
Rich Simon: Welcome everybody. My name's Rich Simon, editor of *Psychotherapy Networker*. Welcome to this series, this *Networker* series on trauma treatment. What we're trying to do in this series is look at trauma treatment today, the latest advances in trauma treatment from a number of different perspectives with a particular emphasis on the practicalities of trauma treatment; the do's and don'ts of working with people who have gone through severe experiences, who have gone through traumatic setbacks of one sort or another.

The idea is to really focus in on skills and what the actual sound, the actual particulars of what various practitioners in the field do under the circumstances and under the demands of working with people who have been traumatized. So today, we're fortunate to somebody who's been at this kind of work for 30 years, a friend of *Psychotherapy Networker*, our own Mary Jo Barrett of The Center for Contextual Change in Chicago. Hey, Mary Jo. How are you?

Mary Jo Barrett: Hey, Rich. How are you?

Rich Simon: You've done something very interesting over the years that I don't think enough therapists do at your center. You have systematically done exit interviews with all of your clients, of all stripes over that time, including your clients who have gone through trauma treatment at your center. Tell us a little bit. What's come out of that? What have those clients told you about what's helpful to them, what's not helpful for them in the treatment that they have received not only at your center but often in previous treatments?

Mary Jo Barrett: What's been the most helpful to me -- I think the most important piece is that when I started doing these interviews, the answers substantially changed to the treatment that we were doing at the center. We really did change the treatment. When you introduce the whole series and talked about skills, there's some very specific simplistic ideas that we learned from the outcome interviews that you can apply every single session. It's almost like when I'm teaching my students or teaching new staff, I'm gonna share with you in a minute, what I call the five essential ingredients to trauma treatment.

I tell people, write these down and put them on your desk and at the end of a good session, you should be able to look at all five and say, "Did I do something? Was there something?" I don't care if you're doing yoga trauma treatment, if you're doing EMDR, if you're doing CBT, child focus CBT, DBT -- across the board,

across all the models, there's a few things that we know that create good treatment for trauma.

Rich Simon: One thing, we spoke about this in the past, there was one thing in particular. This had to do with in a don't category, which is part of our conversation here today about people's experience with previous unsuccessful trauma treatment. Tell us about that.

Mary Jo Barrett: The overall idea that I really want to convey in this particular webinar is that, in our experience, and we're talking, Rich, at this point, I can say maybe over thousands of interviews. It's not just been interviews at the center. It's been at agencies that I consult with. We're talking residential treatment. We're talking child protective services, everywhere; not just treatment at the center. Is that people experience the intervention or the treatment or the working in the system as a traumatic experience that often, if we're talking child welfare because you have to think, we're not just talking private practice here.

We're talking when the child protective service comes in to investigate a child abuse case that the families experience that investigation as traumatic as the child might experience the abuse. When we're defining what trauma is, first of all, we're talking about a psychic, spiritual, emotional, and physical interruption that people lose their equilibrium because of it on all those levels. What happens is therapy is also an interruption; people from the outside coming in, being controlling, telling people what they need to do.

I think the most important message, how therapy becomes traumatic, Rich, is that people in a position of power, which therapists are, and in a position of intimacy and attachment are doing something to the client that they don't even understand why it's happening or why it's doing it. Do you know what I'm saying? It's like they don't -- "Why are you picking this intervention? Why are you doing this to me? Why?" Somebody in a position of power and attachment is doing something to them. Does that make sense?

Rich Simon: Just a moment ago, so we're talking about the whole range from kids on through the entire life span of people that have experienced traumas of different kinds. Where you're starting us is saying that the hallmark of trauma is some profoundly disequilibrating experience that disorders someone's normal patterns of response, their physiological response, their way of looking at the world,

their sense of safety and their sense of intactness. Kind of the hallmark of your model then is a degree of control and predictability that you're trying to communicate.

Mary Jo Barrett: Yes.

Rich Simon: We'll talk in a moment about these stages of treatment, which you consider very important. This theme of predictability, of order, of structure, it's a big part of your work. Talk to us a little bit about that.

Mary Jo Barrett: There's two things. You summarized it beautifully. There's two things. One is, collaboration and predictability. Those are the two main hallmarks of how to organize your therapy so that the client with you in collaboration knows what the different steps are, why we are doing this now. I've often said that trauma treatment is like good comedy.

Rich Simon: Not too many people have made that analogy. Good for you there. Got a laugh out of me. Good for you.

Mary Jo Barrett: Timing is everything.

Rich Simon: There you go.

Mary Jo Barrett: And it's the same in comedy, right? What the difference is I have to pay attention to my timing all the time and my timing is a collaborative effort. My timing is saying to the client during the session, "What's happening now? This is why I'm doing this. How are you thinking about this? What's your impact?" That it really is this constant collaboration. The interesting thing is, and I know you're very familiar with Scott Miller and their work.

