Trauma-Informed Care and Practice (TICP) – Efficient & effective implementation with Thought Field Therapy (TFT) tapping

By: ***Christopher Semmens***, clinical psychologist. Perth, Western Australia

All truth passes through three stages. First, it is ridiculed. Second, it is violently opposed. Third, it is accepted as being self-evident. ***Arthur Schopenhauer***

*There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things****. Niccolo Machiavelli***

Trauma-informed care and practice (TICP) is a framework for the provision of services for mental health clients that originated in the early 1990s and has especially been put forth as a sensible service model since Harris and Fallot's 2001 publication: *Using trauma theory to design service systems.* Trauma-informed care is characterised by three principal considerations in regard to the provision of treatment services:

1. That they incorporate recognition of the reality that there is a high incidence of traumatic stress in those presenting for mental health care services.
2. A comprehensive understanding of the effect on a person of the significant psychological, neurological, biological and social manifestations of traumatic and violent experiences.
3. That the care provided to these clients - in recognising these effects - is collaborative, skill-based and supportive.

In Australia these ideas were the focus of a consciousness raising conference: *Trauma-Informed Care and Practice: Meeting the Challenge* conducted by the Mental Health Coordinating Council (2011) in Sydney in June 2011. The conference was part of an initiative towards a national agenda to promote the philosophy of trauma-informed care to be integrated into practice across service systems throughout Australia.

It has only really been since studies such as the National Comorbidity Study (Kessler et al., 1995); the Adverse Childhood Experiences study (Felitti et al., 1998); and the longitudinal prospective follow up study, the Child Development Project (e.g., Egeland, 2009) that the mythical expectation of exposure to traumatic stress being a relatively rare event has been exploded. We are now operating from a much more realistically informed basis in regard to the quite common incidence of traumatic stress in the general population. Unfortunate figures such as that between 25 and 30% of women have been sexually abused in some way before the age of 18 are now not a surprise to informed health services practitioners (e.g. Fergusson and Mullen, 1999). Also there are reliable estimates that as many as 70% of psychiatric inpatients have been exposed to traumatic stress and most have had multiple experiences of trauma (Fisher, 2003).

It was mainly due to the dual political mobilisations of the Vietnam War veterans and the women's liberation movement of the 1970s that eventuated in the DSM–III of 1980 featuring for the first time the diagnostic category of Posttraumatic Stress Disorder - PTSD (Herman, 1992). The advent of the PTSD diagnosis relieved the burden of non-recognition that traumatised combat veterans who went before had to bear – prior to this their condition was viewed by the United States Veterans Administration (VA) as a non-compensable manifestation of a characterological weakness.

This, of course, was a vital advance. But, despite the very important benefits that have followed its generation, the medical model mindset within which this PTSD diagnosis is usually applied presents significant limitations related to clinical practicalities. To my mind PTSD has better utility as a legal term than as a clinical entity. The requisite number of ticks applied to the 17 symptoms in the right clusters is not going to make much difference to the way that I approach the treatment of a client. The PTSD diagnosis fits with the medical model question: "What is wrong with you?" (See Figure 1.)

