Trauma in counselling and psychotherapy

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mindsite

Program

What is trauma?

How do WE work with trauma?

Multiple perspectives in understanding of trauma

What is trauma?

- Definitions
- Biological perspective
- Cognitive perspective
- Other psychological perspectives
- Medical perspective DSM-5, 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.

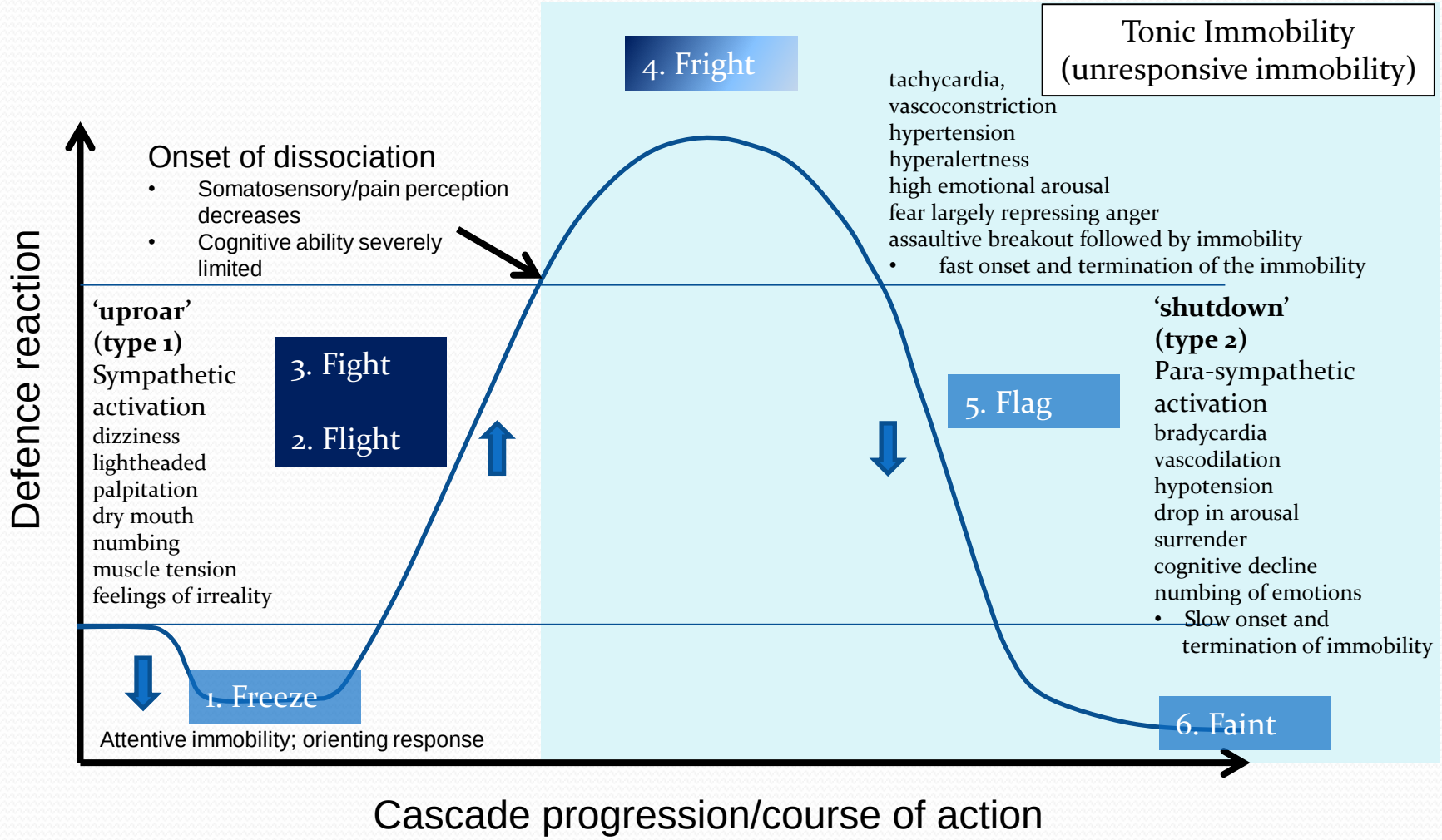
  (Wikipedia)

