

THE BEHAVIOUR INSTITUTE
Diploma in Trauma-Informed Psychotherapy

UNIT 4 • CORE READING 6 OF 6

06

Choosing the Right Approach

Matching treatment to presentation, and closing out this unit's survey

What This Document Covers

This closing document brings together everything covered across this unit's survey of five distinct approaches — TF-CBT, EMDR, Somatic Experiencing, Internal Family Systems, and DBT skills — and addresses directly how a practitioner might actually think through matching a specific presentation to an appropriate approach.

There Is No Single Correct Answer

As the introduction to this unit stated plainly, there is no single approach that is simply correct across all presentations. What follows is a framework for thinking through the decision, not a rigid formula — real clinical decision-making involves genuine judgement, ongoing reassessment, and often a willingness to adjust course partway through treatment if the initial approach is not proving effective for a particular client.

Questions Worth Asking

Is This Single-Incident or Complex Trauma?

As covered across Unit 3, this distinction carries real weight. Single-incident presentations, with intact self-concept and relatively stable relational functioning, are often well served by TF-CBT or EMDR relatively directly. Complex PTSD presentations, involving the additional clusters covered in Unit 3's Document 2, often benefit from a longer initial stabilisation phase — frequently drawing on DBT skills, covered in Document 5 — and may benefit particularly from IFS's direct engagement with self-concept and internal fragmentation.

How Significant Is Current Emotional Regulation Capacity?

A client presenting with significant, ongoing emotional dysregulation, as covered in Document 5, is generally not well served by moving straight into intensive trauma processing, regardless of which specific modality is chosen. Building genuine regulation capacity first, whether through DBT skills specifically or the coping-skills phases built into TF-CBT and EMDR themselves, tends to produce better, more stable outcomes than rushing toward direct processing prematurely.

How Does the Client Relate to Verbal, Narrative Processing?

Some clients engage readily and productively with detailed verbal narrative work; others find it genuinely difficult, overwhelming, or simply inaccessible — particularly clients with significant dissociative features, covered in Unit 3's Document 3. For clients in the latter group, Somatic Experiencing's body-first approach, covered in Document 3, may offer a more viable route than TF-CBT or standard EMDR protocols, at least as a starting point.

Pause and Consider

Thinking back across this whole unit, which of the five approaches genuinely surprised you most — either because it worked in a way you hadn't previously considered, or because it addressed a clinical problem you hadn't fully appreciated before?

A Story to Make This Real

Consider a composite scenario drawing together material from across this unit. A client, “Grace,” 34, presents with a clinical picture matching Complex PTSD, covered in Unit 3: prolonged childhood trauma, significant emotional dysregulation, profound negative self-concept, and a pattern of dissociating noticeably whenever the conversation approaches anything emotionally difficult.

Working through this unit's framework: Grace's presentation is clearly complex rather than single-incident, ruling out moving straight into a standard TF-CBT or EMDR protocol without meaningful adaptation. Her significant emotional dysregulation suggests real value in an initial period of DBT-style stabilisation work, building genuine capacity to tolerate distress before deeper processing begins. Her noticeable dissociation during emotionally difficult content suggests Somatic Experiencing's body-first, carefully titrated approach may be considerably more accessible to her, at least initially, than heavily narrative-based work. And her profound negative self-concept suggests real potential value in IFS, once sufficient stabilisation has been established, to address the harsh internal criticism she directs at herself.

In practice, Grace's treatment might reasonably draw on several of these approaches sequentially, or even concurrently, rather than selecting a single modality and applying it in isolation. This is a common, entirely legitimate pattern in real trauma treatment — the five approaches covered in this unit are not mutually exclusive competitors, but a set of tools that can be combined thoughtfully, based on a specific client's actual presentation and needs.

A Closing Thought on Flexibility

Perhaps the single most important point to take from this entire unit is this: good trauma treatment requires genuine flexibility, not loyalty to a single preferred modality applied uniformly regardless of who is sitting in front of you. The practitioner who knows several approaches well, and who can genuinely assess which combination suits a specific client's specific presentation, will generally serve their clients considerably better than the practitioner committed to a single approach applied indiscriminately.

Going Further: Recommended Reading

None of the following is required, but if this unit has genuinely interested you, these are worth your time:

- “Getting Past Your Past” by Francine Shapiro — an accessible introduction to EMDR from its originator, written for a general audience
- “In an Unspoken Voice” by Peter Levine — a deeper account of Somatic Experiencing and the biological foundations of trauma covered in Document 3
- “No Bad Parts” by Richard Schwartz — an accessible introduction to Internal Family Systems from its originator
- “DBT Skills Training Manual” by Marsha Linehan — the primary source text for the skills covered in Document 5, useful for readers wanting direct, practical detail

A Few Things to Take With You

- No single approach among those covered in this unit is simply correct across all presentations
- Whether trauma is single-incident or complex, current emotional regulation capacity, and how a client relates to verbal narrative work all shape which approach, or combination of approaches, is likely to serve a client best
- Real trauma treatment often draws on multiple approaches sequentially or concurrently, rather than a single modality applied in isolation
- Genuine flexibility across approaches tends to serve clients better than committed loyalty to a single preferred modality

Before You Move On

- Having completed this unit, how would you now describe the relationship between these five approaches to someone unfamiliar with trauma treatment?
- In Grace's story, which sequencing decision do you think mattered most to her likely outcome?
- What are you carrying forward into Unit 5, where we turn to the therapeutic relationship itself, including transference and countertransference?