Good essay on the treatment of complex trauma and sexual abuse

Sociology, Social Issues

Introduction

Survivors of sexual childhood abuse go through a series of intense and overwhelming feelings. These include feelings of guilt, fear and shame. The abusers are fond of telling children that it is their fault that they were abused, removing the blame away from the abuser, who should be blamed and blaming the child. In addition to this, abusers may bribe or threaten the child not to speak up; telling the child that no one will believe him or her. The response of a survivor's family or friends to the revelation of the sexual abuse also has the possibility to cause huge feelings of guilt hence the victim chooses to ignore it.

Everyone seems to have the same opinion that, a shocking event affects the normal human adaptations to life (Lennquist, 2012). Unlike every day's misfortunes, shocking events usually involve intimidation to bodily integrity or ordinary life, or a close personal experience with death and violence. A more neurologically based meaning would be that a shocking occurrence produces an excess of excitation in the brain and corresponding excess external stimuli (Shives, 2008). When ambushed in this way, the brain is not in a position to fully process or incorporate the happening, and reacts through a variety of mechanisms such as shutting down or psychological numbing of usual emotional reaction. Some theorists also argue that in events of tremendous stress, dissociation happens; the victim splits part of itself from the happening, hence in the process producing numerous personalities. The analysis of multiple personality disorder was very rare once, but became for a while it became pretty common in the year 1980s and 1990s. Symptoms of multiple personality disorder, depending on the

clinicians who identify it, always signified earlier trauma, especially if the patient does not remember the trauma.

In the field trial of DSM-IV, a multisite study of persons with trauma histories, PTSD lifetime occurrence alone was 20%, but the occurrence of CPTSD and PTSD was 34%. CPTSD was specially linked with early beginning and long period of trauma. It was rarely found in natural disaster survivors, and usually found in childhood abuse survivors (Friedman et al, 2010).

PTSD can come in as an effect of frequent psychological shock lacking any counseling that is crisis, when there is no acceptance of the events or event, or no one seems to pay attention and the person feels repressed. Problems of Health that have come up after abuse are respiratory condition, digestive tract maladies, sexually transmitted diseases, prolonged aches in women, infertility, incontinence among boys, widespread, neurosis, tremors, sleep disorders, shock and numbness (Courtois and Ford 2013). Prolonged fatigue, circulatory and heart disease, asthma and diabetes are also one of the reported women health problems. Problems of Psychological that have been detected after CSA are anxiety, depression, phobia, shame, low self-worth, self-destruction behavior and guilt and as well as alcohol and drug abuse within women. In a study by Lisak, anger, fear, betrayal, helplessness, isolation, a desire to escape, loss, self-blame, negativity about others and themselves, guilt, humiliation and shame (Sigurdardottir, 2012).

Other study report symptoms are doubts about confused sexual orientation, sexual dysfunction, masculinity and loss of contact with childhood peers. the same outcome obtained from a study on survivors of male adult of CSA where men were establish to be more prone to anger, extroverted behavior,

antisocial behavior, aggressive, behavioral disorders, low self-worth and suffering from emotional problems. Of the 224 men who went to London genitor-urinary unit, 12% of the patients of 18 years and above admitted to CSA, among those, 18% exposed sexual abuse happening after 16 years. Those who endured child sexual abuse were more probable to write a statement on adulthood sexual abuse, have genitourinary problems, and not any of them had recorded the abuse to the police. Persons who are victimized sexually when they were children start to play sex at their very young age, preferred not to use protection and often change partners and are at a high risk of getting sexually transmitted diseases, and they usually have complication with sexual intimacy. These groups of men are more probable to be unfaithful to their wives and they take on too much responsibility in relationships. Furthermore, a relationship between sexual dysfunction, domestic problems and sexually abuse has been discovered, and survivors more often wed alcoholics and are more probable to go through married troubles than persons who were not abused as children (Grossman &Walfish, 2014).

Regardless of these change in orientation understanding their origin and the aftereffects, the persons with DESNOS/CPTSD diagnosis can be a population that is difficult to treat. Psychotherapy is burdened with many complications because of the numeral issues symptoms experience by the client, issues with individual safety, and deficiencies in the capability to apply other life skill and control affect. Exposing these victims' too directly to their history trauma in the luck of their capability to self-regulate, self-emotion or uphold safety in their lives can lead to, associated decompensation and

retraumatization and inability to function (Foa, 2009).

In current years, medication for patients with PTSD has more and more insisted on the use of cognitive-behavioral interventions (Permanent, 2007), including cognitive restructuring and prolonged exposure, techniques for which experimental research support has been availed. The research confirmation of the efficiency of this method in ameliorating the often symptoms of refractory of PTSD is creditable. Regrettably, CBD wholesale application use exposure method to in patients with DESNOS/CPTSD may be tricky if put into use before the patient is safe and stable.