- Developed Counting Method

Biological perspective

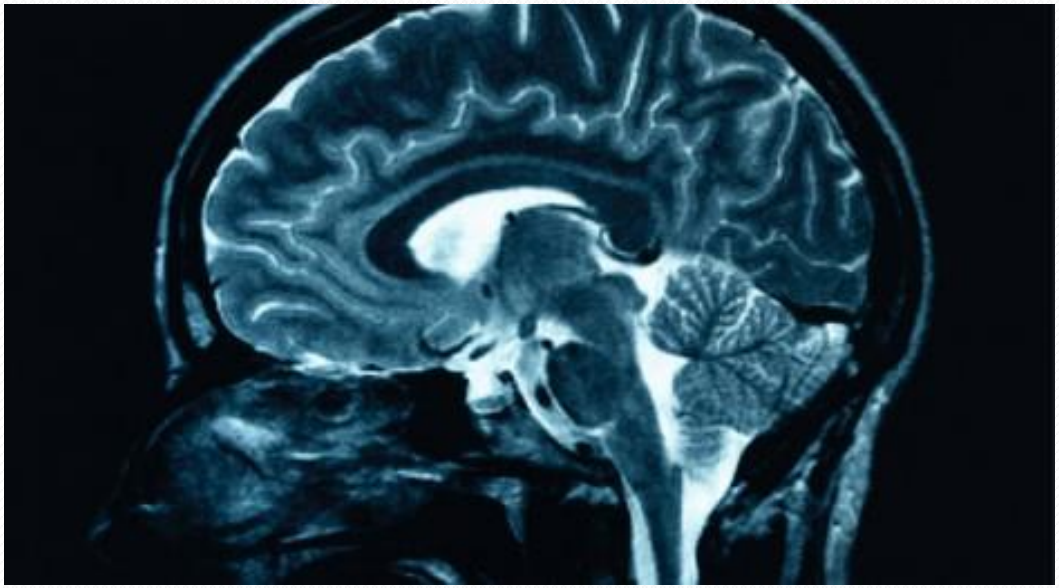
- Observation of the experience of traumatic stress and the longer term after effects
- With the advent of neuroscience and neuroscanning it is possible to look at activity in the human brain
- Sufferers from PTSD have distinctive patterns of brain activity
- They are ‘brain affected’
- Right brain activity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

Short term - schematic illustration of the defence cascade (6 Fs)



