Trauma in counselling and psychotherapy

Jonathan Lloyd / George MacDonald

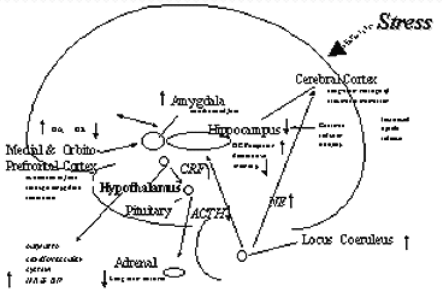
mindsite

Program for Day

10:00–11:15	What is trauma? GM
11:15-11:30	Break
11:30-12:45	How do we work with trauma? GM
12:45-13:30	Lunch
13:30-15:45	Experiential session JL Resolving traumatic memories using metaphor and symbols
15:45-16:00	Review of day GM/JL

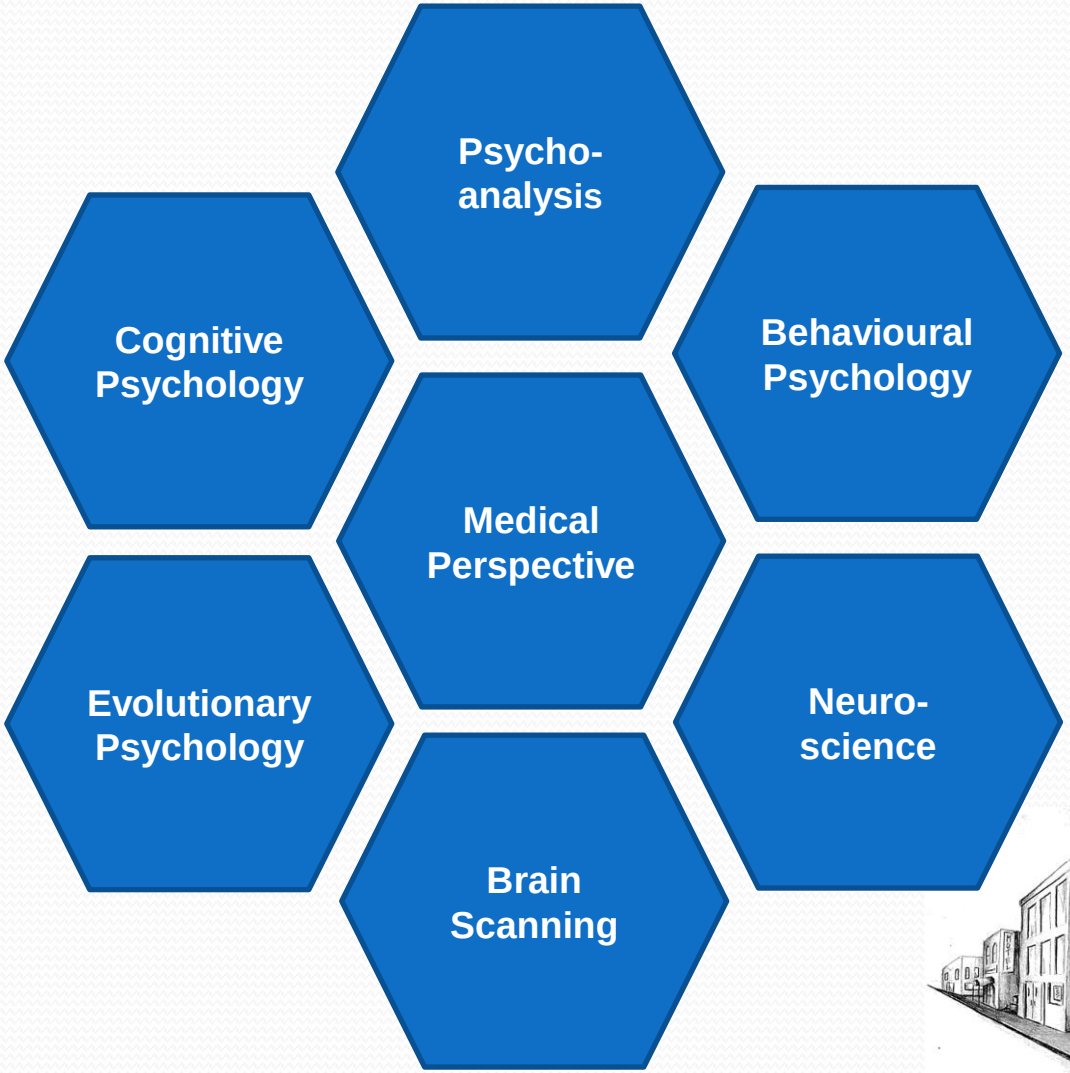
Introductory exercise

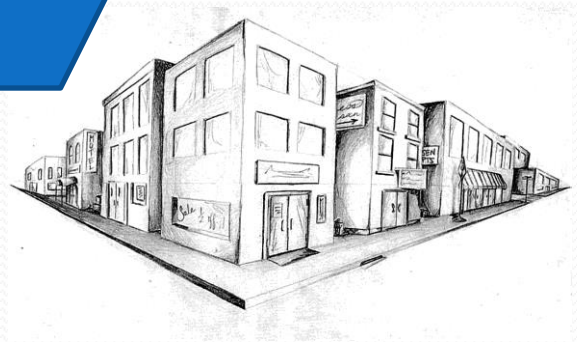
- In groups of 3 or 4:
  - Introduce yourselves
  - Expectations of day
  - Discuss your understanding of trauma



Review Exercise

Multiple perspectives in understanding of trauma





What is trauma?

- Definitions
- Biological perspective
- Cognitive perspective
- Other psychological perspectives
- Medical perspective DSM-IV-TR (DSM-V), ICD-10

Definition – shift of meaning 1

- Derives from Greek word meaning wound
- First recorded use in relation to a mental condition in 1895 edition of *Popular Science Monthly* – 'psychical trauma'
- OED citations from psychoanalysis and psychiatry outnumber references to physical wounds
- Post Traumatic Stress Disorder first included in DSM in 1980.
- Referred initially only to those directly involved
- Then added 'secondary victim' status

Definition – shift of meaning 2

- Trauma with small t and large T
  - Is there a difference?
  - How many small ts make a large T?
- Now also idea of 'transmissibility'
- Historical trauma, cultural trauma, organisational trauma, vicarious traumatisation
- Adopted by many academic disciplines
- Culture is saturated in trauma (Visser, 2011)
- Trauma is culture specific

Definition – Medical (Rothschild, 1995)

- Stress
  - The nonspecific response of the body to any demand (Selye, 1984: 74)
- Traumatic stress
  - Stress resulting from a traumatic incident
- Post traumatic stress (PTS)
  - Stress that persists following a traumatic incident (Rothschild 1995)
- Post traumatic stress disorder (PTSD)
  - Post traumatic stress meeting the definitions of ICD-10 or DSM-IV (V)

