Trauma in counselling and psychotherapy

Dr Jonathan Lloyd / Dr George MacDonald

2nd June 2017

Program for Day

09:30–11:00	What is trauma?
11:45-11:15	Break
11:15-12:30	How do WE work with trauma?
12:30-13:10	Lunch
13:10-13:30	Examples of practitioners in action
13:30-14:15	Example 1
14:15-15:00	Example 2 (tea /coffee at 14:35)
15:00-15:45	Example 3
15:45–15.55	Plenary
15:55-16:00	Review of day

Introductory exercise

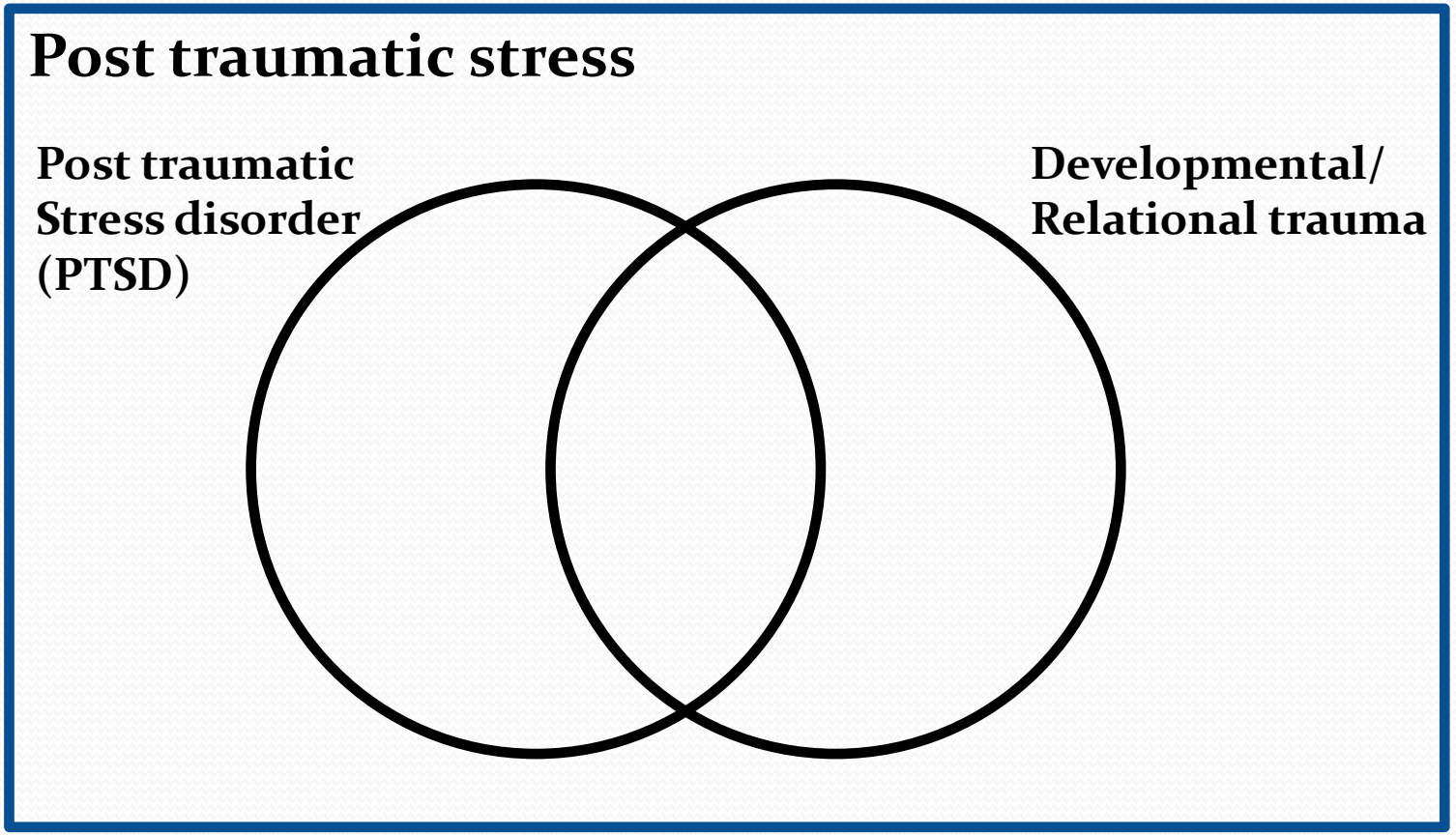
- Introduce yourself
- One expectation of day
- Optionally one understanding or experience of trauma

Introduction

Two central ideas or expressions of trauma

- **Post traumatic stress disorder (PTSD)**
  - **(Acute stress disorder (ASD))**
- **Developmental / relational trauma**

Post traumatic stress



Multiple perspectives

- Etymological perspective
- Medical perspective
- Cognitive perspective
- Evolutionary perspective
- Behavioural perspective
- Neuro science and brain scanning
- Psychoanalysis

No distinction between biology and psychology!

Practitioners

- Sebern Fisher
- Bessel van der Kolk
- Peter Levine
- Donald Meichenbaum
- Frank Ochberg
- Stephen Porges
- Therese Rando
- Babette Rothschild
- Robert Stolorow
- Gordon Turnbull

What is trauma?

