Section II

Strengths-Based Clinical Practices with Varying Populations
When therapists walk away from a meeting with clients feeling good about their work, or a client reports satisfaction and change in their therapy and in their lives, we argue that strengths-based work is being done. When clients have experienced complex trauma, being strengths-based can be difficult. We define complex trauma as a pervasive mindset that often develops from historical and ongoing relationships of abuse, neglect, and violation. Many individuals, couples, and families who have a history of complex trauma come to therapy stuck in survival mindstates and desperately need help managing their lives. Clients with complex trauma often begin the treatment process having been traumatized in relationships that have similar characteristics to the ones they are entering into when they seek help. Clinicians, on the other hand, come to the relationship with the explicit understanding that they are to be helpful. In most psychotherapy training programs, we are taught to begin our therapy after a brief period of “joining” to move quickly into assessment followed soon after by interventions to challenge unproductive behaviors, thoughts, and feelings. We teach skills to extinguish symptoms and create positive behavioral cognitive and emotional changes. Unfortunately, this rapid movement towards challenge and change, in fact, can and often does trigger a survival mind state for clients who have experienced complex trauma. For us, the essence of a strengths-based model is the active and transparent use of collaboration. The client is an active member of the treatment team, as therapists call upon their strengths and resources to create change. We believe in the necessity of transparently using the clients’ strengths and resources and integrating them into the creation of interventions.

Clinicians may be adept in a variety of effective treatment modalities and have an open heart but lack an effective blueprint for optimizing their relational skills and tools for interventions for those with complex trauma. Without a blueprint, when mental health practitioners are in challenging relationships with their clients they may unintentionally re-traumatize clients. Many of the clients who are seen in therapy have been emotionally, physically, sexually, financially, and/or spiritually violated and/or neglected by people who are supposed to be taking care of them. The therapeutic relationship runs the risk of repeating these traumatically stressful relationships. The use of a strengths-based model, integrating clients’ strengths and resources into the treatment design, as well as the therapists’
strengths, mitigates the possibility of becoming a therapeutic traumatic relationship. Armed with a blueprint that is explained step-by-step to our clients, practitioners and clients collaborate so that, as many clients have said about our model, “we are in this together.” One client said, at an exit interview, “there is an order to putting my life back in order.” Through full awareness and by collaboratively using our own strengths and integrating the strengths of the client, we create a non-traumatic healing context. This is the model for treatment we detail in this chapter.

The Collaborative Change Model (CCM; Barrett & Stone Fish, 2014) is a three-stage treatment plan for working with clients who have experienced complex trauma. Although our model is comparable to many other trauma-informed models of therapy, two main differences, which highlight its strengths-based footprint, are its transparent collaboration with clients and other professionals, and the emphasis we place on continuously returning to clients’ resources as a matter of course in each therapy session and the entire therapeutic process. These two concepts are literally part of the CCM protocol.

We will be writing about the first stage of our CCM for working with individuals, couples, families, and communities who have experienced complex trauma, as this is the stage where we introduce strengths-based theory to the clients. The CCM is an organizational blueprint designed to help clients and therapists have a successful therapeutic experience. The first stage, “Creating a Context for Change,” focuses on safety and transparent collaboration with clients. Stage 1 is practiced in every session and whenever a new challenge is introduced throughout therapy.

Developing a new relationship with a helping professional is stressful as is the change process. It can be disorienting and threatening. Clients often experience therapy as something that is happening to them. They have no idea what to expect and they do not understand the rules. Lacking a detailed blueprint for the process of therapy the therapist’s actions may seem confusing, irrelevant, or critical. This stressful situation triggers survival mind states in which it is virtually impossible to achieve therapeutic growth. All of our clients’ energies are focused on surviving while in this state and change is not an option. Neurobiological and developmental research has shown that we learn more effectively when our emotions are regulated and our information processing systems are functioning (Ford, 2009). When the brain is focusing on surviving as opposed to learning, therapeutic techniques and interventions are neutralized and become ineffective at best and re-traumatizing at worst.

Our model follows a clear sequence of stages (creating refuge, assessing vulnerabilities and the function of the symptom, assessing resources, exploring the positive and negative consequences of change, understanding and validating client’s denial, availability and attachment, setting goals, and introducing acknowledgment) and is at the same time flexible and adaptive to therapist style, theoretical model, clinical setting, and client-presenting challenge. Helping others grow and change is a creative and sacred process. The CCM allows each and every client and therapist together to design the creative process of change that fits their strengths and styles. At the same time, the CCM holds that the natural cycle of change occurs in all good treatment for clients with a history of complex trauma. The beauty of the model is that it organizes a journey towards healing much like a blueprint organizes a creation, for all involved in a simple recursive loop that is creative, respectful, practical, client-centered, strengths-based, and effective.

Actually, all good trauma-informed practice has a strengths-based component. All good trauma-informed treatment follows a sequence that focuses on strength throughout its many stages. This has been eloquently articulated in Greenwald’s (2007) fairy tale as an example of trauma-informed therapy. Greenwald tells the tale of a small town with a dragon and the town’s desire to rid itself of the dragon by finding a hero. In the beginning, they find the hero and urge him to slay the dragon but he does not have the desire, courage, or the skills to do the work. The town, in its infinite strengths-based wisdom, finds him a place to work out. They hire a personal trainer and encourage him along as he works hard, experiences both defeat and success, gets ready to slay the dragon, and then, with a great deal of support, is successful. In the final phase of the fairy tale, the town’s people discover why the dragon was attracted to their town to begin with and work constructively together to ensure that
the dragon never returns. Our model follows the same sequence and we often tell our clients about Greenwald’s fairy tale when explaining how therapy works to our clients.

**Literature Review**

There has been an explosion of resources for trauma-informed practice since Trepper and Barrett (1986, 1989) published their first books on the systemic treatment of incest, in which some foundational elements of our model were initially introduced. Some of these new resources have informed our work because they resonate with our model, with feedback from client exit interviews we have conducted, and because they focus on clients’ resiliency and strengths. The trauma-informed practices that have significantly influenced our work focus on ways to create healing environments for clients (e.g., Bloom, 1997; Briere & Scott, 2012; Courtois & Ford, 2012; Herman, 1992; Van der Kolk, 2014; Miller-Karas, 2015). These practices empower clients with a history of complex trauma, value the dynamic interplay between trauma mind states and resiliency, and help therapists create environments in which the natural cycle of growth can be accessed.

