Episode 244- Dr. Julian Ford

[00:00:08] Welcome to inSocialWork. The podcast series of the University of Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers and lifelong learning and to promote research to practice and practice to research. We educate. we connect. We care. We're inSocialWork.

[00:00:37] Hello and welcome to inSocialWork. I'm Louanne Bakk your host for this episode. To adequately capture and present an excellent and enlightening conversation concerning new perspectives on Post-Traumatic Stress Disorder or PTSD and its treatment, this episode is being delivered to you in a slightly different format. Mickey Sperlich will begin the podcast by describing the background of PTSD and changes that have occurred within the PTSD diagnosis criterion when moving from the DSM IV to DSM V. This will serve as a prelude to a dialogue with our guestDr. Julian Ford who will discuss assessment with trauma survivors in understanding complex PTSD from the perspective of a child's experience. He describes several evidence based treatment options for PTSD and benefits and limitations associated with these modalities. Dr. Ford also discusses critical turning points in therapy and strategies clinicians may incorporate at these crucial moments to help clients advance. Suggestions on how to match modalities with clients and personal styles are presented. He concludes by providing suggestions to mitigate secondary PTSD. Julian Ford Ph.D. is a board certified clinical psychologist and tenured professor at the University of Connecticut School of Medicine and School of Law. He is also the principal investigator and director of two treatment and services adaptation centers in the National Child Traumatic Stress Network, The Center for Trauma Recovery and Juvenile Justice and the Center for the Treatment of Developmental Trauma Disorders. Ford was interviewed in April 2018 by Dr. Mickey Sperlich assistant professor here at the UB School of Social Work. We would like to mention that this episode contains some background distortions that are due to technical problems we experienced while recording. Thank you and we hope you enjoy the podcast.

[00:03:09] Hello I'm Mickey Sperlich. Today we'll be talking about new complex perspectives on Post-Traumatic Stress Disorder and its treatment with Julian Ford. Since we will only be listening to a segment a longer recording before we get into the interview I thought it would be helpful to provide some background information as a prelude to the rest of the conversation. To begin our interview, Dr. Ford broadly outlined the changes that have occurred to our collective understanding of post-traumatic stress and its diagnosis. The PTSD diagnosis first enter the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders, or DSM for short, In 1980 with its third edition. The focus then was on understanding the reactions individuals who had experienced rape, torture, genocide, and severe war zone stress were experiencing. And initially people kind of thought of PTSD primarily as a way to understand the challenges veterans were having post deployment like flashbacks to memory of combat. Following a wealth of clinical and research data findings, the diagnosis has been revised several times since. One thing that has involved in particular is the understanding that post-traumatic stress symptoms are far more common than previously thought and that women are actually more likely than men to meet the criteria for diagnosis often in response to childhood sexual abuse or interpersonal violence exposures. The latest revision of the PTSD diagnosis in the current edition of the DSM V has introduced some key changes from previous additions, including that it is no longer thought of as an anxiety disorder but rather considered a trauma and stress related disorder. Another change has to do with the first criterion for PTSD which is the traumatic exposure itself. In the previous DSM IV there was a criterion that not only did a person have to experience the trauma they also had to have experienced fear, helplessness or horror in relation to the trauma. In working with survivors of trauma it has been frequently observed clinically that this criterion was not always met. For example in the case of childhood sexual abuse often the child's abuser practiced what is called

