Into the Breach:

Clinical Perspectives on Trauma-Centered Psychotherapy

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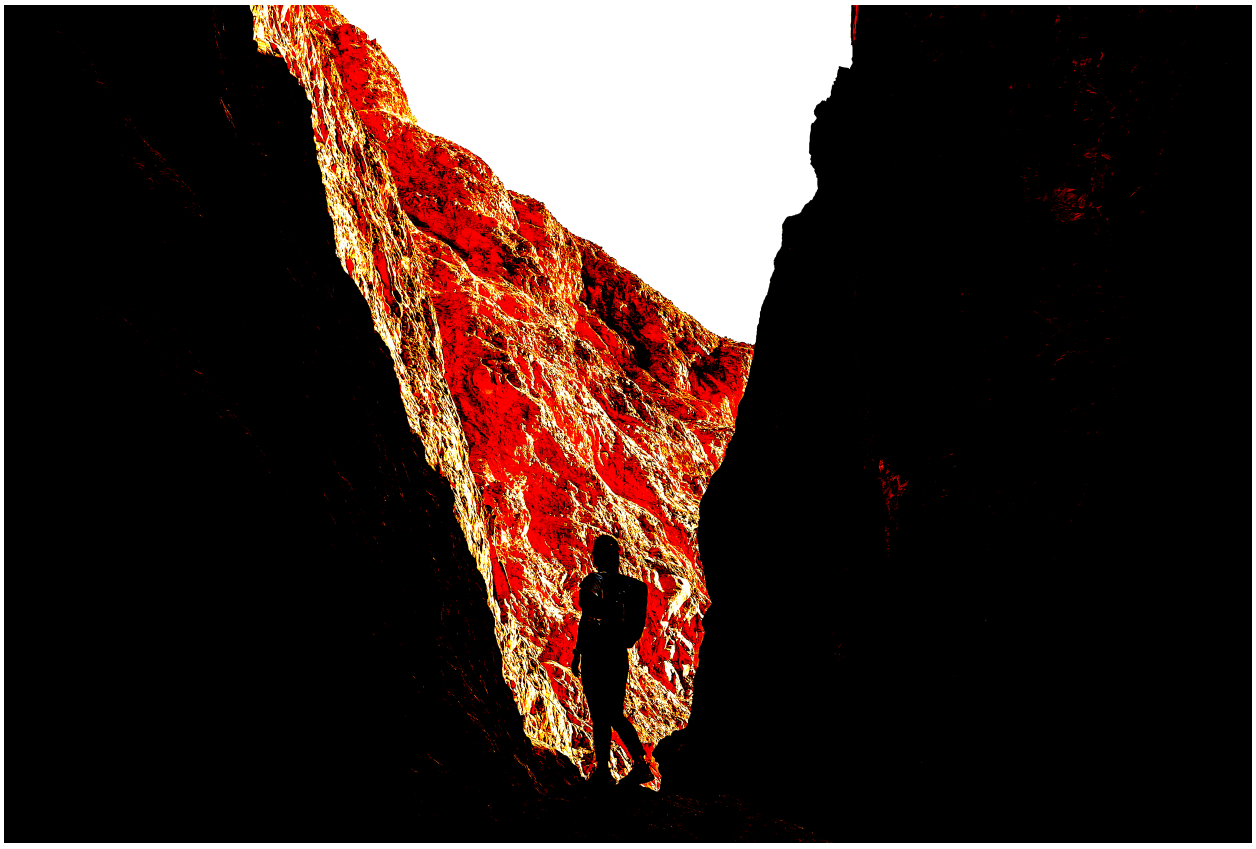
First Published: April 2, 2025



A journal devoted to clinical thinking regarding the psychotherapeutic treatment of people who have experienced psychological trauma, from the perspective of the model of Trauma-Centered Psychotherapy developed at the Post Traumatic Stress Center, New Haven, Connecticut.

From the Editors:

This journal is designed to be a clinical resource for clinicians who are interested in deepening and expanding their understanding of the trauma-centered approach to psychotherapy. The articles will highlight clinical perspectives, challenges, and insights to help clinicians navigate through the turbulent waters of the therapeutic encounter with trauma.

We have been involved in the field of trauma studies since the late 1980s, focusing even more intentionally during our time directing the Post Traumatic Stress Center in New Haven, Connecticut, from 1997 to 2024. We have witnessed not only the trauma field itself moving away from direct engagement with the details of the traumatic event, but also a general diminishment in respect for and expertise in fundamental clinical principles. The increasing reliance on structured and manualized approaches, as well as the more recent shift to virtual settings, has contributed to the divestment in engaging with the trauma narrative. Some leaders have even declared that a full disclosure of the client's traumatic experience is unnecessary in treatment. These changes in emphasis and direction did not change our patients' deep needs for contact and validation, especially in long term therapeutic relationships.

Our commitment to heal our patients' often complex clinical presentations deepened our resolve to train and supervise clinicians in the trauma-centered approach. This lead to our publication of *Principles and Techniques of Trauma-Centered Psychotherapy* in 2015, which forms the foundation of this Journal's perspective. We have found that it takes two years of active experience and supervision to master these skills and then to integrate them into one's own personal practice. Given the shifts in the mental health field, the need for ongoing supervision and clinical forums to discuss challenging cases is clear. This Journal is meant to partially address this need.

The Journal will be open access and published in a continuous manner: the nine articles included in the inaugural issue set the stage for others to follow. We invite anyone familiar with the trauma-centered approach to submit relevant articles to the editors (at hadarlubinmd@gmail.com). We are thrilled to create a place where members of our community of devoted clinicians can share perspectives and dialogue together about this meaningful work.

Let us begin!

Hadar Lubin, M.D.
David Read Johnson, Ph.D.

Table of Contents

The Transformation of the Therapist-Client Relationship in Long Term Trauma Centered Psychotherapy

Hadar Lubin

In our previous work (Johnson & Lubin, 2015), we laid out a methodology for processing psychological trauma, based on a conceptualization of trauma schemas that form after traumatic events. These trauma schemas are triggered later in life when memories of the traumatic event are evoked by current stimuli, and arise in order to avoid the experience of fear and shame associated with the original experience. Though we outlined the five layers of trauma schemas, we did not differentiate sufficiently the dynamics of those based on fear, and those based on shame. We also implied that after the initial phase of treatment in which the trauma schemas are recognized and processed, the remaining work in longer term treatment consisted of periodically decoding the presence of these schemas whenever they intruded into the client's peace of mind.

As I continued to work with a number of clients over many years, however, I have encountered some unusual situations that have led to a revision in our understanding of the complete nature of trauma treatment. This article attempts to describe these revisions.

Fear and Shame Schemas

First, as a general rule, we have found that fear schemas concern the victim's relationship with the perpetrator, and are oriented to the Other, whom one is afraid of. Simultaneously, shame schemas form that concern the victim's relationship to themselves, and are oriented inward toward the Self. Much of the work described in the trauma literature focuses on desensitizing the victim to their fear schemas. However, shame schemas are equally debilitating and in many cases more pernicious and longstanding than fear schemas (Herman, 2011; Lewis, 1987). When the traumatic event takes place early in life, these shame schemas can become integrated into the developing self-representation and influence the formation of personality (Courtois, 2010; Herman, 2007). It is therefore common for these schemas to remain operative well after a successful trauma treatment that focuses primarily on the fear schemas.

I will differentiate the Initial Phase of trauma treatment from the Later Phase. The Initial Phase focuses on unveiling of trauma schemas, tracing their origin to the original traumatic experience, and revising them through an encounter with the discrepant information provided in the present, both within and outside of the therapeutic relationship. This Initial Phase creates the trauma frame for the therapy, obtains detailed information about the traumatic experiences, provides via psychoeducation a common language to

address the maladaptive adaptations to the trauma, and helps the client erect a boundary between the past and the present.

The Later Phase confronts the impact of the shame schemas on the client's relationship to themselves, which largely involves accessing the deeply held, primary needs that were crushed, suppressed, and demeaned by the perpetration. Excavating the humiliated and obliterated self and encouraging the person to seek ways of fulfilling these needs through productive relations with others, is the essential work of this Phase. I have found that engagement with the shame schemas is accompanied by a shift in the role of the therapist.

An Unexpected Observation

It began with one of my long-term clients, and then several others, and when I shared my observations with trauma-centered colleagues, they noticed similar phenomena. The clients had all successfully completed an intense period of trauma work and had continued in treatment for many years (from 4 to 10 years) afterwards. Almost all had been traumatized in childhood, many from early childhood, and thus would be considered as suffering from complex PTSD (Courtois & Ford, 2013). What occurred was a time limited period, years into treatment, of an eruption of new symptoms that were ego dystonic and atypical of the client. These symptoms were most often 1) substance abuse, 2) eating disordered bingeing, or 3) attention seeking behaviors such as sexualized, risk-taking, or interpersonally provocative behaviors. In some cases, I concluded incorrectly that the client had developed an independent disorder and referred them to specialized services. In other cases, I remain confused. Only after this phenomenon appeared in a number of clients, did I consider it as a reflection of a core traumatic process that the therapy had yet to address. What emerged is the realization that these symptoms reflected deeply held needs that had been suppressed by injuries to the Self.

Initial Phase of TCPT

During the Initial Phase, the role of the therapist is to bear witness to the traumatic testimonies, to educate the client about the footprints of the past in their life today, and to tolerate the traumatic projections: the perpetrator, the bystander, the collaborator, the victim, that inevitably are evoked by the intimacy of the therapeutic relationship (Johnson & Lubin, 2015). The therapist functions as a surgeon who cuts through layers of defenses to understand the original traumatic experience. The attention to details about the trauma and the proximity to the traumatic scene inform the therapist about the origin of the fear-based trauma schemas. Simply said, the initial phase of the work helps reveal the layers of the trauma that shackle the individual's psyche and crushes the self.

Thus the Initial Phase of the work targets what might be called the soft-wired effects of the trauma. The work during this phase attempts to attenuate the impact of the trauma schemas on the person's functioning, consisting of rigid adaptations fueled by the heightened anxiety, shame, and fear from the original traumatic event. The surface trauma schemas developed to protect the individual from the danger posed or threatened by the perpetrator. Because these trauma schemas are relational, they are evoked again by the intimacy of the therapeutic relationship, and the image of the Other is projected onto the therapist, who must manage the dual identities of caring therapist and dangerous Other. The therapist relies on the knowledge obtained by the trauma inquiry in order to challenge these rigid and distorted perceptions and help the client revise them based on experiencing the discrepancy between them and the real identity of the therapist. In so doing, the client learns to differentiate between the past and the present. A successful Initial Phase leaves the client with revised, adaptive schemas that increase their social, emotional, and cognitive functioning.

However, it takes some time after the primarily fear-based schemas are diminished before the more deeply held ("hard wired") shame schemas are available for revision. I suggest that the outbreak of new symptoms signals the readiness of the client to attend to their original needs not met by the parents/caregivers. These symptoms express childhood needs for food (bingeing), solace (substance abuse), attention (provocative behaviors), safety (risktaking), materials/money (stealing, gambling), or physical touch (promiscuity) that were demeaned, negated, and punished by the original perpetrators. As long as the person is fearful of the memory of the perpetrator, they will not feel safe to reveal these needs. It seems likely that only when the therapist has been established as a caring presence untarnished by the projections of the trauma schema, can these needs be expressed. This allows the therapist to shift their stance vis-à-vis the client, as will be described below.

Later Phase of TCPT

During the Later Phase, the work is focused on restoring a sense of self that is not altered by the trauma, is not dictated by the perpetrator, and not controlled by the fear-based trauma schemas. The client has a chance to build a revised self or resurrect the self, based on their free choices and desires. During this phase the therapist's role shifts to providing a scaffolding to support the liberated self, becoming a mentor to the emerging self, and being a springboard for the thriving self.

The Later Phase focuses on the hard-wired adaptations resulting from the injuries to the self as well as from living with the trauma for a long time. These primarily shame-based trauma schemas are distorted cognitions about the Self that reflect internalizations of the perpetrator's judgments about the victim that are taken as the meaning of the event (Silberg, 2022). Often they mark the moment when the client's self-development was aborted.

In the Later Phase the therapist's relational position shifts to standing by the side of the client, rather than being the target of their projections of the perpetrator. Therapist and client together face the consequences of the traumatic event on the Self, which is primarily the crushing and denigration of the client's primary needs of childhood. The therapist helps the client to name and recognize the trauma schemas and their relationship to the wounded self. In this phase, these needs - to be held, seen, fed, sheltered, and attended to - rise up powerfully, causing the client to feel humiliated, and to brutally judge themselves as not deserving of care. The therapist's job is to inform the client of the process that led to the crushing of these needs, the legitimacy of fulfilling these needs, and direct encouragement to seek out others in their lives to fulfill these needs.

Types of Childhood Injury Related to Symptoms in the Later Phase of TCPT

Commonly encountered challenges in this phase follow a developmental pattern. The nature of needs-based symptoms as well as the self-denigrating statements of the client will clearly indicate the nature of the wound and the related failure of caretaking. Every child has primary needs for food, comforting physical touch, loving attention, safety, and objects to play with. The acts of neglect and harm committed by the caretakers of the child form the basis of the fear schemas that impact them later in life (Courtois & Ford, 2013). However, the suppression and denial of the primary needs of the child form the bases of the shame schemas, in which the child's self-image is damaged (Herman, 2007). Underneath the self-deprecation and self-criticism lay the pent-up unfulfilled childhood needs. Once the fear schemas have been loosened up in the Initial Phase of treatment, at some point the client feels safe and healthy enough to loosen the shame schemas, releasing expressions of these desires. Common examples include binge-eating, risk taking, promiscuity, and substance abuse, all of which express the inner child's hunger for the parents' missing love and nurturance. This initiates the Later Phase of treatment, where the therapist helps the client identify the core shame schemas involving humiliation, negative self-attributions, and denial of basic needs. The therapist's job is to 1) allow the client to re-experience the humiliation within a caring relationship, 2) counter the negative self-attributions, and 3) encourage the client to seek out the fulfillment of their needs in the world. The therapist provides a scaffolding for integrating past, present, and future elements. This work entails completing the work of mourning the absence of the parental love, building the client's self-esteem, and achieving reparation through real action in the world. The shifting of the therapist's role at this stage provides a supervised path for moving into the future and meeting past needs with present people.

Case Vignettes

Lisa. Lisa was sexually abused by her father throughout her childhood. Her mother was aware of the abuse but did not try to stop it. In addition, Lisa's mother viewed her child as competition for her husband's attention and treated Lisa with cold disdain. The initial trauma work focused on the sexual abuse by her father targeting the trauma schema "I am my father's possession." As the work progressed, Lisa was able to overcome her fear of her father and become emotionally available to her loving husband and children. However later in treatment she began bingeing in an out of control manner, despite never having had eating disordered symptoms before. What emerged was a shame schema linked to her mother: "I am unlovable." In adulthood, Lisa had tried without success to please her mother, to find a way to extract some sign of care from her. The scaffolding that the therapist provided was to team up to look for evidence in the world that Lisa is indeed lovable. Lisa was encouraged to tell the intimate people in her life that it is hard for her to determine whether people really love her. She often returned to the sessions surprised to report that there are many people in her life who love her. As Lisa understood the difference between feeling unloved and having a mother who is incapable of loving, her mourning progressed and her bingeing behavior normalized.

Anne. Anne was sexually abused by a neighbor in her own bedroom from an early age. Anne did not report the abuse to her parents. Instead she sought their love and protection through clinging and attention seeking behaviors that annoyed them. Anne's behaviors became triangulated with the parents' conflicts with each other by redirecting their wrath from each other to her. Anne felt rejected, unloved, and blamed. In adulthood, Anne's intimate relationships failed because she became anxious that she would be rejected, becoming clingy and needy with her partner, and evoking the very rejection she feared. In the Initial Phase Anne worked on her trauma schema of "I am to blame for my failures in intimate relationships" by identifying her parents as the source of the rejection. During this phase she was highly sensitive to any sign that the therapist was critical of her or might not like her.

Some time after this schema was unpacked and understood, Anne was still having difficulty seeking new relationships. She said she felt less worried that she will be blamed, and her clingy behavior had diminished. Suddenly, she began to stay at home and sleep a great deal, not wanting to leave the house. When asked about why this was happening, Anne said, "I

> feel ashamed of myself." This feeling was linked with a memory of her standing in front of her parents who looked at her with great disdain, telling her to go back to her room. The therapist helped her identify that beneath this shame schema lay a deeply felt need to be with people. Once that need was identified and validated by the therapist, Anne proceeded to fulfill that need by "going out and finding people" through events and dating, with the therapist's coaching and encouragement.

The Transformation of the Therapeutic Relationship from Initial to Later Phase

In the Initial Phase of trauma-centered psychotherapy, the therapist's role is to gain entry into the inner world of the client. The therapist is primarily positioned as Other who in any given moment can be perceived as the perpetrator, the bystander, or the collaborator through the trauma projections. The projections that keep the therapist as the Other are there to protect the client from additional harm from the perpetrator. As the therapist gains knowledge of the traumatic narrative, they get as close as possible to witnessing the harmed victim, which establishes the gap that cannot be bridged, as present and past collapse in the client's psychic. A skilled therapist will be able to tolerate the discomfort of bearing witness to the harm and the failure to rescue the client. Doing so successfully is the first step in helping the client differentiate between the past and the present. The role of the therapist is to demonstrate to the client their understanding of how the trauma completely engulfed the self and then to identify the fear-based trauma schemas that form a wall that sequesters the self from the world. Throughout this phase, the therapist is perceived as a representative of other people, with the potential to re-enact the harm that the client experienced in their childhood.

In the Later Phase the therapist is allowed into the inner world of the client and encounters the wounded self. At this stage the client uses the therapist as a resource of knowledge and skills to mend their self. The relational position of the therapist shifts from being the Other to being a collaborator. The defenses that are commonly used by the client are more mature, such as intellectualization, rationalization, and sublimation. At this stage the client comes to an understanding that their needs were not met during childhood and the therapist can help them fulfill them now in the world. Rather than seeking the fulfillment of their needs from the therapist, the client turns their attention to others in their present world for care and attention.

Components of the Shift in the Therapist's Role

There are three main aspects of the therapist's new role in the Later Phase: providing a scaffolding for the work, becoming a mentor, and becoming an enthusiastic audience to the client's accomplishments. All of these are made possible by the client's

progress in dismantling the fear schemas during the Initial Phase, which frees them to perceive the therapist outside of the trauma-based projections. At this time, long suppressed infantile needs come to the fore which are still countered by the shame schemas that negate and invalidate them. The work of this phase is to diminish the hold of the shame schemas on the client. Central to this is the discovery and articulation of the Dream, which is the innate image that the client has about their process of becoming, concretized in a vision of a career, a role, a goal in the future (Johnson & Lubin, 2015, pp. 169-172; Silberg, 2022, p. 90). By keeping this dream present within the therapeutic dialogue, the infantile needs being experienced can be integrated into a mature vision of the future, and in this way, given meaning.

Providing a Scaffolding. At this stage of the work the therapist needs to listen to the dream of the client and articulate its vision. The therapist needs to be able to share that vision with the client in order to build the scaffolding that will support it as the client learns to believe the dream is possible. The therapist needs to remind the client of the dream and to allow the client to borrow the confidence of the therapist in their ability to do so. During this stage the client's self is held by the therapist's mirroring of a mended self. The therapist represents a healthy parent who believes in the child but unlike a real parent the therapist is not the source of sustenance for the client. The therapist is directing the client to the external world to meet the needs that their parents failed to provide. Many rehearsals are expected for the client to pursue their dream effectively.

Becoming a Mentor. Once the Dream has been identified and the client begins to work toward achieving it, the therapist then becomes a mentor in helping the client pursue a career, build a social network, or engage in intimate relationships. Although the work is focused on the project, the therapist keeps an eye for the emergence of the shame-based trauma schemas that will need to be addressed before they can complete the work. The critical characteristic of being a mentor in the trauma-centered psychotherapy context is the constant attention to the emergence of traumatic schemas, and pointing out to the client how they serve to interfere with meeting their unfulfilled but legitimate needs, based on an internalized attack on the self.

Becoming an Enthusiastic Audience to the Client's Accomplishments. This is the final stage of the work that focuses on bringing the project to the finish line and helping the client own their dream. With each accomplishment of the client toward their goals, small or large, the therapist reflects the sentiment of 'job well done' to the client. The therapist points out the client's reluctance to use any descriptors of success and triumph and links this to their shame schemas. The therapist helps the client say: 'yes I did a very good job,' 'I accomplished something very big,' 'I made this happen,' or 'I am a lovable and worthy partner.' Although the needs are fulfilled by activities outside of the therapeutic sessions, the process of internalization of these accomplishments is consolidated through the interactions with the therapist. It is in this phase that it may be appropriate for the therapist to reach outside of the usual therapeutic boundaries and attend

a graduation ceremony, a public speech by the client, or a gallery exhibition of their artwork. In the end, the fundamental humanity of the process of trauma-centered psychotherapy guides the work, for the horrific assault on the self experienced by the client tears at all aspects of their functioning, from deep within to the broader public spaces.

Case Vignettes

Lee. Lee was emotionally abused and neglected by her mother throughout her childhood and young adulthood. Lee concluded that she is invisible and her world is of no importance. After her mother's passing she pursued a career but always felt that she was someone whose story and thoughts are unimportant. Even her closest friends told her on many occasions that her opinions and ideas are insignificant. She accepted these messages and agreed to be quiet and invisible. During the course of therapy, after her childhood trauma was reviewed and her fear-based trauma schema ("My parents hate me.") was processed, Lee articulated a desire to write a memoir, though she did so in the negative: "I had this thought that I would write my memoir, but I know I can never do it, such a grandiose idea!" The therapist noted the emergence of a dream, and focused on her idea. Lee and the therapist quickly identified the relevant shame schema: "I was not seen nor heard because I am not important." They explored what needs were suppressed by this crushing assault, and discovered a strong desire: "I need to be heard," which underlay her idea to write a memoir. The therapist reflected to her that this was a sign that she is ready to mend her injured self. The therapist then provided the scaffolding for Lee by discussing the steps necessary for her to prepare herself for writing her memoir: writing workshops, outlining her story, reading other memoirs, work with a writing coach. The therapist mentored her by reading her drafts, connecting her to other resources, and then, as the book took shape, reflecting back positive feedback and congratulations. Lee finished her book and presented it online and in person at various events.

Susan. Susan was raised by a father who terrorized the children with his temper and a mother who was aloof and emotionally unavailable. Susan became a young adult who was terrified of criticism and fearful of authority. Despite her competence, any time she worked within a hierarchical system, she froze each time she received feedback about her work performance, being unable to discuss the issues with her boss because she assumed they were unavailable and uninterested like her mother. She repeatedly lost her job. After the initial work on her childhood abuse, Susan articulated a dream

to "succeed at my job within a hierarchical system." At this time, Susan got her dream job at a large insurance company. The therapist and Susan both felt that this provided the opportunity to address her fears of being criticized and to achieve a stable, secure professional identity. The therapist's role transformed into that of a professional mentor, and prepared to consult with Susan when the inevitable encounter with her supervisor occurred. Each time her shame-based schemas insinuated themselves into an interaction at work, Susan and the therapist examined it in detail, first by discovering the links to the childhood abuse, then identifying the self-schema (e.g., "I cannot do anything right"), and then encouraging her to risk corrective actions (e.g., asking to discuss the feedback with the supervisor). The clear focus on this process helped Susan, after many rehearsals and trials, to greatly increase her tolerance of constructive criticism, leading to being advanced in the company, and supporting her dream of developing a secure professional identity.

Cat. Cat was sexually abused by her parents' best friend at his home over several years from age 5 to 10. The friend showed much affection for Cat in front of her parents who referred to him as Cat's favorite uncle. Cat was expected to be loving and affectionate to him in return. However, when he had her alone, he told her she was his special girl as he aggressively sexually assaulted her. During the initial phase of the work the therapist helped Cat challenge her fear schemas: "My parents did not protect me," and "The world is a violent and terrible place." These schemas led to chronic conflicts with her parents, acting out in school, and drug abuse. During the Later phase of the work, the client began to explore intimate relationships and pursue her education. The therapist was enrolled as a kind of relationship coach who was available to respond to the many questions she had. She learned to trust that she is loved for who she is, that she can show her affection to her partner based on how she really feels, and that she can say 'no' when she is not interested in love-making. When the shame-based self schemas emerged during this stage of the work, Cat immediately brought them to the therapist to examine their distortions. These included: "On the surface I am special, but no one really knows that underneath I am trash," and "I am a piece of meat thrown out for the dogs to eat." These schemas had to be identified and discussed each time a problematic event took place, in order to reveal the basic needs Cat had: to be loved, to be held. The permission to ask many questions and to have the therapist serve as a relationship mentor helped Cat find out what a safe loving partnership feels like.

Challenges during the Later Phase of Long-Term Trauma Centered Psychotherapy

Minimizing the Trauma Lens. Given the length of treatment, it is not uncommon for the therapist to assume that the client's traumatic schemas have been mostly addressed, allowing the press of current issues to gradually take center stage in the treatment discussion. However, abandoning the trauma lens in understanding the client's symptoms, schemas, and behaviors will lead to ineffective attempts to deal with the outbreak of symptoms, and miss the opportunities to work on the deeply structured shame schemas that haunt the client. I have found that seemingly unrelenting self-derogatory attitudes can be modified when shame schemas can be identified and traced to their roots in the traumatic events of childhood. When newly emerging symptoms related to eating, substance use, or attention seeking behaviors occur, it will be extremely important for the therapist to identify them as expressions of unfulfilled infantile needs and not as symptoms of independent addictive disorders. Failure to recognize their behaviors as reflections of the developmental arrest in the wounded self may lead to displaced behaviors that express the client's disappointment in the therapist's ability to understand their abuse experience.

Shifting Role Too Soon. The therapist should not attempt to shift their relational role in the therapy too soon, as the client will reject their efforts at mentoring or providing support, and seek to maintain the therapist in the role of the representation of the Other. At such times, shifting to a side-to-side position may be interpreted as a threat. It is best to wait for a signal from the client that they are no longer placing barriers (professional or defensive) between them and the therapist. The door will open when they turn their attention from protecting themselves against external intrusion, and instead welcome support in fulfilling their deeply held needs.

Summary

For clients with a history of prolonged early childhood trauma, the treatment consists of two phases, an Initial and then Later phase, each addressing different components of the fear- and shame-based traumatic schemas that formed as a result of the assault on the developing self. The major focus in the Initial Phase is on dismantling the grip of mostly fear-based schemas that distort and restrict the client's experience of the Other. In this phase, the therapist is often viewed in some form as a representative of the Other with its potential to harm. Resolving this lack of differentiation between past and present, and desensitizing the client to triggers of their traumatic memories, rewards the client with greater interpersonal freedom. After a period of some stability, the Later Phase of long-term trauma-centered psychotherapy is initiated when the deeply held infantile needs that have been suppressed by the largely shame-based schemas rise up to seek fulfillment. Sometimes this shows itself in a sudden emergence of bingeing, substance

abuse, promiscuity, or thrill-seeking behavior, and a concomitant rise in self-denigration. The therapist, in collaboration with the client, is advised to view these behaviors as an opportunity to identify the underlying needs that were never met, and to help the client organize a means to fulfill them now, as an adult in the present. Articulating a mature Dream of a healthy self is a crucial step in this work. The shift in focus of the client from protecting themselves from others, to healing their wounded self, gives room to the therapist to shift from an oppositional to side-by-side role. From this new position, the therapist can help the client articulate their dream, provide a scaffold upon which they can begin to seek fulfillment of their needs, mentor their efforts in this regard, and serve as an enthusiastic audience to each success. These transformations are intrinsic to bringing the treatment to the finish line of the client's healing journey.

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Norms of Avoidance among Psychotherapists: A Case Example

David Read Johnson and Hadar Lubin

In trauma centered psychotherapy (TCP), the therapist is charged with taking an active stance toward exposing the client to their traumatic experiences, first through the establishment of the trauma-centered frame, and second by immediately engaging in a detailed description of the events. These axiomatic components of TCP diverge from standard psychotherapeutic maxims, such as: 1) follow the client and do not impose the therapist's agenda, 2) establish safety and trust prior to beginning the traumatic inquiry, and 3) maintain a generally emotionally neutral stance, even toward the client's horrendous traumatic experiences.

In our work with therapists in training and in dialogue with colleagues, we have encountered deeply-held assumptions about the psychotherapeutic endeavor that, in our view, support strongly avoidant tendencies in the therapist. A perusal of numerous acknowledged trauma experts in the field reveals that almost universally they emphasize the importance of open discussion of the traumatic events and the courage it takes to do so. Despite numerous empirical studies of exposure therapy and cognitive-behavioral interventions that show the effectiveness of heightening arousal prior to desensitization, many contemporary therapists continue to hold beliefs that asking a client directly about their traumatic experiences risks serious harm. This view confuses the harm from the original event with the arousal caused in the present from remembering the event. Underneath this is a belief that experiencing intense emotion is harmful. These views do not appreciate that most if not all trauma clients deeply desire to communicate what happened to them to an interested person, even if they simultaneously present obstacles to that revealing. The result is that common guidance to therapists emphasize 1) *delay* in direct trauma inquiry until some degree of safety or trust is established, 2) *regulation* of emotion within certain boundaries (window of tolerance), and 3) *neutrality* in the therapist's demeanor. We have found that these instructions too often raise anticipatory anxiety, lead to outbreaks of emotional distress, and make the client feel that the therapist is disinterested. Together, these effects result in either termination of the therapy or severe acting-out and even litigation against the therapist. As a tertiary clinic that accepted more challenging trauma cases, our Center was often referred clients whose prior trauma treatments ran aground for these reasons.

These contemporary, normative attitudes toward trauma treatment are quite resistant to counter information, largely because the negative effects are perceived as confirming the potentially explosive, brittle nature of trauma. These attitudes are further

supported by longstanding principles from client-centered psychotherapy (i.e., to follow the client), and psychodynamic psychotherapy (i.e., maintenance of neutrality), which in the treatment of neurosis we have no objection to, but which are counterproductive in the treatment of trauma.

In the case we will now present, a unique opportunity occurred due to the first author being hired in a forensic role to review the psychotherapy notes of a trauma clinician as well as the notes from the client's court records. This case reveals, we believe in stark relief, a competent therapist's unknowing and unnecessary avoidance of the traumatic material.

Case Example

The client is a 48 year old married man who endured a course of sexual abuse by the priest at his Church from age 12-14. He was referred to psychotherapy by his attorney specifically for the sequelae of his sexual abuse, which he had revealed after a newspaper article had identified the priest as having molested a number of boys in the past. The therapist, a well-trained clinical psychologist, knew that his notes would be subpoenaed and later provided these to the client's attorney. They had a total of 19 sessions, focused mostly on current issues the client was facing. The first author (DRJ) gained access to these notes, as well as the client's interrogatories, in his role as an independent evaluator for the Court. Here are the verbatim psychotherapy notes written by the therapist regarding the issue of the sexual abuse:

1st session: "He stated that he had been a victim of sexual abuse. He did not go into greater detail about this. I listened and reflected process, content, and affect."

2nd session: "He did not go into details of the sexual abuse."

3rd session: "He had a difficult week. He said that he is scared of continuing to talk about things that he has buried for so long, but that he will continue. I listened."

> These notes suggest that the therapist respects the client's agency in determining when to discuss the details of his trauma. From a TCP perspective, because the therapist has not made an explicit statement about his attitude toward disclosure, the client remains uncertain about whether to do so. Our experience tells us that the client is most likely to conclude that the therapist is either disinterested, or uncomfortable, in this material.

4th session: "We talked about his relationship history and his two failed marriages."

5th session: "We talked about his current sexual relationships…He reported that he had flashbacks to the abuse during sex."

These topics avoided his trauma, though the client reminds the therapist that the trauma is bothering him and interferes with current functioning. From a TCP perspective, the client is directly signaling the therapist that he wants to deal with it.

6th session: "He said that even though he has gone to great lengths in his life to distance himself from the fact that he was sexually abused, that it was always present for him, everyday of his life, often multiple times a day…I listened and reflected process, content, and affect."

7th session: No discussion of sexual abuse.

8th session: No discussion of sexual abuse.

In session 6, the client again makes an attempt to signal the therapist of the importance of discussing the trauma, but the therapist only listens. This is then followed by two sessions where the client avoids the trauma completely. The client tells the therapist he is thinking about his trauma daily, while the therapist does not engage with it over the course of three 45-minute sessions.

9th session: "I mentioned that he has still not told me the actual story of being abused. He said that he had been thinking about this and that he would probably tell me soon, but not today."

10th session: "He said he would tell me the story of his abuse. He described the room where the abuse happened in great detail, but did not go into much detail about the physicality of the abuse. He implied that oral contact and groping were involved. He said that it continued for three years. I asked him to imagine how it might feel to him if the story was about a cousin or someone else close to him and he said he felt a bit more, but he was still rather detached emotionally."

In the 9th session, the therapist finally indicates he is ready to hear the client's story, and in the 10th session receives a more detailed but still avoidant description of the traumatic event. The therapist's attempt to elicit greater feeling by having the client imagine if it happened to a cousin, a technique of distancing, again psychically moves away from the horror of the event, and elicits only continued detachment from the client.

11th session: "He said that he felt a lot of relief after our last session. He said that he has never told the story in that detailed a fashion to anyone. He said that he should have been in treatment before because it has been so helpful. *He said that perhaps we can begin meeting less often because he is doing well." (italics added)*

> The client surprisingly reports relief after the 10th session with its limited disclosure, congratulates the therapist for doing a great job, and then suggests they meet less often! From a TCP perspective, this suggestion means only one thing: the client does not have confidence in the therapist's ability to deal with the traumatic material, who most likely missed something critically important in the previous session (i.e., the traumatic experience). If the 10th session had indeed been helpful, it would surely not have led to such a quick suggestion to terminate.

12th session: "He surprised me by telling me that he had opened up to one of his male friends about the abuse. He said this had been a liberating experience for him."

13th session: "He said that he had opened up about the abuse to his fiancé and his family, and that talking to his siblings had gone better than he had anticipated."

> The client reports that he had opened up to friends and family, even though he had not opened up much to the therapist. This is odd, as it suggests that after the 10th session the client was indeed freed up to talk about his trauma. The therapist also acknowledges his surprise at this turn of events, indicating he too understood the limited nature of the client's revelations in the therapy.

14th session: No discussion of the abuse.

15th session: *"He commented on how it is nice to not always focus on the abuse in our meetings." (italics added)*

> This confirms the TCP hypothesis that the client is managing his perceptions of the therapist's discomfort with a trauma inquiry. The therapist should have responded immediately by indicating his commitment to exploring the traumatic experience.

(*two-month break* in sessions, attributed to his marriage)

16th session: "He talked about his hopes for the future. Very positive, upbeat session."

17th session (*six weeks later*): "He mentioned that his wife is pregnant and they will be moving soon to another state. He would like me to have one of his paintings to remember him by. I was flattered by this and told him so."

18th session: "I thanked him for giving me one of his paintings. We talked about the progress he has made in treatment and the importance of having a trusting relationship."

> The therapist again emphasized the trusting relationship rather than the exploration and resolution of the trauma. He missed completely the client's offer to take care of him through his gift to remember him by, when the therapist should have reassured his client that he did not need a gift to remember him.

19th session: Last session. No discussion of sexual abuse.

Preliminary Discussion

These case notes, albeit only short summaries of the sessions, reveal a therapist who is actively avoiding the details of his client's trauma, but who is unaware of it. The therapist believes that by providing a caring, listening presence, the client in their own time will disclose what they are able to, and eventually receive some relief from this disclosure. The therapist does nothing to establish a trauma-centered frame, does little to clearly indicate the value of delving into the details, and quickly accepts the client's congratulations for his progress despite multiple indications that the client is trying to help the therapist move forward, ultimately sealed by giving the therapist a gift.

The therapist took a non-directive approach and as a result was never told about the details of the trauma. He concluded that the client was not ready to do so and had strong defenses against doing so. He attributed the progress in the therapy to the development of a trusting relationship and a partial reporting of the trauma. In his concluding letter to the Court, written after the therapy had terminated, the therapist reflected:

> "He came into treatment because he had decided to finally confront the sexual abuse he was the victim of as a child. Beginning therapy was very difficult for him, but he knew it was necessary in order to free himself from the demons that had tormented him. He did not want to give any details regarding the abuse…that the feeling of shame and embarrassment were with him constantly….He was finally able to tell the story of the sexual abuse 10 sessions into treatment, though he downplayed it. Telling his story to someone he trusted was a monumental event for him. He told the story in a very detached manner, which is obviously a defense mechanism against the pain he has felt most of his life, and which has greatly impaired his

> ability to live a full and productive life….We had a very good therapeutic relationship but I always felt a distance with him even well into the treatment. I think he is very unaware of this aspect of his personality."

