About Therapy & Recovery - Resources to Inform Your Search

For many people, recovery from significant effects of child abuse requires consultation or therapy with a trained professional; this can also be true for those who want to effectively support someone else in his or her healing. But it is not always clear how to go about finding good professional help. You can greatly increase the odds of finding and benefiting from qualified help if you learn about the stages of recovery from the effects of abuse, about how people successfully change problem behaviors in general, and about how and where to find qualified help. Providing some of this knowledge is my goal for this section.

This section is primarily addressed to adults who experienced abuse as children, though it also has useful information for teenagers, those subjected to violence in adulthood, and people seeking help for loved ones who have been abused or assaulted. (For more information about seeking help for a spouse, partner, friend, boyfriend, etc., see Resources for Spouses, Partners, Friends, etc. For information about finding help for children and adolescents, see How to Find Help by the National Child Traumatic Stress Network.)

This section can be downloaded and printed as a PDF file (its hyperlinks won't work), and has four subsections:

1. Stages of treatment for child abuse trauma
2. Stages of voluntary behavioral change
3. Principles of treatment important for child abuse trauma
4. Specific resources for finding, choosing and evaluating therapists

1. Stages of treatment for child abuse trauma

Among experts in the treatment of people who have suffered from extreme child abuse and other traumas, since the early 1990s there has been a consensus on two points: treatment and healing from the effects of abuse takes place in stages, and there are fundamental principles of good treatment which apply at every stage. In this section, I address the stages of treatment and recovery. My discussion borrows heavily from Judith Herman's classic book, *Trauma and Recovery*, which goes into great depth on these stages and principles.

In this section, I mention particular types of treatment. The "Specific resources" section below (#4 within this overall subsection) has additional information about these treatments and how to find therapists experienced with them.

The first stage of healing and of any helpful therapy or counseling is about:

- Getting a "road map" of the healing process.

- Setting treatment goals and learning about helpful approaches to reaching those goals.
- Establishing safety and stability in one's body, one's relationships, and the rest of one's life.
- Tapping into and developing one's own inner strengths, and any other potentially available resources for healing.
- Learning how to regulate one's emotions and manage symptoms that cause suffering or make one feel unsafe.
- Developing and strengthening skills for managing painful and unwanted experiences, and minimizing unhelpful responses to them.

Please note that the first stage of recovery and treatment is not about discussing or "processing" memories of abuse, let alone "recovering" them. (For more on how the stages of recovery are related to memories of abuse, particularly recovered memories, see "Words of Caution II: Personal Concerns & Questions" on my page, Recovered Memories of Sexual Abuse.)

Of course, everything is not always so perfectly ordered and sequential. For example, during the first stage it may be necessary to discuss the contents of abuse memories that are disrupting one's life. This may be required to help manage the memories, or to understand why it is hard to care for oneself (the abuser suggested unworthiness of care or love, etc.). However, in this case addressing memories is not the focus of therapy, but a means to achieving safety, stability, and greater ability to take care of oneself.

Most important, the key to healing from child abuse is achieving these "stage-one" goals of personal and interpersonal safety, genuine self-care, and healthy emotion-regulation capacities. Once these have become standard operating procedures, great progress and many new choices become possible.

Depending on the person, the first stage of treatment may also involve:

- Addressing problems with alcohol or drugs, depression, eating behaviors, physical health, panic attacks, and/or dissociation (e.g., spacing out, losing time).
- Taking medication to reduce anxiety and/or depressive symptoms, for example serotonergic reuptake inhibitors (SSRIs) like sertraline (Zoloft) or paroxetine (Paxil).
- Participating in Dialectical Behavior Therapy (DBT), a treatment designed to help people who are having serious problems tolerating and regulating emotions, interpersonal effectiveness, and/or self-harming behaviors. (For more information about DBT, see Dr. Cindy Sanderson's excellent Dialectical Behavior Therapy - Frequently Asked Questions.)