grooming behaviors with a child. In other words making them feel special in some way by showering them with gifts or attention or making them feel somewhat complicit in the abuse. As the result, such individuals may not have felt this fear helplessness or horror at the time of the exposure. However because in both clinical and research settings satisfying that particular criterion was not shown to make any difference in terms of still experiencing the full range of PTSD symptoms, it was removed from the DSM V diagnostic requirement. Also with the advent of the DSM 5 the previous three categories of symptoms including intrusive re-experiencing, avoidance and arousal were expanded to include a fourth symptom cluster of negative cognition and mood. Another key change to the PTSD diagnosis is the creation of a dissociative subtype for those with prominent dissociative symptoms. This came about in response to longstanding calls for a complex PTSD diagnosis. Over time many researchers and clinicians concluded that previous versions of the PTSD diagnosis failed to account for symptoms and problems experienced by those in situations of prolonged abuse particularly those experienced as children and adolescents. These problems include the effects of being in captivity and the psychological fragmentation and loss of sense of safety, trust and self-worth that individuals experience as well as their tendency to be re-victimized. Particularly important is the potential loss of a coherent sense of self. Previous versions of the DSM had an associated feature of PTSD called Disorders of Extreme Stress Not Otherwise Specified, or DESNOS for short, which functioned as a sort of stand in for the overall concept of complex PTSD. With the latest DSM edition V instead of a complex PTSD designation or the DESNOS feature the working group for the DSM have come up with the dissociative subtype to capture those with the more complicated form of PTSD. They have also created a PTSD preschool subtype for children younger than six. Another change has been that owing to a better understanding of the chronicity of PTSD and the ability for symptoms to be triggered at various times in a person's lifetime the distinction between the acute and chronic phases is now eliminated and the previous delayed onset is now conceptualized as a delayed expression. In the World Health Organization's International Classification of Disorders, or ICD Version 11, there has also been an evolution of the PTSD diagnosis. In the ICD 11 there are two diagnoses for PTSD. Once you get quote unquote simple PTSD and one for complex PTSD. Overall our collective understanding about PTSD and its complex forms is an evolving process. Julian and I also discussed some of the pitfalls and challenges in fully and accurately assessing PTSD. These include factors related to the nature of trauma and our reactions to it. For some people depending on the circumstances of their lives and how many ongoing stressors they might have it may feel difficult for them to distinguish what the independent effect of trauma might be when life around them feels so fraught and things like poverty and other social determinants of health like having unstable housing or living in unsafe neighborhoods are also having an effect. In other words how do we separate out the effects of previous trauma for someone whose life is so full of traumatic stress? We also discussed how due to the noxious nature of the intrusive re experiencing symptom of PTSD in particular that individuals may have made adaptations in their daily lives and functioning that include many efforts to self medicate away such symptoms and as a result they also struggle with substance use disorders. We also discussed how PTSD is frequently comorbid with other conditions like depression and anxiety and how all of these present challenges for assessing for post-traumatic stress when other conditions are presenting more prominently perhaps, even though the original trauma and the person's reactions to it may be a key driver for many of their conditions. Other challenges involved engaging a person whose primary PTSD symptom is avoidance. If you are actively avoiding thinking about or feeling anything that reminds you of the trauma you may also be avoiding engaging with treatment or the possibility of treatment. For people with complex versions of PTSD this may be particularly pronounced because the reactions to trauma include the profound loss of a sense of safety, trust, self-worth and coherency which I previously mentioned. All of these things of course can complicate our ability to understand the relative effects of trauma and our reactions to it. Another important point we discuss is that overall conferring a diagnosis of PTSD is not the most important thing. What is important is understanding that PTSD is a multi-dimensional framework for understanding enduring and problematic reactions to trauma. In other words it matters far less

whether a person meets all of the diagnostic criteria for PTSD and matters far more with their actual level of distrust isl. Several studies now have shown that those with some of the symptoms of PTSD but not all, which has been called either partial PTSD or sub syndromal PTSD are still at risk for poor mental and physical health. So it is not about diagnosing people but instead really trying to get out what is the person's current level of distress and figuring out how can we help with that in the here and now. Following we pick up with my interview with Julian where I begin by asking more of his thoughts about assessment.

[00:11:43] So what else should we consider in terms of assessing trauma survivors?