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

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

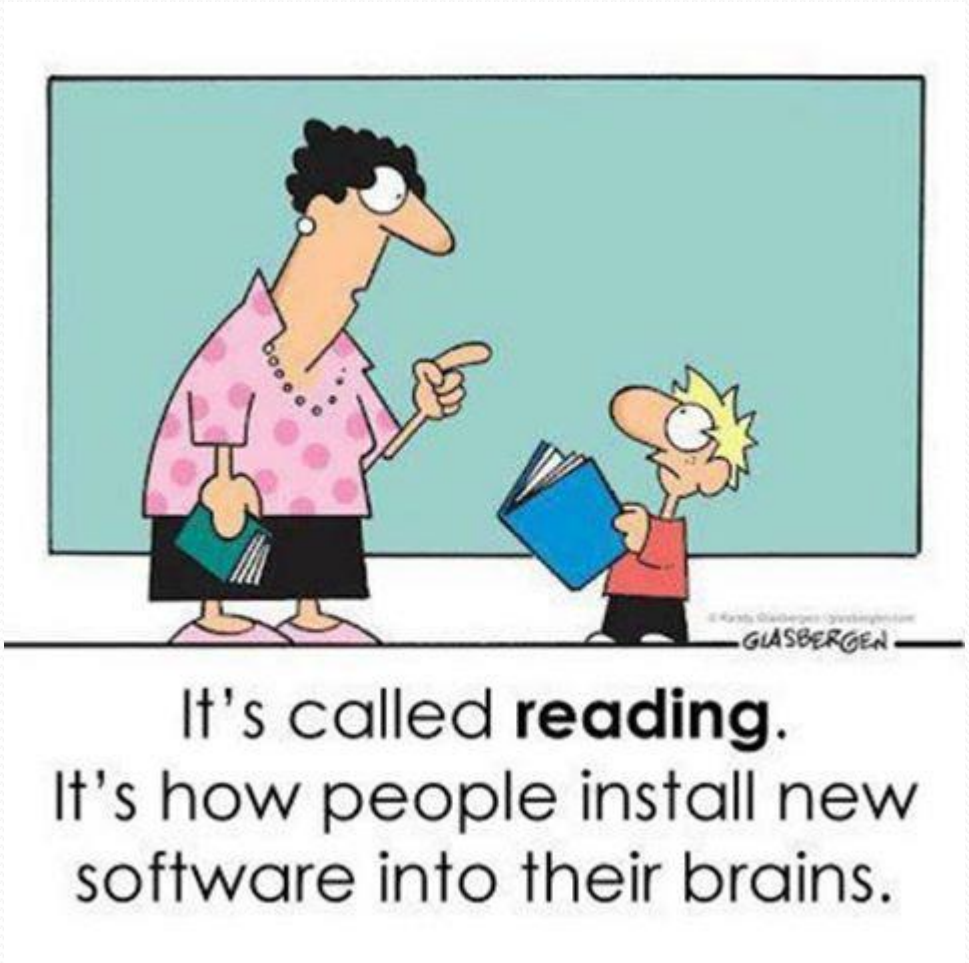


Flashbacks (Schauer at al., 2011)

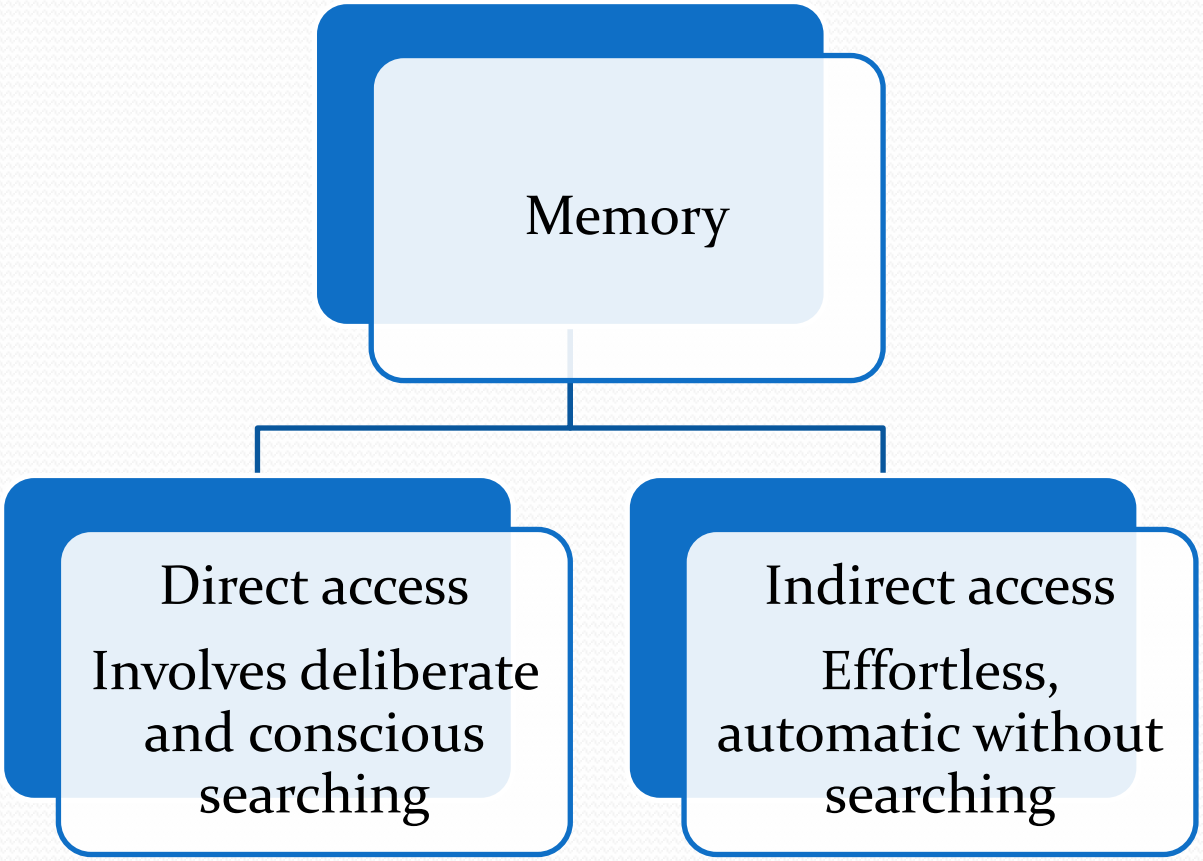
- These involuntary intrusions can be triggered by cues that remind people of the traumatic situation. The reliving can include all kinds of sensory information, such as pictures, sounds, smells, and bodily sensations … A feature of flashbacks is that this event is happening again right at that very 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

