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STAIR Narrative Therapy: A Skills Focused Approach to Trauma-Related Distress

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Abstract: Interest in psychotherapeutic interventions for posttraumatic stress disorder (PTSD) populations that address variants of commonly co-occurring trauma sequelae is emerging. Specifically, treatment approaches that enhance an individual's capacity to experience and successfully modulate emotion, function interpersonally, and access social support are of particular value. The present paper briefly describes emotional and social difficulties commonly experienced by trauma survivors and outlines potential targets for intervention within the context of trauma-focused treatment. Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy is a skills-focused approach designed to foster the development and strengthening of emotion regulation and interpersonal skills and promote resilience. Empirical evidence supporting the efficacy of STAIR Narrative Therapy as an effective treatment for PTSD as well as emotion regulation and social difficulties is reviewed. Implications for treatment and directions for future research are presented.

Keywords: Emotion regulation, interpersonal functioning, PTSD treatment, trauma.

STAIR NARRATIVE THERAPY: A SKILLS FOCUSED APPROACH TO TRAUMA-RELATED DISTRESS

Considerable variability exists between persons in the ensuing psychological and emotional sequelae that potentially follow exposure to a traumatic life event. The most common consequences of exposure to trauma include posttraumatic stress disorder (PTSD), depression, and anxiety and substance use disorders [1, 2]. According to fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* [3], PTSD is the collection of persistent symptoms of re-experiencing (e.g., intrusive recollections or nightmares of the event), avoidance of internal (i.e., trauma-related thoughts and feelings) and external (i.e., trauma-reminiscent people, places, or situations) trauma-related stimuli, negative alterations in cognitions and mood (e.g., persistent negative beliefs and expectations about oneself or the world, distorted perceptions of blame, persistent negative trauma-related emotions, anhedonia, feelings of detachment from others, and difficulty experiencing positive emotions), and hyperarousal (e.g., irritability, engagement in self-destructive behavior, exaggerated startle response, hypervigilance) following exposure to a traumatic event. In addition to the classic symptoms of PTSD, other common trauma sequelae may emanate following trauma, including emotional dysregulation and impairments in social functioning [4].

While excellent treatments have been developed to treat PTSD, these interventions were not specifically designed to target commonly co-occurring emotion regulation difficulties and impaired interpersonal functioning that often emanate following trauma exposure. The present paper describes the emotional and social impairments that may result following exposure to trauma. Then, Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy is described as an innovative skills-focused intervention for trauma-related difficulties. Evidence supporting the efficacy of STAIR Narrative Therapy as a treatment for PTSD and other variants of commonly co-occurring trauma sequelae are discussed. Implications for treatment and directions for future research are identified.

EMOTIONAL REGULATION

Emotional regulation refers to processes that maintain, inhibit, or induce emotional responses in response to a given situation or emotional experience [5], and is generally viewed as a critical contributor to overall positive and effective functioning in day-to-day life [6]. Emotional regulation plays an essential role in developing and supporting relationships, goal-directed activity, and role functioning [6]. Emotional regulation is comprised of a variety of inter-related skills, which include self-soothing activities to reduce negative emotional states, as well as activities that increase positive emotion to facilitate appropriate action. Successful emotional regulation also requires awareness and the appropriate expression of what one is feeling, the assessment of whether associated action tendencies promote or retard one's goals, and the capacity to sustain or modify the feeling depending on whether it facilitates or hinders goal attainment. Inherent in this conceptualization is the idea that adaptive emotional regulation requires flexibility but also control.

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From a clinical standpoint, the majority of affective and anxiety disorders may be characterized as some form of emotional dysregulation [5, 7]. PTSD, for example, often involves contextually inappropriate over- and under-expressions of emotion. Accordingly, the capacity to successfully modulate intense emotions is a critical aspect of posttrauma responding and recovery [4, 8]. Emotional hyperreactivity is generally manifested *via* re-experiencing and hyperarousal symptoms, and may be associated with persistent trauma-related emotions, such as fear, anger, or guilt, aggression and impulsive behaviors, whereas, emotional hyporeactivity is evidenced by subjective feelings of emotional numbing or detachment, social and emotional withdrawal, and an inability to experiencing positive emotions.