Throughout all stages of treatment, it is often necessary to address psychological "themes" and "dynamics" related to one's history of abuse. As discussed below, under "Principles of treatment," some of these are core issues in child abuse trauma that should determine the very nature and structure of treatment. These include:

- Powerlessness

- Shame and guilt
- Distrust
- Reenacting abusive patterns in current relationships

In the first stage of treatment, these themes and dynamics must be addressed when they are obstacles to safety, self-care, and regulating one's emotions and behavior. Therapy can help with recognizing habitual behavior patterns, beliefs, and motivations that maintain self-defeating and self-destructive behaviors outside of conscious awareness or reflection. Increased awareness of these themes and dynamics brings increased understanding, increased ability to take responsibility for them, and increased capacities to choose new, healthier responses and actions. (Mindfulness meditation practices can also help cultivate such awareness and freedom; see my page, Mindfulness: An Inner Resource for Recovery from Child Abuse)

The second stage of recovery and treatment is often referred to as "remembrance and mourning." Even before saying what this stage is about, it is important to note that some people may decide to postpone working on "stage-two issues," and some may decide never to address them (at least in therapy).

The main work of stage two involves:

- Reviewing and/or discussing memories to lessen their emotional intensity, to revise their meanings for one's life and identity, etc.
- Working through grief about remembered abuse and its negative effects on one's life.
- Mourning or working through grief about good experiences that one did not have, but that all children deserve.

After establishing a solid foundation of understanding, safety, stability and self-regulation skills one can decide - mindful of the potential pain and risks involved - whether or not to engage in the work of stage two. In fact, once the first stage of recovery has provided such a foundation, some people realize that thinking and talking about their abuse memories is not necessary to achieve their goals, at least in the short term, and/or that those memories are no longer disrupting their life and no longer of much interest to them. (And sometimes people need to educate their therapists about this!)

For those who do choose to focus on abuse memories, or need to because the memories are still disrupting their lives, there are several therapeutic methods available for "processing memories" in the second stage of treatment. In general, these methods involve "exposure" to the traumatic memories within a safe and healing therapy setting. These treatment approaches can be very effective at ending the influence that abuse memories have over one's daily life, emotions, sense of identity, and self-understanding.

There are different psychological theories about what is involved in processing traumatic memories, and discussing these in detail is beyond the scope of this section. (One theory is that successful treatment involves "extinguishing" habitual and maladaptive fear responses to trauma reminders, and replacing them with adaptive responses. Another is that treatment "transforms" traumatic memories consisting of intense fragmentary sensations

and emotions into more normal and integrated memories, ones characterized by verbal narratives rather than vivid sensations and intense emotions. Also, these theories are not incompatible.)

Theories are much less important than this fact: there are very effective therapy methods that have been proven, through years of clinical experience and extensive research, to bring great relief and healing by tranforming how people experience memories and reminders of child abuse. (Please note: such treatments do not "erase" memories, and are not designed or used to "recover" memories; if you have personal questions about this issue, see the "Words of Caution II" section on my page, Recovered Memories of Sexual Abuse).

The two most studied and research-supported treatment approaches for processing traumatic memories are:

- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure (PE)

EMDR is a treatment that facilitates the rapid transformation of traumatic memories – without having to talk about them in detail, which makes it very appealing and accessible to many people. It is not yet known exactly which components or combination of components of this treatment are responsible for its effectiveness. But a large body of research has proven the effectiveness of EMDR as a treatment for posttraumatic stress disorder (PTSD). (Disclosure: I have conducted treatment outcome research on EMDR, funded by the National Institute of Mental Health.)

