

1-1-2011

Effective Treatment of Complex Post Traumatic Stress Disorder and Early Attachment Trauma

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- Section II entails a critical review of scholarly literature on the chosen topic
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Effective Treatment of
Complex Post Traumatic Stress
Disorder and Early Attachment Trauma

By

Emily Brown Murphrey, MA, LPC

A Doctoral Project Presented to the
Graduate School of Professional Psychology in
Partial Fulfillment of the Requirements for the
Degree of Doctor of Psychology

University of St. Thomas

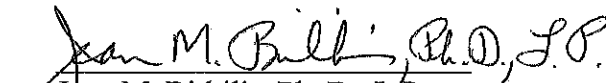
2011

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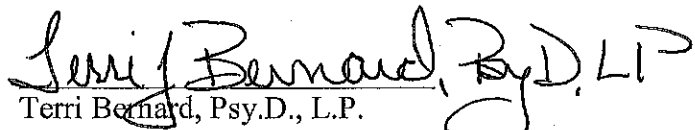
Graduate School of Professional Psychology

This doctoral project was submitted by Emily Rebecca Brown Murphrey, MA under the direction of the chair of the doctoral project committee listed below. It was submitted to the Graduate School of Professional Psychology and approved in partial fulfillment of the requirements for the degree of Doctor of Psychology at the University of St. Thomas.

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Abstract

Research on and disagreements regarding the appropriate treatments for various types of traumas have existed throughout the history of psychotherapy. While approaches have differed over the years, current research suggests that prolonged exposure therapy, long considered the most efficacious treatment for single incident trauma, may be at best ineffectual for treating the condition known as Complex Post Traumatic Stress Disorder, and at worst possibly even deleterious. This project examines the recent literature on Complex Post Traumatic Stress Disorder and Early Attachment Trauma. The project then examines literature that suggests a more effective phase-oriented approach for treatment of Complex Post Traumatic Stress Disorder, and finally offers an original group curriculum that can be used to work with parents and survivors of Complex PTSD when the underlying issue is early attachment trauma.

Acknowledgements

In acknowledging contributions to this project, I must begin at the beginning: to the entire faculty and staff of the Graduate School of Professional Psychology, I thank you for your tireless work and endless dedication to furthering my education and skills as a clinician. Special thanks go to Dr. Jean M. Birbilis, Dr. Mary Brant, and Dr. Skip Nolan. Dr. Brant was my initial committee chair and was a consistent source of support and encouragement. Her dedication and scholarship challenged me to be a better clinician, and her belief in me often kept my head above the water. Her influence remained throughout the course of this project even after she herself had gone. Dr. Nolan picked up where Dr. Brant left off and words cannot begin to express all of the many gifts and life lessons he has given me. Again, my successes as a clinician now and in the future are owed to him (any failures I claim for myself!). Finally, I must acknowledge and thank Dr. Jean Birbilis, who when the time came for Dr. Nolan to move on as well, stepped into the position of committee chair with grace and selflessness for which I will be eternally grateful. Thank you for keeping me focused and on task even when I feared the end was nowhere in sight.

I would be remiss not to recognize the extraordinary clinical supervision I have received during my graduate school career: Dr. Lynn Strauss, Dr. Skip Nolan, Dr. Jean Birbilis, Dr. Larry Kivens, Carla Mortensen, Dr. Betsy McCullough, and Dr. Terri Bernard. You have each contributed your own unique gifts to my career and my personal development; I could not do this work without your contributions.

To the members of Cohort XIV, you were each amazing in your own way. We shared much laughter, a few tears, and a great deal of commiseration throughout this

process, for which I thank you all. Special thanks go to two cohort members particularly: To Peggy Brown, your insights, wit, and overall caring made an often overwhelming task bearable. To Andrew John, your intelligence and clinical prowess kept me on my toes, and your friendship kept me sane. May the world be blessed to see not only the skilled clinician that you have become, but even more importantly, the good man you have always been.

My chosen family has been instrumental in my journey and tireless in their support of my scholastic endeavors. Dr. MaCherie Placide, thank you for knowing when to push me and when I needed a pillar instead. To Jodi Swaja, for being the sister I never had, and to Lisa Sterner, Aaron Ochocki, and Barbara Gottfried, for your tireless devotion, endless babysitting offers, and love and support. You have each contributed your gentle wisdom and goodness to this project in some manner, and I only hope to live up to standards you have set.

Most importantly, thanks to my immediate family. To my son Ian, who was there for the entire journey, you are an absolute delight in my life no matter how busy I may become. So much of this journey has been intertwined with the rare privilege of watching you grow into the amazing young man you are becoming. Your loving smiles and giddy laughter helped me through on more than one occasion. And to Graham, who showed up halfway through (and surprisingly early!), you are my role model of tenacity and raw determination, not to mention one of the great loves of my life! Finally, to Ginger, my partner of eighteen years: You have seen me at my best and sat with me at my worst. Know that even when I failed to show it, I am and will always be eternally grateful for your unflagging support, your infinite wisdom, and your ability to tell me

the things that no one else could get away with. I love you, and I look forward to the next 20 years together (and the twenty after that....)!

Finally, my thanks to Marilyn who knows why....

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Section I: Introduction

Therapists and others who work with trauma survivors have long struggled with the task of successfully treating clients with complex trauma histories, particularly when the original trauma is some type of disruption in the early attachment relationship (Courtois, 2008; Muller, 2009; Schore, 2002). Much time and research has been spent differentiating the effects of “single-incident” trauma from repetitive, recurring, and/or ongoing trauma. The specific cluster of symptoms yielded by this work is used to describe a condition known as “Complex” Post-traumatic Stress Disorder. Complex PTSD is the most difficult for both therapists and clients to manage (Courtois, 2008; Muller, 2009), particularly when the trauma effected some type of disruption in the client’s early attachment process (Muller, 2009).

John Bowlby’s (1973, 1980, 1982) attachment theory is one of the most useful modern conceptual frameworks for understanding both the emotional regulation and the curative powers of psychotherapy (Mikulincer, Shaver, & Pereg, 2003). According to Bowlby (1973, 1980, 1982), humans are born with an innate psychobiological mechanism that protects them from threats and alleviates distress by motivating them to seek nearness or proximity to significant attachment figures in the environment (Mikulincer et al., 2003). A large body of research supports Bowlby’s claim that attachment styles are being formed through interactions with primary caregivers during early childhood (Schore, 2002). While Bowlby primarily emphasized the cognitive processes of early childhood as the main determinants of attachment style and inner working models, more recent work has begun exploration of the importance of attachment throughout the lifespan (Mikulincer & Shaver, 2007). Likewise, Bowlby

(1980) did acknowledge that the development of adult attachment is neither fixed nor frozen, but rather remains malleable, so that various events across the lifespan may produce discontinuity of attachment patterns, induce revisions and result in an update of working models (Mikulincer & Shaver, 2007).

Symptoms of early attachment trauma include difficulty regulating and/or inability to regulate a variety of internal and external systems, including consciousness, cognition, emotion, arousal, behavioral self-management, attachment (both intra- and interpersonally) and existential meaning making (Courtois, 2008; Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005). Traditional modes of therapy and research, however, have ignored attachment issues while focusing almost exclusively on attempts to change cognition and behavior through various types of narrative explorations and expression, often with limited success and in some cases, to the detriment of the client (Courtois, 2008; Ogden, 2006). Even therapeutic models that have included emotional regulation and mindfulness, such as Linehan's Dialectical Behavior Therapy (Linehan, 1993), have addressed these issues primarily as they have arisen in the initial engagement and stabilization phases, largely ignoring long-standing early attachment issues (Courtois, 2008).

One example of the importance of the therapeutic process in healing early attachment trauma has evolved through Relational-Cultural Therapy (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). According to Miller and Stiver (1997), the primary goal of relational/cultural psychotherapy is the creation of new relationships in which clients can include more of themselves, more of their experiences and feelings about those experiences, and parts of themselves that they had to keep out of past relationships. The

focus of therapy broadens from increased independence, self-knowledge, and personal insight to include an increased ability to connect in relationship. The therapeutic alliance is at the core of relational-cultural therapy, and the therapist's role includes not only establishing a connection with the client, but also finding ways to keep the relationship moving towards ever-deepening connection.

However, even in relational psychotherapy, many of the troubling symptoms of Complex PTSD linger, frustrating client and clinician alike. Integrating interoceptive "body-oriented" approaches could provide yet another tool for directly confronting Complex PTSD's core clinical symptoms (Courtois, 2008). Integrating interoceptive or "body-oriented" approaches allows direct confrontation of Complex PTSD's core clinical symptom: experiencing the present with the physical sensations and arousal levels of the past (Ogden, 2006). Focus on clients' visceral experiences becomes an additional tool for increasing self-awareness rather than maintaining a narrow focus on the meanings clients make of their experiences; if trauma is reenacted and re-experienced in physical sensation, then therapy that combines self-awareness and self-regulation may be most effective (Ogden, Pain, Minton, & Fisher 2005).

In relational psychotherapy, the concentration remains on a "top-down" processing approach. Using language and narrative as the point of entry, the therapist promotes changes in cognition and emotion with the hope that these will precipitate changes in the clients' physical or embodied sense of self. Sensorimotor psychotherapy and other expressive psychotherapies are compatible with and would enhance this goal of integration. These therapies enhance integration not by changing the focus of therapy, but instead, by including a piece that is currently missing: "bottom-up"

interventions. These interventions directly address the recurring physical sensations of trauma and proffer higher order change by first promoting resolution of trauma's physical sensations and intrusive sensory recollections (Ogden et al., 2005).

Finally, successful strategies for dealing with early attachment trauma often must also address issues of clients' spirituality. Early attachment injuries have been shown to affect an individual's decision to seek proximity not only to actual attachment figures, but perceived attachment figures (e.g., "God") as well (Mikulincer, Shaver, & Horesh 2006; Reinert 2005). The ability to attach to perceived attachment figures can be important when negative early attachment experiences occur, as an attachment to a perceived spiritual figure may serve as a compensatory attachment role (Reinart, 2005), as well as potentially providing a way for trauma survivors to form a coherent narrative of the trauma experiences (Peres et al., 2007) .

A spiritual component such as mindfulness therapy can become a vehicle for making some meaning of the trauma and beginning to transcend the grief and existential crises that often accompany early attachment trauma (Shapiro, Carlson, Astin, & Freedman, 2006). In other words, survivors can remove themselves from the dramatic content of their story and instead "view his or her moment-by- moment experience with greater clarity and objectivity" (Shapiro et al., 2006). This shift in perspective promulgates self-regulatory skills and a reduction in the core PTSD symptom of "experiencing the past as if it were happening in the present" (Shapiro et al., 2006).

The use of spiritual ideas such as mindfulness and being in the present moment are vital components as well because they activate the frontal lobes of the brain and facilitate communication between the client's "present, adult self" and the part of the

client that is experiencing dysregulating conditions (Ogden, 2006). Finally, mindfulness provides a sense of mastery and allows the client to build confidence (Ogden, 2006).

The goal of this paper is first to better understand the phenomenological view of clients who have experienced early attachment trauma and to use this understanding to suggest a more holistic, respectful and potentially effective approach to treatment of early attachment trauma within the mental health field. An original contribution to practice will then be provided in the form of a twelve-week group therapy curriculum for working with clients who are parenting children who have experienced trauma, clients who themselves have early attachment trauma, or both, with a focus on the importance of addressing early attachment trauma. By addressing early attachment trauma as soon as possible after the trauma occurs, this intervention hopes to simultaneously provide relief for presently occurring symptomology while also preventing the development of later comorbid diagnoses.

Definition of the Problem

Psychotherapists, psychiatrists, counselors, and physicians are often perplexed and frustrated by the inability of current treatment modalities to impact trauma resolution and integration to any significant degree (Cloitre, 2009). Almost 30 years after the emergence of the “false memory” controversy decimated the field of trauma practice and research, strides in fields as seemingly unrelated as neuroscience, gender bias and research, psychopharmacology, somatic therapies, and spirituality have recognized, highlighted, and in some instances, legitimized what practitioners in the field of trauma have long understood: Effective treatment of complex early attachment trauma must include not only work with cognitions and behaviors, but also

professionally and theoretically sound options for addressing trauma's effects on somatic functioning, relational skill, and spiritual concerns (Clarke & Griffin, 2008).

