

New Whiskey in Old Barrels

Comprehensive Resource Model: A Case Study of a New Trauma Treatment Model

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Abstract

Post-Traumatic Stress Disorder occurs when an individual has been exposed to an experience that interferes with the person's ability to undertake normal activities. This disorder has only recently become a consistent focus of attention among healthcare practitioners. Prior to the Vietnam War, its waxing and waning in attention was driven by popular theoretical favor promoted by gender assumptions and major world wars (Herman, 1992). With new data related to this disorder, great hope exists for new interventions that will promote increased quality of life among those afflicted with posttraumatic symptoms. The Comprehensive Resource Model (CRM) (Schwarz, Corrigan, Hull, and Raju, 2017) is one such new intervention, which derives its theory from the most recent neurologic hypotheses of the effects of trauma on the brain and body. This paper aims to prove CRM's efficacy by providing literary evidence supporting its theory, while also demonstrating how the model adds to the current trauma treatment literature.

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Introduction

The National Center for Post-Traumatic Stress Disorder (PTSD) reported 5 out of every 10 women, and 6 out of every 10 men, will experience at least one traumatic experience in their lives, with 7-8% of these people developing Post-Traumatic Stress Disorder (PTSD). These statistics suggest that approximately 8 million people per year will experience PTSD. The National Center for PTSD reports that those which suffer from complex PTSD (CPTSD) are commonly also afflicted with a variety of other interpersonal, emotional, and self-regulation difficulties (Cloitre, Courtois, Sharuvastra, Carapezza, Stolbach, & Green, 2011); with the most severe reported affliction stemming from CPTSD being dissociation. With trauma and post-traumatic symptoms being this prevalent, implementing effective treatments to help facilitate the recovery process is essential. The goal of this evaluation is to address the historic requirements of quality trauma treatment provided by Judith Herman, Bessel van der Kolk, Alexander McFarlane, Lars Weisaeth and John Briere; all of whom are considered leading experts in trauma recovery field, as well as highlight the commonalities between their theories. CRM, a new trauma treatment model, is introduced via a case study. The ensuing discussion includes how CRM fulfills the criteria of theories in the literature, as well as providing key developments in trauma treatment.

CRM is the first psychotherapeutic trauma treatment model to utilize the concept of resourcing as the primary therapeutic ingredient, which informs the therapeutic process. According to CRM, resourcing, defined below, is not just an “add-on” to therapy, in which dual processing is utilized to bring about a decrease in stress related symptoms; rather it is a theoretical and perspective shift in a therapist’s approach to the trauma recovery process. Resourcing is an effort to neurobiologically change the client’s relationship with their traumatic material. This paper will introduce CRM and discuss five essential factors of trauma treatment. These essential factors serve as an education to new therapists reminder to seasoned therapists, and will eventually prove CRM’s efficacy from a literary perspective. A case presentation will be offered to demonstrate CRM’s ability to compress the initial stages of trauma treatment, which allow the client to utilize their own resiliencies quicker and process out traumatic material in a safer and more thorough manner.

Introduction to CRM

CRM is a somatic based trauma processing therapy that utilizes different types of resources in a succinct, scaffolded manner in order to process the split-second intolerable affect that is associated with the client's trauma. A resource is defined by CRM as an internally focused, inherently positive state that is initially activated cognitively and then experienced somatically, in order to facilitate the furthering of trauma processing (Schwarz, Corrigan, Hull, and Raju, 2017). CRM has seven layers of resources that can be utilized in a variety of context-dependent ways. CRM's neurobiological theory is consistent with Panksepp's (1998) animal studies, the later application of this pre-clinical work to the treatment of traumatic dissociation (Lanius, 2012), and the emphasis of embodiment in trauma recovery (Lanius, Paulsen & Corrigan, 2014). CRM has adopted these empirical and theoretical works to inform the neurobiological framework that supports the clinical model of CRM. CRM hypothesizes that the neurobiological resourced scaffolding allows the brain and body to establish a physiological state of sufficient safety, which is different than cognitive-based safety, for midbrain-sourced fear/defense responses to be extinguished. The intention of the approach is to allow the client to access, orient toward, and release the split second experience of intolerable affect that is driving the trauma experience sourced in the midbrain periaqueductal grey (PAG), which sets into motion sub-cortical neural circuitry. CRM's informed neurologic theory (Lanius, Paulsen, & Corrigan, 2014; Panksepp, 1998) suggests there are three brain-body looping systems (Schwarz, et al, 2017) that initiate and perpetuate defense responses autonomically, neurochemically, behaviorally, relationally and cognitively. The defense responses of fight-flight-freeze, hide, avoid, submit or dissociation are understood to translate into psychiatric symptoms, somatic dysfunctions, relational problems and addictions, all of which perpetuate the disconnection from one's self. Through the development and implementation of embodied, internal attachment-based resources, mid-brain sourced affects such as terror, grief, shame, rage and attachment "pain" (Panskepp, 1998) are accessed and processed out, while the client is fully present in the moment; allowing for distorted beliefs and behaviors to be dismantled as they are no longer necessary for survival. CRM proposes to alter the nature and activity of these subcortical "trauma" loops, which allow for

positive affects such as care, nurturing, seeking, and affiliation to be present; and the neurochemicals oxytocin, prolactin, and mu opioids to be released. This signals the superior colliculi that it is safe to orient toward the material, thus promoting the ability to step fully into the intolerable affects before defense responses can kick in. With defense responses being no longer necessary, secondary to the experiencing of triggers, changes in the stimulus-context learning in the limbic system and cortex are ultimately integrated. The scaffolded nature of the resources support and facilitate the client in orienting toward the full consequences their trauma had on their life. The traditional phases of trauma recovery - namely stabilization, processing, integration and reconciliation - occur in quick succession and often occur simultaneously throughout the work, due to the interweaving of resources during sessions.

CRM offers several key departures from traditional trauma treatments. These differences are congruent with many emerging somatic therapies, in that CRM makes efforts to bring awareness back to the client's body in a two-fold process: (1) the body is where trauma is experienced and affectively held, and (2) it is also the place where release, healing and ultimately, New Truth¹ understanding will be experienced. However, CRM differs from the emerging somatic therapies and traditional trauma treatments in some unique ways. Below are three important ways CRM adds to the evolution of trauma treatment.