Strengths-based trauma-informed practice is helped by information we have gathered by interpersonal neurobiologists (e.g., Badenoch, 2011; Siegel, 2010) and by those healers who take a somatic experiential approach (e.g., Levine, 2010; Miller-Karas, 2015). After studying the brain and the effects of trauma on the mind, Siegel (2012) has suggested that there are four essential ingredients for successful therapy: seen, safe, soothe, and secure. Siegel believes that clients must be seen by therapists, feel safe in the therapeutic environment, feel soothed by the process of therapy, and feel secure with the therapist’s skills and competence. When clients experience the therapeutic encounter in this manner, their natural resources for growth and change are accessed.

Strengths-based trauma-informed practice is further enhanced when the mind is helped to focus on body sensations that enhance clients’ access to resources. For example, many trauma-informed therapists are greatly influenced by the somatic experiencing approach (Levine, 2010), which helps explain how the body holds trauma and how the body can release it. Focusing on inner resources and a centered place of warm memories can help clients weather the negative effects of traumatic memories when they arise. Recognizing, honoring, and encouraging clients to attend to their body’s wisdom is a strengths-based practice.

Last, trauma-informed practice that is attachment based (e.g., Hughes, 2006; Johnson, 2005; Muller, 2010; Siegel, 2015) can also be considered strengths-based practice. Hughes’ (2006) work focuses on helping caregivers create loving environments for children who have attachment disorders. Although the term *attachment disorders* seems pathological, it actually helps parents make sense of a child’s behavior in ways that engage them to experience their child in a positive light. Johnson’s (2005) work with couples who have experienced trauma seems to have an effect similar to Hughes’ work. Her work is strengths-based because she helps couples use their commitment, warmth, and inner resources to heal attachment based injuries and the impact of traumatic events. All of the above mentioned trauma-informed, strengths-based practices inform the CCM, which is detailed subsequently.

**Application of the Strengths-Based Technique**

The CCM blueprint divides treatment into three stages and each session has all three stages within it. These stages are modeled after the cyclical phases of natural growth and evolution: The contraction/pause phase is followed by an expansion/growth phase, which leads naturally into a consolidation phase (for more information about these phases, see Barrett & Stone Fish, 2014). The therapeutic healing process happens in these three stages over time, each session includes the three stages, and within each session the same cycle recurs again. This is the blueprint for therapy, both a visual map and a language that organizes the labor of everyone involved. The goal of the blueprint is to help all
participants understand and envision the project and goals of the shared work and to help guide our clients into their own natural cycle of growth.

Stage 1 is Creating a Context for Change, Stage 2 is Challenging Patterns and Expanding Realities, and Stage 3 is Consolidation. Every session includes all three stages, which means in each session we create a context for change, challenge some patterns, and re-ground, helping clients center before ending the session, and engaging with their natural environment. For the purposes of this chapter, we focus on Stage 1.

The foundational work of Stage 1 is the most important stage of the evolving cycle and is actually crucial to the success of therapy. If you do not create a context for change with clients who have a history of complex trauma, they may experience therapeutic interventions from a survival mind state and treatment runs the risk of being re-traumatizing. In most instances, when individuals have difficulties controlling their emotions, cognitions, behavior, and relationships, we believe they are acting from a survival mindstate. They experience themselves as powerless, out of control, devalued, and disconnected and they react to stress from the survival mindstate of fight, flight, and/or freeze. When in a survival mind state, clients are not open to the change process and therapy may actually do more harm than good.

Unfortunately, for both clients and clinicians, Stage 1 seems to be the most misunderstood and least respected stage of therapy. It is skipped entirely or rushed and this undoubtedly creates therapeutic failures. Mental health practitioners see themselves as change agents, yet they risk re-traumatization, misalliance, and premature termination if they do not honor the importance of Stage 1. All clinicians have seen clients who have dropped out of other therapists’ practices quite prematurely and though the ex-therapist may never receive feedback about the premature termination, it is often because the therapist failed to respect the importance of Stage 1.

Most of us are trained to begin our therapeutic relationship after a brief period of “joining” to move quickly into assessment followed soon after by treatment planning and interventions. This rapid movement towards challenge and change is stressful, it can be disorienting and threatening to clients who present in survival mind states. In fact, clients with a history of complex trauma, who are not in survival mind states when they begin treatment, can actually be triggered into survival mind states because something is happening to them that is completely unexpected and danger signals are set off. Without a strengths-based Stage 1 perspective, clients become labeled as resistant.

In Stage 1, we share our blueprint of therapy. We are collaborating with clients throughout the entire process, actively informing them of where we are and where we are going. As transparently as possible, we help clients understand that therapeutic change is a process of moving them from survival mind states to engaged mind states in which they are using all parts of their brains, not just those parts that have protected them in the past. Because repetition is crucial to growth, we repeat these concepts as much as possible in all stages of therapy. Our conversations about the therapy process and how we understand the nature of therapeutic change are deliberate and ongoing conversations. We partner in collaboratively designing the face of therapy.

Actually, when Stage 1 is minimized or rushed, clients with a history of complex trauma may simply stay locked in survival mind states, in some version of fight, flight, or freeze. Practitioners may unwittingly experience their clients as resistant and a negative cycle of interaction envelops the therapeutic context. When the blueprint for therapy follows a strengths-based and natural cycle of evolution, stress reactions are to be expected and can be managed collaboratively by creating a context for therapy and a context for change within each session. This stage of context creation might need to be repeated often in a session and during the overall therapy. When we look at growth and change in nature, we notice that the cycles are repeated, the sun, moon, and tide daily, whereas a tree repeats the same cycle annually. It is not therapeutic failure, nor a regression, it is the natural cycle of evolving—we call it pause and ponder. We pause and cocoon, taking time to recognize the pause and then we gently expand to new thoughts, behaviors, and feelings. Growth and change is a repetitive
cycle. We cannot improve in any area of our life without repetition, thus we repeat the pause and ponder cycles over and over again within the session and throughout treatment.

