuse more adaptive coping strategies. It is important to help survivors develop more adaptive coping strategies rather than risking making matters worse by getting rid of clients' maladaptive defences and leaving them with no coping strategies. Rothschild (2003),



A study by Harper et al. (2007) found clients rated professionals helpful when they could reinforce or teach strategies for managing the intense affect associated with traumatic childhood abuse.

Clients can be taught more adaptive coping strategies by teaching them self-care strategies, distress tolerance strategies, and arousal reduction strategies. Research into the adverse impact of child abuse on brain development and hormone secretion, highlights the importance of engaging in self-care, and arousal reducing activities to promote healthy neuro-endocrine functioning.

The link between a history of childhood abuse and neglect, and neuro-endocrine impacts, including alteration in cortisol production, has been well established (Joyce et al., 2007; Linares et al., 2008). The neuro-endocrine system refers to the system of interaction between our brain/nervous system and the hormones in our bodies. This system helps regulate our moods, our stress response, our immune system, and our digestion, amongst other things. Any disruption to the neuro-endocrine system affects a range of basic psychological and physiological functions. Research suggests that many of the long-term impacts of child abuse experienced by adult survivors result from the chronic neuro-endocrine dysregulation caused by prolonged exposure to abuse and violence (Kendall-Tackett, 2001). Neuro-endocrine dysregulation, in particular an overproduction of the stress hormone, cortisol, may contribute to the difficulties some survivors of childhood abuse experience in tolerating distress.

Research tells us that the bodies of children who are being abused react and adapt to the unpredictable, dangerous environments to which they are exposed. Their nervous systems run constantly on high as they anticipate further danger; this floods the body with fight-or-flight hormones Cozolino (2002). For example, a study by Linares et al., (2008) shows a neuro-endocrine alteration in cortisol production in children with histories of abuse and neglect. This state of chronic “hyper-arousal” persists for many survivors throughout their adult years as well. Even when the abuse and violence has ceased and the environment is ‘safe’, many adult trauma survivors still perceive the threat to be present; their fear is maintained and becomes pathological (Giarratano, 2004b). Research shows high cortisol levels in adult survivors of childhood abuse. A study by Joyce et al. (2007) found that mothering styles that were high in control but low in affection, childhood sexual and physical abuse were all associated with high cortisol levels in depressed adult survivors.

The good news is that a range of interventions and skills can promote healthy neuro-endocrine function. Engaging in activities that reduce stress, such as self-caring activities, distress tolerance strategies, arousal reducing strategies, etc., has been shown to normalise the nervous system and balance hormone levels.

## 8.1 Teach clients self-care strategies

Self-caring activities and learning how to soothe themselves emotionally are important skills for survivors. Engaging in self-care activities can be especially challenging for survivors who may have never learned to ‘self-soothe’ or ‘self-care’. In the act of neglecting, hitting, insulting or abusing a child, an adult sends a clear message to that child that the child is without value or worth. Many abused children grow to adulthood believing that they do not deserve

to experience love, care or warmth. In addition, parents who abuse are often poor at soothing themselves and, consequently, at teaching their children to self-soothe (The Morris Center, 1995). Learning self-care can be a challenge for adult survivors of child abuse, since it requires survivors to develop a radically new understanding of themselves as human beings with the right to feel comfortable, safe and worth-while.

To strengthen clients' sense of self acceptance and self care some of the following strategies can be recommended:

- Call someone (crisis line, clergy, sponsor, therapist, case manager, friend)
- Think of someone you trust and imagine a comforting conversation with him/her
- Keep a list of people you can call in an obvious place; look at it when feeling alone; call someone on it
- Write a letter
- Repeat affirmations (“I deserve to live,” “I deserve to be treated kindly”)
- Remember that being treated badly in childhood was not fair and you deserve to have it different now
- Do something that makes you feel better about yourself; garden, help someone else, cook, be productive, work on a charitable or political project.

## 8.2 Teach clients distress tolerance strategies

Saakvinte et al. (2000) explain that childhood abuse interrupts the normal development of a person's ability to identify and regulate their feelings. In this light, a number of trauma frameworks emphasise the importance of learning skills to regulate feelings (Briere, 2004; Linehan, 1993a; Saakvinte et al., 2000). In the absence of adequate affect regulation skills, even small amounts of distress may be experienced as overwhelming and thereby motivate avoidance (Briere, 2004).

The possible over-production of the stress hormone, cortisol may contribute to the difficulties tolerating distress experienced by some survivors of childhood abuse. In addition, most survivors never learn to self-soothe in childhood because parents who abuse are also often poor at soothing themselves and, consequently, at teaching their children to self-soothe (The Morris Center, 1995). The lack of childhood 'nurturing' experiences, and the lack of being taught how to look after yourself or 'self-soothe' also contributes to difficulties tolerating distress. Acquiring distress tolerance strategies or self-soothing techniques are important for those with histories of childhood abuse.