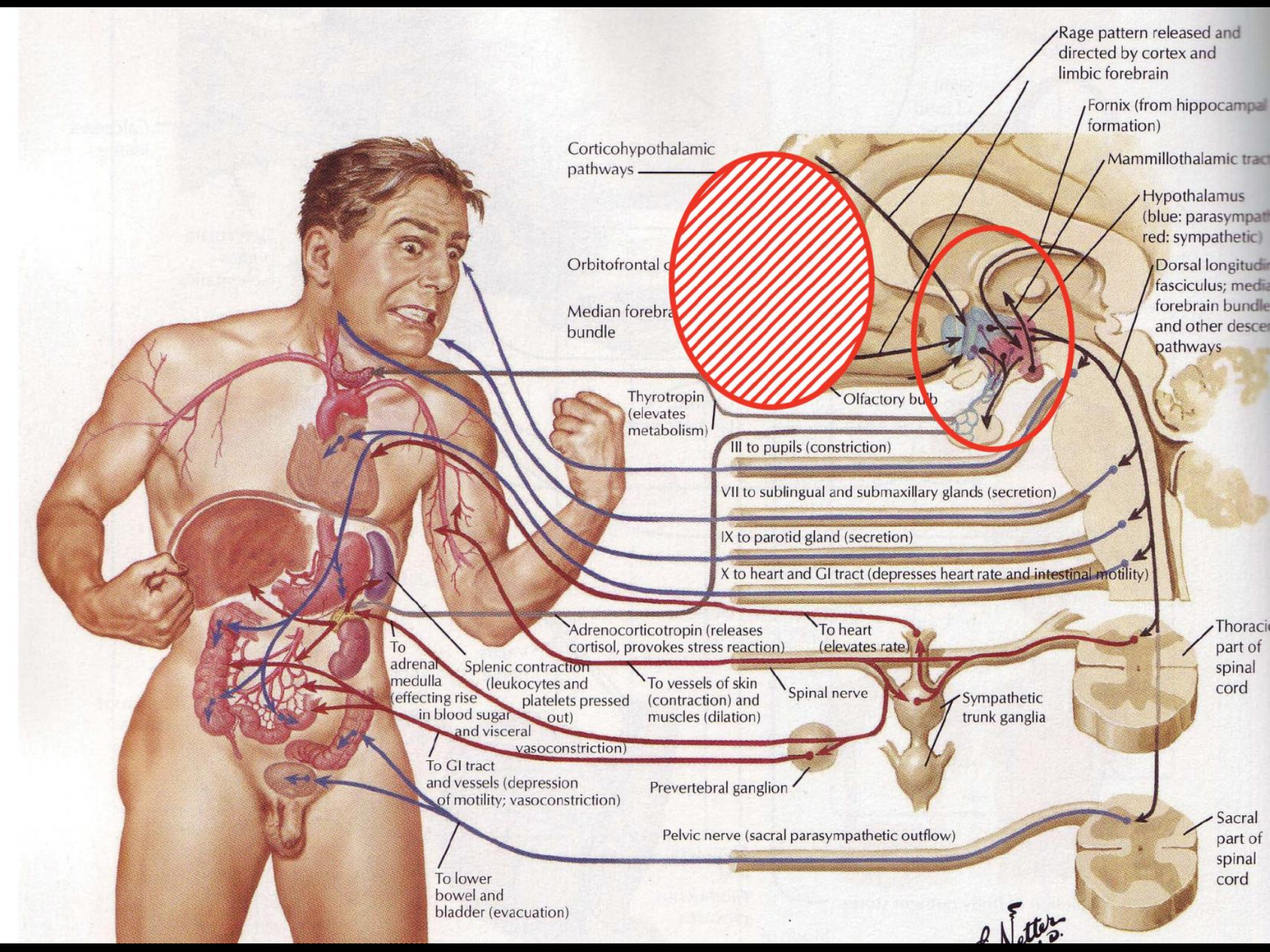
Video clip 4 min – Bessel van der Kolk

Bessel van der Kolk

(1943 -) Boston based psychiatrist, born in Netherlands. Noted for research into post-traumatic stress. His work focuses on the interaction of attachment, neurobiology and developmental aspects of trauma. His major publication, the New York Times bestseller 'The body keeps the score', talks about perceived changes in the role of trauma in psychiatric illness over the past 20 years; what we have learned about the effect of trauma in shaping the human brain; how traumatic stress is a response of the entire organism and how this knowledge needs be integrated into healing practices.(Wikipedia)

The blind leading the blind, Breugel (elder)


WARNING!


Rage pattern released and directed by cortex and limbic forebrain
Fornix (from hippocampal formation)
Mammillothalamic tract
Hypothalamus (blue: parasympathetic; red: sympathetic)
Dorsal longitudinal fasciculus; medial forebrain bundle and other descending pathways
Corticohypothalamic pathways
Orbitofrontal c
Median forebrain bundle
Olfactory bulb
Thyrotropin (elevates metabolism)
III to pupils (constriction)
VII to sublingual and submaxillary glands (secretion)
IX to parotid gland (secretion)
X to heart and GI tract (depresses heart rate and intestinal motility)
Adrenocorticotropin (releases cortisol, provokes stress reaction)
To heart (elevates rate)
To adrenal medulla (effecting rise in blood sugar and visceral vasoconstriction)
Splenic contraction (leukocytes and platelets pressed out)
To vessels of skin (contraction) and muscles (dilation)
Spinal nerve
Sympathetic trunk ganglia
Thoracic part of spinal cord
To GI tract and vessels (depression of motility; vasoconstriction)
Prevertebral ganglion
Pelvic nerve (sacral parasympathetic outflow)
Sacral part of spinal cord
To lower bowel and bladder (evacuation)

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?
  - Simple / Complex trauma (Sanderson, 2013)
- Now also idea of 'transmissibility' and 'vicarious traumatisation'
- Developmental or relational trauma
- Historical trauma, cultural trauma, organisational trauma
- Adopted by many academic disciplines
- Culture is saturated in trauma (Visser, 2011)
- Trauma is culture specific