Statement of Significance

Many recent quantitative studies suggest that trauma that occurs early in the attachment process is one of the most significant predictors of mental health in later life, in general, and the development of Complex PTSD, specifically (e.g., Courtois, 2008; Kaplow & Widom, 2007; Muller, 2009; van der Hal-van Raalte, Van Ijzendoorn, & Bakermans-Kranenburg, 2007; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Heightened awareness and understanding of this issue can lead to more appropriate therapeutic interventions and treatment protocols for clients with Complex PTSD and other early attachment disruption (Cloitre et al., 2009), as well as increasing the possibilities for new and better research and training. By addressing attachment issues early and in a respectful, non-pathologizing way, therapists may be able to decrease, moderate, or even eliminate many of the affective issues clients experience throughout childhood (Spinazzola, Blaustein, & van der Kolk, 2005). Mental health professionals may also be able to decrease the prevalence of secondary affective issues in the adult population (Spinazzola et al., 2005). Finally, by increasing therapists' knowledge and awareness of attachment issues and importance of the therapeutic relationship, this information may be helpful in allowing therapists to work respectfully and effectively with all clients (Ogden, 2006).

Purpose

The purpose of this paper is to explore the interconnection of relationships, physical sensations, and spirituality in the healing process of adult clients with early

attachment trauma. The results of this exploration could then be directly applied within the therapeutic process, thus broadening the treatment options of therapists who are working with clients with Complex PTSD. The purpose of this paper is also to shed some light on the relationship between early attachment trauma and the development of Complex PTSD, deepening understanding of clients with Complex PTSD and hopefully easing the healing process for all participants. Finally, this paper hopes to engender further, and more specific, research on this topic, as well as increasing potential training opportunities for therapists.

Definitions of Key Terms

Several key terms must be defined to increase the usefulness of this paper. These include the following: Trauma, Early Attachment Trauma, Complex trauma, Complex PTSD, Sensorimotor Psychotherapy, Hakumi Method, spirituality, mindfulness, attachment, PTSD, chronic PTSD, and prolonged exposure therapy.

Trauma can be defined as “a deeply distressing or disturbing experience” (Stevensen & Lindberg, eds, 2011).

Attachment is defined as “the resultant of a distinctive and in part pre-programmed set of behaviour patterns which in the ordinary, expectable environment develop during the early months of life and have the effect of keeping the child in more or less close proximity to his mother-figure” (Bowlby, 1988, p. 3). These behaviors continue to be present throughout the life span and tend to be activated at times of high emotional arousal (Bowlby, 1988).

Early attachment trauma refers to a traumatic event or events that cause a disruption or disturbance in the early attachment process.

Complex trauma is defined by Courtois (2008) as “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships.”

Complex PTSD can be defined as a potential result of experiencing complex trauma. Complex PTSD resulting from early attachment trauma has a unique set of symptom clusters and treatment prognoses that is different from PTSD that occurs as the result of a single incident trauma such as rape or multiple traumas that occur only after adulthood has been reached (Cloitre et al, 2009). Complex PTSD is not an official diagnosis in the DSM-IV; however, trauma experts continue to push the efforts to have a differential PTSD diagnosis included in the next revision (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Even the United States Department of Veteran Affairs recognizes Complex PTSD as a useful concept beyond the standard DSM-IV diagnosis (National Center for PTSD, 2011).

The definition used for Post traumatic stress disorder is the diagnostic criteria outlined in the DSM-IV-TR (Stein, 2000).

PTSD is labeled “chronic” when the symptoms are present for three or more months (Stein, 2000).

Sensorimotor Psychotherapy uses a somatically-oriented talk therapy approach, integrating both verbal and body-oriented interventions to focus specifically on the interaction of trauma, attachment, and developmental issues (Ogden & Minton, 2000). In Sensorimotor Psychotherapy, “body-oriented interventions” refers to increasing clients’ awareness of their bodies, their bodies’ reactions to different triggers, and increasing self-regulation skills.

The Hakumi Method is a precursor to Sensorimotor Psychotherapy. It is an experiential body-centered somatic psychotherapy that combines the Eastern tradition of mindfulness with Western humanistic psychological methodology (Johanson, 2006).

The definition of spirituality used here is intended to refer to “the principle of conscious life; the vital principle of [humanity], animating the body or mediating between body and soul” (Yerkes, 1989).

Kabat-Zinn (1989) defines mindfulness as simply “moment-to-moment” awareness.

Prolonged Exposure Therapy (PE) is a 10 session treatment designed to specifically address traumatic memories and emotions associated with PTSD. PE stems from emotional processing theory and the principles of exposure theory (Karlin et al., 2010). After brief psychoeducation, patients are encouraged to repeatedly retell their most traumatic memories in an effort to differentiate present and past and to gain mastery over PTSD symptoms. PE is one of two interventions recommended in the Department of Veteran Affairs/Department of Defense Clinical Practice Guideline for PTSD (Karlin et al., 2010).

Assumptions and Limitations

This work includes the following assumption: results of trauma that occurs in early attachment relationships generally differs from results of other types of trauma in intensity, duration, and symptom clusters. The original contribution discussed within this paper is designed to address only trauma that occurs from a traumatic incident or incidents in early attachment relationships. Single incident trauma, diffuse trauma, and trauma occurring only in adulthood are outside the scope of this work.

This gives rise to several limitations. Little research on successful interventions for treatment of Complex PTSD and early attachment trauma exists of a longitudinal nature, whereas decades of research (e.g., Dorrepaal et al., 2010; Karlin et al., 2010) exist regarding the use of prolonged exposure therapy for other types of trauma. Also, the very nature of the trauma discussed lends itself to difficulty when attempting to measure symptoms and effects quantitatively rather than qualitatively.

Section II: Literature Review

Methods

A thorough search of the literature on trauma (including neurobiological, somatic, and relational effects), early attachment, the therapeutic relationship, and various treatment considerations was conducted. The researcher explored the literature from several angles including theoretical frameworks, treatment implications, and ethical considerations. Examples of the journals that this literature search included are: *Journal of the American Academy of Child and Adolescent Psychiatry*, *Cognition and Emotion*, *Journal of Traumatic Stress*, *Traumatology*, *Psychotherapy*, *Complementary Health Practice Review*, *Professional Psychology: Research and Practice*, *Journal of Consulting and Clinical Psychology*, *Psychotherapy: Theory, Research, Practice and Training*, *Child Development and Adolescent Studies*, and *Journal of Trauma and Dissociation*. Keywords searched include trauma, attachment, PTSD, loss, spirituality, mindfulness, Sensorimotor psychotherapy, chronic PTSD, Complex PTSD, prolonged exposure therapy, and others. In an effort to include the timeliest discoveries in the fields of Complex PTSD and early attachment trauma, the time frame searched focused primarily on the time between 1990 and the present; however, earlier material was reviewed and used due to the importance of attachment theory and its impact on current research and treatment methods.

Literature Review

Recent advances in neuroscience, particularly the development and use of the *fMRI*, have confirmed what many in the field have long held to be true: most of human brain activity happens outside conscious awareness, and the earlier in life that trauma occurs, the more likely it is to have deleterious effects (Muller, 2009). When early trauma disrupts attachment, development is affected on all levels: physical, cognitive, emotional, and relational. To better understand some of the reasons that early trauma is so highly correlated with incidents of Complex PTSD, one must first understand the notion of the “triune brain.” As Ogden (2006) explains, humans essentially have three major brain areas: the brainstem, the limbic system, and the cortex. Also known as the “reptilian” brain, the brainstem is responsible for lower order functioning and instinctive responses (e.g., breathing, heartbeat). When trauma occurs, the brainstem provides the gateway for sensory input (Nijenhuis, 2004). The limbic system or “mammalian” brain includes the hippocampus, amygdala, and the thalamus. This area is responsible for emotion and feeling. This is where procedural learning occurs and where implicit memory is stored. The final area is the “human” brain or “cortex.” This is the area of the brain that exercises control over executive functions of the brain such as selective attention, working memory, self-observation, understanding, and insight (Ogden, 2006). When trauma occurs, the neocortex becomes inaccessible, leaving the traumatized individual to process the trauma using only the brainstem and limbic system (Williams, 2006).

Human beings are unique in the animal kingdom for having highly developed pre-frontal cortices, which provide choices regarding responses to stimuli (Ogden et al., 2005). As the neocortex develops, so does the capacity to attach meaning to sensory input and evoked emotions and then choose a behavioral response based on the integration that occurs. In other words, humans have “flexibility” (Williams, 2006). This ability to be flexible is a slowly emerging skill that arises over the course of development based on early attachment experiences (Williams, 2006). Prior to the development of the pre-frontal cortex, children do not regulate their own emotions, but instead, depend on adult caregivers to respond when the child signals distress (Bowlby, 1973, 1980, 1982). The adult essentially acts as the prefrontal cortex by assimilating and integrating the child’s sensory information, acknowledging the child’s distress, and acting on the environment in such a way that will soothe the child and reestablish homeostasis. In normative development (i.e., absent trauma), as the pre-frontal cortex develops, children will begin to develop autonomy in emotional regulation and the ability to create their own homeostasis (Ogden et al., 2005). When normative development is disrupted, children experience a greatly increased likelihood for developing Complex PTSD (Courtois, 2008).

Current treatment models.

Christine Courtois (2008) gives a thorough explanation and diagnostic differentiation of simple and complex traumas in her article “Complex Trauma, Complex Reactions: Assessment and Treatment.” Courtois (2008) defines complex trauma as “a type of trauma that occurs repeatedly and cumulatively, usually over a

period of time and within specific relationships” (p. 86). As noted by Courtois (2008), researchers consistently found differences in symptom clusters and treatment prognosis between survivors of complex trauma and survivors of single incident trauma. In particular, Courtois (2008) notes that trauma occurring in early childhood interferes with attachment and development and predicts a higher risk for the survivor’s development of Complex PTSD (Courtois, 2008; Stovall-McClough & Cloitre, 2006). The field trial for Complex PTSD for the DSM-IV conceptualized seven areas that are specific to early attachment trauma: alterations in affect regulation and impulsivity; changes in attention and consciousness leading to depersonalization, amnesias, and dissociative episodes; shifts in self-perception; adaptation regarding perception of the perpetrator; changes in relationships with others; somatization, medical, and/or physical manifestations; and shifts in systems of meaning (Courtois, 2008). Prior to identification of these symptom areas, diagnosis and treatment focused almost exclusively on changes in attention and consciousness (Karlin, et.al 2010). By identifying other distinct symptoms, focus of treatment could shift to include the relational, somatic, and spiritual manifestations of this diagnosis. Although the diagnosis was not ultimately included in the DSM-IV, most trauma experts recognize and continue to push for some differential diagnosis in the DSM-V (van der Kolk et al., 2005).

Perhaps most importantly, Courtois (2008) explains the history of “classic” PTSD interventions, most traditionally cognitive behavioral therapy using prolonged exposure and cognitive restructuring. Almost twenty years of research documents the efficacy of the use of prolonged exposure as an intervention for simple PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). As Courtois (2008) explains, however,

while empirical support for these treatments as a preferred intervention in simple PTSD is abundant, the findings do not support their use when dealing with Complex PTSD and in fact, may even be harmful. High drop-out rates based on severity of PTSD symptoms is just one example of the often acknowledged inconsistency of successful outcomes using PE for simple trauma and the need for a different perspective when treating early attachment trauma (Dorrepal et.al, 2010). Another explanation is the high co-morbidity of early attachment trauma and personality disorders. Bradley et al. (2005) noted that most patients of this type are excluded from simple PTSD treatment studies because of their complex symptomology, leaving a gap in the literature concerning early attachment trauma as well as limiting the generalizability of current PTSD studies to Complex PTSD from early attachment trauma (Bradley et al., 2005).

Rather than these traditional methods, Courtois (2008) recommends a three stage approach to treatment based on work by Judith Herman (1992) that relies on the therapeutic relationship as a source of secure attachment and therefore, a base for all of the other work that is accomplished. Because of the developmental and attachment issues that are central to Complex PTSD, Courtois (2008) acknowledges that this approach will almost always necessitate a longer course of treatment, with some clients working for years or even decades. Finally, Courtois (2008) acknowledges that to be most effective, treatment of Complex PTSD must address the “whole person,” dealing directly with the mind-body issues that are central to every aspect of this disorder. This may include such approaches as Sensorimotor psychotherapy, Hakumi, and mindfulness, for example.