We interview people not only at the end of treatment, at the end of sessions just like they've talked about recommending. Where are you at? What was helpful? What do I need to change? Again, it's this timing and kind of like taking a temperature of what's going on in the session. When I talk about the stages, is that at the very beginning; the model I developed, which is an organizational model, is called the collaborative stage model for trauma treatment.

What it means is each step, each stage, you're collaborating, getting feedback, changing, attuning to the client and changing what you're doing based on the feedback whether it's

physiological feedback that you're getting from the client in the middle of the session, they're breathing or they're not breathing, what the color of the skin is, their eyes dilating, or the feedback where they're not talking or they're there. It's this constant recalibrating of the treatment based on the feedback you're getting.

The first stage is creating a context for change. Basically what that means is people are coming into with the context from trauma, which means they're mostly in their trauma cycles, which means much of the time clients are either in a frozen state where when they come out of that frozen state it's the fight flight or submit reaction. Therapy then triggers that.

A lot of times, in the therapeutic moment in the session, the client could be in fight, flight, or submit. That's not the natural cycle for change. That's gonna be homeostatic because they're coming in. They're gonna have their symptoms, whether that's they can't regulate their relationship with you, their communication's poor, they get angry, they get nasty, they dissociate. Obviously, it's gonna stay the same. In the first step of treatment is to teach the client that concept, to talk about, "I don't want this to be a traumatic experience."

I teach them the cycle of what trauma is to have them tell me when, "This is how I look when I'm in fight. This is how I look when I'm in flight. How I'm frozen. How I submit." We create a context. I can give you some specifics in a minute when we talk about the five essential ingredients that they tell me, each client tells me what I need to do. I've had clients who have said to me, which you will appreciate, that sometimes my voice triggers them because I'm a little loud. No, did you know that?

The point is it's really getting that kind of feedback where I say to people, "Where do you wanna sit in the room?" That has been one of the most amazing things to me, is that people walk in my office and they say, "Where should I sit?" I say, "Sit wherever you want." They literally have said to me, "No therapist have ever said that." I've had clients where I've said, "What's gonna make you feel comfortable?"

I've had a client say to me, "The door being open." If I hadn't asked that, I would've never known. Of course, it makes sense. The door being shut, which often happens when you're being abused as a child, you're in captivity. Captivity triggers their

trauma reaction. The therapy room could trigger their trauma reaction.

Rich Simon: You're never sure.

Mary Jo Barrett: You're never sure unless you ask. You can't ask unless you explain the concepts to them.

Rich Simon: In a previous interview that we did about ethics, these first sessions are really very important, how you work, and you like to lay out for people. Essentially you're creating a kind of a contract and you're introducing to them the particular culture of your office, of your way of working with them so a piece of it. We'll move through your stages, at the end of a first session, what is it that you wanna make sure that you've communicated to your client and what the basic information that you've gotten from the client in the course of that time? We can talk more specifically as we get into these five essential ingredients of particulars there, but just to give people this initial sense of it.

Mary Jo Barrett: At the end of a first session, I want them to understand that there are these stages. I explain each of the stages and what the therapy might look like. I absolutely want to hear about any other therapy that they've had in any form, at any time in their life. When I ask about that I wanna know what worked for them and what didn't work for them. I really wanna get as specific as possible about what worked and what didn't.

Like any therapist, I certainly wanna find out what their goals are. I often, at the beginning, because I do this in a more of a second session; but in the beginning, I definitely talk about structure of the room itself. What will make them feel comfortable? Again, very similar to what we talked about in the boundaries webinar that I talk about why I do certain things like why I don't give out my cell. Just the rules and structures of what therapy is about.

I usually ask for a four-session commitment. At the end of four sessions, I said, I think you'll understand the rhythm of this therapy and you'll know whether it feels good. One of my goals is, because I ask at the end of a session, I absolutely want to provide some type of relief or some skill. I want them to go home and feel like they got something out of this. Every session. At the end of the session, I ask. I do ask for usually a four session commitment and then we'll decide whether we should continue or not or what's going on and give feedback.

I usually have a four session feedback and then we give feedback to each other about what we see is going on between us. The other thing that I often do and I don't say people have to do it exactly like me but the concept is to be able to provide the structure and create collaboration and everyone's personality is different. In the first session I often say, "Are you sitting there having questions about me? Is there something about me you wanna know?"

I definitely give them some opportunity to ask me questions. Did they wanna know how long have you been in the field or what about is there any research on this stuff that you're doing. Some people will ask other questions, "Are you married? Do you have kids?" I definitely want an opportunity for that interchange.

Rich Simon: This relates to what you said in the very beginning here about therapy in itself being traumatic. How much of the trauma experience itself do you need to hear about, do you need to have described to you at this first installment of the psychotherapy?

