

## Treatment of Complex Posttraumatic Self-Dysregulation

Julian D. Ford,<sup>1,6</sup> Christine A. Courtois,<sup>2</sup> Kathy Steele,<sup>3</sup> Onno van der Hart,<sup>4</sup>  
and Ellert R. S. Nijenhuis<sup>5</sup>

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The authors describe a three-phase sequential integrative model for the psychotherapy of complex posttraumatic self-dysregulation: Phase 1 (alliance formation and stabilization), Phase 2 (trauma processing), and Phase 3 (functional reintegration). The technical precautions designed to maximize safety, trauma processing, and reintegration regardless of the specific treatment approach are discussed. Existing and emerging treatment models that address posttraumatic dysregulation of consciousness, bodily functioning, emotion, and interpersonal attachments are also described. The authors conclude with suggestions for further clinical innovation and research evaluation of therapeutic models that can enhance the treatment of PTSD by addressing complex posttraumatic self-dysregulation.

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When psychological trauma disrupts formative developmental periods, survivors are at risk for persistent forms of self-dysregulation that have been described as disorders of extreme stress not otherwise specified (DESNOS; Van der Kolk, Roth, Pelkowitz, Mandel, & Spinazzola, this issue). Disorders of extreme stress not otherwise specified involve dysregulation in consciousness (e.g., pathological dissociation), emotion (e.g., alternating between rage and affective emptiness), behavioral self-management (e.g., dangerous impulsive risk taking), bodily functioning (e.g., somatoform disorders), self-perception (e.g., believing oneself to be permanently damaged), interpersonal functioning (e.g., alternating between enmeshment in and devaluation of primary re-

lationships), and sense of purpose in life (e.g., loss of sustaining spiritual beliefs). Complex posttraumatic self-dysregulation is difficult to treat and has been found to be predictive of poor prognosis in posttraumatic stress disorder (PTSD) treatment (Ford & Kidd, 1998). In this article, we describe a phase-oriented integrative model to guide the provision and evaluation of psychotherapy for complex posttraumatic self-dysregulation and discuss several manualized therapy interventions that have been designed to address the challenges posed by posttraumatic self-dysregulation. The phase-oriented model of PTSD treatment is based largely on clinical experience and has not been validated by scientific research. Our explication of the phase-oriented model is intended to aid clinicians and researchers in developing replicable protocols operationalizing the model and its phases to rigorously empirically test the model's efficacy, effectiveness, and utility.

### A Phase-Oriented Integrative Model for Treatment of Posttraumatic Self-Dysregulation

Pierre Janet is credited with first developing a three-phase approach to the treatment of dissociative sequelae of trauma (Van der Hart, Brown, & Van der Kolk, 1989). However, the contemporary development of therapies for

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<sup>1,6</sup>Department of Psychiatry, University of Connecticut Health Center, Farmington, Connecticut.

<sup>2</sup>Private Practice & The CENTER: Posttraumatic Disorders Program, Washington, DC.

<sup>3</sup>Metropolitan Psychotherapy Associates, Atlanta, Georgia.

<sup>4</sup>Department of Clinical Psychology, Utrecht University, Utrecht, The Netherlands.

<sup>5</sup>Cats-Polm Institute, Zeist, The Netherlands.

<sup>6</sup>To whom correspondence should be addressed at Department of Psychiatry, MC1410, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, Connecticut 06030; e-mail: Ford@Psychiatry.uhc.edu.

posttraumatic self-dysregulation did not begin in earnest until it became apparent in the late 1970s that sexual abuse, incest, and domestic violence were prevalent among girls and women (Herman, 1992)—a finding also applicable to men (Gartner, 2000). As clinical observation and research findings led to increasing recognition of the complexity of the clinical presentation and needs of childhood abuse survivors, and as the delayed or false memory controversy emerged, therapists began to develop trauma treatment models that proceeded in phases similar to those articulated by Janet (Briere, 2002; Brown, Schefflin & Hammond, 1998; Chu, 1998; Courtois, 1999; Herman, 1992; Van der Hart, Van der Kolk, & Boon, 1998).

The three phases involve (1) developing a working alliance, enhancing safety by stabilizing suicidality, impulsivity, and pathological dissociation, and acquiring or accessing core self-regulatory skills, adaptive beliefs and relationships that were lost or never attained in earlier development (Ford, Fisher, & Larson, 1997); (2) recalling trauma memories with a goal of achieving “mastery over memory” (Harvey, 1995)—a more inclusive, emotionally modulated, and organized autobiographical memory and a more mindful and self-determined orientation to present living and future planning; and (3) enhancing meaningful ongoing involvement in viable interpersonal, vocational, recreational, and spiritual relationships and pursuits. In practice, phase-oriented treatment often takes the form of a recursive spiral (Courtois, 1999). The issues addressed and biopsychosocial processes involved in each phase frequently are returned to in subsequent phases. For example, the shame, guilt, and disgust associated with a sense of being damaged or a terror of rejection, betrayal, and abandonment tend to emerge anew in each treatment phase even after apparently having been dealt with in earlier phases of treatment. Across all theoretical models of psychotherapy, phase-oriented trauma treatment involves enhancing the recognition (rather than avoidance) of posttraumatic self-dysregulation in tolerable ways and amounts in order to promote proactive self-regulation.