Film clip – Frank Ochberg

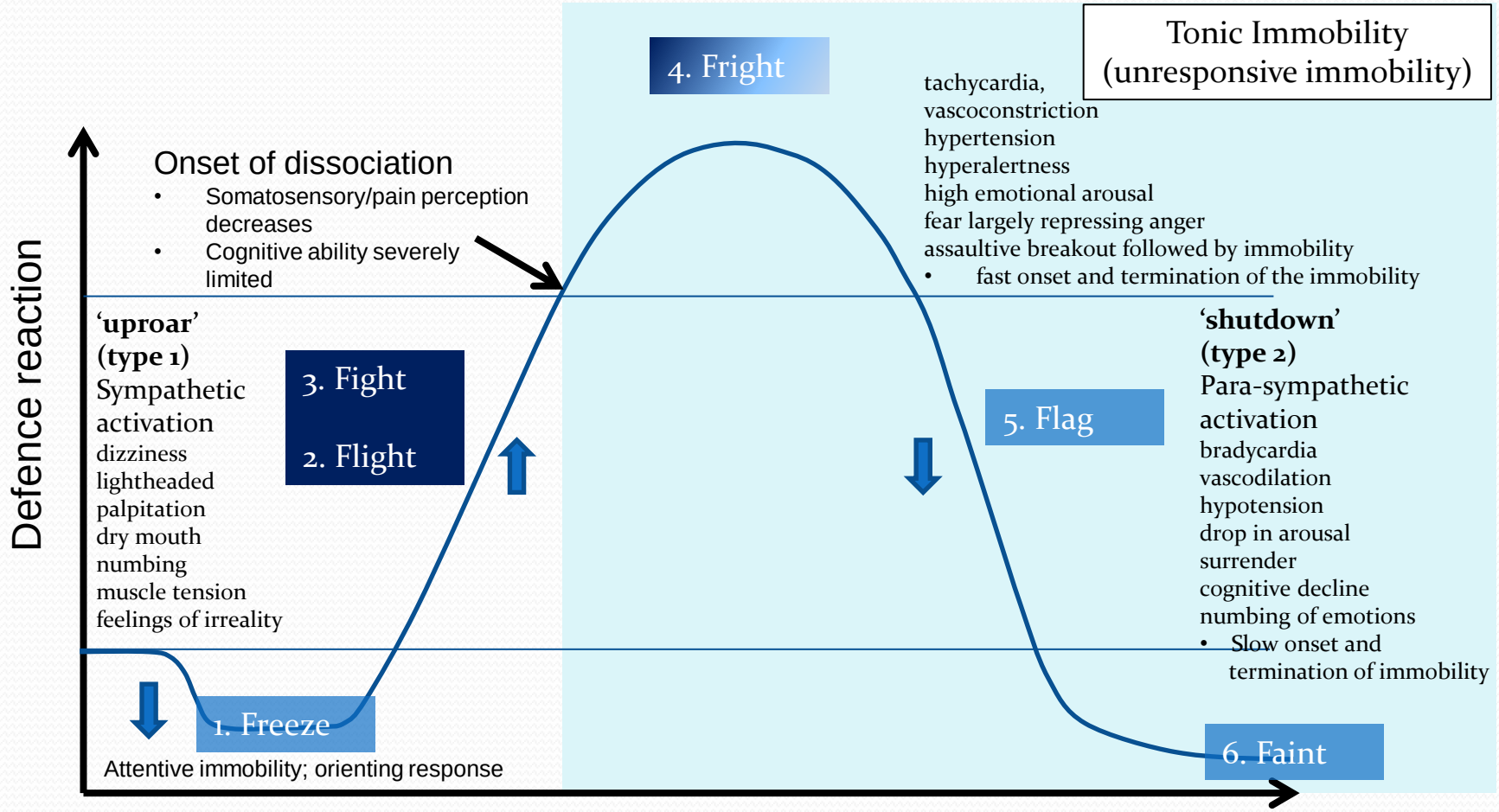
- **Frank Ochberg**, MD (1940-), is an acclaimed psychiatrist, a pioneer in trauma science, an educator and the editor of the first text on the treatment of post-traumatic stress disorder (PTSD). He is one of the founding fathers of modern psychotraumatology and served on the committee that defined PTSD. He is … Clinical Professor of Psychiatry at Michigan State University, where he has also taught in the College of Human Medicine and the Schools of Journalism and Criminal Justice.

- Developed Counting Method

Biological perspective

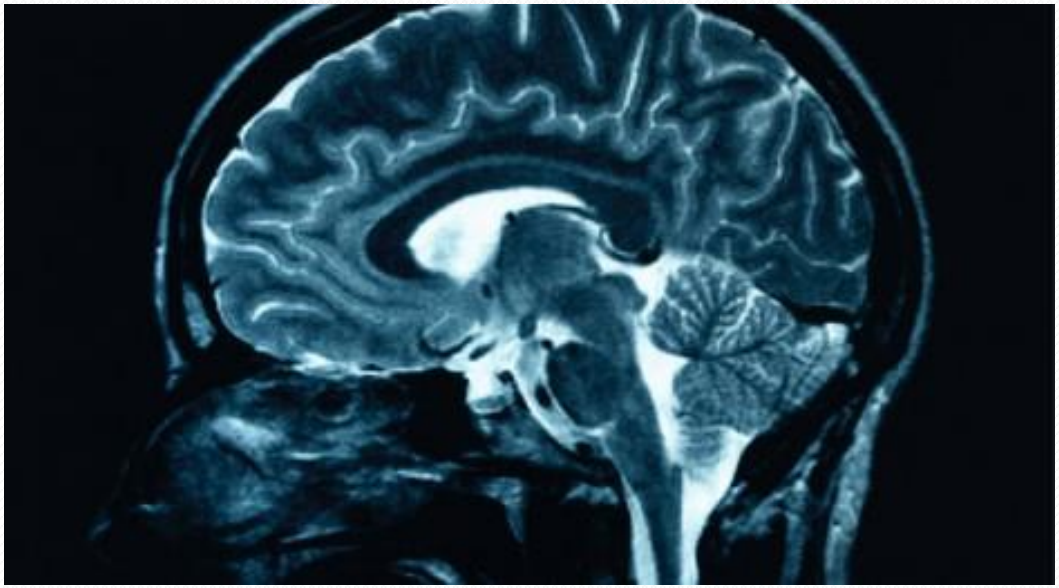
- Observation of the experience of traumatic stress and the longer term after effects
- With the advent of neuroscience and neuroscanning it is possible to look at activity in the human brain
- Sufferers from PTSD have distinctive patterns of brain activity
- They are 'brain affected'
- Right brain activity is reduced

Short term - schematic illustration of the defence cascade



Longer term - neurobiological perspective (Kolassa & Elbert, 2007)

- Hippocampus
- Amygdala
- Medial prefrontal cortex (includes anterior cingulate cortex)



Phenomenological view Flashbacks (Schauer at al., 2011)

- These involuntary intrusions can be triggered by cues that remind people of the traumatic situation. The reliving can include all kinds of sensory information, such as pictures, sounds, smells, and bodily sensations … A feature of flashbacks is that this event is happening again right at that very moment … victims … think they are back in the traumatic situation. The memory of the traumatic event does not seem to be fixed in the context of the time and space in which it actually occurred