Findings from several investigations have revealed associations between poorer emotional regulation abilities and greater PTSD severity and impairments among diverse trauma-exposed populations [e.g., 4, 9-15]. In particular, poorer adjustment has been linked to increased use of emotion suppression [e.g., 10, 13], an emotion regulation strategy that involves inhibiting ongoing emotion-expressive behavior [16]. Further, emotional regulation appears to play a critical role in social functioning and access to social support [e.g., 17, 18]. Specifically, effective emotion modulation and social functioning is dependent upon an individual's ability to successfully recognize, respond to, and express his/her feelings and the emotional expressions of others and understand the reciprocal influence of this process.

SOCIAL FUNCTIONING

A variety of interpersonal difficulties have been routinely documented among trauma and PTSD populations, and the emotional disturbances characterized by PTSD appear to have a direct impact on trauma survivors' social adjustment. For instance, increased difficulties with expressions of anger and irritability are a symptom of PTSD [3] and significant associations between PTSD symptomology and perpetration of intimate partner violence have been documented [e.g., 19]. Further, reports of greater family and marital conflict and poorer relational adjustment have also been documented among PTSD populations [e.g., 20-24]. In these investigations, relational problems have specifically been tied primarily to emotional numbing and dysphoria symptoms of PTSD.

It is possible that reduced emotional experiencing and/or high levels negative emotionality may lead to a number negative relational consequences, such as increased social withdrawal, impaired communication, reduced opportunities to experience positive emotion and receive and provide emotional support. For instance, reduced perceptions of social support were associated with emotional numbing and hyperarousal symptoms of PTSD and co-occurring depressive symptoms among motor vehicle accident survivors [24]. Similarly, dysphoria symptoms of PTSD have been associated with family and peer difficulties, psychosocial difficulties, and perceived social support [25]. Important aspects of psychosocial functioning, such as perceived levels and access to social support have been cited as an important resilience factor in posttrauma adjustment [e.g., 25]. Accordingly, interventions aimed at improving interpersonal functioning may also confer protection against future stress.

THE INTERSECTION BETWEEN EMOTION REGULATION AND SOCIAL FUNCTIONING

Interestingly, success in emotion regulation and social functioning appear to be intrinsically related in a dynamic and reciprocal fashion [26]. An individual's emotion regulation capabilities can be applied to interpersonal contexts which necessitate an awareness of the feelings and reactions of others. Within the social context, effective emotion regulation requires an ability to successfully communicate one's feelings, recognize and respond to the feelings of others, and express feelings in a flexible manner depending on the type of social relationship. For instance, a limited awareness of others' feelings has been associated with reduced social functioning and abilities to adequately access social support [27]. Additionally, cognitive and emotional flexibility within an interpersonal context plays a critical role during times of unpredictable and adverse changes. Specifically, the ability to think about and approach situations in a flexible and adaptive manner has been associated with improved psychological adjustment [28-30]. Similarly, research suggests that flexibility in responding to interpersonal conflicts and contextual changes following exposure to traumatic stressors is associated with increased perceptions of emotional and tangible support [31] and reduced PTSD symptomatology [32]. Accordingly, the capacity to perceive, respond to, and rely on individuals according to their strengths and weaknesses and changes in the environment appear to promote the development of mutually beneficial support systems.

The influence of emotion regulation capacities on overall well-being and social adjustment has been examined in a series of studies among trauma survivors. For instance, greater flexibility in upward or downward regulation of both positive and negative emotional expression relative to social demands was associated with improved posttrauma adjustment among college students following 9/11 [33]. Similarly, the ability to experience positive affect shortly after 9/11 was predictive of both the size and strength of social networks two years later [34]. Accordingly, social functioning appears to be fundamentally linked to successful emotional expression and modulation among trauma survivors, suggesting the need to address impairments in both domains in the context of trauma treatment.

TREATMENT FOCI FOR TRAUMA-RELATED EMOTIONAL AND SOCIAL DIFFICULTIES

Although a number of efficacious treatments currently exist to reduce posttraumatic distress, few interventions have been developed to specifically address emotional and social difficulties commonly experienced by trauma survivors. Historically, interventions for PTSD have emphasized the role of fear and ensuing effects of conditioned fear responses to trauma-related stimuli [35] and have incorporated some

form of exposure-based techniques in order to facilitate habituation of learned associations. Experimental studies suggest that disturbances in the neural circuitry of fear regulation are associated with PTSD [36, 37]. The mechanism of change commonly attributed to the success of trauma memory processing and successful reduction of PTSD symptoms is the extinction of the trauma-associated fear response, which thereby allows access to and reorganization of the trauma memory.

