CHAPTER 1

A Resource Loss Model

> Childhood abuse is not a diagnosis but a life experience.
> —Frank W. Putnam (2004)

The treatment described in this book is the result of more than two decades of listening and responding to the needs and concerns of clients with histories of childhood abuse and other interpersonal trauma experiences. When the first edition of this book was published, Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy was the first demonstrably effective treatment developed specifically for survivors of childhood abuse. It has undergone rigorous empirical evaluation and has been demonstrated as efficacious, feasible, and (most importantly) acceptable to survivors. The motivation for the first edition of this book was derived from the observation that mental health services were not providing programs for survivors of childhood abuse. Fortunately, this is no longer the case; many health care systems are striving to provide trauma-informed services, including the use of STAIR Narrative Therapy.

This new edition reflects the results of more than a decade of work with both survivors of childhood abuse, as well as other survivors of complex interpersonal trauma, including refugees and veterans of combat. We came to understand that the treatment was applicable and valuable to these populations. We also learned that individuals presenting with adulthood interpersonal trauma, such as first responders to the September 11, 2001, terrorist attacks, could develop a complex trauma symptom profile, depending on how horrendous the exposure had been and the degree to which they had social and emotional resources to support them in the recovery process. We realized that STAIR Narrative Therapy was applicable, and indeed could be successfully delivered, to these populations with little adaptation (Levitt, Malta, Martin, Davis, & Cloitre, 2007). The current chapter describes the principles of STAIR Narrative Therapy within the framework of a resource loss model. This model is applicable to individuals who have experienced trauma as children or adults. Chapters 2 and 3 focus specifically on attachment-related resource losses that occur as results of abuse and neglect during childhood.

TRAUMA AND A NEW DIAGNOSIS: COMPLEX PTSD

Community studies indicate that trauma is common, with over 70% of the global population reporting exposure to at least one traumatic event, and 30% reporting exposure to four or more such events (Benjet et al., 2016). Traumatic experiences include those that are interpersonal and often involve violence perpetrated by one person on another, such as physical assault, rape, and combat; they also include other types of experiences, such as serious accidents and natural or human-made disasters. The majority of interpersonal traumas, which include sexual and physical violence, occur before the age of 18 (Kessler et al., 2017). Thus the most devastating traumatic experiences occur to those least developmentally able to cope with them. Childhood abuse and neglect or other maltreatment (all of which are types of interpersonal trauma) are particularly common; more than one in four persons have experienced abuse by a caregiver by the age of 17 (Finkelhor, Turner, Shattuck, & Hamby, 2013).

Since the first edition of this book appeared in 2006, childhood abuse specifically and trauma broadly have been recognized as major public health problems (Teicher & Samson, 2013). Evidence for the long-term adverse mental and physical health effects of childhood trauma in particular has been recognized by the American Heart Association (Suglia et al., 2018). Persons with histories of childhood abuse have an earlier age at onset of psychopathology, greater symptom severity, more comorbidity, a greater risk for suicide, and poorer treatment response than those with no history of abuse who have the same diagnoses (Teicher & Samson, 2013).

The impairment and psychic suffering caused by childhood abuse are enormous. In 2018, the World Health Organization (WHO) identified the particularly complex nature of the effects of childhood abuse and other chronic and sustained interpersonal traumas through the introduction of a diagnosis, complex posttraumatic stress disorder (CPTSD), into the 11th revision of the *International Classification of Diseases and Related Health Problems* (ICD-11; WHO, 2018). ICD-11 is the official diagnostic system used worldwide, including (finally) in the United States. The diagnosis includes not only the traditional symptoms of posttraumatic stress disorder (PTSD), but also the effects that trauma can have on emotion regulation, self-concept, and relational capacities. When the first edition of this book was published, the diagnosis of PTSD as presented by the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000), was the dominant formulation of the psychological effects of trauma. At that time, we discussed problems we observed among survivors of childhood abuse that extended beyond DSM-defined PTSD, particularly regarding emotion regulation, interpersonal functioning, and negative self-concept, but that were not officially recognized. Such symptoms are now addressed in DSM-5 (American Psychiatric Association, 2013), which has added a symptom cluster of "negative alterations in cognitions and mood" that references negative beliefs about self and others, as well as feelings of detachment from others. It has also added a "with dissociative symptoms" subtype of PTSD that identifies one type of emotion regulation difficulty (hypoactivation). However, the inclusion of the CPTSD diagnosis in ICD-11, which provides a coherent and empirically supported profile of symptoms typically associated with complex trauma, makes the problems typically

seen among survivors of childhood abuse easier to recognize, assess, and treat. We discuss the specific symptom profile associated with ICD-11 CPTSD, as well as its assessment, in Chapters 8 and 9.