Cognitive perspective

PTSD is a malfunction of the memory system



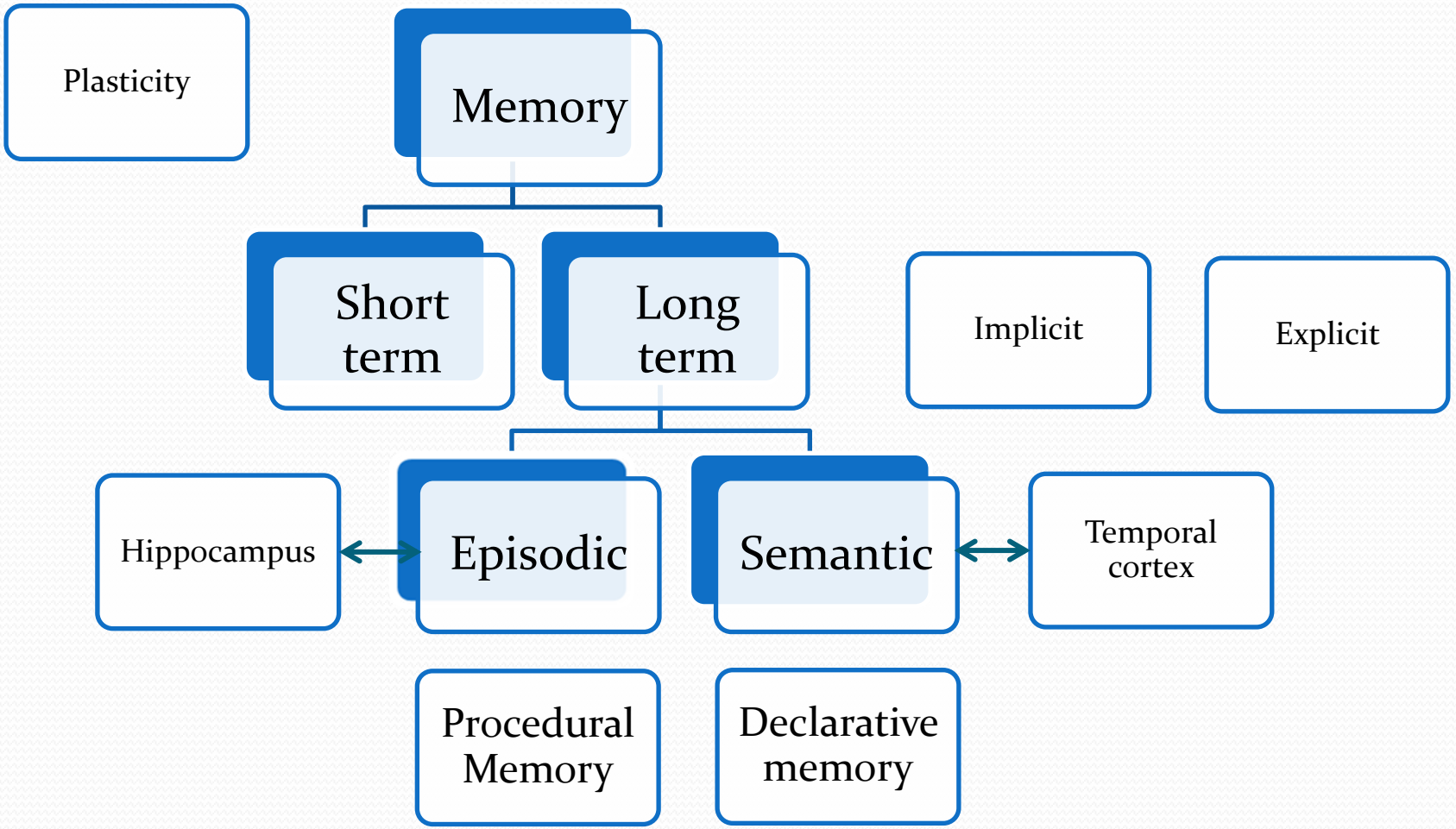
Cognitive perspective - memory



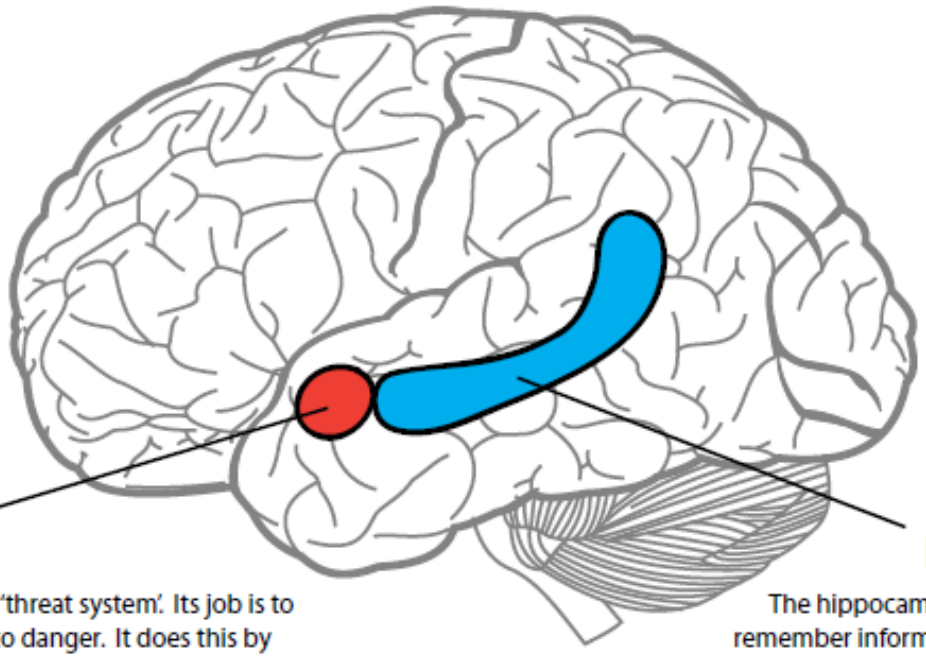
Cognitive perspective - memory

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

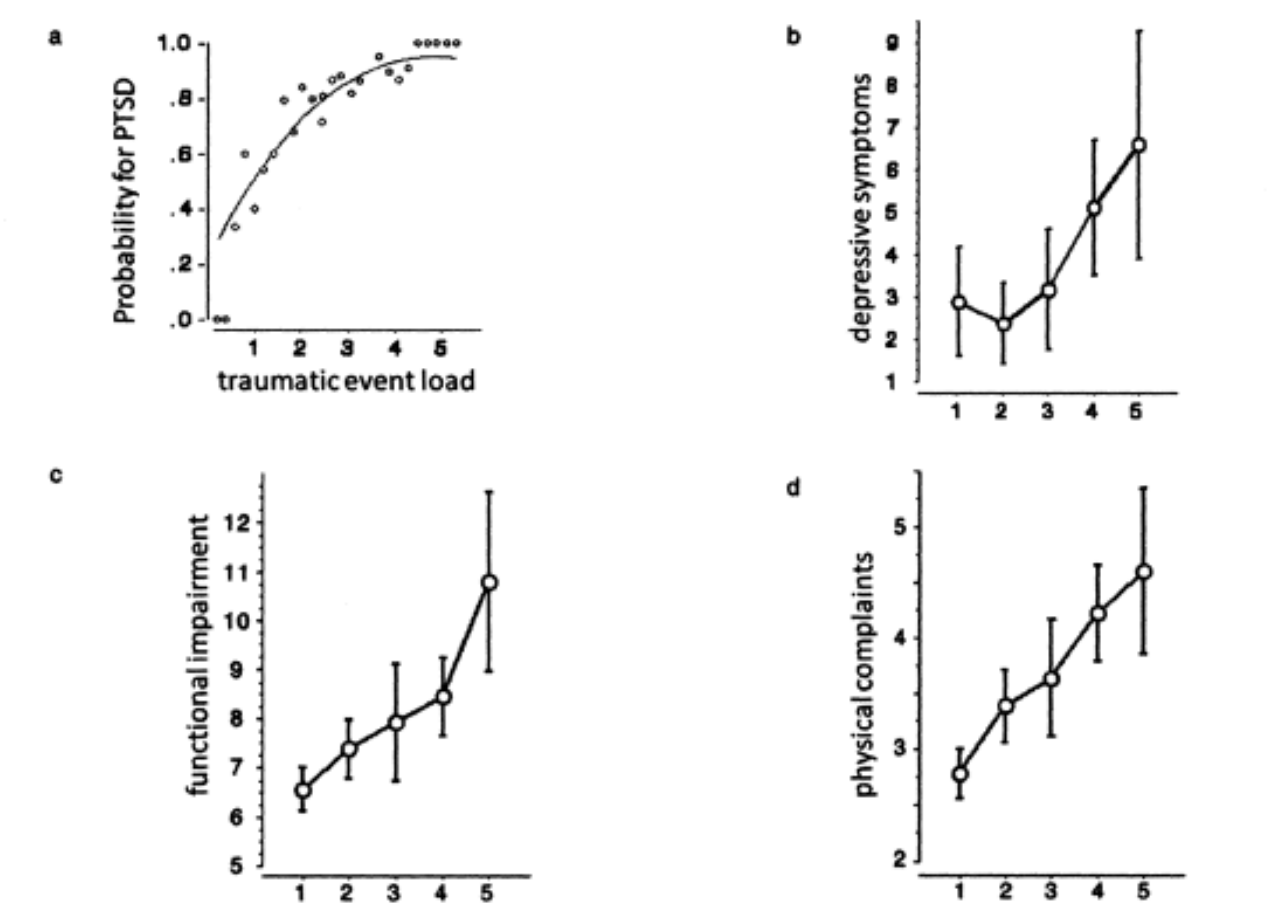
Other psychological perspectives

- 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 - perhaps literary trauma theory has 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 of traumatic events (Schauer *et al*., 2010)

DSM-5 (published May 2013)

- DSM-5 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 approved psychological treatment for PTSD

- Trauma focused-CBT
- Eye movement desensitization and reprocessing (EMDR) (Shapiro and Forrest, 2004)
- Advises against any other treatment
- Advises against early interventions

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)

Importance of the body

For thousands of years, oriental and shamanic healers have recognised not only that the mind affects the body, as in psychosomatic medicine, but that every organ system of the body equally has a psychic representation in the fabric of the mind …

