Trauma in counselling and psychotherapy

Jonathan Lloyd / George MacDonald
27th March 2015
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>09:30–11:00</td>
<td>What is trauma? GM</td>
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<tr>
<td>11:45-11:15</td>
<td>Break</td>
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<tr>
<td>11:15-12:30</td>
<td>How do WE work with trauma? GM</td>
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<td>12:30-13:00</td>
<td>Lunch</td>
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<td>13:00-14:15</td>
<td>Resolving traumatic memories with clean language and metaphor 1 JL</td>
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<tr>
<td>14:15-14:30</td>
<td>Break</td>
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<tr>
<td>14:30-15:45</td>
<td>Resolving traumatic memories with clean language and metaphor 2 JL</td>
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<tr>
<td>15:45-16:00</td>
<td>Review of day GM/JL</td>
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Introductory exercise

- Introduce yourself
- One expectation of day
- Optionally one understanding or experience of trauma
Multiple perspectives

- Etymological perspective
- Medical perspective
- Cognitive perspective
- Evolutionary perspective
- Behavioural perspective
- Neuroscience and brain scanning
- Psychoanalysis

No distinction between biology and psychology!
Practitioners

- Bessel van der Kolk
- Peter Levine
- Frank Ochberg
- Stephen Porges
- Babette Rothschild
- Robert Stolorow
- Gordon Turnbull
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’
- Today OED more references from psychoanalysis and psychiatry
- Post Traumatic Stress Disorder first included in DSM-III 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?
  - Complex trauma (Sanderson, 2013)
- Now also idea of ‘transmissibility’ and ‘vicarious traumatisation’
- Historical trauma, cultural trauma, organisational trauma
- Adopted by many academic disciplines
- Culture is saturated in trauma (Visser, 2011)
- Trauma is culture specific
Types of childhood trauma (Terr, Rothschild)

Types (Terr 1991), Sub-types (Rothschild, 2000)

- Type I – single event
- Type II – multiple events
  - Type IIA – sufficient resources to separate individual traumatic events
  - Type IIB – individual cannot separate individual traumatic events
    - Type IIB (R) – developed resources but trauma overwhelming
    - Type IIB (nR) – never developed resources (typical CPA, CSA)
Definitions – 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 DSM5
### Associated psychiatric disorders and physical illnesses (Sanderson, 2013)

<table>
<thead>
<tr>
<th>Associated psychiatric disorders</th>
<th>Associated physical illness</th>
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<tbody>
<tr>
<td>PTSD</td>
<td>Irritable bowel syndrome</td>
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<tr>
<td>Personality disorders (borderline, antisocial)</td>
<td>Chronic fatigue syndrome</td>
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<tr>
<td>Dissociative disorder</td>
<td>Chronic pelvic pain</td>
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<tr>
<td>Depression</td>
<td>Increased risk of obesity</td>
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<tr>
<td>Anxiety disorders</td>
<td>Type II diabetes</td>
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<td>Phobias (agoraphobia, social phobia)</td>
<td>Hypertension</td>
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<td>OCD</td>
<td>Recurring throat problems</td>
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<td>Eating disorders</td>
<td>Ageing and degeneration of brain structures including hippocampus</td>
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<td>Substance dependency</td>
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<tr>
<td>Self-harming behaviours</td>
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<td>Schizophrenia</td>
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Frank Ochberg (1940-), acclaimed psychiatrist, pioneer in trauma science, educator and editor of the first text on the treatment of post-traumatic stress disorder (PTSD). One of the founding fathers of modern psychotraumatology who served on the committee that defined PTSD. 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

(Wikipedia)
Biological perspective

- Sufferers from PTSD have distinctive patterns of brain activity – especially right temporal lobe
- They are ‘brain affected’, perhaps also ‘brain damaged’ – anterior cigulate gyrus, amygdala
- Some people are genetically more vulnerable – hippocampal size
- Two types of PTSD (flashbacks v dissociation)
Three brains in one