In a recent first interview the following dialogue took place.

**Therapist:** Can you tell me everything about all your past therapy and treatment that worked and did not work for you? What did you like and what did you not like?
(At this point the therapist observes the client shutting down. Her skin became pale, she looked off into space, broke the previous eye contact, and did not say a word or make a move.)

**Therapist:** Remember when you told me that you often shut down as a coping skill? Did it just happen? You look like you might have shut down?

**Client:** Yeah. I did.

**Therapist:** Do you have any idea what might have happened? Do you know what I did that might have triggered the shut down?

**Client:** You asked me to make a decision.

In paying attention and asking questions, the therapist and the client learned important information about the client and their burgeoning therapeutic relationship. They learned that decision making, in the presence of this therapist at least, threatened the client and she shut down. Knowing this information allowed the therapist to create a context where the client would feel more empowered, safe, heard, understood, and secure before she was asked difficult questions.

Stage 1 has seven core components: creating refuge; assessing vulnerabilities and the function of the symptom; assessing resources; exploring the positive and negative consequences of change; understanding and validating client’s denial, availability, and attachment; setting goals (which is not discussed in this chapter); and introducing acknowledgment. All seven components happen in Stage 1 though in an order that fits for each therapist and client encounter. For the purpose of a coherent narrative, however, each of these principles is described separately.

**Creating Refuge**

Strengths-based practice is grounded in encouraging clients to experience themselves as safe and secure enough to change. Safety has to come before evolving can take place. Similar to Siegel’s four S’s (seen, safe, soothe, and secure) safety is part of the therapeutic context and relationship, and is practiced interpersonally and internally. We talk with clients at our first encounters about safe places, safe moments, and safe memories that they can access in therapy and outside of therapy when they experience stress. Creating refuge includes exploring safety, understanding the cultural and contextual variables that may interfere with experiences of safety, multidirected partiality (Bozsormenyi-Nagy & Krasner, 1986), and pretreatment planning.

We train thousands of practitioners in the CCM and spend as much time and energy on Stage 1 with practitioners as we expect them to spend with their clients. CCM therapists must experience safety, both physically and emotionally, in their offices as well. Although the metaphor is overused, reminding therapists to put their oxygen masks on before they help clients’ put theirs on is an apt comparison. To do strengths-based work, therapists must be filled with hope. When depleted, frustrated, and/or experiencing yourself as useless, hope is often the first belief to go. To do good work, therapists must be ethically attuned to their clients (see Barrett & Stone Fish 2014 for further detail). Practitioners often experience profound satisfaction when their clients are making progress. When clients have more difficulty, which is often the case with clients who have experienced complex trauma, they may trigger uncomfortable thoughts and feelings for the practitioner. Without proper Stage 1 work on themselves (recognizing when they do not feel safe and secure and acquiring techniques for returning to their engaged mind states) practitioners may lose balance and end up being less helpful than they could be. Doing well with clients with complex trauma histories requires that
therapists be grounded in the CCM, and be in supervision and/or consultation with other therapists so that they are always engaged in supportive and helpful environments.

Once we have created refuge within, it is time to consider safety with our clients. We ask clients about their internal and interpersonal harnesses. Harnesses are those resources which keep us grounded, calm, cool, and collected. We may explore these harnesses experientially with clients and/or if grounded in somatic experiential theory and technique (e.g., Miller-Karas, 2015), may have clients go into their bodies to experience these resources. If we think it might be helpful, we might also ask clients to think about a time in their childhood when they felt safe and to draw that particular moment on a sheet of paper. We, again, are as transparent as possible, and always open to the possibility that no safe place arises. If they are able to access safety through such an exercise, we let clients know that this drawing is for them and that they do not have to share it with us, encouraging a sense of boundaries and empowerment.

We let clients know that our intent is to create this experience of safety within the context of the therapeutic relationship. We explain that the experience of safety is felt when we are calm, centered, and grounded, when we are in control and experience agency and the ability to be competent. We experience a sense of balance and serenity. When we feel safe, if we sense danger, we sense that we have harnesses in place to tolerate stress, we are capable of coping well, and we feel supported by other(s).

**Contextual Variables**

Strengths-based trauma-informed practice helps therapists and clients focus on creating refuge from contextual variables that dehumanize clients and leave them vulnerable to re-traumatizing events (Stone Fish & Harvey, 2005). Contextual variables that zap strength include but are not limited to variables such as gender, age, religion, race, class, and sexual and gender identity. In Stage 1, we ask about how the sociopolitical culture negatively and positively impacts our clients. Much of what mental health training teaches us is about how the majority culture pathologizes minority cultures and the effects of marginalization. These are real issues and we want to make sure these influences do not negatively impact the positive development of therapeutic relationships. So for example, when we train male therapists working with clients who have been traumatized, we help them acknowledge sexism and the undue privilege they experience based on their gender in the same way we urge white therapists to be cognizant of how their white privilege informs their therapeutic relationships. We ask about how clients feel powerless, damaged, out of control, or disconnected because of their sociopolitical contexts.

What training often fails to acknowledge, however, are the strengths inherent in many minority cultures and communities that offer great social support for our clients. When we have not been trained to see, we forget to ask and treatment may lack this important resource if the therapist does not make a deliberate effort to ask. For example, Rachel sought therapy because she had been sexually abused by her Rabbi as an adolescent. She discussed how the Rabbi traumatized her, not only through his abuse, but because she could not do anything associated with Judaism, nor walk into a temple, because of the impact and memories of what he had done. Rachel’s therapist asked her to think about ways her religious practice was a resource, in what ways she felt connected, in control, and powerful in relation to religion and spirituality and how she could develop that now. Rachel found another synagogue, led by a progressive female Rabbi and developed community, that became a vital and important part of her healing context. Had her therapist not been curious about contextual resources, this may never have happened.