PTSD and memory (Schauer at al., 2011) 1

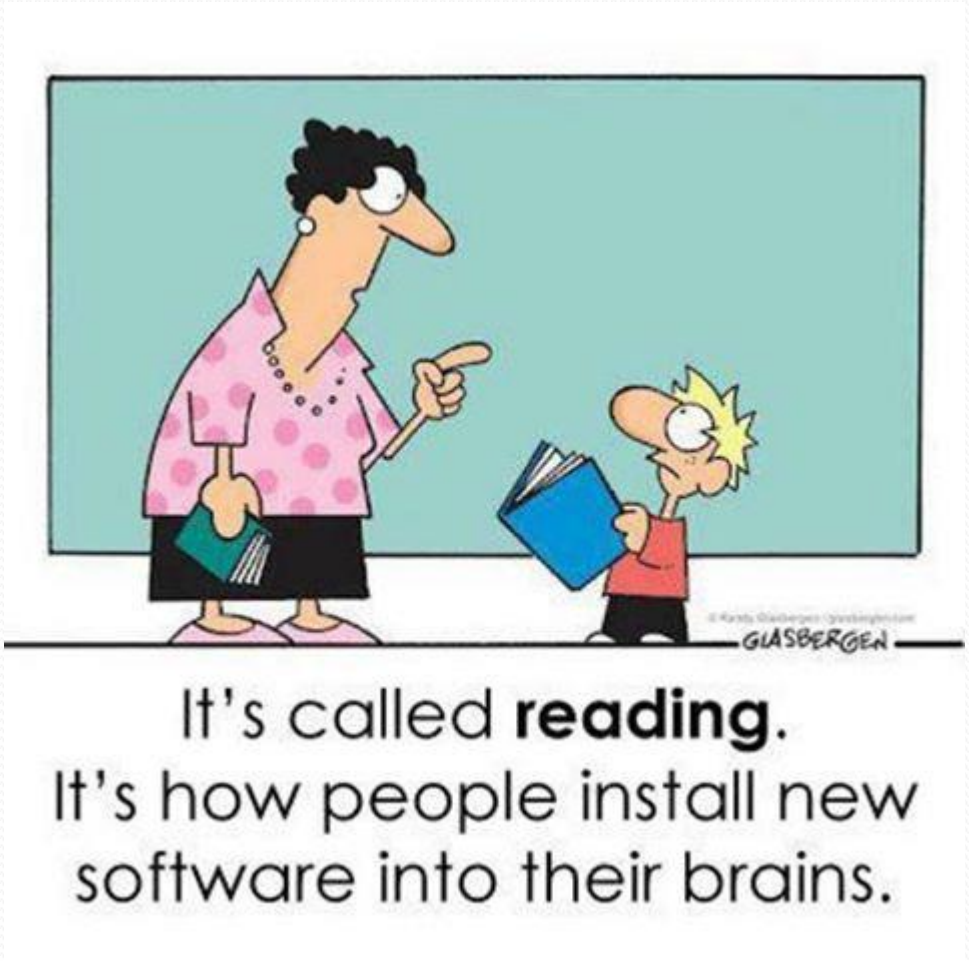
During a traumatic event, mainly sensory and perceptual information (e.g. the sound of a bullet shot or the smell of blood) is stored in memory during a highly emotional state. The mind and body become extremely aroused (rapid heartbeat, sweating and trembling)and are set for actions such as hiding, fighting or running away. This emotional and sensory information is stored in an interconnected neural network which may establish a so-called fear network. This fear/trauma network includes sensory, cognitive, physiological and emotional experience (=hot memory, situationally accessible memory, sensory perceptual representation). Environmental stimuli (e.g. a smell or noise) and internal cues (e.g. a thought) can activate this fear/trauma structure later at any given time .

PTSD and memory (Schauer at al., 2011)2

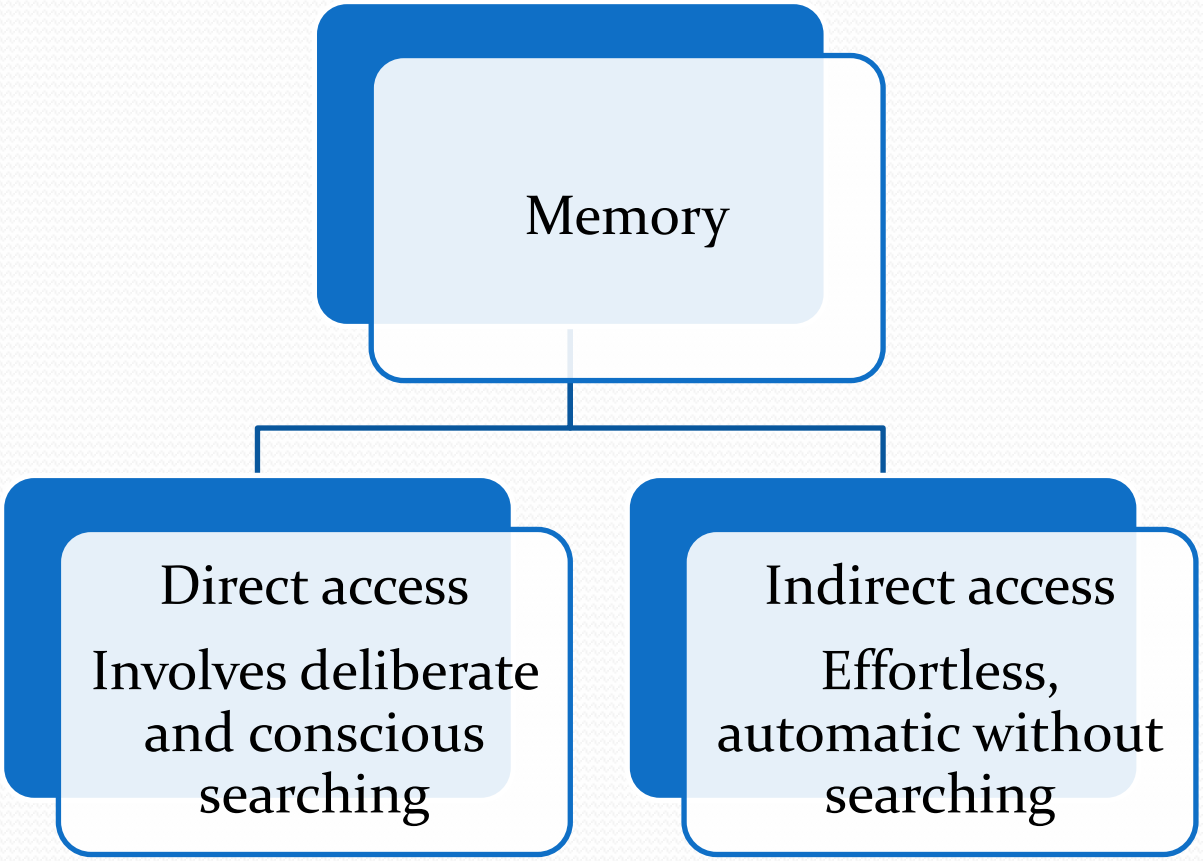
The ignition of only a few elements in the network is sufficient to activate the whole structure. This is thought to be a flashback, i.e. the feeling as if one is back in the traumatic situation with its sounds, smells, feelings of fear, response propositions and thoughts. Since the activation of the fear network is a frightening and painful recollection, many PTSD patients learn to avoid cues that act as reminders of the traumatic event. In contrast to the extensive fear memory, patients who suffer from PTSD have difficulties with autobiographical memory; that is, they are unable to place the fear of the events appropriately in time and space and to clearly position them in a lifetime period. This, and the avoidance of activating the fear /trauma structure, makes it difficult for PTSD patients to narrate their traumatic experience.