DESNOS/CPTSD may be challenging and re-emerge some of the described problems in the previous paragraph. The answer to this, the suggested course of medication from those knowledgeable in treating CPTSD entails the following of curing tasks across a number of core treatment stages. There is overlapping healing work all over the stages and frequently a need to rework skills of stabilization over the treatment course. However as each phase builds on the earlier work, the survivor of trauma acquires growing mastery and control, which openly counteract the victimization powerlessness and its aftereffects continuing. These stages include

Pre-treatment assessment,

The pre-treatment evaluation should be complete, with concentration to analysis within the dissociative spectrum, other symptoms and posttraumatic, comorbidity and safety (Yehuda, 2002). It is important to complete all DSM five axes, with importance on available resources and current stressors for utilization on the development of a treatment plan. This

is as well the point to acquire a wide look at resources and needs, as well as existing resources of health care, which with no trouble can be imperfect by the disability of a client or by his/her own inspiration or by managed insurance coverage care or treatment emotional capacity (Weiner, 2003).

Early stage of safety, education, stabilization, skill-building, and development of the treatment alliance,

According to American Psychoanalytic Association. (2006), the stabilization, safety, and the establishing the frame of treatment and the therapeutic alliance are the early stage focuses. Measured by not the duration but by the necessary skills mastery, this treatment stage could be the main important since the client capacity to function is directly related to it. Complex trauma education and human response elements to trauma provide a skill-building. Skills foundation to be developed includes boundaries of healthy, assertiveness, safety planning, self-soothing and self-nurturing, strategies of emotional modulation, to control trauma symptoms such as dissociative episodes and spontaneous flashbacks. Furthermore, attention to stress management, wellness, and any medical attention is needed. Anti-anxiety and antidepressants and medications drugs are regularly useful and should be considered to aim symptoms of posttraumatic and depression associated symptoms, sleep disorder and anxiety (Nathan, 2013).

Middle stage of trauma processing and resolution,

After stabilization have been developed and utilized as needed, the treatment of the middle stage begins. This stage entails reworking and revisiting the trauma with cautious processing to integrate materials that are

traumatic beside its linked but regularly avoided emotion (Gil, 2013). This stage involves typically the expression profound grief and pain but with the witnessing support of the therapist. The trauma re-working is for all time destabilizing, so the early stage skills learnt treatment provide the skill-set and frame needed to integrate and face the initially avoided materials of traumatic. A wide techniques variety have been developed for dealing out with trauma that are appropriate to this stage of treatment including graduated or prolonged graduated exposure, cognitive restructuring or cognitive processing therapy, reprocessing and narrative exposure, Desensitization Eye Movement and Reprocessing and testimony to name the mainly common (Rathus, 2011).

Late stage of self and relational development and life choice

Self-esteem and identity development and concurrent development of improved skills of relational and relationships is involved in the late stage of treatment (Christine A. 2010). The vital issues of sexuality, intimacy and current life choices, as well as whether to carry on with certain vocational choices and relationships normally happen in this stage, if not early addressed. Furthermore, these stages clients regularly come across an existential disaster linked with a new self-sense and must fight with the integrated trauma memories meaning and with the sufferers they have endured. This stage Survivors regularly struggle to hold close life with converted energy and the future hope. For some, making meaning may entail a dedication to make the world difference, especially with respect to declining violence. This is mainly referred as survivor mission.

The treatment course and its period can differ quite considerably and a range of different treatment methods might be used through the treatment stages. Some clients wait in treatment for years; particularly those with the major broad history of trauma and those with attachment styles that is insecure may never move past the first stage (Goldstein, 2010).

Sensorimotor psychotherapy

According to Ogden, Minton, &Pain, (2006), Sensorimotor psychotherapy was at first developed by Pat Ogden to help in the treatment of trauma. It is a type of therapy that oriented the body by integrates the processing body with emotional and cognitive processing. Rather than emotion or cognition, it uses the body as the main rout of access for medication. One of its main goals is to educate clients to be in a position to trust and listen to their body wisdom. The integral component of this work is mindfulness, not forgetting the essential part of the majority body-oriented therapies. Sensorimotor psychotherapy is stuck in the Hakomi Principles which are five, Organicity, mindfulness, non-violence, spirit holism and unit. Non-violence is accommodating, with kindness, others and our self all parts. Organicity is the in-born trends to move grow toward Wholeness and health. Body/mind/spirit holism assumes that persons three interaction system body, mind, and spirit, and that there is emotional/mental/spiritual element to all events that are meaningful that are experienced in the entire body. Unity means that we are all linked and any change in one part affects change in the other remaining parts (Ben-Shaḥar, 2014).