The purpose of this book is to provide a treatment guide for individuals who have experienced childhood abuse and other interpersonal traumas that result in a wide range of symptoms, including those found in ICD-11 CPTSD. We believe that this book is now needed more than ever, as a result of the addition of CPTSD to the diagnostic nomenclature. However, we recognize that not all of the problems that survivors of childhood abuse and other severe interpersonal traumas experience are captured by this diagnosis. Accordingly, it is our intention to provide a conceptual framework and a treatment program that address the *experience* of chronic interpersonal trauma, rather than a diagnosis. The formulation of the effects of trauma as a resource loss provides an explanatory frame for PTSD and CPTSD, as well as for other disorders and psychological problems that can result from various types of interpersonal trauma. The treatment program presented in this book, STAIR Narrative Therapy, addresses all problems represented in the diagnosis of CPTSD. It can also address other problems, once these are understood in the context of resource loss and resource rehabilitation. The remainder of this chapter describes trauma as a resource loss phenomenon. This includes specifically the types of losses resulting from trauma that occurs during childhood, particularly at the hands of caregivers; the ways in which these losses are represented in the CPTSD diagnosis; and the rationale for STAIR Narrative Therapy as a resource rehabilitation program.

ALL TRAUMAS AS RESOURCE LOSS EVENTS

Resource loss is a critical and universal feature of all traumas: Life after a trauma is diminished. Depending on the trauma, the resource loss may be psychological (such as a person's sense of security, optimism, and social support), material (such as a home, family, schooling or employment, and a community within which to prosper), or both. In addition, certain types of traumatic events and their harshest consequences befall those who are already in circumstances with limited resources. Trauma often comes to people with fewer financial resources. For instance, persons who cannot afford to live in areas outside of hurricane paths and floodplains experience more hurricanes and floods, and more devastating consequences from those natural disasters. Similarly, those who have fewer physical and psychological resources to protect themselves, such as children, elderly individuals, and injured persons, are likely to experience interpersonal violence. Forcible rape among females, for example, is not randomly distributed across the lifespan, but occurs predominantly in the vulnerable years of childhood and adolescence; as noted above, over half of sexual and physical assault occurs by the age of 18 (Kessler et al., 2017).

In addition, those who are most vulnerable to trauma because of limited resources will have more difficulty recovering. The irony of trauma is that recovery requires the presence of resources greater than those the victim often had in the first place. Rebuilding a house destroyed by a hurricane requires more than bricks, mortar, and the owner's own toil; it

also requires a team of roofers, bricklayers, plumbers, and painters. Just as the homeowner's own resources are not enough, the resources of a survivor of trauma are often insufficient without additional investment from the outside. This is particularly true of persons who have been traumatized as children. Childhood is a time when an individual is vulnerable to victimization, and once victimization occurs, the child has even fewer psychological and social resources than before with which to negotiate a recovery process.

Lastly, the traumatized state is not static. If resource regeneration does not occur, the result is not stasis, but rather continued resource loss and degeneration (see Hobfoll, Mancini, Hall, Canetti, & Bonanno, 2011). The unrepaired or partially repaired house will be buffeted by wind, risk further decay, or be entirely destroyed in the onslaught of another hurricane. Similarly, without resource recovery, the psychological and social trajectory for a survivor of trauma will be vulnerable to the vicissitudes of both ordinary life stressors and additional traumas. The risk of a downward trajectory is particularly relevant and evident among those traumatized in childhood. The mandate of childhood is growth—physical, psychological, and social. Trauma reduces the resources necessary not only for recovery, but also for the developmental tasks integral to childhood. As a result, the achievement of such tasks is often compromised, with impairments evident in poor life functioning and accumulating into adulthood.