Cognitive perspective

PTSD is a malfunction of the memory system



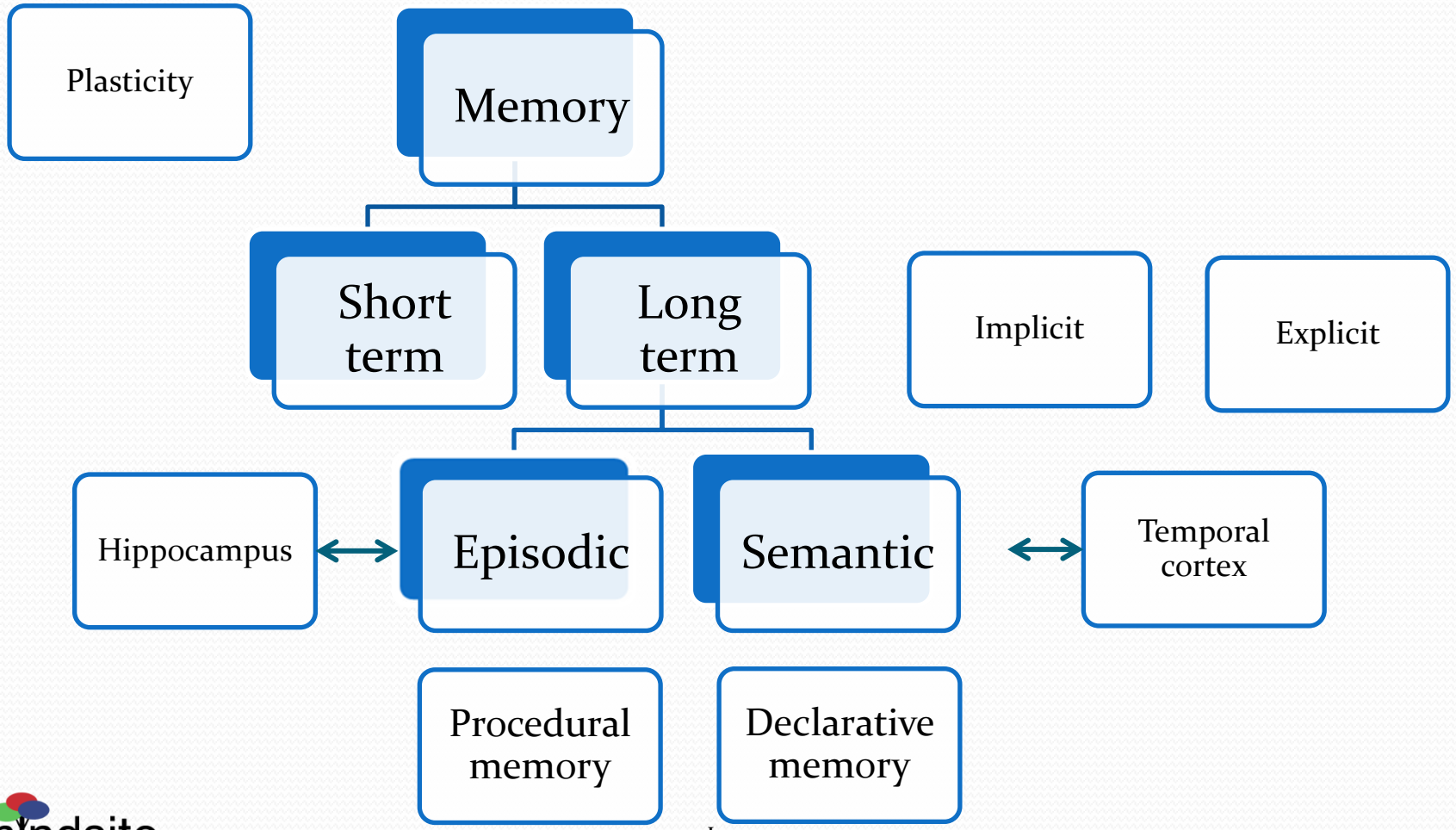
Cognitive perspective - memory



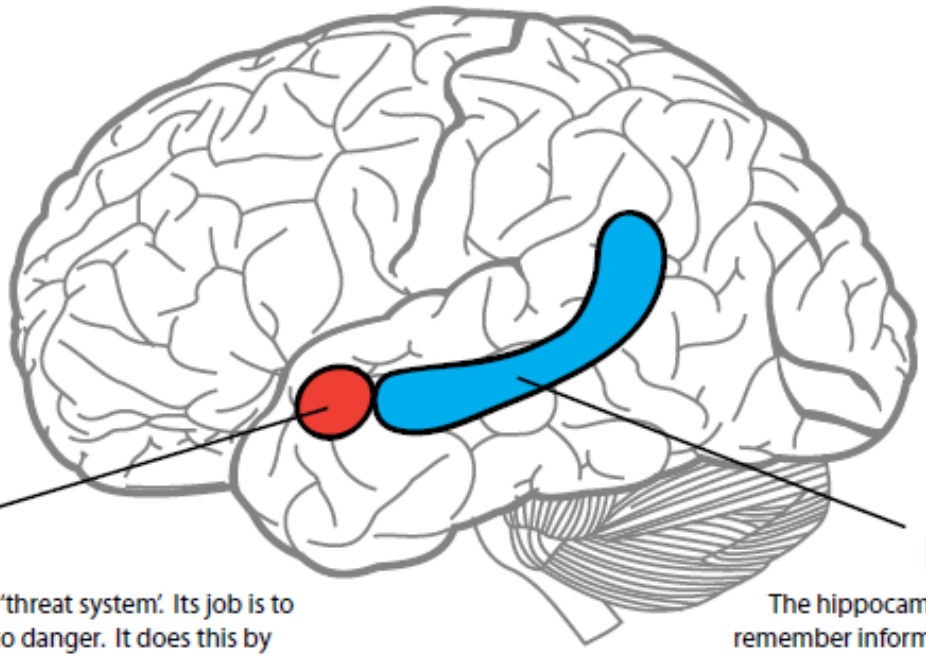
Cognitive perspective - memory

Flashbulb memories

Cognitive perspective - memory



PTSD and memory (cognitive meets neuroscience)



Amygdala

The amygdala is part of our 'threat system'. Its job is to keep us safe by alerting us to danger. It does this by setting off an alarm in our body: by triggering the 'fight or flight' response it gets us ready to act.

Unfortunately it isn't very good at discriminating between real dangers 'out there', or dangers that we are just thinking about: it responds in the same way. This means that it can set the alarm off when we are thinking about an unpleasant memory from the past, even though the danger has passed.

Hippocampus

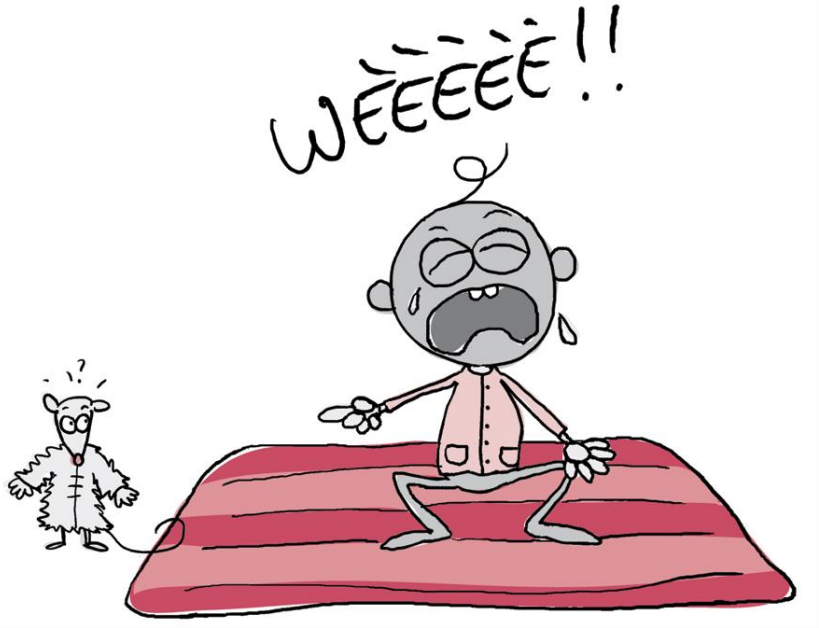
The hippocampus helps us to store and remember information. It is like a librarian, and it 'tags' our memories with information about where and when they occurred.

When our 'threat system' is active the hippocampus doesn't work so well. It can forget to tag the memories with time and place information, which means they sometimes get stored in the wrong place. When we remember them it can feel like they are happening again

minds

Other psychological perspectives

- Behavioural psychology
  - Classical conditioning (Pavlov's dogs, Little Albert)
  - Operant conditioning (Avoidance)
- Evolutionary psychology
  - Natural selection
  - Sexual selection