Because the intended symptoms may be many and entail all types of psycho

biosocial matters, eclecticism and the teamwork with other associates who might have offerings to provide the treatment are vital. Given example, dissociation disorders regularly need precise treatments in order for a resolution to be achieved. Even if a dissociative disorder is the trauma main manifestation combined condition or response, the therapist should be ready to either give precise treatment or to work together with a colleague who is in a position to offer these psychotherapy elements. It is essential to understand that in all treatment modalities these principles are applied and across the setting of all.

Eye Movement Desensitization and Reprocessing is becoming fame and appear very important. Single modality way has been doing well for adults of single traumata. Though, with victims exposed to childhood trauma that is extensive, it often has interrupted process of developmental. When dissociative psychopathology is a significant aspect of the posttraumatic symptomatology, specific resolution of dissociative approaches difficulties should be introduced. In addition psychotherapy of basic individual, and other oriented individual technique interventions, approaches of ancillary such as art therapy, group psychotherapy, music therapy, movement therapy, and body oriented treatments may play an important role for some patients that are selected. Medication should start as fast as possible to event both demoralization and consequences psychobiological.

High affect-based behavior stage is experienced in clients with insecure–preoccupied attachments have, without the capability for secure client cognitive organization. They function depending on strong emotions such as anger, anxiety, jealousy, dependence, anger, and regularly relay to others in

behavior that are tremendous and converse (DeLamater, & Ward, 2013). Their personal capability are normally not well created; they are engage in addictive behavior and are risk-taking in the concern of affect management and they may ironically hug to harmful relationships in an effort to keep away from being alone. This type of client treatment involves ongoing attention to steadiness and reliability of reply on the therapist part to teach and model and relational dependability that, as observed, lessens the nervousness at the center of this style of attachment, leading to more interpersonal security.

Insecure–dismissing clients' attachments are fond of anxiety with intimacy, self-reliance defensive, distress denial, and, in other instances, a stance of opposition or hostility and toward others (Atkinson & Goldberg, 2004). Even though in emotional suffering, they have learned to minimize and deny their feelings. Until the filer of these defenses, they are less probable to seek treatment than others. These victims may take a condescending, dismissing, or contemptuous position with the therapist, making incompetence complementary feelings, anger, discomfort, and a feeling to reject or avoid them, hence placing them at reenactment risk for the new traumatic rejection (Pearlman and Courtois 2005). The therapist must being a position to see beyond the deeds and to emphasize and understand with its self-protection function and origins. The therapist's touching equanimity instead of defensiveness and a position of continuing exploration and support are useful in treating this attachment insecurity type and in reversing the stiff self-reliance.

Although victims with an insecure-dismissing and insecure–preoccupied style

might have a chronic trauma history, those with disoriented, disorganized and dissociative styles of attachment are probable to be over-represented in survivors of complex trauma (Kohen, D. 2010). For these victims, caregivers and figures of attachment have been the confusing source of both danger and comfort and they regularly foresee similar from the therapist whom they come up to with both fear and longing. Because these victims are probable to have extremely deregulated feeling due to history and underdeveloped self-capacity and ongoing relational instability, they are more probable to use move toward avoid and defenses and dissociative behaviors and have a style of interaction that may appear illogic and is disjointed. They are more clearly depressed, distressed, disorganized, occupational impairment and have more social, and might comprise a much bigger hazard to others and themselves due to problem of impulse control, Self-loathing, dissociation, and chronic hopelessness. Medication for complex reactions of this type is clearly more complex and, in response to the need prepare an intervention and to provide an organization, phase oriented model or a sequenced has developed. Early efforts of medication are properly focused toward personal safety, strategies and teaching skills, to maintain affect at tolerable level, and stress on the therapeutic association as a consistency place and help where emotions can be understood and named. Direct traumatic memories treatment is later approached, after emotional regulation skills have been developed by the victim to avoid retraumatization (University Microfilms, 1969).

Others progress through the three stages in a short period of time, and others still take part in treatment at regular intervals as required. Shorter-

term and hybrid approaches are now under progress. The important concern is that different and new ways to the treatment of trauma that are complex are now effective and available. The victims who were once puzzled by their symptoms and who wondered if they will ever receiving assistance and understanding now have the chance to obtain effective treatment, to restore to health, and to get back on the track with their lives.