… trauma is not, will not, and can never be fully healed until we also address the essential role played by the body.

(Levine and Frederick, 1997: 2)

Risk of traumatization/retraumatization

My experience has taught me that many of the currently popular approaches to healing trauma provide only temporary relief at best. Some cathartic methods that encourage intense emotional reliving of trauma may be harmful. I believe that in the long run, cathartic approaches create a dependency on continuing catharsis and encourage the emergence of so-called "false memories". Because of the nature of trauma, there is a good chance that the cathartic reliving of an experience can be traumatizing rather than healing.

(Levine and Frederick, 1997: 10)

Do we need to go back into the trauma

I learned that it was unnecessary to dredge up old memories and relive their emotional pain to heal traumas. In fact, severe emotional pain can be re-traumatizing. What we need to do to be freed of our symptoms and fears is to arouse our deep physiological resources and consciously utilize them. If we remain ignorant of our power to change the course of our instinctual responses in a proactive rather than reactive way, we will continue being imprisoned and in pain.

(Levine and Frederick, 1997: 31)

Babette Rothschild

- Babette Rothschild, MSW, LCSW, has been a recognized specialist in integrated mind and body theory and treatment of trauma and PTSD for nearly 30 years.
- She is the author of four books, all published by WW Norton: the bestselling, The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment (2000); The Body Remembers Casebook (2003); Help for the Helper: The Psychophysiology of Compassion Fatigue and Vicarious Trauma (2006); and the newly released, 8 Keys to Safe Trauma Recovery (2010).
- After living nine years in Copenhagen, Denmark, she returned to her native Los Angeles where she continues to write while maintaining a demanding lecture, training, and consultation schedule worldwide.