The therapist's interpretation of his client's behavior in terms of his personality defenses and character is clear here, instead of considering the client's behavior as a response to therapist's avoidance of the traumatic material and lack of engagement with the client. The therapist was aware of this "distance" between them, but did not know its true cause.

Now if this was all the evidence we had, it would be reasonable to propose that the TCP perspective is a *possible* explanation, but could hardly constitute proof of the ineffectiveness of the therapist. A unique aspect of this case came to light that, in our view, does provide that proof.

A Missing Fact

What the therapist did not know, was that between the 10th and 11th session, the client met with his attorney to respond to the defendant's interrogatories, that is, specific questions from the Church regarding the client's allegations. Due to the first author's role as forensic evaluator, he was given both the therapist's notes and the client's response to the interrogatories, and was lucky enough to notice the overlapping dates of these meetings.

During this meeting, the attorney asked the client to tell him as accurately and in as much detail as possible about the abuse so that his interrogatory would best represent what happened. The client described in excruciating detail the specific acts of the priest:

(Direct quote from the interrogatories:) *"At the top of the stairs in his private bedroom Father masturbated my penis then he performed oral sex on me until I achieved orgasm. Father then demanded that I masturbate his penis and then perform oral sex on him, which I did and he had an orgasm. Sporadically during these occurrences he would also penetrate my rectum with multiple fingers…..At another time in the rectory office where Father conducted day to day operations such as paying bills, he unzipped my pants, masturbated my penis, then took it into his mouth until I achieved orgasm…Father would lay me down on the sofa then unzip my pants and pull them down to my knees; he would then masturbate my penis and perform oral sex on me until I had an orgasm…Father took me with him when he visited patients in the hospital. He had me wait in the car. After he parked the car, he would unzip my pants and masturbate me….He took me to his summer house twice. In the master bedroom Father stripped me naked, told me to get into bed, he then masturbated my penis and performed oral sex on me. He then demanded that I reciprocate and I did what I was told. I masturbated him and performed oral sex on him….."*

The attorney told the first author that the client "had no difficulty" reporting these details in that meeting.

Analysis

Why was the client able to discuss the details so directly with his attorney, and not with his therapist? The answer is that the attorney *asked* him to reveal the details, because the attorney needed the details to pursue the case. Generalities would not suffice. The result is that the client was able to do so. He was not more upset after telling his attorney the details, but less so. A few days later, he reported to the therapist that he felt a lot of relief from the last session, when it is most likely that the relief he felt was from the exposure due to his session with his attorney. This fully explains how he immediately followed up on his own by talking to a male friend, his wife, and family, all because he had revealed the details so completely with his attorney. Here the client was managing the self-esteem of his therapist. Indeed, the client then distanced himself rapidly from the therapist, largely because he understood that the therapist was of no help to him, revealed in two large gaps in sessions, and in his statements: "*that perhaps we can begin meeting less often because he is doing well," and "He commented on how it is nice to not always focus on the abuse in our meetings."*

The therapist asked the client to tell him the story only once and did not pursue the details after a generalized answer, based on his nondirective approach. The result was that the therapist never knew the details of the abuse, for which the client had been initially referred to treatment to deal with, and mistakenly felt that the treatment he had offered had been effective.

The irony of the client's statement in the 15th session is painful: "how nice it is (*for you, the therapist*) to not always focus on the abuse in our meetings." The client, polite and ingratiating, attempts to tell the therapist that he had let him down, a message completely missed by the self-satisfied therapist. The client, when directly asked by his attorney, had no difficulty responding in detail – whatever shame or embarrassment he had did not interfere with his ability to do so. The client's hesitance in the therapy sessions was a direct response to the therapist's behavior, who unconsciously communicated his discomfort with hearing details about the trauma. With great irony, it is the attorney's behavior: direct, active, professional, that reflects most closely the trauma-centered approach, rather than that of a well-trained clinical psychologist.

Summary

Severe trauma requires a specific trauma-centered approach that departs from some of the tenets of nondirective, supportive psychotherapy. Listening, reflecting,

unconditional positive regard, and following the client's lead are not sufficient to overcome the trauma client's assumptions that others are afraid to hear about the horrors of their experience. The trauma therapist needs to establish safety in a different way: by the demonstration of confidence that discussing the details of the trauma will be helpful, by doing so in a timely manner, by actively asking the client to disclose and discuss what happened, and by giving room for the heightened emotions associated with the disclosure. Unfortunately, many of the standard methods of nondirective therapy match and strengthen the client's avoidance, and in so doing, undermine the client's confidence in the therapist's ability to help them.

What this case highlights is the somewhat amazing fact that the direct, active approach of an attorney was more effective than that of a highly trained psychologist who viewed themselves as being trauma-informed.

The Open Conversation Model

Family-Based, Behavior-Specific Trauma Work with Children

David Read Johnson

Working with disturbed, traumatized children and their families, foster homes, residential facilities, multiple providers and legal entities is challenging. Our work until about a year ago was aimed at addressing the underlying traumatic schemas that were often the cause of the child's disturbed behaviors and psychiatric symptoms. This was done by weekly therapy sessions with the child, accompanied by periodic sessions with the parents or caretakers and consultations with other providers. Over the past year, we have made significant changes in our methods, shifting to a family-based and behavior-specific model of trauma work.

By *family-based*, we mean that the entire family is included in all sessions, and treated by a team of therapists who, during the course of the therapy session, have individual meetings with the child, parents, and siblings. The focus has shifted from developing a corrective healing relationship between the child and the therapist, to developing the attachments among the family members and thereby aiding the family as a whole to manage the child's disruptive episodes.

By *behavior-specific*, we mean that we identify each specific disturbed behavior of the child, and then identify those behaviors that are disturbing enough to the caretakers that they are impelled to move the child out of the home to another environment (e.g., hospital, respite, DCF, another relative, residential facility, police). Every effort is made to diminish those "show-stopping" behaviors first, so that the negative effects of expulsion from the home on attachment can be attenuated. Only then do we focus on less severe, though troubling, behaviors in the home. By behavior-specific, we also mean that each disturbing behavior is understood to reflect a specific aspect of the child's traumatic experience, that must be uncovered and openly discussed.

By *Open Conversation*, we mean the method that we have developed to accomplish these goals with the families, based on what we call Variance Theory of Human Relations. An open conversation is associated with strong attachment and intimacy, and a minimum of acting-out or disturbing behaviors. Its aim is to alter the boundary relations among the family members.

Basic Model of Disturbed Behavior in Traumatized Children

Our basic model proposes that each Disturbed Behavior (DB) is the product of certain Current Circumstances that trigger specific traumatic memories. This occurs when aspects of a current circumstance overlap with elements of the trauma. We have found that such overlaps are not general, but instead involve specific elements such as smell, colors, words, gestures, times of day, types of room, that were encoded during the traumatic events. The effect of this overlap is that the child becomes destabilized, confronted with stimuli that refer to two completely different "realities." This state of destabilization then triggers the application of the Trauma schema (TS), whose purpose is to stabilize the child's experience. Stabilization is achieved by rigidifying the interpersonal boundaries. The TS accomplishes this usually by attacking the overlap in experience, which leads to the expulsion of the threatening elements into the environment. This expulsion becomes manifest in the withdrawal, aggression, opposition, or self-injury of the Disturbed Behavior. It is important to note that our model proposes that DB is motivated by anxiety in the child, due to fears aroused in the original traumatic experience and the state of destabilization which occurs when overlaps with the current situation arise. Our model also suggests that Trauma Schemas are fundamentally relational in nature, being methods of stabilizing current interpersonal interactions, rather than being set structures laying inside the client waiting to be played out when triggered. The exact nature and form of the trauma schema, and what elements of the past trauma are evoked, therefore may be determined during the interpersonal interaction in the present, not prior to it.

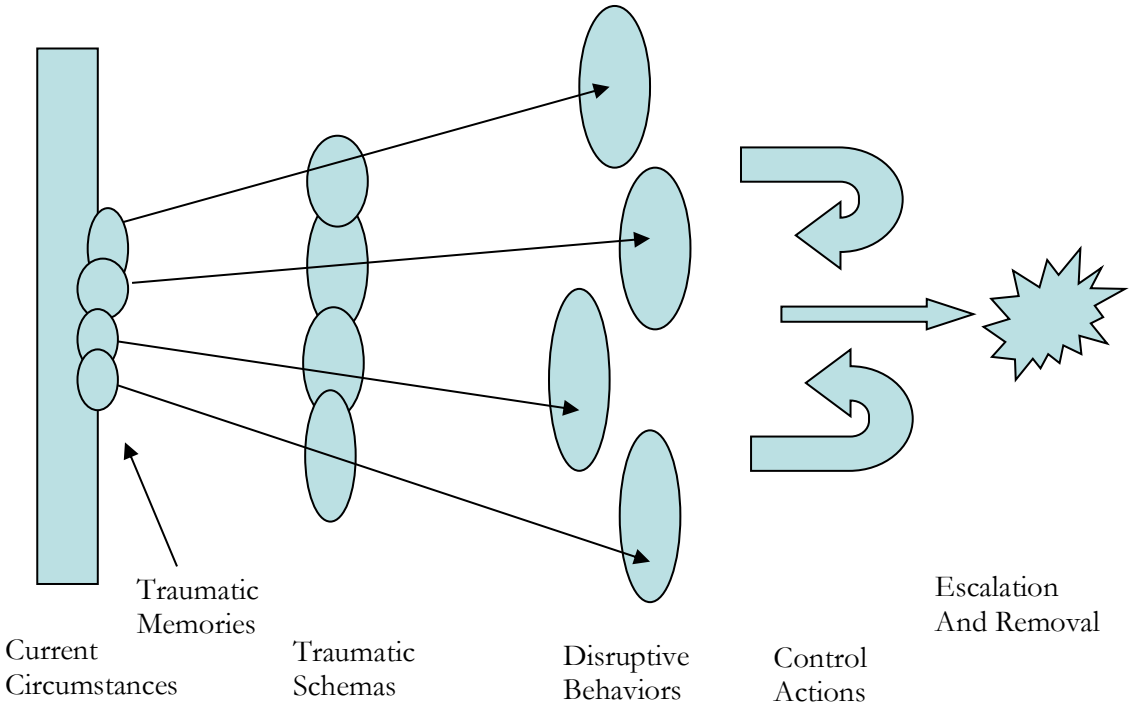
The caretaker, confronted with the DB, attempts to address the dysregulation of the child through Control Actions which are designed to curtail the DB. Thus, the parent says "No.", or engages in disciplinary measures, or may yell or threaten the child, or may bribe or distract, or attempt to console the child. When these CA are successful, we believe that the DB may not in fact be motivated by the child's TS.? Too often they are not successful, and they instead lead to dramatic escalation of the DB by the child, and sometimes will lead to the showstopping behaviors that make the parent move the child out of the home.

This escalation is the result of CA which, no matter how reasonable or well-applied, serves to resist the expelling by the child of the overlapping elements of the trauma. This raises the child's anxiety and sense of destabilization, causing him/her to increase their behavior. The DB almost always carries elements of the original fear, and evokes a complementary response in the caretaker that often mimics the actions of the original perpetrator who "forced" the child. Thus soon the caretaker, more and more frustrated and desperate in the failure to control the child, takes on elements of the original perpetration, leading the child to become more desperate themselves. The reverse also occurs, in which the child's behavior takes on aspects of the perpetrator's behavior, turning parents and siblings into victims. The result is a total loss of control and very often acts of violence between the child and their caretaker. Both sides may feel abused and abusive, at the same

time. These acts of violence are extremely damaging to the tenuous attachments among them.

Thus, it is crucial that this cycle of escalation and failure be interrupted and prevented, if there will be any hope of supporting healthy attachment in the family. Episodes of DB will be inevitable because there is no way to prevent current circumstances from overlapping with aspects of the past traumas. Clearly, the moment of intervention must occur once the DB has begun, and before the caretaker initiates the CA. It will be in this moment that an understanding of the genesis of the DB will need to be applied. Obviously these moments will occur when the therapist is not present, so it is essential that the caretakers are trained to handle these moments. Doing competent trauma work individually with the child, and parental skill training independently with the caretakers, alone, will be ineffective unless the child and caretakers can practice, together, a different way of handling these critical moments.

What we offer the families in these moments we call the Open Conversation, in which the boundary conditions between child and caretaker, present and past, are made more permeable, and the methods of stabilization are changed from those that attempt to secure borders, to those that result from greater mutuality and attachment. In that moment of instability, when the world is spinning around you, instead of closing your eyes and shutting out the world, we encourage you to *hold on* to your parent. Since these children have had prior experiences of trying to hold on to inconsistent, abusive, or absent parents, it is no surprise that this act will be a courageous one.



Methodology

Format

The session is constructed of the identified child, at least one of their immediate caretakers and preferably all of them, and siblings or others who live with them. The work is centered on training the family members to manage their interactions with the child during the DB, so whomever is likely to be present during a DB should be included. Important family members who are rarely present need not be in the session.

Depending upon circumstances, each unit in the family should be represented by a separate therapist on the team, thus the child, one or both parents, and siblings might each have a therapist.

The session begins with everyone meeting and practicing an open conversation. This is lead by the senior therapist on the team. Then each subunit breaks out for 15 to 30 minutes, and then returns for the last 15 minutes in which the Open Conversation includes material that came up in their individual sessions.

The result of this work is a collective Language in the family to represent The Trauma, The Trauma Schemas, The Triggers, The Disruptive Behaviors, and The Control Actions. These can be simply practiced, they can be written down on worksheets, or they can be represented in poems, artwork, skits, or other means. The result of this shared language opens the inner world of the victim to their family, thereby reducing their isolation.

What this work does then, is to provide a space in which the boundaries between Past and the Present are made more permeable, and open, and eventually mundane. The presence of multiple therapists, and combined and breakout sessions, provides for a cushion of numbers, and for coming together and moving apart, that is, an open but safe system.

This model may also help prevent crippling and entrapping transference and countertransference binds that often develop within individual therapist/client dyads, which are examples of stabilization effects of trauma schemas. The improvement in the capacity for attachment is thereby played out within and between family members, rather than with the therapist, who inevitably then has to find a way to loosen the attachment, often with some difficulty.

The Effect of Trauma on Interpersonal Boundaries

Traumatic experience, especially when it occurs in an interpersonal context, dramatically affects the boundary management of the victim. Overlapping or shared experience with others is viewed as becoming vulnerable to hurt, pain, or attack, therefore

it must be severely restricted. In cases of less severe and more discrete traumatic experience, the effect on the boundaries may be limited to those areas that are directly associated with the trauma, such as a car accident may make the boundary management around driving restricted, but not relationships with spouse or children. However, in the vast majority of cases where the trauma is severe and ongoing and occurs early in life, the effects will permeate the entire boundary region of the person.

The manner in which the boundary region is altered is what we call the Traumatic Schema, and in large part consists of rigidifying and narrowing the boundary region in an attempt through clarification to stabilize the experience of contact with the other. Shared experience must become severely limited, and the two dimensional nature of a boundary area becomes collapsed into a one-dimensional line or fence or wall, highly protected, between the person and others. The fundamental aim is to secure the borders of experience against intrusion, rather than to define the core or center of the self. Ambiguity in attribution leads to an experience of fear and instability. Protection is secured by giving up that shared piece and essentially expelling it into the environment/other. States of anxiety that are triggered by intimate interpersonal interactions lead often to projection of distress into the environment, usually through aggressive verbalization or action. The origin of a child's DB lies in overlapping, ambiguous, shared experience, which paradoxically is often generated by attempts of the other to care for, share with, or be intimate with him/her. When the caretaker responds by attempting to block the DB, the child may experience this expelled piece of experience as being pushed back across their boundary, leading to tremendous anxiety and feelings of fear, invasion, or intrusion. The child then redoubles their efforts to protect themselves by intensifying their DB. This is perhaps why so many traumatized children show DB when asked to follow rules or other social expectations. Their negative response irritates and confuses parents who cannot understand why the child cannot hear a simply, "No."

The intensity of these responses is increased in more intimate situations or situations of greater interpersonal proximity. Thus the interpersonal environment of a residential hospital, group home, foster home with other siblings, or foster home without siblings each can generate varying levels of proximity and intimacy. This is why sometimes certain children do better in less intimate settings, or with less intimate foster parents. Taking greater distance in space or time may be required to calm the person down, since it will decrease the experience of overlap between the parties.

Escalation and Dysregulation of the Disturbed Behavior

When the child is triggered, it usually means that a piece of shared experience arises that requires his/her boundaries to become more permeable. The child responds instead by attempting to expel this shared experience into the environment through DB. The parents in turn will respond in various ways, either by caving in and accommodating to the child,

negotiating flexibly with patience, or responding with CA which attempt to diminish or extinguish the DB. Extinguishing the DB will often be experienced by the child as refusing the accommodation and be viewed as highly threatening. The feeling of instability in the interpersonal environment increases, leading to intensification of the DB, desperate attempts to remove themselves from the situation (going to room, locking self in room or bathroom, running away), or aggression. Most parents will experience the DB as intrusive and disturbing also, and will refuse to accommodate, instead expelling this distress toward the child. It will be as if both sides refuse to accept this, and shared space is then completely eliminated. Worse, the expelled experience is then attempted to be pushed into the other as a means of locating it. As these attempts fail, this disturbing piece is then *trapped out in the open*, unclaimed by both sides, and is experienced as free to move on its own. All of us who have had our late-night intense fights with loved ones and spouses know this moment, the passion has risen so high, unknown or deeply hidden things are coming out spontaneously of both parties mouths, and a feeling of complete loss of control arises, making the situation extremely frightening and yet, each party cannot extricate themselves from it. It is at these moments that the roles of victim and perpetrator shift rapidly within the interaction. The child appears to fear an attack or criticism by the parent; in the next moment the child may attack the parent, who feels misunderstood and victimized by the child; the next moment it is reversed again. This spin is due to the fact that the unclaimed piece lies outside the self-boundaries of each party, and each party is attempting to force it into the other, with increasingly desperate effort.

The sudden autonomy of an unclaimed experience is indeed frightening and is almost always resolved by a violent physical or verbal attack from one party on the other, or from both. The concretization of the need to locate the distress in one or the other is played out in physical injury, restraint, and pain. Both parties are often immediately saddened, as this escalation is surely a sign of failure in their relationship. At this point the parties withdraw, and after a recoupment period, resume their interactions.

Prevention of the Escalation of the Disturbing Behavior

Preventing these events and helping the traumatized child and their caretakers to heal, then, requires an alteration in the rigidity and narrowness of their boundary relations. The impermeable line must be expanded into an area, creating a boundary region, and better yet, using this geometrical metaphor, a boundary volume. Rather than an emphasis on securing their borders, the family members are encouraged to define their centers more firmly. This will result in the capacity for greater variance in the boundary conditions of their relationship, meaning greater gradation, greater ambiguity, and greater areas of shared experience in their interpersonal environment. Rather than experiencing variance as a threat, the family should see variant experience as an opportunity for growth, life, animation, creativity, and play.

The means by which this is accomplished is by establishing the capacity for an Open Conversation among the parties.

The Open Conversation

The Open conversation is what replaces the Control Action in the management of Disturbed Behaviors by the child, with the caveat that control actions may have to be employed if the immediate safety of the child is at stake. However, quite often disturbed behaviors rapidly escalate into safety-threatening situations, all the more so because the parents anticipate this escalation due to many prior repetitions of this interaction. Thus it is essential that in the therapy session the child and parents practice the open conversation so that they can more readily employ it and the environment it brings with it into their interactions at home.

What Do We Mean By An Open Conversation?

The OC is a special type of interaction in which the permeability of the boundaries among the various subsystems of reality is sustained and enhanced. The OC therefore attempts to avoid compartmentalization, conclusions, closure, interruption, totalizing agreements, and other forms of reducing discrepant information. However it is not a chaotic or disorganizing interaction.

Reality Subsystems

The assumption is the DB arises due to conflicts among reality subsystems that cannot be identified or discussed openly. The major reality subsystems are: 1) the child's past traumatic events, 2) the parents histories, 3) the immediate current situation among them, and 4) the interaction with the therapy team. Often there are other reality subsystems.

One of the major challenges each of us face is to integrate conflicting perspectives on reality and to construct a coherent version of reality. The problem here is that often it is not possible to integrate completely divergent perspectives on reality, and one is left with contradiction, disagreement, and fragmentation. Such is especially the case in trauma and even more so when the trauma occurred early in the child's life. The OC attempts to create an environment in which these contradictions and divergencies can co-exist.

Therefore, in the OC, it is important that each reality subsystem is identified and that the conflicts among these subsystem's constructions of reality are acknowledged.

One of the major problems in any intimate conversation is that each party makes a statement about their thoughts about a situation, as if the statement was a statement about what reality is, rather than identifying their statement as their thought about what reality is. After all, it is awkward and usually superfluous to presage every statement one makes with "My thought about this is:….."; In addition, if one said, "My thought is that you are trying

to get me to punish you," seems to weaken its impact and open the door to other thoughts about what you are trying to get me to do. Of course the OC intends to open those doors.

Since presumably there is one reality, divergent views of reality must enter into a power struggle for dominance; however, there are many possible thoughts about reality, so the fact that we all have different thoughts about reality does not lead so quickly into a power struggle. This is true because to the extent we share the one reality, we each have a stake in its determination; however, each of our own thoughts are our own, and others do not have the same right to intrude.

Thus one of the methods of the OC will be to identify statements as thoughts.

Including the Trauma Story

Due to the important role of trauma in the child's DB, the OC will include discussion about what is known to have happened to the child as well as what other details and events may have happened, and then how the current DB is related to these prior events. This discussion will be very difficult often because the parents, often who are foster parents, do not have the information, were part of these events, worry that this discussion will harm the child, and worry that speculating about these events will be wrong. The child will not want to discuss these events because they have not discussed them before, they do not really remember them, they do not want to remember them, and they do not want to cause any more trouble than they have. The therapy team will not want to discuss it because they will be accused of leading the child, speculation may lead the child to believe certain things happened that did not. The result is that there are many reasons why this conversation will not be allowed to progress.

Importance of the Open Conversation

The intent of the OC is to open up the boundary regions among ideas, views, and reality-claims between the participants, and different reality subsystems. Essentially this means increasing the experience of variance in these areas, to allow for movement that does not require the reshaping of boundary conditions. Usually the family situation has devolved to a highly bounded interpersonal environment in which each party has secured the borders of their own opinions and those of others, as well as having clearly understood obstacles to discussing various topics. These areas of conversation are difficult exactly because they constitute overlapping territories, views, and thus are fraught with uncertainty, relativity, and diversity.

When a DB or other experience is expelled from one parties' territory but is refused by the other parties, it is subject to being caught or trapped out in the open. Having such dangerous experience unclaimed rapidly increases the anxiety of all parties, as they prepare to defend themselves from invasion by this experience, and thereby attempt to force it into other parties' territories, increasing their anxiety and fear. It is this dynamic that leads to the rapid escalation of affect and eventually violent behavior in the family.

These unclaimed pieces of experience are almost always elements associated with the original perpetration or perpetrator in the traumatic event, and thus are feared for many reasons. It is as if the perpetrator has escaped and is lurking around, stalking, and may leap out at any time. It is far better to locate this unclaimed piece in someone else, child, family member, therapist, DCF, than to have it loose. Thus it is extremely important that the perpetrator(s) are mentioned openly and in detail in every session, as if they were members of the family.

Thus the OC attempts to make these secure borders more permeable and increase the overlap among them so that there is no open, unclaimed space, but rather a shared space among the parties, though this shared space is of necessity less certain, less static, and less predictable. Thus it is the goal for the parties to tolerate greater instability in their relations with each other, compensated by the increase in their sense of mutuality in the shared spaces between them. When anxieties and fears arise that would otherwise be expressed in DB, these can travel across the shared spaces and be processed by the collective, which is likely to be more effective than if pressed upon only one individual.

Identifying Obstacles to the Open Conversation

Silence

A party will respond to a question with silence, refusal, or changing the subject.

Interruption

Another party will interrupt the speaker to offer a divergent view or to invalidate the speaker's comment or authority to make the comment.

Closure

A party will speak in such a definitive manner as to end discussion by concluding what was real, forcing others to comply or to make an outright challenge to their authority. Often closure is accompanied by strong affect that indicates the party will become very upset if challenged.

Claims of Authority

When a speaker is directly asked what their thoughts or opinions are, the rules of engagement declare that they have the authority to answer the question. If they reply in a manner that other intimates feel is incorrect, they are faced with the problem of then challenging the person's authority that they just gave them by asking them the question. Thus, usually they do not challenge them, and stay silent with opposing opinions.

Totalizing Agreements

After a speaker makes a statement, other parties collectively indicate agreement by nodding or saying "yes" 'uh-uh" or nonverbally relaxing.

Denying Disagreements

A party will make a statement that directly disagrees with the previous speaker, without indicating that they are disagreeing, on the assumption that if accepted, their argument will prevail.

Minimizing Small Differences

Often small differences in view are expressed but due to their relative insignificance they are not addressed or minimized even further. Identifying even these small variations in opinion enhances an OC environment, teaching the parties to notice differences rather than push them under the rug.

Not Labeling or Acknowledging Disagreement or Misunderstanding

Due to the social expectation that through language we can communicate effectively with each other, the assumption is made that each party is understanding the other, even when that is obviously not true. Likewise, it is difficult for people to label an interaction as a "disagreement," preferring to continue arguing on the assumption that an agreement needs to be, or can be, achieved (if the other party submits).

Making Statements Rather Than Asking Questions

Due to the pervasive sense of deauthorization that the child and parents often have, they feel a strong need to make their views known, and thus tend to make statements about reality rather than ask questions of other parties' views of reality.

Distaste for Uncertainty

Normally we are encouraged not to speak until we are relatively certain about what we are about to say. In the OC, speakers are encouraged to offer ideas that they are uncertain about.

Suspicion of Speculation

Similarly, we are usually not encouraged to speculate, due to the potential harm it may cause. However, speculation is harmful if it is not identified as speculation, but rather as an assertion of what reality may be. Spec(k)ulation is making conclusions from only specks of data. However, in the OC, speculation is not discouraged though it is always identified as speculation.

Confusing Thoughts about Reality, with Reality

Speakers will make statements about reality without indicating that these are their thoughts about reality, forcing others to either agree or disagree about what reality is, instead of sharing their thoughts about reality.

Confusing Thoughts about Thoughts, with Thoughts about Reality

Speakers will be disturbed by the thoughts of other speakers, but will instead make statements about a different view of reality in the hopes of changing the thoughts of the speaker. The intervention such as, "How do you feel about your child's thought about you?" help to clarify this distinction.

Conducting an Open Conversation

Direct Trauma Talk

First and foremost the therapy team must demonstrate a deep comfort in discussing trauma material, to show curiosity about the child's and family's traumatic experience, and to freely ask questions about what happened, what might have happened, and what did not happen.

Decoding

When the child refuses to participate in the discussion of their DB or trauma, then the therapy team discusses the possible relationships between these two reality subsystems, in front of the child. The idea is to engage the family members in "decoding" the DB, by having a discussion that in most ways is similar to the discussion the therapists would have with each other as they tried to figure out what the DB meant.

Mentioning the Perpetrator

Since the unclaimed experience is so likely to be attached or associated with the original perpetration, the therapy team must mention the perpetrator(s) and include them in the discussion in every session. They must be viewed as permanent members of the family, and even included in circular questioning in asking parties to speculate how the perpetrators felt or thought, or wondering how they would think about events occurring in the family now. The use of concretization may also be considered, such as the use of the perpetrator doll, empty chairs, or other objects to represent them.

Circular Questioning

Circular questioning is a technique in which the therapy team only addresses people who do not have the authority to answer the question. This is opposed to direct questioning, where one asks someone what they think, which they have the authority to answer. In CQ,

you ask party A what they think party B is thinking, or what party B's behavior means. After they respond, you then ask party B what they think party A's comment meant. You only carry on the conversation with the party about the contents of other parties minds, not their own. In this way, the conversation can never be stopped by a party, and it teaches each person to hear and eventually to tolerate the thinking of the other parties. You do not let other parties shut down the thinking of each party. What helps is that people become very curious about what other people think about them (because they never hear it due to the constraints of social intercourse), so they feel like they are listening in on a conversation about themselves. This gives them room, since they are never asked to state a direct opinion about what they think. Among intimate groups, participants have much to say about the thinking of other members.

Pointing Out or Labeling Disagreement or Misunderstanding

The therapy team should be active in verbally pointing out and labeling moments when family members disagree with each other, have different thoughts, or do not understand each other, rather than trying to highlight moments when there appears to be agreement or mutual understanding. This is done simply by stating, "It seems that there are two views of the situation." "It seems that she misunderstands you." "It seems that each of your thoughts about this do not match, or are different." "We have a different view of the situation than you do."

Identifying Statements as Thoughts

To help prevent the parties differentiate between statements of reality and thoughts, the team should use the word "your thought" often, as in "what is your thought about what Jimmy just said?", and "What do you make of Susan's thought?" "Have you noticed that each of you have different thoughts about that issue?" The aim is to engender in the family dialogue a norm that people are understood to have different thoughts about things, even though the authorities in the home may make a decision to do one thing or another. Decisions regarding actions should not be conducted under the illusion that everyone is thinking the same way.

Discernment

Since the aim of the OC is to expand the experience of variance in the boundary conditions of the reality subsystems, by increasing the boundary permeability, it is important that the participants have the experience of opening and closing their boundaries, and moving objects of conversation across the various boundaries. This is often done in a back and forth manner that allows the person to feel the gradations of difference. In practice, therefore, rather than being in a position of imposing an open conversation upon the participants, the therapy team must be willing to allow such a back and forth, opening and closing of boundaries in the conversation, largely by making repetitive loops in the

conversation, going back over old material and revisiting issues and opinions numerous times, each time asking participants to revise their previous assessments of their own and the others' views.

Listening

When a child or any party shuts down, and the other parties indicate that they take this as a sign that they should not continue, or attempt to get the child to talk, they should be told that "Listening is a form of participating," and that as long as the child is listening, they can be affected by the OC. Each person has the authority to talk or not talk and trying to get them to talk is another CA which is doomed to fail, or will begin the escalating event.

Third Party Conversation

Whenever a party closes down or refuses to discuss an issue, the therapy team continues the conversation with the family members, now in the context of the issue itself and their opinions, but also their views about the meaning of the party closing up. If family members also shut down, then the therapy team continues the discussion among themselves, to include the issue, the family shutting down, and the party shutting down. What usually happens is that the shut-down parties calm down, listen to the conversation, and then insert themselves again when they feel that someone has made a misstatement or something needs correcting.

Putting the OC into Action

The hope is that during the session the child emits the beginnings of a DB, in which case the therapy team in collaboration with the family members can actually practice the OC as if it were happening at home. This becomes a powerful means of demonstrating to the family the effectiveness of the OC instead of instituting the CA.

Example of an Open Conversation:

Child	(Lays on floor.)
Mom	Get up, Lori.
Child	(Ignores her.)
Mom	(Gently.) That is not nice; not appropriate Lori. Why don't you get up now and sit in the chair?
Child	(Gets up on knees and goes to chair and pushes it.)
Mom	(More tense.) Lori, don't push that chair. I want you to sit up like I know you can and participate in this session with the doctor.
Child	(Moans loudly and in frustrated tone, pushes chair up on back legs hard and lets it fall back.)

Mom	Lori! Stop that!
Child	(Nearly picks up chair and appears to be contemplating throwing it against the wall.)
DJ	(To Mom.) What do you think is going on in Lori's mind now?
Mom	I really don't know.
Child	(Lightly bumps head against the seat of the chair.)
DJ	I'm sure she is doing that for a reason. Perhaps something we said made her think about one of her birth parents.
Mom	I have no idea really….Lori, are you thinking of your birth mother now?
Child	(Does not respond.)
DJ	Lori is not responding, but do you think she is listening to us?
Mom	Yes, she is listening.
DJ	I think so too, and that is an okay way of participating in our conversation. Now I noticed that she was pushing the chair, and I remember her saying she had been thrown against the wall by her birth father once. I wonder if she is thinking about that.
Mom	Could be, but she also told me once that he pushed her out of her chair when she wouldn't stop crying.
DJ	Hmm, interesting. Because we were just talking about how her sister had been crying last night. Maybe that reminded you, Lori, of the incident with your birth father.
Child	(Doesn't respond but is listening intently.)
DJ	Seems like you are listening….(To Mom) if you notice, as soon as we began to talk together about this, Lori stopped moving the chair and seems to be listening very intently now.
Mom	Yes, it's strange.
DJ	This is an example of what we'd like you to do at home when Lori begins to do one of her behaviors, to start to talk out loud about possible connections to her past, and to carry on the conversation, with your husband, or even alone, if she doesn't want to participate. It's only necessary that she is listening.
Mom	That's no problem, I talk to myself out loud all the time; people think I'm nuts.
DJ	It seems that Lori was reminded of being pushed out of her chair…
Child	(Interrupting.) High chair.
DJ	I stand corrected, High chair! What happened?
Child	I bumped my head.
DJ	And bumping her head. Hard?
Child	Very hard.

DJ	That must have hurt.
Child	(Moving over to her Mom, who hugs her.)
Mom	Did that hurt back then?
Child	Yes. (Puts head in her lap.)
DJ	So it seems Lori like you know now the difference between your birth father and your foster mom: she's not going to do to you what your birth parents did.
Mom	Definitely not.

Expected Outcomes of Open Conversation

- The child and family should become much more comfortable in discussing the past traumatic events.
- The child's serious, show-stopping DB should diminish.
- The family's ability to carry on a conversation in the presence of obstacles put up by the child should increase.
- The family's ability to delay the CA and introduce the OC once the DB has begun should increase.
- More information about the traumatic events should emerge.
- The family's anxiety and/or panic around having DB events should diminish as they understand why the child is showing the DB.
- The family should be able to increasingly differentiate serious, showstopping DB from merely upsetting DB, and be more patient about the resolution of the latter.
- Interactions among all family members should increase in flexibility and tolerance.

Ask Every Child:
A Public Health Initiative Addressing Child Maltreatment

David Read Johnson

I am proposing that every child in the country be educated about child maltreatment and asked, in multiple settings, whether they have been or are being maltreated. Every child.

Why am I proposing this? Because all the work that is being done to prevent, stop, or minimize child maltreatment is not being initiated early enough. We are waiting too long before identifying it, and then beginning to address it. We are spending too great a percentage of our resources attempting to repair damage that has already been done, rather than in preventing damage before it begins. Our current efforts, as well-meaning as they are, are not sufficient to address the problem, and our country's welfare is being burdened by the impact of child maltreatment.

This proposal relies on a public health model of intervention in disease which historically has proven to be effective in reducing the incidence of disease even in the absence of a cure. Through the wide-scale use of early detection and prevention of its proliferation, the incidence and impact of childhood maltreatment can be drastically reduced within a generation.

Our current policy is to wait for the maltreated child to develop psychiatric symptoms, behavioral disorders, or criminal acts, and to spend inordinate amounts of money on expensive treatments and services. But by the time these symptoms have emerged, it is too late. We must inquire *prior* to their emergence, which means that we must ask *every* child; not indirectly, directly; not once, regularly. Not just the poor child, not just the at-risk child; every child.

It is as if children are being thrown off a roof onto the ground, and huge numbers of people are tending to the broken children, rather than stopping the children from being thrown off the roof in the first place. It is as if anyone is allowed to walk onto an airplane without a security check, and then organizing a massive response once a bomb is discovered in the air. Child protection, like air safety, begins by asking everyone, *up front,* rather than focusing on punishing the perpetrators *after* the child has been harmed.

Prevalence of Child Maltreatment

Child maltreatment is a highly prevalent, significantly damaging national health issue. In 2010, there were 3.2 million referrals for child maltreatment in this country, involving 5.8 million different children, or 8% of all U.S. children (NCANDS, 2010). Let me repeat that: in 2010, in the United States, someone called out of concern for one out of every 12 children in the country. Twenty-five percent of these were substantiated,

including 840,000 cases of neglect, 150,000 cases of physical abuse, and 130,000 cases of sexual abuse. There were 2,000 deaths from child maltreatment. Eighty percent of the perpetrators were the children's caregivers. All major authorities believe that the actual incidence of all cases including those unreported is three times that number, or about 3.5 million children each year, every year. In 2011, the Connecticut Department of Children and Families Hotline received allegations involving 81,000 children, of which 19,000 were substantiated. I ask you, if there were 3.5 million cases of tuberculosis, or measles, or any significant disease, the nation would be up in arms, the CDC would declare a health emergency. Dear colleagues, we *have* a health emergency.