What happens in EMDR sessions, and how it is different from what happens in Prolonged Exposure sessions:

- First of all, each treatment involves at least one "preparatory" session before those involving exposure to trauma-related memories. I will not describe those here.
- EDMR has the client begin the exposure phase of sessions by focusing on the most distressing image associated with the traumatic experience, plus the emotion accompanying the image, how the emotion feels in the body, and an associated negative belief about oneself (e.g., "I deserved it," or "I'm unlovable."). Traditional exposure treatments have clients begin the exposure phase by describing, in detail, the very beginning of the traumatic event.
- Then, while holding in mind the most distressing image/emotion/body sensation/cognition, and not speaking, in EMDR the client tracks the therapist's moving finger or a moving light, as they move back and forth across the visual field, for 10 to 40 seconds. In traditional prolonged exposure, in contast, the client continues to narrate the traumatic experience from the beginning, out loud, in detail, in the sequence it unfolded during the original event. Thus not just the eye movements, but the lack of talking as well, are different at this point.
- In EMDR, the client is told, in advance, that during any set of eye movements his or her experience may or may not change, and is not "supposed" to do anything. In typical exposure therapies, the client is told in advance that they must narrate the

memory in detail, in the sequence it happened, from start to finish, if necessary starting over at the beginning, until the end of the session.

- In EMDR, after each set of eye movements, the client is asked, "what are you noticing?" (which is briefly reported), then directed to "go with that" for another set of eye movements (while not talking), after which they are again asked, "what are you noticing?" This basic, repeated sequence is the core and the majority of an EMDR session. In traditional exposure therapies, as noted above, the client continues to narrate the trauma out loud, in sequence, from beginning to end; when the end of the narration is reached, the client is directed to start over again at the beginning.
- In EMDR, if the client associates forward or backward in time, to earlier or later parts of the traumatic event, or even to completely different past events, thoughts about the future, or entirely new ideas, this is all normal and acceptable. The therapist simply checks in after each set of eye movements with "what are you noticing," does not engage in discussion of what the client reports, and directs the client to "go with that" into the next eye movement set. (Of course, if the client gets overwhelmed, the therapist will intervene to prevent the experience from being retraumatizing.) In traditional exposure therapy, if the client deviates from narrating the event in the exact sequence, in detail, the therapist (gently) directs the client to return to where they left off and continue the narration.
- Two other differences, clear from the above, are that EMDR involves many brief exposures, as opposed to prolonged exposures, and allows for incomplete exposure to details of the memory (as opposed to attempting to expose the client to all details; the aim of traditional prolonged exposure here, as described below, is to ensure that no important details are missed).

The above describes very clear differences between EMDR and traditional exposure therapy. Importantly, all of them allow the client to associate, within the session and within exposures, to different memories, themes, and ideas - including positive ones. In fact, anyone who has any experience at all with EMDR, as a client or therapist, is quickly impressed by just how many such associations and connections occur during EMDR sessions. (Therapists and clients report that such associations occur with traditional exposure therapy too, though, not surprisingly, after and between sessions as opposed to within them.)

In short, simple observation shows that EMDR is quite different from traditional exposure treatment in a variety of ways, most relating to allowing and even fostering associative processes within sessions.

Additional Information about EMDR

Because EMDR is still a "controversial" treatment in some ways, it is helpful to provide some information relevant to the controversy. Though I would rather not get into this issue, it is necessary because of the risk that some may decide not to try this very effective treatment due to misleading or inaccurate information in the popular media, on the web, even in scholarly publications. The points below are intended to explain how the controversy arose and to demonstrate that the main criticism of EMDR is not based on facts.