### ***Phase 1: Engagement, Safety, Stabilization***

Treatment first involves a primary emphasis on safety—real and perceived—along with skills building and psychoeducation within the broader context of a relational approach (Brown et al., 1998; Chu, 1998; Courtois, 1999; Herman, 1992). A critical challenge involves enabling the client to gain control of overwhelming affect, impulsive behavior, and self-destructive thoughts and behaviors by anticipating and replacing them with self-management strategies (Linehan, Tutek, Heard, &

Armstrong, 1994). Safety requires control of maladaptive behaviors such as self-harm, suicidality, unhealthy risk taking, substance abuse, eating disorders, and tolerating or inflicting relational aggression. Self-management involves safety planning to assist the client in assuming responsibility for collaborating with people in his or her support network and treatment system to prevent or manage crises and dangerous risk taking (Chu, 1998; Pearlman & Courtois, 2005).

Psychoeducation contributes to enhanced self-management by de-mystifying the treatment process (e.g., collaborative setting and revision of goals; informed consent; parameters of therapeutic boundaries) and explaining the biological, psychosocial, and traumatic aspects of symptoms and disorders. Education enables the client to begin to experience the therapist as consistently present and helpful, rather than as withholding, controlling, rejecting, mysterious, or dangerous. The client’s response to education also reveals strengths that can become a basis for overcoming helplessness without invalidating unmet dependency needs (Steele, Van der Hart, & Nijenhuis, 2001, 2004).

Phase 1 also involves developing an empathic, consistent, well-bounded working alliance that supports and guides the client throughout therapy, and serves as a model for “containing” (rather than avoiding or flooding) intense emotions and impulses. Developing a working alliance with dysregulated individuals often is difficult and time-consuming, with repeated testing of the therapist both directly (e.g., challenging the therapist’s expertise or therapeutic ground rules) and indirectly (e.g., behavioral reenactments or transference reactions; Pearlman & Courtois, this issue). Resolving long standing feelings of mistrust—which often are grounded in a legitimate sense of betrayal and violation in formative relationships that were traumatic or trauma-affected—requires reliability, clarity of therapeutic focus, and good boundaries on the therapist’s part. The most difficult barrier to a working alliance in many cases is that the client has had very few and highly erratic experiences in which she or he could learn how to safely “join” with a caregiver without becoming enmeshed and over-dependent, or detached and both rejecting and rejected. Most fundamentally, as amply illustrated by the clinical research literature on “disorganized attachment” (Ford, 2005), clients may not have experienced caregivers who consistently self-regulated their own emotions and bodily reactions, and who used their own self-regulation as a template that the client likely experienced as a prototype for her or his own self-regulation. Therefore, the client may approach the therapeutic relationship in an apparently “disorganized” manner—alternately demanding and withdrawing, pleading for and rejecting help, being

in crisis or being indifferent—that can be understood as an expression of an inability to regulate intense and often contradictory feelings and impulses in early attachment relationships.

Phase 1 work occurs on nonverbal as well as verbal levels. The therapist tracks the client's nonverbal behavioral and bodily communications (of which the client usually is unaware), and nonintrusively assists the client in recognizing and adaptively utilizing bodily (Ogden & Minton, 2000) and affective (Fosha, 2000) feelings and associated thoughts. Across therapeutic modalities and theoretical orientations, this subtle nonverbal “co-regulation” (Solomon & Siegel, 2003) is critical to the development of a working alliance (Pearlman & Courtois, 2005) and self-regulation.

Early in treatment, while the client is still uncertain about engaging emotionally in a relationship with the therapist and in the work of therapy, crises often emerge both in and between sessions. These may be understood in several ways: as transference trauma reenactments (e.g., the therapist's empathic yet bounded caregiving as a trigger for reexperiencing fears of abuse, betrayal, or abandonment), as a testing of the therapy frame (e.g., probing to determine if the therapist will react aggressively or neglectfully, or become enmeshed and intrusive), or as testing of the client's own capacity to tolerate change and increased awareness (e.g., checking to see if it is safe to feel and express extreme confusion, neediness, rage, or hopelessness). Basic self-care skills and the availability of safe and trauma-sensitive treatment for severe crises are critical resources for therapist and client in Phase 1 treatment (Courtois, 1999; Steele et al., 2001). Pharmacological evaluation (Friedman, Donnelly, & Mellman, 2003) by a psychiatrist familiar with PTSD can contribute to Phase 1 stabilization when provided within the context of alliance- and skills-building.

