Beyond PTSD

# Guidelines for Addressing Post-Traumatic and Continuous Traumatic Stress

Addressing Post-Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (cPTSD)

When dealing with PTSD, whether single incident or complex, there are three key assumptions: 1) the threat of harm is in the past, 2) symptoms are being driven by unresolved intrusive memories, and 3) current behaviors are unhelpful or problematic given that the survivor is no longer in danger. In this circumstance, Judith Herman’s 3-stage model of trauma recovery provides a useful roadmap for what treatment should look like[[1]](#footnote-1). Beginning with establishing a felt sense of safety through learning about trauma and building skills to cope with symptoms and daily stressors (stage 1), trauma survivors then turn to processing and mourning unresolved traumatic memories (stage 2), often through exposure-based interventions (see note below about exposure), with the goal of making meaning of the traumatic experiences within the larger context of their life (i.e. being able to tell the story of one’s life including the trauma and its impact in a way that makes sense). After engaging in this type of adaptive meaning-making, survivors focus on reconnecting with themselves, others, and the world and creating a future (stage 3). This phase often includes finding a mission or answering a call to social action from the newly formed meaning made from their traumatic experience. This three-phased process of trauma recovery can be done with the help of a psychotherapist, but many communities have cultural practices which parallel these three stages and lead to similar outcomes[[2]](#footnote-2).

**A note about exposure**. Exposure-based trauma processing therapies usually involve intentionally remembering or talking about the traumatic event, as it is through activating the memory that the intensity of feelings, body sensations, and thoughts about the trauma decrease or shift. It is important to note that or violence intervention workers, many of whom are recovering from past trauma while facing current and future trauma on (and often off) the job, engaging in exposure-based trauma processing during the second stage of trauma recovery may be counterproductive at best and harmful at worst[[3]](#footnote-3),[[4]](#footnote-4). By activating the traumatic memory through exposure, one triggers the stress response that an individual may have had at the time of the trauma[[5]](#footnote-5). This stress response activation often spills over outside of therapy sessions and can take quite a toll on a survivor’s nervous system, which may temporarily limit their ability to manage their emotions and behavior in high stress situations. Emotion regulation is a necessity for occupational effectiveness, especially when working in a high-risk job such as street outreach.

Addressing Continuous Traumatic Stress (CTS)

When treating CTS, there are two primary treatment goals: differentiating between real and perceived threats, and coping with symptoms and stressors, including ongoing trauma. Outreach workers must have both self-awareness and situational awareness to identify if a felt sense of danger is driven by an internal reaction to a past traumatic experience (i.e. a traumatic memory), which may be potentially triggered by something happening in their environment, or if the threat of harm to themselves or others is real and present. Developing this combination of skills requires a significant investment in self-exploration and a willingness to learn and grow.

Several interventions have been proposed to meet these treatment goals, but four key components appear in most recommendations: creating safe spaces, psychoeducation, building coping skills, and harnessing social support.

**Creating Safe Spaces.** While absolute safety may never be guaranteed, a “relative degree of safety” may be established via “pockets” of safety. This may include developing an internal sense of safety or calm through relaxation and visualization practices, investing in safe relationships, identifying or creating safe havens in the community, and strategic safety planning for situations involving known threats of harm.

**Psychoeducation.** Understanding trauma, types of traumas, and the impact of trauma on the mind and body can normalize common reactions and validate the lived and everyday experiences of individuals exposed to continuous trauma. Knowing what to predict regarding emotional and physiological responses to past and present trauma can increase an individual’s sense of control and empower them to use coping skills to manage distress or problematic behaviors. Opening discussions about trauma can also reduce the stigma around mental health issues.

**Building Coping Skills.** Cognitive behavioral interventions focused on building skills to cope with stress and anxiety, manage intense emotions, and problem solve are beneficial both for dealing with symptoms and discriminating between real and perceived threats. If the present threat is authentic, stress management skills can be used to decrease fight/fight/freeze responses, increase staff’s sense of personal control, and activate the brain’s thinking center so that individuals can make strategic decisions in the interest of safety without creating more problems. If the present threat is driven by intrusive memories from past trauma, the same skills can be used for managing strong emotional reactions and problem solving, in addition to helping individuals shift their thinking about past trauma if it is leading to unhelpful or problematic behaviors. Specific interventions may include mindfulness and acceptance-based practices, relaxation training, cognitive restructuring (changing one’s thinking), and building relationship and conflict-resolution skills.

**Social Support.** Healthy social support has long been cited as a primary protective factor against the negative impact of trauma[[6]](#footnote-6). While traumatic experiences lead individuals to feel fear and distrust, safe connection restores one’s hope and belief in humanity. Additionally, moments of connection with safe individuals calm the nervous system and activate the thinking center of the brain. Safe social support increases a sense of solidarity, connection, belonging, and hope that people are still good, all of which are necessary for the restorative healing of communities plagued by disinvestment, marginalization, and violence.

# Food for Thought

* + What are some ways your organization and its street outreach workers are already **creating safe spaces** to address continuous traumatic stress both on and off the job?
  + What are some ways your organization and its street outreach workers are already **learning about the impact of trauma** to address continuous traumatic stress both on and off the job?
  + What are some ways your organization and its street outreach workers are already **building coping skills** to address continuous traumatic stress both on and off the job?
  + What are some ways your organization and its street outreach workers are already **harnessing social support** to address continuous traumatic stress both on and off the job?
  + What else may need to be done to increase the effectiveness of the efforts you outlined in answering the previous 4 questions? What organizational policies and practices may need to be adapted to help staff adequately address the impact of traumatic stress in their lives?

1. Herman, J. (2015). *Trauma and recovery*. Basic Books. [↑](#footnote-ref-1)
2. Perry, B. & Winfrey, O. (2021). *What happened to you? Conversations on trauma, resilience, and healing*. Flatiron Books. [↑](#footnote-ref-2)
3. Diamond, G. M., Lipsitz, J. D., & Hoffman, Y. (2013). Nonpathological response to ongoing traumatic stress. Peace and Conflict: Journal of Peace Psychology, 19(2), 100–111.  [↑](#footnote-ref-3)
4. Kaminer, D., Eagle, G., & Crawford-Browne, S. (2018). Continuous traumatic stress as a mental and physical health challenge: Case studies from South Africa. *Journal of Health Psychology*, *23*(8), 1038–1049.  [↑](#footnote-ref-4)
5. Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD.* Guilford Press. [↑](#footnote-ref-5)
6. Zalta, A. K., Tirone, V., Orlowska, D., Blais, R. K., Lofgreen, A., Klassen, B., Held, P., Stevens, N. R., Adkins, E., & Dent, A. L. (2021). Examining moderators of the relationship between social support and self-reported PTSD symptoms: A meta-analysis. Psychological Bulletin, 147(1), 33–54.  [↑](#footnote-ref-6)