Intermediate: paleopallium
Limbic System
Emotions

Rational Brain
Neocortex: neopallium
Higher thinking

Primate Brain
Mammalian Brain
Reptilian Brain

Primative: archipallium
Survival, aggression
Short term defence cascade (6 Fs)

Onset of dissociation
- Somatosensory/pain perception decreases
- Cognitive ability severely limited

1. Freeze
   - Tonic Immobility (unresponsive immobility)
     - Bradycardia, vasoconstriction, hypertension, hyperalertness, high emotional arousal, fear, largely repressing anger, assaultive breakout followed by immobility
     - Fast onset and termination of the immobility

2. Flight
   - ‘uproar’ (type 1)
     - Sympathetic activation
     - Dizziness, lightheadedness, palpitation, dry mouth, numbing, muscle tension, feelings of unreality

3. Fight

4. Fright
   - Tonic Immobility (unresponsive immobility)
     - Bradycardia, vasoconstriction, hypertension, hyperalertness, high emotional arousal, fear, largely repressing anger, assaultive breakout followed by immobility
     - Fast onset and termination of the immobility

5. Flag
   - ‘shutdown’ (type 2)
     - Para-sympathetic activation
     - Dizziness, lightheadedness, palpitations, dry mouth, numbing, muscle tension, feelings of unreality
   - Slow onset and termination of immobility

6. Faint
   - Attentive immobility; orienting response

Cascade progression/course of action
Video clip 2 min – Playing Possum
Trauma is rooted in the biological wiring of the brain. This has evolved over many millennia through natural and sexual selection. The selfish gene (Dawkins, 1976) and common sense support this evolutionary perspective.
Waking the Tiger
(Levine and Frederick, 1997)

My observation of scores of traumatized people has led me to conclude that post-traumatic symptoms are, fundamentally, incomplete physiological responses suspended in fear.
Stephen Porges (1945 - ) Professor in the Department of Psychiatry and Director of the Brain-Body Center in the College of Medicine at the University of Illinois. In 1994, proposed the Polyvagal theory linking the evolution of the autonomic nervous system to the emergence of social behaviour. Relevant to several psychiatric disorders including autism and provides a theoretical perspective to study and to treat stress and trauma.
The Polyvagal theory (Porges, 2011)

Specifies two functionally distinct branches of the vagus or tenth cranial nerve. The branches of the vagal nerve serve different evolutionary stress responses in mammals: the more primitive branch elicits immobilisation behaviours (e.g. feigning death) whereas the more evolved branch is linked to social communication and self-soothing behaviour. These functions follow a phylogenetic hierarchy, where the most primitive system is activated only when the more evolved structures fail. These neural pathways regulate autonomic state and the expression of emotional and social behaviour. Thus, according to this theory, physiological state dictates the range of behaviour and psychological experience.
The Polyvagal theory (Porges, 2011)

Most scientific disciplines are stuck in the dualism trap.
The Polyvagal theory (Porges, 2011)

Survival demand

Engage or disengage?

Hyperarousal

Fight response

Flight response

Freeze

Discharge

No discharge
Longer term - neurobiological perspective (Kolassa & Elbert, 2007)

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

PTSD is a malfunction of the memory system and changed beliefs about self, the world and other people.
PTSD and memory (cognitive meets biological)

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.

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.
Flashbacks

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 (Schauer at al., 2011)

Part of the repair process (Turnbull, 2011)
Cognitive perspective - memory

Direct access
Involves deliberate and conscious searching

Indirect access
Effortless, automatic without searching
Cognitive perspective - memory

Plasticity

Memory

- Short term
  - Hippocampus
  - Episodic
    - Procedural Memory
- Long term
  - Semantic
    - Declarative memory
  - Temporal cortex
- Implicit
- Explicit
Behavioural perspective

- Classical conditioning (Pavlov’s dogs, Little Albert)

- Operant conditioning (Avoidance)
The aporetic current of trauma theory rejects its therapeutic roots (Caruth, 1991; 1996)

In some respects - perhaps literary trauma theory has got it right by resisting the medicalisation of the trauma.