Negative Effects of Child Maltreatment

Child maltreatment produces significant negative effects. Both incontrovertible empirical evidence and common sense indicate that child maltreatment leads to numerous negative outcomes that are costly for the individual, their families, and society at large. The psychological effects of child maltreatment include primary symptoms of anxiety, depression, dissociation, attentional deficits, and aggression (Kessler, Davis, & Kendler, 1997; Springer, Sheridan, Kuo, & Carnes, 2007). These symptoms interfere with children's ability to learn and function well in school. Over time, children attempt to manage these symptoms through maladaptive behaviors, including acting out, substance abuse, oppositional behavior, eating problems, and smoking (DHHS, 2003; Kelley, Thornberry, & Smith, 1997). These maladaptive behaviors lead to significant health problems well into adulthood, including obesity, addiction, and serious physical illnesses (Felitti et al., 1998; Springer et al., 2007). Numerous empirical studies conducted by the National Institutes of Health and universities have shown conclusively that child maltreatment is closely associated with adult health problems, including diabetes, certain cancers, liver disease, COPD, high blood pressure, and heart disease (Felitti et al., 1998; Kessler, Davis, & Kendler, 1997). These maladaptive behaviors and illnesses collectively lead to loss of functionality, including divorce, dropping out of school, inability to hold a job, disability, imprisonment, poverty, and hopelessness (Zolotor et al., 1999). People who were maltreated as children are 4 times more likely to be imprisoned, and 3 times more likely to be on disability or receiving entitlements from the state (DHHS, 2008).

Yet, the majority of these maltreated children did not show these symptoms immediately; they took time to develop. The prodromal period during which children just try to hold on may last months or even years. It is these children, unidentified yet suffering, that our system is overlooking.

Financial Costs of Child Maltreatment

The collective financial cost to society for caring for maltreated children through social services, medical and mental health services, transportation costs, and police and judicial costs, is staggering. Annual budgets for State Departments of Children and Families run into the billions of dollars. And these figures do not include private mental health, hospital, judicial system, or police costs. The national child welfare agency recently estimated that the direct costs of child maltreatment are over $100 billion a year, and total costs are $400 billion annually, which is one-third of our annual national deficit (Fromm, 2001; Wang & Holton, 2007). If we add on the secondary costs for these children once they have become adults, in terms of entitlement programs, disability payments, loss of productive work for society, and disproportionate use of prisons, hospitals, and emergency services, the total burden becomes overwhelming. Child maltreatment is crippling our country's ability to function and produce, is interfering with our quality of life, and burdening our entire economic system.

Impact on School Performance

Further, despite years of concerted efforts at school reform, in developing effective models of teaching, training teachers, and administering school environments, we are still losing ground. We are losing ground because of the pernicious effects of child maltreatment on the ability of our children, particularly our underclass children, to attend to the demands of learning. We can replace all the teachers and principals, introduce the most up-to-date curricula, repair all the school buildings, buy new textbooks, and we will still be faced with the problem, for the problem is not only in the school.

Moreover, these effects are self-perpetuating in that maltreated children are more likely to have children at an earlier age, with fewer supports for parenting. As a result, children who have been maltreated are more likely to mistreat their own children. Indeed, if there should be any course that is required in high school, it should be a course in parenting.

The Need for a Public Health Approach

We do not need more intensive treatments for children. We do not need more severe punishments for perpetrators. Instead, we need a public health approach that identifies early stages of maltreatment and empowers the public to act. *We need to move from reporting <u>after</u> the fact, to proactively asking <u>before</u> the act.* The effectiveness of such a socially sanctioned policy can be significant.

We do not have the cure for child maltreatment. But there are examples in history where society has greatly reduced the effects of a health crisis without having a cure. All

of these have utilized a public health, prevention approach. I can give you three prime examples.

First, the most significant medical innovation in history in terms of lowering fatalities among ill patients was not a medicine or a technological advance…..it was requiring doctors to wash their hands before touching their patients (Nuland, 1988).

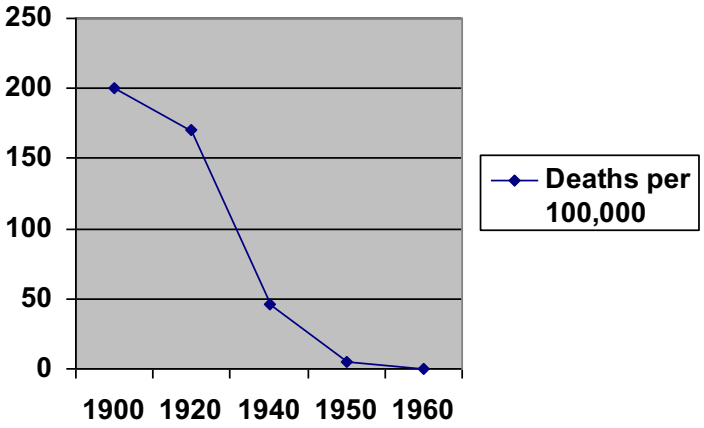
Second, the public health campaign that included new legal requirements to ban smoking from all public places is in the process of greatly reducing the incidence of lung and esophageal cancers as well as many other conditions, without having cures for those conditions. Few of us who grew up in smoke-filled environments in the 1950s and 1960s would have thought it possible to change the norms of our society to eliminate such a pervasive toxic behavior in so short a time. But we did it.

Third, and most relevant to the situation of child maltreatment, is the public health measures used to reduce tuberculosis. I want to spend a little time describing to you what happened.

The Treatment of Tuberculosis

The treatment of tuberculosis is a prime example of how a public health intervention can lower the incidence of a disease without having a cure for its cause (Yancey, 2007).

Tuberculosis in 1900 was a significant national health problem. In 1900, 450,000 people in the U.S. were infected with the disease, and 200 out of every 100,000 people died of TB each year. So great were the numbers that hundreds of sanatoriums were built to house the patients who were given the only treatment known to help, the rest cure developed by Dr. Trudeau in the late 1800s. In Connecticut, these included Undercliff in Meriden, which became a DCF facility in the 1980s; Cedarcrest built in 1910, which is now used by the Department of Mental Health; Seaside in Waterford, 1919, later used by the Department of Mental Retardation; and Laurel Heights, 1910, Uncas on Thames, 1913; and the T (for TB) building of the West Haven VA, 1910, where a few of the outdoor porches remain from the days of TB treatment. It was understood that TB was infectious, so once symptoms were discovered, patients were immediately removed to the sanatoriums. However, soon doctors realized that by the time symptoms had arisen, the patients had already been infecting others. The tuberculin test was developed around 1910, which at least showed whether a person had been exposed to TB, however, a positive tuberculin test still occurred after the period of contagion.



Using both sanatoria and the TB test, the number of deaths dropped a bit to 170 deaths per 100,000 by 1920. However, in 1935, doctors discovered that a chest X-ray was able to identify the presence of the disease prior to it becoming infectious, and over the next decade chest X-rays became increasingly mandatory throughout the society. It was this early detection, followed by removal to the sanatorium, that plummeted the incidence of TB to 45 deaths per 100,000 in 1940, and then only 5 by 1950, when the medicines Rifampin and Isoniazid were invented that indeed eliminated the illness by 1960. Note that public health measures of early detection followed by removal eliminated 97% of the disease.

We cannot afford the damage caused by child maltreatment; for early detection, education, and removal if necessary, either of the child or the perpetrator, are the same measures that will bring this plague to an end. As healthcare professionals did for tuberculosis a hundred years ago, we too can bring the number of maltreated children down. This is the challenge for our time.

The Need for Action

The reduction in child maltreatment will lead to a rapid and dramatic reduction in the need for numerous expensive services that are required today. By 1940, society had decided that everyone should receive a chest X-ray, regardless of how they felt, because no longer could it be assumed that the illness was absent. Society stopped waiting for symptoms to develop. Today, we can no longer make the assumption that child maltreatment is absent; we cannot afford to wait until children report, because most of the time they do not report. They are frightened, intimidated, confused. We cannot wait for children to tell us that their parents used to beat them. We cannot wait for children in religious schools to grow up and then tell us that their minister or priest had had sex with them. We cannot wait for children in sports programs to graduate and then tell us that their coaches were molesting them. How many times do we have to hear the same sentence

from so many victims, often *years* after their abuse: *"If only someone had noticed….if only someone had asked!"*

Most child maltreatment consists of repetitive patterns of behavior that become established within a family or other close personal relationships, and are not challenged or interfered with. They may go on for years and indeed these are often the most damaging forms of maltreatment because the victim's understanding of right and wrong becomes confused. We may not be able to stop the first act of abuse, but by asking children on a regular basis, in a number of locations, in an open manner, we will be able to interfere with its repetition.

Early Detection

Early detection means screening, means inquiring. Despite a great deal of education and attention given to the topic of child maltreatment among medical professionals, current measures for screening are indirect, not comprehensive, and inadequate. Let me demonstrate: pediatricians are required to learn how to identify the signs of child abuse. Here is the list of signs officially published by the American Academy of Pediatrics (2011):

Bruises, welts, or swelling
Sprains or fractures
Burns
Lacerations
Difficulty in walking or sitting
Torn, stained, or bloody clothing
Pain or itching in genital area
Discomfort with physical contact
Pregnancy
Poor hygiene
Inappropriate dress
School absences
Unattended medical needs
Speech disorders
Substance abuse
Low self-esteem
At home with no caretaker
Lags in development
Hypervigilance
Overly compliant, passive, withdrawn
Does not want to go home
Shrinks at approach of adults
Begs or steals money or food
Nightmares or bedwetting
Running away from home
Attempted suicide
If child reports abuse

Note this last one: *"if the child reports abuse."* If. The pediatrician carefully notes the child's behavior and looks for physical signs. He or she does everything but the one thing that is much more likely to result in the identification of child maltreatment. Missing from this list is the most reliable, most obvious, most effective way of assessing whether the child has been neglected or abused: *Ask the child.*

Pediatricians are currently not required to ask the child if they are being hit, neglected, or sexually molested by their parents, siblings, or anyone else. Only if there is a sign of such abuse might they ask. But how often are these signs ambiguous? Often. How often are there no overt signs of abuse? Often. That this reluctance to ask is not due to prissiness on the part of the Academy is shown by the fact that they advocate that pediatricians teach children age 5 and above the names for their genitalia. *Indeed, doctors are obligated to actually touch the private parts of our children as part of the physical exam, but hesitate to ask the child whether they have been touched inappropriately by others!*

Let me give you another example: the Boy Scouts of America. In 1995, the BSA implemented a mandatory program on child abuse for every Cub Scout and Boy Scout in this country, which includes going through a pamphlet on child abuse with their parents, who are required to sign that they had this discussion with their child, and then watching an explicit video about child abuse, each year. Six to nine year olds watch "It Happened to Me," and 10 to 14 year olds watch, "A Time to Tell." The materials emphasize that the most likely abuser is going to be someone close to them, a teacher, a coach, a family member, even a scout leader. They are told to report any such act to the appropriate person immediately and to not be intimidated by the abuser to remain silent. The videos are explicit, uncomfortable, and accurate.

1.6 million young boys, from the age of 6 to 10, and 1.2 million boys age 11-16, or 10% of all boys in the country, are receiving this training. This may be one of the most comprehensive public health interventions in the nation, and thus is a tremendous advance. But again, the program instructs the children to Recognize, Resist, and Report the abuse once it has happened. Nowhere in the educational materials does it instruct the adult leaders or parents to *ask* their children if any abuse is occurring.

The Reluctance to Ask

Why do we hesitate to ask the child? If we are proposing that every child be asked about child maltreatment, then we need to understand the nature of this hesitation. It is clearly a norm in our society, a norm that will need to change in order for us to achieve an effective early detection.

We do not ask because we believe in the rights of privacy. Asking seems intrusive. We do not ask because the child may not be truthful. They may lie and say that everything is fine when it is not. Or they may lie and falsely report on their parents out of spite. We do not ask because we do not want to upset the child if he or she is truthful. Asking seems disrespectful of the parents, or priest, or coach. We apparently believe that by asking we risk tremendous distress for the parents, potential legal action, and needless conflict. So we don't ask.

These all seem to be sensible arguments. What is interesting is that historically, on other issues, these arguments have failed. Let me tell you of some of these examples.

These same arguments were used to resist the implementation of a mandatory, proactive assessment of suicide potential. Debate over this issue persisted until the 1960s, when what is now established practice became the norm within mental health and hospital care. Proper suicide or homicide assessment requires that the professional ask the patient if they are suicidal/homicidal, if they have a plan, access to a means, and whether their action is imminent. The fact that the patient can lie and deny this, can lie and say they are suicidal when they are not in order to manipulate their way into the hospital; the fact that asking patients these questions can upset them or their parents; the fact that these questions are intrusive; all of these facts do not overcome the requirement to ask the patient and to document the answers. To fail to ask the client these questions is now considered malpractice. The reason these objections have been set aside, is that more often than not, patients tell the truth, and more often than not, asking these questions has led to the reduction of suicide and homicide. *We ask our patients if they are suicidal because that is the best way to find out.*

After all, having your general practitioner have you disrobe, perform a breast exam, or rectal exam, is upsetting and intrusive. The physician violates our personal body boundaries. Why? *Because they have to in order to determine if we are okay.* The mental health professional has to ask us whether we are suicidal, even if it upsets us, *because they have to determine if we are okay.* And someone needs to ask the child these intrusive and upsetting questions about child maltreatment, *because we need to determine if they are okay.*

Let me give you another example. Have you ever wondered why you are asked the same questions each time you go to the airport? "Who packed your bags? Have your bags been in your possession since you packed them? Has anyone asked you to carry a package for them? Do you have anything in your bags that could be used as a weapon?" Why do they ask us the same questions? Do they expect the terrorists to tell the truth? There are three reasons. The first is that it is important that someone else has not had access to your bag. The second is that it is often possible to tell if someone is lying. The third is that by asking these questions over and over again, people come to expect to be asked, and learn to be more vigilant. That is, new norms are set. That is why that announcement over the PA system keeps repeating, "If you see any unattended bags, please notify an airport security person." And in just this way, if children are repeatedly asked by their pediatrician or other authorities whether they have been maltreated, over time everyone will know these questions, and new norms will be reinforced.

But questions are not the only thing we encounter in the airport. Everyone entering the airport is now scanned, sometimes with a full body X-ray scan, and bags are looked into, and sometimes with a complete pat-down search including our groin area. Why are these intrusive measures required, why do we allow this loss of privacy? *In order to protect*

air travel. So let us assess the threat: How many deaths from terrorism on airplanes occurred in the United States in 2010? *None*. In contrast: How many deaths from child maltreatment occurred in the United States in 2010? *2,000*. That is the equivalent of 8 jets each with 250 passengers crashing and leaving no survivors, each year. Can you imagine what intrusive measures we would accept if that were the case for air travel? And yet, we hesitate to intrude on our privacy in the face of 2000 deaths of children. Will we allow intrusive questions to be asked, *in order to protect our children*?

As members of society, we are so afraid of asking these important, necessary questions that we are willing to walk by each other, alone in our histories, imprisoned in our private suffering by a norm that maintains our silence. We drive to work past shuttered houses within which our future patients are being harmed. This is how we too are inadvertently contributing to the conditions that are sustaining the problem. Once new norms are instituted, the sense of intrusiveness will be greatly reduced, as it has become with smoking and airport security. After all, despite all your years of complaining, if you arrived at the airport and they gleefully told you that there was no airport security to bother you, and that you (and everyone else) could walk onto the plane, no problem!.....would you? Imagine how distracted you would be on the plane worrying about a potential threat? Yet that is exactly what we are doing now with our school age children, who are walking into school without being asked about maltreatment, and they are as distracted there as you would be on your no-security flight.

We can no longer afford to continue the way we have: we must ask every child. We must ask the child before, not after, the abuse has been disclosed. The effects of child maltreatment are similar to a boulder rolling down a hill: it gathers momentum with each passing moment. By the time we have identified the problem, the momentum of the child's dysfunction is so great, it takes a huge effort to stop it, whereas if we caught it close to the top, much less effort will have to be used. The repeated asking of the important questions helps us all remember the right things to do, providing an opportunity for the person to ask for help or stop their behavior before it gets worse. The purpose is not to go after the parents, but to provide them with education and support. This will be made all the easier if the problem is identified in its earlier stages, before protective measures are required.

Implementing an *Ask Every Child* Program

We believe that an Ask Every Child program can be implemented in a number of already well-established venues where children are likely to be. These are in 1) schools, 2) religious schools, 3) organized sports programs, and 4) pediatrician's offices.

The program consists of four parts: First, through printed materials and open discussion, a *new norm of open conversation* about child maltreatment should be instituted in each of these settings. Everyone needs practice in talking about these issues. Second, *educational materials*, consisting of pamphlets and videos and perhaps annual workshops,

are used to directly educate both children and parents, teachers, religious leaders, and coaches about the potential for child maltreatment. The important point is that the people most likely to perpetrate on the child are people who are close to them and who use the child's trust to control them. The message that scoutmasters are a potential risk should come from scoutmasters; that coaches are a potential risk, from coaches. Third, *protective measures* are put into place that reduce the likelihood that children will be exposed to abuse in their setting. These might include a policy that program staff are not allowed to be alone with a child or take them on trips. Fourth, *opportunities for children to report* whether they have been or are being maltreated are provided. Depending upon the setting, this can be accomplished by the program staff, social service workers, or specially trained counselors. The basic questions are these:

> *Have you ever been without food, left alone, or locked in a room for long periods of time?*
> *Have you ever been put down, called bad names, teased about how you look or act, or ignored for a long time?*
> *Have you ever been punched, kicked, pushed down, cut, or threatened with a knife or gun or other object?*
> *Have you ever been touched in your private parts or used for sex?*
> *Have you ever witnessed other people having sex, seen sexual movies or scenes on TV or the Internet?*
> *Has anyone told you not to tell me about these things?*
> *Has anything else happened to you that has frightened or upset you?*

The identification of a maltreated child will bring to bear external supervision that will curtail the abuse for that child. Rather than removal, the most likely actions will be education, support, and therapy for the parents. In addition, by intervening early, abusers will be prevented from abusing the younger siblings of that child, or other students, decreasing further incidence. Finally, by incorporating these questions at multiple points in the child's life, a norm will be established that will have an effect over time on our entire culture. Children will become more alert and know what to do, just as many of them are quick to remonstrate adults when we delay putting on our safety belts. We will not catch the children before anything has happened, but we will be far earlier than we are now.

Ask Every Child **Programs**

We have instituted Ask Every Child in five schools in New Haven, Connecticut, and are in the process of implementing them in a Catholic Church school, a sports program, and a pediatrician's office. Our method involves: 1) building relationships with the institutional leadership, 2) educating children and adults about the nature of child

maltreatment, 3) modeling open conversations about maltreatment, 4) demonstrating support for potential perpetrators such as parents, religious leaders, or coaches, and finally 5) providing structured opportunities for the children to tell us if they have been maltreated, depending upon the setting and age of the children. This will include directly asking them if they have been maltreated, when permitted by law.

We always use age appropriate language and appropriately trained professionals. We always obtain parental knowledge and consent and give the child the option not to participate. We always indicate our intention to support the child and the involved adults, rather than to investigate or "go after" anyone. We always act within the limits of the law.

In the schools, we have conducted specialized classes and met with individual children. We have passed out informational material about child maltreatment, and provided a mobile app for students to talk with counselors about what is bothering them. We have stood at the door of one high school three times a week in front of a large sign that asks the students to tell us if they have been maltreated. We have conducted surveys of students asking them to indicate what negative experiences they have had. A more detailed description of our programs is available in a companion document.

Anticipated Problems

A number of problems were anticipated as we developed and implemented these programs, most of which did not arise.

This will lead to a huge increase in referrals to State Youth Protection Agencies. DCF referrals have actually decreased in the schools where an Ask Every Child program has been implemented, because we are catching problems well before they have risen to the severity that would require reporting, allowing for more collaborative meetings with parents.

Some students will take advantage of the situation and when angry at their parents, falsely report. In three years, in five schools, with a total of 1500 students, there has not been one instance of false reporting.

Parents or possibly students will complain. There have been no complaints. On the contrary, students have expressed pride in the program and parents have said that the program makes them feel that their children are safe.

This will be far too costly. We have implemented these programs with only a few part-time staff, covering schools of 300-500 children. We have not required expensive equipment, or buildings, or procedures. It turns out the cost of asking questions is minimal.

The presumed benefits will take years to actualize. Not so. Self-report measures have shown an 82% drop in stress levels among elementary students. There has been a 64% decrease in office referrals, a 50% drop in incidents of fighting and aggression, and a 60% drop in suspensions. An objective observer's measurements of student behaviors show statistically significant improvements in mood, attention, social conformity, and

motor restlessness. School climate surveys have shown a dramatic rise in both students and parents assessment that their school is safe.

The Politics of Ending Child Maltreatment

How will we convince physicians, ministers, and coaches to implement these programs? They may feel too exposed to lawsuits; or that they will be at odds with their own patients, students, or parishioners. However, once they realize that instituting a program such as Ask Every Child will demonstrate both an awareness of and desire to protect children, and that everyone will feel safer, the benefits to them will become obvious. The public will want to attend a religious institution that actively screens for potential abuse, or a sports program that identifies coaches as potential risks.

Will medical and psychological treatment providers fear a reduction in their business? The extensive treatment industry that is reliant on expensive and specialized treatments may resist moving services to less specialized and less expensive preventive programs. However, the demonstrated effectiveness of such programs will eventually convince everyone of their value. The problem is so large that it will be quite awhile before providers have this problem.

Will these procedures be susceptible to racial/ethnic bias? Screeners may be more likely to assume the existence of abuse among minority families; they may feel less comfortable reporting abuse in wealthier families who have the financial power and self-confidence to initiate legal challenges. However, this is why the requirement to ask *every* child builds in a fair norm that applies to us all. In fact, the current policy of selecting only certain students – those presumably showing signs of abuse – to ask, is far more likely to be influenced by racial/ethnic bias.

How will we achieve the national political will to pass required legislation? A huge amount of educating the public and the government officials will be required before these efforts can be broadly implemented. However, once programs are established in a variety of settings and show results, pressure on our lawmakers will increase.

A New Vital Sign of Our Nation's Health

As part of their established practice, doctors take the patient's vital signs, which are pulse, breathing rate, blood pressure, and temperature. I suppose I am proposing to add another vital sign of our nation's health: the presence or absence of child maltreatment. *How vital is it to us to identify child maltreatment?* I am not asking to build hundreds of hospitals, not asking for complex equipment, I am not asking for expensive medications or procedures. I am asking only for *seven questions* to be asked on a regular basis. We have an obligation. We cannot wait any longer. We can do this.

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Postmodernism and Posttraumatic Stress Disorder: Reflections Upon Each Other

David Read Johnson

The striking parallels between postmodern discourse and the experience of posttraumatic stress disorder are explored from the perspective of each discipline. Postmodern thought can be viewed as a posttraumatic reaction by intellectuals after the horrors of the Second World War, where the pinnacles of rationality, evolution and physics, were used for purposes of mass destruction. Posttraumatic stress disorder, in its turn, can be viewed as the medicalization of postmodern experience, with its emphasis on incomprehensibility, suggesting that issues such as the debate about memory, compassion fatigue, and countertransference crises are best understood as the failure of modernist paradigms to describe the process of trauma-centered psychotherapy.

My purpose is to examine the striking parallels between postmodern discourse and the experience of posttraumatic stress disorder. I will consider the idea of postmodernism as a posttraumatic symptom among intellectuals; of posttraumatic stress disorder as the medicalization of postmodern experience; of each as an attempt to represent and to prevent representation of horror; and of each as an experience "post" an unnamable fright.

Postmodernism has been variously defined as a description of the experience of recent times, its complexity, bewilderment, flux, and saturation of an increasingly fragmented self; as a presentiment or mood of intellectuals after World War II; and as a radical critique of totalizing forms of linguistic and social power (Waugh, 1992). Sifting through the works of such authors as Derrida, Foucault, Habermas, Rorty, Lyotard, DeMan, Deleuze, and Heidegger, one gathers postmodernism is about incomprehensibility, about the impossibility of reading, communication, and consensual knowledge. The framework is cracked, the fabric torn, the ground beneath no longer solid, all assumptions are turned into questions, truth into a conversation; anything is possible.

The disturbance arising from encountering postmodernism is evoked not only by its intrinsic questioning of basic assumptions of modernity: a stable self, the progress of science, the discovery of unknown building blocks of self, matter, and society; but from postmodernism's status as a shadow of the unsaid. For postmodernism was birthed from two horrendous traumas: the Holocaust and Hiroshima, and the loss forever of any remaining illusion of safety. Postmodernism is thinking after the end of history, by which I mean the revelation of history as a lie, or rather as being indistinguishable from story.

Hiroshima and Holocaust

No doubt these two catastrophes constitute profound historical discontinuities, whose simultaneity cannot be overlooked. The postmodern age - an age of uncertainty - begins under these shadows, unmistakably permeated by death. The paradox of their unrelenting uniqueness despite millennia of human violence has not been resolved. Though Vietnam veterans and battered women were the touchstone for the legitimization of posttraumatic stress disorder, they still remain as intermediaries for the bedrock of trauma that was reached in 1945.

Postmodernism's apocalyptic sensibility is rooted in the crisis faced by intellectuals after the War: both the Bomb and the Oven were a culmination of Rationality and its servants, science, reason, and industry. The Manhattan Project and the Final Solution were purified expressions of physics and evolution, respectively. Hitler's motivation, perhaps more than sadistic desire to be rid of the Jews, was the idealized, totalistic project of purification of the human gene pool through the use of modern genetic research and selection, in order to maximize human capacity for all time. Jews, like gypsies, homosexuals, and the mentally impaired, were impure and required expulsion and extermination, as rodents, or used for scientific experiments, as laboratory mice. The Nazi project was pure Darwin. The ethics of extermination were negated and voided under the guise of privileging science.

Similarly, the Manhattan Project - the most ambitious scientific endeavor ever conceived, was conducted by the country's greatest scientific and mathematical minds. Annihilating 100,000 civilians in Hiroshima and then 90,000 in Nagasaki has been justified successfully on the basis of rationality: in the end, it goes, dropping the bomb saved lives of both Japanese and Americans, due to the expected resistance of the entire Japanese population to occupation. The ethics of killing hundreds of thousands of innocent civilians is overlooked, or, more significantly, transformed through a revision of the victims from innocents into collaborators. By 1945, indeed, no one was innocent.

The wonders of the Enlightenment, which had found their ultimate expression in the burgeoning modern world of science, became unsteady with Einstein, Heisenberg, and Godel, and then faltered as darkness fell over Hiroshima and black smoke rose from Auschwitz' chimneys. How to measure the horror of these two events? On the one hand, to place them on some scale situates them as mere extremes of a continuum, thereby denying their particularity. On the other hand, to set them apart leaves us with no arena for articulation, modulation, mourning, or future comparison. The uniqueness of these events, that is the depth of the fear they induce, must be linked to the revelation of a capacity for destruction, not of a human being, or by extension, any number of human beings, but rather to the "whole" of a class of human beings, that is, genocide. Genocide, the destruction of a genotype, found its birth here. From a postmodern perspective that posits truth and knowledge as a local construction of a self-referent, linguistically coherent

culture, the destruction of the entire Local Group (as I will refer to it) annihilates the basis for knowledge and notions of reality.

Thus, Hiroshima and Holocaust disrupted the orderly progress of modernity, and cast a dark shadow over truth-claims and ethical foundations. In response to this level of catastrophe and evil, two human impulses toward restoration -- retaliation and mourning -- were never successfully engaged (Lifton, 1991). Rather than confront the excesses of rationality and the grand narratives of Western culture, methods of thinking were devised that question rationality and truth itself. For if there is no certain truth, then one may not be impelled to counter falsehood.

Thus the postmodern age was birthed with two contradictory tasks: to explain evil and to explain it away. For the postmodern, there cannot be one, true Holocaust. Therefore, the reality of the Holocaust remains in question, to be discussed, forever. This condition underlies postmodern approaches to all trauma. But then what are we to do with the photographs of mountains of skeletons, videotapes of hundreds of survivors, the ghastly limb deformations in Japanese children, and the smoke from the ovens still choking former residents of Buchenwald? To claim the reality of the Holocaust, Hiroshima, a rape, or incest, is *uncertain*, seems a horror of its own. If anything is possible, then perhaps there is no true basis for ethical conduct. Postmodernism has been accused of being an attempt at flight from the ethical implications of the Holocaust and yet at the same time, postmodernism has been the most tenacious critique of totalizing impulses underlying dictatorial social structures. And thus in postmodernism we see such strange combinations of moral outrage and apology, activism and apathy, self-discipline and self-pleasuring.

Postmodernism as a Symptom of PTSD among Intellectuals

Let us consider the possibility that postmodern writing, as a response to and avoidance of the potentialities of meaning arising from the apocalyptic events of this century, more than a description or even prescription for disordering rationality, is itself a disordering of intellectual thought. In some respects, this disordering is consistent with posttraumatic stress disorder and its sister, complex PTSD.

The traumatic event, Criterion A, so to speak, was the inability of available philosophical, literary, or psychological conceptual systems to explain the Holocaust or nuclear annihilation. Any conceptualization appeared to humiliate itself by attempting to grasp the meaning of these events. Thus overwhelmed, representation failed.

Absence

Variously described, an absence lies at the heart of the trauma victim's experience. Terror re-situates body, mind, and identity into a kind of disappearance, the victim clinging

to passing debris as their conceptual grasp of the situation fails. Because the horror is of the whole disappearing, the framework evaporating, there is no position outside of the event available from which to base a reasonable observation. As Lawrence Langer (1993) laments about the Holocaust, everyone was "in" the event, there were no witnesses, for to stake a claim as a witness, one must eschew the roles of collaborator, bystander, or perpetrator.

Though there is disagreement among postmodern writers as to what is absent, there is undeniably a consensus that something is absent. This absence, or negation, is what distinguishes postmodernism from modernism. Modernism is a critique of the surface as superficial, inauthentic, and compliant, while positing the solidity of the core, with its fundamentals, whether they be atoms, id and ego, or logical functions, that remain hidden and must be discovered through analyses of experts. Postmodernism questions the existence of the center, the grand narrative, foundational truths, or objective reality. "Grounded theory" is seen as a camouflage for some system of power, its basic assumptions limiting rather than supporting possibility, like the trauma victim's perpetrator. Authorities are suspect, the feared enactment always around the corner.

Thus central axioms, as givens, from which other aspects of a system are derived, must remain outside of play; that is, transformations occur among the relationships of non-transforming (i.e., constant) fundamentals, whether they be the speed of light or superego. In this way, the center is really the outside, which as a contradiction proves the untenability or instability of any grounded theory (Derrida, 1978). Thus there is only unstable ground.

Shattering

For the victims of trauma, foundational assumptions about Self and World lie shattered in pieces. Trauma is the experience of chaos, a disordering of a coherency previously known. Victims see through the illusions of safety, fairness, and meaning that motivate and protect us (Janoff-Bulman, 1992). They discover, to their horror, that these structures are not givens, but instead have been made up.

Postmodernism also perceives that reality is a construction, not only in the sense of being arbitrary, or chosen instead of given, but also in the sense of consisting of a multiplicity of elements that can never be completely coherent. Therefore, contradictions, tensions, differences must exist within any construction. Postmodernists refer to such multiplicities as pastiche, or bricolage. Perceived coherencies must be deconstructed to reveal their internal inconsistencies, giving rise to the postmodern ethic that only an admission of bias can establish one's honesty. On this basis, postmodernism accuses the reassuring narratives of the American Dream, Reason, Western Civilization, Globalization, and even the Self as dishonest manipulations of power. Similarly, the trauma victim distrusts such totalizing notions as Recovery, Integration, or Healing, and instead may cling

to their shattering, for to bring the pieces back into a whole is to reconstruct the memory of the event, imbued with its tensions and contradictions.

Incomprehensibility

The inability to feel understood permeates the experience of the trauma victim. The bridge has somehow fallen into the river and there is no way across. For of course there would be no trauma if the rescue team had arrived on time, if the members of the Local Group had intercepted the perpetrator. Trauma occurs when the cavalry arrives a day late, when the fire trucks take the wrong turn, when the neighbors remain quiet as others are taken away. The result is that the sense of "being with" evaporates, and being understood, impossible.

The postmodern perspective proposes a radical critique of understanding and comprehension. In fact it reassembles comprehension as an interpretive act performed on linguistically-formed texts. There is no method that can reveal the exact relationship between a text and the signified….for example, between the client's report of their trauma and what actually happened. Two listeners hearing the same story may very well interpret what happened in different ways. Even when one reads what oneself has written, startling new things are often discovered. The autonomy of the text is underscored here. The question, "what did the author really mean?" is therefore unanswerable, even by the author. In this sense, then, reading (as understood as an activity of comprehension of the author's intentions) is impossible; only a reading, or *this* reading, is possible. So postmodernism, like a trauma victim, insists that understanding is but a cruel illusion.

The Inability to Recall

Another symptom of PTSD is the inability to recall aspects of the trauma, or amnesia, caused both by a loss of cognitive representational capacity due to terror, and later, by difficulties integrating elements of the horror into a coherent self-narrative. In either case, important aspects of the past are left out.

The accusation that the postmodern is a symptom of the inability to represent or witness the Holocaust finds support in the disturbing, ironic fact that two of the most central intellectuals of the postmodern movement were a Nazi sympathizer (Paul DeMan) and a Nazi collaborator (Martin Heidegger). That DeMan, the author of *Blindness and Insight* (1983), who argued that texts were incomprehensible, that reading was intrinsically an incomplete act, was living with hidden texts that he hoped no one would ever read, and that he had no hope of explaining, seems sadly coherent. What is inexplicable is that deconstruction, a philosophy of freedom if there ever was one, was represented by a Nazi sympathizer. He kept this "reality" secret, without ever discussing it, ever acknowledging it as an error, presumably fearing that sometime it might be discovered, and if discovered

without his aid, that it might undermine or eradicate his credibility forever (as it has done). In the wake of the discovery of these anti-Semitic texts, months after his death, some apologists proposed that deconstruction was DeMan's way of admitting his acts, a kind of postmodern confession (Felman & Laub, 1992). Somehow, a simple repudiation was not considered.

Martin Heidegger, whose form of existential philosophy is most relied upon by postmodern thinkers, was a Nazi collaborator. Many texts survive in which he hails the Fuhrer's project to cleanse Germany and to bring German dominion over the world. Though he lived until 1976, Heidegger never repudiated any of these writings. He acted as if they did not exist. Apologists for Heidegger point out that criticism is *ad hominum*, and his philosophical texts should be read independently from any personal failings. After all, why should Michel Foucault's involvement with the sadomasochistic bar scene in San Francisco affect one's reading of his *History of Sexuality* (1990)? Why does such intimacy exist between these postmodern critics of totalizing, restrictive authority and the narrow grip of anti-Semitism, German dominion, and SM, all reflections of the Perpetrator? There can only be one answer: These gaps in memory, these silences covering adamant public announcements, reflect the inability of their hosts to integrate a troubling, traumatic past into current conceptions of themselves, indistinguishable from victims of PTSD.

Foreshortened Future and Meaninglessness

A pervading sense of meaninglessness and foreshortened future are also symptoms of PTSD. The inability to represent the traumatic moment prevents integration into developmental projections of the self through time. Time itself is made finite by the immutability of the perpetrator's act. Without transformation or development, the end seems nearer.

Numerous postmodern writers have equated their perspective with the end of their own discipline. To the extent that each field was modeled on a modernist perspective of progressive analysis of fundamentals (historical patterns and themes, aesthetic forms, metaphysics) that could be logically or at least rationally argued and established, the future of an academic discipline seemed bright. In the postmodern age, development (with its accompanying imagery of root, trunk, branch, and flower) was seen as no longer possible. Art became caprice a la Warhol, a commentary on the surfaces, rather than a revelation of the psychological depths (Sontag, 2001). Philosophy was to be abandoned for language games; history deconstructed as a form of social dominance or hypnosis. That is, the fundamental message of postmodernist scholars is that the constructions of their own intellectual field are made-up, performances, aesthetic gestures….and therefore meaningless and soon to be replaced with the next stylistic variation.

To summarize, it appears plausible that postmodern perspectives reflect an adaptation to an overwhelming failure of comprehension of established frameworks not

dissimilar to that of victims suffering from posttraumatic stress disorder. If so, one could conceptualize postmodern discourse as a type of traumatic schema within academia, being a set of cognitions relatively immune to the attempts of others to rectify their distortions (Held, 1995). In any case, it is clear that striking parallels exist between the postmodern perspective and the experience of trauma victims, and thus it is also possible that postmodern ideas may offer insights into the dynamics of posttraumatic stress disorder, a topic to which I now turn.