In their article, “Treatment of Complex Posttraumatic Self-Dysregulation,” Ford, Courtois, Steele, van der Hart, and Nijenhuis (2005) review a “phase-oriented integrative model” for treating Complex PTSD. This three part model for treatment seems to begin to successfully integrate relational, interoceptive, and skill-building models in the treatment of Complex PTSD. The authors are quick to point out that this treatment model is “based largely on clinical experience and has not been validated by scientific research” (Ford et al., 2005). While this upfront disclosure may eliminate some criticisms, the authors seem to be discounting the importance of qualitative, phenomenological research and experience when developing models for effectively working with clients. These statements also highlight the need for further research in the future. The three phase approach to treat dissociative sequelae and self-dysregulation are listed as follows: Engagement, Safety, and Stabilization; Recalling Traumatic Memories; and Enhancing Daily Life (Ford et al., 2005).

Phase 1: engagement, safety, and stabilization.

Phase 1 is primarily a skill- and relationship- building phase (Ford et al., 2005). Often, clients with Complex PTSD may enter the therapeutic relationship with safety concerns such as suicidality and suicidal ideation that must be immediately addressed. In the broader relational context, the therapist acts as a container for the client while the client is learning skills such as impulse control, regulating overwhelming affect, and managing self-destructive thoughts and behaviors (Ford et al., 2005). Phase 1 involves safety planning, psycho-education, and assistance with immediate maladaptive behaviors such as self-harm, suicidality, and eating disorders (Ford et al., 2005).

Simultaneously, the therapist must begin to join with the client and start to form a working alliance. This is typically a particularly challenging stage of the therapy for both therapist and client alike. When Complex PTSD involves early attachment trauma, clients often present with disorganized attachment styles which lead to repeated testing of the therapist, both directly and indirectly, as the client and therapist very gradually work together to resolve the client's often long-standing and legitimate feelings of betrayal and mistrust in relationships (Ford et al., 2005). The client may self-disclose and then pull away, request help yet deny any help offered, and/or move rapidly between states of crises and indifference. More interoceptive approaches such as Sensorimotor psychotherapy, movement therapy, and art therapies may be particularly helpful during this phase as much of this phase work is non-verbal, with the therapist tracking and increasing the client's awareness of non-verbal behavioral and bodily communication during times of both regulation and dysregulation.

Phase 2: Recollection of traumatic memories.

During the second phase, the client applies the self-regulatory skills learned in Phase 1 in a more direct effort to recall traumatic memories and resolve posttraumatic symptoms (Ford et al., 2005). The therapeutic relationship remains central to the work as the therapist attends to emotional regulation and models safe, non-intrusive co-regulation while attending to traumatic memories (Ford et al., 2005). Several controversial issues arise as the therapy enters Phase 2, the first of which is when to begin this phase of the therapy (Ford et al., 2005). Ideally, the client and therapist would have an open, ongoing dialogue about when to begin this phase and how to proceed once

the phase has begun. Phase 2 then continues until the client's PTSD symptoms appear under control and well-regulated. Perhaps the most controversial issue in Phase 2 is the method by which the traumatic memories are processed (Ford et al., 2005). While repeated "exposure" to the traumatic memories was highly touted for many years as the treatment of choice; recent developments and increases in the amount of data concerning the neurobiology of memory, cognition, emotion, and trauma itself suggest that therapists remain flexible in their approach and closely follow the advances in research as they arise (Dorrepal, et al., 2010; Ford et al., 2005; van der Kolk et.al, 2007). Rather than having the client repeatedly exposed to traumatic memories or attempting unsuccessfully to avoid traumatic recollections, Phase 2 provides an opportunity for the therapist and client to work together to choose from a variety of processes (e.g., Sensorimotor psychotherapy, EMDR, Thought-Field Therapy, etc.) which intervention or combination of interventions may best assist the client in recognizing traumatic memories, understanding the current effects of these recollections, and beginning to gain and maintain self-regulation (Ford et al., 2005).

Phase 3: Building a life in the present.

Many survivors with Complex PTSD despair of ever having a "normal" life or creating meaningful connections with others in a "normal" way (Ford et al., 2005). In Phase 3 the focus of the therapy shifts to the quality of clients' present lives, applying the skills learned in Phases 1 and 2 to assist clients in finding a balance they can live with. This phase may be the most intensive of all the phase work as clients not only begin to experience heightened positive feelings, but also the emergence of deep seated grief and

anguish over early relational experiences. In Phase 3, the therapist must continue to model relational learning by using breaches in the client-therapist relationship to facilitate the client's experiential understanding that relationships can tolerate stress and survive or even thrive (Ford et al., 2005). The authors suggest five "treatment principles" that are imperative to ensure the safety of clients and to maximize positive results (Ford et al., 2005). These authors suggest that therapists minimally maintain the five treatment principles as follows: increase client's ability to regulate extreme arousal states; increase client's sense of personal control as well as a sense of self-efficacy; assist client in maintaining functioning at an adequate level consistent with what has been accomplished thus far; decrease client's avoidance of states and situations that tend to trigger traumatic reactions; and maintain awareness and effective management of the transference and countertransference processes (Ford et al., 2005). The current manualized treatment models that are cited by the authors have been divided into two groups: Cognitive-Behavioral Therapy (CBT) and Interpersonal Self-Regulation and Affect Regulation Therapy (IAT) Models. The CBT models focus on cognitive retraining either through recalling traumatic memories or by specifically addressing PTSD symptoms. In trials of the treatments that confront traumatic memories prior to working with self-regulation, the CBT treatment performed better than a wait-list control situation; however, the drop-out rate was extremely high (43%), and no follow-up was completed for drop-outs. This seems to underline the need for a phase approach to PTSD with the initial focus of increasing affect regulation and client safety. The CBT models that were most effective were those focused almost exclusively on Phase I (e.g., Dialectical Behavior Therapy).

The IAT models differ from CBT by focusing on use of memories to inform current decision-making rather than attempting to modify beliefs about past occurrences. The line between these two models is somewhat diffuse, with the primary difference that IAT models intentionally address attachment within the therapeutic relationship as a primary tool for self-regulation (Ford et al., 2005). All of the models mentioned had produced clinically significant reductions in PTSD symptoms when field-tested, as well as all having relatively low drop-out rates. However, these trials were also more limited in scope, have not all been replicable, and were based on open field testing as well as randomized control situations (Ford et al., 2005). Thus, sufficient clinical evidence has still not been presented that would clearly distinguish either CBT or IAT as the most effective for treatment of Complex PTSD. Almost no research of a longitudinal nature across the three phases exists. This would be an important area for future studies, particularly examining PTSD outcomes longitudinally across all three phases. While psychotherapy has been fairly adept at creating designs to measure symptom reduction, it has only recently become more successful in measuring therapeutic attachment, noting that it appears to be an essential ingredient in successful treatment of Complex PTSD due to early attachment trauma (Norcross & Wampold, 2011).

Therapeutic process.

Miller and Stiver (1997) envision the primary goal of relational/cultural psychotherapy as the creation of a new relationship where clients can include more of themselves, more of their experiences and feelings about those experiences, and parts of themselves that they have had to keep out of past relationships. The focus of therapy broadens from increased independence, self-knowledge, and personal insight to include

an increased ability to connect in relationship. The therapeutic alliance is at the core of relational-cultural theory, and the therapist's role becomes not only establishing a connection with the client, but also finding ways to keep the relationship moving towards ever-deepening connection. Examination of transference and countertransference is essential, with the therapist closely examining and reflecting not only on the connection and disconnection strategies used by the client, but also on those used by the therapist.

In contrast, in psychodynamic therapy the therapeutic relationship consists of two prime experiences. While the patient's past is "brought into the present" or re-experienced, just as importantly, the patient is simultaneously having a new experience in the "here-and-now" (Gurman & Messer, 2003). Traditional psychoanalytic theory values the new experience, but places primary emphasis on the importance of transference in accessing childhood memories and bringing the past into the present (Gurman & Messer, 2003). More "modernist" views of psychoanalytic theory shift the primary importance of transference to the here-and-now analysis (Gurman & Messer, 2003). Neither approach alone, however, has been sufficient for successful treatment of clients with Complex PTSD from early attachment trauma (Courtois, 2008). These clients need the "here-and-now" relational development before they can successfully "bring the past into the present." Without both approaches, the client will stay in a state of emotional dysregulation where recall of memories is traumatic and attempts to have new experiences merely trigger flooding of past traumatic events (Nijenhuis, van der Hart, & Steele, 2004).

Miller and Stiver (1997) dispute the traditional notion of the therapist as interpreter of the client's transference, with the primary goal of analysis helping the client gain insight. While this view may be sufficient to assist a client in the initial phase of treatment as outlined by Ford et al. (2005), in phases two and three, the therapist's interpretations might actually serve to further disconnect or alienate the client. Therefore, the therapist must allow understanding of the client's transference reactions to deepen empathy with the client and understanding of the power of the client's relational images. This understanding then informs the therapist's style of engagement with the client, allowing the therapist to maintain awareness of the client's projections and providing the therapist with ways to convey the differences between the therapeutic relationship and the client's early relational images. The relational model moves the concept of psychotherapy from a one-dimensional exercise involving a neutral, objective therapist as a tool towards a more mutual, dynamic interaction between people. The work of psychotherapy then shifts to helping the client create a new experience by establishing and building a genuine relationship between client and therapist that differs from the client's past relationships (Miller & Stiver, 1997).

Spirituality and Complex PTSD

In his article on spirituality and attachment, Duane Reinert (2005) hypothesizes that the quality of one's early attachment with a primary caregiver can predict future well-being and the quality of a future relationship with God which is important because spirituality may lessen the neurobiological repercussions of early trauma as well as providing trauma survivors with a way to narrate their experiences. Reinert asserts that the idea of God or spirituality can be conceptualized as an internal working model of an

attachment figure and that the more secure one's early attachment experience was, the more these experiences will later manifest in an attachment relationship with God (2005). He further suggests that if early attachment experiences were negative, the idea of an attachment to God may serve as a compensatory attachment role, particularly with persons who have a history of avoidant parent-child attachment (2005). In other words, the relationship with a corporeal primary attachment figure is replaced by the attachment relationship with God.

Reinert assessed 75 college aged Roman Catholic seminarians using the Spiritual Assessment Inventory (SAI) and a self-created "Attachment to God" scale adapted from the Attachment to Mother scale (2005). Reinert found that a history of secure parent-child attachment positively predicted a person's view of God as a secure attachment figure as an adult (2005). Reinert (2005) also explores the ways that each of the attachment styles can impact later views of attachment to God, finding that secure attachment history led to a greater sense of connection to God, while anxious and avoidant attachment histories were linked with higher levels of disappointment and increased instability in relationships with God. Reinert's conclusions seem to flow logically from the theoretical constructs of attachment theory; however, his study has many limitations when applied to treatment issues in Complex PTSD (Reinert, 2005). He chose his sample from a homogenous group of all males who already identified as "highly religious" and were all from one religion (Catholicism) (Reinert, 2005). The instruments used were self-report, as were the determinations of the participants' attachment histories, lending the study to potentially serious criticism of reliability and validity of the assessment instruments and questionable generalizability to broader, more

diverse populations (Reinert, 2005). In their article, *Examining relations among attachment, religiosity, and new age spirituality using the Adult Attachment Interview*, Granquist, Ivarsson, and Broberg (2007) explore even more specifically the impact of a person's early attachment style on future religiosity and spirituality. Granqvist et al. (2007) proffer two hypotheses: first, replicating previous studies, they explore whether positive early attachment experiences result in an internal working model of God as a positive, loving attachment figure; and second, expanding on research questioning the relationship of independent attachment estimates with reports of religiosity and spirituality, they attempt to determine whether the rapidity of changes in religious beliefs can be correlated with early attachment experience (2007). While the Granqvist et al. article is arguably more generalizable than Reinert's article, Granqvist also drew from a rather small sample that was not representative of the population as a whole, potentially limiting the usefulness of the findings to the greater population (2007).