Internal versus External

As is the case with any quality psychotherapy training paradigm, CRM conceptualizes the therapeutic alliance to have three layers of attunement: therapist to self, therapist to client, client to self. Only one of the layers of attunement is externally experienced as the therapist-client relationship. Although attunement between the therapist and the client is necessary for any quality psychotherapy, it is not sufficient in order for the therapeutic alliance to reach its full potential. CRM therapists must also be attuned to themselves, as well as fostering attunement within the client. This is an example of how CRM is constantly trying to move the process from an external to an internal experience. The importance of internal attunement is such a crucial aspect of CRM that the model devotes a substantial amount of time to the subject in its literature and training, which emphasizes the importance of therapists to "do their own

work.” The importance of this rests in the supposition that therapists can only be as attuned with another as they are attuned with themselves. This then is passed on to clients to increase their attunement with themselves, which will then allow them to be more attuned with others and the world, thus increasing the quality of their external relationships. The external world is inescapable, as is the internal world.

Paradoxically, suffering is created as people make grand efforts to attempt to escape their external and internal world. As clients experience internal resourcing, the need for defense responses secondary to the discomfort of external triggers and internally experienced negative affect is significantly reduced.

The role and focus on one’s internal world is also relevant to the facilitation of attachment resourcing. As mentioned above, attachment resourcing is accomplished by drawing the client’s attention and attunement to how their internal parts/ego-states are relating to one another and the “adult self.” By developing internal attunement, it is hypothesized that this activates attachment neuro-circuitry that then activate the body’s intuitive and innate drive to seek connection and affiliation (Schwarz et al., 2017, pp. 37-55). With secure attachment neurobiology in place, orientation towards intolerable affect is possible without autonomic defense responses interfering with the experience of that affect as tolerable. By emphasizing the primary attachment mechanisms as internal, CRM helps clients rediscover and remember their own innate templates of secure attachment and behaviors. In turn, this aids in decreasing any co-dependent features that may present themselves as a consequence of the traditional emphasis on the external therapeutic alliance.

Between sessions, resourcing homework deepens and maintains the recognition that clients have everything they need for healing inside themselves. In-session gains are quickly diluted, if not lost completely, if clients do not continue the reconciliation and integration process between sessions. Some therapies rely on the hope that behavioral and cognitive change will happen as a consequence of realizations obtained through in-session cathartic experience. CRM agrees that the release of held trauma is important in the somatic clearing of trauma material; however, it differs by taking a more active approach that stems from the psychoeducation of the neurobiology of resourcing, by teaching clients how to do their internal resourcing between sessions. When clients assume responsibility for between-session

resourcing, they are beginning to manage their own triggers without the help of the therapist. The knowledge that the client can prevent trauma processing from occurring outside of the therapy session is empowering and self-reinforcing. The more frequently clients engage in their own navigation of triggers and self-regulation, the more easily they are able to step into painful trauma work with the therapist.

Neurobiology

CRM postulates that the mechanism of change happens through mid-brain neurobiology rather than the limbic-cortico system (Schwarz et al., 2017). This makes CRM a bottom-up process, which allows for effective top-down processing being solidified by what CRM refers to as New Truths throughout treatment. CRM suggests that the trauma narrative is *not* as important as the affective healing that occurs during the resourced trauma processing aspects of the therapy. Or in other words, the telling of the trauma narrative is not the key factor of change; rather it happens as a welcomed byproduct of body/brain based safety. The key factor of change is that the mid-brain defense responses (fight, flight, freeze, hide, avoid, submit, and dissociate) are approached, processed, released and ultimately rendered unnecessary, which will by default naturally create a change in the trauma narrative. The narrative changes are further influenced and reinforced by consistently reviewing the accumulation of New Truths and are further solidified in the client's daily functional resourcing experiences between sessions, as well as the application of behavior that reflects their New Truth.

CRM: A Model, not a Technique

CRM is a comprehensive model of psychological treatment rather than a tool or technique. Complex Trauma is so named for the intense layering of traumatic material during early stages of development (Clitre, Garvert, Brewin, Bryant, & Maercher, 2013). Such a complex situation demands a sophisticated approach. CRM argues their sophistication by providing all the necessary components of a complete model. The model spends a significant amount of time discussing the importance of solid case conceptualization skills that include the origins of trauma through developmental and attachment history, as well as a theory underlying healing from start to finish. This differs from a number of other techniques such as Brainspotting (Grand, 2013) and EMDR (Shapiro, 1995). The model contains a developmental

component informed by attachment theory (Colin Ross' 2009 Trauma Theory), sound neurobiological underpinnings supported by literature (Lanius, Paulsen, & Corrigan, 2014 & Panksepp, 1998), and therapeutic techniques and interventions which are used to facilitate and guide case conceptualization. A full model allows for therapists to have a framework from which to work. Comprehensive conceptualization and clinical interventions are used to inform the therapist on critical and relevant therapeutic issues such as the timing of psychoeducation, titration of traumatic material, and how clients can stabilize themselves. It also guides the therapist on how to use the techniques in a manner that will promote healing, while minimizing further damage. Learning a full model adds to the therapist's previous clinical experiences and results in a wider theoretical perspective and repertoire of techniques.

As mentioned above, stand-alone techniques only add to technique repertoire, which have two associated problems. The first is that stand-alone techniques do not offer a full context in which to view the client or guide what intervention to use and when that intervention is appropriate. This means that therapists are responsible for creating their own understanding of the context and possibly imposing inaccurate interpretations that could result in (1) mismatched theories being used simultaneously or (2) ill placed techniques. Mismatched theories could result in clients receiving mixed messages concerning their course of treatment. If an ill placed or ill used technique is chosen, that could result in the re-traumatization of a client. Either possibility is undesirable, and with today's growing emphasis on short-term treatments, there is no time to waste on mixed messages or recovering from mistakes that could have been avoided.

The other benefit from learning a comprehensive model like CRM is it offers newer therapists the ability to have theory and technique that fit together. Traditionally, master's and doctorate programs do a solid job at teaching theory, but due to time constraints in the educational curriculum, struggle to teach therapeutic techniques thoroughly. This leaves new therapists to their own devices in finding techniques that work, with the assumption that because they have sound training in theory, they will be able to use critical thinking skills to find techniques that are theoretically congruent. Unfortunately, this is not always how it works. New therapists are often overly eager, easily persuaded by the trainings they attend

post graduation, and by definition lack experience, which can lead to poor technique decisions.