However, while traditional interventions for PTSD are effective in alleviating the fear-based symptoms of PTSD, the emerging science of emotion suggests that emotions, such as fear, are also experienced and directed within a social context [38]. For example, an individual with PTSD may attempt to decrease anxiety by avoiding unfamiliar social situations, which may provide short-term relief, but lead to possible long-term negative consequences such as social isolation. Accordingly, consideration of the reciprocal influence of emotion modulation and the social context enables us to expand upon fear-based models of PTSD.

Trauma can disrupt the development of emotion regulation and social competency. Specifically, emotional dysregulation can create vulnerability to pathological affective states, while improvement in emotional awareness, modulation, and expression can promote recovery, foster improved social functioning, and confer protection against future adversities [26]. Moreover, impaired social functioning or reduced access to support can create risk for PTSD and other emotional problems, while improved relational functioning can promote recovery and resilience. Psychotherapy interventions that incorporate techniques aimed at broadening existing behavioral repertoires for more effective mood and emotion modulation and developing support-seeking capacities may be particularly useful among trauma populations. Below we describe an innovative treatment that has extended beyond traditional trauma therapies by including skills training in emotion regulation and social functioning.

STAIR NARRATIVE THERAPY

STAIR Narrative Therapy is a skills-focused, phased-based intervention, originally developed for child abuse populations, designed to alleviate trauma-related distress and strengthen interpersonal and emotional capacities. While conventional trauma interventions have received considerable empirical support demonstrating their efficacy in alleviating PTSD symptoms [e.g., 35], these interventions were not specifically designed to target commonly co-occurring emotion regulation and social functioning difficulties that are often experienced by trauma survivors. STAIR Narrative Therapy, a sequential phase-based treatment, expands on traditional fear-based approaches to PTSD treatment by incorporating interventions that address emotion dysregulation and social difficulties commonly observed among trauma populations [7].

STAIR Narrative Therapy consists of two separate phases: the skills-focused STAIR phase and the Narrative Therapy phase. The STAIR phase of treatment is dedicated to interventions designed to target emotional regulation and social impairments and can be implemented in both individual and group formats. Specifically, skills aimed to enhance emotion regulation capacities and improve interpersonal effectiveness are taught and fostered over the course of eight sessions. The second phase of treatment (i.e., the Narrative Therapy phase) introduces the creation of a series of narratives where clients are asked to provide a description of traumatic experiences out loud in a detailed, organized and emotionally engaged fashion. This phase of treatment is implemented in the individual format. Skills practice continues throughout the second phase and successes in day-to-day events are discussed to highlight differences between traumatic events being described and life in the "here and now." Emotion regulation skills are employed during the narrative work as needed. Successful progression through treatment allows for the meaningful reorganization of traumatic memories and reinforces the emotion regulation skills work completed in the initial STAIR phase.

The treatment goals and associated interventions in the STAIR phase include (1) promoting emotional awareness through the identification and labeling of feelings and their triggers as they emerge in daily life; (2) teaching emotion regulation strategies to modulate negative feelings and tolerate distress *via* adaptive affective expression through actions, words and thoughts; (3) fostering the adaptive use of emotions and distress tolerance to facilitate achievement of social goals; (4) encouraging the identification and modification of maladaptive interpersonal schemas that are influencing interpersonal functioning; (5) facilitating the identification of adaptive and achievable social goals in the context of different types of relationships and interpersonal situations; and (6) attaining a sense of emotional and social self-efficacy that facilitates living in the world with compassion and empathy.

Identifying and Expressing Feeling States (Sessions 1-2)

The initial sessions of the STAIR phase focus on facilitating the client in learning to appropriately identify, elicit, and monitor their emotional experience. Survivors of trauma, particularly those with trauma-related conditions, such as PTSD, often have difficulty identifying and labeling their feelings. Some clients may describe feeling overwhelmed by their emotions. For instance, individuals with trauma-related distress may describe feeling extremely angry or anxious, but have difficulty identifying the trigger or labeling painful underlying feeling states, such as hurt, guilt, or shame. Alternatively, some individuals may report persistent feelings of numbness and an inability to feel with little understanding as to why. The client's primary tasks in the first sessions of therapy are to practice the identification and discrimination of their feelings in an effort to promote emotional awareness. Through in-session dialogue and self-monitoring exercises *via* the Feeling Monitoring form, clients are taught how to accurately label their emotional experiences and identify corresponding triggers, thoughts, and current mood-regulation coping strategies. Clients are also asked consider and record whether or not the coping responses they employed were successful. This process facilitates clients in identifying the channels through which

emotions are experienced (i.e., the body, thoughts, and behavior) and beginning to evaluate the effectiveness of their current coping strategies.