At this early stage of treatment, shifts in thinking, feeling, social interaction (including developing trust in the therapist), and bodily and environmental awareness may trigger intrusive traumatic memories. When this happens spontaneously, the therapeutic challenge is to assist the client in using self-regulation skills to contain the memories and related affects—thus assisting the client in managing intrusive reexperiencing and gaining “mastery” of his or her own memory (Harvey, 1996), not total control, but rather the ability to modulate and titrate ordinary remembering and posttraumatic reexperiencing. The client can learn that traumatic memories or affects are not necessarily toxic or overwhelming when modulated with self-regulation skills. The therapist also may comment on trauma-relevant themes (e.g., being or feeling trapped, helpless, blocked, stigmatized) when they are

evident in the client's spontaneous disclosures. This is not confrontational interpretation designed to raise the client's anxiety; rather, it is an empathic and educative statement clarifying and validating the often otherwise confusing and demoralizing thoughts, emotions, and states of mind associated with self-dysregulation. Thematic comments in this early phase do not encourage a deeper delving into the details of trauma memories, but instead assist the client in self-regulation and gradually tolerating self-awareness. Phase 1 treatment thus introduces the possibility of becoming able to safely tolerate trauma memories and symptoms.

### *Phase 2: Recalling Traumatic Memories*

The second phase of trauma therapy is more directly “trauma-focused,” actively involving the client in recalling traumatic memories as well as related body states, emotions, and perceptions in amounts and at a pace that is safe and manageable. Phase 2 applies Phase 1 self-regulatory skills to a focal therapeutic task: *self-regulation while consciously and voluntarily processing traumatic memories and resolving posttraumatic symptoms*. The therapist continues to attend to and set a model for safe and nonintrusive co-regulation, while helping the client to focus more directly on traumatic memories.

Phase 2 involves several controversial issues, including who determines the timing for beginning this phase, how traumatic memories are recalled therapeutically, and when and if therapy can or should focus directly on trauma memories. Clients should make an informed choice about moving into Phase 2 (Courtois, 1999; Van der Hart et al., 1998) based on dialogue with the therapist concerning the purpose of examining traumatic memories and symptoms. This dialogue can dispel fears and false hopes based on widespread misconceptions (e.g., that traumatic memories can or should be eradicated by abreaction) and help the client develop realistic personal goals for memory exploration (e.g., to be able to live a satisfying life while coping effectively with traumatic memories). Some approaches prescribe a shift into Phase 2 that is initiated by the therapist (Rothbaum, Meadows, Resick, & Foy, 2000). Others adopt an explicitly collaborative approach in which the therapist and client continuously evaluate the client's readiness and need for trauma processing in light of Phase 1 progress in self-regulation and the immediacy or urgency of spontaneous trauma memories (e.g., Briere, 2002; Chu, 1998; Courtois, 1999; Van der Hart et al., 1998).

The question of how to process traumatic memories therapeutically is complex in light of the rapidly shifting

evidence base concerning the neurobiology of trauma, cognition, memory, and emotion (Brown et al., 1998; Courtois, 1999; Ford, 2005; Solomon & Siegel, 2003). Treatment models that focus on fear as the core posttraumatic emotion rely upon repeated direct “exposure” to fear-evoking components of trauma memories to achieve habituation of fear responses (Rothbaum et al., 2000). Other models view fear as one of several key emotions that become linked to posttraumatic impairment through maladaptive, trauma-related beliefs. These models use traumatic memory recall more sparingly, with gradual increases in the intensity of emotional distress to focus on therapeutically challenging the fixed beliefs associated with traumatic memories (Briere, 2002; Resick, Nishith, Weaver, Astin, & Feuer, 2002). Models that view fragmentation of episodic memory as the core of posttraumatic impairment rely upon writing or telling the personal story as a means of gaining or regaining coherent narrative autobiographical memory (Courtois, 1999; Harvey, 1996; Van der Hart et al., 1998). These approaches are not necessarily incompatible; research on process and outcome in PTSD psychotherapy is too nascent to justify definitive evidence-based guidelines for therapeutic trauma memory work (Foa, Rothbaum, & Furr, 2003; Nishith, Resick, & Griffin, 2002). Therapists therefore must gauge and be prepared to flexibly revise their approach to assisting each client with trauma memory work based upon clinical assessment of the client’s self-regulation both during and between therapy sessions.

Most often, Phase 2 is viewed as proceeding until PTSD symptoms become manageable (Brown et al., 1998; Chu, 1998; Courtois, 1999; Herman, 1992; Rothbaum et al., 2000; Van der Hart et al., 1998). As traumatic memories are reconstructed, affectively charged states of body and mind are not just expressed (abreaction), but consciously identified and reflectively processed. For example, traumatic grief often emerges due to awareness of profound loss (e.g., of childhood, of innocence, of trust, of relationships, of academic or other forms of achievement or success). Shame and rage may emerge if the survivor experienced disbelief, abandonment, betrayal, or punishment with abusive or neglecting caregivers or key support persons. Phase 2 work involves learning how to experience these intense affects and integrate them into conscious awareness, both in the here-and-now and in a progressively more complete narrative of one’s past, present, and future.

Phase 2 does not necessarily involve repeated recollection of traumatic memories, but may alternatively take the form of interventions that assist the client in recognizing the “imprint” of past trauma in current experiences and posttraumatic symptoms. Because intrusive memories oc-

cur in and dramatically alter the meaning of ongoing life experiences, a careful therapeutic examination of current stressful events can be the basis for teaching clients how to become aware of unwanted memories in tolerable doses—rather than simply trying unsuccessfully to avoid intrusive reexperiencing. The key to such a “present-centered” model of trauma processing is the provision of cognitive schemas and a practical vocabulary that enable clients to recognize the trauma imprint in current experiences while maintaining bodily and affective self-regulation.