Mary Jo Barrett: You are really a smart man because people ask me that question all the time. That's great. I don't wanna know about their narrative until stage 2. That's one of the other biggest mistakes. You're talking about do's and don'ts. People want symptoms, not the clients, therapist, wanna start working on the symptoms, wanna start hearing the story. It is traumatic to tell that story. For us, a lot of change can happen. A lot of psychoeducation happens in stage 1. A lot of information.

Stage 1 is creating this context for therapy. People say, how long is that? It could be 4-6 weeks. It could be a year and a half for some people who have been multiply traumatized in many, many ways. To tell the story too soon is traumatic. To start working on symptoms, to start challenging, because what I call stage 2 is I call it challenging patterns and expanding realities.

Stage 1 is goal setting, is looking at the positive and negative consequences of therapy. That's stage 1. If I give up this symptom, we don't start about giving up the symptoms. We haven't talked about what's the positive and negatives of you telling me your story? If you tell me too much too soon, are you gonna be ashamed, are you gonna be afraid of my judgment. Why would you tell a perfect stranger your trauma history?

In stage 1 is the positive and negative consequences of change, them becoming very clear with what their goals are, me being honest, “Can I really help them? Do I know which type of treatment/intervention will be best?” If they’re telling me about ruminating thoughts and they get stuck in these thoughts and then I think, “Okay, so then let me tell you, teach you a little bit about what CBT is.” Or if they say, “I had one very specific traumatic event and I can’t seem to shake it. I have flashbacks,” and then I’ll say, “Well, let me tell you about EMDR.” If they aren’t feeling anything in their body, they’re completely cut off, I might start thinking about more body centered interventions.

These are all the things that we figure out in stage 1. What stage 1 is about is creating the attachment and creating the structure of therapy, setting the goals and figuring out what strategies, what interventions, what modalities because we have so much to offer trauma now. Thirty years ago, Rich, first of all, we didn’t even call it trauma.

Rich Simon: We didn’t have a category.

Mary Jo Barrett: We didn’t even call it trauma. Now we have so much to offer them but 1) It’s not cookie cutter and 2) you can’t be throwing all this stuff at everybody. It’s really based on what makes sense to them. That’s all what stage 1 is. In stage 1, once we know what their trauma cycle’s like, what their growth cycle is like, which is what I call them. Like how do they grow, how do they expand, what’s their best learning style? They have experiences in their life where they’ve changed already and grown. I teach them that we have a trauma cycle –

Rich Simon: Forgive me. You’ll ask them rather than focusing on this trauma narrative, how would you phrase that question to get at people’s growth cycle?

Mary Jo Barrett: What I talk about is, first of all, I teach about the natural cycle of growth, which is I use a lot of nature metaphors and say, “Look, everything goes into a hibernation. The moon goes away, the tide goes out, the trees lose their leaves, and then they expand. Then they come out of that and expand. The exact same thing happens in trauma. When you first are traumatized, you go in. The difference is you might not have the skills because of what age you were in, because it wasn’t a safe context.

When you came out in a very functional way, you came out of that freeze that with contraction in fight-flight. That's how we are naturally wired as cave people. We came out of the cave and is the lion gonna eat us. If I'm big enough, I'll fight them. If I'm not, so. That's how we're wired. What they did was adaptable. It was good. Now, it's not working for them. Now what happens is I want them to go in and contract in a natural way. When they come out, what therapy's gonna do is when they come out of that contraction, it's gonna teach them skills in a variety of ways so that when they come out it's not fight, flight, or submit. You with me?

I teach that exact thing in the first stage to them and then say to them, "What I need to know is how do you best learn and change? Is it music? Is it movement? Is it by thinking? Is it by reading? Is it by writing? Is it by talking?" Find out when they've had to change anything in their life, when they've had to make decisions, what skills do they have and do they use. What skills would they like to learn?

I would like to learn this. I would like to churn this. Clients do know. I want communication skills. I need to be able to talk about this. I need to know when I start to cry, how I could stop. I need to be able to cry. They tell us. Then what I call that is acknowledgment; acknowledgement of my cycles, how I best learn, change, and grow. Based on their acknowledgement, then in stage 2, I figure out what interventions, what modalities to help them challenge those patterns and cycles and, what I call, expand to new realities.

Rich Simon: We'll get to stage 2 in a moment. Just one thing. This stage 1, does this last you said something about four sessions? I presume it's a range depending on who the person is?

Mary Jo Barrett: Yeah.

Rich Simon: We'll move on to stage 2 in a moment, just give us some final comments on this stage 1.

Mary Jo Barrett: The thing about stage 1 is it is the most important stage because without stage 1 you can't get to stage 2. That is the stage that most people rush through. Whether it's presenting in the symposium or wherever else I teach, people say to me, "I think I've had a client that's been in stage 1 for a year. Is that possible?" The answer is absolutely. When I said four sessions, the four sessions was to

reevaluate and give each other feedback. I would say stage 1 is usually six, eight, a few months, to a year or so.