Types of 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**

$$\text{Stress} = \frac{\text{Force}}{\text{Cross-Sectional Area}}$$

Tensile Stress Compressive Stress

Associated psychiatric disorders and physical illnesses (Sanderson, 2013)

Associated psychiatric disorders

- PTSD
- Personality disorders (borderline, antisocial)
- Dissociative disorder
- Depression
- Anxiety disorders
- Phobias (agoraphobia, social phobia)
- OCD
- Eating disorders
- Substance dependency
- Self-harming behaviours
- Schizophrenia

Associated physical illness

- Irritable bowel syndrome
- Chronic fatigue syndrome
- Chronic pelvic pain
- Increased risk of obesity
- Type II diabetes
- Hypertension
- Recurring throat problems
- Ageing and degeneration of brain structures including hippocampus

Film clip 6 min – Frank Ochberg

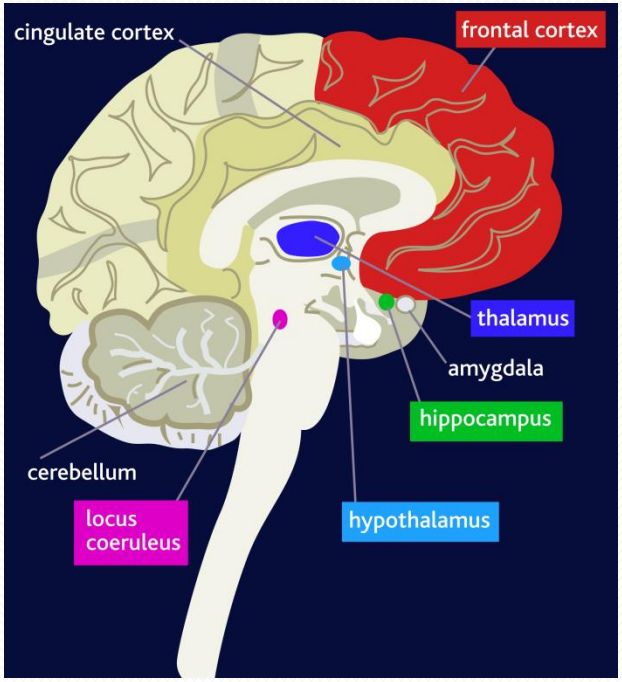
Frank Ochberg

(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

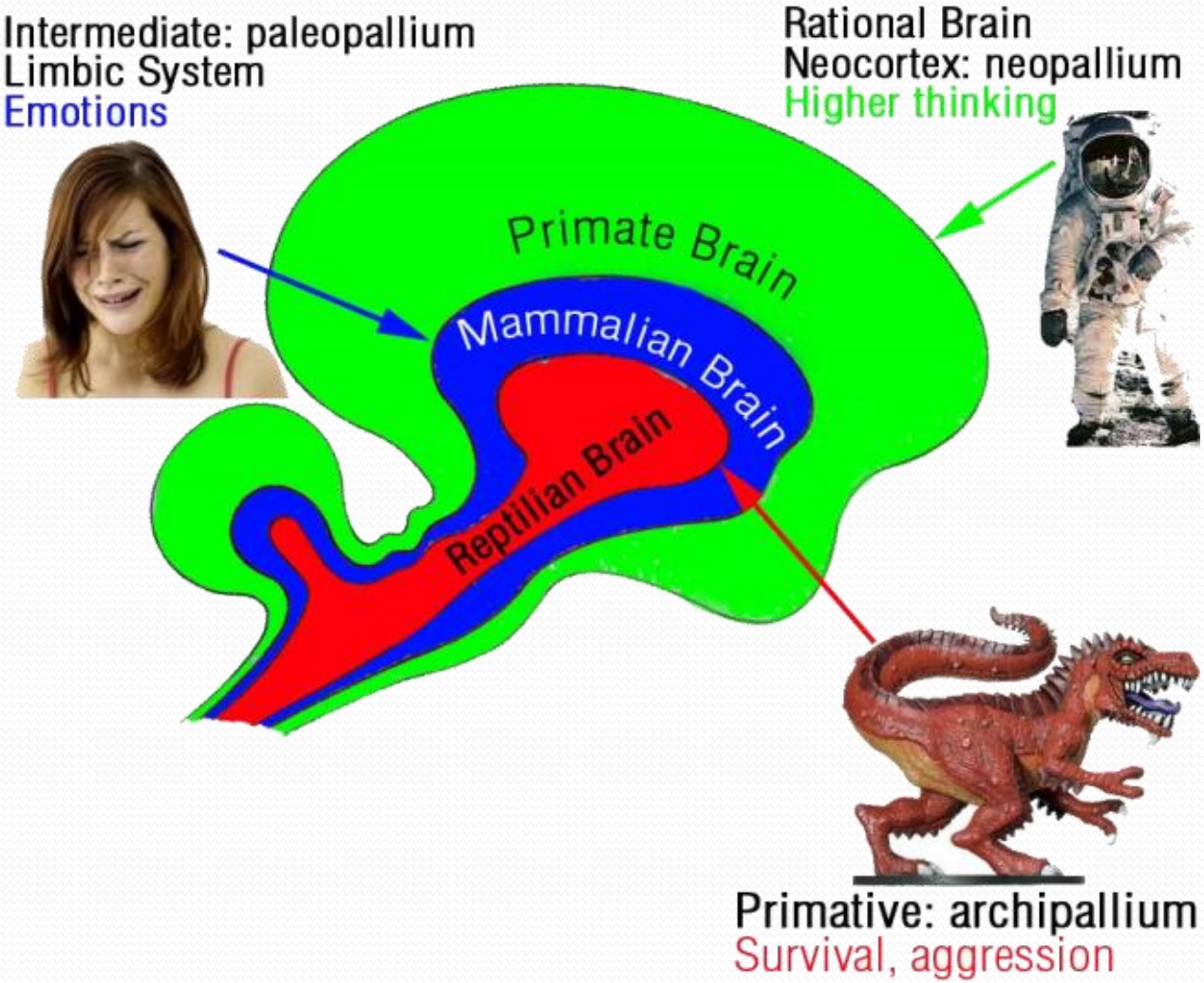
(Wikipedia)