Additionally, during this phase the client is presented with the idea that all emotions serve a purpose and are messengers that guide our decisions and actions and facilitate our communication with others. For example, fear is an emotion which should guide us to leave an unsafe situation and/or modify our actions to ensure our safety. During this process, the client receives positive feedback and validation from the therapist, which creates the potential for learning that the expression of feelings can result in positive, rather than negative, consequences. Accordingly, the client gradually gains insight into their current emotional experience and can develop an enhanced sense of self-efficacy in emotional expression.

Negative Mood Regulation (Sessions 3-4)

Once clients have become proficient in labeling feelings, triggers, thoughts, and coping responses, the next step is to cultivate effective coping strategies to successfully manage intense negative emotions and improve distress tolerance. In these sessions, psychoeducation is presented on the three channels of anxiety/distress: physiological, cognitive, and behavioral and clients are encouraged to identify what he/she experiences and how he/she responds within each channel. During this process, the therapist facilitates the client in identifying and evaluating their current coping responses. Relative weaknesses in coping are identified and clients are taught to modify existing and/or develop new ways of modulating difficult thoughts, feelings, and behaviors. For example, some clients may possess skills for successfully managing emotions, but experience difficulty approaching fearful situations, while others may be able to access sources of social support, but be unable to effectively respond to intrusive or maladaptive thoughts. Each client's unique strengths and weakness are identified, and new coping skills are presented. Coping skills introduced include various cognitive-behavioral techniques, such as cognitive reappraisals, breathing techniques, and distress tolerance. Because not all clients will be receptive to, or find all coping strategies presented helpful, they are encouraged to develop and strengthen techniques that best match their temperament and needs.

It is important to note that during this phase of treatment clients are taught that mood regulation strategies are not intended to encourage the avoidance of feelings, but rather to improve self-efficacy and control over emotions and situations where distress tolerance is necessary. Individuals with trauma-related difficulties will often go to great lengths to avoid situations, feelings, and thoughts associated with their traumatic experience, which can be counter-productive. Accordingly, clients are encouraged to confront distressing situations and difficult emotions as opposed to engaging in avoidance strategies. Specifically, clients are taught skills to enhance their tolerance of distress in relationship to their identified goals. Concomitantly, because effective modulation of feelings requires the elicitation of authentic emotion, an attitude of acceptance towards one's actual feelings is fostered. Clients are taught that gradual acceptance of negative feelings will enhance their ability to experience positive emotions. Through the acceptance of authentic emotion, the client is able to freely and more effectively work on elements of thoughts and behavior that he or she would like to change. The gradual engagement in effective coping and approach-related behaviors strengthens clients' sense of coping efficacy for difficult emotions, thoughts, and situations and broadens existing behavioral coping repertoires to improve future stress responding.

Expanding the Interpersonal Social Repertoire (Sessions 5-8)

The remaining sessions of the STAIR phase are focused on developing skills for enhanced interpersonal functioning. During these sessions, clients are encouraged to explore their emotional and behavioral habits in interpersonal and social situations. The concept of interpersonal schemas, cognitive-affective structures or relational scripts formed in the context of early life relationships with primary caregivers, are introduced. Clients are taught that interpersonal schemas from childhood are brought into adulthood and become templates for our relational behaviors and inform our expectations of others. For instance, in the case of a childhood trauma survivor, early rejecting experiences may have resulted in an interpersonal schema that "to be connected means to be hurt/disappointed," which can lead to negative expectations of others in relationships and avoidant or distant patterns of behavior. Hence, maladaptive interpersonal schema can be self-fulfilling and potentially lead to negative patterns that hinder a client's interpersonal goals.