Seasoned therapists also will benefit from learning a comprehensive model. If new therapists are at times overly eager and easily persuaded, then seasoned trauma therapists can suffer from compassion fatigue (Deighton, Gurriss, & Traue, 2007) and vicarious trauma (Pearlman & Ian, 1995). A seasoned therapist, having experienced a successful practice, can unwittingly fall into a trap: the belief that learning a new model is not important because what he or she has done up to this point has worked well. Nothing can be further from the truth in regards to trauma treatment. This sort of confirmation bias can cause severe damage to a suffering client, as well as to hard won reputations of seasoned therapists. A “dulling of the theoretical edge” can happen naturally over time, yet it can be avoided if seasoned therapists learn new models in order to keep on the cutting edge of evolving treatments.

CRM and a Review of Five Essential Factors of Trauma Treatment

CRM utilizes five traditional factors of trauma treatment. The factors discussed below comprise the traditional phase-based trauma treatment often discussed in the literature. The major point of understanding that CRM challenges the traditional phase-based discussion, is not to argue that phases do not exist. Rather, CRM challenges how to utilize the phases by suggesting that the correct implementation of resourcing in trauma processing builds and stabilizes factors that were once waited for prior to trauma processing.

Therapeutic Alliance

The therapeutic alliance is an essential element of successful psychotherapy (Bordin, 1979). Empirical examinations of the therapeutic process have found the relationship between client and therapist, “the therapeutic alliance,” is one of the most enduring and consistent factors predicting outcome regardless of theoretical orientation (McLeod, 2013). In any interpersonal interaction an alliance is necessary for the accomplishment of the task; this is magnified in the context of therapy. In considering the treatment of PTSD and especially in the case of Complex Post-Traumatic Stress Disorder (CPTSD) (Cloitre, Courtois, Sharuvastra, Carapezza, Stolbach, & Green, 2011), where much of the distress is sourced in early life developmental trauma or neglect, and often perpetuated by a primary care giver in a

repetitive manner (Ogle, Rubin, & Siegler, 2015), the alliance is crucial. Affiliation and trust is challenging for any individual who has experienced interpersonal trauma, especially during development. Factors such as sexual perpetration, emotional and physical abuse, and neglect and death of family members, require children to organize their attachment strategies in ways that protect them from relational pain as adults (Bretherton, 1992). This then leads to detachment, guardedness and avoidance, and ultimately a locus of control shift (Ross, 2009). Attachment disruption and intolerable feelings of survival terror bring human beings face-to-face with existential questions relevant to security and trust, often triggering thoughts and feelings of loneliness, alienation, helplessness and isolation. The therapeutic alliance is the foundation that catalyzes the transformation of an identity defined by trauma, to one of secure reconnection to self and others (Bloom & Sreedhar, 2008).

For Herman (1992), the therapeutic alliance is the most crucial aspect of trauma recovery, given that an intimate and healthy relationship is needed in order to effect change. This necessity is woven throughout her three stages of recovery—safety, remembrance and mourning, and reconnection—and acts as a container to hold the recovery process. The relationship is collaborative, unbiased, and empowering of the client toward autonomy and judiciousness (described as “disinterested” by Herman), which means absent of professional self-gratification. The result is that the therapist will refrain from taking sides in clients’ internal conflicts and refrain from influencing their decision-making abilities (p. 135). This stance is akin to how a protective parent uses persuasion rather than control, mutuality over authority, and knows that ideas are not forced; with the goal being to increase clients’ grasp of their external worlds (p. 136).

Like CRM, Herman places significant emphasis on the importance of understanding traumatic transference and countertransference. Herman eloquently describes how the experience of trauma changes and informs a person’s emotional reaction to authority. Consequently, transference and countertransference can take on a charged, desperate, “life or death” dynamic because of the primary human instinct for survival. CRM agrees with Herman’s mandate that the health of the therapist is considered to be imperative in the development of the therapeutic alliance, in order to hold this charge. If therapists have vulnerabilities in their personalities, characters, or their own unresolved trauma history,

they are susceptible to the desperation of their clients. The result creates a situation in which the therapist is unconsciously using a client's fragility to fulfill his or her own power and/or control needs. The therapist subsequently may inadvertently victimize the client, and the client's attachment trauma may be repeated.

Briere (2002) discusses many of the same features of the therapeutic alliance, emphasizing its use in creating an environment that is conducive to therapeutic nurturing and support, emphasizing the safety of the therapy context and the new possibilities afforded by the therapeutic alliance. A corrective relational experience is based on the client's attachment history in order to provide interactions that specifically counter their developmental history (Castonguay & Hill, 2012). Briere suggests to the trauma therapist that shortcuts do not exist when developing the therapeutic alliance, as patients with CPTSD have experiences that have often led to the development of avoidant, anxious, and/or insecure attachment patterns (Alexander, 1992). It is likely that if a therapist attempts to force the pace of formation of the therapeutic alliance, the patient will withdraw.

The therapeutic alliance starts the moment the clinician and client meet and is experienced as powerful when the relationship proves successful in containing affect dysregulation through this intimate alliance (van der Kolk, McFarlane, & Weisaeth, 1996, p. 538). Developing the therapeutic alliance is far more than a procedural effort. Attunement is defined as attaining a connection with another person to the point of being able to feel the other person's experience in an embodied manner (Kykyri, Kavonen, Wahlström, Kaartinen, Penttonen, & Seikkula, 2016), allowing an appropriate focus on trauma material that is balanced against the client's tendency towards affect intolerance (van der Kolk et al., p. 18). Continual attunement and attending to the client in a conscious and deliberate manner are necessary for the relationship to maintain intimacy and utility.

The therapeutic relationship in CRM is initially secondary to the level of attunement provided by the therapist through immediate use of the model. It is possible for a therapist to be thoroughly attuned, yet the client's experience is not one of a strong relationship. A therapeutic relationship perceived as

secure by the client is developed fully through the use of the model itself. Initially this occurs by facilitating internal resourcing between the client and themselves.

Given that a secure relationship to Self is seen as the primary goal in CRM, the work through this modality is focused on choosing the resource scaffold that promotes this connection, rather than the connection to the therapist or external others. Healthy relationship to the therapist, as well as family and community, is a result of the therapeutic process, rather than the catalyst for healing.

Psychoeducation

The purpose of psychoeducation is to help bring new information and insight regarding the nature of trauma and its effects (Whitworth, 2016), and is offered throughout the trauma recovery process. It is an explanation of: what is happening, why it is happening, and what is needed in order to heal. Such understanding allows for a new perspective surrounding a client's fear of symptoms. This new perspective then allows the client to feel a sense of confidence in themselves and to approach that which they have historically avoided. Psychoeducation provides the client with an opportunity to exercise new information and make empowered autonomous choices (Briere, 2015; Herman 1992).