PTSD from a Postmodern Perspective

Turning the argument over, I will now examine PTSD from a postmodern perspective, as if postmodernism was a mode of thinking or analysis unaffected by trauma itself, which is unlikely. I will argue that a number of dilemmas in our field may be seen as the outcome of holding onto modernist paradigms of trauma. These include the rise of the false memory syndrome debate, compassion fatigue, and the frequency of transference and countertransference crises in trauma psychotherapy.

The Debate over Memory

Postmodernism places brackets around truth; that is, there is no truth, only truth-claims. This is based on the illusion of center, ground, or foundation; we are holding up our own Archimedean fulcrum, suspended in an endlessness of possibility. Essentially, knowledge and truth are viewed as commodities or linguistic possessions of a particular culture/group, which defines reality through language, and then constructs methods of education and privileging of authorities who manage and control the access to and alterations in this knowledge base (Foucault, 1980). These ways of perceiving reality are entirely local to this referent group, and may be discrepant from those of other localities. That is, knowledge and truth are localized entities, not generalized realities.

Trauma remains forever subjective; it lies beyond the endless recounting of factual details, the sum of which cannot be the horror. Therefore any linguistically situated truth claim can be examined to reveal its constructed nature, which includes contradictory, pasted together, elements. Poetry perhaps, which deconstructs linguistic structure to reveal the silences and absences in representation, can approach it.

Though this description of reality challenges the average person's experience, it is remarkably apt in relation to accounts of clients with PTSD; for they seem perpetually caught in a tangle of truth and lie, belief and questioned credibility. Each description of their traumatic experience varies from one recounting to another: each time they dip into the formlessness, a new way of ordering emerges.

If postmodernism makes indistinct the boundaries between the factual and the fictional, truth and non-truth, then how can one communicate about the traumatic event? One commentator has boldly declared that a true trauma story is one that cannot be believed, only when its credibility is questioned might it be true (O'Brien, 1990). The true trauma story is not a well-told one. For trauma is unbelievable. And therefore doubt is an intimate partner of the victim's remembrances and testimony. Postmodernism views this doubt as a necessary condition of traumatization and its treatment. Intolerance of this ambiguity has given rise to one of the major paradoxes and debates in the PTSD field: the credibility of memory.

One side of this debate claims that statements by victims cannot be taken for the truth, due to the questionable nature of memory, self-interest of the victims, and biased practices of over-zealous practitioners. They imply that a memory that is remembered years after the event, in adulthood, by definition is unlikely to be true; that is, if remembered, then it is false; if it is not remembered, then it did not happen. In addition, they accuse therapists of "implanting" these memories in their clients, transferring the imagery of penetration from the incestual parent to the therapist.

The other side supports the truth claims of the victims, protesting that if a person makes such a claim, due to the courage it takes to come forward, it should be believed. To do otherwise is to discourage the victims from reporting the abuse. But indeed memories are not reliable, or at least not entirely reliable, and people do lie. Claims of truthfulness by therapists therefore are hard to support, and thus the credibility of therapists as well as victims have been questioned (Dershowitz, 1994; Hagen, 1997).

From a postmodern perspective there is no way out of this controversy; truth is relative and local, it cannot be either false or true, or pervasive. In fact, as the trauma inquiry proceeds into the minute details of the event, where cognitive processing failed, it is likely that issues of believability will arise. A perfectly remembered trauma with smooth contours in its telling is suspect. Thus, if there is not an issue regarding the credibility of the victim's memories, then it is likely that some manipulation is occurring.

This debate rages not only among professionals, but within each clinician. We too, wonder if our clients are telling the truth, exaggerating or misremembering (Dahlenberg, 2000). Tolerating our own disbelief of our clients is difficult and leads some PTSD therapists towards cynicism and even a desire to seek out "fakes." This is a natural impulse of a therapist, for the very foundation of the enterprise is disturbed by such deceit. In contrast, some therapists may become steadfast advocates of victims; they will testify in any case and declare the presence of PTSD from any cause, just to fight off the enemies of justice. When the very foundation of the enterprise, based on the modernist principles of consensual truth, is disturbed by uncertainty, the debate over the credibility of memory will necessarily arise. The modernist perspective asserts that differentiating truth from fiction is critical. Postmodernism posits that this uncertain boundary between truth and falsehood is endemic to the situation; therefore, it predicts that the therapist's disbelief in the client

should be an expected element in the therapeutic environment. But how is the therapist to handle his or her disbelief in the client? Too often the therapist supports the client's report in the session while holding doubt privately, leading to subtle distancing when asked to write a letter, or give testimony. The certainty with which the therapist says, "I do believe," shifts dramatically between one's office and the courtroom. This discrepancy can create tremendous strain on therapists.

For example, many therapists of trauma patients become involved in writing letters of support for their patients insurance, disability, or legal claims. In these letters, the client indicates to the therapist their need for a strong, unambiguous documentation of their traumatic experience. The therapist often worries that the client has exaggerated their description in the service of their claim, however, if the therapist is to support the claim effectively, they know they cannot indicate they are not sure about what the client has told them. The result is that the therapist dissembles, writes a strong letter, contains their disbelief, but then questions their own ethics or the credibility of the client, or rationalizes the situation in terms of advocacy in general. Following such action, it is not uncommon for the therapist to distance themselves from the client, with negative consequences for the treatment relationship.

Compassion Fatigue

The postmodern view proclaims that empathy – the notion that one can understand another's experience – is an illusion covering unexamined power dynamics. Certainly, trauma is not a shared experience. The monumental aloneness and particularity of traumatic experience so isolates the victim from everyone within their Local Group, that presented with a caring inquiry from someone to describe it, the victim is often overwhelmed with despair. Primo Levi confided that despite his many books, he could never provide enough detail to describe his Holocaust experience, "for my Holocaust lies hovering between the words, drips from the punctuation marks, staining everything, while remaining invisible to all others." (Thomson, 2004). The trauma therapist, whose presence symbolizes the need to know and the ability to understand, is brushed away by the victim's oft-repeated words, "You were not there, how can you understand."

Thus listening is a challenge. This horror that I feel in listening to my client's account, these pictures in my mind that have crept in and disturb me, where do they come from? How is it I can imagine the unimaginable? And what relation does my imagining have with the experience of my client? Can there be any other answer than no relation? Or rather no particular relation. Or rather no determinable relation.

Modernist notions of empathic connection between therapist and client lead therapists to attempt to bridge this gap, to join with their clients. The experience of being misunderstood will be problematized in such discourse, and resolution will inevitably engage underlying power dynamics in the relationship. Seeking understanding when not

allowed to say, "I understand," seeking truth when one cannot say, "I don't believe you," creates tremendous strain in the therapist. The desire to provide solace for the client will inevitably be frustrated; the therapist's desire to empathically link with the client, thwarted. The result is the dilemma known as *compassion fatigue* (Figley, 1995).

Much of therapists' training involves the attempt to become empathic presences, mirrors, or holding environments for clients. However, no matter how much a temporary feeling of connection is established, eventually the reality must be confronted that despite our best efforts to be with them, we had not been with them during the crucial event. In the end, they are left with their trauma and their perpetrator, and what we had implicitly promised is withdrawn or becomes mist. Their eyes cast down, our extended hand now hesitant, we are stilled by the awkward silence.

Postmodernist conceptualizations of trauma therapy predict such compassion fatigue, similar to the useless project of locating the actual floor or ceiling in an Escher drawing. A postmodern revision of psychotherapy will reframe the therapist's aim from that of mutuality and delivery of compassion, to one that embraces the communication of disbelief and the representation of misunderstanding. It remains to be seen whether such a postmodernist psychotherapy of trauma can be fashioned.

Crises in the Therapeutic Relationship

Postmodernism questions the assumed link between author and text; the provision of autonomy to the text de-privileges the author's position, as the text becomes subject to multiple readings. In disturbing the concept of the tree, with its roots, trunk, branches, and leaves, the postmodern claims that texts lay outside of the ground of authorship: they simply exist (Deleuze & Guattari, 1987).

Certainly it is known that traumatic texts, or narratives, are fragmented, incomplete, jumbled in time: combinations of elements as if thrown together. These disturbances are most surely caused by the fear experienced during the moments of the traumatic event.

The traumatic process thus disrupts the continuities and flow of the text, removing pieces seemingly at random, repeating phrases over again, inserting sections out of order, or leaving large gaps that cannot be bridged. The result is a text that seems to have been corrupted, and thus may not be credible. Trauma narrative seems to be a text that has not been edited; for the purpose of the editor is to check for and eliminate these disruptions in continuity, to untangle the jumble and fill in the gaps, so that comprehensibility is maintained. The trauma narrative is more like a painting with graffiti on it; the work has been spoiled, ruined, intruded upon, by *someone other than the author*. It is an un-permitted writing-over of the victim's experience. Is it possible that the cuts and gaps within the trauma narrative are best understood as acts of the perpetrator, rather than the fears of the victim? The victim's testimony has been defaced by the author of the original violent act, who like a censor blacks out what he or she wishes. If so, then a radical de-

centering of authorship has occurred in the trauma narrative, for the victim can no longer be considered its sole author. This has resonance with the nature of the trauma itself, which is the result of the agency of the perpetrator, not the victim. The victim may be better understood as a reporter attempting to communicate the horrendous act of another. The victim falls into silence and incomprehension, as if they were not there, because they were not the author of the event.

This de-centering of authorship arises due to the trace or shadow of the perpetrator within the trauma narrative, and this presents the therapist with a challenge, as the client's voice is stolen in mid-sentence or their syntax is disrupted.

For many victims the perpetrator is the only other person who could testify to the truth of the event, the only authorized witness who could attest to the immoral act. Perpetrators usually do not comply. Thus trauma victims must search for a Third to serve as their Witness, and in the context of psychotherapy that Third becomes the therapist, who is called upon to Witness an event they did not see, to testify in support of a victim they can never fully believe.

Thus a postmodern approach will consider that the therapist is in the room not only with the victim but also with the perpetrator. Neither the victim nor the therapist desire such proximity to the cause of horror and may conjointly agree to avoid it. How often in trauma-focused psychotherapy does that perpetrator figure arise, not as an apparition, but in the client's perception of the therapist, who just at that moment feels victimized by the client's denigrating transference (Pearlman & Saakvitne, 1995)? The shadowed figure, the cause of the original trauma, is transubstantiated in the bodies of the therapist and client, simultaneously, as the good-willed souls scramble to preserve their relationship. As the therapist's objectivity is swallowed by that of the perpetrator, often consultation with a new third is required.

Thus the inherent pastiche of the trauma narrative results from its multiple authorship, gives rise to the not-uncommon relational crises that develop within therapist-client pairs, leading as they do to the therapist's withdrawal and the client's complaints or litigation. Clearly, being aware of the presence of the perpetrator within the discontinuities of the trauma narrative is sage advice for the therapist.

Conclusion

The legacy of modernist paradigms of psychotherapy includes the belief in fundamental truths, empathic connection, and the objective witness. Postmodernism predicts that therapists and clients who attempt to achieve such illusory ground will tire and then falter. The therapist's well-intentioned effort to correct the failed rescue, to become the credible witness to the horror, to repair the cracked framework, will in the end unfortunately only re-enact the tragic loss.

The postmodern vision is a compelling, startling, and radical alteration in basic assumptions of psychotherapy; radical enough perhaps to declare the project of psychotherapy an impossible one. But perhaps the postmodern critique of rationality, truth, and empathy can instead inform the project of trauma psychotherapy, leading to a revision in its basic tenets, but not to its undoing. The key to this possibility lies in postmodernism itself being an expression of traumatic events, and thus not being an independent frame of reference by which posttraumatic stress disorder can be judged. If so, then these two conceptual perspectives are not at odds with each other, but instead are like two strands coiled around each other, forming a stronger cord.

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The Basis for the Miss Kendra Program

David Read Johnson

After about 10 years in which we worked with many children referred by Child Protection, only to discover that they had been exposed to toxic stress years earlier, did we confront the fact that we were working too far downstream and needed to pivot our work toward prevention and early detection. This brought us into the schools, where we needed to figure out a way to talk with children about stressful experiences during the school day, between English and math, without upsetting everyone. With collaborating educators in both elementary and high schools, we developed what is now known as the Miss Kendra Program.

The essence of the program is to establish a regular, safe time and place where we can listen to the children's worries and lived experiences. That's about it. Listening to children for a half hour per week. Now I am not able to secure funding for the program if I say that, so I bring in neuroscience of stress, social buffering, statistics on traumatic events, ACEs, and all sorts of fancy stuff, but the program is really just about listening to students.

The program emphasizes what might be called the "soft skills" of teaching, rather than the "hard skills" which include instructing, managing, organizing, structuring, guiding students. The soft skills include empathizing, listening, showing compassion, and bearing witness to their thoughts and feelings. Trauma and toxic stress, including work stress, tends to toughen people; stress hardens us, rigidifies us, for one must be hard to protect oneself from further harm. To be soft is to be weak, vulnerable, and open to further assault. Teachers sometimes too over the years harden, and tend to emphasize their hard teaching skills. The Miss Kendra Program is a kind of re-balancing, in which some time is set aside for the soft skills of teaching. We have found that the program helps teachers reconnect with the initial motivations they had to go into teaching, and thus has helped teacher job satisfaction, burnout, and retention. More importantly, the program has helped deepen teacher-student relationships.

Methods

Addressing Toxic Stress Proactively

As you know, toxic stress affects each one of us by engaging our bodies and brains, and distracting us from the present task, such as listening to the teacher and focusing on homework. The thing is, though some students are obviously distracted, and are wiggling around in their seat, or looking off into space or furtively from place to place, many students who are experiencing toxic stress are able to "hold on" and behave normally, looking as if

they are listening to you. We ask students and employees to temporarily put to the side their worries and concerns to focus on the work at hand. Thus right now, I am asking that each of you put aside what you are thinking about – what you have to do as soon as this inservice is over, your son's whereabouts, your mother's health status – and listen to me! And like many of your students, you all appear to be listening to me, even though some of you are not. For those students, you don't really know until they take the test, when it becomes clear that they were not listening or did not take in the information.

Bearing Witness to Students' Lived Experiences

We address toxic stress proactively by bearing witness to students' lived experiences. This goes beyond listening, note the term "bearing" which implies holding something, to bear a burden, and indeed, being present and receptive to students' experiences is a burden of sorts, and the program does ask you to carry that burden.

We did not fully appreciate the impact of having a caring adult bear witness to students' worries at first, but we have found that this apparently small thing has tremendous benefits, without fixing the problems, solving racism or poverty, or stopping parents from fighting. I discovered this in my own life. During my teenage years, I experienced two traumas. The first was my parents' alcoholism. My father was a respected doctor at the VA Hospital here in Minneapolis, and my mother was an intelligent and caring mother, president of the PTA and all. At 5 pm things were fine: my father arrived home from work and my mother prepared dinner. By 7 pm they were inebriated and by 9 pm verbally abusive, and sometimes physically violent. By 18, I could not wait to get out and went off to college never to return, sending the annual Christmas card.

My second trauma was that when I was 19, I was nearly murdered. The scar where the hammer hit my head can still be felt. I was a taxi cab drive, and was attacked from behind, probably with the intention of killing me. I was lucky to have turned just so I was hit on the hardest part of my head.

The interesting thing is that I was able to return to work as a cab driver only 10 days after I was nearly murdered, while I never returned home. Even though I just turned 70 years old, I am still more upset by my parent's alcoholism than the attempted murder. I have learned, and I am certain, that that is because I never spoke to anyone about the alcoholism and verbal and physical abuse, where with the attack I had multiple opportunities to report to doctors, police, friends, and family, telling the story over and over, and receiving a lot of support. I milked it for as long as I could! By contrast, I couldn't tell anyone at school – my dad was a respected doctor – and of course I couldn't talk to anyone at home. My two younger brothers and I did not even speak about it, until I was in my late 30s and my Dad was hauled into alcohol treatment for drinking too many martinis at lunch while working at his medical clinic. Only in the family therapy during

that treatment was I able to talk about my experiences, and hear my brothers' experiences, and reconnect with them.

So providing your students with a structured, regular time to express their worries, and for you to bear witness to them, can have tremendous impact.

Now if we just asked students "how are you doing? How are you feeling?" that will not be enough, because most people when asked those questions say "fine," or "okay" or "a little tired." If I asked any of you right now, how are you feeling, you might say one of these things. But if I asked you, "are you worried about any member of your family?" or "is anyone you care about having a rough time, sick, sad, frightened?" you are likely to say "oh my god, yes!" It is impressive how much we can hold inside without knowing it!

Because of this tendency, we need to signal the students that we are aware of, and ready to hear, about the *difficult* things. This is the purpose of Miss Kendra's List, which is put up behind me. These items are prompts that help students identify important stressors that might be affecting them, and beyond that, signal that we are available to discuss these issues. The repeating of this list, aloud in class, helps to secure confidence in the students that difficult things can be discussed.

Now look at this list. [Read it.] Very few people disagree with this list. It is the law. It is in the Constitution. We hear it in church. It is the basis of child protection and equal opportunity laws. The list reflects the basis of our moral universe.

Miss Kendra's List

No child should be harmed because of their race, religion, or gender.
No child should be punched or kicked.
No child should be left alone for a long time.
No child should be hungry for a long time.
No child should be bullied or told they are no good.
No child should be touched in their private parts.
No child should have to see other people hurt each other.
No child should be scared by gun violence at home or in school.

BECAUSE

It makes a child feel bad about themselves.
It makes a child not care about school.
It makes a child feel sad or scared or lonely.
It makes a child feel angry and want to fight too much.
It makes a child feel like not trying hard or giving up.
It makes a child worry a lot about their family.

But strangely, when I say "now we are going to have your students openly discuss the items on this list," many people clutch with uncertainty, anxiety, even fear. "What if someone gets upset, what is they make things up, what if the parents complain, what if we have to report to child protection, what am I to do if they report a problem?" Isn't it odd that though there is agreement that the list reflects the basis of our moral behavior, we don't want our children to discuss it?

The program has been accused of opening a *can of worms,* and for years we apologized for, denied, or minimized this. But we have realized that indeed, the program does open a can of worms. Do you know why? *Who is the can?* Your student, and those worms are wiggling around in him, making his body restless and his mind distracted. You are right that we are opening that can of worms, because that will help our student immensely, even if it means that we have to deal with a few more worms. Allowing students to express their worries will be to some degree a burden for us.

But what is the alternative? To close up that can again. Silence our students. Instruct them on what is right, but not let them tell us what is wrong?

Those of us involved with the Miss Kendra Program stand by this List. We ask that you do too. Your school district and your principal have decided to stand by it, but in the end, as teachers, you must as well, and if you do, you can be secure in the knowledge that you are doing your best to create safety for your students.

But to stand by the list is to allow your students to discuss it. You have a choice, and now is a time to make it. We do not see an alternative and so we are seeking partners in education who make this choice. What will it be? [Sustained look at audience.]

We have been told that the List is a cover for Critical Race Theory. We have been told that students should not ever discuss sex in school. We have been told that the list is secretly promoting trans rights. We have been told that the program clearly has an anti-gun agenda. We have been told to take down the list.

Through an Imaginal Buffer

The program bears witness to the students' lived experiences through an *imaginal buffer*, which is the *Legend of Miss Kendra.* We found that especially for children, having a "legend" brings with it a feeling of safety that allows difficult things to be discussed. Indeed, story and imagination have since the beginning of civilization been the way children's fears have been processed. Just about every fairy tale is about a threat or danger to children: Rumpelstiltzkin wants to take the infant; Hansel and Gretel are cooked in an oven and made into cookies; Little Red Riding Hood is *eaten* by the Big Bad Wolf; the evil queen is after Snow White, Bambi's mother dies. We read these stories to children at night in bed to comfort them, to help them go to sleep! What makes this process work is that as the child is exposed to the possibilities of danger, they are nestled in the arms or held on the lap of their parent. It is that combination of threat and protection that buffers the child's

experience of stress, that builds their capacity for resilience against the troubled times they will surely face in their life.

Imagine if I walked into one of your classrooms and said, "Hey kids, I want you to know that an old lady is in the woods out back and wants to kidnap you and put you in an oven to make cookies out of you!" I would be arrested. However, if instead I said, "Once upon a time, a long time ago, there was a little old lady in a wood, who lived in a hut, and one day a little boy named Hansel and a little girl named Gretel were walking through the forest….." Since I have told this story in schools, I can tell you what happens: "Oh, Dr. Johnson, thank you so much for coming today and taking your time to tell us that wonderful story!" But it is the same content!

The Legend of Miss Kendra tells of a single mom who loved her only child so much, but sadly lost him or her when they were about 10. After a period of grieving, she shows her strength and resilience by volunteering at a school to greet children and ask them if they are okay. Miss Kendra represents the nurturing, caring parent that lies inside each one of *you*, and each one of your students' parents. Indeed, it is the *inner nurturing parent* that lies inside every child, who like all mammals comes out of the womb seeking that caretaker and hopefully finds one in their parents. We are not reptiles, who are on their own from birth, though, sadly, some children experience something similar to that in their lives.

So some people have asked us why Miss Kendra has to be fictional. Are we lying to the students? We actually do not tell them that she is real; we say it is a legend; we say we don't know where she lives; *we leave it up to them.* If they ask where she lives, we say, "Hmm, great question, what do you think?" "New Jersey" "Wow, that is a great answer!" If they ask whether she is real, we say, "Great question, what do you think?" and to whatever they say, we respond, "Wow. That seems pretty good to me."

This is no different than when a child asks us how babies are made and we euphemize; when we take our child to the character breakfast at Disney, we don't tell them that these are not the real characters, but failed actors who are inside the costumes; when we take our child to a puppet show, we don't tell them there are people behind the screen holding up their hands inside those socks; we don't say they are real either; we leave it up to them. When we read a story to our children before bed, do we first tell them that what they are about to hear is false? As psychologists have noted, childhood are the *magic years*, where reality and illusion are mixed; where the child explores and learns about things before being faced with the harsh realities of life. They will have plenty of time for that. Indeed, the most well-researched and scientifically proven fact in my field of psychology, proven over 50 years ago, is the importance of imagination and play in the social, emotional, and cognitive development of children.

And yet as adults we too allow certain things to remain ambiguous! When you see that statement at the beginning of the movie: *"Based on true events"* do you know what that really means? It means that some things in the movie are *made up,* for their

entertainment value, that some things you are about to see are false. Do they tell you which ones? No. They leave it up to us. Do you investigate which ones were true? Probably not. Why? You are watching to be entertained.

And what about Colonel Sanders? Is he a real person or an advertising ploy? [Ask a few people] You see, we don't know. Does this bother you? Have you gone into one of his stores and asked someone who works there? Would they even know? No, so what matters to you as you are walking in to the restaurant? Yes, the *chicken*! I believe it is finger-licking good!

And the same is true for your students: they care much more about what Miss Kendra brings them – care and a listening ear – than whether she is real or not. The story we tell them, the letters they receive, are there to comfort them.

When we first began the program, we worked in a K – 8th grade elementary school, and we met with the middle schoolers to tell them about the program. We told them that Miss Kendra is a fictional person, but asked if they would keep that to themselves when their younger brothers and sisters came home talking about her. They agreed. We thought they should hear the legend so our staff told it to them. Afterwards, silence. Our counselor looked out at them, and then asked, "What?" A particularly tough boy in the back row raised his hand and said, "That's a *real* story. I know people like Miss Kendra" as other students nodded. The counselor, realizing what was happening, asked "Would any of you like to write to Miss Kendra?" and every one of those middle schoolers did, even though they had just been told explicitly that she was not real. *That*, is the chicken. This year alone, there will be 250,000 letters written to Miss Kendra, and "she" will write back to each one.

Impacts

So that is the Miss Kendra Program: being proactive, bearing witness, within an imaginative frame. We did not anticipate that such a simple process would have the impacts that it does.

Improving the Teacher – Student Relationship

As teachers you get to know your students well, you find out about their families, and hear a lot about their challenges. The Miss Kendra Program only deepens this knowledge, as the students share their worries about the items on the List. Having time to listen, to show compassion, builds the bond between student and teacher, giving the student more room to attend to the lessons, and opening the teacher to a softer, more flexible stance.

If we think about education as what happens between a teacher and a student, and understanding that each day consists of hundreds of moments of contact between them, improving that moment can have profound impact. Children need to be seen, need to be

heard, and need to be held. If a moment of contact between a teacher and a student can meet these needs – even in a small way – the foundation for education will be strengthened.

The program has helped to reduce burnout, improve teacher retention, and re-connect teachers to their original motivation to enter the field.

But the program also gives students an opportunity to practice compassion, to hear the stories from their friends, and then be given a chance to show support, verbally, or by going over and offering a hug, or by standing next to them when they tell their story. The program is therefore not only for students who have had a lot of toxic stress, but for those who have not, but who can learn the skills of empathy that will benefit them throughout their lives.

Empowering Student Voice

The program gives time for each student to practice standing up and speaking about their lived experiences, particularly ones that have made them feel uncomfortable. We need citizens who are comfortable speaking up. We all have heard about the female gymnasts who were abused by their team doctor, and none of them had spoken out. Or the hundreds of young boys who were abused by priests or scout leaders, and none reported. Or many rape victims or bystanders to crimes.

Our society tends to ask children to be quiet, to be seen but not heard. We make it clear we do not want to hear from them about upsetting issues. The Miss Kendra Program works to balance this message. We don't want you to throw rocks or become a revolutionary, but we do want you to be able to report to someone when you or your body feels uncomfortable; *to say something if you see something.*

In 2019, during a Miss Kendra lesson on "No child should be touched in their private parts," a first grader in White Bear Lake, Minnesota reported that a man who was running an after school program "at the back of his store" was touching her and her friends. This was reported to the police who decided there was not enough information to proceed. She was only a first grader.

One month later, *in a different school* in the same school district, during the lesson on private parts, a kindergartener reported the same thing: a man running an after school program was touching her. This report was enough to activate the police, who quickly discovered the after school program, arresting the man, who had abused several other children. These events were covered in the local papers.

Note this: The program empowered a five year old and a six year old child to stand up and speak up about what they understood was wrong, leading to the apprehension of a serial predator, when those gymnasts and alter boys and rape victims could not. This is what we mean by *empowering student voice*.

Reducing Disruptive Behaviors

The program also aims to reduce disruptive behaviors. When fully implemented, the program has led to extremely significant reductions, on the order of 80% within two to three years. We calm down students, classrooms, and entire schools, supporting a healthy, humane, and happy atmosphere.

How does the program do this? We used to say that toxic stress built up and poured out of the student in the form of disruptive behaviors. But it is more than that. Most disruptive behaviors are an attempt to *communicate* to others the students' lived experience, which if there is no arena to do so directly, an indirect means is found. Let me illustrate: my older brother hits me, and I come to school and have no one to share it with, so I find another smaller boy and hit him. I am hauled into the principal's office where, like 90% of kids in that situation do, I say I understand that I should not do that, I promise not to do it again, and I apologize. Then the next day I hit another smaller boy. Why? *Because that night my older brother hit me again.* I am trying to communicate to you that my older brother is hitting me, but there is no place to do so directly. If I could talk about it in a Miss Kendra class or in a letter to her, I would not need to hit that smaller boy.

A 5th grade girl is told to move to another seat by the teacher, to break up an argument between her and another student. She erupts, throwing her books all over the floor, crying out, and rushing out of the room. We find out later that her family had been forcibly moved from their apartments three times in the last four months, by landlords showing up and telling them, "Move, now" or her parents who had to make rapid decisions due to circumstances. This young girl told herself that she would not be moved, not be pushed around, one more time. And then that teacher gave her that one more time, even though it was only a seat. Without a program like Miss Kendra, she would be disciplined and her relationship with the teacher harmed. Sharing her story in the program, she would receive compassionate witnessing, support from peers, and her relationship with the teacher would have deepened.

In order for our students to communicate with us, they need to be given a safe and regular space and time to do so. They need to know that we are willing and available to listen to the hard things.

The Case for Imaginal Social Buffering

David Read Johnson and Hadar Lubin

The world would be better served if our children did not experience traumatic or stressful events in their early years. Certainly, efforts to reduce the incidence of these events should proceed. However, an additional tactic is to increase their resilience to trauma, through what are known as *social buffers,* that is, supportive relationships.

Jack Shonkoff, MD, of the Center on the Developing Child at Harvard University, has been a leader in the study of toxic stress in children. His major finding has been that children who have been exposed to adverse childhood experiences (ACEs) can avoid the impact of toxic stress if they have at least one caring adult whom they trust, and who is trustworthy.

> "The single most common factor for children who develop resilience is at least one stable and committed relationship with a supportive parent, caregiver, or other adult. These relationships provide the personalized responsiveness, scaffolding, and protection that buffer children from developmental disruption. They also build key capacities—such as the ability to plan, monitor, and regulate behavior—that enable children to respond adaptively to adversity and thrive. This combination of supportive relationships, adaptive skill-building, and positive experiences is the foundation of resilience*." (National Scientific Council on the Developing Child, 2012).*

Having such a relationship can provide a sense of safety, reassurance, and confidence even in the midst of terrifying events: One merely has to remember being held close by a parent in the middle of a storm or nightmare.

Decades of research have also shown that social buffers have significant impact on adults during stressful times. Studies beginning with the Vietnam War through the Iraq and Afghanistan wars of recent times have consistently shown that the morale of the combat unit is the best predictor of the occurrence of PTSD after returning home (Oliver et al., 1999). Strong support, belonging, and camaraderie among a combat unit buffers each individual from being harmed by the traumatic events being experienced together. In Vietnam, the military chose to send soldiers in one at a time so each member of a unit was "on their own clock," whereas in World War II, units were sent over together, kept together, and sent home together, resulting in far less incidence of PTSD after the war than in Vietnam.

The single best predictor of survival among miners in a mine collapse is how quickly people on the surface communicate to the miners trapped below that they know

what has happened, know they are trapped, and are coming to get them. Miners who hear that message are able to withstand the psychological stress *ten times longer* than those who do not hear it. That is why the very first thing done in a mining accident is for a loudspeaker to be guided down into the mine that blasts that message as loudly as possible (Toro, 2011). *Hoping* that someone will come to rescue them is not enough; the miners have to *know* they are coming.

Thus in attempting to help highly stressed children manage their lives so they can attend to their academic work and not develop dysfunctional behaviors or symptoms, having adults who are consistently caring and available in their lives is critical. Here is where a problem emerges: who will these adults be? Efforts to train their parents and adult family members to be consistent and trustworthy is often challenging; often these are the people who have let the child down through neglect, sometimes abuse, and sometimes other pressures (working two jobs; having PTSD themselves). Mentoring programs make sense, but too often the mentor does not stay with a particular child for long due to job transfer, student's family moving, or inconsistent funding. Given the breadth of the issue in the United States, several million mentors will be required.

The Miss Kendra Program guides teachers and counselors to provide care and attention to stressed children, in structured and limited times. However, the key ingredient in this program is framing the work within the imaginal context of the *Legend of Miss Kendra.* The fictional figure of Miss Kendra is evoked in the children and then substantiated through their writing letters to her, and receiving letters back from her, as well as receiving red wooden beads when they report a stressful experience. Because they receive a letter from her that is specifically addressed to them, children develop strong emotional relationships with her and what she means. Like the other caring adults in their lives (teachers, counselors, parents), Miss Kendra provides a social buffer by caring, listening to, and protecting children. Unlike these other caring adults, she is imaginary, which means she does not get sick, go on vacation, has other work to do or other children to care for. Her age, location, race, and personality are never given, so each child fills in these gaps with what they need her to be. In this way, Miss Kendra is an *imaginal social buffer.*

Imaginal social buffers are few and far between, but of great importance to most children. They include characters from stories and movies, imaginary friends, guardian angels, and stuffed animals. All of these figures provide solace and comfort at difficult times. An incredible example of the power of an imaginal social buffer is depicted in the film *Life is Beautiful* (Benigni, 1997), where the father creatively re-frames the events in a concentration camp for his son. Another influential imaginal social buffer was Fred Rogers (Mister Rogers), a character seen by millions of children on television over 30 years. Unlike other children's shows, Mister Rogers looked directly at the camera (the viewing audience) and spoke slowly and directly to the children, repeating key elements of the social buffer: "I like you just the way you are." "Will you be my neighbor?" "It's okay to

make mistakes." "I'm glad we're together." He showed much patience and desire just to be with his audience members at their own pace. Jerome and Dorothy Singer, psychologists at Yale University, discovered in their research on the impact of the show that children were mesmerized, often speaking back to Mister Rogers during the show. Overall psychological health, imaginative capacity, and happiness increased for children who watched the show in comparison to similar groups who did not (Singer & Singer, 1976). Other scholars have examined the positive impact of the show and the letter-writing Rogers engaged in with his audience (Klaren, 2016), concluding that the imaginal component was essential. Indeed, Miss Kendra follows closely in Mister Rogers' footsteps.

In order to improve children's resilience in the face of adversity, children must have reliable access to a trusted and trustworthy adult. The innate mammalian instinct to reach out for warmth, succor and protection from the parent is essential to our psychological immune system. We carry within us an *internal nurturing parent* whom we seek out in the environment, and hopefully find in our parents and caretakers. In too many cases, children have not found that figure in their family or community, often due to the overwhelming stresses and struggles for survival these adults are experiencing. Miss Kendra is an imaginal figure who represents this possibility for each child - that no matter how bad things are, someone knows about it, and will be there for them. Too many of our children are like miners trapped deep in their troubles, feeling alone, and unable to be heard. Receiving a letter back from Miss Kendra is that welcome call that gives them not just hope, but faith, that someone is coming for them. Believing in Miss Kendra means believing that there can be other adults out there who care; that it is worth it to keep looking. Through its function as an imaginal social buffer, the students' psychological immune systems can be strengthened, leading to healthy development without the stressors themselves being eliminated.

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Effect of Anonymity on Self-Report of Traumatic Experiences among Students in a Public High School

David Read Johnson, Kimberly Jewers-Dailley, Nisha Sajnani, Ann Brilliante, Judith Puglisi, and Hadar Lubin

Early detection of traumatic and abusive experiences, and the psychological symptoms that result from them, is presumably the optimal course in addressing the impact of trauma on our children. Our current system is unfortunately weighted on the back end: intervention is initiated after students demonstrate significant symptoms or disturbed behaviors. Even then, it is still not commonplace to ask children whether they have had traumatic experiences, as much of current models of treatment are focused on symptom and behavioral management. Often suspicions of trauma lead to a referral to a trauma expert. By the time traumatic experiences are identified and dealt with, the conditions are often deeply seated and resistant to treatment. Intensive and expensive efforts by providers and state departments of children and families are required.

The optimal seat of early detection of trauma in children is in the school. Schools are perhaps the major social organization for our children. Access to children is greatest in the schools. Support services are available, including referral to outside providers when needed. Though the country has now adopted a mandatory reporting norm regarding child abuse, we have yet to move to a mandatory inquiring norm, in which every child is asked directly at least annually whether they have had any abusive experiences.

Currently there are many barriers to establishing such a norm. Foremost among these is the hesitance of school leaders to make such broad inquiries about such sensitive subjects. Concerns rise about parental objection, as it is known that a majority of perpetrators of child abuse are familial. Concerns rise regarding availability of counseling services should such events be revealed. The result is a collusive agreement not to ask students about these experiences, providing the systemic avoidance that results in more serious problems down the line.

There have been very few studies of high school students' traumatic experiences. Most studies have examined either populations of students who have been identified as needing mental health services, who have experienced a disaster such as 911 or hurricane, or interestingly, who live in a foreign country. All studies have used anonymous questionnaires. Rosser (2002) studied 149 high school students and found that school and community violence were significant predictors of posttraumatic stress symptoms, and suggests that factors such as poverty, ethnicity, and social decline are not the only explanations for symptomatic expression in high school populations.

A corollary of this line of thinking is that in order to effectively assess students' abusive experiences, obviously this must occur in non-anonymous condition, either in personal interviews or self-report measures. Concerns exist that if students are surveyed without anonymity, they are not likely to report abusive experiences. The aim of the inquiry would therefore be defeated. To our knowledge, the strength of this suppressive effect has not been measured in high school students.

Another strategy is having students report experiences which have happened to people that they know, and not themselves. The thought here is that this may be an indirect way to report their own experiences. Again, however, we are not aware of any studies evaluating the size of this effect.

This study was conceived in order to assess the effect of anonymity and reporting about self or others' traumatic experiences among students in a public high school. In addition, we were interested in assessing the levels of self-reported abusive experiences, symptoms, and other aversive events in such a setting.