**Multidirected Partiality**

As part of creating refuge in the CCM, we discuss with clients who is or was in their social networks and how we might use those individuals as resources in the process of therapy. Boszormenyi-Nagy
and Krasner’s (1986) concept of therapeutic multidirected partiality is something we explain to clients. While in all clients’ lives there are victims and perpetrators, the concept of multidirected partiality suggests that every member of a client’s context is worthy of care and consideration. Although many clients cut off from or give up on multiple people in their social networks, it is our experience that there are untapped resources of social support that may not be mined unless the therapist has a strengths-based approach. There are relationships in our clients’ lives that are toxic, dangerous, and unsafe. These are usually not relationships in which clients receive much in the way of love and support. There are, however, other relationships, sometimes tied to toxic relationships, that can be mined. Helping our clients develop a different understanding of their relationships, with the concomitant development from the guarded survival mind state to the more receptive engaged mind state, is a beginning conversation in creating a context for change.

Although we believe that every person in a client’s life is worthy of care, strengths-based work requires safety consciousness, and we must always seek to determine the risk of harm to clients outside the therapy office. Part of creating a context for change is helping clients assess their current level of safety interpersonally and internally. We often create informal or formal safety commitment contracts that are continuously revisited throughout therapy. Safety contracts can be designed as casually or as detailed as the threat of harm demands. In many ways, Stage 1 can actually be conceptualized as designing an overall interpersonal and internal physical safety plan. One goal of therapy is for clients to find refuge and safety in their lives and to be able to access it when necessary. This is an important way to use the pause and ponder sequence. We help clients take a safety inventory in a pause moment, then re-engage and explore safety, then expand by designing a safety plan, which is examined in each subsequent session.

**Pretreatment Planning**

Pretreatment planning is a necessary and significant part of any strengths-based, transparent, and collaborative protocol and part of creating refuge. We often compare the CCM to a blueprint for building a house, once you have the blueprint then you communicate with the contractor and the subcontractor and make sure everyone is on board and properly tooled to complete the job. Pretreatment planning includes the collaborative measures taken to build a team with professional and personal people involved in our clients’ lives. Strengths-based practice values influence from people who may be able to facilitate the metamorphosis from a reactive to a responsive environment. We begin this process by reviewing past experiences with helping professionals. We ask about other helping professionals: teachers, caseworkers, probation officers, physicians, nurses, alternative healers, psychotherapists, etc. We are interested in both the helpful and the unhelpful interactions and relationships, those that harness the natural cycle of growth as well as those that inhibit growth and development. If we discover, for example, that one of our clients had a positive relationship with a middle school teacher, we ask about the specific nature of that relationship and what was helpful.

Pretreatment planning introduces collaborative work with other professionals in our clients’ lives. When possible, we talk to other professionals with our clients present to create a collaborative and transparent treatment plan. We also discover other professionals’ expectations for our clients and their goals for treatment. We attempt to clarify roles so that duplication of services does not occur, and so that as many of the clients’ needs are met as possible. Ideally, we meet periodically throughout the treatment process.

Pretreatment planning also considers clients’ social network, family, and friendship connections. Many clients with a history of complex trauma have supportive relationships that are undervalued, under recognized and underutilized. We focus our curiosity around the nature of relationships that support engaged mind states contrasted with those in which clients are caught in interactional cycles.
Mary Jo Barrett and Linda Stone Fish

of survival. Therapists and clients often focus exclusively on survival cycles and dangerous relationships that we forget to ask about the “angels” in our clients’ lives. Of course, asking about safety and violence in all of our clients’ relationships is important and needs to be done in individual sessions in a way that promotes self-disclosure. We discuss duty to report and informed, mindful, and engaged ways to probe clients about unsafe relationships in our book (Barrett & Stone Fish, 2014). Strengths-based trauma-informed practice is clear, transparent, and collaborative and clients are partners in keeping themselves and contexts as safe as possible.

Individual, couple, family, and group therapy are discussed in pretreatment planning as options for treatment at different stages of change so if violence makes it unsafe to see individuals together, the blueprint already accounts for individual treatment. Exploration of pretreatment variables may be threatening to clients with a history of complex trauma so that in-session behavior from clients may be from a survival mind state. When we notice clients react, it is time for the clinician to pause, and in the moment recreate safety through techniques that bring clients into a more engaged mind state.

Assessing Vulnerabilities and the Function of the Symptom

The second part of creating a context for change is assessing vulnerabilities and the function of the symptom. We introduce the idea that when people feel vulnerable, they act to feel powerful, in control, and/or to feel valued. We explore the connection between vulnerabilities and symptoms. We believe that the function of many symptoms that clients bring into therapy is to help them feel powerful, in control, and valued. When individuals in survival mind states feel fear and vulnerability, they act to feel powerful, in control, and valued. Because they act from survival mind states, the reactions often become symptoms. The function of the symptom is to help feel less fearful and vulnerable but symptoms end up not being helpful (which is why they are called symptoms). Rather than looking at symptoms as weaknesses, they are framed as attempts to cope with feelings that are experienced as unmanageable.

We assess vulnerabilities internally and interpersonally. Internally, we are curious about mind and body symptoms that make it difficult for clients to function. Flashbacks, states of disassociation, and nightmares are examples of symptoms as are body aches and pains, self-harm, anxiety, depression, suicidality, eating disorders, and/or drug and alcohol use and abuse. Abusive behaviors towards others in the form of emotional, verbal, physical, and/or sexual maltreatment are assessed. When acknowledging the functional and protective nature of the symptoms, we are accessing their strengths and resources. For these symptoms at one time “worked” for the client, helping them avoid painful feelings, memories, and dangerous situations. These symptoms no longer work, yet we can call upon other of the clients’ strengths to create new behaviors that are less avoidant and potentially less harmful to the client. Some clients enter therapy already acknowledging that symptoms are used to cope with vulnerabilities while others experience feeling powerless, out of control, and devalued but have no insight into how or why this occurs.

Intimate relationships that are chaotic or avoidant are seen as vulnerabilities as well. Vulnerabilities and the function of symptoms are often two sides of the same coin in almost all vulnerabilities, particularly where relationships are concerned. When clients have been traumatized in intimate relationships they are likely to avoid or resist intimacy so the function of the symptom ends up making them more vulnerable. Pushing people away or alienating them with one’s behavior serves to increase vulnerability. Strengths-based trauma-informed practice does not shy away from difficulties in our clients’ lives, it helps make sense of them as coping strategies that have been helpful in the past.