The resource loss model thus informs our understanding of trauma recovery. Trauma recovery requires resource recovery (Hollifield et al., 2016). Accordingly, the principle of intervention to which this program adheres is one of recovery of resource losses—in particular, the rehabilitation of the psychological, emotional, and social capacities whose development has been interrupted by trauma.

PSYCHOLOGICAL TRAUMA AS A RESOURCE LOSS

"Trauma" has been defined in medicine as a circumstance in which some part of the body has been suddenly damaged by a force so powerful that the body's natural protections are unable to prevent injury and the body's natural healing abilities are inadequate to resolve the injury without medical assistance (*Stedman's Medical Dictionary,* 2000). The word "trauma" is, in fact, derived from the Greek for "wound." As noted by Chris Brewin (2003), Freud (1920/1955) was the first to define the term "psychic injury" by analogy to physical injury. Freud described psychic trauma as an event that "penetrates a kind of mental skin designed to protect a person from excessive external forces; trauma [is] essentially a 'breach in an otherwise efficacious barrier' " (Brewin, 2003, p. 4). The breach is the result not only of the strength and impact of the external force, but of the inability of the organism or affected area to deflect, absorb, neutralize, or compensate for the injury.

Following this analogy, we describe psychological trauma as a circumstance in which an event overwhelms or exceeds a person's capacity to protect their psychic well-being and integrity. It is a collision between an event and a person's resources, where the power of the event is greater than the resources available for effective response and recovery. Deterioration in functioning occurs, and intervention or resources beyond those the individual has

available are required for recovery. Psychological trauma, like physical trauma, represents a complex relationship between an event and a response. The objective characteristics of a potentially traumatic event—its force, strength, or "dose"—can be quantified, but the impact of the event cannot be determined without taking into account the resources and vulnerabilities of the particular individual who sustains the injury.

CHILDHOOD MALTREATMENT TRAUMA AS A RESOURCE LOSS

This analysis has significant implications for our understanding of childhood abuse or neglect as a major trauma. To continue the medical analogy, it is well known that certain toxic chemicals and environmental pollutants have a significantly greater impact on children than on adults, even when the amount of exposure or "dose" is the same. Children's immature development makes them particularly vulnerable to the effects of such toxins. The impact on their bodily systems is more potent than that experienced by adults, and the effect of a toxin on one system has negative effects on other related and vulnerable developing systems.

Now let us consider, for example, sexual abuse as a powerful physical and psychological toxin to the child because of their immature development. "Sexual abuse," by definition, is physical contact with a child for sexual purposes without the child's meaningful consent. This act is one in which the perpetrator takes ownership of the child's body, which, by definition, is the essential and basic territory of the self. Furthermore, sexual abuse often, if not typically, co-occurs with physical abuse (e.g., Kim, Mennen, & Trickett, 2017). Thus a typical picture of childhood abuse is one in which there are repeated exposures to multiple forms of violence to the body. An effective response to this circumstance requires internal and external resources of a kind and quantity not typically within a child's grasp.

The internal or personal resources with which children can protect themselves are limited by the simple fact of their life stage. Their levels of cognitive, affective, and physical development place significant limits on their capacity to recognize, avoid, or escape perpetrators. Explicit or implied suggestions that sexual activity with a caregiver or other adult is good, or that physical abuse or neglect is deserved, are difficult for children to oppose or resist. They tend to be naive or confused by the threat hiding behind the blandishments and compliments of perpetrators of sexual abuse. Their small size also makes them easy targets for physically abusive adults.

In addition, children's external resources are far more limited than those of adults. When adults experience a trauma such as a rape or motor vehicle accident, or when they witness violence, they are more likely to have a place of safety to recover and/or a social support network on which to rely on for care as needed. In contrast, children have little choice about where they live or on whom they depend. Their home, the traditional source of safety, is also often the source of what most threatens them. The caregivers on whom the children depend are frequently those who are committing the transgressions against them. The necessary alternative in this situation—telling someone about a caregiver's abuse or neglect—can be frightening in its implication of loss of home and caregiver, or attendant sense of betrayal, regardless of the danger posed by the abuse. Even getting access to agencies and

institutions that aim to protect children is difficult or impossible for a child to do alone, as it legally requires the accompaniment or aid of other adults.