Hypotheses

We expect that students will feel more comfortable reporting abusive experiences they have had in the anonymous condition. We are interested in discovering the strength of this effect. Presumably this effect should be less when responding about others experiences, so we predict that there will be a significant interaction effect.

We expect that students will report higher levels on all items in the Other condition, both because the potential pool of people is greater and because reporting about others may be a more comfortable way of reporting about one's own experiences.

Method

Sample: The entire student population of a public high school in New Haven, Connecticut, grades 9 through 12, was surveyed with the Traumatic Experiences Survey (N=309). This survey was used as a Needs Assessment for the counseling team at the school, and therefore was approved by the school principal. If students did report abusive experiences, our counselors were prepared to follow-up with a private inquiry to determine if counseling services or referral to the Department of Children and Families were required, all of which were part of their standard duties in the school.

Procedure: Questionnaires were administered one class at a time over a two week period at the beginning of the school year in September, 2011. Students were told that this questionnaire would be helpful to the counseling staff of the school in "determining the needs of students." The counselor who administered the survey said,

> "Hi everyone. My name is Miss Kim. Some of you may know me. For those of you who don't, I am here at the school mostly everyday talking with students about any issues or worries or stress that they may be experiencing and try to help them. Today I am going to give you a questionnaire about stressful experiences. I am giving this questionnaire to *every* student in the school. Your answers will help me be able to know what students in this school are going through and will help me be able to help them better. So, your answers will help other students. The questionnaire is going to ask you about stressful experiences that you or someone you know may have experienced. The first section is going to ask you do you know *another* student who has had the experiences, and the second section will be asking *you*, if you have had the experiences. Some of you may want to keep your answers private so please respect each others' privacy. If you have any questions, please let me know. You do not have to take this survey. It is completely optional."

Classrooms were randomly selected to receive either an Anonymous questionnaire, or a Non-Anonymous questionnaire (where they were asked to fill in their names at the top of the first page.) Otherwise the questionnaires were exactly the same. The counselor did not mention whether the form was anonymous or not. This resulted in 152 anonymous and 157 not anonymous completed questionnaires (total, 309 students).

Measure: The Trauma Questionnaire was designed from a compilation of other established measures, and covered four areas: 1) Abusive experiences (physical, emotional, sexual abuse, neglect, being forced to work, and family violence), 2) symptoms (depression, anxiety, fear, urges to drink or use drugs, interference with ability to focus in school), 3) other aversive events (pregnancy, arrest, weight gain, hospitalization, death of intimates, sex for money), and 4) whether they had been told not to speak about any of these experiences (See Appendix). The items were worded in a very detailed and direct manner: e.g., "have you been punched, kicked,….. Within each questionnaire, the students were asked to respond to these questions in two forms: "Do you know any other students who have had these experiences?", followed by "Have you had any of these experiences?" They were asked to respond for events in the past six months.

Analysis: Items were scored for presence/absence, resulting in overall percentages as well as the mean number of events or symptoms per student. In addition to the item means, MANCOVA was used to assess the effects of anonymity and Self/Other on the students' responses.

Results

The students filled out the questionnaires without incident. No student declined to participate. No student, teacher, or parent complained about the survey. Several students joked with their friends about the questions. Several expressed surprise to the administrator about how personal the questions were. One teacher, when reading the survey, noted the severity of some of the questions. Several students placed their names on the anonymous forms. Generally the classroom became quiet during the administration of the questionnaire, and students uniformly appeared to take it seriously. Students in the non anonymous condition who did report significant abuse were interviewed privately afterwards (N=7). No referrals were required for these students, (three had already been reported), though four were seen in individual counseling.

Effect of Anonymity. Table 1 lists the results of the survey. Surprisingly, students in the non anonymous condition responded at higher levels than students in the anonymous condition on 17 items and lower on 11 items. Overall responses in the anonymous condition were 9% higher, which was nearly significant [$F(1, 306)= 1.80$, $p< .06$]. When reporting about themselves, the most significant difference occurred for Being Troubled at School ($p<.02$), where students who revealed their names reported more often. When reporting about their friends, students in the non anonymous condition reported more on witnessing abusive events ($p<.01$), neglect ($p<.02$), arguments in the home ($p<.04$), and use of drugs ($p<.05$).

Effect of Reporting about Self versus Others. Consistent with our expectations, students responded at higher levels when asked about other people than themselves, on all but one item (Not Eating). This effect was highly significant [$F(1, 306)= 7.48$, $p<.0001$]. Overall students responded about others at levels of about 45% higher than about themselves.

There were no interaction effects: that is, the effect of anonymity was similar whether the students were responding about themselves or others. There was also no effect of grade level (9-12) or specific classroom on these results.

Abusive experiences. As noted in Table 1, students reported high levels of family violence, followed by emotional abuse and being made to work, then physical abuse and witnessing abuse, and lower levels of neglect and sexual abuse. In this one high school, for example, 93 students reported emotional abuse, 69 students reported being physically abused, 32 reported being neglected, 76 reported being made to work when others did not, 66 reported witnessing abuse on other family members, 16 reported being sexually abused, and 178 (58% of the student body) reported having trouble concentrating in school because of these events.

Symptoms. A large number of students reported that these experiences were interfering with their ability to focus on school work, followed by anger, and then depression. Symptoms of giving up and feeling they will not succeed were reported by about 20% of students. Fear, not eating, and use of substances were least reported. Again the raw numbers are important: 140 students felt angry, 103 felt depressed, 90 nervous, 86 like giving up, 56 felt they would not succeed.

Other Aversive Events. About a third of students (86) have experienced the death of a loved one by disease, and 15% (65) by violence, followed by gaining weight (37 students) and medical hospitalization (34). 59% (182 students) worry about their family or friends.

Factors related to being told Not To Speak. Interestingly, being told not to speak about bad experiences was most associated with Being Troubled at School ($r=.33$, $p<.01$) and Worrying about Others ($r=.36$, $p<.01$), suggesting that not speaking about what is bothering them contributes to the students' lack of concentration in school. Students were more likely to report they had been told Not to Speak if they had experienced Sexual Abuse (56%), Psychiatric Hospitalization (55%), Physical abuse (43%), Not Eating (43%), Being Fired from a Job (43%), or felt Hopeless (41%).

Interference in Concentration at School. This important factor was most associated with students who reported Severe Arguments at Home ($r=.62$, $p<.01$), feeling Depressed ($r=.53$, $p<.01$), feeling like Giving Up ($r=.53$, $p<.01$), and being Physically Abused ($r=.47$, $p<.05$). A Multiple Regression analysis ($F(31, 276)=12.24$, $p<.0001$) revealed that the best predictors of students' loss of concentration in school are experiencing Arguments at Home ($p<.01$), being told Not To Speak about their experiences ($p<.01$), experiencing Fights at Home ($p<.01$), feeling Depressed ($p<.05$), and Witnessing Others having bad experiences ($p<.05$). These results suggest that students' school performance may be most often affected by not being able to talk about negative interpersonal interactions at home.

Discussion

The condition of anonymity did not encourage students to report more openly about negative experiences. We can think of only one explanation for these results: students desire to have their abusive and stressful experiences known. This is consistent with the result that being told Not To Speak was significantly associated with having trouble concentrating at school. It is possible that having a place to put their names on this questionnaire indicated that the school counseling staff were not hesitant to ask these questions, and that students were more open to reporting in the hopes of receiving help. The absence of the name may have cued the students in the anonymous condition that the

staff were not intending to help them and so they reported at lower levels. Remarkably, students who had been told Not To Speak about their experiences were 150% more likely to report it when they had revealed their names!

In either case, the results of this study clearly support the conclusion that anonymity does not suppress students' reporting, and therefore having students identify themselves allows them to receive help. There does not appear to be a need for anonymous questionnaires. The fact that the entire student body of a high school was surveyed with a questionnaire of this specificity without incident or complaint also indicates that there is little reason for hesitance.

This survey also revealed that arguments, fighting, and worries about other family members are the most common concerns for students, and the most likely issues interfering with their concentration at school, rather than the perhaps more injurious but less common experiences of abuse and maltreatment.

The students in this public high school report high levels of stressful events and psychological symptoms. The current approach is to wait until these experiences interfere with their behavior or functioning in school before intervention is initiated. All too often, these late interventions require a great deal of time and expense. Early detection of problems can only help to intervene when the situation is less severe. Annual (or even more frequent) screening for traumatic and abusive experiences in public high schools is therefore recommended, without anonymity. Changing the norms of the school environment and the relationships with parents to allow such regular screening would seem to be of high priority.

Table 1

Results of Trauma Questionnaire, N= 309
(Not Anonymous= 157, Anonymous=152)

Item	About Self		About Others		Total # of Students Reporting
	Not Anon	Anon	Not Anon	Anon	
Total Number per Student	2.24	2.25	3.21	2.99	
Severe arguments	66%	72%	72%	74%	213
Violence in home	41	42	49	52	128
Emotional abuse	29	31	41	46	93
Made to work	28	21	32	31	76
Physical abuse	20	24	41	40	69
Witness abuse	21	22	36	25	66
Neglect	12	9	28	18	32
Sexual abuse	7	4	22	13	16
Symptoms					
Total #/student	2.98	2.72	3.63	3.27	
Interferes with school	62%	54%	62%	62%	178
Angry	48	43	52	44	140
Depressed	34	33	40	38	103
Giving up	30	25	33	32	86
Nervous	29	29	30	28	90
Will not succeed	20	17	23	25	56
Hopeless	20	15	24	20	54
Afraid	16	17	26	22	51
Not eating	16	19	15	15	54
Feel like drinking	12	10	29	21	34
Feel like using drugs	11	10	29	20	32
Other Aversive Events					
Total #/student	.98	.88	2.28	1.93	

Intimate died of disease	32%	24%	36%	23%	86
Intimate died by violence	20	22	30	30	65
Gained weight	14	10	18	17	37
Hospitalized- medical	10	12	18	17	34
Arrested	7	9	36	32	25
Became pregnant	3	3	34	28	10
Removed by DCF	3	4	16	14	12
Hospitalized- psychiatric	4	2	9	10	9
Fired from job	3	1	15	13	7
Homeless	1	1	9	6	3
Received money for sex	1	0	7	3	1
Total Number Per Student	6.20	5.85	9.02	8.19	
Told Not To Speak	26%	17%	42%	34%	67

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An Essay on Sustainability for Socioemotional Programs in Education

For Foundations, Funders, and Philanthropists

David Read Johnson

"Why, after so many years of amazing program results,
are things no better than before, if not worse?"

The Challenge

Why has it been so difficult to build sustainable socioemotional learning (SEL) programs, despite the certainty that they help students achieve success in school? As funders who have supported one exciting effort after another, only to see them gradually fade away, you may have asked yourself this question. In this essay, I will attempt to highlight some of the reasons for these short-lived results, covering statistical, strategic, and systemic factors.

How often does funding begin with a successful, short-term pilot program with a small sample of students? How often is the dream to scale this program to whole school districts, states, or the nation? And how often does the effort end in a plateauing of size and support, and then decline as the next exciting and promising effort takes stage. Success can only occur if the program satisfies the criteria for sustainability and scalability *from the beginning.* Understanding these criteria, which I will attempt to itemize in the following sections, may empower funders to make better choices early and produce the permanent changes we all seek.

A Disclaimer

Giving a homeless man a winter coat, or an impoverished family food, or a young child a set of books – that is, giving a gift – is a deeply charitable and caring thing to do, even though the act will not contribute to the permanent improvement or solution of a critical social problem. This essay does not criticize gifts.

But for foundations and philanthropists who wish to contribute to the ***permanent*** improvement of societal problems, that is, sustainable, effective, and meaningful changes, this essay may help you shift from gift-giver to problem-solver. I may be reminding you of things you already know and have already integrated into your grant-making evaluation process. Hopefully there will be some points that you may be less familiar with, and this essay will sharpen your evaluation of programs you wish to fund.

Philanthropy may have its limits, but it is a critical and important piece in society's efforts to heal our wounds, improve our conditions, and inspire us to do great things. This essay is grounded in deep appreciation for all that you are doing.

Summary

Key Statistical Concepts

- I review some basic statistical concepts that will ground the subsequent discussion about outcomes.

Statistical Factors

- I examine 11 practices commonly employed by nonprofits in reporting results that lead to misleading conclusions, usually implying significant improvements when in fact the results occur by chance.

Strategic Factors

- I emphasize the importance of reaching large proportions of the population, intervening early and preventively, and evaluating the impact of your interventions.

Systemic Factors

- I focus on the systemic issues regarding true sustainability, which means planning for the very long-term, lowering costs, and working with government to secure a stable commitment.

Good News: It is Possible. A Case Example

- I describe what a successful and effective program might look like.

Key Statistical Concepts

First, let me define some statistical concepts that are important in interpreting outcome data that a program may present as evidence of its efficacy.

Population and Sample. The term *population* refers to a group of people who share an attribute and who are more or less equally likely to have a particular amount of that attribute at any particular time. The term population refers to the entire group, or all possible members, such as "all third graders" or "all male students." A *sample* is a subset

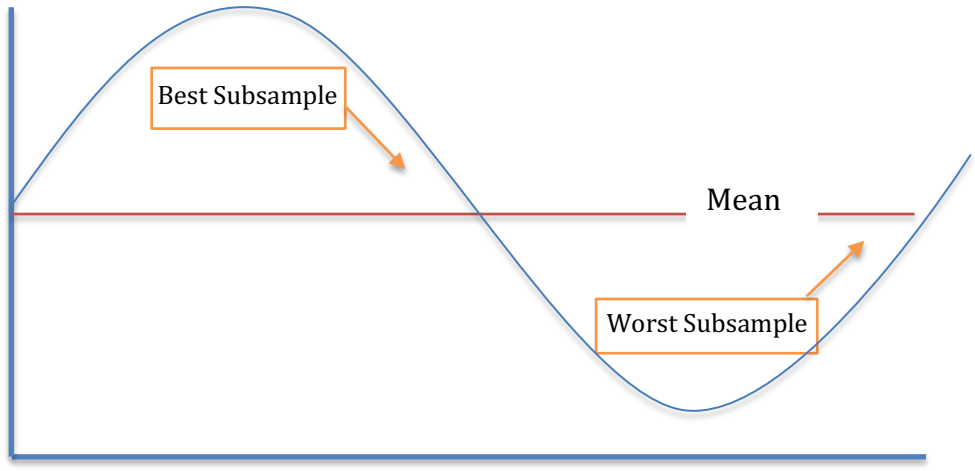
of the population, which is defined either by particular criteria ("All third graders in Forest School" or "Male students under the age of 13"), or randomly (Students are selected by a random draw from the entire population). Therefore, if you measure the attribute of everyone in that population, or any subset of that population, that score should be about the same, or what is called the *population* or *sample mean* (or average).

The Mean. The population mean is the average score for the entire membership, so in a school district, the average reading test score for all third graders is the population mean. If you take any random sample of third graders, they should score (by chance) about the same.

Natural (Random) Variability. Even though the population mean is usually very stable, particular individuals or small subsets of individuals will vary quite a bit around the population mean, from day to day or from test to test. Our moods, temperatures, attention spans, energy, whatever, vary by chance. When you look at the whole population, some people go up, some people go down, and some stay the same. Each day, each year, some schools do better, some worse, and some the same, by chance, even though the overall mean stays the same.

Regression to the Mean. This concept tells us that the scores of small samples of subjects will tend to move (regress) toward the population mean, so a sample that scores very low is likely to rise, and a sample that scores very high is likely to drop, by chance! For example, if you are part of a population with a mean of 3, and on a given day, by chance, you score a 5, then it is more likely than not that the next day you will score lower than 5 (your score will move toward the mean of 3). And another person who scored only a 1, will, the next day, tend to score higher (also moving toward 3). In this way, people on the margins "regress toward the mean." The chart below demonstrates this phenomenon.

Natural Variation in a Population Sample and Regression to the Mean



Statistical Factors

Now that I have shared my definitions of these basic statistical principles, I will demonstrate how some programs can appear to be effective when they are not.

1. Selecting the Worst

A common program design is to work with the kids most in need, or most at risk. If an SEL program works with the 40 kids in the school who scored the worst on attention span in September, then I can pretty much assure you that by June, when we test again, those same 40 kids will score *better* on attention span, simply by chance (regression to the mean)! As the program director, I will attribute that gain to my program, but those scores would have improved even if the program had no effect. Which means that a program that is not effective could produce significantly positive results.

Dieting scams work like this. People begin diets when they are above their average weight. No matter what the program is, on average, they will lose some pounds as they move back toward their mean weight. When we start a diet, we make some initial gains until we are under our mean weight, when we then gain back the weight toward the mean. We end up thinking the diet had some effect.

Thus, if an SEL program selects kids who are at the bottom of some measure, the gains they report may not be due to the effect of the program. A program that randomly selects students (including high-scoring students) from the entire population, would give us much more confidence that any improvement is due to the program's effectiveness and not because of regression to the mean.

The most powerful and convincing evidence of a program's effectiveness is if the program works with the ***entire population*** and produces an improvement in the population mean.

Example A

In one school district, the superintendent had an awards ceremony at the end of each year and awarded the schools that did the best in attendance and test scores. Out of the 21 schools in the district, the top 5 received awards, and their principals were viewed as being especially competent. However, no one kept track of the previous year's scores. So the following year, nearly all of the previous top 5 schools did not perform as well, and a different set of schools were in the top group, being lauded. In fact, the superintendent also gave awards to "the most improved" schools. These were almost always those schools which were at the bottom of the previous year, because they were most likely to score higher due to regression to the mean. Year after year, schools were awarded, even though the district's scores remained unchanged, year to year.

Example B

The VA treated Vietnam veterans who had PTSD with two types of programs: a four-month intensive inpatient program with a concentrated set of therapies, supports, and family programs; and a short-term, supportive program that helped veterans pull their lives together and get back to home and work. A large-scale evaluation of these two types of programs found that veterans in the long-term intensive program did worse by discharge and at 1-year follow-up than those in short-term programs, who improved at discharge and at 1-year follow-up.

The effect was entirely due to regression to the mean: in order to get into the special intensive program, veterans were required to show stability, previous therapy, motivation, and family commitment. They were at the height of their functioning status. Veterans who entered the short-term program were instead upset, having just fallen apart or having a breakdown. They were at the lowest point of their functioning. Thus, over time, the former got a little worse, and the latter got a little better. Once this was understood, it was clear enough that neither program had sufficient effect to shift the population mean, and the intensive programs were disbanded.

Recommendation #1

Beware of the outcome data for programs that work with the subset of the population that are doing the worst, as the improvement they show may be partly or entirely due to regression to the mean.

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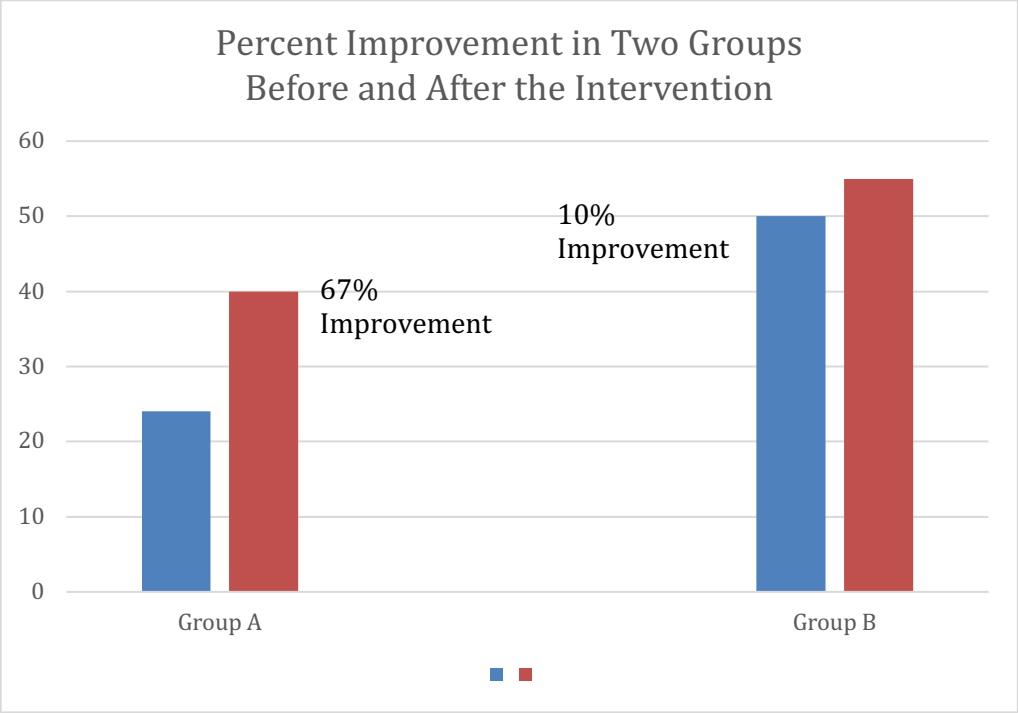
2. Improving "the Most"

A group's actual scores tell us where they place on the measures we evaluate. Sometimes these scores are not that impressive, so programs instead report data that show the *most improvement* from before. These scores are especially susceptible to regression to the mean, because those groups at the bottom are more likely to improve more than those near the mean.

Note in the chart below how Group A has an impressive 67% increase in its scores, compared to only 10% in Group B. Using this criteria, one might conclude that Intervention A is much more effective than Intervention B. The *actual* scores of Group A, however, remain much lower than those in Group B. If these were the number of games won by two different soccer teams, which team would you want your child to be on?



Recommendation #2

Note if a program reports outcome data for the "percentage of improvement" rather than the actual scores. Always ask for the actual scores as well.

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3. Using Many Measures: Shifting Measures

Another common situation occurs when a program uses many outcome measures (e.g., satisfaction, attendance, program completion, test performance, graduation, psychological surveys with dozens of questions). When you have more than a few measures (usually over 5) to choose from, the same statistical process applies with measures as it does with people: By chance, some measures are going to show improvement, and others will show less improvement, on any given day or year. Measures that went up this year are more likely to go down next year, and vice versa. If one highlights the measures that went up this year, and next year highlights the measures that went up that year, one can create an impression that things are continuously improving, when in fact nothing is changing.

Example C

A school district heralded a significant increase in third and fourth grade Reading scores one year. The next year, the district highlighted an increase in second and sixth grade Math scores without mentioning that third and fourth grade Reading had gone back down. When looking at all outcome measures over time, nothing changed, even though the district continued to celebrate its achievements by picking the subset of measures that improved the most each year.

Recommendation #3:

Do not rely on outcome data that report on only some of the program's measures, for only one or two timepoints. Ask for data on all of the measures taken, at each timepoint, for as long as the data has been collected.

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4. Using Small Samples

Many SEL programs begin small, and foundations feed into this by providing "pilot" monies. The result is nearly always a small sample of children. In New Haven, there are 21,000 students. A group of 15 students in a pilot program is a very small sampling of the population, especially when the program is proposing to scale up to change the status of all 21,000 students.

Statistically, the degree of variability from the mean increases dramatically as the size of the sample decreases. Therefore, dramatic improvements are more likely to occur with small samples, which is why many promising small programs look less promising once they begin to scale up.

Medications are susceptible to this effect: New medications studied by drug companies always show stronger results in the beginning. As the years go by, the effects of the drug (a chemical that cannot "change") seem to diminish, as if the drug doesn't work as well anymore. Ironically, the drug companies prefer this, since then they can put out a newer and "more effective" drug that may have exactly the same efficacy.

Recommendation #4:

Program outcome data on small samples cannot be reliably used to estimate the true value of the program when scaled to the whole population.

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5. Excluding Dropouts

Everyone can understand that, if I begin my program with 30 students and end with 20 students who show strong positive results, it is likely that the 10 students who dropped out probably were not having such good results, so they dropped out or were let go. If I report on results from only the "program completers," (explaining that following up with the dropouts is not realistic because of the time and effort involved), I will show strong improvements, even if my program had no effect.

Data that excludes dropouts is not reliable because it tends to exclude participants for whom the program did not produce improvements. The program will say that, "Only those who received the full program should be evaluated," which seems to make sense, but it ignores a subgroup of the participants and creates unreliable outcome data.

Recommendation #5:

Require programs to report the number of dropouts and ask them to include their outcome data when possible. Dropout rates above 10% will make the reported outcome data much less reliable.

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6. Using Selection Filters

Another common maneuver is to identify a subgroup of the population that is more likely to succeed and select members of that group for your program. Then your outcome results are likely to be strong, not necessarily because the program had an effect, but because you selected those people who were likely to be successful. The key is to make the selection process *appear* random.

Example D

Charter schools that accept students from the district lottery use this method to select students more likely to succeed. Knowing that student success is more likely to occur for students with more motivated and available parents (who will get them to school on time, help them with homework, and attend conferences), these charter schools place several small "steps" into the application process that require motivation, organization, and time. Every information session, form, and interview weeds out parents who are less motivated and less available (e.g., working two jobs), leaving a group of students who are more likely to succeed than the overall population of students in the district.

This is the basis of voter suppression tactics: by requiring seemingly small things (a driver's license, a quick test of knowledge, a re-application, an appointment at the office) certain potential voters are sifted out. Voter suppression can then succeed while maintaining an appearance of "fairness." One state legislature, for example, passed a law that if you had not voted in two consecutive presidential elections, you had to re-register. That may sound reasonable, but its intent was to create another hurdle for voters who already have more barriers to voting, such as longer lines at their polling locations, less reliable transportation, and jobs with less flexible schedules.

If programs have a selection process that requires students to attend an informational meeting, fill out a lot of forms or "be registered," or attend an interview with their parent, then it is possible that the program's positive results are a product of this selection process rather than the program itself.

This method can also be employed *during* the program by including various hurdles or tasks that must be accomplished, such as "after three absences you are out." These hurdles help to weed out students early on who are not likely to improve by the end.

Example E

The accomplishments of graduates of Ivy League schools like Yale or Harvard are amazing. The schools applaud themselves for the great education they provide: Yale tells itself, for example, that it produces "the leaders of tomorrow." That is, as they approach funders, they attribute the accomplishments of their graduates to the education they received at Yale. Alas, this is not true. The accomplishments of the graduates of elite colleges are almost entirely due to the rigorous selection process that these schools conduct. They do not produce the leaders of tomorrow; they select the leaders of tomorrow. If these students went to any other college, they would likely do just as well. But it is a good sell.

Recommendation #6:

Be aware that programs may use subtle selection filters to select people who are likely to succeed, or filters that screen out those who are unlikely to succeed.

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7. Real Results

Another issue is how to determine if an outcome is meaningful or not. Clearly, if the goal is to reduce suspensions or improve reading scores, then small improvements may not be enough to change the situation. Remember, any measure will go up 50% of the time by chance, so programs have a 50% chance that their outcome measure will improve, even if their program has no effect.

The standard way of testing whether an improvement can be attributed to the program rather than chance is statistical evaluation. Basically, statistics will tell you "what

is the likelihood that the result I get is simply due to chance?" If that number is 5% or less, then we say that the result is statistically significant. But when there are *many* subjects/people in the sample, significance can be attained by smaller and smaller differences.

Therefore an important criteria is "meaningfully significant," which should be defined before the program begins. For example, if out-of-school suspensions drop from 170 per year to 150 per year after a program is implemented at the school, and statistically this is shown to be significant, the program will present this as evidence that it had a positive effect. But a more important question is: will the students, teachers, parents, and principal feel that this is a meaningful difference? Probably not. If the suspensions dropped to 90, then more likely the people on the ground will "feel" the difference.

This is one of the main reasons "effective" programs may not be taken up by school districts: though they may be statistically effective, they often do not produce meaningful results.

Recommendation #7:

In evaluating the effectiveness of a program, make sure that the outcome measures improve statistically, but, more importantly, evaluate whether the improvements are meaningful. This can only be done by asking stakeholders *beforehand* what a meaningful change will be.

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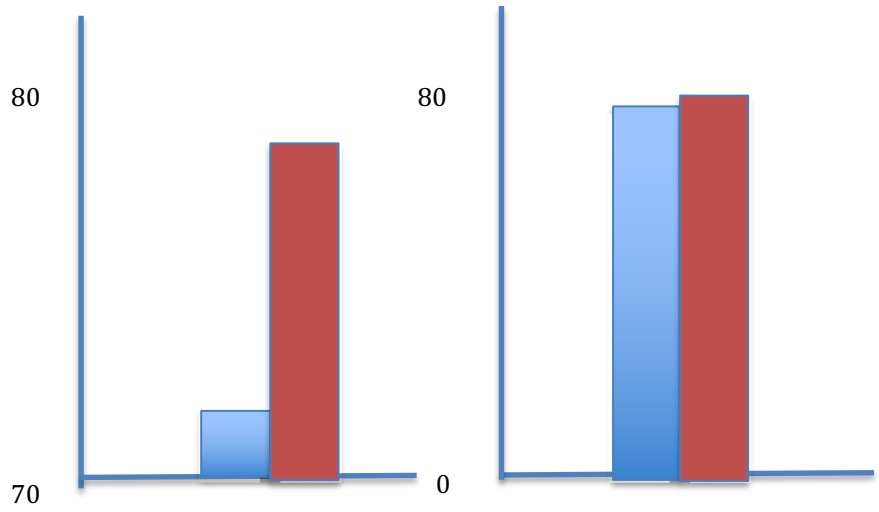
8. Dramatizing Small Differences

A common way to exaggerate the appearance of a small positive outcome is to use unanchored charts. Normally, a graph should include the zero point, which anchors the measure. If instead, the data are presented as it were, "zoomed in," the differences are magnified, as in the chart below.



These graphs show the SAME data. Note that the unanchored chart appears to show a huge increase; when in fact the change was minor.

Recommendation #8:
Do not accept unanchored charts or graphs of the outcome data.

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9. Sometimes Success is Making Things "Less Worse"

Unfortunately, some things get worse over time. Take involvement with the criminal justice system. Very few third graders get arrested. Some middle schoolers do, and a whole lot of high schoolers do. A program that slows the rate of increase in arrests among high schoolers can therefore be a real success, even though things continue to get worse.

Or take dropouts. The national sixth grade retention rate is about 95%; in the first year of community college, it is only 20%. A program that results in a community college retention rate of 40% may appear unsuccessful if we note that this retention rate is less than half the sixth grade rate, but this program would have *doubled* the number of students remaining in school – a truly remarkable achievement.

Alas, funders (well, all of us) prefer lines that go UP, not down. This is why it is hard to get funding for programs for the elderly in nursing homes: no matter how effective a program is at helping functioning among a very old population, the trend line will almost always go down.

Some things, in contrast, get better even without intervention. Reading capacity among youth trends upward, for example. Students read better as they age, so reading scores for students are likely to go up naturally. Reading programs, therefore, are often well-funded. Imagine if I proposed a program to you that aims to increase the height of children, ages 10 – 14? I can guarantee success!

The result is an inherent bias in funding that goes for behaviors that are likely to rise, rather than go down *less so,* even though those latter programs may be just as effective.

Recommendation #9:

Do not shy away from funding programs that help to prevent, slow, or delay decline, even in populations where overall there will be a decline. Evaluate the importance of the measure before making a decision on funding.

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10. Satisfaction

Despite the fact that everyone knows that satisfaction measures are close to meaningless, it is not unusual for programs to publish these as outcomes, and for funders to accept them. Satisfaction measures are not reported if they are not positive. Clients are usually satisfied for the "effort" of program staff, even if they do not feel much better. Many are satisfied by the good intent of the program staff. Most people do not want to complain on official feedback forms because they know that the program staff is relying on this information to support their fundraising efforts. Finally, being satisfied by a program has little or no relationship to its effectiveness: some programs that work clients hard get low scores on satisfaction but high scores on actual improvement.

Recommendation #10:

Ignore satisfaction data. If the program's outcome data consists of only a measure of satisfaction, consider asking them to use other measures before you fund them.

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11. Social Acceptability

Certain self-report measures that are often used by programs involve basic attitudes such as optimism for the future, self-confidence, perseverance, and motivation. These

appear to be better measures than satisfaction measures as they are about deep beliefs that the clients have about themselves. We all believe that inner fortitude, faith, optimism, and grit are essential attributes of success.

Alas, that is the problem: we all believe this, including the clients. It turns out that almost everyone holds these socially-desired beliefs, no matter how bad the situation really is.

Example F

In a study of several hundred middle and high schoolers, which tracked how they were doing in school, their psychological symptoms, and also their involvement with the police/law, it turned out that a cluster of questions were answered in the positive by nearly everyone (90%). Here is the cluster:

I believe I will be a successful person.
I am looking forward to my future.
I feel like I am in charge of my life.
I am trying really hard to succeed at school.
Even though things are difficult for me, I'm not going to let that stop me.

This was true of sixth graders as well as 12th graders. The program initially viewed these results as a positive indicator of the success of the program. These results appeared to demonstrate that these youth's dreams for a better future were strong, and that the program "had instilled hope and resilience" in them.

The problem was that the youth endorsed these questions no matter how bad things were: kids in deep trouble with the law, with high levels of PTSD symptoms, doing poorly in school, and who also endorsed antisocial and criminal attitudes - all endorsed this positive cluster of statements about themselves. Since everybody answered in the same way, these questions are of no help in evaluating whether a program has had an effect or not! It appears that this cluster of socially desirable traits is a widely-held expression of the culture in general. The American Dream.

Recommendation #11:

Outcome data that report positive scores on self-report questions about hope, optimism, grit, perseverance, and resilience, especially when asked only at the end of a program, are of no value and should be ignored. They reflect only what our culture wants us to believe.

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Strategic Factors

12. If We Can't Save Everyone

Real change involves shifting the population mean permanently, such as "improving the performance of America's children on standardized tests." Or "decreasing the violent crime rate in the city." This requires a strategy that reaches everyone, not a small portion of the population. However, once framed on such a large scale, the goal seems impossible to reach. Sometimes, this causes us to think about not trying to save everyone, but as many people as we can, as if we were on a boat that is sinking and we only have lifeboats for so many passengers.

I call this problematic model the "Titanic Model of SEL Programming:" *"Let's identify those students who are ready enough, motivated enough, or have the potential to make it, and provide them with an enriched, extra-resourced program to ensure their success."* It may sound good, but it contributes little to the solution of the larger problems we face. Many SEL programs are of this type.

Example G

The Promise Foundation, originated in New York city, selects high school students of color and provides them with a "team" of peers, mentors, counselors, and advisors who work with them through the college application process and then through their four years of college. This sustained team approach over a period of 5 years with highly motivated students selected for their potential works: over 90% graduate in good standing from college, and quite a number go on to very successful careers and lives. An impressive accomplishment. The cost is approximately $42,000 per student per year. Last year in New York City, they accepted 300 students into the program, out of 100,000 high school

seniors, or .3%. Thus, they are a hugely successful program that does not change the overall population mean at all. They are a lifeboat for the few, for a large per-person cost that precludes the program ever being scaled up.

Recommendation #12:

Do not fund programs for the few that can never be provided to the entire population, unless you are explicitly satisfied with helping only a few.

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13. Celebrating the Exception

Key to the Titanic model is celebrating the exception. A time-tested fundraising strategy is to highlight the journey of a small number of individual successes of the program, usually with a video, testimonial from the client, and a demonstration of the powerful transformation that occurred as a result of the efforts of program staff working as partners with the client. These are powerful "proof of concept" strategies that tug at the heartstrings by "putting a face" on the program. If the goal is to improve the overall status of the entire population, however, this strategy is misplaced. If it is part of a Titanic model effort, then it is fair game.

Imagine a dental hygiene program that aims to improve the dental health of the state's Medicaid population. The solution is to have every child brush their teeth twice a day. At your fundraiser, are you going to highlight a child who brushes his teeth twice a day? Or are you going to find a child whose was slated to have all his teeth removed, but who instead was successfully saved by a team of dentists performing an amazing surgery that your program found for him?

Recommendation #13:

If a program uses "celebrating the exception" but portrays itself as aiming for broader changes in the entire population, then look more closely at its methods of intervention.

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14. Just Because You are on a Horse, it Doesn't Mean You are Going Anywhere

One pattern I have encountered is being satisfied with the intent of a program without checking its actual results. This often leads to the situation of "throwing money at a problem." Take this classic (and real) example:

Example H

A school district has been struggling with truancy in their high schools for years. A proposal is made to create a new category of employee, a "truancy officer," whose job it will be to track truant students and provide them support, go to their homes to assess the reasons for their truancy and encourage them to come to school, and to work with parents. An eminently reasonable idea. By having a dedicated team of people to address this problem, the problem should be reduced. Year after year, the schools pointed out that truancy was continuing to be a problem because they did not have enough truancy officers, so over time, the district increased the department until it employed 49 truancy officers for its 6 high schools, at a cost of $2.5 million a year. Each year, the district congratulated itself for having invested in addressing the truancy problem, and "having the largest team of truancy officers of any district in the state." The only issue was: throughout this entire time, there was no decrease in truancy. In fact, upon analysis, truancy was a little bit ***higher*** *in the schools with more officers per student, which either meant that truancy officers caused more truancy, or (more likely) high schools that had high levels of truancy asked for more truancy officers.*

Either way, it appears that the school district is spending $2.5 million a year for nothing. How come? Because it seems likely that having truancy officers does not address the fundamental cause of truancy, which is probably more related to the economic and psychological issues in these families than "motivation" or "responsibility."