To facilitate the identification and examination of interpersonal schema, clients are asked to monitor interpersonal situations using a worksheet (i.e., the Interpersonal Schema Sheet). The Interpersonal Schema Sheet requires clients to identify and record relevant information from interpersonal interactions such as, "what I thought and felt about myself, what I thought the other person thought and felt about me, what I did, and what are my interpersonal goals for the interaction (i.e., "what I really wanted to happen in the situation and what else could I do"). The goal of these interpersonal monitoring exercises is to facilitate clients in identifying and understanding their relational schema and enhance their awareness of how such expectations influence their current interactions with others. Clients are also taught tools to improve and establish boundaries in interpersonal relationships. Specifically, clients are provided with information about the three types of power balances in relationships (i.e., equal, when the individual has more power, and when the individual has less power), as well as the characteristics of healthy boundaries in comparison to fused or distant boundaries. Then, clients are taught effective communication skills (e.g., "I-messages" and assertive communication techniques) to facilitate the establishment of healthy boundaries. Following the identification of interpersonal schema and their origins, clients are encouraged, with collaboration of the therapist, to consider and practice alternate and flexible ways of relating to others. This work is accomplished in two ways: through

role play and covert modeling. Role plays are viewed as a means to bring schemas to life, thereby allowing for a more detailed review of interpersonal situations and the provision of specific feedback and recommendations. Role playing of commonly encountered or anticipated relationship situations with the therapist creates opportunities for the client to practice newly learned interpersonal and emotion regulation skills and alternative behaviors. Behavioral aspects of good interpersonal relating, such as the use of appropriate voice tone, posture, and eye contact, are also demonstrated during role play exercises. Covert modeling is another technique used to practice interpersonal skills, which requires the client to imagine interpersonal situations and describe and discuss them with the therapist. With both techniques, the importance of flexibility in interpersonal relationships and the need for varied forms for communication depending on the situation is emphasized. The primary objective is to provide the client an authentic emotional experience in which they experience self-efficacy and acceptance by the therapist even as they struggle to practice their new emotional skills. Such practice elicits genuine emotional arousal and facilitates the gradual acceptance of intense emotions as emotion regulation skills improve but in a way that continuously allows the patient to feel in control and safe.

Narrative Work (Sessions 9-16)

While the interventions in the STAIR phase of treatment focus on improving functional capacity and quality of life in the present, the second phase is devoted to facilitating emotional processing of the past traumatic experience. Emotion regulation skills developed and strengthened in the first phase are employed during the second phase in the service of assisting the patient to explore traumatic memories in an emotionally engaged, but regulated way. The Narrative Therapy phase consists of imaginal exposure exercises for trauma memories, with the goal of reducing PTSD symptoms *via* within- and between-session habituation, as evidenced by reductions in reported levels of distress. Throughout this phase, emotional awareness and engagement is fostered through the explicit verbalization and description of trauma-related memories and feelings. During the narrative work, the trauma memory is organized within the structure of a narrative with a beginning, middle, and end, which facilitates emotional processing and provides the client with further opportunity to learn to modulate their trauma-related emotions. Following imaginal exposure, clients engage in an emotion stabilization review exercise where they are guided in labeling and identifying feeling states and selecting and implementing appropriate emotion regulation strategies to manage trauma-related distress.

An ancillary objective of the narrative phase is to continue to foster alternative interpersonal schema. Together, the therapist and client work to identify and modify maladaptive schemas embedded in the trauma narrative in an effort to create a new meaning. Specifically, during this process, it is helpful to differentiate between interpersonal schemas generated earlier in life in the context of a traumatic experience and those of present situations. For instance, a trauma survivor may experience considerable difficulty trusting others out of fear of being harmed. The therapist and client engage collaboratively in examining trauma-related schema and work towards modifying its meaning in the present in light of newly learned information gleaned from therapy work. Trauma reappraisals often involve the recognition that the chronic fear belongs to an event in the past and that changes resulting from the trauma (e.g., loss of sense of worth and capacity to relate well to others) can be purposefully reworked and transformed in the present.

EMPIRICAL SUPPORT FOR STAIR NARRATIVE THERAPY

STAIR Narrative Therapy has garnered empirical support, bolstering its efficacy as a psychotherapeutic intervention for PTSD, as well as other frequently co-occurring aspects of trauma-related psychological distress. STAIR Narrative Therapy has been evaluated primarily among childhood trauma and mass violence populations. Findings have supported the utility of STAIR Narrative Therapy in addressing disturbances in emotional and social functioning and enhancing an individual's capacity to respond to and cope with future adversity.