Basically, it's when clients are not feeling safe enough, when their life is in the outside of their life it is so chaotic and they haven't found ways and their symptoms are very disruptive that you could be in stage 1 for a very long time. That doesn't mean change isn't happening. It is happening but they might have a lot of difficulty really utilizing and integrating the skills without trying to get too specific because they can't process it. They're in trauma so much, in trauma state that learning skills, they can't learn them. If they even learn them, they can't effectively utilize them.

Rich Simon: I'm your client. I'm coming in and I hadn't heard the other interesting thing that maybe we'll get back to later is that adding submit, I think most of us are familiar with fight, flight, freeze and submit. You do a lot of work with child abuse victims and so you have I guess a special sensitivity to that particular state, but let's move into stage here. What would you wanna see in me? What's happened so that in your mind and in the way you're organizing your work with me that we're ready for stage 2?

Mary Jo Barrett: One thought that I wanna say that I hope doesn't make it too complicated but you are always really good at helping organize me so you'll help organize this; is that you can be in different stages with different modalities. For example, you come in and you come in as an individual. As we're talking, I find out that you're also being abused, that there's current abuse, let's say, going on in your marriage or in your couple. It's really hard for you to become stabilized and utilized because you're in a trauma mind all the time when you go home.

We might spend time really talking about how to first start working on your current situation, your marriage or your partnership, before we start ever working on your past trauma and some of your other symptoms. It's also what happens is we're prioritizing with the client. What are the most important things? Somebody could be working on, let's say, an eating disorder and be in stage 2 and be okay with working on that but be in stage 1 in their couple therapy or their partnership. That's important is that it's not this –

Rich Simon: It's not unilateral.

Mary Jo Barrett: Yes. It's not linear. It's just not linear. It informs how you are talking with your client.

Rich Simon: Just so that we get a sense of this, because we're moving through and we have three stages. We wanna flesh out this thing. What's the point then, again? All these things have happened. I'm feeling comfortable. I feel safe with you. We've set our goals. We have a sense of how I learn, my growth cycle. We've done this work. What is it that happens and we're into stage 2?

Mary Jo Barrett: We're agreeing on what the different components of the treatment are gonna be. There's an acknowledgement. The end of stage 1 means I acknowledge what my vulnerabilities are, what my strengths are, I acknowledge my cycles and my patterns, I acknowledge what goals and I acknowledge what modalities and what interventions we're gonna use that, "Yes, I'm gonna have a psychiatric evaluation. I'm gonna do some couple therapy." We're in agreement of what the treatment looks like, the organization and the structure.

Stage 2 is the implementation of the different interventions, organizing that because we don't want people in therapy three or four times a week, that they might come in. For example, I'm seeing somebody right now who's a trauma survivor who's also a domestic violence, a batterer. He's there getting -- she's in individual. They just started treatment. He's starting stage 2 so we don't do couple treatment in stage 1 when it's domestic violence.

He's in stage 2 of his individual work on his own trauma. They're in stage 1 of the domestic violence. He comes once a week to individual. He comes once a week to group. When the group is done in stage 2, when that group is done, he'll then start couples. Stage 2 would be the very specific group using EMDR, using CBT, the specific interventions on the symptoms that [inaudible].

Rich Simon: It's a method model based time of the therapy where certain interventions/methods are being used. The matchup between who it is; we have a whole bunch of tools now with trauma. Part of what happens in stage 1 is you're finding the match between the person and what you think is gonna be effective. Give us a few of your thoughts about how do you go about doing that? What are the hallmarks of being able to do that match effectively? Make sure people get the kind of approach that's gonna work with them.

Mary Jo Barrett: What's interesting is that, as you're looking in a series, when you're looking at all the models now, that what you're gonna see, which is I think wonderful, is that there's even integration within the models. Let me just use an example. DBT, for example, Dialectical Behavior Therapy. There's a huge component that's mindfulness. When you're having Pat Ogden and when she's talking about the body and the sensory pieces, that's also about mindfulness. She also teaches skills. There's certain some cognitive behavioral pieces in her.

The beautiful part is we really are all integrating, that we've in the trauma field come to recognition that this is about thought as well as body and how we're all informed by the neuroscience. That's the nice piece. A lot of times, I just explain the different interventions or the different models and clients will say, "That speaks to me. I wanna try that." For example, I'm trained in EMDR, I might do one EMDR session even though I might not be an EMDR therapist but let them see what it feels like.

We do neurofeedback. I don't know if you're familiar with neurofeedback. We also had to do some biofeedback. I'll do a session or two even though I'm not gonna be the neurofeedback technician. We'll do the session and people will talk about what feels comfortable to them. I'll talk about that CBT uses a lot of homework. I'll show them the manuals. Again, they're involved in learning about themselves. It doesn't mean that every person who treats trauma has to be an expert.