Conclusion

Dissociation may be an extremely effective way to handle emotions that are overwhelming and attachment distress that are related, however when used out of its real context and overused, it can have high interpersonal and personal and costs (Rosen &Frueh 2010)). Here we communicate one very dissociation specific manifestation; the process of dissociative observed during sessions of therapy for example, the client's shifting relational, identity and emotional state due to its significance to the perspective attachment and to its management and understanding. The dissociative process is regularly started during emotional intensity moments linked to past relationship experience attachment usually involving key emotions such as terror and fear, disappointment, shame, despair, and rage that cause internal shifting of the victim, given example as, from feeling in charge and adult, to feeling overwhelmed, young and out of surrounding and behavioral control (Person, 2005). Some time, these shifts are very slight and not easily identified; the only sign to them might be the confusion and shifting feeling state of the therapist's. But sometimes they are florid pronounced. Whatever its demonstration, dissociation is an option for relational capacity and of self

that is regularly in the self-protection interest and regularly takes place outside of the victim’s conscious awareness. From our viewpoint, the job of the therapist is to study and name the procedure while holding on to the position of relational constancy and equanimity. This is to stay within the rich relational structure, using it as the safe stand from which the victim can be assisted to explore the responses or emotional, its association and specific triggers, and the process of dissociative. As the victim comes to appreciate his or her aspects of occurrence and they are not anymore as ailing or threatening, they any more don’t require such tough resistance and accepts exploration of new pattern of behavioral. Repeated dispensation of this type assists the victim to build up an improved knowledge of his or her own internal understanding and a stronger connection with the therapist, hence contributing to the self-capacity growth of self and more secure, improved, inner working models (Sommers, 2014). Communication to the victims in by the therapist should be in a way that the victim does not fell that she or he is the only one suffering or went through that historical frustration.

References

American Psychoanalytic Association. (2006). Psychodynamic diagnostic manual (PDM). Silver Spring, MD: Alliance of Psychoanalytic Organizations. Page 213.

Atkinson, L., & Goldberg, S. (2004). Attachment issues in psychopathology and intervention. Mahwah, N. J: Lawrence Erlbaum. Page 257.

Ben-Shaḥar, A. R. (2014). Touching the relational edge: Body psychotherapy. Page 49.

Christine A. (2010) Understanding Complex Trauma, Complex Reactions, and Treatment Approaches. Washington DC. Page 8.

Courtois, C. A., & Ford, J. D. (2013). Treatment of complex trauma: A sequenced, relationship-based approach. New York: Guilford Press. Page 120-122.

Foa, E. B., & International Society for Traumatic Stress Studies. (2009). Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies. New York: Guilford Press. Page 139.

Friedman, M. J., Keane, T. M., &Resick, P. A. (2010). Handbook of PTSD: Science and practice. New York: Guilford Press.

Goldstein, E. (2010). Object Relation Theory and Self-Psychology. New Yoke: Simon and Schuster. Page 103.

Grossman, L. R., &Walfish, S. (2014). Translating psychological research into practice. Page 598.

In DeLamater, J. D., & In Ward, A. (2013). Handbook of social psychology. Page 225.

In Gil, E. (2013). Working with children to heal interpersonal trauma: The power of play.

Kohen, D. (2010). Oxford textbook of women and mental health. Oxford: Oxford University Press. Page 54

Lennquist, S. (2012). Medical response to major incidents and disasters: A practical guide for all medical staff. Berlin: Springer. Page 365.

Nathan, P. E., Enns, C. Z., & Williams, E. N. (2013). The Oxford handbook of feminist multicultural counseling psychology. Oxford, UK: Oxford University Press. Page 384.

Pearlman, A. and Courtois, A. (2005). Clinical Applications of the Attachment Framework: Relational Treatment of Complex Trauma. Journal of Traumatic Stress, Vol. 18. Page 451

Permanent Peoples' Tribunal. (2007). Repression & resistance: The Filipino people vs Gloria Macapagal-Arroyo, George W. Bush, et al. : Permanent Peoples' Tribunal, Second Session on the Philippines, the Hague, the Netherlands, March 21-25, 2007. Quezon City: IBON Foundation. Page 135

Person, E. S. (2005). The American Psychiatric Publishing textbook of psychoanalysis. Washington, D. C: American Psychiatric Publishing. Page 325

Rathus, S. (2011). Psychology: Concepts and Conection . Cengage LerningCompyright. Page 2056.

Rosen, G. M., &Frueh, C. (2010). Clinician's Guide to Posttraumatic Stress Disorder. New York, NY: John Wiley & Sons. Page 205.

Shives, L. R. (2008). Basic concepts of psychiatric-mental health nursing. Philadelphia: Wolters Kluwer / Lippincott Williams & Wilkins. Page 251.

Sigurdardottir, S. (2012). Deep and almost unbearable suffering: consequences of childhood sexual abuse for men’s health and well-being. Page

Sommers-Flanagan, J., &Sommers-Flanagan, R. (2014). Clinical interviewing. Page 145.

Weiner, I. B. (2003). Handbook of psychology: 10. Hoboken, NJ: Wiley. Page 526

Yehuda, R. (2002). Treating trauma survivors with PTSD. Washington, DC: American Psychiatric Pub. Page 47.