‘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)
Increases with cumulative experience of traumatic events (Schauer et al., 2010)
DSM5 (published May 2013)

- DSM5 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 and multiple 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:
  - direct experience of the traumatic event;
  - witnessing the traumatic event in person;
  - learning of a traumatic event involving a family member or close friend; or
  - experiencing first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media or video, unless work-related).

- The disturbance causes clinically significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning.
DSM5 Definition of PTSD (309.81)

Subtypes:

- Dissociative symptoms: Persistent or recurrent symptoms of either:
  - Depersonalization
  - Derealization
- Delayed expression: Full diagnostic criteria are not met until at least 6 months after the event (onset and expression of some symptoms may be immediate).
For adults, adolescents and children older than 6 years.

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: ....

- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: ....

- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: ...
DSM5 Definition of PTSD (309.81)

- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: ...
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: ...
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g. medication, alcohol) or another medical condition.
Symptoms of PTSD

R – Re-experiencing
A – Avoidance
H – Hyperarousal
N - Negativity
Welcome back
Central to counselling and psychotherapy

- All counsellors and psychotherapists work with trauma even if they avoid clients/patients with a diagnosis or symptoms of PTSD.
- It is just the degree and nature of the trauma that varies; the life stage at which it was experienced and the way in which the individual deals with it.
- Trauma may be buried deeply in the past or the memory may be repressed.
- Clinical example - Lynn.
NICE* approved psychological treatments for PTSD – CG26

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

* National Institute for Health and Care Excellence
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?

- General Principles
- Person – Centred Approach
  - Somatic Experiencing
- Cognitive Behavioural / Narrative
  - Trauma Focussed CBT (TF-CBT)
  - Narrative Exposure Therapy
  - Stress Innoculation Therapy (SIT)
- Psychodynamic
- Other techniques
  - Yoga / Music therapy / Bio-feedback
  - Mindfulness
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Counting Method (Ochberg)
  - Clean language / Metaphor
- Group Psychotherapy (Supportive, Psychodynamic, Cognitive-Behavioural)
Video clip 5 mins – mistakes made

- Janina Fisher
- Jamie Marich
- Peter Levine
- Bessel van der Kolk
- Belleruth Naparstek
- Babette Rothschild
- Stephen Porges
Don’t be put off!

- You do not know when someone comes through the door if they are suffering from post traumatic stress
- Referral is always possible, but can be damaging and ethically questionable
- Not all post traumatic stress manifests itself as symptoms of PTSD. There are different levels of severity and modes of expression
- All counsellors and therapists work with trauma
- And trauma is not a degenerative disease – on balance it tends to get better rather than worse
General principles

- The way we talk about and explain trauma and PTSD is the first step in recovery
- Risk of retraumatisation
- We do not need to go back into the trauma
- Importance of the body
- Client is in charge
- Indirect approaches may be more effective
- Sense of maturing and taking forward
Risk of re-traumatization

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)
Video clip 5 mins – Remembering is not required

Babette Rothschild

Specialist in integrated mind and body theory; treatment of trauma and PTSD. Author of four books: 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 8 Keys to Safe Trauma Recovery (2010) – a self help book.

After living in Copenhagen, Denmark, returned to native Los Angeles where she continues to write, lecture, train, and consult.
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)
Person-centred approaches

- Trauma is first and foremost a relational disorder
- But ‘relationships are so triggering’
- ‘The more we offer the harder it is for the client ... as much as the client may beg’
Somatic experiencing®

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)
### Nine building blocks

1. Create an environment of relative safety
2. Support initial exploration and comfort with bodily sensations
3. Pendulation
4. Restore active defensive responses
5. Titration
6. Uncoupling fear from immobility
7. Encouraging the discharge of energy
8. Restore equilibrium and balance through self-regulation
9. Reorient to the here and now
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.
Whereas in terms of person-centred theory, incongruence is usually seen as a consequence of conditions of worth, the important 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 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