CPTSD is so named because of the complicated layering of defense mechanisms and coping skills that occur consciously and unconsciously in response to the layering of terrifying events that occurred throughout the development of the individual. A consequence of this in the recovery process is the need for a more sophisticated and articulated psychoeducation and trauma recovery process in general. This promotes clients' understanding of the traumatic sequelae they experience in their daily lives. The nature of this complex trauma response creates severe disruption in neurobiological, cognitive, emotional, and relational domains (Cloitre et al., 2011). The result is the creation of inaccuracies and distortions surrounding self and the nature of relationships. Briere (2015) discusses how the inaccuracies and distortions of an unhealthy development are working together in an unfortunate symphonic effort to keep the client perceptually safe or in control. While the specific elements of psychoeducation vary between therapists and theorists, largely dependent upon their therapeutic paradigm, the key element is "enlightening the patient" as to the meaning of their symptoms (Herman, 1992) and the need for

integration as a means to healing. Psychoeducation should be part of the therapeutic process, rather than a separate content-laden chore (Briere, 2015). Attunement and the therapeutic alliance will be crucial to evaluating the client's integration of new information, and how fast and how much information can usefully be presented.

Psychoeducation is of utmost importance in CRM with clients taught: the neurobiology of trauma and resourcing; how to map their ego state or parts system; how fear of both the therapy and healing/change creates obstacles; and why relationship to self is the primary focus. CRM posits that clients deserve to understand and contemplate what is happening and why; and to receive support for the notion that they are smart enough and strong enough to know whatever information is needed to recover. Without psychoeducation, clients are less likely to engage in self-care CRM homework and without the homework, re-consolidation and recovery can take much longer.

Safety, Stabilization and Containment

Building on the central pillar of the therapeutic alliance, attunement allows for the balance of safety, stabilization and containment while processing traumatic material; all of which crucial to the eventual processing of traumatic material. Here, containment refers to the therapist's need to monitor the client's ability to work with intolerable affect, while also teaching the client skills in order to monitor and intervene on his or her own affect.

There are several different layers of safety. Herman (1992) specifically addresses the important role psychoeducation plays in safety. "Knowledge is power" (p. 157) is a primary value that initiates a process through which clients can experience safety. Sharing knowledge allows clients to intellectually validate their experiences during treatment, and therefore the vicious cycle of distorted thinking and erroneous assumptions can be challenged and corrected. The process of having this discussion with the therapist serves two purposes: (1) isolation is not experienced in the moment and (2) reframing cognitive distortions around symptomatology is stabilizing. Another layer of safety involves developing an expanded level of control over the body. According to Herman, this includes interventions such as

medication management; cognitive behavioral techniques; relaxation skills; improving exercise, sleep, hygiene and diet; and general self-care habits.

As a client develops a sense of safety over their body, care and attention must be given to evaluate environmental safety factors, including physical threats, while also evaluating positive relationships that can play a role in their trauma recovery. Van der Kolk et al. (1996), like Herman, emphasizes the importance of self-mastery and a sense of control of physiological, biological and environmental factors:

...as long as traumatized people dissociate, and are plagued by involuntary intrusions of fragments of the trauma, the emphasis in treatment needs to be on self-regulation and on rebuilding. Early exploration and abreaction of traumatic experiences, without first establishing a sense of stability, are likely to lead to very negative therapeutic outcomes. This means that initial therapy needs to focus on security and predictability, and on encouraging active engagement in adaptive action (p. 319).

Cognitive behavioral therapists can provide a range of containment exercises, allowing clients to feel more grounded in the moment through creating an awareness of the relationship between environmental triggers and thoughts that give rise to emotions, which may result in destabilization. Briere (2015) offers an extensive list of techniques and interventions that contribute to the development of distress tolerance and affect regulation, both of which are overarching mechanisms leading to safety, stabilization, and containment.

Additional examples of grounding techniques include: identifying sensations, attending to objects in the present moment, labeling emotions, and touching an emotionally neutral part of their own body to increase awareness of themselves, while also helping orient them to the here-and-now (van der Kolk et al., 1996) These same authors emphasize the importance of orientation to time, place and person, as well as how imperative physical and emotional safety is in stabilization. It is crucial that therapists work with their clients to identify which techniques resonate, in order to determine the techniques that will be the most effective in promoting stabilization and safety.

CRM theory and practice demands that safety and stabilization is promoted during the potentially traumatic experience of “intake and assessment”. This traditional first phase of trauma treatment, which begins when a client is asked about their history and presenting problem, is considered a necessary element through every moment of therapeutic work in CRM. All layers of resourcing are utilized concurrently with all aspects of trauma treatment - including addressing the client’s fear of the work, the trauma processing itself, proper session closure and home work – all for the purpose of safety and stabilization.

Trauma Processing

The therapeutic alliance, psychoeducation, safety, stability, and containment all work together to provide a vessel in which the processing of traumatic material can be transformative. Successful trauma healing may be most accurately described as an art form rather than a protocol-based set of techniques. Effective processing has to do with the continual balance and titration of safety, stability, and containment, along with exposure to and exploration of traumatic material. The actual processing of traumatic material is not limited to the events themselves, but rather includes the confrontation of fears, shame, and helplessness associated with the events. Fear associated with re-engaging with routine life is also an area of focus (van der Hart, Steele, Boon, & Brown, 1993).

Effective therapy, regardless of whether it is relevant to traumatic material or not, involves some level of exposure to the remembrance of uncomfortable or painful events. One of the most significant elements is the therapist’s attunement to the client’s state, moment-to-moment, in order to ensure that the processing is not re-traumatizing. Herman (1992) talks about the importance of empowering the client to make the choice to do this work. Thus, engagement is the initial step for the client in a transformation from victim to survivor.

Herman (1992) includes trauma processing in her second stage of recovery, helping clients reconstruct their trauma narratives beginning with their lives prior to the traumatic events (attachment history), as well as their values, dreams, and important relationships, all of which may help compare the traumatic experience with any positive resiliencies that may have been present prior to the wounding

experiences. Within this model, reconstruction is the next step. Reconstruction is conceptualized as a cognitive exercise without bodily sensation due to its potential to overwhelm and trigger perceptual disorientation. Somatic felt sense and imagery is titrated into the processing as the client's ability to successfully regulate increases. Herman discusses the importance of the therapist helping the client orient, allowing full exposure to the traumatic material while also staying connected in the present moment of the therapeutic alliance. This is echoed in the work of other therapists, including Jim Knipe's use of techniques such as the "Constant Installation of Present Orientation and Safety" (CIPOS) within Eye Movement Desensitization and Reprocessing therapy (EMDR) (Luber, 2012).