- EMDR was aggressively marketed before much research had been conducted on it, with some fairly extreme statements about its ability to "cure" PTSD in a few sessions, and without significant effort to explain how it works in terms of widely accepted academic theories. Thus it was inevitable that EMDR would be criticized (and at times viciously attacked) by some academic researchers – an outcome easily understood by anyone familiar with academic politics and the tendencies for conflict between therapists and researchers in the field of clinical psychology.
- The primary and most repeated critique of EMDR, as opposed to its promotion and promoters, is this: "What works isn't new and what's new doesn't work." By this is meant that the only substantial difference between EMDR and traditional exposure treatments like Prolonged Exposure is the eye movements, and that the eye movements add nothing to the treatment. This critique can be addressed as follows:
    - It is true that some studies have found that the eye movements do not make the treatment more effective, though this issue is not settled.
    - However, it is not true that EMDR minus the eye movements is basically the same as exposure treatment.
    - In fact, there are several major differences between EMDR and traditional exposure treatments; this is very clearly demonstrated in the comparative description above.
    - Therefore, the claim "what's new doesn't work and what works isn't new" obscures just how different EMDR is from traditional exposure treatments, despite the fact that it overlaps with them too. In fact, as any informed academic theorist or researcher knows, and as explained below, using brief exposures and allowing clients to follow associations and deviate from sequential narration, according to the dominant model of how exposure treatment works, should prevent the therapy from being effective. But EMDR research, and clinical experience every day in thousands of therapy offices around the world, proves this is not so.
- Finally, for those interested in pursuing the scholarly work on the EMDR debate, a good place to start is a journal article by Susan Rogers and Steven Silver, Is EMDR an exposure therapy? A review of trauma protocols. My discussion above overlaps with theirs in many ways, but they provide much more theory and references to relevant scholarly work. They also provide case examples, which give a feel for the treatment and how it can help unique individuals. The article is one of several articles in a special January 2002 issue of the *Journal of Clinical Psychology* on EMDR.

Additional Information about Prolonged Exposure

Prolonged Exposure therapy is the other most-researched treatment for postraumatic stress disorder, and very established in the academic mainstream. (Of course, this does not guarantee it is the best approach for a particular person; this is also true for EMDR, in fact any treatment when it comes to unique individuals rather than groups of research participants.)

The theory behind how PE works is the Emotional Processing Model of Edna Foa and Michael Kozak. These authors have presented this model in several influential papers, particularly these:

> Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. Psychological Bulletin, 99, 20–35.
>
> Foa, E.B., & Kozak, M.J. (1998). Clinical applications of bioinformational theory: Understanding anxiety and its treatment. Behavior Therapy, 29, 675–690.

While these are long and fairly technical papers, some people may find reading them to be useful. Their theory can be summarized briefly as follows:

- People with anxiety disorders, including postraumatic stress disorder (PTSD), suffer from pathological "fear structures" in their "memory networks."
- Fear structures are networks of information that provide a program to detect and escape threats. These structures contain information about the stimuli associated with the feared situation (e.g., threatening faces, sexual images) and responses to it (i.e., bodily responses of fearfulness, escape behaviors), as well as information about the relationship between these responses.
- Pathological fear structures include extreme response elements (e.g., pounding heart, shaking body), unrealistic expectations about the likelihood of harm (i.e, convinced one will be harmed in very safe situations with one or two aspects reminiscent of the original abuse), and resistance to change even in the face of contradictory information (e.g., repeated experiences of people getting angry without becoming violent).
- The fear structure in PTSD is large and can "pull in" all kinds of stimuli that remind the person of the original trauma. It is continually but incompletely activated, such that people with PTSD from child abuse repeatedly get "triggered" by reminders of their trauma but, because they immediately engage in escape and avoidance behaviors, don't get the experience that the reminders themselves are not actually dangerous.
- The goal of treatment is to modify the pathological fear structure. This is accomplished by helping clients experience the stimulus aspects of the original trauma(s) in a safe setting, and experience them fully, so that they can truly learn that reminders of the trauma (aside from actually dangerous situations) are not dangerous and need not result in massive fear, avoidance and escape responses. In this way, it is possible to incorporate "corrective information" into the fear structure (e.g., I am safe even when remembering. Just because something reminds me doesn't mean it's happening again).
- For treatment to be effective, it must fully activate the fear structure, and it must provide corrective information that truly does not fit with the pathological structure and thus can effectively modify it.

