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Introduction

This volume presents a detailed account of a form of psychotherapy for survivors of extensive childhood maltreatment that I first introduced exactly 20 years ago in the book *Not Trauma Alone: Therapy for Child Abuse Survivors in Family and Social Context* (*NTA*; Gold, 2000). At the time, I was struggling to formulate and articulate a framework for working with individuals who were extensively abused early in life that differed in essential ways from the prevailing, trauma-centered form of treatment. I eventually came to refer to this alternate perspective as contextual trauma therapy (CTT).

The core insight that distinguishes CTT from other treatment approaches is that survivors of prolonged childhood trauma suffer not just from the impact of the damaging things that happened to them but also from the consequences of the beneficial conditions that were not provided for them. These are people who have not only been beaten down by repeated encounters with trauma and violence but have also been deprived of the most fundamental interpersonal developmental resources that children require—ones that many of us have trouble imagining any child growing up without. It is this factor that constitutes the context of repeated traumatization from which CTT derives its name, and that distinguishes this model and its attendant treatment strategies from other trauma-relevant therapies. Once we have recognized the existence of the deficient interpersonal/developmental conditions that almost invariably accompany (and foster) repeated traumatization in childhood and adolescence, we will be in a substantially better position to appreciate the

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Contextual Trauma Therapy: Overcoming Traumatization and Reaching Full Potential, by S. N. Gold

far-reaching consequences of these surrounding circumstances. They render the individual vulnerable to recurring acts of manipulation and coercion, dramatically compound the impact of traumatic events, and, most important, contribute to difficulties displayed by the survivor that extend well beyond those attributable to traumatic experiences themselves.

When I wrote *NTA*, I found that stepping outside the predominant paradigm, glimpsing a different way of understanding complex traumatization, and communicating it to others proved to be an inordinately challenging task. At the time that *NTA* was published, the prevailing model for working with survivors of all types of trauma was to make the central focus of treatment the confrontation of the traumatic events that the survivor had lived through. This was the case even though, almost a decade earlier, psychiatrist Judith Herman (1992b) had proposed an alternate approach to working with people who had lived through especially pervasive trauma, one that could be traced back as far as the pioneering work of French psychologist Pierre Janet in the late 19th century. She argued that prolonged, pervasive trauma is qualitatively different and leads to much more fundamental and wide-ranging psychological damage than single discrete traumatic events, a syndrome that she labeled complex posttraumatic stress disorder (C-PTSD).

CTT initially arose from my own clinical experience and my supervision of scores of doctoral trainees at a university-based trauma training clinic, the Trauma Resolution & Integration Program, where the survivor population overwhelmingly fits Herman's (1992b) C-PTSD conception. These were people for whom treatment that primarily or exclusively focused on traumatic events did not yield improvement, was insufficiently helpful, or, in some instances, was unequivocally harmful. CTT builds on Herman's model by proposing that prolonged early adversity differs from circumscribed types of trauma that occur later in life not merely because it is ongoing or repeated but because of the additional impact of the developmentally inadequate family context in which it occurs.

A great deal has changed in the 2 decades since *NTA* was released. Only recently has the C-PTSD diagnosis been officially recognized in the most recent edition of the *International Classification of Diseases* (World Health Organization, 2018). In concert with this milestone, empirical research is greatly extending our understanding of the nature of C-PTSD. In conjunction with other lines of research, these findings compose a robust empirical panorama consistent with CTT theory. These findings, in combination of with an additional 20 years of clinical and supervisory experience, make it possible to more clearly delineate the CTT model and its rationale than when *NTA* was written.

GUIDING PRINCIPLES OF CONTEXTUAL TRAUMA THERAPY

In contrast to many forms of therapy for survivors of psychological trauma, interventions do not compose the essence of CTT. It is, rather, a conceptually driven treatment approach. Thorough familiarity with the CTT theoretical

formulation, therefore, is indispensable for treatment effectiveness. CTT recognizes that among survivors of prolonged child maltreatment, each individual comes to therapy with a unique constellation of factors. Each has been influenced by a distinct personal history; family background; trauma history; pattern of diverse gender, racial, sexual orientation, national origin, and religious identifications and experiences; psychological difficulties; developmental deficits; and adaptive strengths. A defining feature of CTT is arriving at an awareness of these aspects of the client's experiential background and how they shape the client's functioning and sense of self—rather than structuring treatment primarily around diagnostic categories and corresponding predetermined interventions. Although CTT regularly draws on treatment objectives and strategies, they are suggested rather than mandated. Therapy does not consist of a prescribed series of procedures delivered in a set sequence. Although major areas of focus and associated interventions are offered here as a guide, in CTT, therapeutic goals and strategies are arrived at, modified, sequenced, paced, and executed primarily through an ongoing process of collaborative negotiation between client and practitioner.

