Exposure

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Abstract: This essay explores the challenges of psychotherapeutic work with adult clients who have suffered trauma as children. It discusses the evidence for best practices and how to respectfully integrate client preferences as described in the evidence-based practice process. Despite this knowledge, there are gaps between evidence-based practices as presented in research studies and the reality of putting them into practice in real-world settings.

Keywords: trauma, exposure, cognitive-behavioral therapy, sexual abuse

A white woman in her early 30s sat across from me wearing an identical jacket. The khaki jacket, fitted and accessorized with metal detailing, was made of a soft, comfortable twill. My client, Tabitha, and I kept wearing the same jacket on the same day we saw each other.

She now covered her face with a scarf. “I can’t do this.”

I leaned forward. “Keep breathing.” I took a deep breath myself to demonstrate. I tried to slow my speech to emanate calm. I didn’t think a person could decompensate from a therapy session but felt we were close. “Put both your feet on the floor.” I uncrossed my legs, following my own instruction, even though Tabitha couldn’t see me from under her scarf. “You’re okay. You survived. Breathe in slowly.” My chest expanded and the jacket encased my rib cage. “Let it out slowly.” The jacket loosened as my body shrunk from exhaling.

“I can’t do this,” she said again. She flung off the scarf, ejected herself from the couch, and ran out the door.

“Tabitha!” I called after her.

I heard the squeak of the front door to the reception area. She had left the suite.

I sat in my failure, feeling like a student again, even though I had over 25 years of experience working with sexual abuse victims. What had I done wrong?

I reviewed my methods. I had followed the research-supported treatment for trauma: trauma-focused cognitive-behavioral therapy (CBT). Cognitive-behavioral therapy, in general, as the hyphenated name implies, focuses on behavior and its reinforcements, as well as people’s beliefs and thoughts—their *cognitions*. However, *exposure* is the defining feature of trauma-focused interventions. Exposure involves the process of coming to terms with abuse-related associations and memories by examining them in detail within the supportive context of therapy rather than avoiding them. *Avoidance* is assumed to underlie people’s failure to deal with abuse and other trauma. Unable to tolerate the anxiety aroused by cues and memories of the trauma, people avoid them and, thus, can’t process through the abuse and resolve it.

My first job out of a master's degree in social work was working with child sexual abuse victims in the early 1990s, conducting forensic interviews for the Austin, Texas police department. At that point, this work still involved the use of anatomical dolls, although that has gone out of fashion now. By their construction, the dolls may invite sexual curiosity and exploration, possibly resulting in false positives of abuse when it may not be present. My job was to video-record the interviews for the police case and provide crisis counseling to victims and their parents. From the earliest point in my career as a social worker, I've been eliciting and hearing detailed accounts of abuse, although I didn't know then about exposure and its role in treatment.

During that time, my career goal was to treat children after they made what we refer to as *the disclosure*, which was beyond the crisis counseling that I provided. After I left that job, I attended a one-year post-graduate clinical training and then received a PhD in social work. As an academic, I embraced the evidence-based practice movement that social work adopted in the early 2000s. The standard definition of evidence-based practice that originally came from medical school training involves a process of decision-making for providers. Providers need to find out the best available evidence or research support for treating a particular problem. They also need to weigh this knowledge with agency resources and their own training to determine whether they can provide the research-supported practice. The final ingredient is whether clients, when educated about their options, prefer to use the science-backed method. I bought the argument that you wouldn't want your medical doctor to not know the latest studies on your particular problem before prescribing an intervention. For emotional, behavioral, and psychological problems, why wouldn't there be the same standard of care?

In evidence-based practice, there are various views on what constitutes evidence. The one I subscribe to is from medicine, which considers the meta-analysis the go-to study. Meta-analysis involves a comprehensive review of all studies that have been done on a topic, quantifying them together in an overall statistic. In this way, meta-analysis can tell us much more than the individual studies and can summarize an entire body of knowledge.

As a way to develop and archive these kinds of in-depth reviews, an international organization called the Cochrane Collaboration acts as a repository. Two such Cochrane reviews relate to the treatment of trauma and sexual abuse. Bisson, Roberts, Andrew, Cooper, and Lewis (2013) conducted a systematic review of therapy studies for people with chronic post-traumatic stress disorder (PTSD) (over three months). According to the *Diagnostic and Statistical Manual of Mental Disorders*, the symptom profile for PTSD involves a traumatic event and an aftermath of four symptom areas: 1) re-experiencing the trauma; 2) avoidance of memories; 3) arousal and reactivity; and 4) cognitive and mood disturbance (American Psychiatric Association, 2013).