Assessing Resources

Assessing resources is as important as assessing vulnerabilities because clients’ strengths are the cornerstone to the healing process and to a strengths-based approach to treatment. Resources are the
non-symptomatic behaviors that we use to help regain power, control, and value. Although clients often enter therapy in despair with the firm belief that they are continually experiencing symptoms they are not, in fact, always symptomatic. We explore resources as both a way to work towards safety and a means to effect change. An awareness of the clients’ resources will help create a context of change while an awareness of their vulnerabilities will help design later interventions. For example, if a client is an introvert, we would not recommend group psychotherapy in the initial phase of treatment. Clients prone to introversion might have difficulty in a psychotherapy group because they have to engage with other people. While inability to engage in social support may keep them stuck in survival mind states, introversion is actually seen as a resource that is highlighted in Stage 1.

Resource assessment is similar to vulnerability assessment in that we are curious about internal and interpersonal resources. Internally, we ask about ways that clients have used resources to be able to experience being in control, powerful, and connected. We ask about psychiatric medication, and sometimes clients report that medication is the only thing that they can count on to calm them down and feel in control. We believe it is important to discuss our collaboration with the medical community and how useful it may be to have a thorough psychiatric evaluation in circumstances surrounding medication. Clients have told us that they really appreciate this discussion in the beginning stage of therapy. They contrast our approach with previous therapists who have suggested a psychiatric evaluation in a middle stage of therapy, causing clients to wonder whether their therapist believed they were mentally ill and what they said or did to alarm them. Terry’s quote is a good example of assessing resources in therapy.

Terry is a 45-year-old teacher whose earliest memories include being in a car accident in which his father drove into a tractor-trailer and killed his mother and younger brother. Terry developed such severe anxiety symptoms whenever a school shooting occurred in another community that his survival mind state made it impossible for him to function in the classroom. He was interviewed after treatment about what he remembered being helpful:

In the second or third interview, I had brought a cycling helmet into session because I was training for a half Ironman. My therapist asked me about the training and throughout therapy, which lasted about a year, she kept going back to something I said in that session about my confidence in my athletic abilities. Whenever I would feel defeated, fearful, anxious, or depressed, she would somehow bring it back to my confidence as an athlete, how I felt powerful and in control while biking and running and actually swimming as well. I guess I assumed therapy would be all about me opening up the past and learning new ways to focus on the present but instead it felt like she was encouraging me to hold onto what was good and build different kinds of muscles as well (Barrett & Stone Fish, 2014, p. 94).

Resources are interpersonal as well. Clients feel powerful, in control, valued, and connected in some of their friendship networks, extended family, and work or mentoring contexts. While there are many people in our clients’ lives who have treated them horribly, there are often a few who have been angels and who have enabled and encouraged their progress in life. An integral aspect of strengths-based trauma-informed therapy is bringing these angels into the change process, figuratively or in reality. When inquiring about relationships in which clients feel valued, we often find themes that these relationships have in common and they can be highlighted in the therapeutic relationship. So, for example, in Terry’s case, when he was asked about relationships where he felt powerful, in control, valued, and connected, he talked about friends and colleagues who shared his sense of humor. His therapist asked whether that was something he wanted to bring into their relationship and they talked about the use of humor as a resilient but sometimes delicate response to traumatic events.
Strengths-based trauma-informed practice also highlights the value of community as a resource for practitioners as well as clients. Working with clients who have a history of complex trauma is difficult work that is best done in collaboration with other professionals and gathering as much support as possible. None of us are expert at everything. Most communities are filled with practitioners who are experts in areas that a particular therapist is not and it is the expectation that practitioners consult with and refer clients to other strengths-based trauma-informed practitioners throughout the community.

Exploring the Positive and Negative Consequences of Change

The fourth component to creating a context for change is discussing the positive and negative consequences of change. When we discuss the positive and negative consequences of change for specific goals our clients are setting, we help them begin the process of using their engaged mind state. Thinking about change can be a trigger into survival mind states because change is uncomfortable, and breeds uncertainty, which may trigger fear and danger. When we are thoughtfully engaged in articulating some of the possibilities that the change process elicits, we help clients begin to experience some control over a process in which they have felt powerless in the past. Communicating and being mindful, which are two of the important components to engaged mind states, helps clients experience the possibility that they can indeed change and that their lives will improve.

In the process of engaging in creating a context for change, clients begin to understand that the symptoms they have been experiencing, which are incredibly painful, have their uses. They have come to recognize, for example, that cutoff keeps them from experiencing rejection or that anger outbursts keep them from getting hurt. What they are learning in this part of therapy is how these negative consequences keep them stuck in survival mind states and in interactional cycles of survival. Therapy, by its very nature, is intended to change clients’ lives. In the change process, we may leave behind things that we may not be aware we will miss until we miss them. Preparing clients for what they will miss makes it easier when they come up against the negative consequence of embarking on the journey they are taking.

Many clients come to therapy to work on intimate relationships that they know are clearly destructive. Although clients can give you all the reasons they should leave these toxic relationships, they are often unable to extricate themselves, and if they do, they are pulled back in all over again. Family members and friends have told them they deserve better than this, that the person they are involved with is abusive, neglectful, not worthy of them, using them, and does not value them. It is obvious that clients and their communities clearly understand the likely positive consequences of change. They know that leaving this destructive relationship will please those who worry about them, free them to be available to meet someone who will treat them better, and will enable them to start living the life they deserve and had always imagined for themselves. It is much more difficult, however, for them to contemplate the negative consequences of leaving the relationship.

The negative consequences of leaving the relationship are often covert and avoided and become part of a negative interactional cycle. One negative consequence, for example, is fear of how the break up will affect the partner. They may fear that partners will harm themselves, the client, or other loved ones. Consequently they wrestle with their sense of responsibility for this aggression. This is a complicated dilemma because family and friends have told them repeatedly that they only have control over their own thoughts, feelings, and behavior. On the other hand, our clients have the lived experience of how other people have impacted—if not completely dominated—their thoughts, feeling, and behaviors. When we talk about the negative consequences of change, we must take into account the stark reality of destructive, toxic, and/or abusive relationships and how difficult they are to leave.