I, Rich, am still basically a contextual family systems therapist. I still do a lot of family and couple. As a trauma therapist, I need to be informed about all the different interventions. That's why the webinar's so great. Everybody can't learn all of this and you could still be an effective trauma treatment. The other thing that I wanna say is that so many times people say, "I don't work at a place like the center that has everything." That's true but you live in a community.

One of the things that I found is, we're not gonna lose money if I refer to you for SE because you're gonna refer to me when it's couple. If we really are looking at the most effective trauma treatment. There is no way anybody should say they completed trauma treatment if they live in a family or a partnership where their family or partners haven't been involved. There's no way that their kids shouldn't have been involved.

If we really work together in a healthy way that was not traumatic, really contextually and work together, no one's gonna lose money because we're referring to each other. I see you smiling but you know as well as I do that that's one of the reason people don't collaborate.

Rich Simon: This whole collaborative theme really goes across the board. It really is woven through all your decision-making and your way of working. Before we move to stage 3, the people have their experience and this is more like what we think of simplistically when we're just ignoring the particulars of people and their relationship like a medical intervention. We give them EMDR or SE or all the different brand names in our field. That's certainly part of stage 2. Anything else you wanna tell us about stage 2 that's important?

Mary Jo Barrett: No, but just to remember that they'll be at different stages so I could be doing communication skills in my couple. It really is about this organization. You don't want it to be chaotic. The therapist does have to be organized and understand why they're doing what they're doing.

Rich Simon: Again, here I am. I'm in stage 2. I've done my CBT, feeling some ability to regulate my mood. I don't get so triggered, easily triggered with things that resemble the trauma stimuli. What is it that puts me across the threshold into stage 3?

Mary Jo Barrett: I've got the great answer for that one. When clients come in and start reporting to you what they've done without breaking it to you and say, "What should I do?"

Rich Simon: That is a good answer.

Mary Jo Barrett: It is. That's it. They come in and they say, "This is what happened this week and this is what I did. What do you think?" Or they come in and they might not even see it as positive yet but that – I was just thinking of a story I'm gonna tell you. That's the biggest sign. I'll tell you one of the great –

Rich Simon: They have a sense of agency about their own life.

Mary Jo Barrett: Yes. Here's the piece. In stage 1 and this is what I talk about in my compassion fatigue workshop, in stage 1, what we've learned from the outcome research, which we do need to talk about those five things quickly at some point. What we've learned is that

really how a client defines healing, growth, and change is that they, through the treatment process, learned, gained and got access to resources that were inside themselves; resources in their family and resources in their community.

The therapist was facilitating them getting access to those resources. In stage 1, the way I teach people is that the clients are like plugging into us like we're an electric outlet and getting our energy, which is energy is the synonym for resource. Did you know that?

Rich Simon: I'm learning all kinds of things in our conversation. Thank you.

Mary Jo Barrett: Energy is a synonym for resource. They plug into us. This is a good metaphor, like we're an outlet and we stream our ideas, help them find theirs. In stage 2, they're developing their own resources, getting organized. In stage 3, they're unplugged from us and they are managing their own resources. What's so fascinating is that this is, that's what we see.

One of the interventions that we do a consolidation, which is what I call stage 3 is consolidation, is that one of my favorite things that we do is that when we think we're ending with a family or an individual, we have another therapist who's not their therapist interview them and ask them, "So tell us, what were your strengths when you started? What were your vulnerabilities? What exactly did you learn? What skills did you get out of therapy?"

That exit interview that we're talking about is an intervention because the client then goes, "Wow, look where I've come. Look what I've learned. Look how I've changed." I have a bunch of really fun creative things. I'll have a session in consolidation where I say to them, "Let's pretend that it's our second session. Let's everybody look and act like they did the first time." Or an individual, "Do you remember what you looked like? Do you remember what you acted like? Let's sit in the chair."

Rich Simon: That's fun. I like that.

Mary Jo Barrett: I also, I have a crystal ball in my office where I say, "Let's look in the future because change never stops." That's one of the messages here is that this cycle change goes on. Let's look. Mostly I look at the developmental life cycle and say, "Where are you gonna need therapy again? What do you think you're gonna need to do different when your kids grow up or you've lost your

parent or a child becomes a teenager? When are going to need the support and the resource from outside of you, again, just like you did this time?"

There's a relapse prevention plan. This interview. We talk a lot about celebrations so that it really is the sending the message that you have mastered a lot and that this process will keep – it's an evolution. You never stop changing and growing. You might need outside resources, probably will, again.

Rich Simon: You described this transition from stage 2 to stage 3 and people sense of agency and when they're reporting on things they've done rather than coming to you to ask you what they should do. This termination time, which is not forever after but this particular installment of growth and recovery from their trauma, what's the point at which that particular phase of their relationship with you or treatment can end? What's the marker for that?