### *Phase 3: Enhancing Daily Living*

For many trauma survivors, developing or regaining a “normal life” and connecting with others in “normal relationships” are daunting challenges. This may be due to specific skills deficits, but also may be the result of having to prematurely develop and apply social and cognitive skills to the survival of traumatic experiences and their aftermath—rather than being able to acquire and utilize these skills in the course of ordinary psychosocial development. Phase 3 can involve some of the most difficult work (Van der Hart et al., 1998), but can also be enormously satisfying for the therapist and client alike (Herman, 1992), as it is the culmination and application of the work of the previous two phases. In this phase, the quality and balance of the client’s life (i.e., work, play, rest, relationships) is the focus. Self-management skills taught in Phase 1 (Linehan et al., 1994) can be refined, strengthened, and more broadly applied in Phase 3.

Phase 3 frequently involves intensive work on a profound difficulty in knowing what to hope for or expect from life, and a fear of change (Steele et al., 2001, 2004). Self-dysregulation often becomes a “normal” state of body, mind, and living, and as such can serve as a baseline for defining what to expect and hope for in life. A “normal” life can be a double-edged sword, bringing with it heightened joy and excitement with each new gain and positive experience, and simultaneously, strong feelings of grief and anger concerning the loss and struggle that posttraumatic dysregulation has caused. As a result, any deviation from the familiar can be terrifying, leading to a monotonous and restricted lifestyle interspersed with periods of chaos. Regaining self-regulation can involve fear of *any* change (Steele et al., 2001, 2004; Van der Hart et al., 1998), whether internal or external. As one incest survivor described it: “When my father started having sex with me, *everything* changed. Change to me represents the most awful thing that could happen. Sex hurt, so change will hurt.”

Therefore, Phase 3 focuses on fine-tuning the self-regulatory skills developed in Phase 1 and the conscious

understanding of the impact of past traumatic experiences developed in Phase 2, applying these skills and understandings to address problems and derive satisfaction in daily life. The goal is for the client to acquire experiential evidence of safety and empowerment, and to thus gradually replace constricted or self-defeating beliefs, schema, and goals that have resulted in a constricted lifestyle with a more flexible, specific, and self-enhancing personal framework. Thus, a crucial agenda in Phase 3 is to gradually assist the client in reexamining the changes that she or he has been able to make in Phases 1 and 2, activities that involved safely expanding her or his range of awareness, emotion, beliefs, activities, and interpersonal relationships. This reevaluation should include thoroughgoing consideration of the actual (vs. anticipated) risks and costs of each change, as well as its benefits. It also should focus on the client's decisions, including choices to refrain from changing until ready (or to pull back from changes when frightened or overwhelmed), to underscore the client's sense of self-control. The goal is to enhance the client's capacity to simultaneously feel in control of her or his own perceptions, emotions, thoughts, goals, decisions, and actions, while recognizing and managing intense dysregulated feelings, impulses, and thoughts.

In Phase 3, the therapist continues to facilitate relational learning by modeling and providing guidance in repairing breaches in the patient–therapist relationship, such that the client experientially comes to understand that relationships can be preserved or can be regained when the therapist (or others) commits empathic errors (i.e., fails to mirror the client's needs or emotions, or fails to live up to the client's idealizations). This also involves developing ways of approaching relationships in a graduated manner using the coping and emotion processing skills learned in treatment to understand (Ford, 2005) and manage the posttraumatic distress associated with ordinary glitches and difficulties that arise within normal intimate relationships *in the present*.

### **Treatment Principles Throughout Phase-Oriented Treatment**

Across all phases of therapy, several technical precautions are generally recommended to maximize safety, trauma processing, and reintegration (Briere, 2002; Chu, 1998; Courtois, 1999; Harvey, 1995; Herman, 1992; Pearlman & Courtois, 2005; Steele et al., 2001, 2004; Van der Hart et al., 1998). These precautions hold true for psychotherapy in general, but require adaptation to address the specific issues involved in complex posttraumatic self-dysregulation.

First, *treatment must enhance the client's ability to manage extreme arousal states*. Effective treatment assists the client in self-monitoring arousal states, clarifying perceptions and thoughts, labeling emotions, and carrying through decisions that result in actions which prevent or manage the extremes of hyperarousal (e.g., panic, impulsive risk-taking, rage, structural dissociation) or hypoarousal (e.g., emotional numbing, relational detachment, exhaustion, paralysis, hopelessness) that are associated with complex traumatic stress disorders.

Second, *treatment should enhance the client's sense of personal control and self-efficacy*. Developmentally adverse interpersonal trauma fundamentally interferes with the acquisition of a sense of personal control and self-efficacy (Solomon & Siegel, 2003). In Phases 1 and 3, particular attention needs to be paid to assisting clients in simply recognizing ways that they are (or can be) personally and interpersonally effective and able to safely feel a sense of pride and confidence without being overwhelmed by negative emotions (e.g., fear, shame). In Phase 2, trauma processing and narrative reconstruction must be timed and structured to support the client's ability to not only tolerate trauma memories or symptoms but also to gain a sense of self-efficacy and a coherent life story that encompasses success and growth and as well as trauma and decline.