Another negative consequence of leaving a relationship that is toxic is the feeling that people have about themselves. Most people do not enter into a loving relationship with the motivation to hurt someone else. Even adult children in toxic relationships with their parents who may be angry at
their behavior use their anger to protect themselves, not necessarily to hurt another. Most people do not like to think of themselves as perpetrators of others’ harm. “I am not a bad person, I am a good person and it is not my intention to hurt anyone,” is a mantra we hear over and over again when people think about their own behavior. The negative consequence of leaving a relationship is that it hurts others and flies in the face of our definition of self. This needs to be acknowledged as we move forward in the change process.

Self-destructive behavior provides another opportunity to explore the positive and negative consequences of change. Clients may come to therapy ready to acknowledge that overeating, for example, is starting to become problematic but they are unaware of how the negative consequences of stopping are going to be addressed. Overeating is a convenient way to relax and forget about your problems. Abstaining completely or even reducing frequency or quantity of average consumption may very well result in having to face problems that feel insurmountable. Discussing the negative consequences of change examines the specifics of how overeating helps clients cope, and helps the client project what losses will be experienced when this coping mechanism is no longer utilized.

The intent behind addressing negative and positive consequences is to acknowledge major behavioral patterns and minor ones. Each time a change is warranted, negative and positive consequences should be discussed. So, for example, if a partner states that she wants to spend more time with her partner, she is encouraged to identify what she would be losing. This ensures that the change process, when it occurs, becomes something that the client implements with full awareness. When clients examine both positive and negative consequences and recognize that the advantages to changing outweigh the disadvantages then they are ready to take the risk of the negative consequences. We often find, if we do not spend enough time discussing this component to creating a context for change, that we become more invested in the change process than the client.

Understanding and Validating Denial, Availability, and Attachment

The human brain allows us to function by compartmentalizing experiences, thoughts, and emotions. Although this is a highly successful survival strategy in everyday life, when our brains compartmentalize certain aspects of our experience, our engaged mind is less available. Many clients who have not had the experience of being able to self soothe when in distress adapt by compartmentalizing painful feelings. These feelings are then, often, unavailable for processing and therefore misunderstood. The feelings are there and clients react from them but they often do not have access to them in a way that is helpful.

Attachment style affects our ability to access emotional states, process memory, and understand responsibility in relationships. Clients who have attachment styles that tend to be avoidant, preoccupied, disorganized, insecure, or dismissive often have a difficult time directly accessing and controlling emotions and so are often unavailable to themselves and others. They may have trouble taking responsibility for their behaviors or acknowledging the impact of their behavior on self and others. They may also have difficulty acknowledging the impact of others’ behaviors on them, or simply even remembering facts, or situations. Clients who are lucky enough to have lived with responsive caregivers have a mediating variable that is not present with clients whose attachment to caregivers is not secure. Responsive caregiving facilitates the capacity to stay present in the moment and incorporate new information and access most aspects of their experience, in other words, to be in an engaged mind state. In creating a context for change, we explore denial, availability, and attachment.

Our strengths-based perspective conceptualizes denial as a strategy formulated—consciously or unconsciously—while in a survival mind state. The process of compartmentalizing and denying material is a coping mechanism for surviving unmanageable stress. The problem, of course, is that in a survival mind state, most stress is perceived as dangerous and unmanageable. The survival mind is singularly focused on the perceived threat and lacks access to engaged mindfulness and feelings of
control, power, value, and connection. Instead, in survival mind state, threat makes it so that we do not have available an awareness of the facts, the impact, and/or our relationship to what is occurring. This lack of availability is another way to look at dissociation and denial. We simply speak of what we have available to us in the real or perceived moment.

It may seem counterintuitive to validate a part of behavior that we have learned in our training is a defense mechanism that keeps people from being honest with themselves and others. In fact, this unavailability is alive and working in almost every situation of complex trauma. Part of creating a context for safety includes understanding the importance and the effects of unavailability in clients’ lives. The unavailability exists internally and interpersonally. We experience this, as therapists, in the room with our clients, when they do not have an experience available to themselves or when we are aware they are no longer available in therapy or engaged with family members.

When clients are able to acknowledge the effects of complex trauma and how their behavior is affected by it, and how their behaviors and feelings affect others, they have integrated a strengths-based trauma-informed perspective. It is paradoxical that one way to survive a threatening thought, feeling, or action, whether triggered internally or interpersonally, is to avoid the facts of the trigger, the impact of the trigger, or to take responsibility for the threat. Yet it often occurs that, in order to survive a perceived threat, avoiding its existence allows us to survive. Although adaptive for a while, however, we often adapt by becoming unavailable to the narrative of our lives or the narrative becomes unavailable to us. When clients understand how the adaptation was useful, take responsibility for the ways in which it has outgrown its usefulness, and are open to the possibility of experiencing life differently, they are ready to move on with the change process.

**Introducing Acknowledgment**

We believe that the role of acknowledgment is one of the most powerful and most underutilized interventions in therapy with complex trauma. Acknowledgment is the burgeoning recognition of how clients understand their symptoms and how they contribute to their problem cycles. Acknowledgment is an increasing awareness of impact, facts, and responsibility, and clear statements about what they are committed to changing. Each acknowledgment in a session can easily be woven into the client’s goals. So once again, just like the cycle of change and the stages of therapy, acknowledgments happen repeatedly during a session, and throughout the stages of treatment. When a client acknowledges a thought, a feeling, or a behavior during a session it is the practitioner’s responsibility to capture that moment and integrate it into the process of change.

**Client:** I just wish I knew how to handle my anger.

**CCM Therapist:** Wishing that you knew how to handle your anger is a great start. Recognizing that you want that to change is incredibly important. Should we make that one of our goals?

**Client:** Sure, sounds like a good idea.

**CCM Therapist:** Let me share with you some of my ideas of how we might learn some skills that will help you meet your goal.

Following is another example:

**Client:** I have absolutely no idea of how to handle my daughter’s cutting. I just don’t understand it! I am completely overwhelmed.

**CCM Therapist:** You saying that and me knowing that is really helpful. I bet her cutting is triggering a lot for you, which makes it even harder to know what to do.