Based on this description of the model and how it views effective treatment, it makes sense why traditional exposure therapies like Prolonged Exposure insist that clients narrate their

traumatic memories in detail, in sequence. This is seen as the only way to ensure that the fear structure is fully activated: if clients are allowed to "jump around" or to associate to other memories (as in EMDR), the thinking goes, then they might avoid key aspects of the memory and fear structure. And if they do not activate it fully, they will not be able to truly incorporate corrective information and transform the fear structure so it is no longer pathological.

In short, traditional exposure therapies like PE insist that clients narrate the trauma out loud, in detail, from start to finish, so the therapist can be sure that the client is fully activating the fear structure, fully engaging with the emotions, and really getting the full benefit of the treatment. Similarly, clients are required to listen to an audiotape of their narration of the trauma in between sessions – again, to ensure full activation and incorporation of corrective information as hearing the tape over and over again generates less and less fear and avoidance responses. However, it should be noted that many therapists modify traditional exposure therapy by beginning with less traumatic memories, by not requiring the "homework" of listening to oneself narrate the trauma on audio tape, and in other ways that reduce its stressfulness.

Importantly, I have focused on these two highly-researched treatments for changing one's relationshp to traumatic memories, but there are certainly others that people with child abuse histories have found helpful. One common component is exposure to distressing aspects of the memory in a safe and structured setting. Again, the main point here is that there are effective and relatively rapid methods for dealing with intensely distressing memories. People do not have to be tortured by them for years.

The third stage of recovery and treatment focuses on reconnecting with people, meaningful activities, and other aspects of life.

I am not going to describe this stage further. Instead, I recommend Judith Lewis Herman's classic book, Trauma and Recovery, which describes the three stages of recovery in depth and detail.

2. Stages of voluntary behavioral change

Over the past two decades very important work has been conducted on the stages of change that people go through in order to voluntarily change their own behavior. This work emerged from those studying how people quit addictive behaviors, but is applicable to other habitual behaviors that people have a hard time quitting. Two of the best known people who have conducted and presented this work are Carlo DiClemente and James Prochaska.

Generally speaking, experienced and skilled therapists understand the stages of change, even if they do not think about them in terms of this model. They are also skilled at matching what they say, and the treatment methods they provide, to where their clients are (in relation to particular "problem behaviors") in the stages described below.

Before describing the stage model, it's important to note that this work is particularly relevant to people in the first stage of recovery.

- During this stage of recovery and treatment, people are often struggling with deeply habitual strategies for managing painful, trauma-related emotions – strategies that have become ineffective, destructive, or even retraumatizing.
- Such behaviors include dependence on alcohol or drugs to block out painful experiences or promote positive ones, deliberately harming their bodies to become numb or feel alive, compulsive use of pornography or food, impulsive and aggressive venting of anger on others, provoking others to reject, abandon or abuse them, etc.
- For those who grew up in situations where more healthy ways of handling intense negative experiences were not learned, such behaviors can become very ingrained habits and be difficult to change. They may be experienced as the "only" way to cope with certain painful experiences – or the only sure-fire way that doesn't require trusting or depending on others. People may know they are self-destructive and/or harmful to others, but feel like giving them up would make things even worse. When I refer to "problem behaviors" below, this is what I am referring to, and this may include behaviors that you, understandably, at least for now, see not as "problems" but as survival skills.
- In short, whether these ways of coping were learned during times of abuse and neglect or some time later, they are not working very well any more (if they ever did). Further, they have become ingrained habits and automatic reactions that are difficult to quit and replace with more helpful ways of coping. However, people can change such behaviors, and understanding some general principles about how voluntary behavior change occurs can help a lot.