Biological perspective

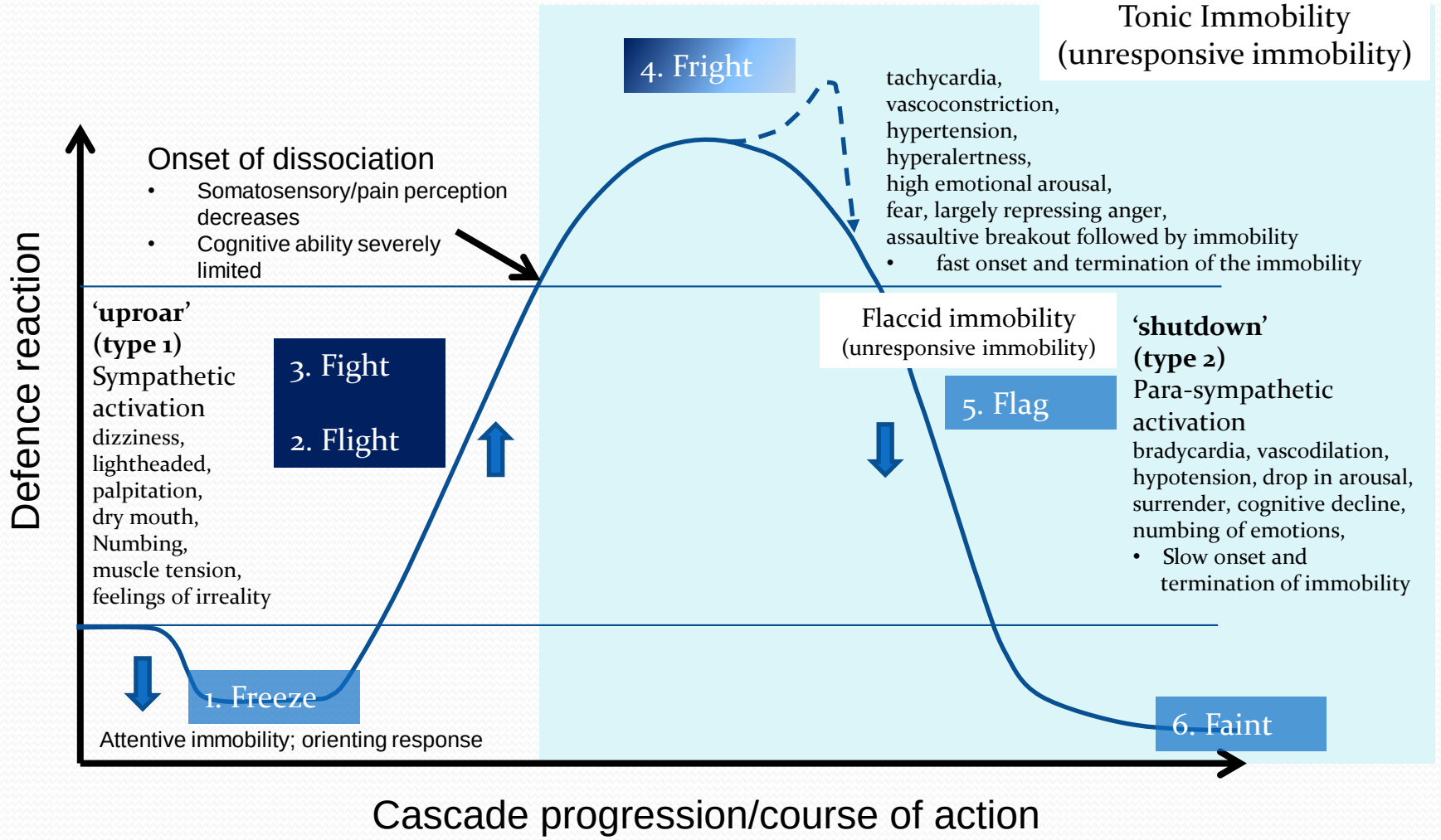
- Sufferers from PTSD have distinctive patterns of brain activity – especially right temporal lobe
- These can be seen.
- They are 'brain affected', perhaps also 'brain damaged'
  – anterior cigulate gyrus,
  – amygdala
- Some people are genetically more vulnerable e.g. hippocampal size
- Two types of PTSD (flashbacks v dissociation)



Three brains in one



Short term defence cascade (6 Fs)



Video clip 2 min – Playing Possum

Link to Evolutionary Perspective

- **Trauma is rooted in the biological wiring of the brain**
- **This has evolved over many millennia**
- **Natural and sexual selection**
- **The selfish gene (Dawkins, 1976)**
- **Common sense**

Peter Levine

(1942 -) American therapist, author, educator specializing in the treatment and understanding of chronic stress and tonic immobility, more commonly known as Post Traumatic Stress Disorder (or PTSD). Books include *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*, the New York Times Best Seller *Waking the Tiger: Healing Trauma*, and the self-help book *Healing Trauma*.

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.