Using the Adult Attachment Interview (AAI) as their instrument, the authors determined that high parental loving scores, particularly high maternal loving scores, directly correlated in an increase in high scores of God as a loving image (Granqvist et al., 2007). Likewise, low maternal loving scores correlated with an internal working model of God as a distant attachment figure (Granqvist et al., 2007). Likewise, Granqvist et al. (2007) found that quality of maternal attachment correlated significantly with the age and rapidity of religious change. Granqvist et al. reported strong correlations between high maternal attachment and slow, early religious changes whereas high maternal rejection was associated with rapid, intense religious changes later in life (2007). These findings underscored Granqvist's theory that in cases of poor

maternal attachment, the idea of God as an attachment figure might be used as a compensation later in life (2007). Finally, in their article *Spirituality and Resilience in Trauma Victims*, Peres, Moreira-Almeida, Nasello, and Koenig (2007) posit the idea that spirituality is vital to healing Complex PTSD because spirituality provides trauma survivors with a way to form coherent, comprehensive narratives of their experiences. In their work, Peres et al. (2007) explore the neurobiology of trauma with particular regard for the decrease in activity in Broca's area and the difficulty clients with Complex PTSD experience in forming coherent narratives of their experiences, indicating temporary lapses in pre-frontal dependent cognitive processing or thoughts that must be processed through the pre-frontal cortex. Peres et al. further suggest that spirituality may be a key to increasing the comprehensibility, meaningfulness, and manageability of the lives of clients with Complex PTSD (2007). Spirituality, then, may serve as a tool of sorts to restore cognitive aspects that may otherwise remain unintegrated in the trauma survivors' healing processes. This view of spirituality as both an outgrowth of the attachment system as well as a cognitive tool to compensate for poor attachment leads to the example of a particular practice that has been effective for trauma survivors: Mindfulness.

Mindfulness and Complex PTSD

One definition of Mindfulness is the ability to experience the present moment without judgment (Shapiro et al., 2006). Kabat-Zinn defines Mindfulness as "...the regular, disciplined practice of moment to moment awareness or *mindfulness*, the complete "owning" of each moment of your experience, good, bad, or ugly." Like

Ogden (2004) with Sensorimotor psychotherapy, Shapiro et al. focus on the use of Mindfulness as more of a tool than a spiritual practice. The authors offer the idea that the practice of Mindfulness is essential for adults with early attachment trauma because it keeps the pre-frontal lobes active and facilitates communication between the “adult self”/”witnessing ego” and the earlier self that is experiencing the dysregulating conditions. Thus, Mindfulness is itself a useful tool for emotional regulation because it increases awareness and develops flexibility and adaptability in responding to emotional states (Shapiro et al., 2006; Ogden, 2004). In fact, Linehan actually incorporated mindfulness into her protocol with Dialectical Behavior Therapy (Dimoff & Koerner, 2007). Clients with complicated symptoms may experience emotional numbing and chronic hyperarousal which can cause deficits in attention, difficulties in learning, functional impairments, and limited awareness (Shapiro et al., 2006). Mindfulness allows the client to accept rather than suppress emotions and may reduce emotional numbing and chronic hyperarousal (Ogden, 2004). While Ogden (2004) also recognizes that Mindfulness is important for its ability to promote a sense of mastery and to build confidence for survivors of early attachment trauma, Shapiro et al. (2006) pushes this idea further by noting the importance of “explicitly bringing [the spiritual essence] back into [their] model.” They posit that Mindfulness can essentially assist in providing meaning, purpose, and ultimately transcendence over traumatic experiences (Shapiro et al., 2006). Like Peres et al., Shapiro et al. (2006) support the idea that professionals must attend to the spiritual as well as the cognitive, emotional, and interoceptive healing processes of clients with Complex PTSD.

Many of the current evidence based treatments for PTSD are actually predictive of poor outcomes in Complex PTSD. However, Dorrepaal et al. (2010) have suggested and begun to explore the use of psychoeducation via group process as an effective means of stabilizing clients with Complex PTSD so that they can more easily regulate affect and tolerate the emotions that arise with other types of treatments (Dorrepaal et al., 2010). The following original contribution to practice also uses psychoeducation and the therapeutic relationship within a group context to increase understanding of early attachment trauma and to decrease much of the symptomology that can occur as a result of early attachment trauma.

Section III: Original Contributions to Practice

Introduction

Complex PTSD has long baffled clients and therapists alike. When the diagnosis occurs as a result of early attachment trauma, professionals often find it difficult to treat, resistant to short-term interventions, and predictive of increased mental health issues in later life (Cloitre, 2009). The original contribution to practice that is proposed is a curriculum for a group therapy intervention for clients who are either parenting a child who has experienced trauma or have experienced early attachment trauma themselves and wish to address potential intergenerational trauma issues. The curriculum includes a training manual for professionals who work with traumatized clients, including specific techniques and their appropriate use, with special emphasis on assisting the client with pacing the trauma work. By bringing more attention to the treatment of early attachment trauma, this intervention hopes to serve not only as a vehicle for reducing current

symptomology, but also to provide some preventative relief from the development of later comorbid diagnoses.

Ethical Considerations

Because the group is designed to augment more intense, focused treatment for Complex PTSD, several ethical concerns arise. These issues range from misuse of the material as a primary intervention to secondary trauma for the therapists facilitating the group. Because of the potential fragility and high risk for the populations the group is designed for, this material must be used only as an adjunct with more individualized, target-specific treatment; as a condition of group membership, group members should also be engaged in individual therapy as their primary source of support and treatment. Ideally, members would sign releases so that all the therapists involved could exchange information as deemed appropriate to provide the most positive, corrective experience possible.

Another potential ethical issue is the use of the curriculum by practitioners who are not educated in the various types of trauma and in Complex PTSD with early attachment trauma specifically. Offering the group to survivors of single incident trauma or adult trauma might at best be useless, but at worst be detrimental. Without the appropriate knowledge and skill base, the practitioner risks the safety and well-being of clients.

Each group should always consist of two co-facilitators for the emotional safety of the therapists as well as the clients. The information revealed within the group is

likely to be highly emotional and, without proper support, could even lead to secondary traumatization for the therapists (Duncan, S. F. & Goddard H.W., 1993).

Careful consideration should be applied to the initial decision of inclusion and exclusion of group members. Typical reasons for exclusion include, but are not limited to, traumatic brain injury, acute psychosis, active chemical dependency, and sociopathic personality traits (Yalom, 1985). Also, because of the sensitivity of the material processed, continuity of group members should be a primary consideration (e.g., all group members are mothers of trauma survivors, or all victims are adult trauma survivors, etc.). Significant deviance from other group members could lead to high drop-out rates as well as possibly being iatrogenic to all group members (Yalom, 1985).

Choice of Materials and Exercises

The curriculum provided in Appendix B was developed based on research from a wide variety of sources including group theory, child development, and trauma research. The material chosen reflects an attempt to consider and promote the therapeutic factors of the group therapy process such as “installation of hope” and “universality” (Yalom, 1985). The material is also designed to promote and enhance safety and trust within the therapeutic relationship. (Norcross & Wampold, 2011). Finally, the information included in the manual often over-simplifies information in an effort to educate participants rather than confuse them. For example, while many varied theories of development exist, the choice was made to include only Erikson’s theory of development as it is both simple to present to the layperson and easy to understand. This is especially important if participants are in Stage 1 of their trauma healing process, as

psychoeducation can be a non-threatening way for Phase 1 participants to begin processing highly charged information (Dorrepaal et al., 2010).

To date, the group has been used only for mothers of children who have experienced early attachment trauma. Further research could include groups with a focus on the Adult survivors' of Complex PTSD or a group for fathers of children who have experienced early attachment trauma.

Assessment Instruments

To assess the effectiveness of this curriculum, it is suggested that clients be administered two assessment measures, the *Parent Child Relationship Inventory* (PCRI) (Gerard, 2011) and the *Trauma Symptom Inventory* (Briere, 2011), in both the first and final sessions. These scores can then be compared to determine whether, following the information and processing from the group, the client notices a difference in the nature of the parent-child relationship and/or the experiencing of trauma symptomology.

The PCRI is uniquely suited for assessing this curriculum in that it focuses primarily on changes in relational qualities rather than some of the more behaviorally focused instruments available. The PCRI is a 78 item instrument designed to measure parental attitudes towards parenting (Boothroyd, 2011). The items are divided into seven content scales with two validity indicators (Boothroyd, 2011). The scales measure parental support, satisfaction with parenting, involvement, communication, limit setting, autonomy, and role orientation (Boothroyd, 2011). The measure also accounts for social desirability (false positive answers) and inconsistency in answering the items

(Boothroyd, 2011). While the standardization process accounted for racial and educational differences similar to the United States population, the authors decided not to include separate norms for race or education even though the differences were significant (Boothroyd, 2011). This could result in potential diversity issues among both race and class when using the instrument. Separate norms are given for male and female parents (Boothroyd, 2011). While internal consistency and test-retest reliability appear very high for the PCRI scales; construct and content validity are a bit more questionable, as the author did not include the literature review to which he refers in the manual (Marchant & Paulson, 2011). Also, there is some evidence for predictive validity based on several studies cited by the author (Marchant & Paulson, 2011).

So far the group has only been conducted with female participants. This presents gender diversity issues, particularly as the PCRI noted significant differences in parenting scores for men and women. As always, the potential exists for diversity issues regarding race, class, and sexual orientation as well. The PCRI was normed on “traditional” two parent male-female households, which could raise diversity questions when dealing with same-gender parents, non-biological caregivers, and single parent households.

The Trauma Symptom Inventory (Briere, 2011) was chosen as a measure to assess any potential decrease in trauma symptoms following participation in the group. Although the test does not take into account the actual trauma experienced, the simplicity of the test; its high content validity; and its inclusion of built-in validity scales make this a desirable choice (Fernandez, 2011). Some have criticized the internal

consistency of the scales with regard to concurrent and discriminant validity; however, the scale has repeatedly demonstrated high internal consistency scores as well as equaling, and in some instances, surpassing the concurrent validity of similar scales (Fernandez, 2011).

One criticism of the TSI is that it is designed to measure symptoms of any trauma, not necessarily complex trauma related to early attachment. However, the author more heavily weighted scales that assess for interpersonal violence particularly of a sexual nature (Fernandez 2011). While this is a valid criticism levied by reviewers when discussing use of the TSI for accurately assessing all PTSD symptoms, this could actually lend itself to even more accuracy for determining Complex PTSD symptoms related to early attachment trauma, as this type of trauma tends to be specifically of an interpersonal nature.

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Appendix A

Appendix A is a selected resource guide including some of the local and national advocacy, mental health, internet, and educational resources on attachment, Complex PTSD, and Mindfulness. Many other potential resources may also exist.

- David V. Baldwin, PhD.
Eugene, Oregon USA
E-mail: <http://www.trauma-pages.com>
- International Society for the Study of Trauma and Dissociation
8400 Westpark Drive, Second Floor, McLean, VA 22102
Telephone: 703/610-9037
Fax: 703/610-0234
E-mail: info@isst-d.org
- Trauma Center at Justice Research Institute (Bessel van der Kolk)
The Trauma Center at JRI
1269 Beacon Street
Brookline, MA 02446
General Tel: (617) 232 - 1303
Clinical Intake: (617) 232 - 0687
Fax: (617) 232 - 1280
E-mail: www.traumacenter.org
- Sensorimotor Psychotherapy Institute (Pat Ogden)
P.O. Box 19438, Boulder, CO 80308
Phone: (303) 447-3290 or 1-800-860-9258 Toll-free
Fax: (303) 402-0862
E-mail: office@sensorimotorpsychotherapy.org
- National Center for PTSD
United States Department of Veteran Affairs
Website: www.va.gov

- The Center for Victims of Torture
St. Paul Healing Center and International Headquarters
649 Dayton Avenue
St. Paul, MN 55104
USA
Phone: 1-877-265-8775
Alternate Phone: (International Code +1) 612-436-4800
E-mail: CVT@CVT.org

- HealTorture.org
E-Mail: HealTorture@cvt.org

- National Child Traumatic Stress Network

NCCTS — University of California, Los Angeles
11150 W. Olympic Blvd., Suite 650
Los Angeles, CA 90064
Phone: (310) 235-2633
Fax: (310) 235-2612

NCCTS — Duke University
411 West Chapel Hill Street, Suite 200
Durham, NC 27701
Phone: (919) 682-1552
Fax: (919) 613-9898

Website: <http://www.nctsn.org/>

- Zero to Three:
National Institute for infants, toddlers, and families
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Appendix B

Relationships After Trauma

A Therapeutic Group for Survivors of Early Attachment Trauma and/or Mothers of Trauma Survivors

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6/1/2011

The following is a therapeutic group curriculum designed to address the impact of early attachment trauma on both parent and child and various ideas of dealing with the aftermath of this trauma. The curriculum is designed for professional use in practice; however, the curriculum still needs to be assessed for construct validity. Various session outlines and potentially helpful handouts are located in the appendices at the end.