Many current approaches to mental health treatment focus on changing distressing events and circumstances. They pay little attention to accepting, finding meaning for, and tolerating distress. Dialectical behavioural therapy emphasizes learning to bear pain skilfully (Linehan, 1993b, p. 96). Distress tolerance skills have to do with the ability to accept, in a non-evaluative and non-judgmental fashion, both oneself and the current situation. Although the stance advocated is a non-judgmental one, it is not one of approval: acceptance of reality is not approval of reality. Distress tolerance behaviours are concerned with tolerating and surviving crises and with accepting life as it is in the moment. Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons (Linehan, 1993b).

## 8.3 Teach clients arousal-reduction tools i.e. always ‘reduce the pressure’

In situations of early childhood abuse, the trauma and shock of the abuse interferes with the ability to regulate emotions, causing frequent episodes of extreme/out of control emotions, including anger and rage (Linehan, 1993a). Arousal-reducing tools can assist survivors in regulating their emotions.

As explained previously, a state of hyper-arousal is a natural response to a dangerous situation or threat. Many survivors of trauma remain in a constant state of alarm because the fight/flight response is triggered repeatedly (Giarratano, 2004b), and without evident purpose (Cloitre, Cohen, & Koenen, 2006). A state of hyper-arousal may include feelings such as anger or anxiety.

A state of **anxiety** is common among trauma survivors because it is typically generated by experiences that are unpredictable, uncontrollable, or unfamiliar, i.e. the characteristics of trauma or danger. Anxiety ensures readiness for coping with an unidentified danger (Cloitre et al., 2006) and so has an adaptive function. This may be because multiple, unidentified trauma reminders exist in the environment that trigger anxiety, or because trauma causes survivors to psychologically, and biologically, adapt to ‘living in a dangerous world’ (Cloitre et al., 2006). Teicher (2002) explains that early exposure to stress creates molecular and neurobiological change, altering neural development so the adult brain can survive in a dangerous world.

**Anger** is usually a central feature of a survivor's response to trauma because it is a core component of the survival response in humans. Anger helps people cope with life's adversities by providing increased energy to persist in the face of obstacles. High levels of anger are related to a natural survival instinct (Chemtob, Novaco, Hamada, Gross, & Smith, 1997).

Symptoms caused by hyper-arousal include:

- Having a difficult time falling or staying asleep.
- Feeling more irritable or having outbursts of anger.
- Having difficulty concentrating.
- Feeling constantly ‘on guard’ or like danger is lurking around every corner.
- Overbreathing, hyperventilating
- Being ‘jumpy’ or easily startled (Giarratano, 2004a)

### 8.3.1 The importance of always reducing ‘the pressure’

When working with survivors of childhood abuse, it is important to use arousal reducing techniques or, as explained by Rothschild (2003), to ‘reduce the pressure’. Rothschild (2003) draws on an understanding of the physiology of the brain and how it responds to danger, emotion and traumatic events, to illustrate the hazards of addressing traumatic material before the client is equipped to manage the process. She explains that traumatic memory can be easily triggered, accelerating hyper-arousal out of control, causing intense physical symptoms and/or flashbacks. Until triggers are identified, they are unpredictable. In order for clients to feel safe in life and therapy, they need to be equipped with tools to help them contain reactions to therapy and triggers, and to halt the out of control

acceleration of hyper-arousal. Being able to apply the brakes aids clients in daily life, and also gives them the courage to address difficult issues (Rothschild, 2003). Rothschild (2004) stresses the importance of never helping clients call forth traumatic memories unless the therapist and client are both confident that the flow of anxiety, emotion, memories, and body sensations can be contained.

Arousal-reduction strategies make it possible for clients to have control over their traumatic memories, rather than feeling controlled by them (Rothschild, 2004).

Knowing when to ‘apply the brakes’ is as important as knowing how. The timing can be gauged by watching for physical signals of autonomic system arousal transmitted by the client’s body, tone of voice and physical movements (Rothschild, 2004). When the client turns pale, breathes in fast, takes panting breaths, has dilated pupils, and shivers or feels cold, the part of the nervous system that is activated in states of stress (i.e. the sympathetic nervous system) is aroused. Stress hormones are pouring in. These symptoms mean it is time to calm the client down. When a client sighs, breathes more slowly, sobs deeply, or flushes the part of the nervous system that is activated in states of rest and relaxation, the parasympathetic nervous system, has been activated, and stress hormone levels are reducing (Rothschild, 2004).