**Client:** That is for sure.
CCM Therapist: You recognizing that gives me some ideas about the direction our sessions could go. You are acknowledging that you feel overwhelmed and you have acknowledged before that when you feel overwhelmed you retreat and, using your words, “go home and lick your wounds.” You’ve also talked about wanting to be more involved in parenting her so we can work on different things for you to do when you are overwhelmed instead of retreating.

Acknowledgment sessions signal the end of Stage 1, and are the set-up for Stage 2. It seems as if, once people can acknowledge that what they have been doing is not working and that they have the power and control to change their behavior, we can move into Stage 2, which is the work of changing that behavior. Acknowledgment sessions are another example of the importance of an organized approach to treatment. They mark the delineation between stages when working on a specific goal.

Remember that a person can be in Stage 1 in one form of treatment and Stage 2 in another. For example, a couple may work all the parts of Stage 1 and then acknowledge how they contribute to their interactional cycle of survival and clearly be ready to start making changes, which is Stage 2 work. Although in Stage 2, however, when they begin to struggle with communication and deeper intimacy, one partner or both may realize that there are some individual or family of origin issues that they must address and for those issues, we pause and reorganize, utilizing Stage 1 language and interventions. Refocusing on safety, goals, assessment of needs, and resources is not conceptualized as a regression or set back to Stage 1. Rather, this oscillation is a simple and elegant part of the natural cycle of change, which includes pausing, regrouping, refocusing, and then moving into expansion. Like the blueprint for a house informs construction, we are forever running into unforeseen circumstances in which we must consult the blueprint, so that we can move forward in a constructive way that respects clients’ needs for feeling valued, in control, and powerful.

Acknowledgment sessions can be formal or informal. Some of this depends on the practitioner’s style and work environment, and some depends on the clients, their particular situation, and why they were referred for treatment. When practitioners work in formal environments where paperwork is completed at the end of Stage 1, then acknowledgment sessions are more formal. Acknowledgment occurs and a treatment plan is designed which begins Stage 2. In some agencies, acknowledgments and a treatment plan are written and signed by both clients and practitioners or even by the team that is working with the clients. In less formal settings, acknowledgments may not be formally documented but they nevertheless must occur for treatment to move to Stage 2.

When treatment is mandated by the judicial system then the acknowledgment sessions tend to be more formal as well. Probation officers, caseworkers, and judges may want a formal statement not only that their clients are following through on treatment but also that they have acknowledged problematic behavior and have established concrete goals towards working on change. When working with other professionals, the CCM practitioner can explain to all involved how Stage 1 sets the stage for helping clients reach treatment goals in Stage 2 so that everyone is working the model together.

Case Example

Jody Smith (21) and James Smith (22), a white, heterosexual couple, had their two daughters (a 3 year old and a 1 year old) removed from their home after a neighbor called the police because Jody and James left the girls home alone. The girls were staying with James’ aunt and the couple was mandated to attend parenting classes and engage
in family therapy. They were assigned to Kaylea, a CCM-trained practitioner. When Jody and James began treatment, they wanted the girls back and blamed the neighbor for them being removed. In the first session, James stated: “We are coming here to get the girls back and we will do anything you tell us but just to be clear, we did nothing wrong. The bitch who reported us did it for revenge. I called the police on her boyfriend last month because he pulled a gun on me and she wants me to pay. I’m thinking about calling a lawyer and suing her ass.” Jody agreed with James. Kaylea appreciated the couple’s perspective and their goals for therapy and explained how she could help them reach their goals. She understood, at this point, that they both felt powerless, devalued, and out of control, and she expected therapy to help them change this.

Creating Refuge

Kaylea talked with Jody and James about safety both outside and inside the therapy room. Both expressed a great deal of rage at their neighbor, Jody’s mother, and James’ parents for not taking the girls, and anger and blame towards each other for their current situation. They both acknowledged lots of yelling but a commitment to a non-violent relationship following an incident when they were first together that scared both of them enough to commit to, and to maintain, a pact to never touch each other or anyone else when they were mad. Affirming this tremendous accomplishment, Kaylea explored safety in the therapy room by talking with the couple about their experience of safety and by explaining the CCM stages and the change process. Following numerous conversations about safety, vulnerability, how the brain works, and survival mind states, Jody and James began to feel safe enough to explore some of their own behavior. They both acknowledged that they were quick to blame others for their problems, that they actually could use some parenting tips when they were overwhelmed, because everyone could, and that they did leave their children unattended on numerous occasions. They were not ready, however, to take responsibility for their behavior, nor for their children being taken from them.

Kaylea explored the couple’s contextual variables that helped and hindered them. They shared experiences they both had had growing up feeling poor and “broken” compared with some of their peers, based on incidents that occurred in school and in their neighborhoods. Jody told a story about a school teacher that made her not trust the system to currently attend to her and her family’s needs: “When I was in seventh grade, my family was evicted for like the tenth time and I came to school really tired and really late because we were sleeping on my auntie’s couch and it was me and my sister and not a lot of room and we had to take two buses to get to school because she didn’t live in the district. I walked into class one day, I’ll never forget it, and this stupid teacher, in front of the entire class, looked at me with a huge scowl on her face and she said, ‘what’s the excuse this time Jody-girl, parents abandon you and run off to Vegas?’ All the kids laughed, I turned bright red and slumped over to my desk. No apology, no nothing, the only notice I ever got was negative.” Kaylea helped Jody make the connection between this and other horrific experiences as a child and teenager and her current experience of feeling powerless, disconnected, and devalued.
Assessing Vulnerabilities and Function of the Symptom

Because both Jody and James mistrusted authority, access to social support or outside help was threatening and dismissed. Child Protective Services had been called to their home on a few other occasions, and in-home family therapy was offered. The Smiths talked about how awful that experience was for them, they were angry and resistant and refused to try any of the techniques offered by the agency’s puppet, which is what they called the in-home therapist. Kaylea and the Smiths discussed the function of their resistance. They felt powerless and devalued by Child Protective workers and the in-home therapist so they took whatever power they could muster to resist help. They both recognized, in fact, that this strategy was something they used with their families and their friends. They needed help with the children but when it was offered, it felt like criticism so they could not take it. Their coping mechanism, when dealing with unmanageable stress from trying to raise two small children on a limited budget and all alone, was to isolate and avoid anyone who might tell them that they were inadequate.