Traumatic Event

Fragmented memories of the trauma

Changed beliefs about:
- Yourself
- The world
- Other people

Fear

Sense of threat

Avoidance means that the beliefs go unchallenged

Avoidance means that memories remain unchanged
The linen cupboard metaphor

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

Memories in PTSD are 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 – CG26

- Prolonged exposure (Foa et al., 1991; 1999; Marks et al., 1998)
- Image habituation training (Vaughan et al., 1994)
- Imaginal flooding (implosive flooding) therapy (Keane et al., 1989)
- Imaginal exposure and bio-feedback-assisted desensitisation treatment (Peniston & Kulkosky, 1991)
- Cognitive reprocessing therapy (Resnick et al., 2002)
- Cognitive-behavioural treatment (Fecteau & Nicki, 2005; Paunovic & Ost, 2001; Blanchard et al., 2003)
- Cognitive therapy for PTSD (Ehlers, et al., 2005)
- Cognitive restructuring (Marks et al., 1998; Tarrier et al., 1999)
- Cognitive trauma therapy (Kubany et al., 2003; 2004)
- Brief eclectic psychotherapy (Gersons et al., 2000) – some psychodynamic
Cognitive Processing Therapy for rape victims (Resnick and Schnicke, 1996)

- Session 1 – Introduction and education phase
- Session 2 – The meaning of the event
- Session 3 – Identification of thoughts and feelings
- Session 4 – Remembering the rape
- Session 5 – Identification of stuck points
- Session 6 – Challenging questions
- Session 7 – Faulty thinking patterns
- Session 8 – Safety issues
- Session 9 – Trust issues
- Session 10 – Power and control issues
- Session 11 – Esteem issues
- Session 12 – Intimacy issues and meaning of the event

Group or individual basis, client characteristics therapist considerations
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.
Side effects of CBT/clinical trials

- Reports in CBT literature:
  - (Initial) symptom exacerbation
  - Side effects mild and transient (Foa et al, 2002; Taylor et al, 2003)

- Epistemology of clinical trial
  - What gets studied: what does not get studied
  - Researcher bias
  - How participants are selected
  - What happens to dropouts
  - Control groups – What is TAU?
  - Is effect purely a result of the active component of treatment
  - How can other components of treatment be excluded – double blind trials of psychological therapies not possible
Psychodynamic approaches to working with trauma

- Revisit what is trauma?
- Psychodynamic model of trauma based on defences – attempts to reconcile with biological model (Wilson et al., 2001)
- Increasingly focuses on the significance of 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 have been painful. Trauma is experienced in another place and time from that in which it originated.
- Beyond the pleasure principle (1920)
- Moses and monotheism (1939)
When post-traumatic stress disorder (PTSD) first made it into the diagnostic manuals, we only focused on dramatic incidents like rapes, assaults, or accidents, to explain the origins of the emotional breakdowns in our patients. Gradually we came to understand that the more severe dysregulation occurred in people who, as children lacked a consistent caregiver. Emotional abuse, loss of caregivers, inconsistency and chronic misattunement showed up as the principal contribution to a large variety of psychiatric problems (Dozier, Stovall & Albus, 1999; Pianta, Egeland & Adam, 1996) (Bessel van der Kolk, 2011)
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?
- Trauma in childhood influences development of brain esp. limbic system and right brain – links to attachment theory, relational trauma (Schore, 2010), developmental trauma (Heller et al., 2012)
- For Khan environmental failure in any form constitutes “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)
Psychoanalytic view of trauma (Scharff, 2005)

Fairbairn sees conversion as the process of substitution of a bodily problem for an emotional one. The patient speaks through a part of the body that resembles the problem to be expressed, and so is used to symbolize it, which brings some psychic relief. Body language is needed because the trauma that produces the problem has occurred before words are acquired or has overwhelmed the capacity for verbal thinking.