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Introduction

The purpose of this group is to assist those dealing with early attachment wounds either as the parent of a traumatized child or as a traumatized adult who wishes to explore ways to contain the intergenerational effects of trauma. For example: Parents whose children have experienced an early attachment trauma; adults who have Complex PTSD and/or early attachment wounds who are currently parenting, have had their parental rights terminated, or are considering parenting but worry about the effects of intergenerational trauma.

The intake process should be conducted in an individual interview format. The therapist should gather information about the client's family of origin issues, trauma history, and early attachment disruptions, and the reasons why the client thinks the group might be beneficial to him or her at this juncture in his or her life. (See appendix for potential intake questions).

Although originally designed as a twelve week curriculum, the curriculum may be adjusted to fit other time frames (e.g., eight weeks or ten weeks) by combining two groups into one week (e.g. Group 6 & 7). The group is designed for each session to last 2 hours with a 15 minute break after the first hour. If a group is only going to be eight or ten weeks, one idea is to eliminate the break and work the whole 2 hours. Ideally, the group will be held in a location that offers plenty of space for various exercises, a whiteboard and/or chalkboard, and, if at all possible, childcare for group members.

Group 1: Why Are We Here?

“Why Not a Regular ‘Parenting Class?’”

A typical parenting class covers traditional parenting skills such as physically caring for a newborn, infant or toddler; age appropriate discipline; or ways to communicate. The traditional parenting class does not typically address the emotional and psychological importance of early attachment and the ways that early attachment may be effected by trauma. This group differs by exploring in depth the nature of early attachment trauma, how it can occur, the effects it may have on parenting, and perhaps most importantly, the essential component of the parent’s own early attachment experiences and how these may be affecting the parenting relationship. An exploration of attachment experiences is essential because these experiences directly impact not only early social and emotional development, but also the process of brain development and the ability to regulate emotional arousal.

General Group Format

Below is a proposed format for the group. This format may be adapted to suit the needs of a particular group (e.g., the number of weeks may need to be changed; childcare may or may not be available, etc.):

- 1. Check in**
- 2. Brief review of homework**

3. Group rights

Work with the group to develop their own set of group's rights together. This allows them to begin the group with a sense of ownership already established (Yalom, 1985).

4. Education**5. Break****6. Process time relating to educational topic****7. Assignment of homework****8. Check out****9. Next week's topic****10. Closing affirmation**

Most of the closing affirmations are taken from a book called The Tao of Motherhood. Using a single source is a convenient way to transition from group to group, and this book presents the opportunity to practice mindful reflection. However, other writings may be substituted for affirmations as is appropriate for individual groups. This is at the discretion of the facilitators.

Exercises

I. Word Association

A. Purpose:

1. To promote interaction among group members
2. To promote group cohesiveness, bonding, and healthy attachment among group members
3. To stimulate thinking regarding the words presented in this activity in the context of group members' children

B. Materials:

1. Index cards
2. Pens

C. Words:

1. Parent
2. Family
3. Child
4. Trauma
5. Child development
6. Self-care
7. Nurturing
8. Attachment

9. Parent
10. Discipline
11. Resilient
12. Bond
13. Safety
14. Play
15. Restoration

D. Activity:

1. Prior to the session, the facilitator writes one word on each index card.
2. Have group members write down the first word they think of when they read the word
3. After everyone has written their first thought on each index card, have group members read out loud what other group members thought about that word
4. Facilitate conversation regarding similarities/differences
5. End by asking: “How does this activity help group members in their parent/child relationships?” Facilitators are looking for some level of awareness that the words people use may have many different meanings depending on context, thereby increasing clients' sensitivity to use of language when trauma is a factor in the relationship.

II. Broken Pot

A. Purpose: To begin a discussion around the grief and loss that occur as part of early attachment disruption and/or when a trauma occurs; to give clients a tangible, tactile way in which to begin to express their grief; and to demonstrate that, while the family is different due to the trauma that has occurred, the family can still be a unique and beautiful “whole.”

B. Items needed:

1. Small clay pot for each member of the group (therapists should complete the exercise as well)
2. Pillow case for use in smashing each of the pots
3. Small hammer
4. Glue
5. Any variety of collage materials including glitter sparkles, magazine pictures, words, fabric, etc.

C. Activity

1. Have clients place their pots into a pillowcase and gently break each pot with the hammer. This is an excellent metaphor to point out the way that trauma affects our lives.

Have clients look at their pieces of pottery and reflect on ways their life has become more fragmented due to trauma.

2. With the materials provided, have clients decorate each of their clay pot pieces to reflect themselves, their families, their values, etc.
3. Glue the pieces of the pots back together and allow sufficient time to dry. Discuss the transformations of the broken pieces into something that is cohesive and beautiful **EVEN THOUGH** it looks different than it did prior to the smashing.

Group 2: Trauma

What is Trauma?

Trauma can be defined as an event or occurrence that a person is not able to fully integrate or make sense of (Cloitre et al, 2009). Children and adults experience a wide variety of events as traumatic. These events include but are not limited to the following:

- Divorce
- Death
- Complex trauma
- Domestic violence
- Early childhood trauma
- Medical trauma
- Community and school violence
- Natural disasters
- Neglect
- Physical abuse
- Emotional abuse
- Sexual abuse

- Refugee & war zone trauma
- Terrorism
- Traumatic grief

Complex trauma differs from simple trauma and thus is more difficult to treat. Complex trauma is generally characterized by exposure to multiple or prolonged traumatic events (Cloitre, et al, 2009).

Trauma can be divided into three essential categories: single incident trauma, multiple exposure traumas, and an environment of trauma. Single incident trauma is a trauma that occurs only once. Examples include automobile accidents, house fires, or major medical incidents. Multiple exposure traumas occur when a person is exposed to multiple traumas. These traumatic events may be of the same type (for example, multiple incidences of abuse or several instances of flooding in river communities) or they may be of different types (for example, if a client were raped, lost her job, and was involved in an automobile accident). Finally, there are instances where the environment itself is traumatic, for example, living with ongoing domestic violence or living in a war zone (Courtois, 2008; Muller, 2009).

Another common way of assessing the traumatic impact of an event or events is to use the following characteristics as guidelines: Is the traumatic event acute or chronic? Does it affect the person physically or emotionally or both? Was the traumatic incident intentional or accidental? Was violence involved, and what was the timing of the traumatic event? (Courtois, 2008; Muller, 2009).

Resolved v. Unresolved

Yet another important aspect when dealing with trauma is to determine whether the trauma is “resolved” or “unresolved.” “Resolved” trauma does NOT mean trauma that no longer has any impact on the traumatized individual. Instead, resolved trauma involves events where the person has been free to explore and process the trauma that occurred. This then frees traumatized persons to move onto their next set of normative developmental tasks (Bowlby, 1980).

Unresolved trauma is trauma that has not been explored or processed or in some cases even acknowledged. To parent effectively after trauma occurs, the parent must not only help the child seek resolution for his or her experiences, but the parent must also explore what, if any, trauma, resolved or unresolved, lies in the parent's past and be willing to seek resolution for those experiences (Shapiro et al., 2006).

How Does Trauma Affect Parenting?

To begin to answer this question requires exploration of the normative parenting process. If parenting is viewed as a job, then what are the tasks parents are expected to perform and what are the ultimate goals? Below is a list of some of the dominant culture's expectations of parents:

- To develop a secure attachment
- To teach and guide
- To instill morals, values, beliefs, ethics
- To discipline

- To set limits
- To follow through
- To listen
- To protect
- To keep the children safe
- To help children internalize skills such as: trust
- To help children learn interdependence by instilling self-confidence and use of adults
- To provide unconditional love
- To provide consistency, predictability, reliability
- To be “mindful” of our children- aware and open to what the child needs
- To provide the basic needs
- To pass on traditions, culture, prayer
- To teach about issues such as oppression, sexuality
- To model healthy problem solving and feelings management techniques

([Http://deltabravo.net/custody/parentingskills.php](http://deltabravo.net/custody/parentingskills.php);
www.childtrendsdatatabank.org)

Do these expectations fit for the clients in the groups? Are there particular tasks or goals that clients feel need to be added to the list? As group members begin to become more aware of the massive undertaking of normative parenting,

they can more easily see why it is essential to discuss the impact of trauma on parenting.

Exercises

I. What is Trauma?

A. Purpose:

Begin to gently yet intentionally expose group members to a wide variety of sensory experiences as they integrate the information they are receiving through the groups.

B. Materials:

1. Markers
2. Poster board or Dry Erase Board

C. Activity:

Members call out as many words as they can come up with that are synonymous to “trauma;” facilitator records words on poster board as they are called out; the group members BRIEFLY (3-5 minutes) process the impact of seeing the words they have come up with written.

II. Reading Aloud

- ##### **A. Purpose:** Using Children’s literature to build empathy and promote understanding of the ways that children process trauma

B. Materials needed:

1. A Terrible Thing Happened
2. Christopher's Anger

(when working primarily in non-dominant cultural groups the first book may be more appropriate as the story is less specific and more generalizable across a broad range of cultures and beliefs)

C. Activity:

1. Read the book
2. Briefly discuss groups' reactions, feelings, etc.
3. Are members able to empathize with the thoughts, feelings, and sensations of the children in the books?

Group 3: Feelings

What Are Feelings?

Feelings can be defined as emotions, thoughts, and beliefs regarding a situation. Affect labeling, or giving feelings words, can play a significant role in managing negative emotional experiences, and recent studies with fMRI suggest that affect labeling can even change neurocognitive pathways (Muller, 2009).

Useful questions to be explored when discussing feelings include:

- What are *clients'* feelings regarding the trauma they and/or their children have experienced?

Many clients may not yet be able to name even basic feelings. This is an appropriate time to hand out a list of feelings words or a feelings chart (see Adjunctive Materials) and begin to discuss what these words mean and how they may be applicable to various situations.

- How do clients cope with feelings?
- How do clients' children cope with their feelings?

Exercises

I. Feelings cards

A. Purpose

1. To build empathy for emotions a child may be experiencing; how overwhelming these multiple feelings may

be for children; and the ways these emotions can affect children's behaviors.

2. To build a vocabulary of "feelings" words
3. To help participants begin to associate affect with feeling (affect-labeling) by giving examples of different displays of emotion.

B. Materials needed:

1. Deck of feelings cards (with BOTH pictures and words)
2. Posterboard
3. Markers

C. Activity

1. Pass around your deck of feelings cards
2. Have parents choose and pull from the deck as many feelings as they believe their child is experiencing.
3. Facilitator reads the cards NOT picked
4. Each individual group member reads the cards he or she picked and the facilitator makes a list on poster board/ white board, etc.

5. Process participants' experiences of seeing the feelings listed together.

Group 4: Normative Child Development

Ages and Stages (Erikson)

Erik Erickson (1950) delineated a stage model of development that is fairly easy for clients to understand. The purpose of introducing this material to clients is NOT to overwhelm them, but to simply help them develop an appreciation for what is normative development and what may be trauma-related. It is important to stress that the stages cover cognitive, social, emotional, and behavioral development, and that the ultimate goal of stage resolution is interdependence (the ability to function both independently and in relation with others), as well as the fact that other developmental theories exist and Erikson's theory is gender-biased. Erikson's stages are listed below. With some groups it may be helpful to provide them with a handout on the stages; however, some groups may find this overwhelming.

- Trust v. Mistrust (birth-16 months)
- Autonomy v. Shame & Doubt (16 months-3.5 years)
- Initiative v. Guilt (3.5-6years)
- Industry v. Inferiority (6-12 years)
- Identity v. Role Diffusion (12-18 years)
- Intimacy v. Isolation (19 years –until ~30 YEARS)
- Generativity v. Stagnation (30's & 40's)

- Ego Integrity v. Despair (50years and up)

What About The Brain?

To fully understand early attachment trauma, it is imperative to have some understanding of the brain and how it works because trauma that occurs in the early developing brain is most likely to cause damage, now and in later life (Muller, 2009). Early trauma disrupts not only attachment, but also the child's physical, cognitive, emotional, and relational development.