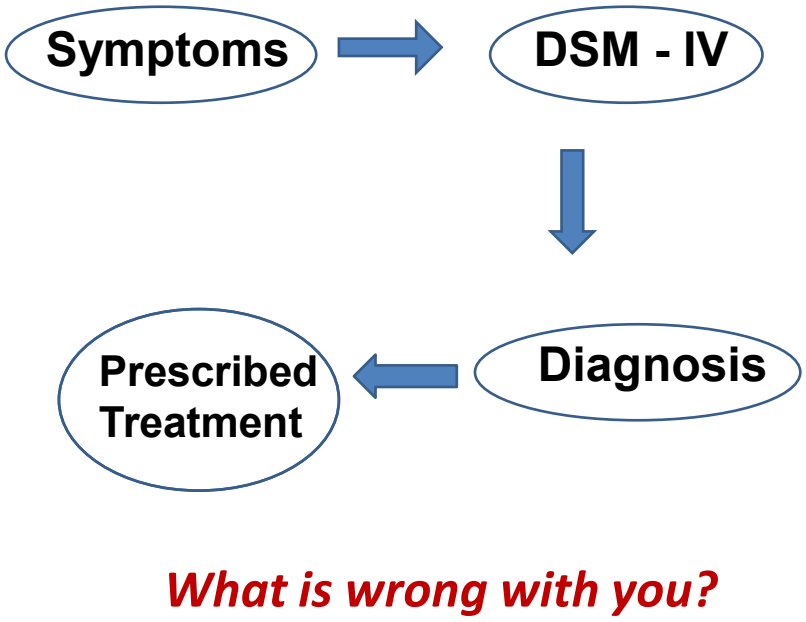

Figure 1. A representation of the medical model conceptualisation of the relationship between "symptoms" and "treatment."

The trauma-informed movement, on the other hand, points to an orientation towards a client where the question in the mind of the practitioner is: "What has happened to you?" Symptoms are here seen as manifestations of (or, as some have persuasively put, attempted solutions to) the unresolved life issues that, one way or another, to a greater or lesser degree, most of us carry (see Figure 2).

This approach can perhaps be seen in contrast to the process of diagnosis that can cynically be viewed as essentially a pigeonholing or labeling exercise. While this model of service delivery is enlightened by a focused awareness of the stark realities of the circumstances of the people who find their way into our care, conventional approaches to actually resolving the distress-laden life issues and the instances of traumatic stress that may be revealed through this lens remain cumbersome and, in the main, lack user-friendliness. What is currently regarded as the "gold standard" approach to traumatic stress is a prolonged exposure protocol (Foa & Rothbaum, 1998) that does not readily lend itself to dealing with numerous unresolved life issues and multiple instances of traumatic stress that may be interpersonally generated – circumstances that have come to be referred to as complex traumatic stress.

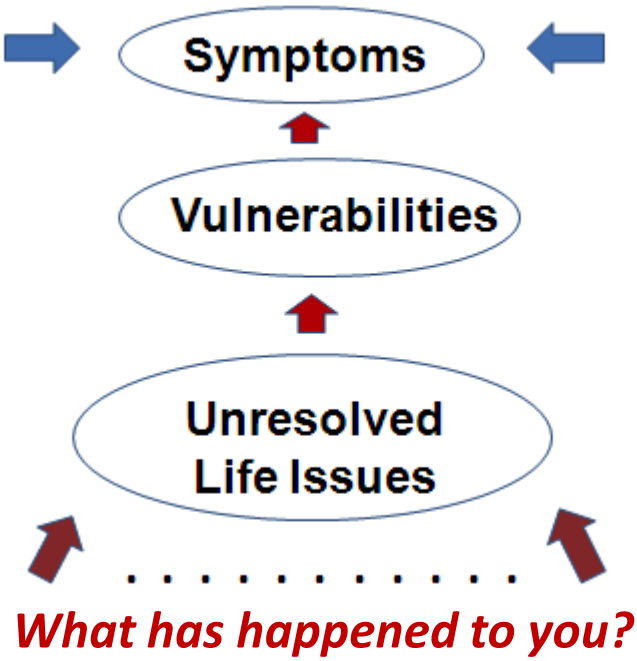

Figure 2. A representation of a trauma-informed model of service delivery as contrasted with a medical model.

The remarkable discoveries forged by Dr Roger Callahan (1985; 1995) under the banner of Thought Field Therapy (TFT) since 1979 would seem to be perfectly suited to be applied within the trauma-informed model. TFT is an exposure therapy that can be thought of as a form of Wolpe's (Wolpe, 1958) reciprocal inhibition utilising, instead of the interface of the autonomic nervous system as in the 1958 version, the interface of the acupuncture system with the client tapping with their fingers on various points on the body and face. The most compellingly intriguing aspect, apart from the numerous additionally elegant elements of TFT (the subject of a separate paper), is the typical rapidity of the clinical response witnessed with its successful application – usually a matter of minutes. Accounting for this quality of TFT presents a conceptual challenge that remains a leap too far for many who would choose to adopt an outright dismissive attitude to this suggestion in preference to the discomforting experience of an open minded confronting of the possible limitations of one's own operating paradigm.

