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The Treatment Challenge*

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Therapists working with adult survivors of childhood abuse quickly become familiar with the triad of C's: "confusion, chaos, and crisis". To this, one might add another C, *challenge.* This is challenging therapy for both survivors, who struggle with life and recovery, and therapists, who struggle with containment of the work and finding adjunctive resources for individual psychotherapy. I would like to outline a problem-solving approach that matches treatment planning with a range of possible interventions. This decision making process helps clinicians stay grounded in a therapeutic stance, rather than being caught in the anxiety (sometimes panic) that the work engenders. It also opens up the possibility of creating an outpatient team to share the therapeutic work. Years of experience in the trauma field have taught me that a therapist can not do this work alone.

Why is there confusion, chaos, and crisis in the lives and therapy work of clients who were abused as children? Survivors, despite intelligence, intelligence, and even professional competence, are confused by the ongoing struggle with relationships, parenting, and the waxing and waning of symptoms over many years. The more seriously affected survivors have a lifestyle filled with chaos and crisis. The symptomatology of the posttraumatic disorder spectrum of adult survivors is intense and destabilizing. It is not unusual for these clients to suffer from debilitating depression, suicidal ideation/behavior, self-mutilation, panic, flashbacks, hallucinatory re-experiencing of traumatic memories, body memories, nightmares, and dissociative experiences ranging from "spacing out" to internal ego states, to discrete dissociative identities with amnesia. There are often relationship difficulties, questions about sexuality, and sexual avoidance or compulsion. Survivors are frequently revictimized by rape or battering. Substance abuse and/or an eating disorder are typical comorbid conditions. And then there may be concomitant medical problems such as migraine headaches, chronic pelvic pain, or irritable bowel syndrome. I have also observed a number of connective tissue disorders (e.g., rheumatoid arthritis and mixed collagen vascular disorder). A client may easily meet the criteria for six or seven DSM-IV diagnoses (how daunting for the therapist!). These symptoms interfere with one's ability to function and are, in themselves, frightening and humiliating.

Therapists are taxed not only by the difficulty of the work and the nature of the traumatic material, but often feel helpless and overwhelmed in the face of frequent crises. The therapy work requires staging and exquisite pacing and containment to avoid further decompensation. However, in spite of our best technical efforts as clinicians, the three C's-correction, four C's are still part of the work and are to be expected.

One of the most useful experiences that I ever had was as a consulting psychiatrist to a case management practice *(Community Connections* here in Washington). Clinical case management is the comprehensive management of mentally ill clients in the community. It "strives to bring order out of chaos, to stabilize the client in the community, and to encourage the highest level of function during treatment." The concept has much to offer us as trauma therapists. There are often too many current life issues to be ignored. We see a range of clients with a variety of skills and backgrounds. Many keep their lack of skills well hidden until a crisis develops. I have learned not to assume that survivors know "Normal 101" (hopefully, this progresses to 401 in the later phases of therapy). How can they, coming as they do, from such dysfunctional backgrounds? Case management takes a broad look at needs and resources, including available health care options. Case managers for insurance companies are often pleased with this broad-spectrum approach and the thoughtful emplacement/conservation of resources. I try to integrate case management and mentoring with the Psychotherapy of trauma survivors.

In my experience, it is helpful to create a checklist of all possible resources for treatment planing. Here is my personal l□□□□(to which I encourage you to add others):

- **Outpatient Evening and Weekend Groups**
  individual, group, current family/significant others, expressive therapies (particularly art/poetry theropy)

- **Outpatient Psychoeducational Groups**
  Aftereffects of trauma, life skills, parenting

- **Self-help and Support Groups** *(recommended selectivity)*
  Alcoholics/Narcoltics Anonymous, Overeaters Anonymous, Survivors of Incest Anonymous

- **Pharmacotherapy** *(by a psychiatrist experienced in the trauma field)*

- **Consultants in the Trauma Field**

- **Physician/Medical Consultants**

(continued)

Internists or family practitioner, gynecologist, neurologist, gastroenterologist

- **Health/Wellness Consultants**
  Dentist, nutritionist, exercise councelor, financial advisor/teacher

- **Employment Resources**
  Allies at work, employee assistance professional, vocational rehabilitation counselor

- **Housing Resources**
  Low-income housing, crisis beds or housing in the community

- **Personal Support Network**

- **Partial Hospitalization/Intensive Outpatient programs**
  Trauma-focused, chemical dependency, eating disorders

- **Inpatient Hospitalization**
  Detoxification unit, specialty trauma unit, general psychiatric unit (with admitting psychiatrist and trained staff, if possible)

Partial Hospitalization and Intensive Outpatient Programs deserve increased consideration in the acute care of the survivor. Partial hospitalization is approximately one-third the cost of inpatient hospitalization and has creative possibilities for either day or evening treatment. It may be useful both in preventing inpatient hospitalization and as a step-down to shorten an inpatient stay. A skill-building, stabilization approach can be a wonderful supplement to individual outpatient therapy, in addition to providing much-needed socialization for the client. Chemical dependency programs have long used evening partial programs for after-work treatment; now eating disorders programs are following this model. With the recognition of the numbers of trauma patients in treatment and their need for specialized treatment, we have created a continuum of care including all levels of structred ambulatory care with a "menu" of day and evening group therapies.

* Adapted from Turkus, J.A. (1995). *Crisis intervention.* In C. Classen (Ed.), *Treating women molested in childhood.* (pp. 35-61). San Francisco: Jossey – Bass.