The goal of this session is to give clients a basic understanding of how the brain works and how it is affected by a traumatic incident during early attachment. Again the idea is to impart a rudimentary understanding without overwhelming the client with details. This is most easily done by discussing the brain as having three different parts that come online at different stages of development: the brainstem, the limbic system, and the cortex (Ogden, 2006). The brainstem is responsible for the most basic and instinctive of functions (e.g., breathing, heartbeat). The brainstem is most comparable to the brain functioning of a reptile. When trauma occurs, the brainstem provides the gateway for sensory input. Next is the limbic system (which includes the hippocampus, amygdala, and the thalamus) which controls emotion and feeling. This is where procedural learning occurs and where implicit memory is stored. All mammals share these abilities. Finally is the cortex or the part of the brain that makes us unique as humans. This is the area of the brain that exercises control over executive functions of the brain such as selective attention, working memory, self-observation, understanding, and insight (Nijenhuis, 2004).

The highly developed pre-frontal cortex distinguishes humans from the rest of the animal kingdom because it provides the ability to choose responses to stimuli rather than acting solely based on instinct (Van der Kolk, 2005). Prior to the development of the pre-frontal cortex, children are able to act only out of instinct and emotion, relying on adults to regulate the child's response to the environment when a child is in distress (Ogden, 2006). For example, at the end of a long day and a tiring shopping trip with bright lights and strange people, a toddler is likely to tantrum if told "no." The toddler relies on the adult caregiver to act as a pre-frontal cortex by removing the child from the excess sensory stimuli, changing the environment as needed, and soothing the distress (van der Kolk, 2005). The child who is unable to depend on early attachment relationships to meet these needs experiences a greater likelihood for developing Complex PTSD (Courtois, 2008).

Exercise:

A. Purpose:

To make the concepts of developmental stages more user friendly and to illustrate how trauma can affect development.

B. Activity

1. Describe a "make-believe" family (e.g., 37 year old parent, 14 year old male, 6 year old female, and 2 year old female)
2. Have a group discussion of what the normative development features might be for each child, e.g.:

- a. 14 year old: puberty, change in sleep patterns, social life revolves around friends, awareness of social norms, intimate interests, egocentrism, moodiness, broadening of thinking skills
 - b. 6 year old: increased control of body, memory developing, engages in pretend play, basic comprehension of consequences and rules, magical thinking, rapid language development, cooperative play, group play, development of cultural awareness
 - c. 2 year old: mobilization, solitary play, aggressive with others, often frustrated, recovers quickly when upset, limited internal control, intense exploration of their environment, persistent, imitates language
3. Ask group to then name ways that normative development might be affected for each child based on information learned earlier. Answers might include:
- a. 14 year old: difficulty controlling feelings and behaviors, blame, shame, self-doubt, guilt, and anger
 - b. 6 year old: difficulty controlling behavior, self-doubt, prefers solitary play, guilt, shame, does not engage in pretend play
 - c. 2 years old: clingier than usual, marked increase in difficulty controlling feelings and behaviors, regression in developmental

milestones that have already been achieved, tantrums, marked increase in aggression.

Group 5: Interaction between trauma and development

Strategies of Survival: “Coping Skills” or “Acting Out”

. Some professionals divide survival strategies into two categories: positive (also known as “coping skills”) and negative (also known as “acting out”). Because the degree of shame that exists around trauma is typically already potentially high, clients may be less than receptive to this division and may become defensive. It can be helpful instead to conceptualize these as one group that includes all the strategies of survival, and then to discuss which of these strategies may no longer be helpful or may even be harmful in the present.

Exercise

Have group members brainstorm as many potential coping strategies as they can. Group Leader writes these on one piece of poster paper. Next, group identifies which strategies are no longer helpful. Group leader circles each of these on the original sheet of paper to reiterate that these are all simply attempts to cope with trauma. On a new sheet of paper, group leader lists all of the coping skills that remain helpful in order to emphasize various ways of choosing to cope. If a particular group member disagrees or insists that an “unhealthy” strategy is in fact helpful, the facilitator may wish to explore this concept further with the group or with the individual at the break.

Groups 6 and 7: Resiliency, Relationship, Connection, Attachment

Attachment Is Neither A Disorder Nor A Dichotomy

Attachment is neither a disorder nor a dichotomy. Attachment is a life-long process that can be and is influenced by a range of factors and events. Early attachment styles of both the parent and the child are important to explore because these early styles are predictive of adult attachment styles. However, because attachment is a life-long process, many situations will mediate changes in attachment styles from infancy to adulthood.

The Continuum of Attachment essentially covers the spectrum between secure attachment and insecure attachment, with four distinct types of attachment acknowledged: secure, anxious-resistant or ambivalent insecure, anxious-avoidant insecure, and disoriented-disorganized.

To sustain, develop, and secure attachment within a relationship, the primary attachment figure must demonstrate four primary behaviors in developmentally appropriate contexts:

- Proximity Maintenance
- The relationship as a Safe Haven
- Some degree of distress when separation occurs
- Ability to view relationship as a “secure base”

Attachment Is A Two-Way Street

Early attachment refers to the behaviors exhibited by both the infant and caregiver in the infant-caregiver relationship. Examination of early attachment is essential because human beings core ability to regulate emotion is developed through the attachment process. When trauma occurs during the early attachment process, the traumatized person's ability to regulate emotion may be effected. One of the most useful conceptualizations for re-regulating emotions is the concept of Mindfulness (Shapiro, et al., 2006).

Spirituality And Attachment

One definition of Mindfulness is the ability to experience the present moment without judgment (Kabat-Zinn, 1989). Ogden (2004) focuses on the use of Mindfulness as more of a tool than a spiritual practice. The author offers the idea that the practice of Mindfulness is essential for adults with early attachment trauma because it keeps the pre-frontal lobes active, facilitates communication between the “adult self”/”witnessing ego” and the earlier self that is experiencing the dysregulating conditions. Thus, Mindfulness is itself a useful tool for emotional regulation because it increases awareness and develops flexibility and adaptability in responding to emotional states (Ogden, 2004). Clients with complicated symptoms may experience emotional numbing and chronic hyperarousal which can cause deficits in attention, difficulties in learning, functional impairments, and limited awareness. Mindfulness allows the client to accept rather than suppress emotions and may reduce emotional numbing and chronic hyperarousal (Ogden, 2004).

Ogden (2004) also suggests that Mindfulness is important for its ability to promote a sense of mastery and to build confidence. In a 2006 article, Shapiro et al., pushes this idea further by noting the importance of the spiritual component of Mindfulness. They posit that Mindfulness is essential for providing meaning, purpose, and ultimately transcendence over traumatic experiences (Shapiro, et al., 2006) Shapiro et al., support the idea that professionals must attend to the spiritual as well as the cognitive, emotional, and interoceptive healing processes of clients with Complex PTSD (2006). Shapiro et al., merely focus on the particular spiritual practice of mindfulness as a means of promoting resiliency (2006).

Mindfulness has seven foundations as outlined by John Kabat-Zinn (1989). These are non-judging, patience, beginner's mind, trust, non-striving, acceptance, and letting go. The three distinct parts or qualities of mindfulness are as follows:

- Awareness of the internal organization of experience rather than the story or insight;
- Awareness is focused on present experience rather than past or future; and
- Awareness is curious and interested rather than interpretive or intent on change (Kabat-Zinn, 1989).

Exercise

Do a brief (30 second-two minutes) mindfulness exercise with the group. What feelings, sensations, words, or images does this evoke for participants? Discuss.

Group 8: Shame, Blame, Anger

What are shame, blame and guilt?

Shame:

Internalizing: Shame is a disconnection from self, and inability to trust intuitions and internal experiences; prior to internalization, shame remains a feeling and is passed on; once internalized shame becomes prolonged indefinitely. Feeling “seen” in a painfully diminished sense; i.e., “There is something wrong with ME, and there is nothing I can do to remedy the situation” (Kaufman, 1985).

Blame:

Externalizing: Holding someone responsible for actions, mistakes, judgments, errors, etc. and attributing these to an inherent character flaw in the person being blamed (as opposed to requiring the person to take responsibility and/or repair the situation without blaming)

Guilt:

Pre-internalized shame: Guilt is shame that has not yet been internalized. It remains a feeling and passes on as all feelings eventually do. Therefore, the critical differentiation is not between “shame” and “guilt” but between “shame as affect” and “internalized shame.”

Group 9: Healing our own grief (Being the parent you didn't have)

Opening Pandora's Box

Survivors of trauma often avoid exploration of traumatic memories for fear of “opening Pandora’s Box.” The question then becomes which version of Pandora’s Box do they accept? Does Pandora’s Box contain a never-ending tide of misery or a constant ebb and flow of healing and transformation? Grief is not about absolutes. Even in the absence of trauma, parent-child relationships are typically complicated, confusing, and filled with a variety of contradictory feelings. When trauma is present, these relationships and memories become even more complicated, resulting in fear of even exploring these relationships. However, parents must begin to deal with their own grief in order to effectively address the myriad of feelings their children face. The myth of Pandora’s Box is an excellent example of this complexity and can help us understand that we can transform that which is painful into something more hopeful and positive (Bassoff, 1991).

Pandora's Box, in patriarchal mythology, was the container of all evils, unleashed on *mankind* by the greatest evil of all - the first woman. In Hesiod's version, Woman was sent to man as a punishment for the theft of fire from the gods by Prometheus. Zeus gave Pandora a box filled with all the miseries of mankind: death, disease, famine, despair, etc. Zeus knew that

Pandora would not be able to contain her curiosity and would open the box, thus releasing all strife on mankind for the first time.

However, the name Pandora originally means "Giver of all gifts", and was a name of the divine *Maya*, the all-creative and all-giving aspect of the Mother God figure. Pandora was also a title of the Earth-Goddess Rhea. In the original version, Pandora held not a covered box, but a vase, typically a cornucopia, or womb-like symbol frequently used as a symbol of death and rebirth. From this vessel she poured out blessings upon all of humanity. The entire meaning of the myth changed when Erasmus mistranslated the Greek word for "vase" as meaning "box." The classical legend of Pandora's Box is thus one of the most extreme examples of patriarchal "mythic inversion" (Walker, 1983).

Both stories of Pandora's Box center on the same object, but depending on one's perspective, the object can be one of despair and hopelessness or an object of blessing and hope. Although clients cannot change the past, just as clients can change their view of Pandora's Box, they can transform their beliefs about the meanings of the past.

Am I Just Being Selfish?

Often survivors will avoid exploring the grief that surrounds their traumatic experiences out of a belief that to do so would be "selfish." Survivors sometimes make statements like: "That's in the past so it shouldn't bother me;" or "S/he

can't change what s/he did in the past so what's the point in dwelling on it.”

However, grieving is not a selfish activity, but a necessary and normal part of all relationships. Grieving relationships is about awareness and self-care rather than self-centeredness or selfishness. Also, people attempt to repair their childhood relationships NOT ONLY because they want another chance to “do it right”; people also want their caregivers to have a second chance to love them the way they deserved to be loved and cared for (Bassoff, 1991).

Honoring our pain

Finally, many fear that to attempt reparation of traumatic past relationships, survivors somehow dishonor themselves and invalidate their very real suffering. As Bassoff (1991) states, however, “[d]eveloping compassion for the wounded [parent] does not preclude honoring the pain of the hurt child within oneself.”

Exercise

I. The Shame Jar

- A. Purpose: to help the group members begin to honor their own grief and say goodbye to shame and guilt.
- B. Items needed:
 - 1. small slips of paper
 - 2. markers for everyone
 - 3. a shame and guilt jar

C. Instructions:

1. Have each group member make a list of things they feel they “should’ve” done, feel guilty about, view as personal failures, etc.
2. For each item listed, does the following apply: “If I had had the power or awareness, I would have changed the situation. I didn’t have either and I did the best I could.”
3. If this applies, the participant puts the stated “failure” into the shame jar. If this does not apply, explore what might have made a difference and more effective ways to deal with the issue.
4. Perform a ritual to symbolically destroy these pieces of shame and guilt (e.g. Pour clear water and salt into the shame jar and stir until the papers become indistinguishable from each other and create a paste that can be disposed of easily; while burning is a powerful symbol, this is not necessarily advised because the facilitator must be able to maintain and ensure the safety of the group.)