Third, *treatment must assist the client in maintaining an adequate level of functioning consistent with her or his past and current lifestyle and circumstances*. At no point should therapy substitute for a “life worth living” (Linehan et al., 1994), nor be a direct precipitant of—or a form of tacit collusion with—a view of the client as permanently damaged (Van der Kolk et al., 2005). Empathizing with the client's struggle with fundamentally altered self-perceptions is done in the service of growth, not to confirm or reify a sense of disability. By helping the client experience and work through painful emotions, traumatic memories, and fundamentally altered beliefs about self, others, and life meaning, therapy bolsters functionality by enhancing the client's internal and external resources (Herman, 1992). However, functionality may be reduced temporarily at critical junctures in therapy (Jehu, 1989) when the client is grappling with the challenges posed by personal safety (Phase 1), traumatic memories and related symptoms (Phase 2), and relationships and life pursuits (Phase 3).

Fourth, *treatment must enhance the client's ability to approach and master rather than avoid experiences (internal bodily–affective states as well as external events) that trigger intrusive reexperiencing, emotional numbing, and hyperarousal or hypoarousal*. Avoidance is a hallmark of traumatic stress disorders, and resolving avoidance is a benchmark for successful treatment. However, avoidance

may be driven by a healthy motivation to survive overwhelming experiences—and only becomes problematic when it is automatic and opaque to the survivor. Mastering avoidance and developing ways of actively engaging in both positive and negative experiences and memories requires growth in the form of a shift from automaticity and reactivity to conscious self-regulation (Ford, 2005). A fundamental challenge in all three phases of trauma treatment, therefore, is to help the client become progressively more able to recognize the subtle and obvious ways in which she or he copes with actual or anticipated danger or distress by avoidance—and then to identify safety signals that can help the client to modulate anxiety and use more effective coping tactics (Ford, 2005).

Fifth, *therapists must be aware of and effectively manage clients' transference reactions and countertransference*. Transference and countertransference can be understood as the result of fear or other intense emotions exceeding a person's capacity to engage or modulate activation, or when biological, psychic, or relational stimulation exceed the person's capacity to develop a coherent integrative understanding and strategy for adaptive action. Self-dysregulation can complicate or alter the specific themes that arise in transference or countertransference, requiring the therapist to consciously model and utilize self-regulatory skills to manage her or his own secondary or vicarious trauma reactions (Pearlman & Courtois, 2005), while primarily focusing on the client to provide a secure emotional presence and reliable therapeutic boundaries.

### Treatment Models for Complex Self-Dysregulation

Several manualized treatment models have been developed or adapted for the treatment of posttraumatic self-dysregulation and subjected to open trial studies or preliminary randomized trials.

#### *Cognitive–Behavioral Therapy*

Several cognitive–behavioral therapy (CBT) models have been adapted to address the challenge articulated by Rothbaum and colleagues (2000): “Some trauma survivors are reluctant to confront trauma memories and to tolerate the high anxiety and temporarily increased symptoms that sometimes accompany exposure” (pp. 78–79). Some CBT models prepare clients with severe self-regulatory impairments for traumatic memory recall, while others address PTSD symptoms and self-dysregulation without memory work.

*Cognitive–Behavioral Therapy for Women With PTSD Secondary to Childhood Sexual Abuse* (CBT-CSA; McDonagh-Coyle et al., 2005) is a 14-session intervention adapted from exposure-oriented CBT originally developed for rape survivors. In a randomized trial, CBT-CSA was more effective than a wait-list control condition or a social support and problem-solving skills therapy (present-centered therapy, PCT; see below) in improving PTSD symptoms and self-dysregulation (e.g., anger, dissociation, trauma-related beliefs) at 6- and 12-month follow-ups. However, CBT-CSA had a high (43%) dropout rate in this study, and treatment outcomes for noncompleters were not assessed.

*Cognitive Processing Therapy* (CPT, Resick et al., 2002) is a 6-week 12-session manualized individual therapy designed to modify trauma-related beliefs with briefer and more titrated traumatic memory recall work than exposure-based CBT. Cognitive processing therapy provides PTSD education, two sessions of modified intensive traumatic memory recall (i.e., review of the client's written account of a traumatic rape), and reexamination of trauma-related beliefs via Socratic questioning focused on themes such as safety, trust, power, and intimacy. Results of a randomized trial with 121 female rape survivors assigned to either CPT or an exposure-based CBT showed the two treatments to be comparable in achieving clinically significant reductions in PTSD and improved self-regulation—with CPT superior in reducing two of four guilt subscales. Dropout rates were comparable in both treatments (27%). Almost half (41%) of the study sample reported childhood sexual abuse histories, and subsequent analyses demonstrated that, compared to women with no history of childhood sexual abuse, these women had more severe self-regulatory problems before treatment but were equally able to benefit from either CPT or the exposure-based CBT (Resick, Nishith, & Griffin, 2003). Cognitive processing therapy has been adapted for women survivors of childhood sexual abuse (CPT-SA) in a manualized 17-session protocol that was found to be superior to a minimal attention control condition in reducing trauma-related beliefs and PTSD symptoms in a quasi-experimental study (Owens, Pike, & Chard, 2001).