Briere (2002, 2015) uses the concept of the "therapeutic window" as the context in which to facilitate trauma processing. The therapeutic window is akin to Siegel's (1999) window of tolerance; it has been suggested as an imperative concept to understand in processing complex emotional trauma (Corrigan, Fisher & Nutt, 2011). Both involve "...adjusting treatment so that trauma processing that occurs within a given session does not exceed the capacities of the survivor to tolerate the level of distress—while, at the same time, providing as much processing as can reasonably occur" (Briere, 2015, p. 111). While operating within the therapeutic window, Briere utilizes exposure (triggered memory), activation (triggered cognitive and emotional responses, including larger schemas), disparity (orienting the client to the fact that the trauma happened and is not happening), and processing (exploration versus consolidation, intensity control, and goal sequence) (Brier, 2002).

Experts have noted that the particular technique used may not be the most critical variable in trauma treatment (van der Kolk et al., 1996 p.435). While the review is of a single event trauma rather than complex, type 2 trauma (Terr, 1991), nevertheless van der Kolk et al. (1996) found that exposure to memories is the essential element to the effective treatment of post-traumatic symptoms. Once again, an over-emphasis on exposure treatments was cautioned due to their potential to exacerbate trauma symptoms and, in the worst-case scenario, re-traumatize the individual.

Trauma processing in CRM is somatic based, which means it is affect-focused and mid-brain-based. The mechanism for change is hypothesized to be that of fully orienting toward, fully feeling, and

releasing capped emotions that drive defense responses. CRM theory does not hold the narrative or relationship to the narrative to be of primary importance in resolving Complex PTSD. Trauma processing occurs through attunement to the somatic and emotional story rather than a cognitively focused story, all within a neurobiological scaffold of internal resources. It is theorized that this allows access to the PAG and other midbrain structures that perpetuate defense responses, which are understood to manifest as psychiatric symptoms, addictions, and relational dysfunction. When emotions are no longer experienced as intolerable, and therefore no longer necessitate a defense response, the entire infrastructure of the traumatized self can be dismantled. Trauma processing is seen as beginning with attention to obstacles relevant to the therapy; obstacles to resourcing and continuing through all aspects of treatment including the choice to allow thorough healing to ultimately occur.

Reconciliation and Integration

Reconciliation is the process of bringing opposing parts into a harmonious relationship, for instance: past versus present; adult self versus wounded parts of self, and victim-perpetrator-rescuer behaviors. Integration is the action of bringing the conflicting aspects together to form a whole or an experience of “oneness.” Together, reconciliation and integration mark the ultimate goal for engagement in the painful task of processing trauma. Following the sequential nature of traditional phase-based treatments, reconciliation and integration take the form of an “ending.” Resolutions occur at the end of sessions, the end of a specific piece of the trauma work, and at the termination of therapy. Each layer of reconciliation builds a scaffold of new meaning that lends itself to an overall, integrated transformation in all aspects of the client’s life.

The therapeutic process should promote a clearer understanding of trauma narratives, allowing choices to be made from a place of empowerment and autonomy (Herman, 1992; Briere, 2015) and operationalizing a different meaning in relation to traumatic experiences. The client acquires new insight and understanding, having endured the processing of the most feared and dreaded aspects of his or her life; they are empowered to engage the world in a proactive rather than victimized manner. The importance of putting meaning into action is emphasized (Herman, 1992; van der Kolk et al, 1996) such

as: developing a “new self”; re-education as to what is healthy and normal, and/or finding intimacy in relationships. Operationalizing this through behavioral change may include learning self-defense, or engaging with the self and life differently, facing fear and conflict in a proactive rather than a reactive way.

The development of a coherent narrative (i.e., one that is clearly articulated and well-organized with substantial detail yet little affective activation) is an important part of reconciliation and integration (Briere, 2002). Increased awareness of the details of one’s story, as well as issues of control and power at the time of events, allow for a shift in emotional valence in the context of memory. A coherent trauma narrative increases a sense of control over experiences, decreases feelings of chaos, and enhances the sense that the universe is predictable. Gaining meaning from the experience provides closure and fits into existing models of understanding (Briere, 2002, p.21). According to Amir, Stafford, Freshman, and Foa (1998), a coherent narrative may support more efficient cognitive and emotional processing. It has been empirically demonstrated that the more clearly articulated, well organized, and detailed the narrative became (i.e., coherent), the less trauma symptoms the individual experienced (Amir et al., 1998; Foa, Molnar & Cashman, 1995). It is noteworthy, however, that these studies were focused on PTSD, rather than on more-complex posttraumatic stress presentations.

Reconciliation and integration can also be conceptualized in the context of van der Kolk’s et al. (1996) idea of the “twin issues of helping patients” (p.17). These two aspects are: (1) helping clients regain a sense of safety surrounding their bodies and (2) helping the clients complete an unfinished past. These goals are accomplished in the reconciliation phase by practicing identification of emotions as information rather than as the impetus for defense responses; continuing to allow memory to be an act of creation rather than simply data collection; and recognizing the potential difference in the existential meaning of the past, compared to the existential meaning once reconciliation and integration has occurred in the present.

Reconciliation and integration in CRM are initiated and facilitated throughout the therapy and not thought to be important only at the end of a significant piece of work. Each obstacle to treatment that is

worked through begets reconciliation and integration, as well as each small step toward secure attachment to Self. CRM home work is imperative for the quickest, most thorough transformation, particularly when that work is done within the 5 hour window post-session in which the brain is the most neuro-plastic and therefore amenable to change (Ecker, Tadic, & Hulley, 2013). CRM does not believe that integration is a necessary goal for work with DID clients, given that it is ultimately their choice as a human being as to whether or not they want to live as an integrated whole, or if they prefer a dissociated internal system that operates smoothly and without internal or external perpetration.