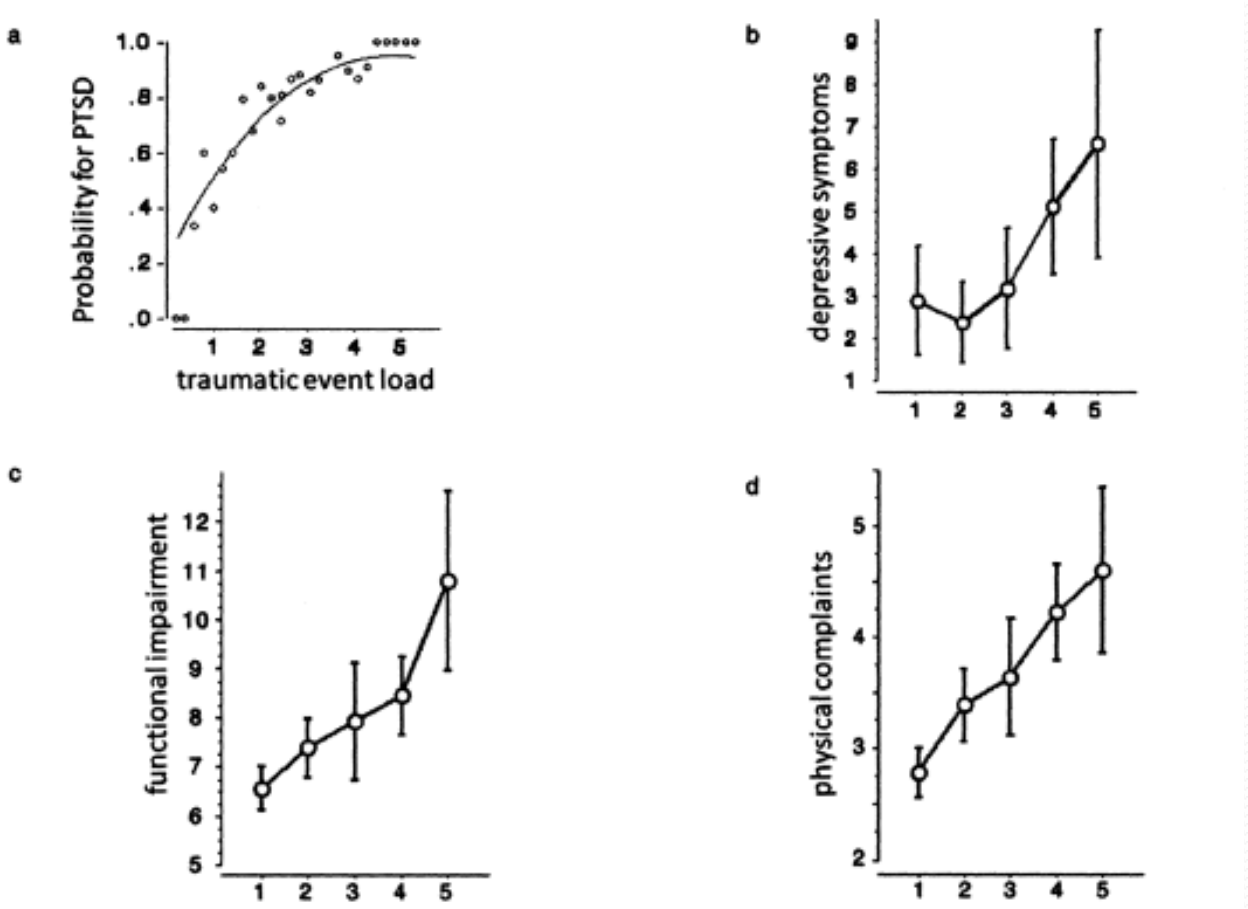


Literary approach of Trauma

- The aporetic current of trauma theory rejects its therapeutic roots(Caruth, 1991, 1996)
- In some respects - literary trauma theory may have got it right.
- 'Afterwardness' (Laplanche, 1999)a deliberately awkward word that foregrounds the odd temporality of an event not understood as traumatic until its return (see Luckhurst, 2004: 8-9)

Medical perspective - probability of developing PTSD

Increases with cumulative experience (Schauer *et al*., 2010)



DSM IV-TR Definition of PTSD (309.81)

- Criterion A
  - The person has been exposed to a traumatic event in which both of the following were present
    1. the person experienced, witnessed or was confronted with an event or events that involved actual, or threatened death or serious injury, or a threat to the physical integrity of self or others
    2. the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganised or agitated behavior

DSM IV-TR Definition of PTSD (309.81)

- Criterion B
  - The traumatic event is persistently reexperienced in one (or more) of the following ways:
    1) recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions. **Note.** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
    2) recurrent distressing dreams of the event. **Note.** In children, there may be frightening dreams without recognizable content.
    3) acting or feeling as if the traumatic event were recurring (including the sense of reliving the experience illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note.** In young children trauma-specific re-enactments may occur

DSM IV-TR Definition of PTSD (309.81)

4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
5) physiological reactivity to exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

DSM IV-TR Definition of PTSD (309.81)

- Criterion C
  - Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
    1. efforts to avoid thoughts, feelings, or conversations associated with thee trauma
    2. efforts to avoid activities, places or people that arouse recollections of the trauma
    3. inability to recall an important aspect of the trauma
    4. markedly diminishing interest or participation in significant activities

DSM IV-TR Definition of PTSD (309.81)

5. Feelings of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loved feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

DSM IV-TR Definition of PTSD (309.81)

- Criterion D
  - Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
    1. difficulty falling or stating asleep
    2. irritability or outbursts of anger
    3. Difficulty concentrating
    4. Hypervigilance
    5. Exaggerated startle response

DSM IV-TR Definition of PTSD (309.81)

- Criterion E
  - Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month
- Criterion F
  - The disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

DSM-V (published May 2013)

- DSM-V extends scope of definition of PTSD and acute stress disorder – sexual assault is specifically included, as is a recurring exposure that could apply to police officers or first responders; criterion A2 deleted; 4 clusters of symptoms (re-experiencing, heightened arousal, avoidance, negative thoughts and mood or feelings); specific criteria for pre-school children; lowered diagnostic thresholds for children; dissociative sub-type introduced.

DSM 5 changes criteria but ignores psychological abuse

- DSM 5 identifies the trigger to PTSD as **exposure to actual or threatened death, serious injury or sexual violation**. The exposure must result from one or more of the following scenarios, in which the individual:
  • directly experiences the traumatic event;
  • witnesses the traumatic event in person;
  • learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
  • experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).
- The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. It is not the physiological result of another medical condition, medication, drugs or alcohol.

How do we work with trauma?

- Medical approach – NICE Clinical Guideline 26
- Person-Centred
- Psychodyanamic Approach
- Other approaches
- Link into afternoon

NICE Clinical Guideline Number 26

- Based on ICD-10 but refers to DSM-IV TR which distinguishes 'acute stress disorder' from PTSD
- Excludes 'enduring personality changes after catastrophic experience' (ICD-10 code F62.0)
- Restricted to people who have experienced exceptionally threatening and distressing events – excludes divorce, loss of a job or failing an examination. In these cases, a diagnosis of adjustment disorder may be considered.

NICE CG 26

- PTSD can develop in people of any age following a stressful event or situation of an exceptionally threatening or catastrophic nature.
- PTSD does not usually develop following generally upsetting situations such as divorce, loss of job, or failing an exam.
- Effective treatment of PTSD can only take place if the disorder is recognised. In some cases, for example following a major disaster, specific arrangements to screen people at risk may be considered.
- For the vast majority of people with PTSD, opportunities for recognition and identification come as part of routine healthcare interventions, such as treatment following an assault or accident, or when domestic violence or childhood sexual abuse is disclosed.
- Symptoms often develop immediately after the traumatic event but the onset of symptoms may be delayed in some people (less than 15%).
- PTSD is treatable even when problems present many years after the traumatic event.
- Identification of PTSD in children presents particular problems, but is improved if children are asked directly about their experiences.
- Assessment can present significant challenges as many people avoid talking about their problems.

NICE CG 26

- **Recognition in primary care and general hospital settings**
- Symptoms typically associated with PTSD are as follows:
  - **re-experiencing** – flashbacks, nightmares, repetitive and distressing intrusive images or sensory impressions; in children, these symptoms may include: reenacting the experience, repetitive play or frightening dreams without recognisable content
  - **avoidance** – avoiding people, situations or circumstances resembling or associated with the event
  - **hyperarousal** – hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating
  - **emotional numbing** – lack of ability to experience feelings, feeling detached from other people, giving up previously significant activities, amnesia for significant parts of the event
  - **depression**
  - **drug or alcohol misuse**
  - **anger**
  - **unexplained physical symptoms (resulting in repeated attendance).**

NICE CG 26

- If it is not immediately clear that symptoms relate to a specific traumatic event:
  - ask patients if they have experienced a traumatic event and give examples (such as assault, rape, road traffic accidents, childhood sexual abuse and traumatic childbirth)
  - consider asking adults specifically about re-experiencing (including flashbacks and nightmares) or hyperarousal (including exaggerated startle response or sleep disturbance).