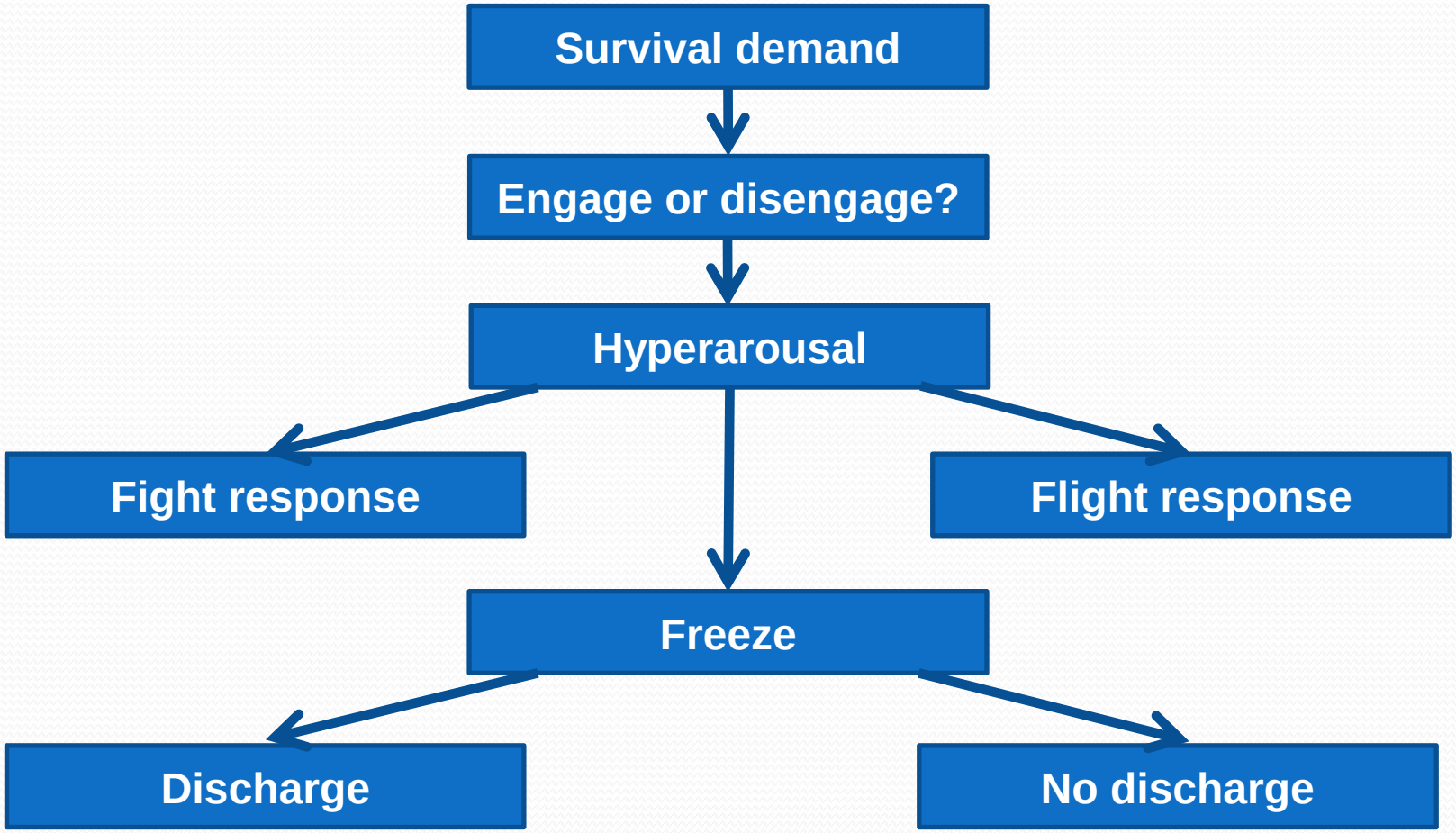
The Polyvagal theory (Porges, 2011)

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 immobolisation 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.

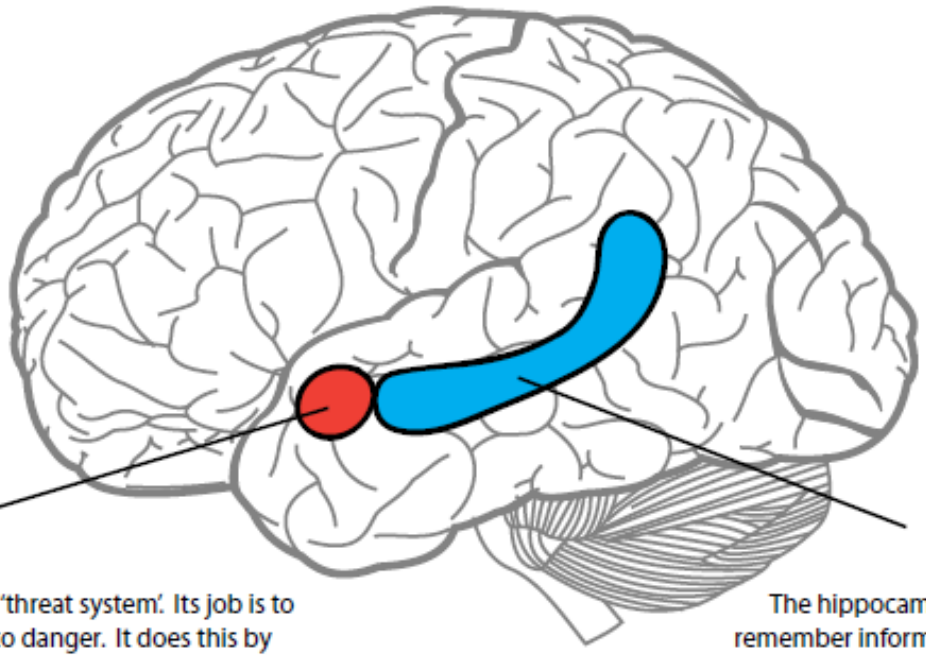
The Polyvagal theory (Porges, 2011)

Most scientific disciplines are stuck in the dualism trap.