The resource limitations of children confronted with maltreatment lead us to define such maltreatment as a trauma in all of its essential characteristics. In particular, children who are abused are individuals who are helpless in the face of repeated, unavoidable, and inescapable transgressions against their bodies. A child's resources are no match for the immediate and consistent threat of physical or sexual assaults by an adult, particularly when that adult is a parent or other caregiver.

SPECIFIC RESOURCE LOSSES ASSOCIATED WITH CHILDHOOD MALTREATMENT

The resource limitations a child experiences in confronting the trauma of maltreatment are defined by their life stage and yield a circumstance in which the child rarely succeeds in warding off or neutralizing sexual or physical threats or neglect. In addition, once the trauma occurs, its presence creates a cascade of resource losses that continue during its typically chronic course and have significant consequences long after the abuse ends.

The most immediate consequences of childhood abuse or neglect are the losses of physical safety and physical integrity. Less evident, but equally profound and perhaps unique to childhood maltreatment, are the losses of many psychological and social-developmental opportunities and advances, which are diminished or negated as either direct or indirect results of the maltreatment. Childhood abuse or neglect is a trauma perpetrated by an adult, usually an important caregiver upon whom a child depends significantly for psychological and material resources. It occurs during a time of life when many developmental tasks, involving the growth of emotional and social competencies, are being completed; these tasks require sustained contributions by caregivers, family members, and the community. Under conditions of maltreatment, these necessary resources are often deficient or disturbed, compromising the child's ability to complete these tasks successfully. Lastly, it is critical to note that recovery from the effects of maltreatment, like recovery from all traumas, requires the investment of additional "repairing" resources. But for a child or adolescent, this investment often requires the initiative of the caregiver—and if the caregiver is the perpetrator of the trauma, they are motivated to ignore, hide, or deny the maltreatment. This aspect of abuse or neglect, the silence and stigma associated with it, adds to further resource loss (i.e., the support and intervention of the community). All of these losses and the absence of intervention in a time of development conspire to create substantial functional impairment among adult survivors of childhood maltreatment.

Acknowledging all these circumstances, we have catalogued the potential resource losses that childhood maltreatment engenders in both the short and long term. They include (1) loss of healthy attachment and healthy sense of self, (2) loss of effective guidance in the development of emotional and social competencies, and (3) loss of support and connection to the larger social community.

Loss of Healthy Attachment and Healthy Sense of Self

One of the most devastating aspects of childhood abuse or neglect is that the perpetrator of the trauma is almost always a parent or other important caregiver. The implications of this circumstance as a resource loss are staggering. The attachment of a child to a parent or other primary caregiver creates the base for learning about the essentials of living. This attachment is a resource from which springs the evolution of effective agency, self-definition, and autonomy. It is intended to provide sufficient safety and security for the child to explore and learn about the world, and to grow in confidence and autonomy. Ideally, a caregiver provides a secure base or home for "refueling" of resources to explore the world. This secure base involves the caregiver's availability to act as a facilitator to the child's growing capacities in self-management and effective interaction with the social and physical environment. The power of the parent as a source of safety was documented during World War II. Child psychiatrists in London noted that that children were better off staying with parents during bombings than being separated from the parents for the "safety of the countryside"; indeed, children did rather well if their parents did well by them and were psychologically healthy themselves (Carey-Trefzer, 1949). Children look within their immediate environment, and particularly to their caregivers, to gauge safety and interpret the level of threat in a particular situation.

Children use their parents as anchors or reference points to understand the meaning of traumatic events, understand cause and effect, experience safety and support, obtain comfort, and receive guidance in effective coping. Maltreatment is essentially a betrayal of the assumption of care by a parent for a child (DePrince et al., 2012), and in every aspect of the betrayal of parenting responsibilities, there is a definable loss.