The tremendous practical consequence of absorbing and applying the CTT model is that it not only allows survivors to overcome their debilitating experiences of traumatization but also enables them to acquire, bolster, and extend the capacities for productive and gratifying adult living denied to them as a result of the developmentally inadequate interpersonal environment in which they were reared. What this means is that survivors of complex traumatization come to be able to exercise capacities and capitalize on potentials that they were unaware they possessed. Ultimately, with the types of interpersonal support, experiential connection, and practical guidance that were relatively absent while growing up and that they may have not realized they were deprived of, they are able to establish a quality of relational, educational, occupational, and spiritual attainment they may have previously yearned for but did not fully believe was within their reach. This orientation to treatment outcome is consistent with the conclusion of Andresen, Caputi, and Oades (2010) that "mental health consumers view recovery as leading a meaningful life, and have criticised traditional clinical measures for being too disability-oriented" (p. 309).

The full expanse of these types of therapeutic gains, this rich quality of life, and the associated transformations in self-perception, emotional equilibrium, and interpersonal connectedness are not and cannot be achieved in time spans of weeks or months. They also are not attainable via an exclusive reliance on rote implementation of unmodified, preexisting interventions that are meant to be applied regardless of the idiosyncratic histories, experiences, understanding, and difficulties presented by each survivor. Treatment goals this ambitious require dedication and follow-through by both practitioner and client, and a willingness to creatively tailor therapy to match the individual and their past and present circumstances.

Despite the time and effort entailed by this type of treatment approach, it is inexpressibly rewarding when someone who has lived a life steeped in

pervasive terror, shame, and despair not only overcomes their trauma-related symptoms but radically improves their quality of life. These improvements in quality of life can, for example, include attainments such as going off disability, becoming gainfully employed and self-supporting, and earning the solid respect and confidence of superiors and coworkers; breaking out of isolation and self-loathing to form deep and enduring relationships embedded in a broader a sense of community; and moving from a sense of emotional desolation and pervasive meaninglessness to a profound experience of living a life imbued with purpose and spiritual significance.

OBJECTIVE AND STRUCTURE OF THE BOOK

This book is designed to explain the CTT model, how it differs in fundamental ways from other trauma-relevant approaches, its conceptual and practical applications, the three major components of CTT treatment, and particular interventions routinely used in this approach. Although the primary target audience is practicing therapists, clinical researchers, graduate students, and others are likely to find it useful. Survivors of extensive childhood trauma may find in these pages clarity about life circumstances other than trauma that have powerfully affected them but of which they may have been only dimly aware. Friends and loved ones may better understand survivors' difficulties that transcend those attributable to traumatization.

The first four chapters lay out in detail the conceptual model that informs CTT. Chapter 1 provides an overview of the CTT model and emphasizes the experiential nature of trauma and the importance of and basic principles regarding the treatment relationship in CTT. It also introduces the proposed construct of complex traumatization (CTr), a variety of forms of impairment related to prolonged or repeated trauma that includes C-PTSD but extends well beyond it. Chapter 2 discusses the nature of trauma; the crucial conceptual distinction between the terms *trauma* and *traumatization*; how research findings have refined our understanding of traumatization over the past several decades; common obstacles encountered by survivors in attempting to access effective trauma treatment; distinctions among posttraumatic stress disorder, C-PTSD, and CTr; and the differing treatment requirements of these three forms of traumatization. In contrast, Chapter 3 explores the context in which prolonged childhood maltreatment regularly occurs and from which CTT derives its name: an ineffective family environment that fails to provide the interpersonal supports essential for adequate psychological development, socialization, and enculturation. Recognizing these circumstances and how they limit and warp the child's psychological functioning in ways that transcend the effects of traumatization can greatly enhance the effectiveness of therapy for CTr. The trauma-focused perspective presented in Chapter 2 and the contextual model covered in Chapter 3 are integrated in Chapter 4 into a comprehensive conceptual framework. That framework draws on newly emerging lines of research that converge with and validate a host of clinical observations

garnered from decades of clinical experience working with adult survivors of prolonged childhood trauma.