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.

Waking the Tiger (Levine and Frederick, 1997) (employs focusing (Eugene Gendlin))

My observation of scores of traumatized people has led me to conclude that post-traumatic symptoms are, fundamentally, incomplete physiological responses suspended in fear

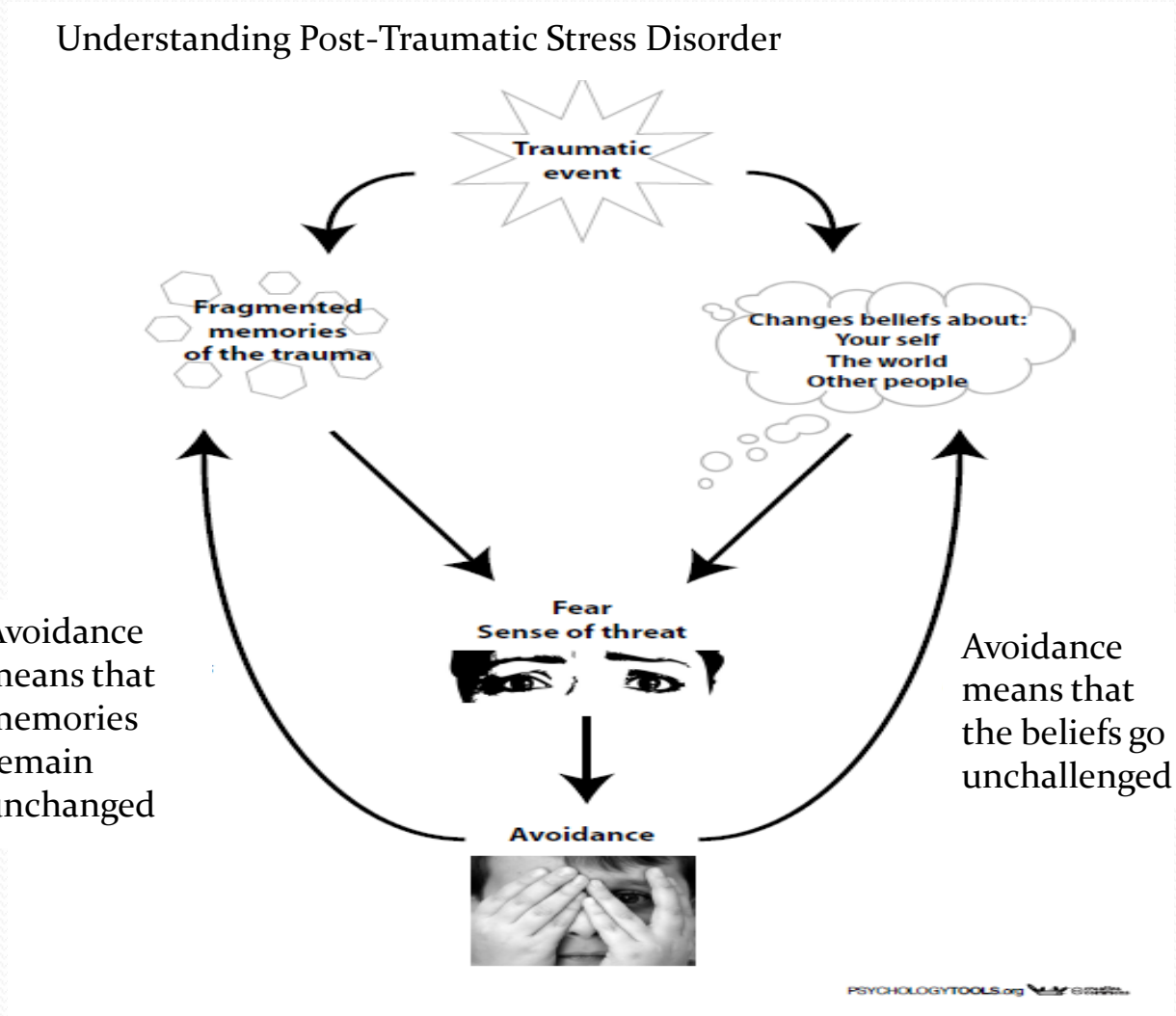
Cognitive approach to treating trauma (Foa, 1997)

- 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

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



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.