[00:11:50] Well I think it's it can be very helpful to keep in mind that when an individual's experience trauma in the earlier part of their life and their childhood that that complicates not only their overall outlook and can lead to some very difficult symptoms like PTSD, but it also can affect how they develop in their view fundamentally of the world, themselves, relationships because that's what's happening in childhood. So there's a group that has been working within the child traumatic arrest network which is an organization nationally that funds a number of really excellent centers in communities all over the country. And this group has been working on what's called the Developmental Trauma Disorder Syndrome. It's not a DSM V diagnosis, it was not accepted by the DSM V but this group and I'm one of the proponents is pushing to get it included in updates of the DSM. And the main difference is that it's a lot like the complex PTSD symptoms that we were talking about, but it's very specific to how children are affected by trauma. And this can include things such as difficulties with just feeling angry and being aggressive in a way that can lead kids to get diagnosed with disorders like oppositional defiant disorder. It can lead kids to space out and just not be aware of themselves and dissociate and in ways that can lead them to get diagnosed with disorders like Attention Deficit Hyperactivity Disorder, ADHD. And this is a this is a proposed syndrome which again can occur with any other mental health disorder of childhood. But the emphasis really is on helping clinicians to understand how children cope with a sense of being unsafe. So Developmental Trauma Disorder is a whole another way of understanding PTSD from the perspective of a child's experience. And there is also there is a childhood version of PTSD that has been put forward and that is part of the DSM V and can be very helpful because sometimes young children, even children in elementary school, will enact some of the PTSD symptoms in play or in symbolic ways that are not as obvious as some of the adult PTSD symptoms. So there's a number of nuances and different ways of looking at PTSD. Again I just want to highlight that for children PTSD can often look different than adults even though it's fundamentally the same disorder of just not feeling safe and feeling as though you have to be on guard all the time.

[00:14:47] Once you talk about trauma and childhood in relation to post-traumatic stress I think a lot of people increasingly are aware of the ACES study, the Adverse Childhood Experiences and how there's a lot of talk about assessing for traumas using the ACEs. And I'm wondering if you could talk a little bit about how those things differ in terms of using the Aces as an assessment tool or assessing looking at traumatic stressors and PTSD symptomatology.

[00:15:15] That's that's really a great question Mickey, and really they should go hand in hand because the ACEs, it includes some very probably traumatic experiences like abuse in childhood physical or sexual abuse or exposure to violence. But it also includes some challenges that children face growing up that can also lead them to feel as though they have to be on guard and be in survival mode even though their lives may never have been objectively in danger but they've still had to essentially survive on their own in some ways emotionally and and relationally. So the ACEs includes assessments of whether an individual as a child experienced parents or caregivers who had difficulties with mental health issues or addiction or legal problems. And those are really important considerations that aren't necessarily considered to be traumatic stressors but they are just as difficult for children as being directly assaulted and in some cases they are even harder because they

are basically ways in which a child can feel as though she or he is is simply not protected or may even be scared of the very person who they would want to view as protecting them. So the ACEs really kind of opens our eyes to the fact that the children can end up being on guard and being in survival mode not just because they were directly exposed to traumatic stressors but sometimes also because of an absence of protection or even though the ACEs don't specifically address this sometimes because they simply don't have the opportunity to develop a secure sense of attachment and trust with their primary caregivers. And this may be through no fault of the caregivers. So this is not about blaming parents or caregivers. It's simply acknowledging that when children don't feel safe it can happen for a variety of reasons and when they don't feel safe they can end up being on guard and having exactly the kinds of symptoms that we describe as PTSD even if they were never directly hit beaten or abused.

[00:17:29] That's a really important point. I'm going to shift gears a little bit and talk about what you see is some of the evidence based treatment options for PTSD. Are there options for clients who are perhaps unwilling or maybe unable to safely do intensive trauma memory processing and then related to that how do we select amongst these different approaches that match the client and also your particular style as a therapist?