A similar outcome occurs with soup kitchens, homeless shelters, in-home services, and mental health services. The argument is made when applying to your foundation for funding: "There is a terrible need for X in our community, therefore we need to hire Y number of people to address that need." Though these actions appear to make sense, unless address the *cause* of these problems, they are unlikely to change the situation.

Recommendation #14:

Assess the effectiveness of every addition of resources. Fund programs that address the root causes of problems.

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15. Emphasizing Prevention

We oil the squeaky hinge after it starts squeaking. We put on snow tires after the first snowfall. We send a friend to therapy after they become depressed. And we fund programs to address problems after they have emerged.

No doubt you understand the importance of prevention and have been shifting your resources from repairing damage to preventing damage. But it is difficult to do this, as so many societal forces are oriented to *urgency*.

It is hard to get funding for preventive *maintenance*. It is hard to fund a program that helps kids who are not *yet* upset. It is hard to get funding for people who *might* become homeless. Despite the fact that we all know that if we did fund these things, there would be fewer upset kids and homeless families.

We are drawn to fund emergencies and breakdowns; to rescue the drowning rather than teach people to swim. This is how we as humans operate. The relative lack of funding for prevention is the number one reason for the lack of progress in many of our social problems.

Recommendation #15:

Intervene *earlier*. Encourage your programs to start earlier, younger. Have them develop a causal model of the problem and then work backward to the root of it, and direct their energies and your funds there. Reward them for addressing problems before they emerge, rather than after.

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Systemic Factors

16. Forever

Students benefit from socioemotional programs: the whole child requires guidance socially, emotionally, cognitively, physically, and morally. Stresses from home and neighborhood, as well as school, burden our children, who need arenas to express their worries and practice adaptive coping skills. For how long?

Forever.

Socioemotional learning is lifelong, which means that these services are necessary from pre-school through high school (and beyond). A time-limited intervention such as a summer program or 8-week module or intensive weekend, even if wildly successful, will not create a permanent solution to this problem. Each year, a whole set of new students arrive at school. Therefore, any SEL program that is time-limited will, in the end, be of little help.

Example I

When I tell funders that they should think about "forever" in every decision they make, they often look at me in a kind of blank, part-worried, part-confused way, struggling to hear what they know is true but do not want to accept. It reminds me of the look that my son, Adam, gave me when he was young and coming to accept the need to brush his teeth. He asked me, "Dad, how long do I have to keep brushing my teeth?" "Forever," I replied wistfully. And he gave me the same half-puzzled, half-horrified look that funders give me when I say that word to them.

In the 1960s, school districts were confronted with the decision to air condition their schools. The technology had advanced to the point that this was feasible. I can guarantee that no one at the time proposed that the district install air conditioning equipment into schools "for three years" after which "the building will be able to cool itself." No, the decision to air condition the schools required an initial investment and ongoing maintenance costs, but everyone understood that the investment meant "forever." The annual maintenance costs of heating and air conditioning a school are far greater than the cost of maintaining most SEL programs.

As obvious and humorous as this example is, funders, school districts, and program directors continue to act as if funding an SEL program for a limited time could possibly make sense. It does not.

Recommendation #16:
Do not fund time-limited programs. Confront the issue of sustainability from the beginning.

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17. Entropy

The second law of thermodynamics tells us that entropy is always increasing: highly-ordered states move toward less-ordered states. Things spread out. In order to achieve a highly-ordered state (i.e., a highly-functional program, a high degree of performance), a huge amount of energy is required. New programs are often conducted by charismatic, energetic founders who have gathered around them a group of very excited, loyal, and talented individuals. They work day in and day out to build their vision for improving society, gathering momentum. This pushes the potential of the program out to the upper margin of possibility, and as you would expect, over time this has nowhere to go but back toward the middle. As initial staff and even the founder move on, as excitement drops, as problems mount, the level of performance falls as well.

Certain actions can help: building capacity in the leadership team, creating standardized manuals and procedures with monitoring for fidelity, investing in a robust quality assurance program. Nevertheless, entropy is a constant presence, and even when an SEL program is successful and is integrated into the system (school, mental health, legal, state), performance will tend to regress to the mean, whose value must be consistently maintained.

Example J

Imagine running a burger joint in your hometown, and creating a truly terrific hamburger that people come from all over to eat. That in itself is a real accomplishment. Now imagine creating a franchise of your store, consisting of 20,000 stores around the nation, with 250,000 employees, who cook your burger in exactly the same way every time, so that customers can rely on it no matter what store they go into. Yes, a McDonalds, a Starbucks. The effort to maintain consistency in quality is THE most challenging aspect of scaling any product. In fact the cost of

maintaining quality goes up substantially as the size of the organization grows: small businesses may spend under 10% of their income on quality assurance, while large businesses may spend up to 40%! For burgers, this may mean the heat of the oven, the amount of ketchup and mustard, the time of the order. For SEL programs, it is much more about the behavior of people responding to a wide range of interpersonal situations: a far more complex and variable product!

Recommendation #17:

Nonprofit founders and key funders are faced with this troubling truism, from the start: *Eventually the program will be administered by a person you don't know, and who doesn't know you. It will be less effective and efficient than it was at its beginning. Therefore the program must be designed from the beginning to take this into account, with plans for spending greater effort to maintain its quality as it scales up. Otherwise if its effectiveness and consistency are reduced too much, it will be discontinued.*

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18. Money

It is remarkable that, time and time again, program directors do not consider the financial realities of sustainability when they design their programs. Too often, initial funding success leads to expenditures per student that are far higher than any school district could possibly sustain once they take over the program. School districts typically spend approximately $12,000 per student, which represents a gross under-funding due to public resistance to higher school budgets. An SEL program that costs $1,000 per student per year, for example, constitutes an 8% increase in the school budget! Totally not possible.

Therefore, it is incumbent upon both funders and programs to set the price of the program, per student, at a level that will eventually be acceptable to the ongoing system that will be asked to sustain the program (usually state or local governments). I have prepared an estimate of what these costs might be, based on working closely with my local mayor:

Johnson's 3/30/300 Rule of Sustainability

The following are suggested minimum criteria for evaluating SEL programs, when brought to scale:

- The total annual program cost must be no more than **3%** of the school district's annual budget (preferably less).

- The program must cover at least **30%** of the entire student population (preferably more).

- The program must cost no more than **$300** per student per year (preferably less).

Remember, school districts will accept a program and its cost at a time when it has the extra money. Over time, it is more than likely it will have less money, and you do not want the cost of your program to place it at risk for being cut.

Recommendation #18

To be frank, programs that do not meet these criteria should not be funded. A new program that comes close to these criteria and has a reasonable scale-up plan that reduces per-person costs over time might be worth the risk. Maybe.

19. Undercutting the Community

The desire to help out a beleaguered community is laudable, and leads many to create nonprofit programs that provide "desperately needed services." Social work and mental health programs, community-based health clinics, food banks, legal services, and medical services are common examples.

A potential unintended consequence of these efforts is competition and undercutting natural sources of support and service already in the community.

Example K

In New Haven, the number of Black-owned businesses has dropped, despite over 900 nonprofit agencies, Yale University, and local businesses providing consistent support. A legion of Yale social workers services the Black community. However, these charitable services have wiped out local businesses that cannot compete with the free care offered: There are no longer many Black dentists because citizens get free dental care at Yale; no longer many Black lawyers because of the City's free legal defense agency; no longer many Black-owned after-school or day care businesses because of low-cost care provided by nonprofits. The only local, minority-owned businesses are hair salons owned largely by Dominicans, nail salons owned largely by Asians, liquor and convenience stores owned largely by South Asians, and barbershops owned by Blacks. When Yale University decides to provide haircuts for free, there will be no more Black-owned barbershops either.

This debilitating effect of charitable giving has been criticized in relation to gifts to African nations (Dambiza Moyo's book, *Dead Aid)* and Black communities in the U.S. In general, the mantra here is:

Do not provide direct supports; instead, support the providers.

However, supporting local providers leads to a diffusion of funds and less efficiency because local providers are networked into their communities and will divert resources to various other needs. Nonprofits can provide direct services with more efficiency and control. Thus, funders often tend to stick with their group of reliable nonprofits that provide direct services.

Recommendation #19:

Do not invest in programs that provide free or inexpensive services that in the end can and should be provided by the community. Instead, invest in programs that support the eventual providers, even if that means less efficiency.

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20. Being Essential

In assessing the long-term viability of a program, one also has to consider whether the service provided is an "extra" or an "essential." An extra is something that will be cut if a state or city or school district runs into financial problems. No matter how well you convince the current mayor or superintendent or governor that what you have to offer is really wonderful, unless in the end it is viewed as "essential," it will not last.

Now what determines whether a service is "extra" or "essential?" The answer: State or Federal law. When the city or school runs into financial problems, and there is a law *requiring* X, X will be retained. Everything else is at risk. For example, for years Art and Music and Recess were deemed "essential," and all schools offered them. Then, sometime in the 1990s, they were deemed "extras," and they quickly diminished.

So, the SEL program you are considering will, in the end, have to be viewed as more important than Art or Music or Recess in order to be sustained. And covered by law. I apologize for this discomforting piece of reality.

Recommendation #20:

Assess the degree to which the service that is provided by the program is likely to ever be deemed essential. If likely, then *at the beginning of funding,* thought should be put into the longer-term strategy of revising the laws or standards to require such service.

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21. The Law

So, from a systemic point of view, the sustainability of any SEL service is largely dependent upon it becoming codified into the law, or standards of practice that are regulated by the civil authority: city, state, or federal. Think about the effort against smoking: not until the laws were changed did smoking dramatically decrease. Laws support enforcement as well as provide the public with greater confidence in implementing the services or policies.

Philanthropy can help for a number of years. Nonprofits can do the heavy lifting for a time. But, in the end, because of Forever, Money, Entropy, and Being Essential, the Law must be involved. Working in collaboration across agencies, nonprofits, and advocacy groups, a foundation/funder can help to bring about lasting change through a planned approach to local and state governments. Hard work, yes. But necessary for success.

Conclusion

- Understand that the reasons that more progress has not been made are real and deeply embedded in our society and human condition. Be patient, but not naïve.

- When evaluating possible investments, be sure to examine outcome data with an eye towards regression to the mean, random measurement error, selection bias, and dropout analysis.

- Whenever possible, support programs that attend to a large part of the population, emphasize prevention and early intervention, and utilize a model that addresses the root causes of the conditions they aim to influence.

- Carefully analyze the unit costs of the proposed program at the beginning to make sure that the cost per student per year will reasonably allow for scaling and sustainability.

- Insist that the governmental or social agency that is expected to pick up the costs at the end of the grant period participate in the program design, implementation, and evaluation from the beginning.

Good News: It is Possible!

A Program That Meets Most of These Criteria

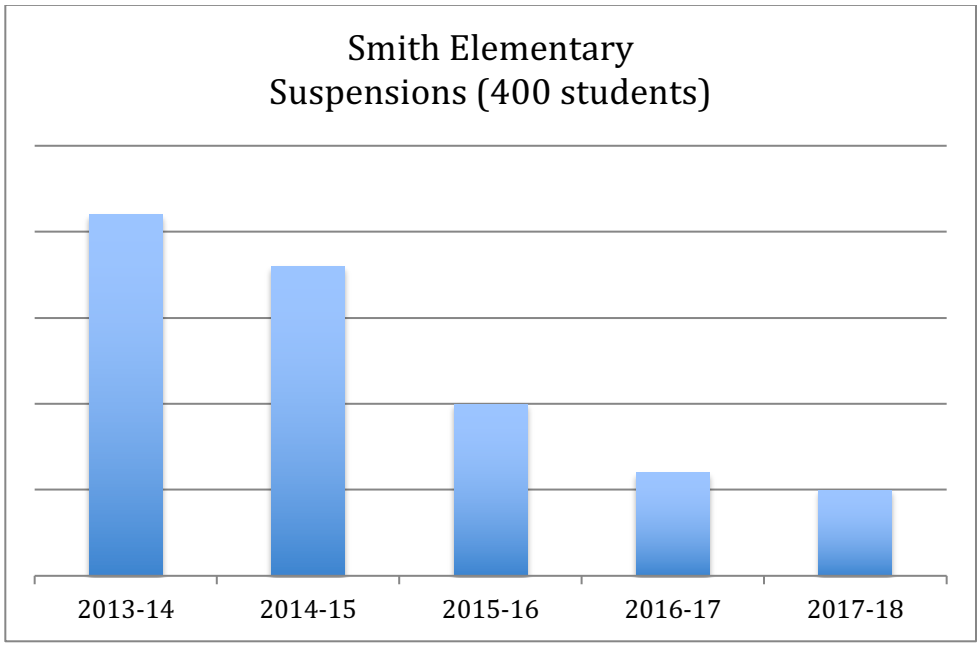
I set out to answer the question, *"Why, after so many years of amazing program results, are things no better than before, if not worse?",* but I must say that, in reading through this essay, it seems hard not to conclude that the situation is not promising.

But the situation is not hopeless. Keeping these challenges and recommendations in your decision-making toolkit will enhance your ability to move the needle – permanently – on the societal problems that matter most to you. The SEL field needs help in achieving higher levels of efficacy, and you are in an excellent position to exert influence in that direction.

Any school will require a number of interlocking programs working together to meet the many diverse needs of students. Some will be Tier 2 or Tier 3 interventions designed for subgroups of students, in addition to other very specialized programs. However, I would now like to present what it would look like if a nonprofit program did meet many of the above standards. Let's say that the program provides comprehensive

Tier 1 socioemotional supports to youth in grades kindergarten through high school, addressing states of stress among students during the school day.

KEY: The program is delivered to ***all*** students within a given school on a ***weekly basis*** throughout the school year, over ***many years.*** Here is what solid outcome data might look like:



Discussion

The program results are for all students in this school, and therefore indicate a significant improvement in the mean of the whole population (school). There are, therefore, no regression to the mean effects. The results show not only statistically significant levels, but also meaningfully significant levels: large drops in out-of-school suspensions for bad behavior. The program uses behavioral data, not satisfaction or self-report data. All data is anchored.

The program is delivered over multiple years using the same measures, so there is no shifting of measures, or reporting only one-year values. The program does not have dropouts or selection filters: all students who attend the school receive the intervention.

The program is designed to address the roots of stress and to intervene preventively. The program does not undermine equivalent services in the community. The program trains teachers to deliver the intervention, instead of relying on outside clinicians.

The cost of the program is $25,000 for the first year, followed by $5,000 per year after that, well under the 3% of the school's annual budget. The program covers 100% of students, above the 30% mark. The program costs $50 per student during the first year, and $10 per student in the years after that, well under the $300 mark.

Criteria Not Met

The program may not yet have been deemed essential, and so is at risk of being cut when a new principal or superintendent is hired. The program may not have succeeded in influencing governments to make SEL programming a requirement, and therefore it has not been embedded within state standards. The program should partner with other agencies and advocacy groups to exert influence on government policies.

Nevertheless, many of the concerns I have raised in this essay have been addressed by this nonprofit program.

To establish a meaningfully effective and cost-effective SEL program that has a real and sustained impact, most of the issues raised here will need to be satisfied. It may be a tall order, but lasting change has always required that!

Treating the Existential Wounds of PTSD[1]

Hadar Lubin MD

Psychotherapeutic interventions have been trending toward those that target specific symptoms. In the field of trauma treatment, exposure treatments aim to reduce re-experiencing and avoidance symptoms; cognitive-behavioral interventions target the distorted cognitions underlying negative affects and cognitions; and psychopharmacology focuses on hyperarousal symptoms. Treatments are increasingly manualized and formatted as a series of procedures.

However, in many forms of psychological trauma, in addition to symptoms, injury lies in the existential wounds to the core sense of the person's humanity. Severe trauma, especially when it occurs in childhood, strikes at the heart of the victim's connections to other people, to society, and to self. They often feel marginalized and unaffiliated or worse, that they are repulsive and no one wants to be close to them. Any attitude or behavior that supports these distortions only deepens the victim's psychic pain and mistrust of other people. All three existential modes of *being*, *having*, and *doing* are critically harmed, evident in victims' statements of absence, loss, and helplessness. "We are nothing, we have nothing, we can do nothing." The feeling of annihilation is profound, symbolized best by the image of the "black hole of trauma," and "the hollow stare," depersonalization to the extreme. Trauma has been called *soul murder* (Schreber, 1955; Shengold, 1989), and indeed trauma victims question their very existence.

PTSD treatment must address the symptoms of the disorder, but the psychotherapist must also help to heal these existential wounds, and it is here where understanding what it means to be a person comes to the fore. The client not only looks to the therapist for their technical knowledge regarding their anxiety and depression, but hopes also to find the bridge back home: to be carried from the world of the dead back to the world of the living, to become human again. For victims of severe trauma, especially, the therapist's own humanity must therefore become part of the healing process. This soul resuscitation journey often comes in surprising forms, not only within the main dialogue between therapist and patient, but in the glances, gestures, and small humane transactions between them: a hand on a shoulder; the way a door is opened; a cemetery visited; a recipe shared; a walk around the block. For trauma victims, presence is not a given. Presence must be regained.

Trauma Therapy Must Engage with What It Means to Be Human

The trauma field, as well as mental health in general, continues to shift toward more technical, manualized, and time-limited approaches that implicitly de-emphasize direct and

[1] Published June 24, 2025.

engaged connection with the client. Treatment that positions the clinician in a removed or disengaged posture may inadvertently reinforce the existential wounds experienced by clients. The therapist, unaware of the scope of their work, misses the opportunity to repair this chasm. Therefore, effective trauma treatment needs to embrace an expanded role for the therapist, who must act beyond the role of the technician, and include behaviors that may not normally be associated with the neutral, dispassionate psychotherapist (Gerson, 2001; Yalom, 2012).

Health providers' actions are governed by the needs of their particular patients. Health care providers who work with the elderly and disabled must attend to many bodily needs: their patients might need to be carried, clothed, fed, or bathed. Providers working with severe mental illness might need to take their patients to social activities, picnics, or movies. DBT requires therapists to be available to their borderline patients by phone as needed. In community psychiatry, therapists visit their patients' homes, while rehabilitation programs often take place outside the therapist office. Children's play therapy may involve craft-making, physical touch and role playing. Thus therapists of trauma victims must also adjust the scope of their work to include addressing the existential injuries, which requires specific interventions appropriate to that task.

Trauma-Centered Psychotherapy (TCP) Approach to Existential Wounds

The ripple effects of trauma are far-reaching, expanding from the victim's core self to their behavior, to family, to community, and to society. All of these effects must be attended to in treatment and are critical to healing. In TCP, the clinician must be thoroughly familiar with the darkness surrounding trauma, and the collective failure of society to protect or care for the victim. In all stages of the treatment, the therapist's own humanity is the first aide and the essential healing element of being with the client. The main principles of TCP: *immediacy*, *emotionality*, and *engagement* are informed by the universal human needs crushed by severe trauma: to feel the urgency to be understood when we are wronged, to be filled with intense emotions when remembering horrors, and to withdraw or hide from others when threatened. Because trauma schemas are relational, the presence and engagement of the therapist as a fellow human being has great potential for providing the discrepancy between past and present that will provide the sense of safety sorely desired. Trauma-centered therapists must therefore include existential factors in their treatment formulation.

Constraints on the Therapist's Actions

The trauma-centered therapist is encouraged to be present in the session as a human being, but not in a way that alters the professional nature of the therapeutic relationship. The therapist's attends to the humanity of the client in the service of the client's recovery:

the therapist's presence as a real person is always *directed toward the client*, and does not include any self-disclosure of the therapist's personal life, nor celebrating any interests or skills of the therapist. The focus is always on the *client's* strengths, qualities, dreams, and interests. In doing so, the integrity of the therapeutic relationship is preserved. The therapist's interest is to help the client realize those aspects of their own humanity that survived the trauma, rather than to reassure or bolster the client through demonstrations of the therapist's humanity. The trauma-centered perspective is one that is always grounded in the person's complex relationship to their traumatic experience; it is not a rationale for being nice to, or caring for, the client as a means of compensating for their loss.

Validating Strengths

From the beginning of treatment, as the trauma history is obtained and the traumatic details are explored, the clinician must keep track of attributes and innate characteristics that were either relied on during the trauma or reverberate in their life today. These characteristics, such as intellect, humor, grace, humility, compassion, creativity, spirit, or kindness, stand in contrast to the psychic pain associated with trauma. Examples include: the abused child who protects their younger siblings from the wrath of the intoxicated father, and then becomes a foster home care-taker; or the rape victim who musters her courage to read her victim statement and becomes an advocate for voiceless victims; or the neglected child who devotes her career and life to medicine to provide help when needed. These strengths must then be recognized as the details of the trauma are explored. There will be tension between recognizing both the client's strengths and the horror, pain, shame, or failure inherent in the traumatic experience. Disaster brings forth both courage and error, a dichotomy not easily integrated by anyone, much less the victim. Yet the therapist should work with the client to help them hold both truths about their experience; both are essential and do not replace each other.

What is critical is that each strength recognized must be intimately linked to the traumatic experience, otherwise the client will experience this as an avoidance of the trauma, and an empty gesture intended to compliment them. The client will be disappointed by the former, and patronized by the latter.

Trauma-centered psychotherapy that addresses the client's existential wounds must accept the inherent dichotomy in every traumatic event: "I was overwhelmed and defeated by the perpetrator vs. I have survived and continue to fight for my recovery." "The trauma numbed my emotions and deadened my spirit vs. I care for my children and partner with great devotion." The therapist works with the client to accept the truth of each side of this existential dilemma, and to resist the desire to resolve this dilemma by embracing one side or the other. Such a resolution will be empty and hollow. True healing comes from the ability to tolerate this dichotomy which allows the person to own their choices today and heal the wounds of the past. Existential triumphs against the forces of the trauma, (e.g.,

helplessness, hopelessness, cognitive and emotional distortions, paranoia and mistrust) are assured by embracing reality in all its complexity. Differentiating between past vs. present, real vs. perceived, and memory vs. the immediate moment are the keys to correcting trauma-based distortions.

Clinical Example 1

Karen was raised in a family with very modest resources. Both her parents worked long hours to provide for their children. She was taught from a very early age that she would have to pull herself up from the deepest holes, by herself. Karen found the spiritual community of her family's church to be a source of love and comfort. After college, she was given a starting position in a local agency that served her community, and gradually ascended to a leadership position. After her marriage failed, she maintained an amicable relationship with her ex-husband but raised her two children alone. She was respected at her work and her community. She continued to attend church and taught there. In her late fifties, her son was murdered in her community. His sudden and violent death devastated her and rendered her unable to work. She developed severe symptoms of PTSD and depression, became socially withdrawn, and stopped attending church. She felt God had betrayed her, and her faith dimmed. She presented to treatment when her job was threatened.

From the beginning of treatment, she expressed both her deep pain of losing her son and strong anger at God for not protecting him. This sense of betrayal and loss of her faith shielded the unbearable pain of losing her son, in part by directing her anger at God rather than the perpetrator. As we explored her relationship with her son, she shared how they enjoyed going to church together, reflecting on the pastor's sermons after each service. Her symptoms subsided, but she felt separated from her lost son. I reminded her of how much faith had been a part of her relationship with him, and asked if the perpetrator had murdered it. She paused, looking confused, and said, "I don't know." "How might you find out?" I replied. Shortly afterwards, Karen reported she went back to church for the first time since her loss. She was surprised how held and supported she felt. As her treatment progressed, she increased her church involvement, attended a theological studies program, and was ordained as a pastor herself. She became very involved in the community in the fight against urban violence and deepened her relationship with her faith. She successfully re-established her connection to her son through her faith and religious studies.

Whenever possible, the trauma-centered therapist seeks opportunities to validate the client's strengths in response to actually witnessing them in action, so that their validation can be experienced as authentic and real. Merely pointing out these strengths is often not enough. For example, a client may be a devoted parent which is evident when they bring their child to the appointment. Or the client may be technically inclined and installs an alarm system in their home, which they demonstrate during a session online; or the client is an excellent baker which is evident when they bring a pastry to the session. In each case, the therapist has an opportunity to acknowledge the attribute and then, most importantly, link it to the traumatic experience, as in this example.

Clinical Example 2

Sue was neglected and physically abused by her mother and violently sexually abused by her father. She is the oldest of five siblings. Her abuse started as early as she can remember. From very young age she was tasked with the care of her siblings. These duties included babysitting, changing diapers, preparing food for them, and keeping them safe. She performed these tasks lovingly and in a caring way. Nonetheless, at the end of the day, when her mother came home from work, she criticized her and put down 'the poor job' Sue had done. In the evening when her father arrived, she was beaten and several times was sexually violated by him. Her way of coping with the terror of the abuse was to dissociate and to try harder to do better in caring for her siblings. As an adult she married a caring man and had two daughters. She went to school to become a special aide teacher. Despite the fact that she excelled at school, she failed to keep a job and eventually became fully disabled. Her older daughter had a severe learning disability which required a great deal of help and advocacy. Despite her severe symptoms, she fought fiercely for her daughter's rights and safety.

When she began treatment, she was highly dissociative and depressed. As the above trauma history was obtained, her therapist noted her ability, even as a child, to split between the way she cared for her siblings and the way she coped with the abuse. Her perspective was that she failed with both. As the details of the trauma were explored, the therapist always showed an active interest in her disabled daughter. She invited Sue to bring her daughter to the session. When she did, the therapist observed how her client competently, patiently, and passionately interacted with her daughter, who exhibited disruptive behavior during the meeting. The therapist pointed out how Sue was able to be fully present with her daughter as she calmly handled her disruptive behavior, even though at the same time Sue was emotionally flooded with memories of her trauma. The therapist

showed how moved she was by Sue's capabilities. The client was clearly impacted by the therapist's statement because she had witnessed her interaction with her daughter.

This is an example of how simultaneously the therapist engages with the details of the trauma but identifies attributes that were spared despite the abuse. As the treatment proceeded, Sue was able to link the feelings of incompetence to what her parents had told her, rather than to her own self-evaluation. She understood that the dissociation helped her survive the horror of the sexual abuse, but when generalized into her job performance, rendered her unable to work. As she was able to differentiate between past and present, she became less symptomatic and was able to own her positive attributes. She later successfully took on a volunteer job as a special aide teacher assistant.

The fact that trauma does not completely destroy all aspects of the victim's endowed attributes is a testimony to the resilience of humanity. Having the clinician tap into these humanistic characteristics highlights to clients what has been preserved. This foundation is essential for healing.

Symbolizing Repair and Renewal

Expressing *symbolic gestures* of humanity during therapy, such as those that express humor, grace, kindness, curiosity, encouragement, humility, and respect, are the building blocks to the restoration of the client's shattered perspective on humanity. The therapist should not be reluctant to express them. Again, due to the severity of the existential crisis experienced by trauma victims, concrete actions in the context of a state of presence have the most impact on the healing process. These actions depart somewhat from the standard role of the psychotherapist but are intentional and thoughtfully rendered. These symbolic gestures must adhere to ethical guidelines, must be informed by client-specific trauma factors, and must be beneficial to the client, not the clinician. Doing so opens pathways to restore faith in humanity that will help the client successfully reenter society.

Examples of common symbolic gestures could include: sharing poems, photos, artwork, or baked goods; or repairing a meaningful item.

The following are the main principles guiding this practice:

- They must be of low financial value.
- They must be executed with consent.
- They must be symbolic: that is, linked to the meaning of the client's specific traumas and be healing-promoting, rather than being a gift or fulfilling a real need.

- They must not fulfill a need of the therapist.
- The meaning should not be to undo what the perpetrator did; but rather the therapist-as-a-real-person's recognition of the client's humanity.

Clinical Example 3

Lisa was verbally and emotionally abused by her mother. She never met her father and was told he left when she was born. Throughout her childhood Lisa was a very 'good girl' trying to appease her mother who in return put her down and criticized her at every opportunity. Lisa graduated from college and secured a very prestigious job where she was valued and well compensated. She bought a small condo apartment and invited her mother to move in with her, hoping her mother will appreciate the life she created for herself. Instead, her mother continued to put her down and be critical. Lisa felt afraid of and shamed by her mother's abuse which left her muted and voiceless. After her mother passed away, she continued to feel unseen by her friends and never had the courage to speak up when she felt misunderstood or when was wronged. She presented to therapy with a nagging feeling that she missed the opportunity to stand up to her mother, who now was dead for many years. During the early part of the therapy, she learned to identify her trauma schemas, she successfully differentiated between past and present, her symptoms of depression and anxiety lifted but her regret about not confronting her mother lingered. I asked her where does she still find her mother? She said in the cemetery every year but she never can get out of the car and approach the graveside. We worked on what she would like to tell her mother and she agreed to write it on paper. As the anniversary neared, she became increasingly distressed and said: "another year of being muted even though I have everything I want to say on paper." I asked if there is anyone from her support system who she trusted to join her? She said emphatically that no one even knows of her trauma, and anyway they make her feel invisible, for example by never asking her opinion. She asked if I could join her and I agreed to do so. When the anniversary of her mother's passing arrived, we met at the cemetery. We walked together to the graveside where Lisa read her piece to her mother. She then tore the paper into small pieces and dug it into the adjacent ground. On the way to our cars, she said she felt as if a huge weight was lifted. Shortly after this event, Lisa confronted her friends and asked to be treated like every other member of the friends group. She continued to speak up, to voice her opinions and to assert her positions. She was surprised but happy to discover how eager her friends were to listen.

Clinical Example 4

> Lee was physically and verbally abused by both of her parents. They told her that she will never mount to anything. Lee's dream was to become a pastry chef. During her adolescence she experimented with baking after school. When her mother came home, she yelled at her and threw away her baked goods. Her father beat her for wasting food. Shortly after high school, she secured a waiting job at a local bakery. She became increasingly depressed and was referred to treatment at our Center. The bakery owner promised to give her a job when she felt better. After her acute symptoms subsided, Lee asked me if I liked baking? I told her I did. She then brought me a small baked good to sample. I did and told her it was delicious (I told the truth!). She asked if I could bring a cookie I had baked into the session. I agreed. Lee tasted it and told me very gently what I could do better (she was right). I thanked her for the constructive criticism and told her I will work on it. She smiled. After a handful of such exchanges several years into the treatment, Lee decided to apply to the Culinary Institute of America to become a pastry chef. She got in, graduated, and secured a teaching job there in the pastry department. She later told me that being able to 'teach' me how to bake better was very meaningful to her in that she realized that she was not as negative and severe as her own mother. For two years after she completed treatment, at Christmas, she delivered a small tray of cookies for our staff, and as delicious as these cookies were, the tray was more importantly filled with gratitude.

Both of these examples illustrate the healing power of symbolic gestures to concretize the client's innate strengths and capacities. Although not viewed as traditional parts of psychotherapy, when contextualized within the trauma narrative and conducted with mutual consent, these symbolic human gestures can become a significant catalyst for healing.

Witnessing Accomplishments

Another dimension of therapist intervention is a selective attendance at critical, meaningful events in the client's life, such as graduations, exhibitions, or book launches. Though the therapist is always mindful of the impact of their attending these events, when the event represents an overcoming of the traumatic injury and a resumption of the connection to society, the therapist may consider participating as a way of witnessing these victories. The therapist participates in a limited way within the bounds set by the formal

event, and does not participate in the less formal parts (reception, dinner). The event should have a direct link to the client's trauma and trauma schemas, such as a public lecture or book launch for someone who was threatened into silence, or a graduation for someone who was told they were worthless.

Clinical Example 5

May was physically abused by her father early in her life. Her father had been a successful store manager until he lost his job after a severe injury, which coincided with the onset of the abuse. He stayed at home, drank, and withdrew from the family. May's mother, a nurse, worked long shifts and when at home focused her care primarily on her youngest daughter who was medically ill and required much attention. May, being the oldest, was expected to help with household chores. She felt neglected but understood the family's challenges. Her mother gradually abdicated all her duties as a mother to May, including attending school functions for the other siblings, or demonstrating any interest in May's social life. As a teenager, May formed a close friendship with a schoolmate who not only provided support but also invited May to her home where she received better care. A couple of years into their friendship, her friend died by a suicide that left May devastated. May's parents did not provide any solace and prohibited her from attending the service. It was at that point that her connection to her family died, and as soon as she was old enough she left home. May later became a successful professional, married a man who was aloof, and had a daughter to whom she was very devoted and available. After her divorce, May became even more involved with her daughter and maintained a very intimate relationship with her after she left home. May's experience as a mother was a source of pride and relief for her, as it demonstrated that she was not following her mother's footsteps.

May presented to treatment to address symptoms of PTSD from childhood and to make sure they will not intrude on her ability to be a good mother to her daughter. Tragically, several years into treatment, when her daughter was in her mid-forties, she died in a car accident. May became severely depressed and withdrawn. She became obsessed about the memorial service, which we linked to her not being allowed to attend her best friend's service. She said it would be very meaningful for her if I could attend the memorial service, as a witness to her presence. At the service, I found May surrounded by family and friends, supporting her as she shook with pain. She appreciated that I knew that the meaning of the event went

beyond her daughter, to include the overcoming of her mother's restricting her from attending her best friend's service so long ago.

This example illustrates how a personal formal event in the client's life is connected to an earlier traumatic event. Agreeing to come to the memorial service underscored the discrepancy between the original traumatic event and the present, where May received her family's support. Not attending would have strengthened the trauma schema: 'I have been left alone with my grief,' which serves as a barrier to benefitting from the support she did receive.

Marking Transformations

In the trauma-centered approach we use *therapeutic ceremonies* to facilitate the societal repair needed to allow the client re-enter their social circle. It is a celebration of a homecoming that is experienced in conjunction with the knowledge of the trauma and the recognition of society's collective failure. Family members, friends, and/or members of the community bear witness to the harm, share the burden of the pain, and commit to do better. The victim is heard, seen, and validated while their social circle is held accountable, express regrets, and invests in working on reparation.

The TCP clinician uses the transformative power of therapeutic ceremonies to demarcate an important milestone in the treatment by concretizing changes that often seem elusive to clients. The format, location, and timing of the ceremony is co-determined by the therapist and the client. The core of the ceremony includes a symbolic representation of the client's transformation that involves an action. Examples include: an object that symbolizes the harm done by the perpetrator is destroyed, buried, or released; a letter written by the client to themselves, the perpetrator, or others is read; an object representing the burden, constriction, or pain of their suffering is broken, or let go. It is important that a person serves as a witness to the proceedings, representing society at large, and that during the ceremony they speak and acknowledge the trauma, admit to the failure to protect, and commit to working with the client to prevent further harm to others in the future. Often family members are invited to serve this function, which can be especially powerful due to their intimate relationships with the client. In some cases, the therapist may serve as this witness, though it is often best for the therapist to stand by the client's side as a support and mentor. Due to the formal nature of these ceremonies, the therapist's behavior is contained within the roles prescribed, providing a clear context for the variation from normal therapeutic interaction.

The ceremonies can be utilized in individual or group therapy. In individual therapy at the Post Traumatic Stress Center, a ceremony at the Remnant Wall was conducted in which the client placed their diaries, artwork, or creative writing in a display case at the Center as a way of both letting them go, and preserving them. In the Women's Trauma

Program, an annual ceremony is conducted to mark the progress of group members during the year, and can be part of a group therapy culture to perform annually (e.g., the women trauma group that I facilitate uses therapeutic ceremony at the beginning of each year to celebrate the gains of group members' work the prior year and to imagine new transformations in the new year).

Clinical Example 6

Joan grew up in a very affluent household. She is the youngest of three. Joan reported emotional and verbal abuse by her parents who were always critical and dismissive of her. Joan looked up to her father, a successful businessman, and wanted to follow in his footsteps, mostly to prove him wrong for putting her down. Despite an impressive educational pedigree, Joan was never able to maintain a gainful job. She was financially supported by her parents despite their relentless disapproval of her failures. In public and within their social circles, her parents attributed Joan's impressive educational accomplishments to their financial support rather than to her intelligence and effort.

Both of her siblings did very well professionally, and attributed Joan's failure to launch her career to laziness. She felt ashamed and humiliated. Joan experienced her emotional wounds as invisible to others, while her failures were always put on display by her family.