Mary Jo Barrett: What we usually recommend in consolidation is that you're going down to very few sessions, that you might go to once a month, once every six weeks, that you –

Rich Simon: Gradually, okay.

Mary Jo Barrett: Usually the client says, "Okay, this is boring. I'm done. I don't wanna keep coming here." We, again, they have a lot of power and control over that decision.

Rich Simon: That's part of the conversation?

Mary Jo Barrett: Yeah.

Rich Simon: We've gone through the three stages. Let's go back and look at something that cuts across all of these stages, which is what you like to call these five essential ingredients of good trauma, of effective trauma treatment. Take us through your list.

Mary Jo Barrett: My list is, the first one which is exactly -- do you remember the Atlantic Monthly when years ago when they did the research about what good treatment was and they said it was the relationship?

Rich Simon: Uh-hum.

Mary Jo Barrett: That's exactly what we found; that the relationship was one of the most essential ingredients. However, there was very specifics

about what the relationship was. The specifics were that, and this is that the clients told us over and over again that they really valued the therapist and they valued the therapist because they felt the therapist valued them and that came out of the collaboration. That they felt it was a partnership. That the therapist had absolutely skills and things to teach them and they also respected the client enough to believe that they had things to learn from the client. That was the language that they would use.

They really talked about feeling valued and valuing the therapist. They talked about that they felt empowered, that the process of therapy made them empowered. They didn't feel like something was happening to them. What they said that often for the first time in their life, that therapy provided a meaningful vision of the future. Literally would say things like, "I believed for the first time that things could get better. I had hope. I saw a future."

When we asked them what about the therapy. They said therapists would talk about it. They would say, "When you do this, this will change. Can you try this? Let's see how this happens." That there was this focus on change and growth and in the future much more than in the past and much more than what happened to them that basically hearing what happened to them was enough, was really about understanding their cycle, but it was really a very future oriented, not a past oriented, therapy.

Rich Simon: That seems like a very, a really important point and particularly into as far as do's and don'ts of trauma treatment. You're putting together the idea of relationship and as we know, relationships are also often about ain't it awful. You can bond with people about a hopeful vision of the future but you can also bond about suffering and how terrible things were in the past and you can veer too far in this direction. What you're saying is this relationship is a relationship organized around hope and organized around new possibility.

Mary Jo Barrett: Of course, you have to have empathy. You can't go, "Hey, that was no big deal. Get over it." It's saying that was unbelievably traumatic and painful and horrifying and no child should go through that or no person and; it's the big and. And you do heal from this. And you do change. And it's an and. I think that's the piece. That piece about the meaningful vision of the future, feeling empowered by that meaningful vision. I wanna just say one other thing, Rich, that people commented in terms of this relationship what I think this is really significant, that the more relationships

they had that were like this, they thought was that helped them change more.

It really goes back from the idea of this one to one, my therapist is everything. Because my therapist is everything doesn't supply a message of this can be generalized to the world. It's like, "Okay, great. You, now I'll have to be attached to you forever and when we're done it's another traumatic event." The more people -- and that's why I believe good trauma treatment involves group and involves family and couple because it is showing them that their world, they can have those relationships and have the skills in their world. People talked about the secretaries. That the secretary provided the confidence.

They liked having different therapists and groups because it just kept generalizing that there was a lot of good people out there and people could grow and change. I think that's really significant.

Rich Simon: That's great. I agree with you. We have about ten minutes here. Let's continue on all these ingredients that are really important. Let's talk about skills.

Mary Jo Barrett: The second one is, they all talked about learning skills; skills about mindfulness. The whole piece of what we've learned from the neuroscience about mindfulness, before that was even talked about; we've been doing these interviews for 20 years. I think I mentioned in the article that I wrote for the Trauma issue was that the client said, "Now I understand why you used to say to us let's just stop and breathe," because now that she's doing yoga, I didn't know why I was saying let's stop and breathe back 25 years ago, except I said it.

Rich Simon: **[Inaudible]** the time.

Mary Jo Barrett: Right, because I needed to breathe, right? Now we know that that issue of learning skills and mindfulness. For me, how I teach it with the client is you need to pause so that when you come out you can make choices so you're not just in trauma cycle. The learning the skills about mindfulness, lots of different ways. Learning cognitive behavioral skills, communication skills. People just talked about skills. I finally learned how to talk.

I finally learned how parenting skills, how not to repeat the patterns of my own traumatic history. Every single interview, every single one, they talked about skills and still used them.

Again, I mentioned that in the article. My very first client, I wasn't doing the model then. When we interviewed her when she was 32, she'd still talked about skill sessions that I had taught her. I was just doing family therapy.

Rich Simon: That's what came across for her.