Case Presentation

Doug is a divorced, Caucasian male in his 50s. He is the oldest of three sons born to young parents who divorced when he was six years old, his mother remarrying five years later. Doug's father introduced him to marijuana and cocaine when he was 4 years old. His father's drug misuse was frequent during Doug's childhood, prior to his abrupt abandonment of the family and leaving them in significant debt, which persisted for a two-year period until his mother remarried. Doug's stepfather, a successful businessman, was severely emotionally and physically abusive to all family members. During this second divorce Doug's academic performance declined and he refused school. Prior to his sixteenth birthday Doug was twice involuntarily committed to inpatient psychiatric hospitals for a combined 16 months – to adult wards - at the instigation of his step-father, during which time his mother never visited. He experienced seclusion, restraints, 32 ECT treatments and anti-psychotic medication. Affiliation and trust became major issues, with only one healthy therapeutic relationship with a caregiver maintained. After his hospitalizations he served briefly as a military medic, describing terror while deployed in a combat zone and that he felt “horrible about the things I did.”

While still serving, a brief relationship resulted in the birth of a daughter, but he was refused all access and has never met his daughter. He married when he was 20 years old and the couple had two daughters, but divorced four years later. A period of frequent moves and job changes followed prior to his re-connection with his father. Doug lived with his father for a year, developing problems with alcohol, drugs and gambling, prior to his father leaving him and the debt behind. They did not speak

again prior to his father's death two years later. A relatively stable period followed with a 15 year relationship, and fatherhood to this woman's young son; he separated from his wife two years ago.

Doug struggled with intermittent depression during this relationship, prior to a grand mal seizure in 2008, which resulted in brain damage. He has experienced adverse effects from anti-epileptic medication, becoming bedbound and depressed with passive suicidal ideation. His seizures were poorly controlled and he was plagued with nightmares, bizarre nighttime rituals and behaviors. Previous experiences demonstrated psychiatric or psychological care was resisted. A spiral of loss followed with an inability to work, financial hardship, and marital and relationship problems.

Assessment

Doug's diagnosis was obtained from a semi-structured, bio-psychosocial interview with this clinician. The diagnostic impressions (DSM-5, APA, 2013) stemming from this interview resulted in the following diagnoses:

- 309.81 (F43.10) Post-Traumatic Stress Disorder with Dissociative Symptoms to stressful events, Chronic, Severe
- 296.33 (F33.3) Major Depressive Disorder, Recurrent, Severe
- Epilepsy per client's report

Course of Treatment

Doug attended 24, 90-minute psychotherapy sessions. Meetings were scheduled bi-weekly, with total treatment time lasting one year and two months. Initially, Doug presented as skeptical, hopeless and nihilistic regarding therapy. He attended despite the experience of overwhelming suicidal ideation; he had no active plans of suicide because of the impact this would have on his son. His demeanor, speech and body posture were formal yet relaxed, and he did not volunteer information spontaneously.

Through the forming of the therapeutic alliance the therapist recognized Doug's intelligence, skepticism and guardedness, and chose to start treatment with an intellectual introduction, providing psychoeducation of the scientific and theoretical underpinnings of trauma, PTSD, and dissociation. An explanation of CRM as the specific intervention and how CRM worked was also provided. The

communication stance of the therapist was direct and transparent in an effort to engage Doug in a therapeutic relationship that met his need to maintain emotional distance and understand how change happens, as well as respond to Doug's vigilance to any interaction that was inauthentic or patronizing. This stance is an example of how the therapeutic alliance, in conjunction with psychoeducation, works with and towards the construction of safety, stabilization, and containment.

The next several sessions focused on the simultaneous interweaving of education about CRM and the experiential use of CRM's resourcing skills, which occurred parallel to gathering the case history material. This was done in order to promote a conscious awareness and full-embodied presence, moment to moment, while recounting extremely traumatic material in his case history. This served two purposes in the development of safety: (1) it prevented the process of remembering during the intake assessment from being re-traumatizing, and (2) it allowed the brain and body to become familiar with the neurobiology of resourcing concurrent with painful emotional and physical activation. Throughout these initial sessions, fear of the work, as well as fear of remembering the truth of his life, resulted in noticeable efforts to dissociate and distract. This made the introduction of these resourcing skills imperative, in order to keep him in the process itself while promoting his willingness to return to therapy. During these initial sessions his fear was validated and addressed directly through discussion and resourcing, while the reality of his issues of abandonment, attachment difficulties, and lack of trust of others became more apparent. The use of CRM resourcing provided Doug with an alternative to his defense responses that stemmed from his negative childhood attachment experiences, and supported his ability to navigate painful activation physiologically, relationally, emotionally, and cognitively. Crucially, through this decrease in the immediate fear responses to both trauma work and resource development, Doug was able to experience the therapist as attuned and the therapy as legitimate. This created a strong stabilizing force that acted as a significant motivating fact in which the remaining of the therapy was carried.

Doug's tendency to dissociate was most evident during these initial sessions, and in particular when focusing on the fear of the work. Doug was at times concrete and adult and at other times seemingly adolescent in his resistance and denial. Doug lapsed into childlike hopelessness, helplessness,

tearfulness, doubting, and the need for flight from the therapy. On a number of occasions, Doug indicated his desire to stop therapy altogether and leave the session. The therapist directly addressed these younger parts of self, communicating validation and compassion to address his need for the defense responses to manifest (through fight, flight, freeze, hide, avoid, submit), as well as the switching between states of self that occurs secondary to the discomfort of the triggers during history taking and remembering. Further psychoeducation and CRM resourcing experiences were provided for these younger self-states in order to create a relationship between the younger states and “adult” self, as well as to strengthen the trust in the therapist.

This facilitated the discussion around the emotional reality and neuroscience of attachment disruption, survival terror, the locus of control shift, and historical coping skills. The dialogue allowed Doug to manage intolerable feelings of rage, grief, shame, terror, and disgust. He learned that the mid-brain based defense responses ultimately created cognitive belief systems and stimulus-context learning that reinforced the need for the dissociative states and psychiatric symptoms, and that could be dismantled through therapy. CRM resourcing was coupled with this cognitive process of psychoeducation in order to remind both the adult client and the child states that everything that was needed to survive was in fact inside himself. Special attention was paid to reinforcing the awareness of his ability to regulate his activation, and to enhance the reality of the neurobiology of attunement and attachment in building internal resiliencies to the remembering of painful material. Younger ego states were concurrently given the corrective experience of being truly seen and understood; addressing both adult needs and child needs through education and experience when fully resourced contributed to therapeutic relationship building and ultimately reconciliation and integration, which furthered Doug’s intrapersonal relationship.

Interestingly, as a client who presented as logical, concrete and skeptical of seemingly esoteric material, he easily stepped into these more abstract concepts, immediately assessing and connecting to the attunement and attachment resources that at first would have been judged as esoteric. Doug was taught how co-consciousness (Schwarz, et al., 2017) was relevant to “staying awake” to his habitual defense

response of ego states that perpetuated dissociation. While his high tendency to dissociate triggered more shame and self-loathing, this activation was also used as a target for further trauma work.