*Skills Training in Affect and Interpersonal Regulation With Modified Prolonged Exposure* (STAIR-MPE; Cloitre, Koenen, Cohen, & Han, 2002) is a 16-session manualized one-to-one psychotherapy intervention constructed to address Phase 1 treatment by first providing eight sessions to teach skills for mood regulation, distress tolerance, and emotion management in interpersonal contexts. The final eight sessions address Phase 2 treatment through a CBT traumatic memory exposure intervention modified to prevent cognitive or affective

dysregulation. In the first randomized clinical trial of a phase-based trauma treatment, STAIR-MPE resulted in enhanced mood regulation and reduced severity of interpersonal problems and PTSD symptoms for women CSA survivors (Cloitre et al., 2002). Self-regulatory functioning improved following the first eight sessions, but PTSD symptom improvement occurred only after the second set of eight sessions focused on traumatic memory “exposure” work. Dropout rates were low (< 15%), suggesting the importance of a phase-based approach in which self-regulatory capabilities are bolstered before trauma memory work is done.

Adaptations of CBT have been developed for three clinical populations most of whose members have trauma histories, many of whom have co-occurring chronic PTSD and self-regulation problems. *Dialectic Behavior Therapy* (DBT; Linehan et al., 1994) was developed for adults with parasuicidal borderline personality disorder. Dialectic behavior therapy is a 24-session combined group education and individual psychotherapy intervention that teaches four skill sets: distress tolerance, affect regulation, interpersonal effectiveness, and mindfulness. Two controlled trials of DBT show reductions in self-injurious behavior and dysfunctional interpersonal beliefs (Linehan et al., 1994) and binge eating (Telch, Agras, & Linehan, 2001). Given the high prevalence of chronic trauma exposure among suicidal adults and borderline personality disorder patients, DBT has been conceptualized as a Phase 1 trauma therapy approach that addresses safety, stability, self-regulation, and therapy engagement.

Najavits (2002) developed a manualized group CBT for women or adolescent girls with comorbid PTSD and substance abuse: *Seeking Safety*. Seeking Safety teaches more than 80 “safe coping skills” (e.g., grounding detachment from distressing affects and counteracting dissociation; assertiveness; self-monitoring; healthy self-nurturing; asking for help; time management). Similar to CPT, Seeking Safety challenges fixed beliefs, including those related to either or both PTSD and addiction. Seeking Safety does not involve any trauma memory recall work whatsoever, instead teaching skills for managing traumatic stress and co-occurring addiction symptoms. An open trial assessing women who completed Seeking Safety showed evidence of clinically significant changes in addiction and PTSD severity comparable to those with a relapse prevention intervention and superior to addiction treatment as usual, as well as of greater change in anxiety, depression, hostility, suicidality, and interpersonal problems than either relapse prevention or treatment as usual (Najavits, 2002).

Two approaches to CBT for comorbid PTSD and substance abuse include exposure-based trauma memory

work. Triffleman (2003) developed the 40-session *Assisted Recovery from Trauma and Substance Use Disorders* (ARTS) as an adaptation of a briefer intervention that had reported evidence of positive outcomes for completers, but a high (>60%) dropout rate (Brady, Dansky, Back, Foa, & Carroll, 2001). The ARTS program teaches self-regulatory and relapse prevention skills prior to doing traumatic memory exposure work. *Transcend* (Donovan, Padin-Rivera, & Kowaliw, 2001) is a 12-week group therapy that conducts PTSD education, self-management skill training, cognitive restructuring, and one session of trauma memory recall. Transcend demonstrated clinically significant reductions in PTSD and substance use that were sustained at 6- and 12-month follow-ups with military veterans.

### ***Interpersonal Self-Regulation and Affect Regulation Therapy Models***

Other interventions specifically address posttraumatic self-dysregulation by enhancing interpersonal functioning and affect regulation (Alexander & Anderson, 1994; Cloitre & Koenen, 2001; Fonagy, 1998; Fosha, 2001). Despite some overlap in technique and focus with CBT, these interpersonal self-regulation and affect regulation therapies (IAT) differ from CBT in three key ways. First, IATs teach specific skills for social problem solving and affect regulation, rather than the cognitive reevaluation and stress or fear management skills emphasized in CBT. Second, IATs use both current stressor experiences and memories of past traumas as a vehicle for examining and changing problematic interpersonal decisions and emotions (e.g., guilt, shame, anger, complicated grief), in contrast to CBT’s focus on modifying distorted beliefs and reducing fear and anxiety. Third, IAT therapists intentionally address therapeutic attachment as a strategy to enhance client self-regulation. The line between CBT and IAT is not always clear, especially in adaptations of CBT that emphasize affect regulation and interpersonal skills (e.g., STAIR-PE, CPT, Seeking Safety).