Group 10: Our Children Are Not Us (Giving Them What They Need, Not What We Think They Should Have)

Being a “Good Enough” Parent

An essential part of the healing process is developing the habit of nurturing ourselves. Society has engaged in a lengthy history of trying to define “the perfect parent.” The reality, though, is that children don’t need “the perfect parent;” they need a “good enough” parent. What is the difference? The “good enough” parent is a human being with all the adherent faults and foibles this entails; rather than pretend to be perfect, however, the “good enough parents” seek insight into their feelings and behaviors; apologize when they make a mistake, and thus model for their children what it means to be human. “Good enough” parents give their children unconditional love, while also giving them the gifts of responsibility, values, and character (none of which can be learned from the “perfect parent.”) The job of the “good enough” parent includes the following:

- To teach and guide
- To instill morals, values, beliefs, ethics
- To discipline
- To set limits
- To follow through
- To listen
- To protect

- To keep the children safe
- To help children internalize skills such as: trust
- To help children learn interdependence by instilling self-confidence and use of adults
- To provide unconditional love
- To provide consistency, predictability, reliability
- To be “mindful” of our children- aware and open to what the child needs
- To provide the basic needs
- To pass on traditions, culture, prayer
- To teach about issues such as oppression, sexuality
- To develop a secure attachment
- To model healthy problem solving and feelings management techniques

(Winnicott, 1953).

One of the most important ways to ensure that we are “good enough parents” is to take time to nurture ourselves so that we have nurturing to give to our children. Below is a list of ideas for self-nurturing. Review these with the group and have them generate a list of their own.

Ideas for self-nurturing

- Keep a journal

- Create a sanctuary (place or time) you set aside where you can give yourself permission to feel your grief (and other feelings).
- Wear a piece of inspirational jewelry
- Read a favorite book or poem
- Take a moment each day to center yourself and listen to your heart.
- Read a daily affirmation (There are a wide variety of affirmation books available; however, you can also create your own).
- Plant a flower
- Develop safe and comforting visualizations
- Take a hot bath or shower
- Smell an essential oil
- Go for a walk or a run
- Wrap yourself in a warm blanket and have a cup of tea
- Do something “just for you”

Exercise

I. Gentle Reminder Cards

A. Purpose: to help parents become more conscious of the ways that they might be gentle with themselves as well as their children.

B. Materials needed:

1. small pieces of cardstock
2. markers
3. stickers, Band-Aids, colorful stamps, &/or any other creative materials

C. Instructions

1. Have the group brainstorm synonyms for the word “gentle” (Examples include *serene, calm, still, considerate, kind, patient, tender, tranquil, composed, loving, etc.*)
2. Have group members write these individual words on pieces of cardstock and decorate them.
3. Each member now has his/her own stack of “Gentle Reminder” cards.
4. Instruct members to stash the cards in various places (e.g., glove compartment of the car, a desk drawer at work, a kitchen cabinet, a dresser drawer, a purse, etc.) so that they will find them randomly at later

dates and thus be reminded to be gentle with themselves and others.

Equally important once we have mastered nurturing ourselves is to master the art of nurturing others. Below are some ideas for ways to nurture children; however, nurturing in any relationship involves a healthy sense of boundaries and our own ability to regulate our emotions.

Nurturing Children

- Establish routines for mornings, bedtime and other transitions
- Try to eat at least one meal together.
- PLAY, PLAY, PLAY!!!!!!!!!!!!!!!!!!!!
- Give compliments that are positive, specific, and behavioral rather than ones that are personal (e.g. “I really liked the creative way you approached your disagreement with your brother.” vs. “You’re awesome (smart, pretty etc.)”)
- Give directions that are clear, calm, and concise.
- Call or text your teenager just to say, “Hi”
- Remember that no matter how it seems, your child’s ultimate goal is to please you and get your attention.
- Emotional regulation is a learned skill; teach your child age appropriate exercises for grounding, breathing, yoga poses, and other ways to self-soothe.

Groups 11 and 12: Closing Group

Goodbyes Aren't Supposed To Be Easy

Many of the participants will likely express some type of discomfort or dismay that the group is ending. By discussing the concept of “goodbyes,” they are allowed to share their fears and to again experience a sense of belonging as other group members share similar feelings. Just as importantly, this discussion allows the therapists to model for the clients an experience where relationship (therapist-client) disruption need not be trauma-inducing; that difficulty with transitions is a normative response; and that emotional regulation can be maintained even if past traumas are triggered.

Internalizing Relationships

Heinz Kohut wrote, “a clear, clean, polished mirror will repeatedly reflect the developing person as he actually is and give him a firm and true sense of his own identity. A cracked, dirty, smeared mirror will reflect an incomplete, obscured image that provides [a person] with an inaccurate and distorted view of himself” (Bassoff, 1991) The ultimate goal of the group is help participants to be mirrors for their children that are clear and clean as opposed to being distorted through the lens of trauma. This reflection allows the relationship to be internalized by the individual, strengthening the bonds of attachment, and in essence facilitating the continuity of the relationship even though the two people may no longer be in physical proximity with one another.

Hopefully, the group experience has been a rich and fulfilling one for the participants. Therefore, facilitators should spend some time with the group reflecting on ways that the group relationships have been internalized, what this internalization means, and ways to maintain that feeling of connection even though the group itself is over.

The Importance of Rituals

Rituals can play a very important part of saying goodbye. Rituals provide a concrete way to express the difficult mix of emotions that relationship disruption can induce. The “right” ritual varies as much as the personalities of each different group. The ritual need not be elaborate, complicated, or expensive. The ritual simply needs to provide the members with a way to mark the importance of the group as the group is ending. (See Adjunctive Materials for ideas).

Re-administer the PCRI and the TSI

Exercises:

I. Group Journey

- A. Purpose: To reflect on group attachment and building relationships by having group members work together to reconstruct their journeys.
- B. Material needed:
 - 1. Poster paper or tag board for each week of group
 - 2. Markers
 - 3. Tape
- C. Activity:

1. On each piece of poster paper write the group theme for one week.
DO NOT INCLUDE THE ACTUAL WEEK NUMBER the topics were covered. Make one sign for each individual group topic.
2. Place the pieces of poster paper in a pile in random order.
3. Have the group work together to put the poster papers in the order the topics were covered, taping them in order around the room.
4. Provide three minutes for this activity.
5. Participants must complete the task without talking or using words.
6. Process the activity with group members. What have they experienced on their individual journeys? Their journey as a group? Has anything changed for them? If so, what? What are their plans now that group is ending?

II. Affirmation Activity

- A. Purpose: Provide individuals with affirmation from other group members, and give them an opportunity to affirm themselves.
- B. Materials needed:
 1. Blank paper (if possible try to find paper with a “child-like” theme)
 2. Markers (enough for each group member to have one)
- C. Activity:
 1. Provide each member with a blank piece of paper
 2. Have each group member write his/her name on the paper.
 3. Member then passes the paper to the left.

4. Each member writes an affirmation on the paper about the person whose name is on the paper.
5. Continue passing papers to the left until each person has his/her own paper back.
6. Have each member quietly read the written affirmation to themselves.
7. Give each member a new piece of blank paper.
8. Have group members change each of their affirmations into “I” statements, and write these statements on the new paper.
9. Group members then read their “I” statements aloud.
10. Spend a few minutes processing the exercise.

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Weekly Handouts For Group Members

The following outlines are in handout format. The leaders may choose to use these as handouts for group members for each of the group sessions.

Handout 1

Introductory session

Educational Topic: Why Are We Here?

- What do we mean by “Relationships After trauma?”
- Why not a regular “parenting class?”
- Overview of Group Structure and Basics
 1. Every _____ (day of the week)
 2. _____ weeks (#of weeks)
 3. 6-8pm promptly
 4. Closed group
 5. Psycho-educational/experiential as well as therapeutic group
 6. Re-stimulation of own trauma: recommend therapy
 7. Attendance is expected
 8. Child care is/is not available
 9. Expectations of Homework

Format:

For The Evening

- a. Brief introduction of facilitators
- b. Brief introduction of group members
- c. Icebreaker
 - e.g., 2 truths and a lie regarding their family
- d. Creation of group rights
- e. Explanation of mandated reporting

f. Introduce general group format

1. Check in
2. Brief review of homework
3. Group rights
4. Education
5. Break
6. Process time relating to educational topic
7. Assignment of homework
8. Check out
9. Next week's topic
10. Closing affirmation

Pretest

Administer PCRI & TSI (assessment instruments)

For PCRI, use child that you feel relationship is most strained

Will re-administer at end of group

Break (10-15 minutes)

Exercise:

Homework assignment:

Check out

Next week's topic: Trauma-What is trauma? How have your own experiences of trauma as a child &/or adult effected your parenting decisions? What are your belief systems around resolution, healing?

Closing affirmation: The Tao of Motherhood p. 41 "Clarity" or p.128 "Healthy Parenting"

Handout 2

What is “Trauma”?

Educational Topic: What is “Trauma”?

- What is trauma?
- Resolved v. Unresolved
- How does trauma affect parenting?

Format:

Welcome new members

Brief introduction of facilitators

Brief introduction of group members

Icebreaker

Creation of group rules/rights

Explanation of mandated reporting

E.g. Group rights

- I have the right to:
 - Ask questions
 - Be myself
 - To learn
 - To make mistakes q
 - To be safe
 - To express my opinion
 - To be heard
 - To confidentiality
 - Not to be judged
 - To express my feelings
 - To cry
 - To have me time
 - Not to be perfect
- Brief review of Group format
 - Check in
 - Brief review of homework
 - Group rights

- Education: topic Trauma. What is it? Types of trauma. How does childhood trauma impact parenting? Resolved/Unresolved?
 - Break
 - Process time relating to educational topic
 - Assignment of homework
 - Check out
 - Next week's topic
 - Closing affirmation
-
- Educational Topic: What is "Trauma"?
 - BREAK (10-15 minutes)
 - Process time:
 - Exercise:
 - Homework assignment: Self Care
 - Check out:
 - Next week's topic: Feelings
 - Closing affirmation: The Tao of Motherhood p. 57 "Trust"

Handout 3

Feelings

Check-in

Brief review of Homework

Review group rules/rights

Educational Topic: Feelings

- What are feelings?
- What are your feelings regarding the trauma you and/or your children have been exposed to?
- How do you cope with your feelings?
- How does your child cope with his/her feelings?

BREAK (10-15 minutes)

Process time:

Exercise:

Homework assignment:

Check out

Next week's topic: Normative Child Development: Ages and Stages/Development with trauma

Closing affirmation: The Tao of Motherhood p. 105 "War"

Handout 4

Normative Child Development: Ages and Stages

Check-in

- **Brief review of Homework**
- **Review group rules/rights**
- **Educational Topic: Normative Child Development: Ages and Stages**

Ages and Stages (Erikson)

Goal: Independence or Interdependence?

Planes of development:

- Cognitive
- Emotional
- Physical
- Psychosexual
- Psychosocial
- **What about the Brain?**
- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment:**
- **Check out**
- **Next week's topic:** Developmental impact of trauma
- **Closing affirmation:** The Tao of Motherhood p.25 "Detachment"

Handout 5

Developmental Impact of Trauma

- **Check-in**

Brief review of Homework

Review group rules/rights

Educational Topic: Developmental Impact of Trauma

Strategies of survival

“Coping Skills” or “Acting Out”

- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment:**
- **Check out**
- **Next week’s topic:** Resiliency, Relationship, Connection, Attachment
- **Closing affirmation:** The Tao of Motherhood p. 47 “Self-Care”

Handout 6

Resiliency, Relationship, Connection, Attachment

- **Check-in**

Brief review of Homework

Review group rules/rights

Educational Topic: Resiliency, Relationship, Connection, Attachment

- Attachment is not a disorder or a dichotomy
- Attachment is a two-way street
- Spirituality and attachment

- **BREAK (10-15 minutes)**

- **Process time:**

Exercise:

- **Homework assignment:**
- **Check out**
- **Next week's topic:** Shame, Blame, Guilt, and Anger
- **Closing affirmation:** The Tao of Motherhood p.168 "Paradox"

Handout 7

Shame, Blame, Guilt, & Anger

- **Check-in**
- **Brief review of Homework**
- **Review group rules/rights**
- **Educational Topic:** Shame, Blame, Guilt, & Anger
- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment:**
- **Check out**
- **Next week's topic:** Healing our own grief (Being the parent we didn't have)
- **Closing affirmation:** The Tao of Motherhood p.169 "Resolution"

Handout 8

Healing Our Own Grief (Being The Parent We Didn't Have)

- **Check-in**
- **Brief review of Homework**
- **Review group rules/rights**
- **Educational Topic:** Healing our own grief (Being the parent we didn't have)
 - Pandora's box
 - Grief is not selfish
 - Compassion does not mean forgetting or even forgiving
- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment:**
- **Check out**
- **Next week's topic:** Our children are not us (Giving them what they need not what we think they should have); begin process of ending group
- **Closing affirmation:** Quote by Marianne Williamson

Handout 9

Our children are not us (Giving them what they need not what we think they should have)

- **Check-in**
- **Brief review of Homework**
- **Review group rules/rights**
- **Educational Topic:** Our children are not us (Giving them what they need not what we think they should have)
 - Being a “Good Enough” Parent
 - Nurturing Ourselves
 - Nurturing our Children
- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment:**
- **Check out**
- **Next week’s topic:** Saying Goodbye
- **Closing affirmation:** Quote by Kahlil Gibran

Handout 10
Ending Group

- **Check-in**
- **Brief review of Homework**
- **Review group rules/rights**
- **Educational Topic:** Saying Goodbye
 - Goodbyes aren't supposed to be easy
 - Internalizing relationships
 - The Importance of Rituals
- **BREAK (10-15 minutes)**
- **Process time:**
- **Exercise:**
- **Homework assignment**
- **Check out**
- **Goodbye Ritual**
- **Closing affirmation:**

Adjunctive Materials for Group Facilitators

The following includes various handouts for different group sessions, feelings lists, feelings wheel, instructions for making feelings box & feelings cards, etc.