[00:17:54] Well those are great questions. And again that could be an entire seminar but I'll summarize briefly. So there are there are a number of treatments for PTSD that are psychotherapies so they're not medication related. There are only two medications that have shown some promise with adults with PTSD and none with children. So medications can be helpful with other symptoms like anxiety, depression, or even serious symptoms like psychotic problems but medications don't really cut it with PTSD except to help with those related symptoms. What does seem to help is therapy where the individual either as an individual one on one or sometimes a parent and child it may be a parent child therapy or it may be family therapy but for the individual child or adult to be able to work through to talk through and come to a different understanding of the experience they had in traumatic events that have occurred in their lives. Now that can be done in a number of ways. The probably the most demanding way which can be highly effective but can also be very difficult is called prolonged exposure. There's a variation of that for children. That's called trauma focused Cognitive Behavioral Therapy. And these involve retelling a story of the traumatic memory repeatedly. And there's another version called Cognitive Processing Therapy and there's a cognitive restructuring therapy too that involves developing a kind of a clear and personally meaningful story. So not a fictional story but a true life story of this is what happened to me, this is how it all unfolded, this is how I got through it, this is how it's affected me. Now talking about traumatic in that way is the most single most direct way to be able to help a trauma survivor to recognize that they don't have to run and hide from those memories. That they in fact can take ownership as Judith Herman have said, really to make meaning and take ownership of the memories rather than feeling as though the memories are kind of haunting you and you are never able to really gain a sense that you can go on with your life. When that kind of therapy is helpful it can be done in a much gentler way. The Eye Movement Desensitization and Reprocessing, EMDR involves doing that kind of trauma narrative but doing some of things like moving your eyes back and forth, which seem kind of nonsensical but they actually are very helpful ways of distracting and reducing some of the emotional intensity of that retelling or that narrative discussion. And there's a there's a variety called Narrative Exposure Therapy that was developed in Europe and has been used in both Europe as well as in Asia and Africa that involves the kind of developing a personal testimony about what has happened to me so that I can live with that experience and feel as though I have stated in the way that it's important to me. Those are all potentially very powerful and helpful ways of regaining a sense that you are in control of your life and the memories are not going to control you anymore. It can also be very stressful to do that even with the best therapeutic guides. There are other therapy approaches that basically enable a person to do what I would call trauma processing but not trauma memory processing. And the difference is that when you're doing trauma processing you are

looking at how you react in your current life and ways in which you have shifted from being open to experience and optimistic and hopeful and in many ways able to just be the person you want to be within, limits as we all have, and how you've instead had to be basically in a kind of a self protective survival mode. So there are therapies that have been developed that help people to process the effects of trauma and some of those therapies involve confronting kind of the emotions that you experience currently and emotion focused trauma therapy is one. Others of them work on how trauma has affected your relationships with people in interpersonal psychotherapy is one that does that. And there's another one called Skills Training for Affect and Intrapersonal Regulation or STAIR which does that as well. There's another therapy that that I've actually been responsible for developing that's called TARGET, Trauma Effect Regulation Guide for Education and Therapy. Sorry, it's a mouthful. The only difference with that in that therapy is that's a therapy that helps people to process their current experiences in exactly the same way that people process trauma memory, step by step and figuring out exactly what is your emotional reaction, what are you thinking, what are your goals, what choices did you make and how is that all driven by either a part of your brain that we call the alarm, which is an area in the brain that basically signals us to pay attention and survive, versus how how can those choices be made based upon the better angels of your nature who you are as a person and your core values. And amazingly enough, when people realize that they actually have a choice. I think this is really an element in every one of those therapies. We just, in TARGET we just try to make it very explicit that when you have a choice between reacting based on a sense of threat and danger you never can completely rule that out. You always have to at least include that as a possible choice. But you also have another choice which is based upon what you truly believe and who you are as a person. And trauma survivors often have lost track of that. Not for any lack of intelligence or strength. It's simply because they've been very busy just surviving day in and day out and once they recognize that there's there's another way to live that doesn't rule out being cautious and being very careful about safety but that allows them to tap into some of their deeper character strengths and core values, that is actually a way in which people have learned to shift so that now they're viewing their lives not just as a constant state of survival but actually as a series of opportunities with some reminders that still have to be dealt with with caution and with care. So that's a quick summary. There are many roads to that end destination but that's really where every every evidence based treatment for PTSD is intending to end. At that point where the trauma survivor knows that there's more to them and more to their life than just simply survival but they always have to pay attention to the fact that their body has now been basically sensitized so that survival is more on their radar screen than it would be for somebody else. And if that's respected that doesn't have to control your life.