- Case - Sam
Each new trauma brings back 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

INDIVIDUAL AXIS

EVENT AXIS
- Acts of God
  - e.g. earthquakes
  - floods
- Accidental
  - e.g. high risk sports

CARELESSNESS
- Not sought out
  - e.g. earthquakes, floods
- Sought out
  - e.g. war, torture, major transport accidents

NEGLECT
- Man made
  - Intentional
    - e.g. hijack
    - bomb disposal work
    - high wire artists
    - smoking cigarettes
  - careless
    - e.g. not wearing seat belts

(Garland, 1998)
Other less direct approaches

- Trauma not brought to mind
  - Neuro-feedback
  - Yoga
  - Minfulness
  - Music therapy
- Trauma is (can be) brought privately to mind
  - Eye movement desensitization and reprocessing (EMDR)
  - Counting method (Ochberg)
- Trauma is brought; or comes metaphorically, or metonymically to mind
  - Transference
  - Dream work
  - Stories
  - Clean language / metaphor
EMDR (Shapiro et al., 2004)

- Short term treatment
- Possible for therapist to avoid explicitly entering the trauma
- AIP model
- Three pronged approach (past, present, future)
- Eight phase protocol
- Counter indications – dissociative disorders, complex trauma, poor physical health, epilepsy, drug/alcohol abuse, suicidal ideation, eye disease/surgery/contact lenses, legal issues
Eight phase protocol

1. History taking
2. Preparation
3. Assessment
4. Desensitisation
5. Installation
6. Body scan
7. Closure
8. Re-evaluation
The counting method (Frank Ochberg)

- Only one small part of a longer 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
Prevention and early intervention

- CBT
  - Psychological debriefing - single session 24-48 hours post trauma – evidence?
  - 4-5 sessions CBT 2-4 weeks posttrauma promising?

- When and How
  - Debriefing – early intervention might speed the integration of information transfer by forcing sensory memories into words.

- Follow the data – theory be damned (Turnbull, 2011)
Prevention and early intervention after disasters and acute traumas

- Acute preventive work after traumatic events is always social or community based (Salli, 2005)
- Gordon Turnbull
- Allan Turner (2012)
Group versus individual

- Practical limitations
- Evidence of effectiveness after disasters or group traumas
- Many documented treatments include a combination of individual and group work
- This is also seen in manualised treatments like Mentalization for Borderline Personality Disorder – arguably a medicalised name for a form of relational trauma
Video clip of practitioner in action ~20 mins

- Vote
- Necessary to understand clients
- ‘Horses for courses’
<table>
<thead>
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‘Maya’ – Frank Ochberg: Counting Method

- Maya is ~40 years old woman
- Systematically tortured raped 10 years ago
- Perpetrator officer from ‘state department of social service’
- Threatened to take her child away
- 6-7 specific episodes
- Suffered from painful intrusive memories
Christina is a woman in her 40s, married with two children. Originally from Latvia – lived in the UK for 12-13 years. 6 years ago had an accident while rushing to pick children up from school. Minor head injury which cleared up. Now ‘cautious’ in traffic and has flashbacks ‘mainly in the road situation’. Anxious when husband is driving. Husband insisted that she go to the GP because she was ‘driving him mad’ – she doesn’t see the problem. Diagnosis of PTSD confirmed by a clinical psychologist.
Ray was a radio operator on patrol in Iraq, when two Improvised Explosive Devices in close proximity went off, launching him into the air. He remembers waking up in a hospital two weeks later.

He has been diagnosed with severe PTSD and Traumatic Brain Injury

He suffers from Tourette-like convulsions, headaches, chronic pain, vertigo, nightmares and tinnitus.

He was brought by a student to a group case consultation that Peter was leading.
### Practitioners in action

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Everyone is different and every experience of trauma is unique. It is not just about PTSD. Each individual needs to be worked with in a different way. History of trauma and client are relevant. Highest priority to avoid further damage. For some, the pursuit of the details of traumatic events may be appropriate – at some point, as part of longer term work. Risk of re-traumatisation, developing dependence, false recovered memories. If trauma is a disorder of the memory system – remembering may not be possible, or may be preverbal. For most, less direct approaches are preferable and other techniques can be safely employed in shorter term work. Necessary to bring the body into therapy.