Mary Jo Barrett: Right. The skills have to be both cognitive, body, spiritual, teaching how to pause, to make choices, so it's an integration of what we know, of what I said, that's the integration of all the models. The important piece of this, the clients are saying this. This is from getting the feedback. The third thing they talked about was the strength orientation. That so much of the treatment came from what was their resilience. It's not that we didn't hear the story of their trauma. It's not that we didn't talk about their vulnerabilities.

We certainly understand what triggers them and their relationships. We understand their symptoms. And we utilize their own strengths, focus on their strengths, focus on that relationship and their strengths to design the treatment and in each session what they're good at. Usually what I talk about is look how even some of your trauma your symptoms have worked for you in terms of how you've benefited from them in your life for now.

Even the symptomatic behaviors that you're trying to talk about. That's why we spend a lot of time talking about the positive and negative consequences of change, that there's a loss. These symptoms have worked for them. You really have to explore how they're worked, what are their other strengths that they can replace the symptoms with; the function of the symptom. The fourth piece that every client, these are the things that statistically significant to all the clients said, was this issue of they all used the word, "I felt safe."

When we asked some more questions what made them feel safe, it was that predictability. It was being a partner, knowing what was gonna happen, there were clear boundaries of the relationship, there were clear boundaries about the therapy, there were goals, we could say this is what we're trying to teach you, this is what we're learning. All that predictability and structure, that there was a model, that they knew what was gonna happen made them feel safe. People could not change if they didn't feel safe. I'll give you a great example. One person, this is a simple one.

One person we interviewed said that one of their last therapies was so painful for them. I might've even talked about this in the ethics one, because I just think it's such a great example, is that their therapist never touched them. Did I talk about that in the last one? Where the therapist wouldn't hug them, never shook their hand. The therapist didn't because they knew they were a sexual abuse survivor. They thought they were having respectful boundaries. I guess the client interpreted it as, "I'm damaged. Something's wrong with me. They wanna stay away from me. I'm eliciting sexual reaction in him so he doesn't wanna touch me." She had an entire narrative about this.

Rich Simon: What an interesting story. Sure.

Mary Jo Barrett: Which could've been -- one of the things that I talk about in stage 1 is touch. I am a touchy therapist. I put my hand on people's shoulder when they leave the room. I might even just touch them in a session to get their attention or to be loving and supportive but I talk about that. Those issues of safety, people talk -- like I mentioned to you. We say it overtly what's gonna make you feel safe and what's not so overt is the whole piece about teaching the structure.

Rich Simon: Let's just align that, because that just seems so crucial. No matter how brilliant and clinically intuitive we think we are, there is no substitute for the sort of thing that you, in particular like to do, make these things explicit. Asking questions, approaching all of this in this spirit of collaboration, "You need to tell me what I can or can't do as far as helping you to feel safe or making you feel uncomfortable."

Mary Jo Barrett: Just think about it in terms of the meta issue of how, when you are being traumatized, this is literally the opposite. Even if we're talking about a tornado or a hurricane being the traumatic thing.

Rich Simon: They don't ask your permission.

Mary Jo Barrett: They don't ask. They don't talk. They don't collaborate. They don't say, "Okay, so how are we gonna rebuild from this?" They just do it. That's the difference. Therapy is not happening to them. It is happening with them. That's the overall thing. The final piece is what I call, from the good old family therapy days, creating workable realities. That's what I call it. What the client said was, "It was helpful that they knew that the therapist knew

what they were doing, that the therapist had a plan, that there was some evidence based.”

We have that whole conversation about evidence based and obviously, our outcome shows both, that it's not enough just to do an evidence based treatment if you don't have who you are in the relationship. Again, doing an evidence based treatment is like doing something to them. We'll go through these CBT steps, it's not gonna work without the collaboration. However, people do want to know you've had experience, that this works. I call it creating a workable reality, meaning that if you do these things, I do these things, there will be some shift and some outcome. That's what clients said. It's a little different than the meaningful vision of the future.

That does give hope, but this one is talking about the therapist having confidence, being organized, knowing what they're doing, and being and organizing and structuring the treatment. That, it sort of fits in, it bookends the first one, it's still about the relationship. In a way, it puts it all together because it's talking about the structure, the relationship, the skills, all of that means, “This is gonna work.”

Rich Simon:

It's more defined. It's not a general expectation of hope. It's not a generalized concept. It's a workable reality. What makes it workable and it's workable in these particular ways, these things. Listening to this, our vast *Networker* audience out there, and they've certainly just listening to you give us all this structure, I think, will be helpful to many of us. If you're gonna give some specific suggestions to people about whatever their level of experience, whatever their training background happened to be and they wanna get better.

They wanna be of more service to their clients. They wanna be more effective in doing this work in addition to listening to this conversation over and over again, in either what we've spoken about or perhaps what we haven't spoken about, how would you focus people? What's the next step for them?