The Polyvagal theory (Porges, 2011)



PTSD and memory (cognitive meets biological)



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.

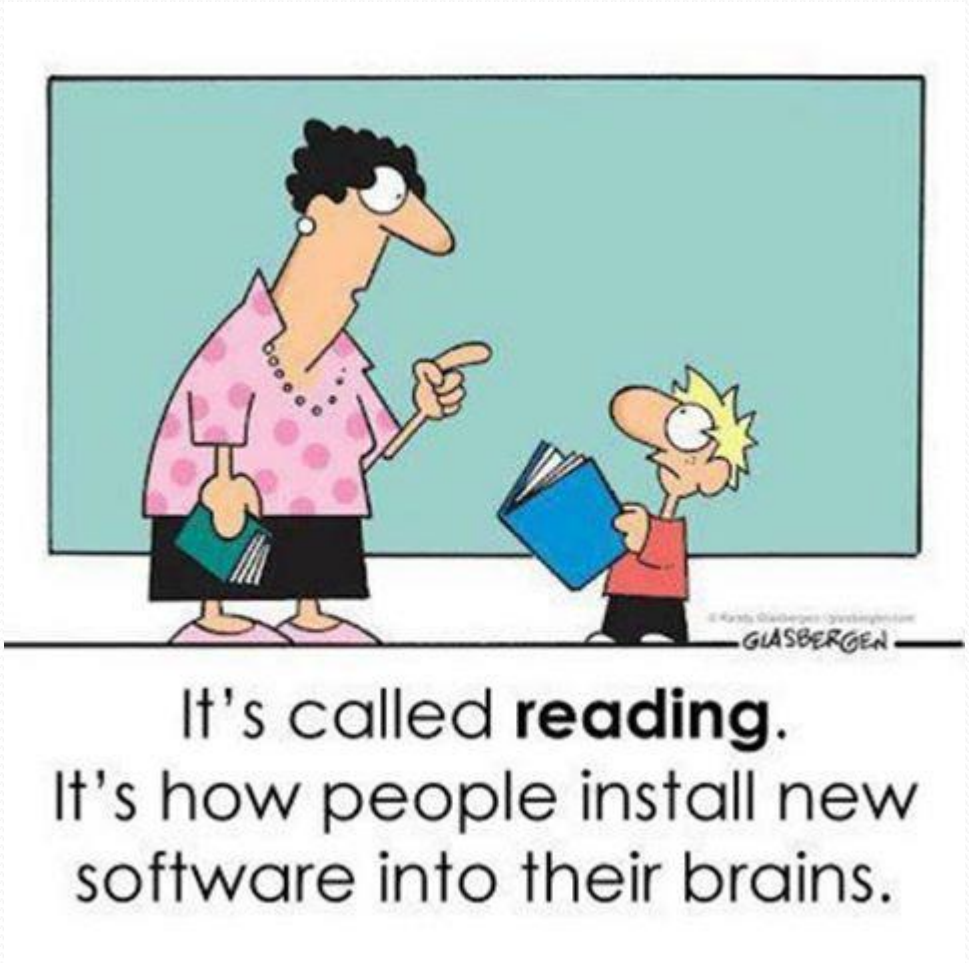
Hippocampus

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

Cognitive perspective

PTSD is a malfunction of the memory system and changed beliefs about self, the world and other people