Chapter 5 marks a transition from conceptual and empirical material to consideration of the practical clinical implications of the CTT model. It focuses on how the CTT conceptual framework guides the initiation of treatment: being alert for difficulties not directly attributable to traumatization that arise from having been reared in a developmentally insufficient interpersonal environment, approaching the initial contact with the client in a way that enhances establishment of a resilient therapeutic relationship and promotes robust treatment outcomes, conducting a pretreatment assessment that goes beyond a consideration of trauma history to encompass the client's interpersonal/developmental context, and formulating an initial case conceptualization to be collaboratively revised with the client as treatment progresses. Chapter 5 concludes with an overview of the three major spheres of CTT:

- the evolution of a collaborative therapeutic relationship designed to provide the type of development-enhancing interpersonal environment that was not an adequately consistent feature of the survivor's family of origin;
- collaborative conceptualization of the material the client brings to treatment; that conceptualization is aimed at both (a) assisting the survivor to make sense of their confusing history and its continuing debilitating effects and (b) guiding survivors through the reasoning process to help them develop more refined judgment and decision-making skills; and
- collaboratively identifying adaptive living capacities that the client needs to acquire or bolster and jointly negotiating the methods via which these competencies will be mastered.

This triadic model makes it explicit that CTT consists of concrete interventions and also the intentional evolution of a type of a treatment relationship and conceptual understanding that are key contributors not only to trauma resolution but also to psychological maturation.

Chapter 6 consists of a detailed delineation of how the relational component of CTT is implemented. It includes coverage of the indispensable role of this component in the transmission of developmental capacities, socialization, and enculturation, and it examines the conditions necessary for establishing a productive treatment alliance with survivors of CTr. It also provides a survey of potential obstacles to forming a collaborative alliance with complex trauma survivors, offers recommendations for productively navigating these challenges, and considers the key role of therapist self-care in supporting the evolution of a productive survivor-responsive therapeutic relationship.

Chapter 7 describes the manner in which the conceptual aspect of CTT is executed. It explains how experiences of threat (i.e., trauma) and experiences of deficit (i.e., developmental deprivation) conjointly act to hinder capacities for sound reasoning. This discussion is followed by coverage of principles to be applied in the collaborative reasoning process jointly engaged in by client and therapist, and the cognitive capacities attainable via this enterprise.

The chapters that follow each offer methods for carrying out a particular treatment objective commonly addressed in CTT. Chapter 8 focuses on overcoming the intense ongoing *dysphoria*, an umbrella term for various forms of distress, that is a core component of CTr. Dysphoria often needs to be tackled early in therapy to prevent it from diverting attention from other treatment goals and sapping motivation needed to fuel progress.

Chapters 9 and 10 deal with the intricate topic of dissociative experiences and helping survivors learn to modulate them. CTT proposes that at their core, dissociative phenomena are expressions of what is colloquially referred to as "spacing out" or "zoning out." Like dysphoria, these experiences can radically impede work toward other treatment goals. Chapter 9 discusses strategies for helping clients learn to establish greater mastery over dissociative experiences. Chapter 10 presents an extended annotated transcript of an initial assessment session with a client who had reason to believe that many of his difficulties were dissociative in nature.

As a means of avoiding and desperately trying to temper their dysphoric mood and distance themselves from intrusive traumatic thoughts and recollections, survivors of CTr frequently rely on addictive and compulsive behaviors. Chapter 11 explores the relationship between traumatization and these counterproductive attempts at coping and how to help clients reduce their reliance on and ultimately relinquish them.

Methods for processing traumatic material—frequently considered the core if not the totality of trauma-related treatment—are surveyed in Chapter 12. The chapter delineates the conditions that render survivors of CTr ready to approach this potentially destabilizing task in a way that will be productive rather than seriously detrimental to them. It provides an overview of programs of intervention for processing trauma and elaborates on a model for classifying them to help the practitioner decide which program may be best suited for a particular situation.

Throughout CTT, an overriding objective is to equip the survivor to enjoy a more adaptive, effective, and gratifying adult life. As other treatment goals up to and including resolving trauma via processing methods have been achieved, client and therapist can increasingly focus on improving the survivor's quality of life. Chapter 13 examines this territory and presents a case history[1] that illustrates in detail how the components of this overarching objective can be identified and attained.

The Epilogue provides a dramatic case example of the circumscribed but critical accomplishments that can be produced when CTT is applied under conditions of limited time and correspondingly restricted treatment resources.

[1]All client names and many of the potentially identifying elements of their circumstances in the case histories presented in this volume have been altered to protect their privacy and adhere to the tenets of confidentiality. None of the quotations in this volume attributed to clients are from external sources. All are derived either from the author's own cases or from doctoral trainees he has supervised. For this reason there are no citations applicable to these quotes.

This case history demonstrates that CTT, although usually long term because of its ambitious objectives, can be adapted as a short-term approach when circumstances require it. It also illustrates that capacities of enduring value can be attained in as little as a few weeks.

It is my hope that the approach delineated in this volume will equip and inspire therapists to travel breadths of this scope and consequence with their intensely traumatized and functionally restricted clients. It is a privilege to accompany survivors of complex traumatization on this journey. I cannot think of any work that is more rewarding.