NICE CG 26

Screening

- **Screening after a major disaster**
  - Those coordinating the disaster plan should consider using a brief screening instrument for PTSD 1 month after the event for individuals at high risk of developing PTSD following a major disaster.
- **Screening refugees and asylum seekers**
  - Those managing refugee programmes should consider using a brief screening instrument for PTSD for:
    - programme refugees (people who are brought to the UK from a conflict zone through a programme organised by an agency such as the United Nations High Commission for Refugees) and
    - asylum seekers at high risk of developing PTSD.
  - This should be part of the initial refugee healthcare assessment and of any comprehensive physical and mental health screen.

NICE CG 26

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NICE CG 26

Assessment and coordination of care

- GPs should take responsibility for initial assessment and coordination of care of PTSD sufferers in primary care and determine the need for emergency medical or psychiatric assessment.
- Ensure that assessment is comprehensive and includes a risk assessment and assessment of physical, psychological and social needs, and is conducted by a competent individual.
- Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment.
- If management is shared between primary and secondary care, establish a written agreement outlining the responsibilities for monitoring individuals. Where appropriate, use the Care Programme Approach (CPA) and share with
- the sufferer, their family and carers.

NICE CG 26

Support to families and carers

- Consider and, when appropriate, assess the impact of the traumatic event on all family members and consider providing appropriate support.
- With the consent of the PTSD sufferer where appropriate, inform their family about common reactions to traumatic events, the symptoms of PTSD, and its course and treatment.
- Inform families and carers about self-help and support groups and encourage them to participate.
- Effectively coordinate the treatment of all family members if more than one family member has PTSD.

NICE CG 26

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NICE CG 26

Language and culture

- Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers.
- Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions.
- Pay particular attention to the identification of individuals with PTSD where the culture of the working or living environment is resistant to recognition of the psychological consequences of trauma.

NICE CG 26

Care across all conditions

- When developing and agreeing a treatment plan, ensure individuals receive information about common reactions to traumatic events, the symptoms of PTSD, and its course and treatment.
- Do not withhold or delay treatment because of court proceedings or applications for compensation.
- Respond appropriately if a PTSD sufferer is anxious about and may avoid treatment (e.g. by following up those who miss scheduled appointments).
- Keep technical language to a minimum and treat patients with respect, trust and understanding.
- Only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed.
- Ensure that treatment is delivered by competent individuals who have received appropriate training.

NICE CG 26

Comorbidities

- **Depression**
  - Consider treating the PTSD first unless the depression is so severe that it makes psychological treatment very difficult, in which case treat the depression first.
- **High risk of suicide or at risk of harming others**
  - Concentrate first on the management of this risk in PTSD sufferers.
- **Drug or alcohol problem**
  - Treat any significant drug or alcohol problem before treating the PTSD. **1C**
- **Personality disorder**
  - For PTSD sufferers with personality disorder, consider extending the duration of trauma-focused psychological interventions.
- **Death of a close friend or relative**
  - For patients who have lost a close friend or relative due to an unnatural or sudden death, assess for PTSD and traumatic grief and consider treating the PTSD first (without avoiding discussion of the grief)

NICE CG 26 - Treatment of PTSD

Early interventions

- ***Watchful waiting***
  - Consider watchful waiting when symptoms are mild and have been present for less than 4 weeks after the trauma.
  - Arrange a follow-up contact within 1 month.
- ***Immediate psychological interventions for all***
  - Be aware of the psychological impact of traumatic events in the immediate post-incident care of survivors and offer practical, social and emotional
  - support.
  - For individuals who have experienced a traumatic event, **do not** routinely offer brief, single-session interventions (debriefing) that focus on the traumatic incident to that individual alone.

NICE CG 26 – Early Interventions

Interventions where symptoms are present within 3 months of a trauma

- Offer trauma-focused CBT (usually on an individual outpatient basis) to people:
  - with severe post-traumatic symptoms or with severe PTSD within 1 month after the event
  - who present with PTSD within 3 months of the event.
- Consider offering 8–12 sessions of trauma-focused CBT (or fewer sessions – about 5 – if the treatment starts in the first month after the event). When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary.
- Ensure that psychological treatment is regular and continuous (usually at least once a week) and is delivered by the same person.
- Consider the following drug treatment for sleep disturbance:
  - hypnotic medication for short-term use
  - a suitable antidepressant for longer-term use, introduced at an early stage to reduce later risk of dependence.
- Do not routinely offer non-trauma-focused interventions (such as relaxation or non-directive therapy) that do not address traumatic memories.

NICE CG 26 – Early Interventions

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- support.
- For individuals who have experienced a traumatic event, **do not** routinely offer brief, single-session interventions (debriefing) that focus on the traumatic incident to that individual alone.

NICE CG 26 – Interventions where symptoms > 3 months after

- Offer trauma-focused psychological treatment (trauma-focused CBT or EMDR) to all patients, usually on an individual outpatient basis.
- Consider offering 8–12 sessions of trauma-focused psychological treatment when the PTSD results from a single event. When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary.
- Ensure that trauma-focused psychological treatment is:
  - offered regardless of the time elapsed since the trauma.
  - regular and continuous (usually at least once a week
  - delivered by the same person.
- Consider extending trauma-focused psychological treatment beyond 12sessions and integrating it into an overall care plan if several problems need to be addressed, particularly:
  - after multiple traumatic events
  - after traumatic bereavement
  - where chronic disability results from the trauma
  - when significant comorbid disorders or social problems are present

NICE CG 26 – Interventions where symptoms > 3 months after

- If the individual finds it difficult to disclose details of the trauma(s), consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the trauma.
- Do not routinely offer non-trauma-focused interventions (such as relaxation or non-directive therapy) that do not address traumatic memories.
- For PTSD sufferers with no or limited improvement after a specific trauma-focused psychological treatment, consider:
  - an alternative form of trauma-focused psychological treatment
  - pharmacological treatment in addition to trauma-focused psychological treatment.
- If PTSD sufferers request other forms of psychological treatment (e.g. supportive therapy, non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), inform them that there is no convincing evidence for a clinically important effect.

NICE approved psychological treatment for PTSD

- Trauma focused-CBT
- Eye movement desensitization and reprocessing (EMDR) (Shapiro and Forrest, 2004)

Medication for PTSD

- NICE recommends paroxetine (SSRI)or mitrazapine (NaSSA), but only if trauma-focused CBT rejected; cannot be started due to risk of further trauma; not worked in past; or severe depression or hypersensitivity affect ability to benefit from psychological treatment
- Amitriptyline (TCA) or phenelzine (MAOI) under the supervision of a mental health specialist

How do we work with trauma?

- Person –Centred Approach
- Cognitive Behavioural / Narrative
  - Trauma Focussed CBT (TF-CBT)
  - Narrative Exposure Therapy
- Psychodynamic
- Other techniques
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Counting Method (Ochberg)

Person-centred approach (Turner, 2012)

If significant events are significantly beyond our expectations then we have difficulty in symbolising them in awareness. A traumatic event contains elements that are likely to be so far beyond our previous experience that we initially find it difficult to incorporate the new experience into our self-concept. We and the world are not as we have assumed and we no longer know how to cope. Also the environment that we thought that we understood and could predict has turned out to be unpredictable. This sets up anxiety – sometimes of an extreme nature. In terms of person-centred theory, anxiety is one of the consequences of incongruence.

Person-centred approach (Turner, 2012)

Whereas in terms of person-centred theory, incongruence is usually seen as a consequence of conditions of worth, the imporrtant aspect of incongruence in critical incident responding is in relation to inaccurate or reluctant, symbolisation, not conditions of worth. Colleagues suggest that the 'conditions of worth' argument still applies – it is those who have been previously damaged by external conditions of worth who have greatest difficulty in symbolising the new information but I do not see this correlation in the people with whom I work. It seems to me that it is the train crash or a gunman, and so on, which has caused the disturbance not conditions of worth.