Mary Jo Barrett:

How I would focus is this work takes a lot of energy. This is about creating a context where clients tell you the resources they need, tell you the resources they have, and then there's an exchange of resources. Even though I made the joke about the did you know that the synonym for resources is energy, the fact is that's really serious because it means you as a therapist, you as a clinician, need

to maintain your energy. You do need to be able to maintain your hope, maintain your skill level.

These are what clients are telling us. They need our skills. They need our hope. They need our presence and to be in good physical shape. They need to be able to value us. I would say that it takes a lot of energy to do this work. The energy is intellectual energy, emotional energy, spiritual energy, physical energy. The one thing is to maintain your health, maintain your own energy. That in fact, that is a key piece in trauma work. That if you're in your own trauma cycle, you cannot be helpful.

You have to be able to know your own process of how to go in and pause and how to come out and grow and expand and know what's happened; and know what's happening to you in this session so that you can be what I call, ethically attuned. You really have to be able to attune to yourself on all those levels so that you can be present and ethically do this work, which is to be able to know all these skills and to have the energy. I think the other piece is to organize your treatment.

I'm very clear with what I'm gonna be doing each session. That doesn't mean I don't respond to where the client's at. I know what our themes are. I love to think about it as, again, how we know about the repetitions of the neurotransmitters. There's only a few things that you keep – once you know your client and you know how they change and you know their sequence, then you just keep repeating it over and over.

I have a plan each and every session. I think at the end, I wanna be able to step back and go, "Have I given them some vision of the future? Have I taught them a skill today? Have I created a boundary and a structure? Do they know why this session was doing what?" Get their feedback. It really is encapsulating everything we've talked about, which is not so hard to do.

Rich Simon:

There was a very helpful book by a surgeon who also writes for the *New Yorker*. I've forgotten the title, about protocols. When you're doing a complex task like trying to help people who have really gotten slammed as people who've been traumatized have, the importance when you have to bear in mind five or six things, to have not a protocol as a robotic a program that you do the same thing over and over again but just in the way you're organized and you make sure that you've done and you keep coming back to it

because the challenge can be awesome and you need to have a structure to make sure that you don't get lost in it.

Mary Jo Barrett: I was just gonna say, you could look at any one of my sessions or any session of anybody that really does trauma treatment contextually and you could be able to say, oh, when I show video tapes when I teach or when I'm at the *Networker*, I can show a tape and give these five things and people will be able to point them out and they'll be even point out each stage of the session. I divide my session into three stages.

It's all there and then the depth is what comes between the client and myself. There is this structure. It's not robotic. I like that word. It's not robotic. It's very flexible. The depth and the narrative, it's not cookie cutter because it's created from the therapist and the client to meet their needs.

Rich Simon: That's the origin. We're almost out of time here. People who would like to follow up and training opportunities. You mentioned resources throughout our conversation. Where can they follow up? Where can they read in addition to your March 2010 issue of *Psychotherapy Networker*, which is on your website and Mary Jo's unforgettable piece in here called, "Therapy in the Danger Zone." Her very first trauma case or case of childhood sexual abuse. Really one of the most remarkable things that we've ever published. I heartedly recommend it. In addition to March 2010 and it's up on the *Networker* website, where would the other resources and other kinds of training opportunities, Mary Jo?

Mary Jo Barrett: They can certainly go to our website, which is www.centerforcontextualchange.org. We talked about our training opportunities. We have long, short, and certainly I'm going to be presenting the model, I think, in a two part at the *Networker* symposium this March. Plus, there's tapes throughout the years from the *Networker*. Hearing the model, there's lots of opportunities and certainly would love to work with anybody that would like me to come and train to learn more about it.

Rich Simon: Also, what Mary Jo just said, on the fulfillment page for this webcast, you'll have a direct link to Mary Jo. We'll put up a link actually to this *Networker* piece and perhaps some other things following this webcast. Let me just bring to people's attention to our comment board. Again, and particularly because of Mary Jo because she's collaborative, because she's relational, she will read and, with her vast energy, will more than likely respond to

comments. Again, we keep saying this over and over again, but I can't emphasize it. This is the beginning of the conversation. The most meaningful part is what people listening to it, what you do with it.

You can continue this conversation both within this webcast. Share what you learned, what stood out, what you agreed with, what you disagreed with, connections you made through the website. Mary Jo with our usual accustomed graciousness has agreed to read and respond. We're just about out of time. I loved this last part that you said because you embody it, my friend, so perfectly. The kind of energy that's required for this work. I know for years and years, for three decades, I know you did this.

I think it's only in the last few years, I really understand what that energy in addition to all the structure and the thoughtfulness you've laid out that makes such a difference in doing this work. I feel better about our profession that you, my friend, are part of it. Thank you for being with us this afternoon. Look forward to seeing all of you in the coming weeks for this webcast on these current advances in trauma treatment. See you next time. Bye. Bye.

[End of Audio]

Duration: 64 minutes