There is a profound loss of a sense of security and personal safety; associated with this is a restricted capacity for curiosity and exploration about the world. There is also the loss of a healthy trajectory of affective organization. The developing capacity for self-soothing is challenged by physical and sexual violations in particular, and guidance from the abusing caregiver is often absent, irregular, or deviant. Moreover, there is significant disturbance in the development of a sense of autonomy and agency. Rather than recognize and protect the necessary but vulnerable authority of the child as an agent of their own experience, the maltreating caregiver acts in such a way that the child becomes an extension of the caregiver's own sexual and aggressive impulses. The betrayal of the attachment bond often leads to loss of trust in intimate relationships, with long-term consequences in the management of future interpersonal relationships.

Lastly, childhood maltreatment leads to loss of the capacity for self-love and positive self-regard. Healthy attachment includes expressions by the caregiver of positive regard for the child, which the child internalizes. Under circumstances of abuse and neglect, the child still absorbs the messages communicated by the caregiver, but they are negative: "You are bad," "Look what you made me do," "I should give you away," "I will give you away if you tell anyone." These messages establish a working model of a self-identity as "bad" that is often not consciously formulated and can be difficult to identify and change in later years.

Moreover, neglect or sexual and physical abuse often elicit feelings of shame and guilt that are integrated into the child's self-identity, leading to feelings of shame and guilt about who they *are* versus what *was done to them*.

Loss of Opportunities for Social and Emotional Development

Childhood maltreatment derails the development of important life skills, particularly emotional and social competencies that lead to effective self-management and interpersonal relationships. Children who are maltreated often come from families in which parents or caregivers often were maltreated themselves as children, are limited in emotional expression and interpersonal functioning, and often suffer from PTSD and other mental health problems themselves (Anderson, Edwards, Silver, & Johnson, 2018; Widom, Czaja, & DuMont, 2015); thus they are less than ideal role models for learning such skills.

In addition, maltreatment within the home setting creates paradoxical and conflicting information about acceptable and effective rules for living. For example, standard rules of sexual and physical behavior are applicable in general, but not in the home. These inconsistencies, often unexplained, can create inappropriate social behaviors that lead to peer rejection and loss of confidence in the survivor's own perceptions and judgments about social realities. The diminished emotional and social competencies associated with maltreatment are further exacerbated or result in continued social and emotional injury and loss in the larger social environment during both childhood and adolescence. For example, compared to their peers, children who have been abused have greater difficulty socializing with peers and managing conflict, are more uncomfortable with high levels of emotion, expect little social support from adults in resolving social difficulties, are less confident, and report lower self-esteem (Naughton et al., 2013; Perepletchikova & Kaufman, 2010). In adolescent years, those with abuse histories are more likely than their peers to develop mental health problems (McLaughlin et al., 2012), drop out of school, engage in substance abuse and delinquent behaviors, and experience interpersonal violence both as victims and as perpetrators (Amstadter et al., 2011; Carliner, Gary, McLaughlin, & Keyes, 2017).

In adulthood, individuals with a history of childhood abuse often report a profound sense of lost opportunities in realizing desired goals in both their work and personal lives. Widom, in her work following a cohort of children who experienced abuse and are now grown up, reports individuals with histories of childhood abuse are more likely than their peers without such histories to fall short in achieving expectable life milestones, including achieving fewer years of education, having more criminal arrests (Horan & Widom, 2015), living in less desirable neighborhoods, and engaging in illicit drug use (Chauhan, Schuck, & Widom, 2017; Chauhan & Widom, 2012). Childhood abuse also has long-term effects on emotion processing that persist into adulthood (Young & Widom, 2014), and such persons suffer from increased rates of depression and anxiety throughout their lives (Jaffee, 2017; Li, D'Arcy, & Meng, 2016). Perhaps, as the ultimate behavioral expression of all that ails them, person with abuse histories are more likely to attempt suicide than are their peers without such histories (Liu et al., 2017).

Loss of Perceived Support of the Community

It has become clear that welcoming children into the larger community enhances their development, including self-esteem, social skills, and physical well-being. The support of the community is expressed in the explicit valuing of children as community members. This is demonstrated by acknowledgment of their presence in the community, concern about their experiences, expression of positive regard, and active efforts to provide them with appropriate roles. Children who have been maltreated often do not experience full and positive engagement in the community. This can occur in many ways and for many reasons. Children who have been maltreated may be hampered in integrating themselves if their emotional resources are primarily absorbed by the demands of the home environment (i.e., managing maltreating parents and experiences). Their lesser social and emotion regulation skills, as described above, may make them less attractive to peers, teachers, coaches, religious leaders, or other important figures of influence. Furthermore, silence about the maltreatment may create feelings of alienation and a loss of any authentic sense of relating to peers, teachers, or other members of the community.