Callahan's own thinking on this has been to recruit the possibility that there are elements of quantum mechanical theory applicable to the explanation of an active ingredient, specifically in the form of the notion of "information" (Bohm & Hiley, 1993; Callahan, 2000).

The author has been operating from essentially a trauma-informed approach from early on in his utilisation of TFT approaches in his clinical psychology practice, which has been since 1997. This has been done in the absence of an awareness of, until fairly recently, the formal trauma-informed movement.

The author's framework (Figure 2) is spelt out to clients and they are sensitively asked what he refers to as the "four questions plus one." These are:

"Tell me about your life – has there been any trauma, disruption or loss in your life?

How was the parenting that you got from your parents?

Is there anything else that you think I ought to know?"

These questions can be asked with great confidence in the ability to, in most cases though not all, quite quickly resolve any distress or disturbance that might thus be revealed as being associated with these issues. Utilising such a trauma-informed approach has facilitated, often, rapid and remarkable success in the treatment of all sorts of presenting problems.

An evidence base in accumulating offering empirical support to the clinical observations of the rapid, pervasive and persisting resolution of traumatic stress achieved both by the author over a period extending beyond 18 years, and also by others working with a similar approach around the world. Principal evidence (Connolly, Roe-Sepowitz, Sakai, & Edwards, 2013; Connolly and Sakai, 2011; Sakai, Connolly, & Oas, 2010) has been derived, not from the somewhat artificial constraints of conventional institutionally based experimental interventions, but in the very real circumstances of the survivors of the Rwandan genocide of 1994. In discussing their findings Connolly et al 2013 say: "In this study, a single TFT session administered by supervised community leaders, recently trained in TFT, provided evidence to support earlier findings (Connolly & Sakai, 2011; Sakai et al., 2010) that TFT could be effective in reducing longstanding and severe symptoms of PTSD." (p. 30)

Particularly illustrative of this approach in action – a trauma-informed attitude to the presenting problem together with the utilisation of TFT in the resolution of the revealed life traumas and issues – have been a number of stunning successes in particular specific cases in areas where years of the best of what medical model providers have offered has been without success. The author has had repeated successes in two particular areas along these lines – non-specific infertility and migraine headaches.

In cases that include: 4 years of unsuccessful in-vitro fertilisation (IVF); 6 years of unsuccessful IVF; referral from an IVF clinic, at the client's request, just prior to instituting IVF procedures; 15 years of medical model migraine treatments; and 10 years of conventional migraine treatments – the questions that were asked in the first session (the 4 questions plus one) had not been raised in all those years of treatment.

In all of these examples there were significant unresolved life issues, with accompanying elevated levels of emotional distress and pain that were revealed through asking those questions. These were quite quickly (within a few to several sessions) resolved through the application of TFT techniques. This trauma resolution correlated with resultant pregnancies (in the first two cases, with IVF, within a week of termination of the therapy; and in the third case, before IVF was initiated); and alleviation of migrainous interference to the lives of the migraine sufferers.

It is curious that despite such stunning successes, repeated around the world every day, together with the publication of David Feinstein's three reviews of the evidence for the effectiveness of TFT approaches in American Psychology Association (APA) journals (Feinstein, 2008; 2010; 2012), guardedness, suspicion, resistance and hostility continue to abound – perhaps something to do with the practical reality and applicability of the wise words beneath the title above.

Christopher Semmens

Clinical Psychologist

Perth, Western Australia, 10 July 2015.

www.tftau.com; www.christophersemmens.com.au

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