Cognitive approach to treating trauma (Foa, 1997)

- Emotional engagement (i.e. feeling the feelings)
- Constructing a coherent narrative
- Altering perniciously negative views of the self and the world – including inadequacy (and sheer badness) of the self along with the dangerousness of other people

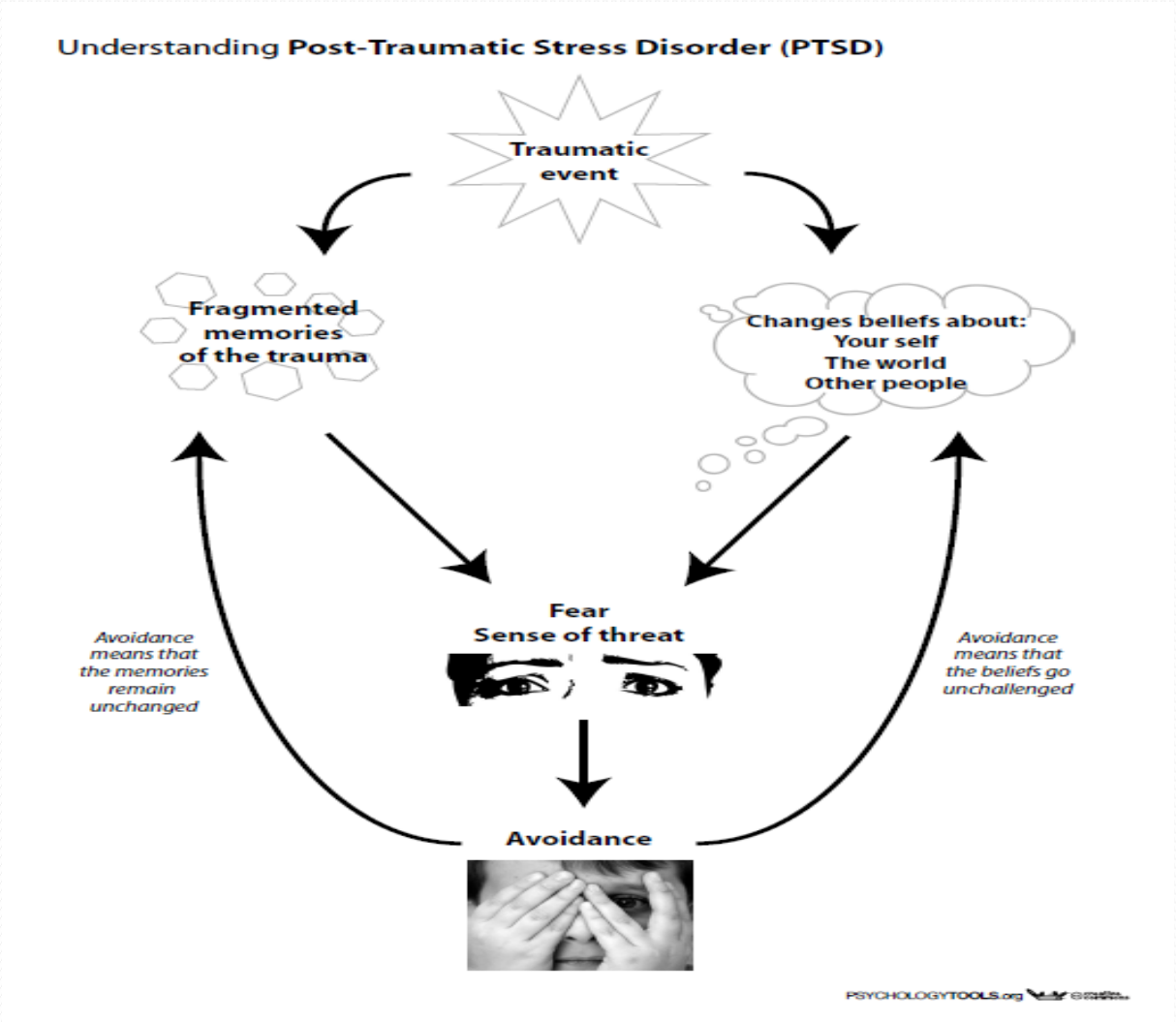
Complex PTSD

- Until today … there is no settled diagnostic category for the type of continuous interpersonal trauma that goes along with continuous shutdown reaction
(Schauer & Elbert ,2010)
- Herman (1992) suggests classification:
  - Type I traumatic events lead to psychological consequences after a single exposure
  - Type II events happen repeatedly over an extended period e.g. survivors of torture; childhood sexual abuse; prisoner-of-war camps – may lead to enduring personality changes (ICD-10 F62.0) oherwise called disorders of extreme stress.

PTSD and memory

- Survivors can begin their recovery only when the truth is finally acknowledged. But "secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom" (Herman, 1992)

A cognitive-behavioural understanding of PTSD



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Useful diagnostic instruments for PTSD

- CIDI – Composite International Diagnostic Interview (section M, interview & diagnosis according to DSM-4 and ICD-10; developed by WHO)(WHO, 1997).
- CAPS – Clinician Administered PTSD Scale (interview & diagnosis according to DSM-4; also measures severity and intensity); currently the gold standard.
- SCID – Structured Clinical Interview for Mental Health (PTSD interview and diagnosis according to DSM-4)
- PDS – Post-Traumatic Stress Diagnostic Scale (self-report measure filled out by the patient; measures the frequency and occurrence of PTSD symptoms; can be applied in interview form [PSS]). (Foa, 1995)
- UCLA PTSD Index for DSM-4 (self-report or interview; child, adolescent, and parent versions; measures frequency and occurrence of PTSD symptoms; diagnosis according to DSM-4).

The linen cupboard metaphor

Treatment of Post Traumatic Stress Disorder (PTSD) **The Linen Cupboard Metaphor**

Memories in PTSD are a bit like items stuffed in a messy linen cupboard. Whenever you brush past the cupboard the door flies open and items fall out: In other words, whenever you come across a reminder of the trauma you have flashbacks or intrusive memories, and feel intense fear. A typical response is to try to stuff things back in the cupboard, and to close the door as quickly as possible. But this just keeps the problem going: memories are jammed in the cupboard, and the door will still swing open at the lightest touch.

Treatment for PTSD involves

- slowly taking things out of the cupboard
- examining them carefully
- folding them neatly
- putting them back in the right place

In this way, memories of the traumatic event find their proper place: you can find them if you choose to, but they won't come back so often when you don't want them to.

mindsit

Trauma focused CBT

- Originally developed for the treatment of children and adolescents
- Law enforcement, medical examinations, safety needs
- Needs of mental health care, enhancing caregivers motivation, reviewing prior therapy experiences, establishing collaborative working relationship, providing assistance in overcoming concrete barriers
- Focus on therapeutic engagement of families
- Commitment to attendance (contract)
- Gradual exposure based on classical conditioning theory and observational learning
- Graduating therapy

Core values of TF-CBT (Cohen *et al*., 2012)

- **C**omponent based
- **R**espectful of individual, family, community, culture, religious practices
- **A**daptable
- **F**amily focused
- **T**herapeutic relationship centered
- **S**elf –efficacy focused

Assessment strategies (Cohen *et al*., 2012)

- **C**ognitive problems
- **R**elationship problems
- **A**ffective problems
- **F**amily problems
- **T**raumatic behavior
- **S**omatic problems

Structure and treatment components (Cohen *et al*., 2012)

- **P**sychoeducation and **P**arenting
- **R**elaxation
- **A**ffective expression and modulation
- **C**ognitive coping
- **T**rauma narrative development and processing
- **I***n vivo* exposure
- **C**onjoint parent-child sessions
- **E**nhancing safety and future development
- Grief focused components

Narrative Exposure Therapy (NET)

Raw experience + meaning = narrative

(Holmes, 1999)

Narrative Exposure Therapy (NET)

Session 1: Diagnosis and psychoeducation

Session 2: Lifeline

Session 3: Start of the narration beginning at birth and continuing through to the first traumatic event

Session 4 and subsequent sessions: Rereading of the narrative collected in previous sessions. Continuing the narration of subsequent life and traumatic events.