[00:25:23] Right. Right. Well I like what you're talking about that really resonates with a lot of social work values in terms of being very present focused and very client centered and all about empowerment, but that's a lot to choose from and so I'm just wondering if you have any guidance for us about how do we match these different modalities with clients and also with our own personal styles.

[00:25:45] That is really the 60,000 dollar question, Mickey. No one knows the exact answer to that but I'll give you the best answer that I can from years of experience and listening and learning from a lot of clients and a lot of my colleagues. I would say the best place to start is rather than adopting a particular therapy because it just happens to be the one that you've come across or that you've had an opportunity to be trained in, really look into several of these therapies and notice the differences and then think about each client very individually. One client may come into treatment or may over time in treatment be very clear that there are certain things that have happened to them that they just can't seem to get over can't seem to get past and that individual might really benefit from the prolonged exposure approach. But another individual who feels very similarly and who also is telling you as a clinician, "But you know what, I just can't figure out how could somebody do something like that to another person, how can I ever trust anybody ever again?" for that individual

you just hear the way in which their thought processes and some of their core beliefs have been changed. And for that individual Cognitive Processing Therapy or Cognitive Therapy might be exactly what they need not because it's a better therapy, but because that's what they're saying their challenge and dilemma is. So I would say the best way to match the therapies to the client is figure out what it is that your client is telling you they need help with that is their way of expressing how they have learned to stay in survival mode. If as therapists we also have to consider and I take your point very very seriously, some of us are just not cut out to do prolonged exposure therapy. It's just too grueling. For others it's the most efficient and direct and it's it's like doing a procedure with laser precision where you're inflicting the least possible damage. If as a therapist you are drawn to one or several of these therapies. I think that's still that's worth considering but only in so far as you don't treat every client as one size fits all. That would be the provision.

[00:28:08] Right. I really get your point about that there's not one size that fits all but I'm wondering if in your experience you've seen some sort of critical moments or turning points for people in PTSD therapy and what you see as some of the basic principles for handling those moments or assisting people with those moments and related to that how can we as clinicians handle some of these challenges, things I'm thinking of things that are might be very provocative for us or just overwhelming perhaps.

[00:28:37] That's probably the six hundred thousand dollar question. And I say that with all seriousness as well as tongue in cheek because all of these interventions, therapeutic interventions can be very very beneficial. But there are always moments where every one of us as therapists, as social work clinicians, no matter what our backgrounds are and our training, where we are deer in the headlights. Where something happens that is shocking or that is just a major challenge like a very very stuck point. So I think of times like when a client says "I can't take this anymore I just want to die" or "I'm I'm going to kill myself" or when a client comes into a session and we see very evidently signs that they've been harming themselves or in a session where a client becomes so emotionally distressed that they go into a complete dissociative state and it's as if you're no longer there and they're clearly back in a full dissociative flashback. Those moments are I think exactly where therapy can begin or tragically in some cases can stop. And the reason for that is that those are moments when regardless of exactly what the reaction is, we can be very sure that a client is experiencing a traumatic sense of threat in that moment in the therapy session. That does not mean that the therapist, that we as therapists have done anything to threaten them. That is not a comment on the therapist actions or a lack of actions in any way shape or form other than that that may be the moment at which a very thoughtful sensitive gentle conversation to help this client to begin to reflect or continue to reflect on how their life experiences have affected them. That may be a moment where because of other things happening in that clients life or just because the therapeutic progress they're making where they are able to break through the walls of denial are numbing. And what they find is not paradise and happiness and bliss, but they find a lot of emotions that they've been keeping behind the dam as we were talking about earlier. It's not necessarily a flood. Sometimes it's just a kind of stop. So what do we do as therapists in those moments? Well I don't think that we can at that moment try to do any particular therapeutic technique. I think the crucial thing at that moment is to be present in the room with that client at that moment. And what that requires is exactly what they say on every airline and that is put on your oxygen masks. So the crucial first step is to mentally step back not to go anywhere and not to lose focus on that client. But to have stepped back mentally and just regroup and at that moment focus very very intently on what is it that my client is really attempting to achieve here. Not what are they doing alone. What is it that they are saying to me saying to themselves what is it that they're trying to achieve here. And very often what they're trying to achieve is some sense of how do I understand these incredibly difficult feelings that I'm having. Or how do I tell somebody this awful awful stuff that I really don't want to talk about with anybody in my life that I don't want to think about myself. If we as a therapist at that moment pause and then help the client to recognize that whatever they need to share