Bisson et al. (2013) located 70 randomized controlled trials, which are considered the gold standard for research. In all, trauma-focused CBT and eye movement desensitization and reprocessing (which many consider another type of exposure therapy) outperformed other therapies like non-trauma-focused CBT and psychodynamic therapy. However, there was also more drop-out in exposure-based therapies (as well as in the regular CBT treatment) than the other therapies. The hypothesis about the drop-out is the difficulty of clients being able to tolerate the anxiety of facing the details of the abuse.

All different types of trauma were represented in the Bisson et al. (2013) meta-analysis, but Wilen (2014) only centered on the specific trauma of sexual abuse occurring in childhood. The results of her dissertation indicated that trauma-centered approaches were more effective at treating PTSD symptoms while present-focused approaches were more effective in treating depression symptoms.

Tabitha had originally come to therapy wanting to get back together with a same-sex romantic partner in Thailand, where Tabitha had taught English. The romantic partner was an American businesswoman who, when their break-up had turned nasty, accused Tabitha of needing therapy. I suspected that Tabitha had hoped that therapy would win this woman back, a not uncommon motive for seeking treatment.

I had a difficult time getting underneath Tabitha's superficiality and people-pleasing. Our main connection seemed to be that we kept wearing the same jacket. We agreed it went with everything, although we didn't mention to each other they had come from Target. She said her mother had bought hers, although Tabitha had only described her mother as critical. Tabitha's mother supposedly did not know about her sexual orientation, even though Tabitha had been involved with girls since adolescence and Tabitha was currently living in her house.

Tabitha's mother was also financially supporting her since she didn't have any means. Despite being in her mid-30s, Tabitha didn't hold marketable job skills. Exploration of her teaching experience led me to conclude that she didn't have a degree, certification, or licensure in teaching. She claimed that a difficult co-worker in her previous job was the reason she wouldn't get a good reference from the Thailand job. Thus, prospects for future overseas jobs were bleak.

When I mentioned to Tabitha her tendency to stay on the surface in as gentle a way as possible so as not to arouse her defenses, Tabitha admitted she wanted "rainbows and unicorns." Tabitha, with great reluctance, finally accepted the break-up and no longer fantasized about returning to live in Thailand with her ex-girlfriend. Although she adamantly wanted to keep coming to therapy, she wasn't clear on what she wanted to work on next beyond a vague goal of self-improvement. Her future career goals were similarly ill-formed. She talked about either going to film school or getting an undergraduate degree in biology.

As the sessions wore on and we delved into childhood, she revealed sexual abuse by an older cousin when she was about five. I explained the possible role of unexplored trauma in people who have trouble with current-day functioning. Tabitha did not seem to meet the criteria for PTSD. She denied nightmares, flashbacks, depression, and anxiety, but she did avoid thinking or talking about the abuse. I explained how trauma-focused treatment worked and warned that it meant directly confronting her memories. She was agreeable to going this route.

After that, we started the first step, which was for her to gain practice in being able to calm herself since discussion about the abuse might prove anxiety-producing. I coached her on deep breathing and progressive muscle relaxation in the session and prescribed practicing these skills for five minutes a day. I told her about being able to find YouTube videos on these techniques, gave her Dr. Kristin Neff's website with some free meditations on self-compassion

(http://self-compassion.org/category/exercises/), and mentioned some apps that other clients had found helpful in doing this work.

The next step was to formulate a hierarchy of memories in rough order of how difficult they were to talk about. The theory is that with exposure to the memories by activating and processing them in a supportive context, the anxiety associated with each one would eventually dissipate. No longer avoiding the memories, clients can integrate the experience, understand how it has led to faulty cognitions about the self (e.g., "The abuse was my fault."), about others (e.g., "People will hurt me."), and about the world (e.g., "The world is a dangerous place."). Once these are brought to the client's awareness, they are deconstructed to determine the extent to which they are realistic. Clients can then choose and practice alternative beliefs that offer a healthier and more functional perspective.