Observing Doug's ability to grasp these concepts and experience the effect of CRM resources, the therapist took the opportunity to provide psychoeducation about how to use this process as homework. Periodically, Doug and the therapist reviewed in session the importance of feeling his newly acquired attachment resources in an embodied manner, while being able to use the breathing skills to regulate the distress that was being triggered around the experience of attunement and felt sense of attachment in general. This was emphasized relevant to the paradox of the painful and confusing nature of attachment in CPTSD, in which the reality of "I need to attach to survive, but attaching makes me feel like I will die" becomes paramount with no possibility of resolution. Of note, Doug was encouraged to keep his focus between sessions on deepening the neurobiology of resources, rather than allowing trauma processing to occur without the therapist present. Doug was cautioned that the more often and more deeply he experienced a non-dissociative, fully embodied state, the more the trauma material would arise. In order to prevent trauma release from becoming an overwhelming state between sessions, it was important for him to be able to nurture the parts of self driving the trauma memories and "tuck them away" inside the body with CRM resourcing, until work with the therapist could resume in the next session.

The following traumatic experiences were processed within the neurobiological scaffolding of brain and body-based safety that is the foundation of CRM: childhood and adolescent attachment disruptions with mom and dad, shame and self-loathing secondary to locus of control shift issues of his attachment disruptions, inpatient psychiatric hospitalization experiences, betrayal of family and treatment providers, and the combat experience in which Doug was involved directly in the wrongful death of an adolescent civilian. Each of these traumatic experiences was processed with a variety of resource scaffolds, which were chosen by both therapist and Doug within the context of attunement between Doug and the therapist, as well as between Doug and himself.

Doug was able to spontaneously interpret the connection between these traumatic experiences and his psychiatric, medical, and relational symptoms in the present. These interpretations emerged

organically without direction or suggestion by the therapist. Attachment resourcing to facilitate trauma processing was significantly triggering for Doug in the initial sessions (sessions 1-10), due to his earliest trauma being a result of deep attachment wounding, chronic abandonment, neglect, and abuse by his caregivers. Therefore, the development of CRM resources necessitated simultaneous processing of painful material in order to clear the way for positive neuroplasticity, which had a direct positive effect on Doug's habitual defense responses.

The turning point in Doug's recovery, as well as his willingness to engage in the therapeutic process of posttraumatic growth (Tedeschi & Calhoun, 2004), occurred after working through the significant portions of grief connected to his parents and his role in the death of the adolescent civilian during combat. Remembering his adolescence and military career no longer created a trigger (whether emotional, cognitive or behavioral) and therefore no longer necessitated defense responses that manifested in psychiatric symptoms, addictions or intolerable affect. Once the mid-brain based defense responses were no longer needed, Doug reported spontaneous changes in his belief systems and more "room and space" to reconsider himself and his life as worthwhile, meaningful, and hopeful. In particular, the locus of control shift that led to self-blame, self-hatred and worthlessness was significantly transformed. Specific CRM Core Self work, in session twenty-two, catalyzed a further remission of his depressive and posttraumatic symptoms that were directly associated with his social withdrawal and self-loathing.

New Truths were created after each piece of trauma processing and came to provide a scaffold of positive memory integration, reconsolidation and neuroplasticity (Lane, Ryan, Nadel, & Greensberg, 2013; Ecker, Tadic, & Hulley, 2013). This resulted in the correction of the locus of control, thus reinforcing his willingness to continue with this integrative process post-treatment. After 24 sessions Doug chose to take a break, with the reported intent of continuing to build on the gains that he made during the formal therapeutic process. During the last session, Doug spoke about the spiritual awakening his treatment had allowed and his desire to pursue this, as well as hope that he could be helpful to others, especially other veterans. This idea of spiritual stirrings is largely absent from formal education of trauma

processing, however as spirituality is an overwhelmingly significant factor in the human condition; it is a common “side effect” of CRM clients.

During the closure of his therapeutic process in the last few sessions, Doug reported being more comfortable speaking openly with his step-son about relational issues that he experienced as a child and how his attachment style was in some ways replicated in being a father to this son. He also reported reaching out to his daughters in efforts to reconnect; however, there were no return efforts. Crucially, Doug was able to move through this possible rejection in a manner that was understanding and compassionate, rather than internalizing the rejection as a shame-based validation of his unworthiness.

It is noteworthy that around month nine of his treatment, he discontinued his psychiatric medication with no adverse effects. He continues with his anti-seizure medication as prescribed. Specific issues mentioned in Doug’s psychosocial history that were not processed directly included grieving the loss of his primary long-term marriage and reconciling his relationship with his mother and brothers. Doug reported having moments of anxiety and explained that when he utilized his New Truths and resourcing the anxiety diminished quickly, in comparison to when he tried to ignore or avoid his anxiety. Doug discussed in closing that he would most likely re-engage in treatment at some point to build further resiliencies and productivity, as he returns to the workforce and expands his social interactions.

In the final sessions, the therapist observed less physiological activation, more future-oriented speech, positive mood-affect congruency, significantly more personality integration, and an increased ability to observe himself. Doug was able to verbalize his conscious awareness of familiar ego state activation, and identified how he could make conscious choices that were congruent with his New Truths, rather than letting his younger ego states “run the show.” His ending of therapy was considered and informed by his New Truths.

Discussion

This paper has discussed five factors that several authors identify as crucial to trauma treatment: (1) therapeutic alliance, (2) psychoeducation, (3) safety, (4) processing, and (5) reconciliation. The course of treatment described in the case example shows how these factors are implicitly and explicitly

incorporated into the theory and practice of CRM. Furthermore, CRM includes the International Society for Traumatic Stress Studies recommendations for best practice in treating CPTSD including: providing psychoeducation, being phase based, providing emotional regulation skills (resourcing), allowing for a tailored approach, and a narration of trauma memories; all of which are categorized as a first line of interventions for quality trauma treatments (Cloitre, et al., 2011).