As the therapy progressed, she realized that her parents failed her and the way they treated her had contributed to her lack of success. She learned that by keeping her wounds to herself, she had enabled the situation further, in a way that protected of her family. "I wish I had figured this out before my parents died, so I could have told them how they had broken my spirit. We decided to create a special ceremony in which she could tell her parents how she felt. Joan invited a good friend to be her witness, and the three of us met outside of my office in a nearby public garden. Joan brought a carton of eggs to the ceremony. During the ceremony, she carefully broke each one as she told them the ways they had broken her spirit.

At the end, her friend gave her a long hug, and told Joan that she will help clean up the mess, both physically and metaphorically. Shortly after the ceremony, Joan contacted each of her siblings and spoke to them about her parent's abuse. Unexpectedly, they responded to her with great care and validation, which she had craved all her life.

Timing: Projections and Relational Stance

As I have described in a previous work (Lubin, 2025), long-term trauma-centered psychotherapy takes place roughly across two phases. The early phase consists of conducting the detailed trauma inquiry, identifying the trauma schemas, and desensitizing the client to trauma triggers. During this phase, the therapist's roles as ally and/or helpful witness are quickly transformed by the projections of perpetrator, victim, collaborator, or bystander that constitute a trauma schema. In the latter phase, when the treatment focuses on working through the deeper impacts of trauma on the client's self-conception, the transference typically is released from the trauma schemas, allowing the client to perceive the therapist much more as a person, and mentor.

As a result, it is often during the latter phase that work on the existential wounds can flourish, allowing the therapist to more effectively implement the suggested interventions mentioned above. In the early phase, for example, the client may be inclined to suspect ulterior motives to the therapist who points out one of their strengths. The client is also more likely to interpret a symbolic gesture or action as the therapist's attempt to compensate for the actions of the perpetrator, leading either to unhealthy attachment or, when not consistently applied, a sense of betrayal.

Each therapeutic relationship is entirely unique, requiring the therapist to flexibly adapt to and transform with the changing nature of the work. This becomes a template for growth and healing that ushers the client into a successful return to society.

Summary

Our primary existential task is adapting to the ever-shifting demands that life imposes. The traumatic experience is the antithesis to adaptation, for the victim is forced to accommodate to an overwhelming power. The result is impairment in the ability to flexibly adapt to the demands of life, as every experience is filtered through a distorted lens of trauma. Gradually, if left untreated, the negative effects fan out into more and more of a person's life, leading ultimately to the erosion of hope and existential fatigue. The existential wounds of the trauma hollow the person's sense of humanity, leading to psychic pain and suffering. Managing the symptoms of PTSD is certainly necessary and often the initial focus of treatment, but it is hardly sufficient for true healing. Healing from trauma must also restore the capacity of the traumatized individual to adapt and respond to the existential needs of living. Existence itself is at stake in trauma, and trauma-centered psychotherapy is best when this is understood from the outset. Sharing basic human experiences within the therapeutic relationship becomes the building block of hope and the foundation of sustained mental health.

In this paper, I have discussed several interventions that specifically address existential wounds, which include 1) validating strengths, 2) symbolizing repair and

renewal, 3) witnessing accomplishments, and 4) marking transformations. I noted that these interventions usually occur later in treatment when the therapeutic relationship is less shaped by the roles of the trauma schemas, when the therapist-as-a-real-person is accessible to the client.

Understanding the existential wounds of trauma helps the clinician value the healing powers of human presence in the face of horror. Failure to understand the value of existential needs for human presence can inadvertently leave the victim alone again, despite symptom relief. Failure to use our shared human characteristics reduces opportunities to build bridges back into society. The trauma-centered clinician must be courageous to enter the therapeutic relationship as a fellow human being, not only as a witness to the original pain, but to be part of its transcendence.

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The Multiple Functions of Psychoeducation in Trauma-Centered Psychotherapy[1]

Hadar Lubin MD

Psychoeducation plays an important role in Trauma-Centered Psychotherapy (TCP), one that is integrated into all phases of treatment and which reflects the method's axioms, principles, and techniques (Johnson & Lubin, 2015). In the early part of treatment, psychoeducation supports the treatment rationale and helps to establish the trauma-centered frame. In the Getting the Details phase, it helps contain the heightened emotions associated with disclosure by providing a trauma-centered language that is shared by therapist and client. This shared language facilitates communication and limits regression in the face of confronting overwhelming, embarrassing, fearful, and shame-inducing experiences. In the Decoding phase, psychoeducation empowers the client's capacity to understand the relationship between current triggers and their roots in traumatic experiences.

Psychoeducation in TCP is therefore different from traditional uses, where psychoeducation was used to enhance compliance with therapy by providing the treatment rationale for both medications and psychotherapy. Knowledge about one's diagnosis, prognosis, and treatment presumably helps clients tolerate the symptoms and side effects. This is not the primary role of psychoeducation in trauma treatment.

Psychoeducation in TCP plays a similar role to that in Cognitive Behavioral therapies, where the aim is to identify unhealthy or distorted cognitions, and to replace them with more healthy ones (Beck, 2020). In TCP, the target is instead the client's trauma schemas (consisting of both cognitive and emotional patterns), which are distorted by the conditions of the original traumatic event. The trauma-centered language provides the scaffolding upon which the client can identify their trauma schemas, and then work to limit their effect.

However, psychoeducation in TCP has different functions depending upon the domain of experience being focused on: the regulation of the Self, management of interpersonal relationships, and adaptation to the wider social environment. I will now describe each of these domains.

Function I: Empowerment of the Self

From the beginning of treatment, as the trauma-centered therapist gains knowledge of the trauma and the way it reverberates in the life of the client today, the building of a mutual language begins. Every time that a trauma schema is identified, the therapist pauses

[1] Published September 7, 2025

to explain and to define the new words that comprise the trauma language. These include trauma schema, trauma lens, the gap, the trauma grid, and discrepant information. This is repeated until the client uses these descriptors accurately. Understanding the concepts is often easier than emotionally and psychologically revising their perceptions, which develops over time.

Gradually the client utilizes their growing knowledge and conceptual understanding to confront and then alter their trauma schemas. They learn how the trauma and the perpetrator shaped the lens through which they view themselves, others, and society. They gain mastery in navigating through triggers and trauma reenactments. In doing so, the client's passive and helpless stance as a victim is transformed into an active stance of a student who can master the task of healing. The cognitive distortions that are shaped by the trauma are targeted with discrepant information that opens new possibilities and options. Clients are taught how to see similarities and differences simultaneously in order to differentiate the past from the present, real from the perceived, and actual danger from the memory of danger. They also learn to understand how they use trauma schemas to stave off fears of being hurt again and, by doing so, then miss opportunities to be supported.

Psychoeducation in the domain of the Self specifically targets the fact that trauma is incomprehensible and a chaotic experience that renders the person helpless and out of control. The shared conceptual structure and the understanding that follows results in empowering the client.

Clinical Example

Client: I don't feel comfortable to go outside of my home; it is crazy out there.
Therapist: It is understandable that you feel unsafe given that you were raped at your friend's party.
Client: Yes. My surroundings must be safe.
Therapist: Perhaps you believe that all places outside of your home are dangerous?
Client: Exactly.
Therapist: We call this your trauma schema: "The world is dangerous and I should avoid it." But actually, the person who raped you is dangerous, not your friend's house or much of the world. This trauma schema isolates you and prevents you from experiencing good and safe things in the world.
Client: Do I use my trauma schema because of my rape?
Therapist: Yes. The experience of the rape led you to feel unsafe and fearful that you will be harmed again. So you conclude 'the world is dangerous,' and distort the reality that not all experiences in the world are harmful to you. This distortion is your trauma schema.
Client: That makes sense. So, I can change it?

Therapist: Yes. This you can learn and master here.

Clients who are more intellectually inclined will understand and master the language quickly. However, clients who are less intellectually inclined will also benefit, if sometimes at a slower pace. Concretizing the recovery process makes it less elusive, which enhances hope. Knowledge not only empowers the client by the acquisition of information, it helps them alter their relation to the trauma, liberating themselves from the control of the perpetrator. This increased agency of the self transforms the client's passive position as a victim to an active stance of mastery and control. By exercising higher-level defenses such as intellectualization, the client is reminded that the trauma did not eradicate everything (e.g., cognitive functions, learning new information, exercising flexible thinking). All of these factors help to limit regression in the therapeutic relationship.

Finally, having the therapist share their operating framework with the clients gives the client an experience of an authority who is transparent and open, in contrast to many perpetrators, whose true motives and intentions were kept hidden.

Thus, psychoeducation can have a critical role to play in facilitating the delivery of trauma-centered psychotherapy, particularly in empowering the client to identify trauma schemas, decode them, and reset them in line with more normative, healthy patterns of emotional and cognitive regulation.

Function II: Empowering Interpersonal Relationships in Trauma-Centered Group Therapy

Originally the psychoeducational mini-lecture at the beginning of the group therapy session was conceptualized as a cognitive distancing technique designed to limit regression as information about trauma is being shared (Lubin & Johnson, 2008). However, as experience with the method deepened, we observed that though each lecture did provide a distancing effect for many in the group, each time a few members found themselves triggered by the trauma-related content. We noticed that the split in the group between those who were empowered and those who were triggered led nearly always to the empowered members reaching out to help the triggered members, often demonstrating their integration of the trauma-centered concepts. Each lecture triggered a different set of members. As a result, the main function of psychoeducation in group therapy has been re-considered.

The trauma-centered, psychoeducational lecture at the beginning of each group meeting is used as a stimulus that evokes a gradient among clients' responses. The key trauma-centered elements in the lecture include 1) mentioning the perpetrators and how their actions reverberate in members' lives today, and 2) details of traumatic events tailored to match some of the members' experiences. These elements produce the range of responses among group members.

Depending on the lecture theme, many members of the group will feel empowered by the newly acquired knowledge, while others will feel emotionally aroused due to its connection to their particular trauma. This gradient of emotional response divides the group into those who need support and those who can provide it. The heterogeneous nature of the group's membership (clients are selected with different traumatic experiences, e.g. sexual assault, physical abuse, domestic violence, early childhood trauma, motor vehicle accidents, urban violence, natural disasters) and the unique trauma narrative of each individual participant, greatly enhance the breadth of this gradient. This essential heterogeneity assures that no lecture will evoke the same response from everyone.

The therapist who gives the lecture tracks the nonverbal cues of group members as they engage with the material. Those who are empowered will be visibly engaged and eager to apply the new information to advance their healing. Those who are triggered by the topic will become anxious, withdrawn, or avoid eye contact as they try to manage their heightened anxiety. These reactions will be visible to the therapist and to some of the group members. The therapist, expecting this gradient of responses, keeps in mind the relevance of the lecture theme to clients' respective trauma narratives. Group members who feel empowered can be easily encouraged to share with the group their reaction to the information and to support those who seem upset. Group members who are evoked will benefit from being supported and held by their therapeutic social circle, being a stark contrast to their original traumatic experience. If the lecture does not trigger anyone, it was not trauma-centered enough. If it triggers too many members, it did not respect the heterogeneity of the group's issues.

During the discussion post-lecture, the therapist can energize the gradient by asking an empowered member in the group why they feel supported by the information to strengthen their embrace of this newly acquired knowledge. Alternatively, the therapist can underscore the uncertainty or ambiguity that disturbs the evoked group members in order to activate the support available from other group members. Because each lecture triggers a different set of members, over time each group member has an opportunity to act as a helper, or be the one who receives support from others. The group dynamic becomes incredibly rich, as group members engage with each other, de-centering the group from its reliance on the therapist. A sense of immediacy in meeting the imbalance introduced by the lecture permeates the group atmosphere, providing ample opportunities for each member to practice sharing their experiences, expressing emotional responses, and integrating the conceptual framework of the trauma model. Periodically, if needed, the therapist can refer back to the lecture as a helpful scaffolding for the group's work.

The method strengthens the purpose of group therapy: to create a social atmosphere of peers who are dedicated to helping each other, as fellow human beings. No longer helpless, members are thrust into action. As a result, their capacity to heal and to advocate in the face of trauma greatly expands.

Clinical Example

> Anne was sexually abused by her stepfather from the age of 5 through 12. After puberty and throughout her adult life she felt as if she was 'damaged goods' and disgusting to others. She avoided men and was not able to engage in sexual relations. The trauma-centered lecture focused on the effects of trauma on intimacy. The healthy vulnerability inherent to intimacy was contrasted with the painful vulnerability associated with the traumatic moment. The norms of safe intimacy were highlighted while the acts of intrusion and violation by the perpetrator were underlined. After the lecture, Anne became visibly upset and tearful. She stated in a broken but strong voice: "No one can ever understand what happened to me, so why should I bother trying to find a person to love?"
>
> Karen, who joined the group after a car accident and primarily feared driving, responded to Anne and said: "I think I can understand you. I feel the same even though I am married and I was not sexually abused. Since the accident I have avoided any intimacy with my husband because I feel I need to be on guard all the time. Your abuse created the trauma schema that you are worthless, but I want to tell you that I value you. You have been a big help to me in this group."
>
> Anne: "I never thought about it this way, I always felt everyone perceived me as disgusting."
>
> Karen: "You are not. I have learned a lot from you, which helped me understand my own vulnerability."
>
> Other members of the group joined in supporting Anne, rejecting her distorted views of herself and congratulating Karen for sharing with the group.

This example illustrates how the theme of the lecture split the group between those who were feeling empowered vs. emotionally aroused, and between those who need help vs those who could provide it. Karen identified Anne's trauma schema ("I am damaged goods") and effectively challenged it by providing discrepant information ("I value you.") Other group members shared their knowledge and experience in the service of both communicating their own pain while simultaneously supporting those experiencing pain in the present moment.

Function III: Empowering the Client to Face their Family and Society

In the later phases of treatment, largely but not exclusively in individual therapy, the trauma therapist provides opportunities for the client to explain to family or society at

large what they experienced and how it affected them, through in-session role-plays. People from their family or work setting, especially those who seem not to understand them, can be "brought in" to the session to have direct conversations, with the therapist playing their roles. Here, the client functions as the "expert" who holds the knowledge of trauma and its effects, rather than the victim who was swept away by them. The client is given the opportunity to apply the information they have acquired over the course of treatment. Often the client will instruct their family members about how their trauma schemas played out within their interaction with loved ones or co-workers. Rehearsing these important conversations in the session empowers the client to directly and effectively address challenges outside of the session. This process undermines the experience of shame inherent in being a victim, and instead evokes a feeling of pride and mastery over having gained perspective on one's condition. Instead of feeling peripheral or de-roled in their family, this work can aid the client to regain a respectful position within the wider social environment.

Example of Role Play

Client:	No way I will share my trauma with my husband. He will find me disgusting.
Therapist:	Since your husband is not here, let me play him so you can practice this conversation.
Client:	Ok. Here we go: Bill I cannot have sex with you even though I do love you.
'Bill':	Do you not find me attractive? Did I do something to make you feel like that?
Client:	No.
'Bill':	I am confused. What else can be the reason? Do you love someone else?
Client:	No. Of course not. I can't have sex with *anyone*, ever!!
'Bill':	But why?
Client:	If I will tell you why, you will think I am disgusting.
Therapist:	This is your trauma schema ('I am disgusting') and it is standing in the way of your marriage. Tell Bill about your schema and its relation to your trauma.
Client:	Now?
Therapist:	Yes.
Client:	Bill, I feel if you knew what happened to me you will find me disgusting and leave me.
'Bill':	I love you so much and I find you very attractive. That's why I want to make love to you. What makes you feel that way?
Client:	I was sexually abused by my father for years. As a result, I developed the

idea that I am dirty and unattractive. I am afraid when I have sex with you, I will remember the abuse, and I will think you will find me dirty and disgusting. This is what is called my trauma schema.

'Bill': Honey, I am so sorry to hear about it. What a monster. He is the dirty one, not you. I can do whatever makes you comfortable but you have to tell me so I will not cause you pain.

Client: Just knowing what I'm dealing with will be so good. Can you be patient with me?

'Bill': Of course. I had no idea this was coming up every time I ask to have sex with you. But wow, I can understand why!

Client: (Tearful. To Therapist.) I actually believe every word you said as Bill. I think I must be much more open with him.

Therapist: I agree. We can always practice here when needed.

In this example the therapist voices the position of the family member and notes the evocation of the trauma schema. Through the safe environment of the roleplay, client and therapist can practice open conversations with their family member. The therapist can coach the client when needed. The client becomes prepared to help their family member understand the origin of the trauma schema in the abusive acts of the perpetrator, just as the therapist had done with them in the treatment. By encouraging the client to engage with their loved one, the therapist helps the client gain control of the exchange and establish a mutual understanding with their family member. With this shared framework, the client and family member are more equipped to break the repetitive interactions that burden their relationship.

Clinical Example

Lee was emotionally and verbally abused by her father as long as she can remember. The father often told her that she would amount to nothing and when she excelled in any endeavor, he squashed it by belittling her achievements. As a result of this experience, she gave up on her dream to become an artist despite her natural gift in the arts. Instead, she pursued a job as a manager of a small company.

Lee married and had two children. Her devotion to them and their education was deep and loving. She spent extra time to support their many interests and artistic outlets. Her husband often complained that Lee was too involved with the kids and did not give them time to themselves. Paradoxically, his remarks caused many arguments between them, which then led her to withdraw from him and spend more time with the kids. Nevertheless, she did not like the hostility towards him that these arguments

evoked in her, which made her feel that she had failed as a mother and a wife, confirming her father's original criticisms.

In this session, after the details of her abuse were explored, we identified her trauma schema: "I am not good at anything that I care about." I pointed out its origin in the criticisms of her father, and how that had led to her decision to quit her dream to be an artist. We explored the many ways her father's abuse had solidified this schema. She agreed to identify times when this schema was evoked by similar remarks from her husband. Next, we agreed that it would be helpful for her husband to know about this schema, for no doubt he did not appreciate why she reacted so strongly to his comments. After several rehearsals where I played the role of her husband and criticized her care of the children, Lee was able to give a precise and thoughtful response that explained how his comments evoked her early experiences with her father, and activated her trauma schema about failure.

Lee agreed to let her husband know when his remarks triggered this schema and to listen to him more carefully to identify differences from her father. After a few exchanges like this over the following several weeks, her husband became more careful in his remarks and Lee, instead of withdrawing, was able to see that he was not saying the same thing as her father. Instead of conflicting with each other, they became a team that worked to remove the presence of the perpetrator from their relationship.

Incorporating trauma-centered language into the family's communication empowers the client to deal more forthrightly with their trauma schemas, and opens up opportunities for family members to join together with the client in standing up against the pernicious effects of past traumatic experiences.

Conclusion

Psychoeducation in trauma-centered psychotherapy fulfills a number of important roles: 1) as a tool in confronting and altering unhealthy trauma schemas and cognitive frameworks; 2) enhancing interpersonal engagement in group therapy, and 3) empowering both client and family members to stand together, rather than against each other, in facing the impact of trauma schemas on their relationships. In these ways, psychoeducation addresses healing at the level of the self, others, and society at large. All three functions derive their power from the basic human capacities of the client: to be able to learn new knowledge and language, to exercise their capacity to help others in need, and to be able to educate one's significant others and invite them to join in the effort to resist the impact of trauma. Instead of being a victim, the client becomes a student, an educator, and an

advocate. Together, these functions greatly support the client's healing. The incomprehensible and chaotic nature of traumatic experience is transformed into a source of knowledge, even wisdom, that can bring not only reparation but also flourishing to all the domains of life.

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The Healing Power of the Therapeutic Relationship in Trauma-Centered Psychotherapy[1]

Hadar Lubin

The role of the therapeutic relationship in healing from trauma has been obscured by the focus on reducing the symptoms of PTSD (particularly re-experiencing and hyperarousal symptoms) either through medication, relaxation, and desensitization methods, or through skills-building and cognitive-behavioral strategies aimed at improving emotional regulation. But traumatic experiences also strike at the heart of our humanity, impair our ability to connect intimately with others, and eradicate a sense of affiliation with family, community, and society. Repairing these relational and existential wounds, which result from acts of the perpetrator, lies largely in the realm of the therapeutic relationship, where the client can reforge a bond with an Other, and heal their capacity to connect with their community and society at large.

This important work takes place throughout the course of treatment, and gains centrality in the later phase when the therapeutic relationship is at its most durable. Due to the axiom of trauma-centered psychotherapy that *every trauma schema is relational,* there are many opportunities for the therapeutic relationship to impact the various chasms, disconnections, and dissociations that result from the trauma. In this article, I will describe the multiple paths available to the therapist in the restoration of the human bond that has been shattered during the traumatic experience.

The long-term nature of treatment for early childhood trauma and other severe traumas is not measured by the length of time but rather by the successful ability of the therapeutic relationship to grow. This is particularly important in the processing of shame schemas in the later phase of treatment when the therapist's position is no longer as 'the other.' Here, the therapist becomes the client's ally, as the projections are no longer infused with the perpetrator role. The early projections tend to evoke the perpetrator role in the trauma schema, while during the later stage the projections reflect a shared humanity, in which shame is mitigated and can be acknowledged and processed. The therapist's ability to respond to the shifting roles within the therapeutic relationship will be essential to the client's long-term growth post-trauma. A dyadic relationship with a therapist who is unable to be fully present as a human being is likely to be experienced as unsafe by the traumatized client, which will spur their projections onto the therapist as perpetrator, regardless of the safety of the moment. This dynamic will prohibit the long-term benefits seen in trauma-centered psychotherapy.

In this article, I will highlight three areas where the therapeutic relationship has a particularly central role in the treatment process. First, in the early phase of treatment when the client projects the four roles of the trauma schema onto the therapist (i.e., perpetrator,

[1] Published September 7, 2025

victim, collaborator, bystander), requiring a flexible and agile response from the therapist. Second, throughout treatment when the therapist's role is perceived in a particular social image of the Other, requiring of the therapist a welcoming response to the victim:

A. In the role of the *Homecoming*, at moments of disclosure of details of the trauma.
B. In the role of *Human Being*, at moments when the client feels they have been cast out of humanity.
C. In the role of *Society*, at moments when the client feels they have been Left Behind and Forgotten.

And third, in the later phase of treatment, when the therapeutic relationship has transformed into one of collaborative effort, the therapist will have the opportunity to respond to the client's expressions of *gratitude* in ways that will consolidate and deepen the repair of the relational wounds. At all three points, the therapist must respond somewhat precisely in order to avoid common pitfalls that might set back the client's progress.

The Multifaceted Roles of the Therapist

The therapeutic relationship in trauma-centered psychotherapy is multi-faceted, actively changing, and deeply engaged in nature, due to the pervasive impact of trauma. The therapist must bear witness to the loss and grief, emotionally hold the client when the floodgates open, set limits to out-of-control behaviors, teach how to trust again, and overcome the shame and self-hatred that prevents the client from rejoining society. The therapist is not unlike a FEMA worker, who pulls a victim from the rubble, sits down with them to comfort them, gives firm direction to keep them from further harm, and rejoices with them when their pet is found.

Trauma-centered therapists are familiar with their position as 'other' in the early part of the therapy, and understand the importance of transforming their stance to be 'by the side' of the client in the later part of the treatment. In the early phase of treatment, the therapist probes into the details of the trauma in order to understand the far-reaching, detrimental effects on the client's psyche, interpersonal relations, and existential security. This process calls for a very dynamic and engaged stance by the therapist (principle of *engagement*), tolerance of affect (principle of *emotionality*) and exposure to the horror of the trauma (principle of *immediacy*). Successfully doing so creates an arena in the later phase of treatment within which the client can practice how to re-engage in trusting relations that are not stained by the imprint of the perpetrator.

Often therapists who work with traumatized clients find themselves preoccupied by rescue fantasies that are linked with an appreciative response from the client. The rescue fantasy requires resisting the client's projections of the core roles of perpetrator, bystander, and collaborator, which paradoxically distances the therapist from the client, who experiences them as not understanding their situation. There is no role of rescuer in a

trauma schema, as trauma is by definition a situation where no one came in time. Thus, the therapist must tolerate being experienced as the perpetrator, bystander and collaborator to fully understand the extent of the harm. However, gradually through treatment, the roles of ally and mentor - side-to-side with the client - will emerge, restoring the link between intimacy and safety. The therapist's capacity for flexibility, and ability to tolerate multiple roles, will indeed result in the rescue of the viability for healthy and safe relationships post-trauma.

The therapist may feel reluctant to show this flexibility and instead attempt to maintain the therapeutic relationship in one dimension, that of the benign and supportive counselor, consistent with their skills-based role. In contrast, the therapist's ability to transform their role within the session in response to the changing presentation of the client is the essence of a relational reciprocity that was wholly sacrificed during the traumatic event. The perpetrator's rigid control over the victim eliminated any measure of reciprocity or agency. The therapist's ability to exercise this agility of roles without evidence of harm, manipulation, or betrayal of the client builds a base of confidence and interpersonal flexibility in the client. The active and dynamic environment within the therapeutic relationship provides the client with a laboratory to make mistakes and then gain mastery in their relationships outside of the office.

The Impact of the Victim's Relationship with the Perpetrator

The victim has a relationship with their perpetrator for the rest of their life. This relationship often creates significant harm to the client's subsequent ability to form and sustain intimate relationships. To a great degree, this relationship is in competition with the client's developing relationship with the therapist. The therapist is paradoxically afforded an opportunity to alter this harmful relationship in moments when the client projects the role of perpetrator onto the therapist. This projection includes not only the elements of active harm and abuse committed by the perpetrator, but also the acts of omission of care, connection, and reciprocal bond. Trauma creates a distorted bond that is simultaneously intimate and lacking in mutuality, existing in an atmosphere of darkness and void. This core betrayal serves as the basis for the importance of the therapeutic relationship in healing relational wounds.

The perpetrator-victim relationship is deeply unstable. The abused child sees their father being nice in one setting and monstrous in another. The battered woman sees her partner showering her with gifts and love, and then rapidly shifting to being abusive, controlling, and threatening. The generous boss transforms into a predator who lures his employee into intimacies, but then retaliates when boundaries are set. This shifting stance of the perpetrator towards the victim will be reenacted in the therapeutic relationship in rapidly shifting projections toward the therapist.

The unpredictable and shifting stance of the perpetrator causes the victim to rigidify their interpersonal boundaries in post-trauma relationships. Any shifts, verbal or nonverbal, detected in their present relationships will be experienced as dangerous and will be resisted. The therapeutic relationship will therefore need to tolerate the unstable nature of the client's projections and at the same time, soften the client's rigid responses (stemming from their desire to protect themselves). Hence the therapist will be tasked with both stabilizing and increasing the flexibility of boundaries within their relationship. The capacity to hold these two functions is only possible when the therapist behaves in the fullness of their humanity and maintains their contact with the client. The rise of the perpetrator in the therapeutic relationship will engender desires on both parties to avoid or distance themselves from each other, as each party will experience the other as aligned with the perpetrator. At the same time, the shifting stance of the perpetrator toward the victim, from harmful to comforting, will engender desires to join with the perpetrator, again experienced within the other party. The deep and nascent desire for a safe bond with another must be untangled from the perpetrator and attached to truly reliable and safe people such as the therapist. When the therapist tells the client that "yes, things were dangerous in the past, but that now, here with me, it is safe," they run the risk of repeating exactly what the manipulative perpetrator said: "You are safe with me." The client must learn the answer to the question, "Is the therapist being nice to me now because he is grooming me like my perpetrator, or are they being truly nice?" *Thus, both negative and positive reactions to the therapist can be projections based on the trauma schema.* Through this important differentiation, the transition from seeking intimacy in the comforting aspect of the perpetrator to knowing how to identify safe intimacy, can occur. Through the therapist's secure and continuous engagement, the client can work through the alternating projections from the perpetrator and allow the experience of a safe bond with the therapist to gradually emerge. This differentiation is established through the experience of safe bond with the therapist who engages as a fellow human being.

Critical Opportunities for Relational Repair

The therapeutic relationship affords opportunities for repair and rebuilding of the connection to others, to humanity, and to society. The trauma therapist must be aware of all three of these circumstances:

A. When the client discloses new details of their trauma, being a moment of *Homecoming*.
B. When the client expresses that they have been cast out of humanity due to the horror of the traumatic event, being a moment of presence as a *Human Being*.
C. When the client expresses that they have been Left Behind and Forgotten, being a moment of societal *Acknowledgement*.

These circumstances in the treatment provide an opening into the inner experience of the client who believes they are not welcome, do not belong, and have been cast out of the world, which has moved on. Addressing these moments successfully will create a bond, a bridge, and a springboard for the client to return home.

The Moment of Disclosure. The original traumatic event exists forever, frozen in time, immutable, unforgettable. In contrast, the moment of disclosure of the memory of the event holds real possibility of a different outcome: a revision of the experience of the homecoming. Each time the client reveals a memory, the client-therapist relationship has the chance to enact a healing homecoming. Nothing can be as powerful in countering the isolation and helplessness resulting from the original trauma. What happens in the encounter between client and therapist at that moment can support presence over absence, validation of experience over invalidation, and comfort over misunderstanding. The therapist is tasked in the moment to *demonstrate* 1) that they are *listening* intently, 2) that they understand the *enormity of the harm* in both its fear and shame aspects, and 3) that they *feel the emotions* appropriate to the event, especially fear, horror, embarrassment, sadness, helplessness, and shock. These must be demonstrably visible to the client. Thus, the therapist physically leans forward when they sense a disclosure is in process; they affirm the enormity of the harm (e.g., "that was horrible," "I can't imagine how painful that was," "that was sadistic and cold-hearted"); and they express emotion ("I feel so sad to hear that," "that is terrifying," "oh my god!" "that makes me feel enraged"). The therapist's failure to recognize the importance of these moments at best will be disappointing to the client and at worst, will repeat the harmful homecoming they received immediately following the traumatic event. When these moments are not well-managed, the victim feels that they are not being believed, are exaggerating or manipulating for sympathy, or are being blamed for what happened. It is critical for the therapist to understand that the client is anticipating an inadequate response and will be quick to conclude that the therapist has failed in this moment, so the therapist must behave in a strong, unambiguous manner on all fronts (much more than most therapists are trained to do). Yes, there will always be the unbridgeable gap between client and therapist over the traumatic event itself; but the gap that occurs in the moment of disclosure can be avoided. When the therapist manages these moments successfully, the client will feel seen and heard, believed and emotionally held. This experience is not only therapeutic in its own right, but will pave the way toward the consolidation of a collaborative and trusting therapeutic relationship in the face of the detrimental effects of trauma.

Being Cast Out of Humanity. The effects of the trauma are far-reaching and reverberate throughout the client's life. Acts of perpetration, particularly interpersonal ones, may cause physical pain or injury, humiliation, terror, and loss, but often at the core is being treated as less than human, as an object, a tool, a possession, as trash. At heart, trauma is devoid of human presence. This experience erodes or eradicates the victim's sense of their own humanity. After all, if the victim is not treated as a sentient being, then

they are cast out of membership in humanity, emptied of their rights as human beings. Some victims of trauma may not have this experience, while others keep this level of experience buried inside. However, at some point in the treatment, a client may express these thoughts and feelings about being not worthy as a human being, or having been cast out. It is at these moments the trauma therapist must be prepared to respond immediately and authentically not as a skilled professional but as a fellow human being. Responding this way at other times will have little effect as the client will simply interpret this as the therapist being nice.

How does one respond as a fellow human being? This is unique to each person, but it certainly does *not* include behaving in a manner of an intervention, or a technique. In my experience, it is about doing less, not more; not *doing* psychotherapy, but responding spontaneously, authentically, empathically, openly. In these moments, the client must feel welcomed, joined, valued. For some therapists, this may be communicated through posture, gesture. For others, eye contact. And for some, the softness of words. The therapist must be aware that the client is not prepared to smoothly accept these responses, given the depth to which they feel they have sunk. One client told me, "You don't understand; I am a dirty piece of gum squished on the cement, that people walk on every day without noticing. I cannot imagine why you would want to stop and look down at me and reach out your hand. All I can do is dirty you." The therapist must be prepared to be present to the client under these circumstances.

Successfully responding in these moments targets the hollowing effects of trauma, which cause clients to feel like they are an empty shell, a ghost. Untreated, the client progresses toward existential fatigue, demoralization, and hopelessness. Failing to show up in these crucial moments as a fellow human being will confirm, again, that the victim has been permanently exiled from humanity over a chasm too wide to cross. Encouraging the client to reach out to the therapist on the other side will not be sufficient; *the therapist must reach out across the chasm toward the client* (again, not commonly included in therapist training). As a result, successful moments consist of temporarily diminishing the hierarchical differences between therapist and client, who meet as equal human beings. Both sides must contribute to the bond, so the client does not fall back into the abyss.

Being Left Behind and Forgotten. The existential fatigue that emerges in the years post-trauma is greatly exacerbated by the peripheralization and lack of affiliation with the community and the society at large. Society generally exhibits short-term memory about traumatic events, in part to avoid reminders of society's contribution to the perpetration, as well as the emotional distress expressed by victims. As society forgets and moves on, the victims are psychologically left behind and feel more and more invisible, leading to greater social isolation. A pernicious bifurcation occurs, as the world moves along one path while victims move along another. The trauma-centered therapist must be aware of this bifurcation and be attuned to moments when the client expresses distress about it. In these

moments, the therapist has an opportunity to help repair this rift by understanding their role as a representative of society.

The fundamental reparative role of society in trauma is *acknowledgement*. The basis of all monuments, museums, holidays, ceremonies, statues, and anniversaries is to acknowledge and to remember. Often these are concrete, physical representations of the victim's pain and suffering, courage and sacrifice, and a declaration of "never again!" through which society acknowledges its responsibility to prevent a repetition of the perpetration. In the shadow of every monument lies an acknowledgement of society's failure to protect its citizens. Public concretization of memory transforms trauma into a *collective* experience, and thereby significantly reduces the marginalization and isolation experienced by many victims. Sharing the burden of the trauma has a profound impact on trauma victims.

The trauma-centered psychotherapist should be prepared to respond to these moments when the client expresses their alienation from the larger society, at the family, institutional, and larger societal levels. A proper response usually involves a concrete action that represents memorialization and direct acknowledgement of the client's personal traumatic experience, in the presence of the therapist but preferably other people, and preferably outside the office context. The elements of such responses include: 1) a semi-public environment, 2) a crafted ceremony that honors the client's experience, 3) a role for the audience in responding, validating, and acknowledging responsibility for the trauma, and 4) a physical, concrete representation that remains visible as a permanent mark or sign of the traumatic experience. Often these ceremonies are conducted with only one client, but they can also be conducted with a number of similarly traumatized clients, as in a group therapy context, which enhances their impact (Lubin & Johnson, 1998). These ceremonies allow the victim's narrative to be publicly shared, their psychic pain to be validated by the witnesses present, and new pathways to be imagined for the victim to re-enter society. In doing so, a template is provided for both clients and society to repair the wounds of perpetration. Again, nothing can undo the disjunction between victim and society at the moment of trauma, but now during the treatment, the experience of isolation and disconnection can be transformed into a collective net that catches the victims when they fall (Johnson & Lubin, 2015, pp. 240-241).

Gratitude in the Later Phase of Treatment

In the later phase of the treatment, the client often expresses their *gratitude* to the therapist. The expression of gratitude denotes the client's deeper understanding of their personal growth and healing and - even more importantly - their own humanity. This state of gratitude arises when the client can experience the relationship with the therapist without the fear of harm. The client is now capable of experiencing a healthy mirroring and mutuality in the relationship with the therapist, who has shifted to a side-to-side position

in relation to their traumatic experience. The emergence of gratitude in the therapeutic relationship should not be considered by the therapist as a reflection of their good work, that is, should not be taken as a compliment, but rather as another therapeutic opportunity for repair, requiring a specific response. Missing this opportunity will limit the full benefit of treatment. More importantly, the client's expression of gratitude should not be interpreted as marking the end of treatment, but rather beginning a new phase where the client applies their learning to relationships with family, friends, and co-workers.

In essence, the traumatized client tends to conceive of intimacy as a transaction, even if benign: "you the therapist have helped me greatly, and now I want to thank you. That is: you give something to me, and now I will give something to you." But in healthy intimacy, this state of gratitude and good feeling is *shared*, its affect moves across the boundaries of self and other, lying somewhere in between; *not you and me, but we*. This state of flow or mutuality is deeply reassuring and fulfilling to human beings throughout our development. Thus, in the moment when the client expresses gratitude, the therapist has a powerful chance to heal the client's separation from others.

Client: I want to thank you so much for all you have done for me….You saved my life. I was so hopeless before and terrified of living, and now you have lifted me out of all that.
Therapist: We make a good team. The awesome progress you have made is something that we did together.
Client: (Smiles broadly.)
Therapist: (Smiles also.) Can you allow this to be *our* success?
Client: (Nods.) I haven't felt like this in a very long time.

