

Wisconsin Public Psychiatry Network Teleconference (WPPNT)

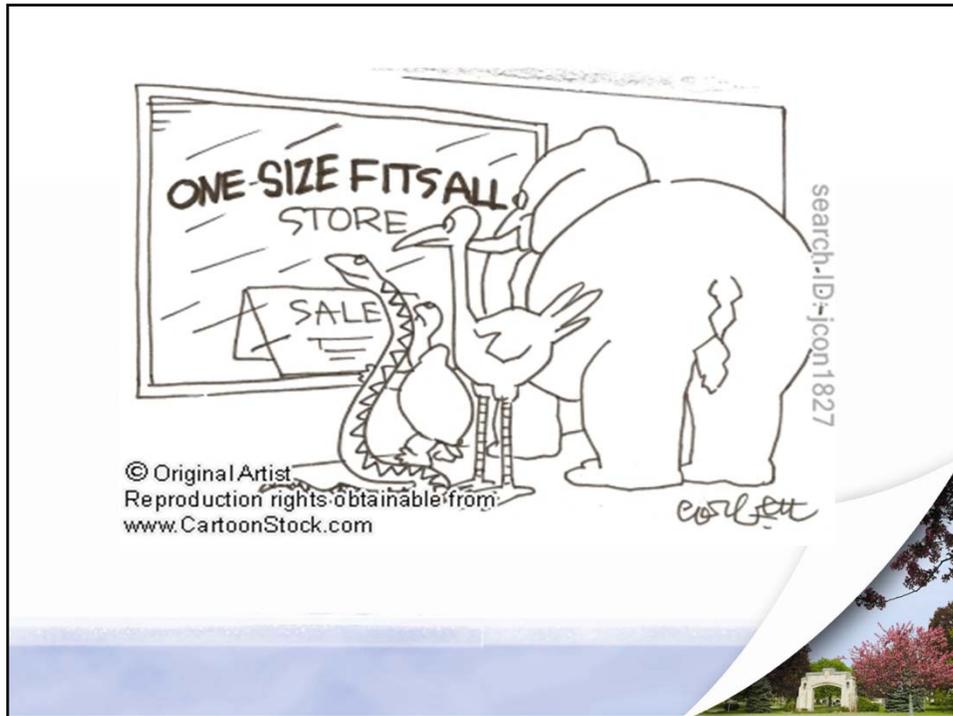
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Challenges in Treating Trauma: One size does not fit all

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Agenda

- DSM-5 Definition of trauma (see handout)
- Common Treatment Challenges
- Principles of treatment
- Challenges
 - Transference
 - Countertransference
- The polyvagal theory and trauma clients
- Wrap up

DSM-5 Definition of Trauma

(See handout for a review of DSM-5 Criteria)

- Exposure to a traumatic or stressful event is the CORE feature of all disorders in this classification
- Stressor criteria more explicit (re: trauma), eliminated subjective reaction, **4 symptom clusters (*Intrusion, avoidance, negative alterations in mood and cognition, alterations in arousal and reactivity*)**. Separate criteria for children under 6 years.

Common Treatment Challenges

- The client becomes angry at you – Client A
- Boundary issues – Client B
- The “resistant” client – Client C

Client A

You have been working with client A for about 4 months. You have a solid working relationship and you have begun to talk about closure. During today's appointment, something has just not felt "right". Although you are talking and discussing, you feel uneasy and you have been picking up on client non-verbal's – their body language is more rigid than usual, their tone of voice is different, and their answers are short. You decide to just forge ahead and the session ends at the regular time but with obvious discomfort.

**REMEMBER**

**ALL MATERIAL IS THERAPEUTIC
MATERIAL
(KNOWING HOW AND WHEN TO
USE IT IS THE KEY)**

Principles of Treatment

- Focus on the relationship
 - Set ground rules & apply them in a relational manner
 - Tailor treatment
 - Titrate treatment
 - Maintain our COMPASSION
 - How this relates to the working alliance and unconditional positive regard
 - Transference and countertransference
 - Think “polyvagal theory”

Ground Rules

(Adapted from James & Gilliland, 2013, p.111)

- ✓ Start on time and finish on time
- ✓ No physical violence or threats
- ✓ Speak for/about yourself
- ✓ Everyone has a right to be fully heard
- ✓ **WORK IN THE HERE AND NOW**
- ✓ Face all issues or request a “time out”
- ✓ Discussion around the use of graphic and abusive language that is not in the context of therapeutic material

Ground rules, continued...

- ✓ Deal with the elephant in the room – that is what you have been trained to do – nonverbal messages and body language will be dealt with openly
- ✓ Sessions can only take place if clients are free of any drugs/substances that alter their consciousness (including over-medication with prescription drugs)

Tailoring Treatment

- How?
- When?
- Why?