The five stages of change below have been found to describe all voluntary behavior change, whether one is getting professional help or making changes on one's own:

- **Precontemplation stage**
  - At this stage, people lack an awareness that they have a problem. If they go to treatment, they feel pushed to do so by others, but they are not (yet) committed to getting help, and may be "resistant" or passive in therapy. They are avoiding steps to change their behavior (consciously and/or unconsciously). Others may see them as "in denial."
  - At this stage, trying to get people to focus on behavior change is completely ineffective, because it simply doesn't match or meet them where they are. (We can all remember, and not fondly, times when others pushed us to make changes before we had even come to terms with the fact that we had a problem.) Instead, it is most helpful to give people a chance to discuss their mixed feelings and thoughts about the problem behaviors, and how they see the costs and benefits of changing and not changing. In having such discussions, it is essential, but can be very difficult, not to take sides in their internal debate and argue for change. This is essential because doing so puts you in the position of advocating for change and leads them to "argue the

other side" (of their mixed feelings) and justify their behaviors rather than thinking about change.

- It would be hard to overemphasize how important it is to understand this stage, in general and in relation to therapy. For more on how to relate effectively to people in the precontemplation stage, including people you care about but are having trouble helping, see the next section of this page, Resources for Spouses, Partners, Friends, etc., especially the information and resources on "motivational interviewing."

- **Contemplation stage**
  - At this stage, people are distressed about their own problem behaviors, wanting to get some control over them, seeking to evaluate and understand their behavior, and thinking about making change. They haven't yet acted to make a change, and have not even committed to doing so. But they are definitely evaluating the pros and cons of sticking to their behavior versus making changes.
  - Important change processes or interventions include "consciousness raising," that is, learning new facts and information that support making the change, and "self-reevaluation," or beginning to see oneself as someone who could be free of the problem behavior and embody alternative constructive behaviors. Again, the focus is not yet on behavioral change – which would still be a mismatch – but on strengthening people's motivation and commitment to make a change.

- **Preparation stage**
  - At this stage, people are intending to change their behavior, ready to change in terms of both attitude and behavior, and on the verge of taking action. They are engaged in the change process, and prepared to make firm commitments to follow through on the action option(s) that they choose.
  - Similar processes and intervention are helpful here as in the Contemplation stage, with an increasing emphasis on strengthening the commitment to change and to follow through with change behaviors. Still, it's not about giving people methods for change, let alone pushing them to take action, but about strengthening their motivation for the specific actions that they are on the verge of choosing and taking.

- **Action stage**
  - At this stage people have definitely decided to make change, are very motivated to change, and have verbalized or otherwise demonstrated firm commitment to doing so. They are making active efforts to modify their behavior and/or their environment, and are willing to seek out and try suggested strategies and activities for bringing about change.
  - Here a wide variety of behavioral change methods, from self-help methods to specific therapy interventions and a variety of other resources, including exercise and other training programs, are finally appropriate for others to suggest and to help them use. It is still essential that people's freedom to

choose, and to use behavior change methods in their own unique ways, are respected.

- **Maintenance stage**
    - This stage refers to a time when the behavior change has been made and maintained for at least several months (six months is commonly used as an indicator of entering this stage). At this time, people are working to sustain changes achieved thus far, and considerable attention is focused on avoiding slips or a relapse. People may still experience fear or anxiety about possible relapse, and worry about how they would deal with a situation that presented a high risk for relapse. They may face less frequent but quite intense temptations revert back to problem behaviors or bad habits. These are very normal and natural experiences, and are totally consistent with continued strong motivation and commitment. Indeed, when people no longer fear relapse, they may be at higher risk for "letting down their guard" and making a slip. However, as time goes on and the behavior change becomes more ingrained in their lives, such fears and temptations tend naturally to decrease.
    - A wide variety of behavioral change and maintainence methods are useful during this time. The mix of methods may evolve, with some becoming no longer necessary and others becoming more appropriate. But people are still making use of various methods to "stay on track" and to continue the new behaviors and positive habits they have developed.

All of us can remember behavior changes that we've made by going through these stages. You're probably in the midst of (at least) one now. If you've been focused on someone else who "needs to make a change," particularly someone you've been trying to persuade to make a change, it would probably be helpful to reflect on your own experiences of going through these stage in relation to something particularly difficult, then to think about where in the stages of change the other person is now, and how effectively you've been relating to him or her.