### **Physiology of the brain**

As explained previously, the limbic system (amygdala and hippocampus) is the area of the brain that initiates the fight, flight or freeze responses to perceived threat. The cortex (the more rational, outer-layer of the brain) is the seat of our thinking capacity. The cool, rational cortex is in constant communication with the amygdala and the hippocampus. The amygdala processes emotions before the cortex gets the message that something has happened. For example, the sound of a loved one’s voice is communicated to the amygdala, and the amygdala generates an emotional response to that information (for example, pleasure) by releasing hormones. When someone is threatened, the amygdala perceives danger and sets in motion a series of hormone releases that lead to the defensive response of fight, flight or freeze. The hippocampus helps to process information and assists in the transfer of initial information to the cortex which works to make sense of the information. The hippocampus is vulnerable to stress hormones, in particular the hormones released by the amygdala’s alarm. When those hormones reach a high level, they suppress the activity of the hippocampus and it loses its ability to function. Information that would make it possible to differentiate between a real threat and an imagined threat never reaches the cortex meaning that a rational evaluation of the information isn’t possible. Therefore, the amygdala continues to sound an alarm inappropriately.

**As such, safe and successful trauma therapy needs to maintain stress hormone levels low enough to keep the hippocampus functioning (Rothschild, 2004).**

### **8.3.2 Arousal Reducing Strategies**

#### **Distracting your thoughts**

Exercises designed to distract can be helpful when attempting to reduce states of hyper-arousal (e.g. anger, anxiety).

### **Breathing control exercises**

Increased respiration is one of the body's fight/flight responses. Trauma survivors whose response is firing too rapidly can chronically over-breathe. This can lead to hyperventilation and may contribute to panic attacks in some people (Giarratano, 2004b). Controlled breathing techniques are used to slow the respiration rate. Our breathing rate has an impact on our heart rate, blood pressure and the rest of our body. Breathing at the correct rate slows the bodily processes, lowers arousal, and in turn reduces tension and stress. Slowing the breathing rate is an effective method of turning off the 'fight/flight' response. The breathing rate normally increases in the presence of a perceived threat.

It is helpful to use controlled breathing techniques at the first sign of anxiety or panic. It might be helpful for clients to use these techniques before tackling difficult situations, and anytime they are feeling tense or anxious

## **9 TEACH CLIENTS TO MONITOR THEIR THOUGHTS AND RESPONSES**

Cognitive Behavioural Therapy (CBT) can be an effective tool with trauma survivors. CBT works with cognitions to change emotions, thoughts and behaviours. The goal is to understand how certain thoughts cause stress and make symptoms worse. CBT for trauma includes learning how to cope with anxiety and negative thoughts; managing anger; preparing for stress reactions; handling future trauma symptoms; addressing urges to 'self-soothe' with alcohol or drugs and communicating and relating effectively with people (National Centre for PTSD, 2008). The CBT model, when used with survivors of child abuse, usually focuses on the 'here and now' rather than on revisiting the trauma itself (Henderson, 2006).

## **10 TEACH CLIENTS INTERPERSONAL AND ASSERTIVENESS SKILLS**

A child should not equate his/her dependence on an adult for nurture, safety, love and connection with taking a risk. Once betrayed however, future attachments and interpersonal connections do require risking disappointment and perhaps shame, neglect and/or abuse. In adulthood, survivors of childhood abuse often find it risky to make connections between their past and present, their thoughts and feelings. Most survivors need the support of interpersonal connections to restore meaning and wholeness in their lives (Saakvinte et al., 2000).

Impairments in interpersonal relationships are of crucial importance for understanding the effects of child abuse on mental health outcomes. Research consistently shows that child abuse is linked with difficulties in interpersonal relationships. In a study by Collishaw et al. (2007) almost half of those reporting abuse in adulthood showed significant abnormalities in interactions with peers in adolescence. At the same time, peer relationships in

adolescence emerged as one of the strongest predictors of resilience within the abused group. This study found that only those individuals with good relationship experiences across childhood, adolescence and adulthood are likely to demonstrate resilience. Collishaw et al. (2007) explain that children who have experienced abuse are less likely to bring positive expectations or interpersonal strategies to a relationship. Instead they may see others as untrustworthy and unpredictable, and relationships as a potential source of conflict rather than a source of support and enjoyment.

A core component of DBT (dialectical behaviour therapy) is teaching clients interpersonal response patterns. These skills are very similar to those taught in many assertiveness and interpersonal problem-solving classes. They include:

effective strategies for asking for what one needs

saying no, and

coping with interpersonal conflict

Linehan (1993b) suggests that it is helpful for interpersonal skills' training to focus on situations where the objective is to change something (e.g., requesting that someone do something) or to resist changes someone else is trying to make (e.g., saying no). The aim is to maximize the chances that a person's goals in a specific situation will be met, while at the same time not damaging either the relationship or the person's self-respect (p. 70).

## Donate Now!



## Partners



## Testimonials

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5. **5**
- *I commend this workshop to service providers and those involved in social services to ensure you are up to date on the issues surrounding caring and appropriate responses to people who have experienced child abuse.* **ALAN WOODWARD**

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