Lastly, the stigma of maltreatment and general discomfort about recognizing its presence may keep community members at a distance from a maltreated child or youth. The tendency to "blame the victim" emerges from the distress that is elicited by recognizing and responding to victimization. It forces recognition of malfeasance toward a vulnerable person, and in the case of childhood maltreatment, adult malfeasance toward an innocent person. Children who have been maltreated can make adults uncomfortable, because they challenge the belief system that the world is benevolent and that we are all competent to take care of ourselves. The desire to maintain this illusion leads us to expect an unrealistic level of competence in children to defend themselves (Langton, Berzofsky, Krebs, & Smiley-McDonald, 2012).

The alternative to "blaming the victim," which is to recognize the existence of maltreatment, leads to other kinds of difficulties. There may well be confusion and uncertainty about how to intervene, and reluctance to do so. Indeed, data indicate that while the majority of Americans view childhood maltreatment as a serious problem, it is rarely reported ("How America Defines Child Abuse," 1999). The impulse to intervene in the activities of a family where a child is being victimized by a parent or other caregiver conflicts with traditional beliefs about the integrity and autonomy of the family unit. Strategies for intervention have been developed through family courts and the development of agencies that monitor the safety of children, but there is a sustained tension between these interventions and beliefs about the privacy and authority of the family unit and its potential superiority as a context for caring for children.

Finally, as exemplified by the development of safety-monitoring agencies, children who have been maltreated, like all persons who have experienced trauma, require the extension of social and community resources. Such resources include money, time, and effort. If such resources become scarce, sympathy for these children may yield to feelings of resentment or indifference. Those with more resources may lose patience with those who have fewer of

them. Thus the consequences of childhood maltreatment as a resource loss ripple out to the community in which a maltreated child lives and needs to be supported. Reactions to the diminution of resources often lead to conflict and reduced integrity of the community and its members. The integration of a maltreated child into the community is strained. Stigma remains, and the child still feels alienated and out of the mainstream. The alienation generated by the silence is transformed into alienation generated by resentment.

SUMMARY AND IMPLICATIONS FOR TREATMENT

This chapter has described the myriad ways trauma during childhood results in developmental losses regarding the effective growth of emotional, cognitive, behavioral, and social capacities. The treatment philosophy described in this book affirms that recovery from childhood trauma requires the rehabilitation of resources and life skills that were derailed or denied in the skirmish to survive in a chronically abusive environment. Our treatment is at heart a resource recovery program, with an emphasis on reclaiming and building emotional and social competencies. We adhere to the notion that resources above and beyond those necessary for basic survival must be recruited and accumulated in order to recover from the damages inflicted by a trauma. In addition, like many other researchers, therapists, and survivors, we have found that emotional processing of the trauma is a powerful if not a critical component in trauma recovery.

Accordingly, we have developed a two-module treatment program in which the development of resources and emotional processing of the trauma are equal and balanced partners. The first treatment module, STAIR, is dedicated to building emotional and social competencies as resources. The second treatment module, Narrative Therapy, involves the emotional processing of the traumatic events in the context of a safe and supportive environment. The ordering of the components is purposeful. Resource development precedes the trauma-processing work because skills in emotion regulation and social connection not only help improve functioning in day-to-day life, but can support the effective use of Narrative Therapy. Although we encourage flexibility in the ordering of treatment modules so that they are sequenced to meet the needs and preferences of individual clients, empirical support for the benefits of this particular sequence is provided in Chapter 4.

We have proposed that in the course of a life that includes childhood maltreatment or exposure to other chronic traumatic events, the development of CPTSD is the result of insufficient resources with which to heal from the trauma. In the same way, we propose that in the course of therapy, confronting the pain of multiple traumatic memories requires the presence of emotional and interpersonal resources to be successful and healing. The treatment is in essence a recapitulation of the appropriate order of development in the ideal case: The fortunate person is provided with the advantage of the accrual of multiple and diverse resources as they face their life challenges.