The therapist's response reflects back to the client that they view their accomplishment as a mutual one. Note the therapist does not simply push the credit for the accomplishment back onto the client, as "no, this was *your* accomplishment, I just helped you through the steps," which unintentionally denies the state of mutuality. The therapist's response should aim to point out to the client what it feels like to be *with* someone, as two human beings. The expression of gratitude by the client should not be framed as a heroic accomplishment of one person overcoming life's obstacles, alone. Triumph over trauma is not heroic, it is communal. It is not the elimination of symptoms but the transcendence of existential death via the re-establishment of a human bond with another. Proper handling of gratitude in the treatment relationship will empower the client in their relationships with their loved ones, and marks the beginning of the final phase of trauma-centered psychotherapy.

Summary

Comprehensive trauma treatment involves more than symptom reduction and learning of emotional regulation skills. Repairing the relational and existential wounds that result from acts of perpetration takes more time and relies on the impact of the therapeutic relationship. I often share with clients the knowledge that though the moment of the trauma is experienced alone, recovery must occur in a social context. The former characterizes the nature of the traumatic moment, and the latter is a prerequisite for healing post-trauma.

The essence of this article is that the transition from the darkness of trauma back into the light of the living occurs through meaningful relationships, where vulnerability is experienced without harm. Given this monumental task, the client-therapist relationship is central to healing and the reduction of suffering. Our shared humanity is universal, not personal, therefore is available at any moment, from anyone, and can be exchanged with a smile, a kind word, a presence. Importantly, these intimate moments can be accomplished without the therapist's self-disclosure or blurring of roles. Trauma-centered treatment is built on a relationship between two human beings, in which the client is the beneficiary, and the therapist is the guardian of its integrity. *My belief is that the therapeutic relationship does not stand to the side of the treatment, but is a critical intervention within the treatment in its own right.* The therapist's understanding of how the traumatic experience wounded the client's capacity for relationship in its multi-faceted ways helps provide a discrepant experience that repairs the capacity for intimacy with others post-trauma. In the critical moments described above, both client and therapist interact as full and authentic human beings, not as the symptomatic patient and knowledgeable therapist. Success depends on the therapist's understanding of human presence, empathy, and authenticity and their skill in employing these qualities in the present moment. The result will be a client who has extracted themselves from the unhealthy bond with their perpetrator, freeing them to pursue healthy relationships with others, being a true measure of healing.

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Treating Traumatized Clients with Narcissistic Personality Disorder[1]

Hadar Lubin

This paper will review the specific methods required in managing PTSD with clients who also suffer from Narcissistic Personality Disorder (NPD). It is important to recognize that the client who meets criteria for both PTSD and NPD will present to treatment with two independent wounds, i.e. that caused by the traumatic event, and the alterations in their character caused by the conditions in their childhood that led to NPD. If the personality dynamics are not managed effectively, the therapy will be significantly hindered and most likely derailed. The trauma-centered therapist's standard approach to the trauma inquiry may challenge the assumptions underlying the NPD client's identity, and will be immediately rejected in a flurry of direct or indirect attacks on the competence, integrity, or intelligence of the therapist.

In contrast, those clients whose trauma schemas utilize narcissistic features, but who do not suffer from NPD, will respond to the standard inquiry in much the same way as other clients. They will not block the trauma inquiry and will express interest in the links between their behavior and the traumatic event.

After the trauma frame has been set, the clinician must evaluate if the clinical presentation of the client is consistent with the diagnosis of NPD or is rather a reflection of narcissistic defenses arising from the client's trauma schemas. The former requires sensitivity to the narcissistic wounds to avoid allowing them to derail the treatment. The latter requires an immediate focus on the connection between the details of the trauma and the narcissistic defenses that developed subsequently to the traumatic event.

Therefore, the trauma-centered psychotherapist's first task is to make a differential diagnosis between NPD, and PTSD with narcissistic features. Though clients with NPD and those with narcissistic features in their trauma schema may present initially in a similar manner, the therapist will need to be able to differentiate these clients quickly, as the therapeutic approach to each type of client is fundamentally different. Like other pervasive conditions such as borderline personality disorder and dissociative identity disorder, NPD forms the core structure of the client's personality/identity and will provide no self-reflective position from which to develop awareness of the distortions in perception arising from the trauma schema. Narcissistic features of a trauma schema, on the other hand, are malleable and functional, and will loosen when linked to their cause in the traumatic event.

[1] Published November 11, 2025

Narcissistic Features of Trauma Schemas

Clients who present to treatment with narcissistic features without NPD use these protective strategies to avoid the pain associated with the trauma. These traumatic narratives often involve direct attacks on the person's ego in the form of verbal and emotional abuse that are experienced with intense shame and humiliation. The shame schemas that are formed as a result of the abuse are activated by criticism in interpersonal settings, which then trigger compensatory responses characterized by inflated and self-referential claims of ability or identity. In essence these responses are ways to erase or deflect the experiences of worthlessness and rejection.

As soon as these defenses are linked to the trauma, the client will shell them off, clearing the path for the therapy to proceed. The direct link to the traumatic narrative introduces a boundary between the perpetrator and the victim, allowing the actions of the perpetrator to be held accountable.

The narcissistic defenses are usually expressions of the actions of the perpetrator, (verbal and emotional abuse; active neglect by caregiver), and to the self-attributions formulated by the abused child. The traumatic narrative will provide the necessary information for the therapist to make the links between the abuse and the specific narcissistic defenses. As soon as these connections are made and shared with the client, the defenses loosen up and room is made to replace them with adaptive ones. Clients will often express that they feel a lightening of a burden in their mind or their heart. These responses can be clues for the therapist that indeed these are defenses rather than a personality disorder.

The client is now ready to learn how to build up their self-esteem by seeking people who truly see their worth, eliminating the need for the narcissistic defenses. The therapist can engage the client's endowed abilities to aid in the trauma work, but it is not necessary to declare them as assets in order to support the client's ego, as is needed with clients with NPD.

Clinical Example

Jean is a 60-year old single woman who held a prestigious position in an Ivy League university. She had multiple graduate degrees with an impressive resume. Throughout her childhood, she was put down by her very successful father, who was a full professor in another Ivy League institution. He told her numerous times that she will amount to nothing despite her intelligence and capabilities. She spent the bulk of her adult life studying hard, and earning various degrees. Nonetheless she never secured a job that reflected her academic success. She presented to treatment when her prestigious job was threatened due to her anxiety and complaints of not being appreciated.

Joan	I cannot believe I am treated as if I have never been to school. I have several degrees and I have to beg for office and administrative support. I cannot perform my job this way and I don't appreciate being undervalued by everybody.
Therapist	Your resume is indeed impressive, so what do you think leads people to treat you as if you have no value?
Joan	I think they are jealous about my accomplishments and try to sabotage my success.
Therapist	I wonder if their behavior reminds you of your father, who put you down and sabotaged your self-confidence?
Joan	My father has been dead for eight years but he is still inside my mind (tearful).
Therapist	Yes, he really hurt you and caused you harm. Was he like this with your siblings?
Joan	No. I was the only one who pursued a higher education like him, but he did not like that I was able to engage in debates with him. He liked to be the 'knowledgeable one.'
Therapist	Instead of being proud, he competed with you and harmed you.
Joan	(Tearful.) It really resonates with my experience. Maybe I see things around me from this point of view?
Therapist	We call it a trauma schema. When you try to get people's approval, you expect them to put you down, so you developed defenses that make you feel better in the face of an impending criticism. When you make statements about your competence, it makes people less eager to help.
Joan	Wow, I definitely do that. I think I need to change course; it makes me feel bad. It's just how my father acted, and I hate that!
Therapist	Let's work on knowing the difference between the two.

In this example the client presented with her narcissistic defenses poised to protect her as the therapist engaged in the trauma inquiry. As soon as the link between her traumatic experience and her current struggle at work was established, she was ready to dismantle these defenses. She was forthcoming about her contribution to the problems at work, reflecting the relief she experienced as her knowledge about the trauma's effects deepened. She was also quick to voice her dislike of acting in a similar manner as her father. The therapist can be confident that she can be recruited to do the necessary therapeutic work.

Narcissistic Personality Disorder

Clients with NPD were likely to have been treated as an extension of a self-involved parent who used their identification with their child to ward off an inner sense of unworthiness and abandonment (Johnson, 1987; Weinberg & Ronningstam, 2022). The child becomes the center of their adoration and love, but not based on natural attributes the child possesses, but rather in the service of propping up the parent's self-esteem. The child's identity becomes fused with the inflated aspirations of the parent, but always vulnerable to moments of severe rejection and disappointment if one fails to live up to the parent's expectations. Later on in life, when others do not treat the person in the same manner, they experience a shattering of this false self, what is called the *narcissistic wound*, which brings on intense states of rage, hurt, and judgmental behavior towards others.

Due to the impact of this dynamic on the development of the child's personality, the NPD client's response set to the trauma inquiry will be rigid and uncompromising, often unleashing a torrent of demeaning, entitled, and self-promoting attacks on the therapist. The client cannot see their parent as a perpetrator precisely because of their fused identification with them, in addition to the fear that if they differentiated, the parent will collapse. Knowing how to manage this fragile state is paramount to the success of the therapy.

The trauma-centered clinician is not expected to mend the original narcissistic wound but to successfully perform a detailed trauma inquiry without evoking the original narcissistic injury. The therapist has to be careful to not let the narcissistic wound derail the treatment. Therefore, in pursuit of protecting the viability of trauma-centered psychotherapy, as the traumatic details are explored, the clinician must find a way to support the narcissistic defenses without replaying the relational arrangement that led to the development of NPD in the first place.

If the therapist does not support the client's fragile ego while they are remembering their past, the client's vulnerability will crest, leading to attacks on the therapist's competence and value. Any attempt to link this response to the trauma will be ineffective, as the narcissistic wound is too intense and pervasive. The client will experience this interpretation as a complete rejection of them as a person.

This minefield of wounding will remain present throughout the therapy. Therefore, the therapist must help create a *protective ego shield* for the client early in the therapy in order to manage these moments successfully. The therapist accomplishes this by actively supporting the positive attributes that the client possesses, in the service of bolstering the ego's stability during the evocation of fear and shame while exploring their trauma.

Over time, with consistent repetition of this approach, clients begin to trust that the positive feedback from the therapist is offered with no strings attached and with an authentic sense of empathy toward their suffering. The positive attributes of the client should not be exaggerated, rather used to remind the client that they can trust them while

navigating through the vulnerable moments of therapy and life. The therapist aims to establish the independence of their strengths from the management of the parent-child relationship.

The therapist will know when the narcissistic wound is no longer a threat to the therapy when the client does not employ these defenses when the therapist comments on the effects of the trauma on their psyche. At this point, the therapist will be able to address, gingerly, their trauma schemas and offer ways to revise them.

Clinical Example

Joe is a 42-year old man who has been married for five years. The couple had a child three years ago, which made his wife less available for him, which he resented. He was sexually abused by a priest when he was nine years old for four years. His stated reason to begin therapy was the tension between him and his wife, and not feeling love for his child.

Joe	I don't want to talk about my abuse. I put it behind me. I am here to address my relationship with my wife.
Therapist	I understand but I would like to hear more about the abuse as it may help me understand your struggle with your wife.
Joe	I don't see any connection, and can't imagine you will discover any relevance to it. I know a lot about trauma from reading, and it is definitely not relevant.
Therapist	It sounds like you like to read a lot.
Joe	I like to be informed and master the topic.
Therapist	That sounds like something that really helped you in your life. I know how well you did at graduate school and in your business.
Joe	I don't like not understanding what is going on with my wife. I thought she loved me. In the beginning, she was excited to spend time together. She broke her promise.
Therapist	Did anyone in your life break a promise that hurt you?
Joe	Interesting question….I suppose the priest did. He promised to guide me spiritually, you know, get involved with the church. I used to love going there.
Therapist	How did he break his promise?
Joe	He spent a lot of time with me, reading the scripture, and talking about it but then he stopped.
Therapist	Stop talking to you?
Joe	No. He stopped paying attention to me when other boys joined. I thought I was special to him. He actually told me I was.

Therapist	When the abuse began, did he tell you that you were special to be with him?
Joe	(Upset.) Yes, I felt horrible when he started touching me and rubbing my buttocks, but I liked being special. When I grew a little older, he began to avoid me and spent more time with the new younger boys. I felt so rejected and discarded.
Therapist	What he did was wrong and hurtful. He abused you and then let you down. I wonder if the birth of your child, and your wife's extra attention to him and away from you, reminded you of the way the priest abandoned you.
Joe	(Tearful.) Oh my god, I never thought about it. It makes sense.
Therapist	With your very curious mind, I think we can explore more connections to this time in your life.
Joe	Yes. I need to think about this more.

This example illustrates how this client initially refused to speak about the trauma and communicated strongly that the therapist does not have anything to offer, due to his high level of knowledge about trauma. At this point, inquiring about details of the trauma would have failed, as the client would checkmate the therapist's implication that their knowledge was superior to the client's. The therapist understood that the narcissistic injury will stymie the therapy. Instead, the therapist picked up on the client's pride in his intellectual capacities. By bypassing this obstacle through supporting the client's protective shield, the therapist was able to make one, specific connection to the trauma, identify the trauma schema, and recruit him to explore its implications. It is important to note that the trauma-centered therapist should not explore the original relationship with the parent that led to the creation of the client's narcissism. Rather, the therapist should keep their focus on the ways to address the trauma while successfully avoiding the sinkhole of the narcissistic wound.

Later in the therapy, as clients feel more secure that the therapist is not there to harm them or put all the blame on their parent, the therapist may have the opportunity to gently address the original narcissistic wounds in the service of mending the fragile ego. Gradually, real qualities of the client's self - both real talents and imperfections – can be acknowledged. Having more adaptive defenses at their disposal, clients can build an inner strength that is reliable and rewarding. The increased flexibility and self-reflection may present as increased use of humor, self-effacing observations, and authentic pride in the natural attributes they do possess.

Pitfalls. The therapist should be careful in engaging with the grandiosity of the client, always being discerning in naming the natural attributes the client is endowed with. Overinflating these attributes will make the client with NPD fearful of not meeting these expectations, and re-experiencing the shame and emotional abandonment of the original narcissistic relationship with the parent.

The therapist has to be flexible and change course when the client starts attacking their competence. It is a signal that the narcissistic injury is in the way of the trauma work. The therapist must bolster the client's fragile ego first, in order to allow the detailed inquiry to take place. In dealing with clients with NPD, the therapist must communicate to the client that they will not challenge their worldview, and will reliably support their protective ego shield. By doing so, the therapist provides the best chance to help the client mourn their losses from their trauma, which in turn will gradually mend some of the pain inflicted by the original narcissistic injury from childhood. The therapist, like the parent, supports the ego of the client, but unlike the parent, does not need them to support their own ego.

Conclusion

Conducting trauma-centered psychotherapy with clients who are diagnosed with NPD and who also suffered trauma requires extra attention to the multiple wounds that are at play. If the narcissistic wounds are not managed well, the successful exploration of the traumatic narrative and release from the distortions of the trauma schemas will not be possible. Knowing the difference between NPD and narcissistic features of trauma schemas will be crucial for keeping the client and the therapy on track.

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Editorial

Screening for Psychological Trauma Should Be Mandatory in Every Medical and Psychiatric Setting[1]

David Read Johnson and Hadar Lubin

This article will present the argument that a screening for psychological trauma must be included in intake assessments in every psychiatric and medical setting, including inpatient, emergency, and outpatient settings, and should be considered mandatory, not unlike the standard for conducting a suicide/homicide assessment. We join a near unanimous consensus among experts in traumatic stress that screenings are essential.

We will summarize the substantial evidence for 1) the critical role of psychological trauma in the development and/or exacerbation of both psychiatric and medical symptoms, 2) the relevance of co-morbidity as an indicator of psychological trauma, 3) the implications for accurate diagnosis and treatment, and 4) the frequent misdiagnosis and mistreatment of patients that result from not considering the impact of psychological trauma.

We will address the role of avoidance and time-efficiency as bases for not implementing this policy. We will also acknowledge the need for a continuum of assessment measures that are tailored to specific settings, and will suggest relevant versions of these instruments.

Our rationale proposes that accurate diagnosis supports effective treatment, leading to optimal outcomes for our patients. Without an assessment for psychological trauma, much time, energy and money are lost in treatments that are often unsuccessful.

The Important Role of Psychological Trauma in Illness

Psychological trauma is one of the major contributing factors to psychiatric and medical illness (Friedman & Schnurr, 1995; Green & Kimmerling, 2004; Resnick, Acierno, & Kilpatrick, 1997; Schnurr & Green, 2004). Like high blood pressure, traumatic stress is a silent killer. Trauma has direct, primary effects, such as PTSD, DID, and other anxiety disorders, but also indirectly leads to a wide range of symptoms and syndromes, such as substance abuse, depression, personality disorders, and stress-mediated medical conditions. Further, patients' maladaptive attempts to manage their levels of stress through smoking, overeating, lack of exercise, and use of substances, can over time lead to or exacerbate very serious medical conditions. In these ways, psychological trauma plays a

[1] Published December 29, 2025.

role in conditions as widely varied as ADHD and ODD, eating disorders, GI distress, migraines, lung cancer, and psychosis (Felitti et al, 1998; Kessler et al, 1995).

Due to its wide-ranging impacts, psychological trauma must be assessed as part of any psychiatric or medical evaluation, prior to determining a diagnosis or treatment plan.

Co-Morbidity

Psychiatric and medical disorders have a high degree of co-morbidity, in some cases extremely high levels (Kessler et al., 1995). If these conditions were independent of one another, caused by specific physical diseases, this level of co-morbidity would not be present. Presumably, many of these conditions co-occur because they have a shared underlying cause. There is a strong consensus that one of these underlying factors is psychological trauma, which causes a state of extreme stress, which in turn leads to a wide range of symptomatic expression. Consider these data:

Percent of Patients with These Conditions who Report a History of Trauma: (Kessler et al., 1995)

Anxiety Disorders	85-90%
Depressive Disorders	45-75%
Eating Disorders	50-75%
Substance Abuse Disorders	75-95%
Dissociative Disorders	100%
Borderline Personality Disorder	80-90%
Somatoform Disorders	50-60%
Obesity	36-45%

Both the National Co-Morbidity Study (Kessler et al., 1995) and the ACES study (Felitti et al., 1998) demonstrated that a history of psychological trauma was strongly associated with negative health outcomes, including, for high ACE scores, a 20-year reduction in life expectancy. These effects were dose-related, meaning the greater frequency and severity of traumatic exposure determined the likelihood of developing a wide range of medical and psychiatric illnesses (Schnurr & Jankowski, 1999; Walker, Newman, & Koss, 2004).

Proposed Pathways to Symptom Expression

The process through which psychological trauma operates begins with its immediate and direct effects, which then spread into secondary problems, which when managed in unhealthy ways, lead over time to serious health consequences that may not appear to have any relationship to the original trauma (Johnson & Lubin, 2015). As a

result, providers are often unaware of significant traumatic events in the lives of their patients that bear directly on their symptomatic presentations.

Primary Effects

Trauma, abuse, neglect, and maltreatment have direct effects, which include anxiety, hyperarousal, depression, fatigue, flashbacks, muscle tension, risk-taking behaviors, sleep problems, and dissociation (APA, 2022).

Secondary Effects

The primary effects gradually expand to include hypertension, joint pain, headaches, accidents, GI distress, skin problems, and mood fluctuations, as a result of the high levels of sustained stress within the body and mind (Selye, 1956; Schnurr & Green, 2004; Schnurr & Jankowski, 1999).

Maladaptive Behaviors

People attempt to diminish or manage these primary and secondary effects through maladaptive behaviors, which include smoking, drinking alcohol, taking drugs, eating unhealthily, and reducing exercise. The maladaptive behaviors are used to calm down, solace, or distract the person from the increasing levels of discomfort. A key feature is that the person's attention shifts from the memories of the traumatic event onto the bothersome symptoms of headaches, sleeplessness, anxiety or panic, or depression.

Tertiary Effects

These behaviors, over time, lead to many acute and chronic symptoms and syndromes that come to the attention of medical providers. These conditions include obesity, migraines, respiratory problems and cancer, liver disease, high cholesterol, heart disease, stroke, and metabolic disorders (Felitti et al., 1998; Kessler et al., 1995). These pathways explain why psychological trauma can be so strongly linked with major medical illnesses, as was demonstrated in the ACES study (Felitti et al., 1998). For example, even though lung cancer is caused by smoking, the smoking was initiated and maintained in order to manage the stress experienced from prior traumas. In a similar manner, overeating can lead to obesity, alcohol and drug use, then to GI, liver, and kidney malfunction, and result in hypertension, diabetes, heart and stroke risks.

In addition, maladaptive social behaviors such as withdrawal and isolation, aggression, entitlement, and rigid routines can lead to negative life events such as divorce, job demotion or terminations, and loss of social networks, which then compound stress. Over time, the combination of physical problems with social problems inevitably leads toward existential fatigue, hopelessness, and permanent disability.

Insufficient Data

There is currently a rapidly growing and consistent body of knowledge and data confirming the importance of psychological trauma in human health. This crucial relationship will be better consolidated within professional circles as more data is collected. One of the most important sources of data will come from regular screening for trauma: the absence of regular screening for trauma prevents health care professionals from becoming aware of the pervasive impact of trauma (Green, Epstein, Krupnick, & Rowland, 1997). Up to the 1980s, the conviction that combat had no particular impact on the psychological disorders of veterans was supported by the practice of not asking veteran patients if they served in combat. Once this question was consistently asked, the data in support of PTSD among combat veterans came rapidly, leading to more accurate diagnoses (e.g., PTSD vs. schizophrenia) and better treatments (e.g., SSRIs vs. anti-psychotics).

Age of Injury

There is a consensus that trauma, abuse and maltreatment that take place during childhood have more significant impacts on the development of self, personality, and capacity to function, than traumatic events that occur later in life (with some exceptions) (Courtois & Ford, 2013). Within childhood trauma, the intensity and duration of trauma, whether the perpetrator of the trauma was an intimate familial/parental person, and whether there was a person present who buffered the experience by providing support and validation, are also key factors in determining the extent of later life dysfunction. This knowledge highlights the importance both of assessing the presence/absence of trauma among children, and assessing childhood traumas among adults (and not merely focusing on recent events).

Why Screen for Trauma?

Assessing Psychological Trauma Improves Diagnostic Accuracy

Many symptoms may be the direct result of trauma, and without knowledge of the presence of trauma, the diagnostician can make errors. For example, psychotic symptoms may be flashbacks rather than hallucinations. Anxiety and depressive symptoms may be symptoms of PTSD rather than anxiety or depressive disorders. Manic symptoms may instead be hyperarousal symptoms. In children, lack of concentration can be misdiagnosed as ADHD, anger and defensiveness may be misdiagnosed as ODD, hyperarousal and risk-taking can be misdiagnosed as Impulse or Conduct Disorders. Complaints about body pain, breathing or heart problems, GI distress, or headaches may be misdiagnosed as medical rather than stress-related conditions. Substance abuse and addictive disorders may be the results of domestic violence, sex trafficking, or other abuses.

Assuming that accurate diagnosis is a critical component of modern medical practice, the pervasive role of psychological trauma in symptom development, alone, is sufficient reason to require an assessment of trauma at intake.

Proper Diagnosis May Prevent Unnecessary and Ineffective Treatments

Most treatments are based on the diagnosis. Not having an accurate diagnosis may then lead to unnecessary and ineffective treatments. Not considering psychological trauma in the diagnostic picture often leads to the following impacts on treatment:

1. Standard treatment regimens prove ineffective, either due to inaccurate diagnosis or inadequate doses of medication.
2. The patient is gradually prescribed multiple medications for the same condition.
3. The patient undergoes multiple interventions that prove ineffective or even exacerbate their symptoms.
4. The patient presents with an ever-transforming set of symptoms, reflecting an intermittent rather than consistent pattern.
5. Medications prescribed work only for a while and then "stop working," leading to the prescribing of another medication.
6. Providers, out of a desire to help, continue to offer alternative treatment options despite having little confidence in their efficacy, leading to increasing frustration with the patient, and ultimately skepticism about their complaints, which is nevertheless not shared openly with them.

Ruling Out Trauma is Essential in Psychiatric Research

One of the main challenges in psychiatric research into new medications is to prove that the impact of the medication is stronger than placebo. Many studies of psychiatric medications have demonstrated weak efficacy (Thase, 2006). We believe that one of the reasons for this is not ruling out a history of psychological trauma among the research subjects. In a survey of depressive symptoms at a VA medical center where we worked, patients on the PTSD unit scored significantly higher on measures of depressive symptoms than patients on the Depression Unit! Thus, ruling out a history of trauma will produce a purer sample of subjects who have the actual targeted medical condition, leading to a better chance to prove the efficacy of the medication. Ruling out trauma among research subjects will be prudent in any study of medication for conditions other than PTSD.

Why Do Providers Not Screen for Trauma?

Tradition

Years of not including a trauma screening has itself caused resistance to change among health care practitioners.

Avoidance

Asking patients about traumatic, abusive, and neglectful experiences is uncomfortable, and most practitioners will need practice to become comfortable with it. In the end, only a mandate from legal authorities will have sufficient power to achieve compliance. The same reluctance occurred in the 1960s when the assessment for suicide and homicidal ideation was introduced into practice. Until then, many practitioners believed that simply asking these questions might provoke patients to attempt suicide. Ultimately the benefits of inquiring became clear, as will the benefits of assessing for trauma. Asking a few questions about trauma may be uncomfortable, but no more so than many dental, medical, and surgical interventions that patients must endure. *Discomfort is not a justification for not receiving proper and effective treatments.*

Time. Adding questions regarding traumatic experiences to any assessment will add time to the intake process, not only because of the additional questions, but because of the time required to listen to the answers. Providers will naturally feel the need to respect the patient's need to be heard. Self-report measures streamline this process to a degree.

Suggested Screening Tools

Principles

Each assessment should be tailored to the needs of the specific setting, and include only that information that is *actionable*: meaning that the information derived from the screening can be used in making decisions relevant to the setting regarding diagnosis, treatment, and discharge planning and referral. In assessments for psychotherapy, these measures can be administered through an interview, as all the information will be relevant to the task of psychotherapy. In emergency room or medical settings, where the focus is on rapid diagnosis and treatment over a short-term, with referral back to other providers, the assessment can be made through self-report questionnaires and be more limited in scope.

Though in this article we recommend a number of screening tools that have been used in clinical and research settings, providers may decide to edit or select parts of these instruments that fit their needs more precisely. Though there is a benefit to using established measures, it is more important that providers use tools that are useful in daily practice with their patients. The essential task of the medical or psychiatric professional is to get an answer to the following question, presented in whatever form is preferred: *"Traumatic events can cause or exacerbate many medical and psychological symptoms, so it is important for me to know if you have ever experienced an event that was traumatic, abusive, neglectful, or very harmful?"*

For most settings outside that of psychotherapy, where the actionable tasks will typically not involve an exploration of the patient's traumatic experiences, merely becoming aware of the presence of trauma will be especially helpful to the clinician in

determining the relationship between the patient's traumatic stress and their presenting symptoms. In addition, knowing about the presence of trauma will cue the provider to:

1. Maintain an open mind about the diagnosis.
2. Anticipate that the patient may not respond to standard treatments in the expected ways.
3. Consider switching medications or changing the dose, rather than adding on new medications.
4. Hesitate before suggesting too many treatments.
5. If treatments are not working well, consider inquiring more about the relationship between their past traumatic experiences and their current levels of stress.
6. Consider referral for trauma treatment.

In the following discussion, five types of assessment will be used, from most to least complex:

A. Structured Clinical Interview. A lengthy, detailed inquiry of the patient about whether or not they have experienced specific forms of trauma, abuse, neglect, or maltreatment, followed up by even more specific questions about the details (e.g., age, duration, severity, identity of perpetrators). This interview is clearly appropriate in explicitly trauma-focused clinics or practices.

For Adults: PTSC Clinical Interview for Assessment of Trauma History (Johnson & Lubin, 2015). This clinical interview consists of a general screening question, followed by inquiry into five main types of trauma (sudden loss; illness, injury, disaster or combat; physical abuse; emotional abuse; and sexual abuse). Details of each event are discussed.

For Children: Trauma Events Screening Inventory for Children (TESI-C) (Ford et al., 2002) consists of detailed questions about 17 traumatic events, with detailed follow-up questions, phrased appropriately for children.

B. Detailed Self-Report Questionnaire. A lengthy, detailed checklist of specific forms of trauma, abuse, neglect, and maltreatment, indicating whether they occurred, and whether they are bothering the patient at the current time. This form can be filled out in the waiting room or at home, and therefore does not require the presence of the provider.

Traumatic Life Events Questionnaire (Johnson & Lubin, 2015). This Self Report measure is a checklist of 70 events in 11 categories, marking both presence or absence, and whether the patient is bothered by them now.

C. Simplified Self-Report Questionnaire. A short checklist of the main categories of traumatic experiences which the patient can fill out in the waiting room or at home. This is appropriate in settings that do not require an in-depth exploration of trauma.

Adverse Childhood Experiences Questionnaire (ACEs), (Felitti et al., 1998). This is a 10-question screening tool that provides a score from 0 to 10, covering both traumatic and abusive events, as well as dysfunctional family environments. The overall score itself can be used to give the provider a quick sense of the degree to which the patient's trauma history is a factor.

Or:

Life Events Checklist for DSM-5 (LEC-5), (Weathers et al., 2013). A 17-item checklist of major traumatic events, covering most categories. This checklist is explicitly tied to the criteria of the DSM-5.

D. Brief Trauma Screen. A small number of screening questions, either on a form or asked by the clinician, which serve to establish whether traumatic experiences may be a factor in the presenting symptoms. If yes, then a follow-up inquiry can be conducted. The advantage of these forms is their efficiency.

For Adults: Brief Trauma Screening Tool (Johnson & Lubin, 2025). A brief screening tool with one question for presence, type of event, current bother, and link to current symptoms:

Brief Trauma Screen (Johnson/Lubin, 2025):

1. Have you ever had an experience that you consider traumatic, abusive, neglectful, or harmful? Yes____ No____
2. What type of event was it? _____
   _*sexual abuse or assault* _*natural disaster, terrorism*
   _*physical abuse or acts of violence* _*combat*
   _*emotional abuse or severe humiliation* _*sudden loss of loved one*
   _*witness to one of above* _*community violence*
3. To what extent are you bothered by memories of this event now?
   ____0 to 10. (0 = none; 5 = often; 10 all the time).
4. Do you think that this event might have anything to do with your current symptoms (either psychological or physical)?
   ____ 0 – 10. (0 = none; 5 = some; 10 = definitely).

For Children: Child Trauma Screen (CTS), (Lang & Connell, 2017). Brief screening tool with four questions on presence of physical and sexual abuse, and general events:

Child Trauma Screen

1. Have you ever seen people pushing, hitting, throwing things at each other, or stabbing, shooting, or trying to hurt each other? _Yes _No
2. Has someone ever really hurt you? Hit, punched, or kicked you really hard with hands, belts, or other objects, or tried to shoot or stab you?
   _Yes _No

3. Has someone ever touched you on the parts of your body that a bathing suit covers, in a way that made you uncomfortable? Or had you touch them in that way? __Yes __No
4. Has anything else very upsetting or scary happened to you (loved one died, separated from loved one, been left alone for a long time, not had enough food to eat, serious accident or illness, fire, dog bite, bullying)? What was it?_____

E. Follow-Up Clinical Inquiry. An interview by the clinician asking for specific details of the event(s) that are relevant to the actionable tasks of the setting. The clinician should focus on the information that they need in order to accomplish the actionable tasks of their meeting, such as diagnosis, treatment or referral:

Follow-Up Inquiry
(Details): Tell me some of the details about the event(s):
- Age occurred
- Frequency
- Severity
- Duration
- Identity of Perpetrator(s)
- Details of the Event

(Effects): Tell me about some of the effects you experienced as a result of this trauma?
- Psychological: anxiety, panic, depression, flashbacks, social withdrawal, hyperarousal, sleep problems, interpersonal conflicts
- Medical: body pain, heart palpitations, GI problems, hypertension, weight gain/loss, headaches
- Behavioral: smoking, drinking, drug use, over/under eating, taking risks

(Treatments) Tell me about your previous treatments?
1. Have you had treatment for PTSD or for the consequences of this event?
2. Have you had treatments for your condition that worked only for a little while, and then stopped working?
3. Were you ever put on more than three medications for the same condition?

Suggested Screening Tools by Setting

Type 1: Psychiatric Settings

Psychiatric settings can be divided into two main categories: those in which psychotherapy is involved, in which case the clinician must have a detailed understanding of the clients' traumatic experiences, and those that are short-term, assessment-based encounters such as emergency rooms and medication evaluations, where only the presence

and type of trauma may be needed. The trauma inquiry occurs in addition to the standard assessment of symptomatology.

A. Trauma Centers

Actionable Tasks: diagnosis, treatment, creating alliance

In these settings, the client is usually aware that the purpose of the visit concerns their traumatic experiences, and are expecting to be asked detailed questions about them.

Tools Recommended (see above list):

A. Structured Clinical Interview
B. Detailed Self-Report Questionnaire

B. General Psychiatric

1. Outpatient psychotherapy

Actionable Tasks: diagnosis, treatment planning, creating alliance, determining whether trauma is a focus of treatment

Tools Recommended:

C. Simplified Self-Report Questionnaire
E. Follow Up Inquiry

2. Inpatient short-term settings

Actionable Tasks: diagnosis, discharge planning, referral

Tools Recommended:

C. Simplified Self-Report Questionnaire
E. Follow Up Inquiry

3. Inpatient longer term (PHP, IOP)

Actionable Tasks: diagnosis, treatment planning, referral

Tools Recommended:

B. Simplified Self Report Questionnaire
E. Follow Up Inquiry

C. Psychiatric Medication Evaluation

Actionable Tasks: diagnosis, medication, referral

Tools Recommended:

C. Simplified Self-Report Questionnaire
E. Follow Up Inquiry

Type 2: Medical Settings

Medical settings can be divided into two main types: those where an ongoing relationship with the patient is established such as in Primary Care and Pediatrics, and often OBGYN, where the clinician should have a more than cursory understanding of the nature of their patient's traumatic experiences; and those of a short-term or targeted focus such as emergency rooms and specialists, where only the presence and type of trauma needs to be known. Though all medical settings may begin with a Brief Trauma Screen, the length and depth of the Follow-Up Inquiry can vary according to the actionable tasks of each setting.

A. Primary Care
Actionable Tasks: diagnosis, treatment planning, creating alliance
Tools Recommended:
D. Brief Trauma Screen
E. Follow Up Inquiry

B. Emergency Room
Actionable Tasks: diagnosis, immediate treatment, discharge planning and referral
Tools Recommended:
D. Brief Trauma Screen
E. Follow Up Inquiry

C. Specialist
1. OBGYN
Actionable Tasks: diagnosis, treatment, creating alliance
Tools Recommended:
D. Brief Trauma Screen
E. Follow Up Inquiry

2. Pediatrician
Actionable Tasks: diagnosis, child protection, treatment, alliance
Tools Recommended:
D. Brief Trauma Screen
E. Follow Up Inquiry

3. Other Specialties
Actionable Tasks: diagnosis, treatment
Tools Recommended:
D. Brief Trauma Screen
E. Follow Up Inquiry

Conclusion

Data collected and clinical experience over the past 40 years demonstrate the significant impact of psychological trauma in the development of and/or exacerbation of a wide range of both psychiatric and medical symptoms and illnesses. It is imperative that the patient's trauma history be included in determining their diagnoses, and then formulating their treatments.

> *Put directly, to conduct an assessment of someone's psychological or medical state, without knowing or inquiring about their traumatic experiences, should be considered a form of malpractice.*

Not only is a trauma assessment helpful in determining diagnosis and treatment plans, but the presence of prior trauma may be critical in understanding the patient's unanticipated response to treatments, including lack of response, temporary response, or negative response, often in a manner that is confusing to the provider.

Providers of psychotherapy who do not attend to their client's traumas may provoke the client to become more symptomatic as an attempt to communicate about their traumas to the clinician. For other providers, not being aware of the trauma history may prevent them from making an appropriate referral to trauma-based treatments and relevant providers.

Though the exact degree to which trauma may be involved in the etiology of mental and medical illness can be debated, there is no question that trauma *may be* a factor. Therefore, trauma (or toxic stress) can be understood as another *vital sign* that must be assessed at each clinical visit. We understand that this is a significant change in traditional practice, and that it involves both a measure of additional time and skill on the part of providers in an overworked health care system. But we believe that *there is no other choice* if the best interests of the patient are to be considered. In the long run, these additional measures will make the healthcare system more efficient and effective, and our patients better served.

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