Assessing Resources

Jody and James, while alienated from family and neighbors, had created a united front against the world, which was a resource that Kaylea explored with them. They had never seen this as a strength and once they began to explore it, noticed that they had another untapped resource in their biking community that they could use. The Smiths were avid motorcyclists and were part of a community of cyclists who acted as family members to each other and many had offered on numerous occasions to help Jody and James with their daughters, yet Jody and James had never taken them up on their offers because of their avoidance of social support. The other untapped resources they had going for them was their work ethic. They were both employed full time and well respected at their jobs. Part of the reason they had left the children unattended had to do with work schedules that were inflexible so there were certain hours of the day when they both had to be at work. Because they had no help with the children and took their responsibilities seriously at work, the children were removed. Jody and James had taken their work ethic for granted until it was highlighted as a tremendous strength by Kaylea and offered up as a hopeful ingredient in putting their lives back together.

Exploring the Positive and Negative Consequences of Change

When Kaylea first introduced this concept to the Smiths, neither Jody nor James could think of any negative consequence to getting their girls back. Kaylea worked hard to help them see some of the negative consequences. For the Smiths to be the kind of parents they wanted to be, they had to acknowledge that they needed help from other people. The negative consequences of asking for help were many; they could be disappointed, they could get criticized, the children could get hurt by other people, the children could get close to other people, which might cause envy for the Smiths; that is,
their united front might crumble, et cetera. Each of these consequences was explored in detail and discussions ensued about what they would do if and when any of these things occurred. The fear of facing what felt to both of them was unmanageable stress, if they let others into their lives, helped them recognize why change was so intimidating. In Stage 1, Kaylea made it clear to the Smiths that she was not asking them to change their behavior, just to acknowledge the complexity of the change process.

**Understanding and Validating Client’s Denial, Availability, and Attachment**

Once safety was established and the Smiths began to trust Kaylea, they began talking about the consequences of leaving young children unattended. In the initial interviews, Jody and James denied leaving the girls alone. Once they felt safe with Kaylea, they were able to acknowledge that they did leave the girls alone but it only happened a couple of times and the girls were asleep and never noticed they were gone and they had no other options, and this was the best thing for their family, and more excuses ensued. As Kaylea explored the concepts of denial, availability, and attachment with the Smiths, they shared more about what actually happened. In fact, the girls had been left alone on numerous occasions when they had no babysitters and two to three hours of work overlap and a few times had been badly hurt. They left them in a pack-n-play once and came home to find the younger stuck under the equipment with a broken arm after the elder had gotten out by toppling it. Child Protective Services had been called once when the elder was found in the street, having been able to open the front door to their apartment and leave the building. They also came home once to find the elder daughter feeding the younger fried chicken wings with bones in them that she had found in the refrigerator. Jody shared this incident in therapy and James admitted that it was the first time he had heard it.

While Kaylea fully acknowledged that what the Smiths had done was troubling, illegal, and unsafe, she also explored with both Jody and James how these incidents could have occurred. She told them that the human brain has the ability to compartmentalize experiences, thought, reactions, and emotions so that we can function. While this is a successful survival strategy, when we compartmentalize certain aspects of our experience, our engaged mind state is less available. Because Jody and James believed that they had to leave their children alone to survive, they denied, not only that they were doing it, but also that it had severe consequences. In order for them to move into Stage 2 of treatment, and just as important, before they could be safe enough to parent their children again, they had to acknowledge that what they did was wrong and that it had profound and serious consequences for their children.

**Introducing Acknowledgment**

Many sessions ensued with Kaylea helping James and Jody acknowledge their behavior without blaming others. Kaylea, the caseworker, and the Smiths met together many times to discuss progress and unsupervised visits with the girls. They all agreed that unsupervised visits had to wait until both parents were able to acknowledge their
behavior and its direct contribution to the girls’ placement outside their home. Kaylea continued to explore the Smiths’ understanding of their survival mind states, their vulnerabilities, and their resources. The Smiths saw danger, disappointment, and criticism everywhere and both responded by retreating, avoiding, and blaming. Kaylea continued to remind them that they knew how to work hard and help each other and that they could use these skills to be self-reflective and engage in mindful contemplation of how they could tolerate acknowledging that they had made mistakes and needed help. She reminded them of the cycle of change, that pause and ponder does not have to be frightening, and that they could practice self-soothing techniques and lean on and encourage each other to take responsibility for their behavior.

Acknowledgment is the acceptance and open admission that we have a problem and that we will address it. Acknowledgment involves taking responsibility for the impact of our behavior and is a process integral to change. Immediately after one supervised visit, James and Jody came to session depleted and withdrawn. When Kaylea gently probed into their drained expressions, Jody broke out in sobs of grief and James put his arm around her shoulder. When she was finally able to put words to her sorrow, Jody talked about how vulnerable her little girls are and how scared they must have been when they were left on their own. “No one saw how vulnerable I was growing up and so I guess I just figured I shouldn’t see theirs but I was wrong. I am their mother and I should have protected them.” “It is not too late,” Kaylea said, “it is not too late.” Slowly but surely, with enough encouragement, collaboration, and hope, both James and Jody were able to acknowledge that they could not leave the girls home alone and that they could not parent alone and that they needed help.

Mindfully following the natural flow of change by helping a client stay grounded and organizing the session through the use of a strengths-based model is in our experience the most effective way to create and sustain change both inside and outside of the office. The therapists use their own strengths to stay attuned to the client’s trauma state and then to creatively design interventions to interrupt traumatic patterns, inside and outside of the office, and then to help the client develop alternative pathways to create and maintain healing. The interventions and therapeutic models used need to be based on the strengths of the clients and collaboratively designed and agreed upon between therapist and client. Together they are the treatment team. We believe and, through years of qualitative interviews with clients, have confirmed that change happens as a result of the strengths-based energy that comes from our minds, our hearts, and our souls. It is the exchange of this energy through our relationships, through our hope, our creative ideas, and our passion and compassion that we continue to create energy between us that will produce the desired change.

References
Mary Jo Barrett and Linda Stone Fish