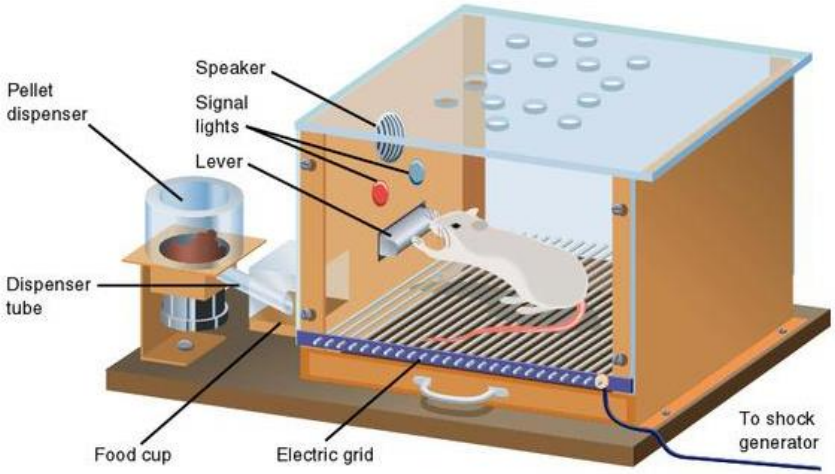
Flashbacks

- **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)**

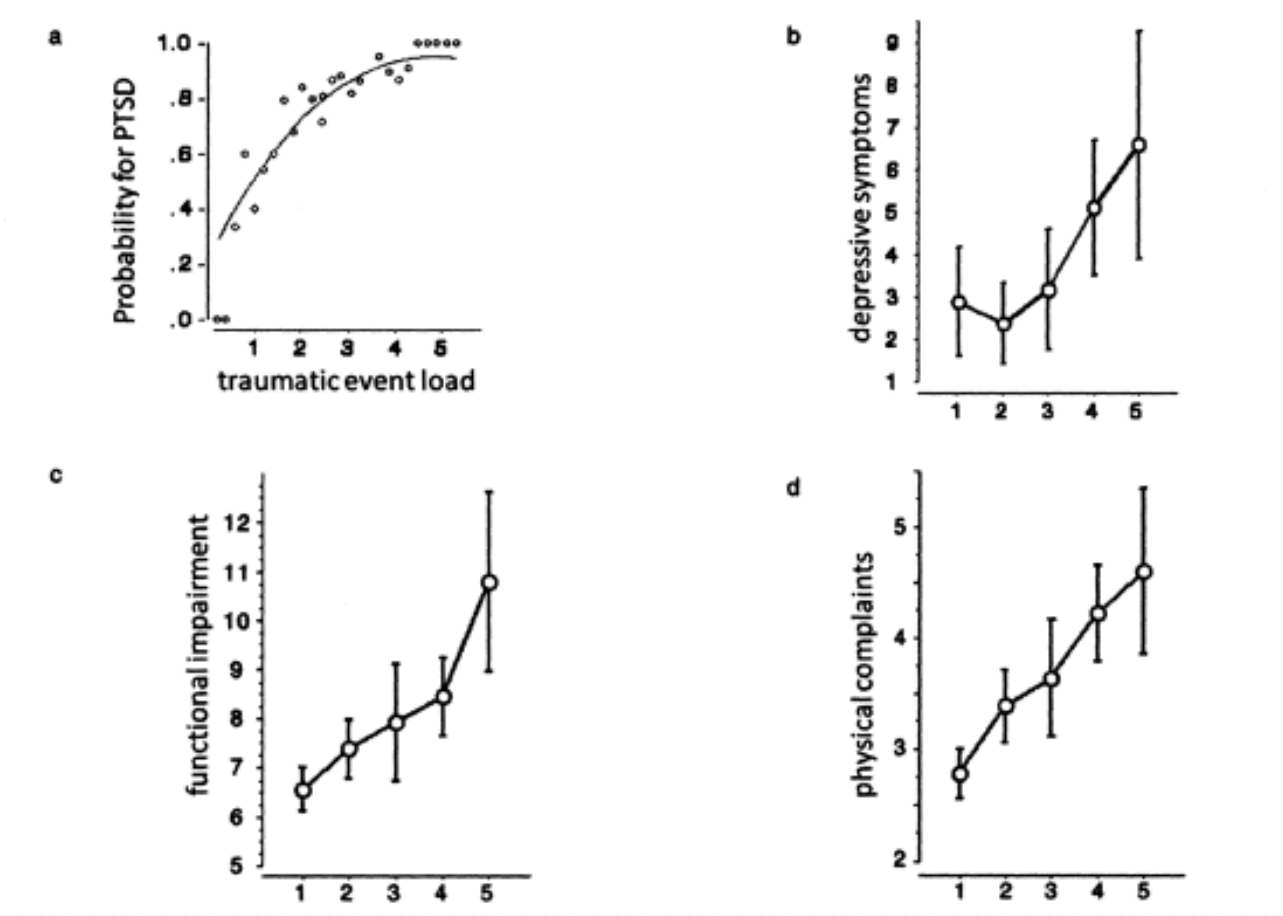
Behavioural perspective

- **Classical conditioning (Pavlov's dogs, Little Albert)**

- **Operant conditioning (Avoidance)**



Medical perspective - probability of developing PTSD



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 (ASD) – 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).**

Symptoms of PTSD

R – Re-experiencing

A – Avoidance

H – Hyperarousal

N - Negativity

Symptoms of PTSD

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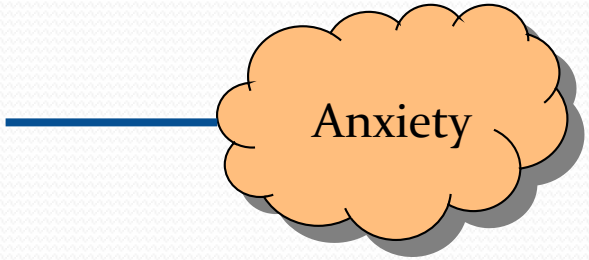

Symptoms of PTSD

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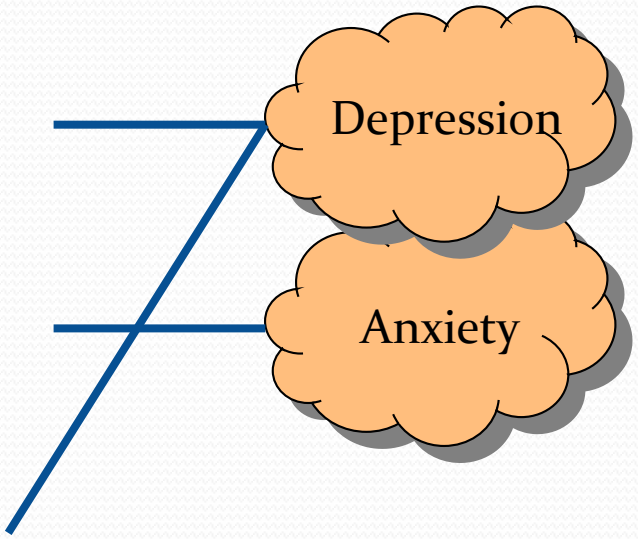