Cloitre and colleagues [7] evaluated the efficacy of STAIR Narrative Therapy among a sample of 58 women with childhood abuse-related PTSD. Consistent with the standard protocol, STAIR Narrative Therapy was delivered over the course of two phases. Phase 1 included eight weekly sessions of affect regulation and interpersonal skills training, while Phase 2 consisted of eight weeks of trauma processing. In comparison to participants in a wait list condition, individuals who received STAIR Narrative Therapy demonstrated significant improvements in affect regulation problems, interpersonal skills deficits, and PTSD symptoms. Further, gains were maintained at three- and nine-month follow-up periods. In particular, at the nine-month post-treatment assessment period, significant improvements were observed on measures of interpersonal problems, social support, and family, work, and social functioning.

Specifically, the STAIR phase produced improvements in negative mood regulation and anger expression, but not PTSD symptoms, suggesting the relative specificity of symptom reduction associated with each phase. Also, therapeutic alliance and negative mood regulation improvement predicted participants' response to the Narrative Therapy phase of treatment. Accordingly, the therapeutic relationship and skills training may have enhanced participants' ability to successfully modulate negative emotions during the Narrative Therapy phase. Treatment outcome was associated with significant improvements in interpersonal skills, role functioning, and social support. Findings bolstered the utility of skills training in trauma treatment to enhance social and emotional functioning.

Empirical evidence also suggests that STAIR Narrative Therapy may be effective even when implemented in a flexible manner. Specifically, STAIR Narrative Therapy was evaluated in a sample of 9/11 World Trade Center terrorist attack survivors [39]. In this investigation, clinicians were permitted to skip or repeat protocol sessions based on their relevance to the patients' presenting symptoms and deficits, end treatment prior to completion of the entire protocol if

satisfactory improvement had occurred, and/or incorporate non-protocol sessions in order to discuss a current life stressor or crisis that warranted clinical attention. Length of treatment varied between 12 to 25 sessions and therapist experience ranged from no prior training to extensive prior training in cognitive behavioral therapy intervention. Findings demonstrated significant improvements on measures of psychological distress and social and emotional functioning among participants who received the flexibly-administered treatment. Further, STAIR Narrative Therapy produced large effect sizes on measures of PTSD and depression and medium to medium-small effect sizes on measures of interpersonal problems, alcohol and drug use, social support, and functional impairment. In particular, STAIR Narrative Therapy reduced the reported use of coping strategies reliant on substance use and improved the utilization of social support. Accordingly, STAIR Narrative Therapy appears to be efficacious even when delivered in flexible manner, suggesting its applicability to diverse trauma populations, symptom profiles, and clinical settings.

Recently, Cloitre and colleagues [40] conducted a randomized controlled trial of STAIR Narrative Therapy with women with childhood trauma-related PTSD. STAIR Narrative Therapy was compared against two control conditions: supportive counseling followed by exposure (Support/Exposure) and skills training followed by supportive counseling (STAIR/Support). Results indicated that participants who received STAIR Narrative Therapy were more likely to achieve sustained and full PTSD remission relative to the two comparison treatments. Interestingly, the superior benefits of STAIR Narrative Therapy emerged primarily at the three and six month follow-up assessment periods. STAIR Narrative Therapy produced greater and sustained improvement in PTSD symptoms, interpersonal problems, negative mood regulation, anger expression, and perceptions of interpersonal support as compared to the Support/Exposure condition and in interpersonal problems as compared to both control conditions. STAIR Narrative Therapy was also associated with fewer cases of worsening PTSD relative to the control conditions. It appears that the benefits of STAIR Narrative Therapy may continue to occur overtime and be a consequence of the cumulative and complementary benefits of each treatment phase.

It is worth noting, however, that comparable improvements were evidenced among participants in the STAIR Narrative Therapy and STAIR/support conditions. Specifically, participants in the STAIR/Exposure and STAIR/Support conditions demonstrated statistically equivalent improvements in in PTSD depression, and anxiety symptoms, negative mood regulation, anger expression, and perceived interpersonal support. Although the benefits associated with STAIR/Support were lower than those seen in the sequential treatment condition, results suggest that skills-focused only interventions, such as the STAIR phase, may warrant future investigation as a stand-alone intervention for trauma-related distress.