Final session: Re-reading and signing of the whole document

Basic elements of NET (Schauer at al, 2011)

A. Construction of a consistent narrative of the patient's biography.
B. The therapist supports the mental reliving of the events that the patient will go through and the emotional processing that goes along with this. The therapist assists the patient in creating a chronological structure of the initial fragments, emphasizing the time and place, and the traumatic experiences that happened. The therapist assumes an empathic and accepting stance.
C. The therapist writes down the survivor's testimony. In a subsequent session, the material is read to the patient, who is then asked to correct it or add missing details. The procedure is repeated across sessions until a final version of the patient's biography that includes all essential traumatic experiences is reached.
D. In the last session, the survivor, the translator, and the therapist sign the written testimony.
E. The survivor keeps the narrative of his life story. As an eyewitness report, it may serve as documentary evidence for human rights violations or for legal purposes.

Psychodynamic approaches to working with trauma

- Revisit what is trauma?

Freud and trauma

- Studies on hysteria (Breuer and Freud, 1893-1895)
- 1897 rejects traumatogenic theory of neurosis (Sandler *et al*., 1991) – Trauma becomes defined as a painful remembering of an event, which in itself need not be painful (Visser, 2011). Trauma is experienced in another place and time from that in which it originated.
- Beyond the pleasure principle (1920)
- Moses and monotheism (1939)

Modern Psychoanalytic view of trauma Winnicott, Stolorow, Khan

- Pain is not pathology.
- Is there any such thing as adult traumatization – or is it always retraumatization.
- Relational trauma in childhood influences development of brain esp. limbic system and right brain – links to attachment theory (Schore, 2010)
- For Khan environmental failure in any form constituted "trauma" for an infant or a child right up to the age of adolescence (Cooper, 1993)
- A clue to the true nature of trauma lies in the isolation, alienation and aloneness that accompany it. In the belief that the horizons of others can never encompass those of the traumatised.

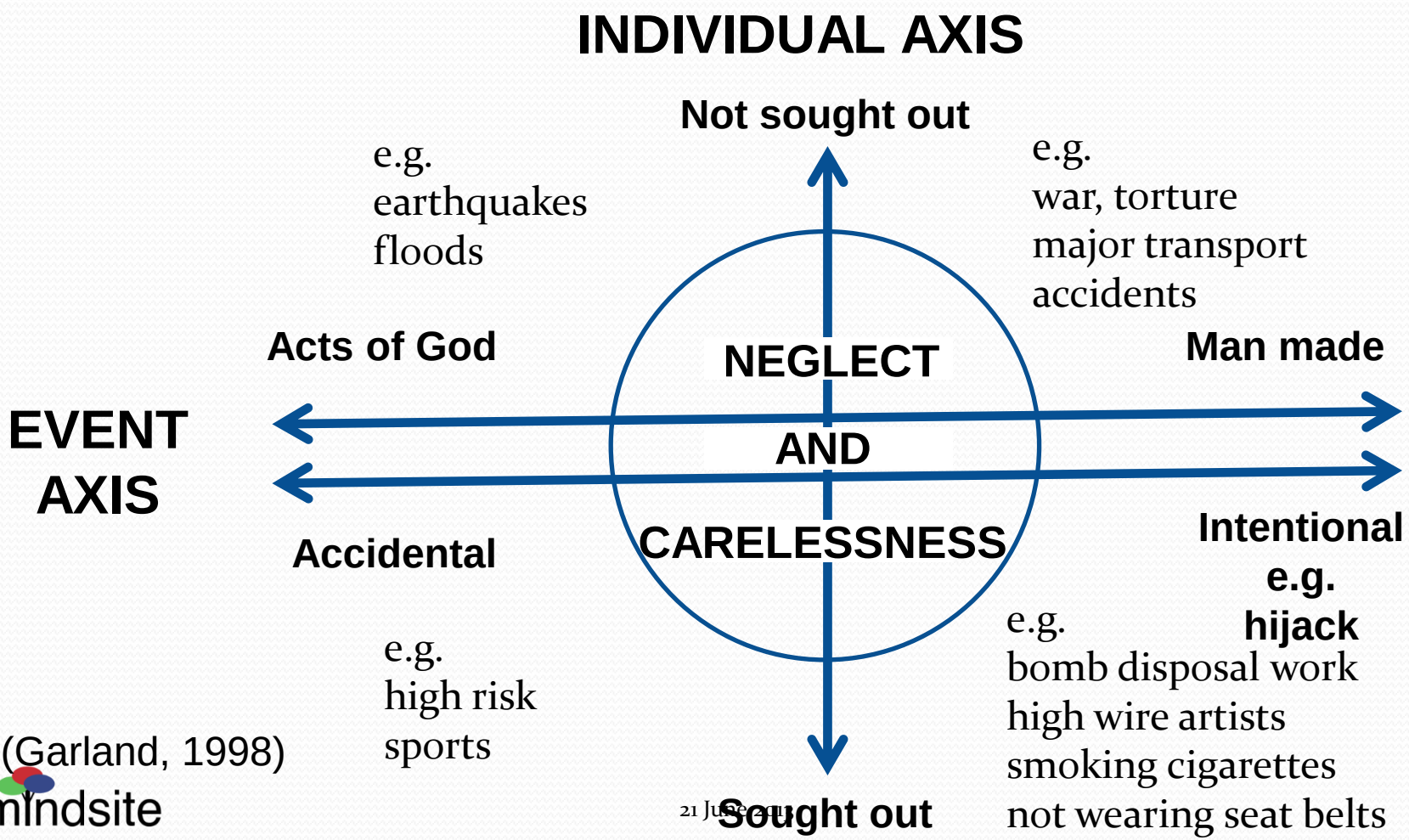
Modern psychoanalytic view of trauma

- Robert Stolorow starts with the concept of *Befindlichkeit* developed by Heidegger. "Psychological conflict develops when central affect states of the child cannot be integrated because they evoke massive or consistent malattunement from caregivers" (Stolorow, 2007: 3)
- The dichotomy between insight through interpretation and affective bonding with the analyst is revealed to be a false one when once we recognize the insights that the therapeutic impact of analytic interpretations lies not only in the insights they convey but also in the extent to which they demonstrate the analyst's attunement to the patient's affective life (Stolorow, 2007: 5)

Each new trauma brings back every previous trauma

Primo Levi said in a telephone conversation to Raabi Elio Toaff "I can't go on with my life. My mother is ill with cancer and every time I look at her face I remember the faces of those men stretched on the benches at Auschwitz" (Gambetta 1999, as cited in Schauer *at al*, 2011).

Classification of traumatic events



(Garland, 1998)

Trauma and mentalization

- Functional deficits in mentalization, particularly those resulting from psychological trauma illuminate severe character disturbance (Fonaghy, 1991, 1995; Fonaghy and Target , 1997; Target and Fonaghy, 1996)
- Relates to attachment theory

Other approaches

- Eye movement desensitization and reprocessing (EMDR)
- Counting method (Ochberg)

EMDR

- Short term treatment
- Avoids need for therapist to explicitly enter the trauma
- Creating safe place
- Client moving into some aspect of trauma
- ‘Clicking it in’
- Response from client

The counting method

- Only one small part of a long term therapy
- Prepare client
- Develop relationship
- Use selective medication
- Appropriate when considerable progress has been made but intrusive recollections remain
- Focus on single, specific episode
- Process
  - Setting stage
  - Counting
  - Telling trauma story
  - Reflection and closure

Link into afternoon

- Everyone is different and every experience of trauma is unique
- Each individual needs to be worked with in a different way
- History of trauma is relevent
- Previous history of client is relevent
- Highest priority to avoid doing further damage
- For some, the pursuit of the details of traumatic events may be appropriate – at some point, as part of longer term work
- However, if trauma is a disorder of the memory system – to what extent is remembering possible
- For most, less direct approaches are necessary and other techniques can be employed in shorter term work