The *Trauma Recovery and Empowerment Model* (TREM; Fallot & Harris, 2002) is a group psychoeducational intervention initially designed for women with co-occurring major mental illness and PTSD, and subsequently adapted for men with severe mental illness, women with severe addictive disorders and histories of victimization, and adolescent girls with addictive or psychiatric disorders. The trauma recovery and empowerment model focuses initially on the survivor’s personal and relational experience to facilitate the reinstatement of psychosocial and psychosexual development that was

interrupted by adversity (e.g., family and community poverty, racism, mental illness) and trauma. The model then provides a supportive (gender-separated) group milieu in which each survivor can disclose memories of trauma while reintegrating those memories into a personal life narrative. Field testing with men and women with severe mental illness indicates that TREM is associated with clinically significant reductions in PTSD and improvements in self-regulation and social adjustment.

*Present Centered Therapy* (PCT; McDonagh-Coyle et al., 2005) and *Present-Focused Group Therapy* (PFGT; Spiegel, Classen, Thurston, & Butler, 2004) are, respectively, individual and group interventions designed to reduce PTSD and self-regulatory problems by enhancing social problem solving skills and awareness of the relationship of PTSD symptoms to risky or problematic relationship choices. Both PCT and PGFT have adapted features of interpersonal therapy, which was developed to treat depression and has been applied to the treatment of traumatic grief (Shear et al., 2001) but not to posttraumatic self-dysregulation. In the randomized trial by McDonagh-Coyle and colleagues, PCT had a low (<10%) dropout rate and was comparable to CBT-CSA and superior to a wait-list condition in posttreatment reductions of PTSD and affect dysregulation. In a pilot study, PFGT achieved clinically significant reductions in PTSD, risky sexual or drug use behavior, and sexual revictimization, and improved interpersonal functioning (Spiegel et al., 2004).

*Trauma-Focused Group Therapy* (TFGT; Spiegel et al., 2004) and *Emotion Focused Therapy* (EFT; Paivio & Nieuwenhuis, 2001) are, respectively, group and individual treatments that adapt existential and gestalt therapy modalities to enhance trauma survivors' ability to recognize, express, and overcome the negative emotions and intrusive memories of childhood abuse. Emotion focused therapy emphasizes emotion awareness as an alternative to posttraumatic emotional avoidance and numbing, using the recall of trauma memories and current trauma-related stressor events as a vehicle for accessing and learning to manage negative affects. In a randomized study with adult survivors of child abuse, EFT was superior to a wait-list condition, with evidence of clinically significant reductions in negative emotions, PTSD, and psychiatric symptoms, and improvement interpersonal orientation (Paivio & Nieuwenhuis, 2001). Trauma-focused group therapy is designed to increase awareness of and enhance skills for integrating emotions that have been fragmented, dissociated, or numbed due to trauma. A pilot study indicated that TFGT was associated with clinically significant reductions in PTSD, risky sexual or drug use behavior, and sexual revictimization, and improved interpersonal functioning (Spiegel et al., 2004).

## Conclusion

Several manualized interventions for the treatment of posttraumatic self-dysregulation have been developed and appear promising in clinical application and early clinical trial scientific findings. These interventions have adapted features of cognitive-behavioral (CBT) and interpersonal-affect regulation (IAT) therapy modalities that previously were found to be effective in the treatment of PTSD and psychiatric disorders that co-occur with PTSD (e.g., depression, substance abuse). Both CBT and IAT interventions consistently use a phase-oriented approach, emphasizing Phase 1 work on skills for self-regulation as a precondition to therapeutic disclosure of traumatic memories (whether via purposive "exposure" exercises, or by reexamination of the personal meaning and effects on emotion and relationships of intrusive trauma reexperiencing symptoms).

As a corollary of the focus on posttraumatic self-dysregulation, an important unanswered question requiring scientific study is whether there is a way to reliably and validly determine when a survivor with self-regulatory impairments has achieved sufficient self-regulatory competence to be able to both safely and beneficially engage in Phase 2 trauma-focused work. At present, therapists must rely upon an assessment of key risk factors known to be related to safety (e.g., suicidality, risky behaviors, affect lability, involvement in dangerous relationships, substance use), but how to predict when or if a survivor can safely and beneficially sustain engagement in Phase 2 treatment based on different degrees or acuity or severity of even these high profile factors is not known. The predictive value of self-regulatory capacities per se (e.g., object relations, affect regulation skills; Ford et al., 1997; Ford & Kidd, 1998) as indicators for Phase 2 treatment also requires replication and cross-validation with a variety of clinical populations and alternative therapeutic modalities.

There is much overlap both within and across the two major domains of therapies for posttraumatic self-dysregulation, as well as between these treatments and the better-established therapies for PTSD per se. Given the evidence that CBT interventions designed for rape survivors are helpful for the 57–73% of female survivors of childhood sexual abuse who complete treatment (McDonagh-Coyle et al., 2005; Resick et al., 2002), it will be important to study when, for whom, and how to provide these efficient and potentially efficacious interventions so as to hasten the recovery of as many trauma survivors as possible without inadvertently causing harm. Given the lower dropout rate attained by Resick and colleagues (2002) compared to that by McDonagh et al. (2005), one

possibility that should be addressed is that trauma-focused CBT may be particularly helpful and best tolerated if a specific adult traumatic insult is the initial focus. Exposure-based CBT focused on more distal childhood traumas may inadvertently lead to problems with affect and information processing due to the greater compromise in these capacities associated with childhood (and therefore with attempts to recall memories of oneself that are not only traumatic but also from a developmental period when these capacities are formative and not bolstered by adult adaptations).