with us we're here for them. And we can take whatever time is needed and in whatever way is safe and is right for them. And that may be something that has to be repeated a number of times. Now that's often kind of summarized as grounding and grounding is a useful concept. But I think that very often grounding can be misunderstood as a kind of a technical intervention that you do where you basically tell your client to breathe and feel the sea under their body and begin to feel their body again and listen to your voice, all of which can be very helpful. But it's not going to actually help that client to recognize that they can come through this moment. Unless we as therapists are actually helping them to focus in on what's most important to them right at this moment. That's the key.

[00:33:44] That sense that you are not alone in what you're going through and that I. I'm really here for you. Yeah that's I think that's really critical and I think it may or may not be the right time at that moment. But also just providing some of that sort of psycho educational piece of explaining how you're not alone, in fact other people experience what you've experienced. Often times people think that there's just this whole constellation of problems that they have and they don't see the ways that they're connected and really related and have their genesis in trauma. So sometimes just providing that basic information I think can be very helpful in and of itself to clients.

[00:34:28] That makes total sense as a very nice way of putting it. And in essence to say what you're experiencing now makes complete sense because you're trying to figure something out you're trying to get through something that is really tough. But what you're feeling and what you're thinking we can sort that out. We'll just need to do it one small step at a time. And I'll be with you every step of that way. That is a crucial message and I think we probably probably most of us in training have heard that and we know that as practitioners as well. But the key is to remember that in the moment. That's the challenge because these are moments where I think every clinician has a kind of instant alarm reaction. If you don't have an alarm reaction that I would have to be concerned that you're not paying attention but if you do have an alarm reaction that doesn't mean that you're not a therapist who can't cut it. It means you're recognizing on a very visceral bodily level intensity of your client post-traumatic stress reaction. And as you do that if you know that it's really a part of how they've tried to survive and now they're trying to do something that adding one extra crucial element and that is it's one thing to survive it's another thing to understand how you've survived what you're capable of and who you are. And that's what can come out of these turning points. Not just I got through it and my client got through it and they their anxiety level, their stress level went down from nine and a half on the suds scale to only three. But we both together are understanding something about what has happened to this client and how she or he has coped and the strengths that this client has but also how this client has had to use those strengths to stay on guard and on edge and that's PTSD. Where can you go for this kind of information, I'll take a moment for a noncommercial plug here if I may. There is a web in our series that a group that I'm working with were part of the Center for the treatment of developmental trauma disorders. Part of the National Child Traumatic Stress Network but it's for adults as well as kids. And we're doing a series of webinars every month that shows dramatizations of real therapists with clients who are actors but they are as realistic as you can imagine. Every single therapist who's done this has said that this is just as real as being with real clients, but it's privacy protected. And these webinars show in films exactly these moments and they show how a therapist moves through that moment not perfectly, by getting some of the input from both the actor clients and the therapist. What was going through their minds, what they would do differently. So I just want to recommend these webinars not because I have something to do with them but because they're exactly what I've always wanted to see. What do therapists do, What choices do we have and how do we handle these turning point moments. These are accessible through the National Child Traumatic Stress Network. And if you just, people can just google NCTSN.org. They are part of what's called the Learning Center. This child traumatic stress network and anybody in the world can sign up at no cost to become a member of the learning center and then to get announcements every month. We have one of these webinars, the

next one happens to be coming up on February 15 at 1:00 p.m. Eastern Time.

[00:38:22] That's terrific. I think as I work with students I think they're really asking for something like that that is heretofore not been available. So that's wonderful been involved with developing that.

[00:38:32] It's been a real pleasure.

[00:38:35] Well. I have one last question for you and that is related to all this. We're talking about really fighting with our clients and being with them and hearing those disclosures and really being with people in their pain. We know from a lot of research now that that has an effect on us. There is such a thing as secondary traumatic stress. And so I'm just wondering how can we prevent that, or how can we mitigate that when it happens?

