

Questions Asked During Live Webinar Broadcast on 05/10/2017



Developmental Trauma Disorders

Presenter: Malcolm Horn, LCSW, MAC, SAP

How do you feel about CPT (Cognitive Processing Therapy) for PTSD following the 12 week program?

A: As I am not as familiar with CPT as I am with the broader CBT, my answer may not be as succinct as it could be. However, from what I know about CPT, it seems like it would be a good adjunct to other modalities. If the patient already has good coping tools, then CPT would be great—it sounds a little like EMDR in the sense that it helps the patient process through the trauma. If they don't have coping tools, then I'm not sure CPT would be effective. I really like Seeking Safety for trauma and substance use—Seeking Safety helps patients manage the symptoms of PTSD that they have likely been self-medicating with substance use. Personally, I think each clinician needs to have several different modalities in the “toolbox” because each patient is in a different place and has different needs.

<http://www.treatment-innovations.org/seeking-safety.html>

How long do you allow your client to repeat the trauma over and over in group or in individual sessions? I have had a client for over 2 years who is a vet and has childhood abuse who never talks about the present good stuff but just continues to repeat the PTSD events. Others in my DBT class get frustrated with him doing this.

A: I don't really allow them unless I see a benefit. If a patient continues to repeat their trauma and talk about it in group but isn't making progress on treatment goals, then I have to wonder why they continue to share it. I have had several patients that enjoy the “victim” stance and seem to want to stay as a victim because it gives them a good reason to not have responsibilities. I may pull them into an individual session and talk to them more about where they want to go (what their goals are) and how their trauma may be interfering. I have a couple patients that like to use their trauma as an excuse to continue to use; for these clients, I do not sit through processing with them (because we already have done so and it tends to pop up when I am confronting problematic behavior such as drinking or avoiding responsibilities). Processing trauma is good and can be healing—being stuck in it and not trying to work through it is a problem. There is a distinction between those that cannot work through it and those that do not want to work through it.

I work in a juvenile detention facility, so we don't usually have them long term. Any short term interventions you would recommend?

A: Seeking Safety. I love this modality—it's great for PTSD and SUD. It helps clients identify and utilize safe coping tools to deal with the PTSD. I like this modality because it's also empowering and gives control for their recovery to the client. I also like it because you don't have to be licensed to use it. It's very flexible and you can tailor it to the needs of your group or individual.

<http://www.treatment-innovations.org/seeking-safety.html>

<http://www.rehabs.com/pro-talk-articles/seeking-safety-an-evidence-based-model-to-address-trauma-and-addiction-together/>

Are Dr. Feletti's writings the best place to start for further study of ACE's? Who else should I be reading/researching?

A: There are so many great authors and works:

William Foege, M.D.

Bessel van der Kolk (leading author on the paper to have Developmental Trauma Disorder included in DSM-5, author of *The Body Keeps Score*)

Gabor Mate (author of *When the Body Says No*)

Peter Levine (author of *Waking the Tiger* and *In an Unspoken Voice*)

Tian Dayton and Claudia Black also have some great works on childhood trauma, emotional abuse/neglect and how they image adults.

I also recommend the websites: <https://www.cdc.gov/violenceprevention/acestudy/index.html> and

http://www.preventchildabuse.org/images/docs/anda_wht_ppr.pdf and

<https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>

Somatic therapies are often used in treatment of complex trauma. At what point in substance abuse treatment would such treatments most likely prove useful?

A: It depends on the severity of the somatic issue and if the patient sees it as being connected to their trauma. If it's relatively mild (headaches or stomach problems that do not significantly interfere with engaging in treatment or life) then I start with educating the client about stress and ways for them to be in-tune with their body and what it is telling them. I also try to work on helping them tolerate their discomfort—that it is ok to not always feel great. Helping them identify how their body is communicating to them and then identifying how to cope with it: for example, stretching, yoga, deep breathing, mindfulness. If their trauma is severe and they would benefit from biofeedback or other therapies, then I refer them out since that is not a skillset I feel proficient using. I often feel that my “specialty” is really about figuring out how to put as many tools in the hands of the patient (which often means I send them to someone else or collaborate with someone else).

Of course, the first thing to do is make sure that there isn't an actual medical condition that needs treatment.

When having a session with a child who you believe has adverse childhood experiences, what are some examples of questions you could ask to get the child to open up to you if you are having trouble getting them to talk with you?

A: I don't. Kids often do not respond to direct questions. I sit with them, we play, draw pictures: my goal is to create a safe place for them with a safe adult. At some point (after I know them better) I may be able to ask them things like “I hear you got in trouble at school yesterday—what happened?” I may ask them very open and broad questions “tell me about your mom” or “what are your favorite things to do?” If I suspect or have proof that they have significant trauma, I refer them to someone that specializes with kids & trauma. I only have a few kids that I work with and I only work with them because I also work with their parents. I wish I was more helpful with this question but kids are not my forte.

Would you do something in the first session to help a client manage their emotions? (For example, teach him/her a breathing technique, give him/her a handout on meditation, etc.)

A: Absolutely. When I know someone has trauma, my first session has two objectives: 1) explain and educate them about trauma and how it affects the brain—the limbic system, fight/flight/freeze, and 2) give them some techniques they can use that day. Deep breathing and mindfulness are the two I use the most. If I have time, I also convey to them that the symptoms they are having are reasonable and normal: that it is ok to feel how they feel and that there is no shame. Particularly those that were traumatized by their family, they have deep feelings of shame and poor self-esteem, so I want to relieve them of that.

What are some ways to keep a client engaged without a legal mandate? No shows and cancellations are high especially with this population until their trust issues are addressed.

A: Good question. Motivational Interviewing from the get-go. I also work really hard to make it “safe” to leave treatment and come back when they are ready. Unfortunately, many of our clients do struggle to stay engaged and to have internal motivation; making sure that they know working on their trauma (or their SUD) can happen at their pace is a key goal of keeping them engaged.

Do you know of studies that show which groups of people are more likely to experience DT? I would imagine that they closely mirror those groups and ethnicities more subject to addiction from poverty.

A: While DT is seen across all populations, certainly those coming from a lower socioeconomic group and minority groups are at risk. I do not have research that backs that up, only my own professional experience and knowledge about those that are at risk for SUD (often a correlation for DT).