Potential interview/intake questions for group member selection

Section 1:

Begin by collecting basic demographic information (e.g., name, contact information, insurance if applicable, releases of information if needed, etc.). This is a good time to cover informed consent, mandated reporting, etc. Once the basics are collected, use this section to get a brief understanding of why the client is there (e.g. “How did you hear about the group?”, “What would you like to get from the group?”, “What types of trauma have you and your family experienced?” etc.)

Section 2:

Collect a brief outline of the client’s trauma history from birth until the present. This does not need to be extensive, but the questions should be short and direct as this is typically a difficult subject to discuss with a stranger. Include questions about the family’s mental health history, chemical dependency issues, incidents with child protective services, etc. This section should answer any questions you might have regarding developmental trauma and/or intergenerational trauma.

Section 3:

Have client describe his/her relationship(s) with his/her child(ren). Examples of appropriate questions might include the following:

- How do you spend quality time with your child(ren)?
- What activities does your family do together as bonding activities?
- How do you discipline your child(ren)?
- How would your child(ren) describe the parent child-relationship between you?

Affirmations

- ◆ There is a miracle in every new beginning
- ◆ Save a space for sunshine☀☀, rainbows☁, and dreams....
- ◆ It's okay to cry.
- ◆ We often learn best from our mistakes.
- ◆ Take time to PLAY!!!!
- ◆ I know people care about me.
- ◆ I will do something today that will make me feel good.
- ◆ I can be different from my friends and still be okay!
- ◆ You only fail when you stop trying.
- ◆ Be patient with yourself ~ you are growing every day.
- ◆ Make your life an act of love.
- ◆ Be kind. Everyone you meet has worries
- ◆ Courage makes everything look different.
- ◆ A person who makes no mistakes does not usually make anything. Edward Phelps
- ◆ Give some special thanks today just because you're free.
- ◆ Imagination is like a magic carpet; it can take you anywhere!
- ◆ Be patient with yourself.
- ◆ Be kind to the people who live in your house.
- ◆ Only you can decide how you are going to act.
- ◆ It's not doing the things we like, but liking the things we do that makes life happy.
- ◆ Look for the magic within yourself.

Excerpted from: Kids Thot-a Day

- ◆ There is no way to be a perfect parent, and a million ways to be a good one. *Jill Churchill*
- ◆ Parent's love is peace. It need not be acquired. It need not be deserved. *Erich Fromm*

Quote from Kahlil Gibran's *The Prophet: On Children*
Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you, and yet they belong not to you.
You may give them your love but not your thoughts,
For they have their own thoughts.
You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow, which you cannot visit, not even in your
dreams.

Kahlil Gibran
The Prophet, On Children

Quote by Marianne Williamson

"Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us.' We ask ourselves, who am I to be brilliant, gorgeous, talented, fabulous? Actually, who are you not to be? You are a child of God. Your playing small does not serve the world. There's nothing enlightened about shrinking so that other people won't feel insecure around you. We are all meant to shine, as children do. We were born to make manifest the glory of God that is within us. It's not just in some of us; it's in everyone. And as we let our own light shine, we unconsciously give other people permission to do the same. As we're liberated from our own fear, our presence automatically liberates others."

From: Williamson, M. (1992) A Return to Love: Reflections on the Principles of "A Course in Miracles." Harper Collins.



DOMESTIC ABUSE INTERVENTION PROJECT

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Instructions for Making Feelings cards

1. Find pictures of people displaying various emotions. (Good places to look include old magazines, stock photography books, computer clip art and Google images, e.g.).
2. Glue images to sturdy 4x6 white cards, or if using computer images print them on 4x6 photograph paper.
3. On the opposite side of the photograph, write the actual word for the feeling
4. Using a laminating machine or self-lamination paper, laminate the cards.

Instructions for Making a Feelings Box or Jar

1. Find an old box or jar (shoe boxes, oatmeal containers, empty, clean peanut butter or mayonnaise jars make good containers).
2. Use colorful paper, pictures, stickers, colorful tape, and any other creative decorations to decorate the box or jar.

List of Feelings Words

A's

Anger	Apathy	Afraid	Alienated	Ambivalent
Anxious	awkward	Annoyed	Alone	Apathetic
Alarmed	aghast	Appalled	Aching	Apprehensive
Agonized	Acrimonious	Accepted	Accepting	Amazed
Amused	Alive	Affectionate	Attached	Able
Active	Adequate	Adored	Alert	Accountable
Attentive	Authentic	Aware	Assertive	Appreciated
Amused	Amenable	Ambitious		

B's

Bothered	Bitter	Burdened	Bugged	Belligerent
Bored	Bashful	Breathless	Boxed (in)	Bugged
Bright	Blessed	Brave	Balanced	Blissful
Bonded				

C's

Cold	Crabby	Cruel	Crushed	Cantankerous
Cross	Combative	Cheerful	crestfallen	Conspicuous
Callous	Childish	Concerned	Cautious	Contrite
Cowardly	Choked (up)	Calm	Comfortable	Clever

D's

Destructive	Defiant	Despondent	Discordant	Disconsolate
Distraught	Dejected	Deceitful	Different	Disconnected
Distant	Divided	Doubtful	Dubious	Disappointed
Distrustful	Desperate	Doomed	Defeated	Deprived
Diminished	Dismayed	Depressed	Dismayed	Divine

E's

Elated	Enthusiastic	Energetic	Evasive	Enraged
Exasperated	Empty	Enervated	Exhausted	Embarrassed
Edgy	Easy	Encouraged	Envious	Eager
Earnest	Energetic	Euphoric	Expressive	Exuberant
Experienced	Excited	Exhilarated	Ecstatic	Empowered

F's

Fabulous	Furious	Fuming	Frustrated	Fed-up
Flat	Feeble	Fatalistic	Fearful	Fantastic
Flaky	Flustered	Frantic	Frightened	Freaked (out)
Fidgety	Frail	Frigid	Foreboding	Flexible
Free	Focused	Forceful	Fortunate	Fulfilled

G's

Gleeful	Grouchy	Grumpy	Groovy	Gracious
Grateful	Guilty	Gloomy	Glum	Grief-stricken
Great	Glad	Guarded	Grounded	Gentle
Gratified	Genuine			

H's

Hateful	Hysterical	Hurt	Harassed	Heartbroken
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Hollow	Hesitant	Haggard	Horrible	Horrified
Hostile	Helpless	Hypocritical	Hurt	Happy
Helpful	Harmonious	Heroic	Honored	Hopeful
High	Humble			
<u>I's</u>				
Irate	Irritable	Infuriated	Irked	Incompetent
Isolated	Indecisive	Inferior	Irresolute	Intimidated
Intolerant	Insane	Important	Independent	Included
Inspired	Invigorated	Invincible	Interested	
<u>J's</u>				
Judgmental	Joyful	Jovial	Judicious	Jubilant
<u>K's</u>				
Kind	Keen			
<u>L's</u>				
Lonely	Lost	Lazy	Listless	Liberated
Light	Lighthearted	Loved	Loyal	Lucky
<u>M's</u>				
Moody	Mad	Misunderstood	Melancholy	Manipulative
Miserable	Mindful	Marvelous	Meek	Merciful
Motivated				
<u>N's</u>				
Noble	Nervous	Nauseated	Needy	Nice
Neat	Non-judgmental			
<u>O's</u>				
Overwrought	Overjoyed	Obnoxious	Odd	Overwhelmed
<u>P's</u>				
Proud	Pestered	Perplexed	Paranoid	Perturbed
Petrified	Paralyzed	Pained	Panicky	Picky
Pathetic	Pensive			
<u>Q's</u>				
Quarrelsome	Qualified			
<u>R's</u>				
Rageful	Reactive	Rueful	Restrained	Rejected
Rude	Rash	Repulsed	Restless	Radiant
Rational	Reasonable	Receptive	Relaxed	Relieved
Regenerated	Replenished	Respected	Rooted	Recognized
Reassured	Revitalized	Resolute	Restored	
<u>S's</u>				
Sad	Sullen	Spiteful	Seething	Sorry
Sneaky	Sheepish	Squeamish	Shallow	Stunned
Shy	Shaky	Scared	Sick	Sluggish
Suicidal	Sorrowful	Somber	Serious	Stressed
Sensitive	Serene	Skillful	Settled	Soothed
Spirited	Steadfast	Successful	Sustained	Supported

Satisfied Secure

T's

Terrified	Terrorized	Tearful	Touchy	Tentative
Threatened	Tragic	Troubled	Triggered	Tenacious
Thrilled	Tolerant	Tranquil	Thankful	Tender
Triumphant	Trusting	Tender		

U's

Understood	Useful	Useless	Up-tight	Uncertain
Upset	Undone	Unhappy	Unglued	Unsettled
Uncomfortable		Unwavering	Unsure	Understanding
Unique	Unbiased			

V's

Vacant	Violent	Vivacious	Vindicated	Violated
Valiant	Valued	Valuable	Vital	Virile

W's

Whiny	Weepy	Weary	Weak	Worn (out)
Worried	Wavering	Warm	Willing	Wise
Wonderful	Worthwhile	Worthy		

X's

Y's

Yearning	Yielding			
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Z's

Zealous

Ideas for ending rituals

- Give each person a colored stone and briefly explain why you relate that particular person with that color (e.g., Red=passionate &/or fiery; blue=calm, serene; purple=wisdom, etc.).
- If the group was particularly moved by one of the closing affirmations, make each participant a copy of that affirmation.
- For each participant, make a small scroll containing the one positive word you would use to describe that participant. Tie the scrolls with ribbons of meaningful colors (See stone example above).
- Make small self-care/nurturance boxes (Could also call them Pandora's Boxes) (include items such as a butterfly charm to signify transformation, an old key to signify that they hold the key to their own success, a colored pebble, etc.). These should be small, inexpensive tokens of remembrance.

Ideas for self-nurturing

- Keep a journal
- Create a sanctuary (place or time) you set aside where you can give yourself permission to feel your grief (and other feelings).
- Wear a piece of inspirational jewelry
- Read a favorite book or poem
- Take a moment each day to center yourself and listen to your heart.
- Read a daily affirmation (There are a wide variety of affirmation books available; however, you can also create your own).
- Plant a flower
- Develop safe and comforting visualizations
- Take a hot bath or shower
- Smell an essential oil
- Go for a walk or a run
- Wrap yourself in a warm blanket and have a cup of tea
- Do something “just for you”

Nurturing Children

Establish routines for mornings, bedtime and other transitions

Try to eat at least one meal together.

PLAY, PLAY, PLAY!!!!!!!!!!!!!!!!!!!!

Give compliments that are positive and specific (e.g. “I really liked the creative way you approached your disagreement with your brother.” Rather than “You’re awesome (smart, pretty etc.)”)

- Give directions that are clear, calm, and concise.

Call or text your teenager just to say, “Hi”

Remember that no matter how it seems, your child’s ultimate goal is to please you and get your attention.

Emotional regulation is a learned skill; teach your child age appropriate exercises for grounding, breathing, yoga poses, and other ways to self-soothe.