[00:39:04] Well I think you hit on the crucial point to begin with where you asked can we prevent it or maybe we should consider can we mitigate it. I think it's mitigate because I think it's an inevitable part of being a caring human being and being a helping professional to be effective. So I don't think there's any way to prevent any of us as clinicians as clinicians and training from having very strong reactions. In fact as we said it's actually in some ways it's a very good sign. Question is what to do about those reactions so that they don't interfere with our ability to be present and effective with clients and to be present and effective in our personal lives outside of therapy as well. And best advice I have is very similar to the approach that I've learned from experience in working with clients in those moments that are so intense and turning points. There are many many moments in every session that resonate personally for me with every client I meet with. And if as I am thinking about that client and thinking about exactly how I can be most helpful. Mostly after the session sometimes starting in the session as long as it doesn't interfere with my concentration on what my client is telling me and being aware of where they are and who they are, but especially after the session of privately or talking with a colleague in a consultation or supervision to think about and make the connections between what clients have told me and how they're feeling and what they're going through and experiences in my own life. Now that doesn't mean doing therapy on myself but there is a kind of a therapeutic value. Essentially walking the walk and doing exactly what we're asking and guiding our clients in doing. Not because of any pathology or anything that's necessarily a problem but because we all have reactions that than if unprocessed can become sense of unsafeness. Yes that's well that's what I think is ultimately the genesis of secondary traumatic stress. It's not the emotional intensity even though that can be very very challenging. It's the sense that somehow talking with this client I come away from that just feeling less safe, like I'm not a very good therapist, I may be failing my client or clients or my life just doesn't seem to be all that great or I'm just not so safe in my life. You can see that it's not the intensity of the clients emotions. It's that sense that there's something that I need to be watchful about and I'm not being watchful enough and that's hypervigilance. It doesn't have to be PTSD it's just hypervigilance because of being concerned legitimately about safety. So bottom line recommendation, make the connections privately or in whatever way makes sense for each one of us between what the client or clients have shared and what it means to us personally. And I think if we do that then we will find time to exercise, eat well, get enough sleep, have good times with our friends and families and do all the other good self care things that we definitely know are really crucial for every helping professional.

[00:42:31] I really like your emphasis on really examining our own reactions and I think it's really much more than that it's really addressing the things that come up for us in sessions and how that evokes our own past and our own reactions and that's the real critical part, not necessarily just self calming and soothing which is important but really really examining what's going on.

[00:42:55] And I think just to absolutely agree with you. I think the clients recognize when a

clinician is doing that. They don't have to know about it. In fact I don't think it's it's almost never a good idea to self disclose "Well I thought about what you told me and that reminded me of this experience I've had," that almost never a good idea. Once in a long while that may be therapeutically useful, but for the most part it's a private process that is our business as clinicians. But I think that our clients recognize when they're talking to someone who is basically putting their own house in order well they're helping the client to put their house in order.

[00:43:36] Well wow we've covered a lot of ground here.

[00:43:39] We have indeed.

[00:43:40] And I just want to thank you so much for doing this and also for all the good work that you're doing related to traumatic stress nationally and internationally. And just thank you so much.

[00:43:53] Well I'm the one who should be thanking you Mickey for the work that you are doing in the perinatal area and for inviting me to do this and I just hope that there's some some ideas here that will be helpful to many many of your and my social work colleague.

[00:44:09] Terrific. Thank you.

[00:44:11] You've been listening to Dr. Julian Ford's discussion on complex perspectives on PTSD and treatment. I'm Louanne Bakk. Please join us again at inSocialWork.

[00:44:34] Hi I'm Nancy Smyth, Professor and Dean of the University at Buffalo School of Social Work. Thanks for listening to our podcast. We look forward to your continued support of the series. For more information about who we are as a school our history our online and on the ground degree and continuing education programs we invite you to visit our website at www.socialwork.buffalo.edu. And while you're there check out our technology and social work Resource Center. You'll find it under the Community Resources menu.