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

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?
- Psychodynamic model of trauma based on defences
- Increasingly focuses on relation trauma in childhood.

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.

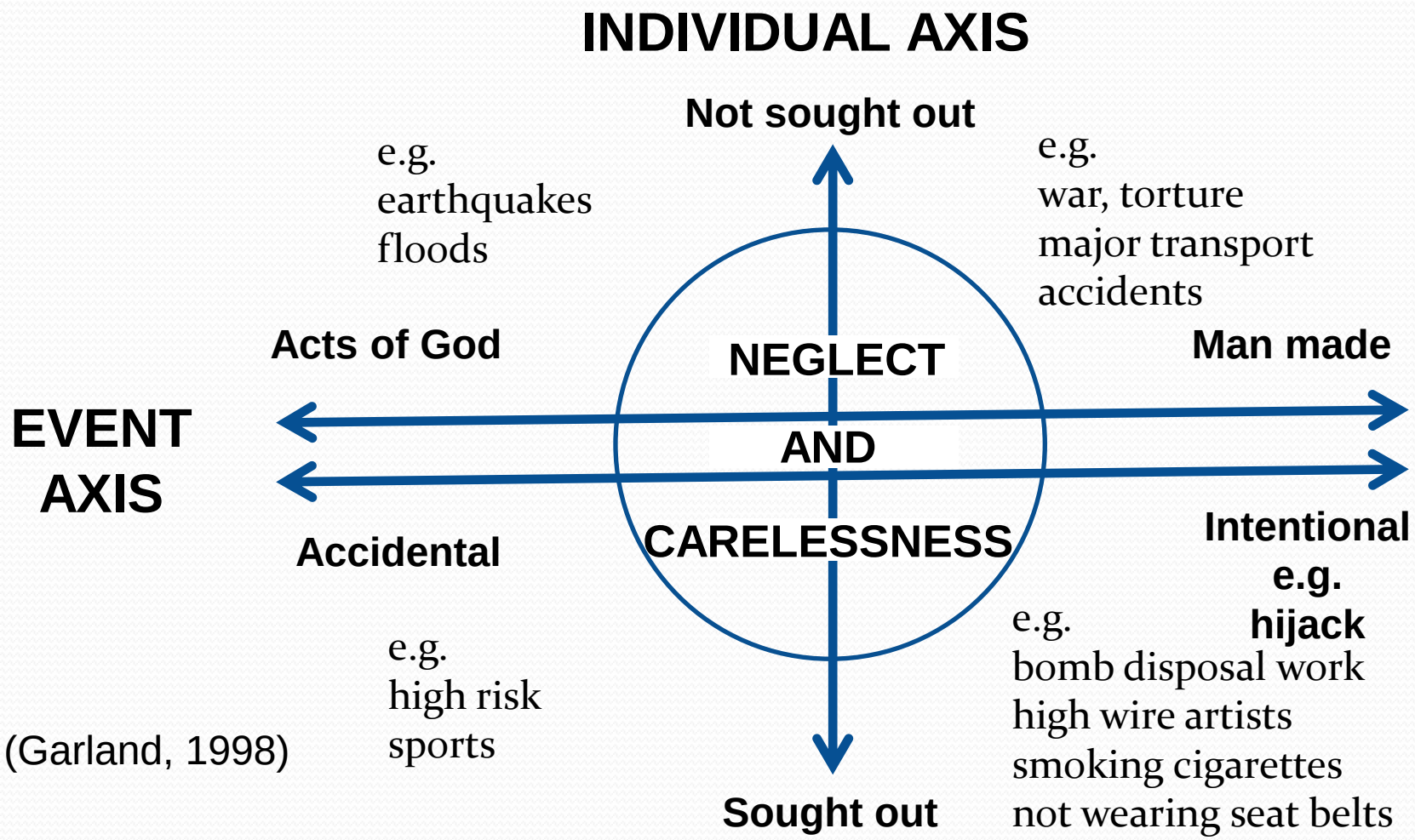
Modern psychoanalytic view of trauma

- 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)

Relational or Developmental Trauma

- Related to effects on the brain – especially right brain

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 relevant
- Previous history of client is relevant
- 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