Based on promising controlled (Cloitre et al., 2002; Paivio & Nieuwenhuis, 2001; Resick et al., 2002) and open (Donovan et al., 2001; Spiegel et al., 2004; Triffleman, 2003) trial findings for interventions that carefully prepare chronically dysregulated survivors with self-regulatory and interpersonal skills, it also is possible that sufficient preparation can make Phase 2 traumatic memory work safe and beneficial for most if not all such individuals. However, the approach taken to Phase 2 traumatic memory work by these interventions also tends to be more gradual and more focused on sustaining self-regulation than that often described in CBT for PTSD (Rothbaum et al., 2000). It may be for some clients that no amount of work to maintain and strengthen self-regulatory capacities is sufficient to prepare them for Phase 2 interventions. The psychic and somatic integrity of the person should never be compromised by attempts at the mastery of traumatic memories. No treatment for trauma survivors fails to acknowledge the primacy of the survivor's integrity, but the priority of that first principle requires vigilant attention in the delicate second phase of therapy.

Although more limited in scope and empirical grounding, preliminary evidence concerning the benefits of interventions for chronic complex PTSD and co-occurring disorders that do not directly prescribe traumatic memory work suggests that Phase 2 may not necessarily require directed exploration of traumatic memories (Fallot & Harris, 2002; McDonagh-Coyle et al., in press; Najavits, 2002; Spiegel et al., 2004). Interventions that focus on current adjustment can help survivors to understand and manage PTSD and comorbid symptoms and posttraumatic self-dysregulation, particularly if education clearly links these problems in current functioning with the biological and psychosocial adaptations necessary to survive trauma (Ford, 2005). The skills needed to manage current impairments may also serve as a "tool kit" that survivors can use, should they choose to disclose and reexamine traumatic memories—or as a way to be more cognitively and affectively aware of intrusive traumatic memories and thus to address core avoidance. Research is needed to determine when, for whom, and how such

a "present-centered" approach to trauma-focused therapy will be effective, as opposed to therapy that directly prescribes traumatic memory work. At present, we simply do not have sufficient scientific or clinical evidence to determine whether it is necessary to directly address traumatic memories for PTSD treatment to be effective.

While the importance of a working alliance grounded in collaborative client-therapist decision-making and the enhancement of client resources and resilience through education and skills is dealt with more extensively elsewhere (Pearlman & Courtois, this issue), it is important to note that research defining the nature, longitudinal course across the phases of therapy, and relationship to PTSD treatment outcomes (for survivors with or without posttraumatic self-dysregulation) is almost nonexistent. Phase 1 engagement, Phase 2 retention and gains, and Phase 3 application and integration all depend, in theory, upon not only technique but also a therapeutic alliance. A collaborative working alliance may depend upon the therapist's ability to assist the survivor with self-regulatory crises that are likely to cause a breach in the survivor's sense of trust, commitment, and hope. Thus, the focus on self-regulatory skills adopted by the therapies discussed in this paper may provide both a renewed incentive and an operational roadmap for research on the nature and role of the working alliance in trauma therapy.

A focus on self-dysregulation also is a reminder of the need for clear operational definitions of the core constructs within the domain of self-regulation (e.g., affect regulation, interpersonal problem solving, object relations). To treat posttraumatic self-dysregulation it is necessary to know what exactly self-dysregulation is and how it is associated with trauma and PTSD. It also is imperative to know what self-dysregulation is *not*, in order to not over-inclusively define all problems associated with certain types of traumatic stressors or developmental epochs as forms of posttraumatic self-dysregulation. Dismantling of the concepts of self-regulation and dysregulation is needed both in theory and in empirical research (Ford, 2005) for trauma therapists to know what they are treating in addition to PTSD and its co-occurring disorders and impairments. In so doing, clinical researchers will be able to develop clearer theoretical models and empirical studies testing the nature of the relationship between PTSD and self-dysregulation, as well as between recovery from or prevention of PTSD and enhancement of self-regulation. Such studies must address several key unanswered questions, including whether treating PTSD per se is necessary or sufficient to achieve improvements in posttraumatic self-dysregulation, and whether (and when, how, and for whom) enhancing self-regulation can remediate or reduce the severity of PTSD.

Continued clinical innovation and rigorous scientific research clearly are needed to determine not only the most effective methods for the treatment of posttraumatic self-dysregulation, but also strategies for matching and staging of therapeutic interventions over the course of treatment to safely and beneficially promote self-regulation, symptom management, and quality of life for the diverse individuals who suffer complex traumatic stress disorders. Fewer than 20 clinical trials and fewer than 10 studies examining the process of therapy and change have been reported for “uncomplicated PTSD” (Foa, Keane, & Friedman, 2000; Nishith, Resick, & Griffin, 2002), so it is understandable that the evidence base is just beginning to evolve for posttraumatic self-dysregulation. We hope this overview of the phase-oriented model and of emerging therapies for self-regulatory sequelae of trauma will encourage the development of increasingly integrative and effective trauma treatments.

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