Importantly, where people are in the stages of change determines:

- What they are open to hearing from a therapist, partner, friend, or anyone else.
- Which treatments or interventions they are ready to benefit from.

A couple of other key points:

- The stages almost always play out in cycles, in which people gradually advance, and occasionally "relapse" back to earlier stages in the process before eventually moving forward again. All of us have bad habits with which we have struggled in these stages. Every one of us has sometimes, typically during times of stress and/or lack of support, reverted back to old problem behaviors and to pre-contemplative or contemplative stages in relation them.
- For those traumatized by child abuse, there are likely to be many behaviors that are problematic and suffering-increasing. At any particular time, only some of these will be addressed by moving forward through the stages of change in relation to them. The first stage of treatment and recovery involves coming to terms with the need to

change deeply ingrained habits that developed as "survival skills" during the abuse, and developing the motivation and commitment to change, then working hard to make use of change methods that are available. Achieving safety and stability, and increasing acceptance of and mastery over one's emotions and conditioned responses to abuse reminders, is very much about progressing through the stages of behavior change. This is true whether one is dealing with dependence on drugs and alcohol, repeating abuse dynamics in current relationships, or a variety of other problems common during the first stage of recovery.

- Understanding these stages of change, how they play out in cycles, and how child abuse can result in many problem behaviors that cannot all be changed at once or without occasional "backsliding," can be very helpful and bring more patience and acceptance of ourselves and others.
- If you seek out treatment, keep these stages in mind. When you are focused on a particular goal, or on a particular type of behavior change that you want or that other people are pushing you to make, you can make use of this model. You can discuss with your therapist, or another trusted and supportive person, what kinds of conversations and interventions will truly meet you where you are, and will truly empower you to sort through your own mixed feelings – about your behavior and its consequences, and about your own values, motivations, and options for change.

For more information about the stages of change:

- The Addictions Alternatives web site has a nice, brief overview of the stages of the model.
- ETR Associates has a good page on the processes of behavior change as described by the model.
- The University of Rhode Island's Cancer Prevention Research Center has a more detailed overview.
- The National Health Care for the Homeless Council has a 5-page PDF document that nicely lays out the stages of change, as well as appropriate interventions at each stage.

3. Principles of treatment for child abuse trauma

There are several important principles of treatment that anyone seeking good professional help in dealing with the effects of child abuse should know about. I cannot list them all or spell them out in great detail. However, in this section some crucial ones are introduced and described, to aid with interviewing potential therapists or consultants and reflecting on one's experiences in treatment. Reflecting on these principles can be particularly helpful at the beginning of therapy, while establishing trust, as well as during other difficult phases.

Competence. Not all professional therapists are competent to provide treatment to people with histories of severe child abuse, or with particular sorts of problems that can result from extreme forms of abuse. Competence requires but is not guaranteed by extensive experience and training in work with survivors of child abuse, or ongoing supervision with more a senior and

qualified therapist. (Section 4 below has resources for interviewing therapists to gather information about their likely level of competence.)

Empowerment. The core experience of child abuse, like all severe traumas, is disempowerment: one's needs, wishes and choices (including not to be abused) are ignored and trampled upon. Because child abuse involves violation and betrayal of trust by a more powerful person, it is essential that the therapist and therapy not repeat these patterns.

- Thus good treatment is not something that a more powerful professional requires the client to accept and "comply" with, as the medical model of therapy tends to assume. Therapists with this approach and/or attitude are much less likely to be helpful.
- Rather, the client must be educated about the treatment process, informed of options, and involved as a partner in the formulation of treatment goals and decisions about how to go about achieving them. (There are exeptions, of course, in cases where clients are at immediate risk to harm themselves or others and not able to make safe choices on their own; however, even then, the client should be given as many options and choices as possible.)
- Two other principles related to the therapist working to empower the client are worth noting here: neutrality and disinterestedness.