At the time of the abuse, Tabitha's mother had left with Tabitha's siblings, running away from a supposed hex that she believed her husband's family had put on her. Tabitha was left with her father, his sister, and her sister's children. Tabitha's aunt was, therefore, in charge of Tabitha, her own children, and her other sister's children at times, including a 14-year-old boy.

Tabitha was initially flattered by her 14-year-old cousin's attention when he wanted to watch TV with her in a bedroom—"I remember thinking, 'Hey, that's pretty cool. He wants to hang out with me.'"—until his attention became weird and confusing.

Tabitha told her aunt after several such events, who, in turn, revealed it to her sister, the mother of the 14-year-old. The mother came over and confronted Tabitha, placing a towel around her neck. She kept asking Tabitha if it happened and would noose the towel closer each time Tabitha said yes.

"Did it happen?"

"Yes." Tighter went the towel.

"Did it happen?"

"Yes." The nubs of the towel scratched against her skin as the noose grew closer.

"It didn't happen, did it?"

"Yes, it did."

"Did it happen?"

At that point, Tabitha feared strangulation if she didn't retract her statement. She swallowed, her voice already hoarse, and gave in. "No," she said.

After Tabitha ran out of the suite, I gave her a few minutes and then sought her out. When I

opened the bathroom door across the hall and called her name, she answered from a locked stall.

I found myself relieved she was still in the building—and still alive. "How are you doing?" I asked, recognizing how woefully inadequate the phrase was.

"Not good."

"It's up to you, okay, but do you want to just come in and talk a bit, just to calm down? I don't want you driving like this."

"I'll be fine," she said. "I'm going to stay in here for a while."

"Take your time."

I felt terrible leaving her in the bathroom, but I couldn't force her to come back either.

That was the end of our treatment. Tabitha left that day without speaking to me. She didn't respond for a few months to the email I sent inquiring after her well-being and asking if she wanted to schedule another appointment to talk about what had happened. The epilogue to my work with Tabitha was a nice email two months afterward saying, though some of the sessions had been helpful, she wasn't up to the kind of work we were doing.

Up until then, she had been so cooperative. Now, I realized, too cooperative. She had passively gone along with my recommendation for treatment—since she didn't have goals other than getting her girlfriend back—until it became too painful. I pride myself on being able to read clients well and being sensitive to their responses, but I didn't pick up on the fact that Tabitha was going to be unable to do this work. She didn't seem to have the ability to set a boundary until it was too late, and she saw no other option than leaving therapy.

Recall that in the Bisson et al. (2013) meta-analysis, drop-out was higher in the more trauma-focused treatments, likely because of what clients experience, similar to what Tabitha experienced. Experts in the area of sexual abuse treatment, Briere and Scott (2014) and Foa, Hembree, and Rothbaum (2007), talk about the necessity of monitoring exposure-based work to make sure it's not overwhelming the client's capacity to manage it. Foa et al. (2007) talk about frequently assessing Subjective Units of Distress, a 1-to-10 scale of the amount of anxiety the client is experiencing. In my experience, clients find the continuous requests to quantify their experiences annoying, so I haven't taken up this practice. Perhaps I should have done so in this case. Most of the time, when women are talking about the details of abuse, they will cry and there is marked emotional release. However, Tabitha never cried in our sessions, even when the scarf was over her head.

It's a fine line between working respectfully within the boundaries of the client's capacity to manage, and, at the same time, not facilitating avoidance. In exposure-based work, avoidance by the client is itself to be avoided since it is part of the negative reinforcement cycle. People feel anxiety due to cues or memories and then push them away, never habituating and getting past

them. Unfortunately, avoidance as a coping strategy is reinforced.

I'm still doing the exposure-based work with other sexual abuse victims, and also with those who have been physically abused, have witnessed domestic violence, or have suffered a life-threatening medical crisis. In all these cases, people admit that I am the only person to which they have confessed the details of the trauma. I recognize the honor of filling this special role: encouraging them to tell their story in a supportive context where they can safely explore the messages they internalized from the experience.

However, it's never the breakthrough—or even progress—I expect. CBT tells us to be realistic in our thoughts. Perhaps it is not realistic to look for breakthroughs and immediate benefits, but instead accept the "layers of the onion" theory—that our work has resulted in some significant peeling back of a layer of pain, secrecy, and confusion. Maybe that's enough and more than other approaches might achieve, even though the peeling back can be painful in itself.

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