Herman (1992), Briere (2015), and van der Kolk et al. (1996) all suggest the therapeutic relationship be fully developed and solid prior to trauma processing. Therapists utilizing CRM advance this idea by understanding that the model develops and deepens this relationship. Attunement is considered crucial in utilizing CRM to its highest efficacy, because only an attuned therapist will choose the most beneficial sequencing of resources and correctly decide when to use them, thereby determining the depth of the work. Attuned use of the model, which enhances the intuitive process, rather than implementation of rigid protocols deployed without creativity, allows for neurobiological safety and containment to be at its strongest, even if emotional safety in the relationship is not initially present. The success of the model and its therapeutic efficacy is the catalyst for developing a strong therapeutic relationship. This is not to say that one does not need to create a relational envelope of rapport, unconditional regard and compassion from the moment the client enters the office. However, there is no need to “wait” for the therapeutic relationship to be deemed strong enough in order to begin trauma work. The point here is that a CRM therapist wants to begin immediately teaching their clients that they have the ability to be internally resourced and do not have to depend entirely upon the “external” therapist. Teaching resourcing immediately upon the start of therapy invites clients to consider that they are not as fragile as they may feel and that the therapist has trust in their physiology to heal.

The therapist’s attunement to Doug’s skepticism and guardedness about somatic therapy indicated to the therapist that resourcing combined with an intellectual, cognitive, and didactic approach would help build trust faster than resource development alone. Noting Doug’s fear of the therapy itself informed the development of CRM resource scaffolds within the context of this fear that was driving his need to remain cognitive and intellectual. With each successful experience relative to the target issue

being processed, Doug's trust in the therapist deepened, allowing for further resource scaffolding, as well as more comprehensive psychoeducation being deployed parallel to processing. This initiated the process of Doug further trusting himself as he saw that resourcing had immediate effects on his defenses, autonomic nervous system and avoidant tendencies.

The therapist's choice to identify and address the child ego states added another layer of attunement and allowed for Doug to feel truly seen and understood. This also allowed the therapist to increase the therapeutic alliance with the ego states, as well as showing Doug that being in a different relationship with his ego states or parts of self was possible. The more exquisitely attuned the therapist was to Doug's dissociated parts of self, the more willing Doug became to follow suggestions; not only during trauma processing, but also during his time at home. The sturdier the relationship became the more in-session and between-session compliance there was.

Teaching Doug skills that promoted access to internal resources rather than the expectation that only the therapeutic relationship would provide him with a sense of external connection became evidence for Doug that he could start trusting himself in a way he had not been able to previously. This allowed him a different therapeutic experience and initiated his journey toward a different relationship with self. Throughout Doug's treatment he was continually educated on the mechanisms and purpose of each intervention as needed, in a manner similar to how therapists are taught during CRM trainings.

Traditional trauma treatments discuss the importance of external safety—with the therapist, the home environment, and the primary support system. While external support is certainly helpful, one cannot fully depend on the safety of the external environment or relationships with others. We are ultimately alone in the relationship we have created with ourselves. CRM provides the opportunity through use of the model itself to create, develop, and maintain a secure relationship, showing clients that they have everything they need inside themselves to live a connected, joyful life, whether alone or with others. While all human beings are wired to connect with others and belong to a group and community, without a secure relationship with self, those external relationships become more of a codependent survival necessity rather than something to be enjoyed and celebrated.

The emphasis that CRM places on teaching the client the neurobiology of brain-and-body-based safety directly supported Doug's need for intellectual understanding, as well as helping him become comfortable engaging with the interventions. Without an understanding of the science of CRM, Doug would not have been receptive to the legitimacy of therapeutic work that to the "naked eye" may appear esoteric or based in imagination.

For this client, trauma processing started immediately, as the need for processing associated with the fear of therapy itself was revealed in the first several sessions. However, there was nothing linear about addressing this fear. Fear of the trauma material was evident at various times throughout the 24 sessions, depending on the content. In particular, the focus on the truth of his life in the context of his parents and the role he played in a civilian death in combat necessitated sessions being dedicated solely to facing and feeling the visceral pain associated with these truths. The attachment disruption work, as well as being responsible for the death of another human being, required full CRM scaffolding (using all the resources available in the model) in order to provide sufficient brain-and-body-based safety to allow full orientation toward the intolerable affect. When Doug was able to experience the intolerable emotions without defense responses immediately taking over, the triggers associated with these defense responses, coping skills, and psychiatric symptoms that caused distraction and avoidance of his historical truths became minimized. Neurobiological resourcing was provided concurrently with the exposure to traumatic memories. The resource scaffold allowed Doug to stay within the window of tolerance (Siegel, 1999), accessing and feeling fully his emotions without feeling that they were intolerable. This led to the dismantling of subcortical, cortical, neurochemical and stimulus context learning. With fear responses thus extinguished there was now room and space for memory reconsolidation that did not include distorted cognitive beliefs, autonomic responses driving fight, flight, freeze, hide, avoid, and dissociate. It was these defense responses that maintained his depression (shame, self-loathing and rage), dissociation, and posttraumatic stress symptoms.

One of the most hopeful aspects of Doug's treatment was his willingness to engage in his work between sessions, specifically his New Truths obtained after each significant piece of work and practicing

attunement/attachment behaviors between wounded parts and secure internal attachment figures. It is hypothesized that this particular piece of “homework” is designed to maintain the gains made in the context of secure attachment neurobiology. Doug was also instructed to stay consciously aware of the following process issues: dissociating from his physical body, childlike reactivity in relationships, and denigrating treatment of the self. Given the fact that one of Doug’s hobbies was writing fiction, he was encouraged to explore writing a story that represented his healing journey.

Conclusion

This paper has discussed the five common features of trauma treatment: the therapeutic alliance, psychoeducation, safety, trauma processing, and reconciliation. The case example and discussion demonstrated how CRM extrapolates and has embraced these elements to produce a comprehensive model consistent with the neurobiological underpinnings of Panksepp (1998), Lanius (2012), and Lanius, Paulsen, & Corrigan (2015), as well as the theoretical work of Ross (2009). The case has clarified the essential elements of quality trauma treatment and how they come together in this model to produce a therapy acceptable to patients, as well as challenging therapists to sharpen their theoretical and practical skills. Compassion fatigue is often discussed as a common byproduct of those who work in trauma recovery as a specialty, as well as in the field of mental health in general (Merriman & Joseph, 2016). CRM offers a path for therapists to have “compassion satisfaction” (Ray, Wong, White, & Heaslip, 2013) by bringing individuals into a more functional, accepting relationship with themselves. The result of this treatment allows patients to experience their own internal resources, thereby simultaneously reconciling their pain while creating room in their lives for more meaningful choices. Future studies should focus on providing empirical evidence of CRM’s utility as a treatment model, and the specific neurologic aspects upon which the theory of CRM is based.

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