  By "neutrality" is meant that the therapist does not take sides in clients' inner conflicts (e.g., Should I leave or should stay? Do I trust her or not?), but helps clients identify and work through their mixed feelings and come to their own decisions and solutions. Often people expect therapists to give them advice or tell them what to do – but this can take power away from clients, prevent new learning and growth, and even increase their attachment to maladaptive patterns as they react negatively to being "told what to do".

  By "disinterestedness" is meant that the therapist does not use the client to meet his or her needs. This principle not only covers more extreme examples, like sexual exploitation of the client, but more subtle things like the therapist using the client to gratify needs to be admired, respected, etc. This also refers to the therapist not using the client to promote a personal agenda, for example, about how abuse survivors should relate to family members or the perpetrator. Of course, as Judith Herman points out, this is "an ideal to be striven for, never perfectly attained" – since therapists are, after all, human beings with their own needs and motives for doing therapy, personal biases and limitations, etc.

Connection. Disconnection is another core experience of child abuse. Thus a therapist must be capable of connecting with her or his client, of being present as another human being with genuine relatedness and empathy.

- However, some people with severe abuse histories may be unable to accurately perceive the therapist at times, and may "project" their own

difficulties connecting (or those of the perpetrator or an unprotecting parent), onto the therapist.

- Also, connection does not mean "closeness" or "intimacy" in the traditional sense of non-therapy relationships, and boundaries between the therapist and client are absolutely essential. Therapists who share too much of their own experience, become over-involved or engaged in "rescue missions" are not helping their clients, but violating the principles of neutrality and disinterestedness. This can do tremendous damage to the therapy relationship, disempower the client, prevent healing, and even retraumatize the client.

Therapeutic frame. Because the therapy relationship can be an intense experience, and involves addressing vulnerable areas of one's life, it is absolutely necessary that the relationship is bounded by a "frame." This can be understood as the collection of "ground rules" that create consistency and stability in several dimensions of the relationship, thereby ensuring that it can be safe and healing.

- Elements of the therapeutic frame include the length of sessions, starting and ending on time, cancellation and payment procedures, confidentiality and its limits, etc.
- The frame helps ensure that the relationship will be a healing one, in which expectations can be established and clarified, boundaries can be maintained, and intense emotions, memories and other experiences can be contained and managed.

Much more could be said about principles of treatment. The point here has been to spell out a few that are particularly relevant to people with abuse histories. Please know it is your right to ask potential therapists to describe the principles of treatment that guide them in their work with people who have experienced child abuse.

4. Specific resources for finding, interviewing, choosing, and evaluating therapists

The Sidran Foundation has an extensive list of therapists and clinics around the country that specialize in treating people with histories of severe child abuse. See their page on Information and Referrals from Sidran's Resource Specialist. Neither I nor the Sidran Foundation can vouch for every therapist on the list; but they can usually, at a minimum, provide some good leads.

As described above, EMDR is a therapy proven to help people decrease the distress associated with memories of traumatic experiences. It is also practiced by thousands of therapist around the world, many if not most of whom are very experienced with stage-oriented treatment of people who were abused as children. You can find EMDR therapists through the Find a Therapist service of the EMDR International Association. EMDRIA's primary objective is to "establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education."

There are some more general resources on the web about how to choose a therapist. Here are three that complement each other well:

- Click on "How to Choose a Therapist" at the web site of Dr. Patti Levin
- Dr. John Grohol's How to Choose a Therapist (a bit biased when it comes to degrees and training, but has a lot of helpful information)
- So You Wanna Choose a Therapist (flippant and superficial in some ways, but covers issues not mentioned by others)

The Consumer's Guide to Psychotherapy, by Drs. Jack Engler and Dan Goleman (author of the best-selling Emotional Intelligence), is an excellent book available in paperback from Amazon, both new and used (some really cheap), and may be in your local library. Though it was published in 1992, and is not up to date on the latest treatment innovations, this book has a great deal of timeless wisdom about choosing a therapist, the nature of therapy, different schools of therapy, etc.