The STAIR phase has also demonstrated efficacy as a group-based intervention for chronically hospitalized complex trauma survivors. Trappler and Newville [41] examined the efficacy of the STAIR phase in a sample of 24 inpatients with co-morbid PTSD and schizophrenia. As compared to a supportive therapy control group, patients who underwent STAIR showed significant improvement on measures of psychotic and PTSD symptoms. Specifically, patients who received STAIR demonstrated greater reductions in positive symptoms, emotional withdrawal, tension, depressed mood, unusual thought content, blunted affect, excitement, and PTSD intrusion and avoidance symptoms.

In sum, STAIR Narrative Therapy appears to be an efficacious intervention for trauma-related distress, including commonly co-occurring emotional and social impairments. Additionally, evidence suggests that STAIR Narrative Therapy may also foster continued improvement in mood regulation and interpersonal skills among trauma survivors even after treatment has ended. We suspect that the benefits of STAIR Narrative Therapy may be due to trauma survivors' improved ability to effectively manage emotional distress stemming from current and future stressors and develop and utilize social support.

IMPLICATIONS AND FUTURE DIRECTIONS

Empirical evidence suggests STAIR Narrative Therapy may be an effective treatment for alleviating posttraumatic distress and improving the emotional and social impairments commonly seen among trauma survivors. The skills-building focus of the STAIR phase provides trauma survivors' with an opportunity to learn techniques that facilitate effective coping with immediate sources of distress, as well as, encourage improved social functioning and flexibility. The focus on enhancing emotional regulation capacities and interpersonal success may also serve a protective function by encouraging the continued growth of strength-based capacities, thereby improving future responding in adverse or stressful situations.

Developing and strengthening trauma survivors' capacity to manage difficult emotions, as well as successfully seek and utilize social support, can alleviate trauma-related distress and facilitate posttrauma recovery. Successful trauma treatment, which involves emotional engagement with feared trauma memories, may also enhance an individual's self-efficacy for managing and tolerating difficult situations and emotions that may be encountered in the future. Through trauma processing, the experience and impact of the trauma can be reflected upon and incorporated into the person's life in a way that provides meaning and facilitates successful functioning and relationships. Improved emotion regulation helps clients in this process [7] and fosters an appreciation for the deeply interpersonal nature of emotional life and relationships and a greater sense of connection, compassion, and empathy for others.

There are a number of fruitful avenues for future research within the area of skills-focused interventions for trauma-related distress. Although evidence suggests that multi-component trauma interventions, such as STAIR Narrative Therapy, can be effective in producing improvements in emotion regulation and social functioning, it remains unclear the extent to which such interventions produce clinical improvement above and beyond traditional PTSD treatments.

Findings from Cloitre and colleagues' [40] dismantling study suggest that greater long term benefits are associated with a combined skills training plus exposure-based intervention or skills only apporaches as compared to an exposure plus supportive counseling condition. Future investigations are necessary to determine the effectiveness of such interventions among trauma populations and as compared to traditional treatments for PTSD.

Further, little is known regarding the underlying mechanisms of change in skills-focused interventions. Examining the extent to which changes in perceptions of self-efficacy, behavioral and interpersonal flexibility, and other emotional and social regulation abilities account for symptom reduction would be valuable. Moreover, although originally developed for survivors of early childhood trauma, STAIR Narrative Therapy appears to be a promising intervention for other trauma populations, particularly among patients with compromised emotional and social functioning. Accordingly, it would be beneficial to continue evaluate the efficacy of this treatment approach among other trauma populations. Similarly, research efforts aimed at identifying the particular symptom profiles, such as more pronounced emotional numbing symptoms of PTSD [42], of patients that may benefit from the incorporation of skills training approaches would be valuable.

In sum, emotion regulation and social difficulties are commonly experienced by trauma survivors. While excellent treatments have been developed to treat PTSD, these interventions were not specifically designed to target commonly co-occurring emotion regulation and interpersonal difficulties that often co-occur with PTSD. Evidence is encouraging for STAIR Narrative Therapy, an effective skills-focused intervention that enhances emotion regulation capacities and interpersonal functioning. Future research should be directed towards the continued identification and elucidation of factors associated with improved emotional and social functioning and adaptive responding following trauma exposure.

DISCLAIMER

The views and opinions of authors expressed herein do not necessarily reflect those of the Department of Veterans Affairs.

CONFLICT OF INTEREST

The authors confirm that this article content has no conflict of interest.

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