Titrating Treatment

- How?
- When?
- Why?

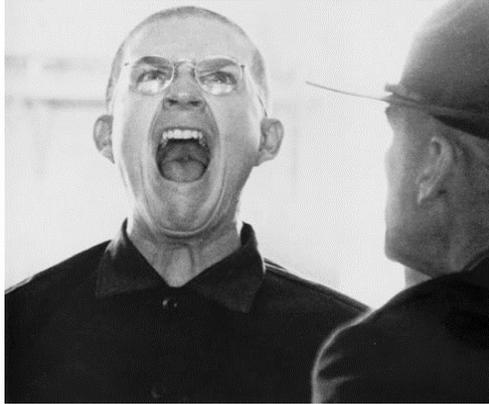
Boundary Concerns

- Wanting a hug
- Description and/or discussion of graphic material that is not directly or obviously related to therapeutic material (i.e. all material is therapeutic material)
- Strongly held opinions voiced in treatment related to victimizing others (racially motivated language/comments)
- Others

Client B

Tom is a middle-age male who presents due to difficulties at work with his colleagues. He has been written up 2 times by his supervisor due to “inappropriate” and unwanted behaviors – repeated bringing co-workers gifts (food items and trinkets) and being overly friendly (holding doors open for co-workers, “yes mam, no mam” language).

“People say I am creepy, but I grew up in the South and I have manners”.



Transference & Countertransference

(Knight, 2009)

Transference – with complex PTSD survivors, the dynamics of dominance & submission are re-enacted in the therapeutic relationship

Concordant countertransference – an empathetic connection in which the worker identifies with the client and this is manifested as over identification, over idealization, enmeshment, survivor guilt, & excessive advocacy for the client

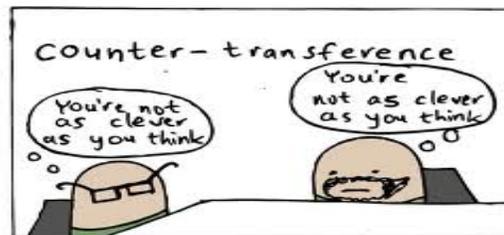
<http://www.youtube.com/watch?v=KL82kN4kPac>

Transference & Countertransference

(Knight, 2009)

Complementary countertransference

The clinician's own issues may be activated by the client's projections and may produce avoidant responses such as denial, minimization, distortion, and empathetic withdrawal from the client



Transference & Countertransference

(Knight, 2009)

Boundary issues

Avoid errors of commission (e.g. role of advocate & losing objectivity) & omission (e.g. avoidance of addressing issues of a sexual nature)

legal questions should always be answered by a lawyer NOT a mental health worker!



Transference & Countertransference

(Knight, 2009)

Self-destructive behaviors

the balance of beneficence (“do good”)

&

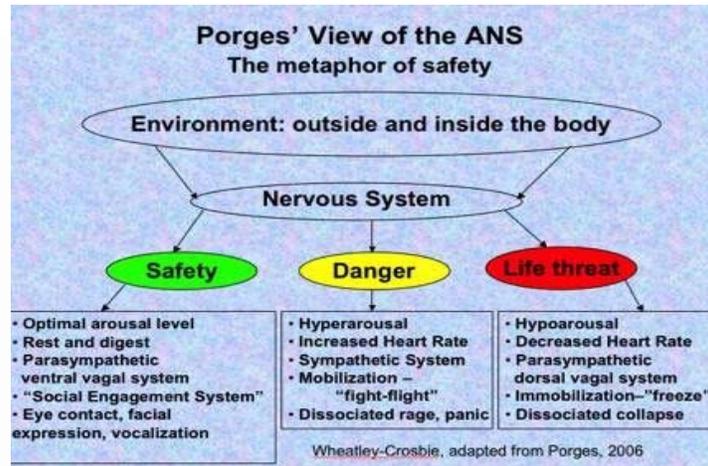
Non-maleficence (“do no harm”)



The Polyvagal Theory (Porges, 2011)

- Refers to the dual (poly) role of the vagus nerve
- Compassion, and therefore our ability to be compassionate, is neurophysiologically incompatible with judgmental, evaluative, and defensive behaviors and feelings (Porges, 2011).
- Neuroception – our bodies’ ability to detect risk.

Polyvagal and challenging client issues



Treatment Resistance

What is resistance – really?

How and why does it manifest in our offices?



Client C

13 year old who is bright intellectually but socially awkward. You have been working with the client for over 6 months – you feel good about the therapeutic alliance but recently you have begun to be unsure about whether or not you are making any progress. Your client has a known history of early childhood neglect – known physical abuse and suspected sexual abuse – prior to the age of 2.



Application and Discussion

- Tailoring Treatment
- Titrating Treatment

References

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