Symptoms of PTSD

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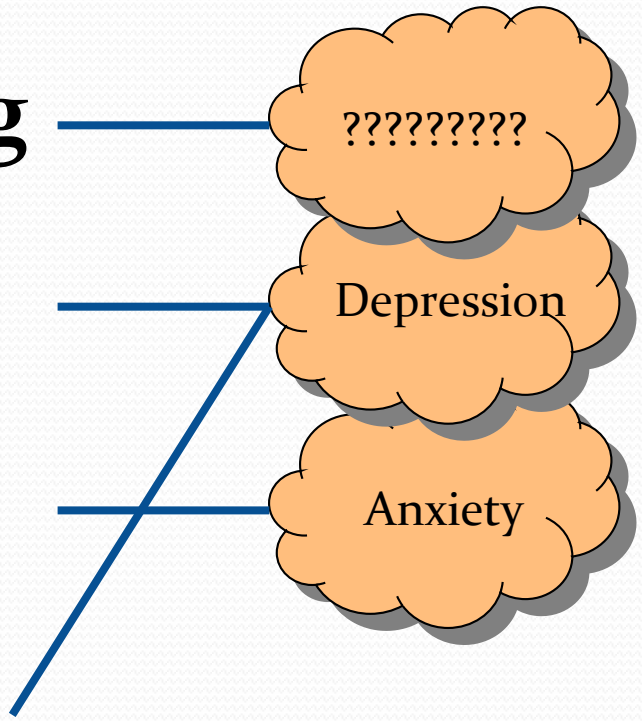


Trauma beyond PTSD

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 mis-attunement 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)

Video clip 1:43 – Trauma beyond PTSD

How do WE work with trauma?

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'**

Video clip 3:00 – Medication for PTSD

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
  - Bio-feedback
  - Yoga / Music therapy / Art therapy
  - Meditation / Mindfulness
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Human Givens Rewind Technique
  - Counting Method (Ochberg)
  - Clean language / Metaphor
  - Psychodrama
- 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’**

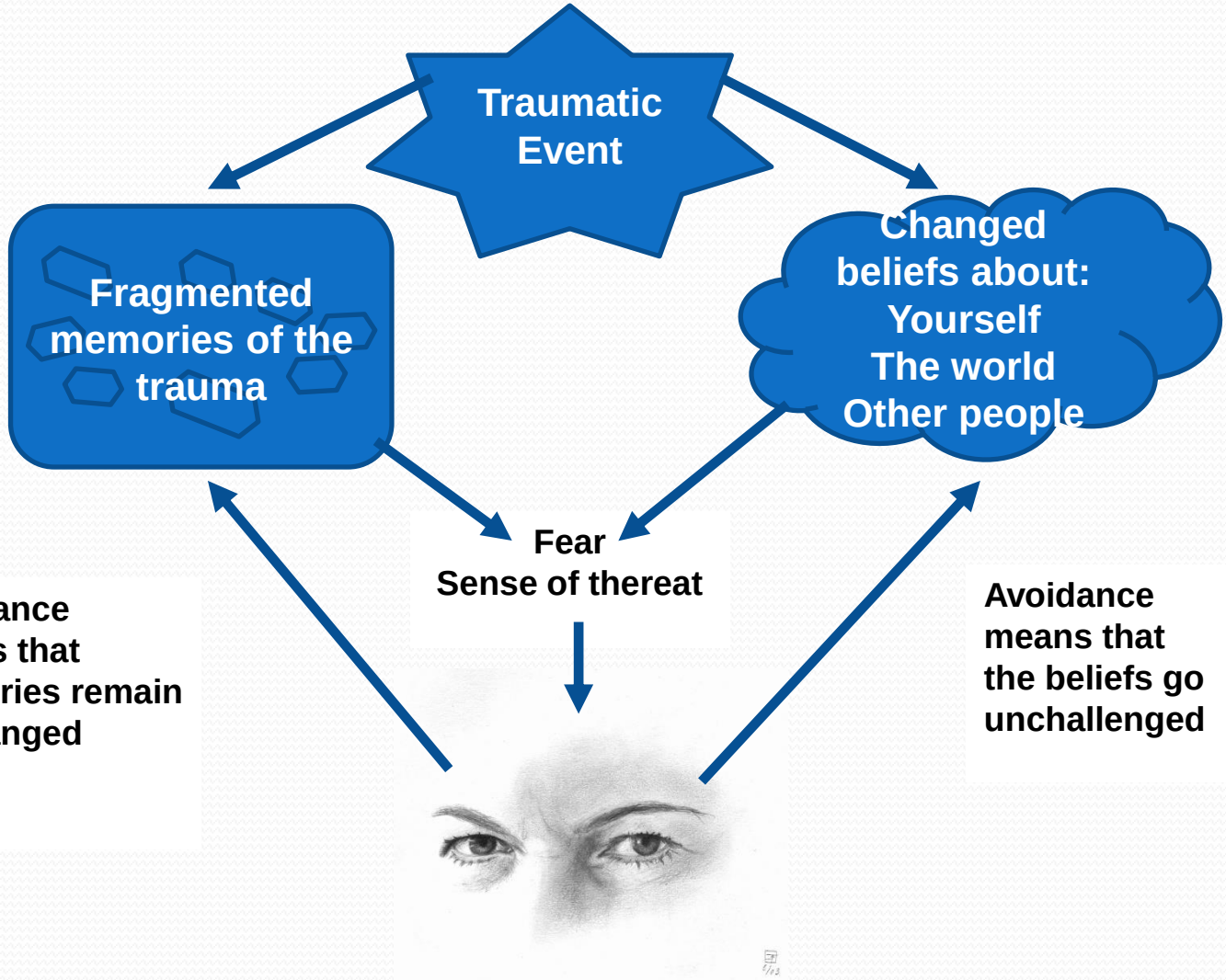
Somatic experiencing®

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

A cognitive-behavioural understanding



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 tl 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 *at 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

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)**

Trauma is not just about dramatic incidents

Psychoanalysis provides a way of thinking about developmental / relational trauma and a number of ways of working with it through the medium of the unconscious.

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).

Other approaches direct and indirect

- **Trauma not brought to mind**
  - **Neuro-feedback**
  - **Yoga**
  - **Meditation / Mindfulness**
  - **Reiki**
  - **Art therapy**
  - **Music therapy**
- **Trauma is (can be) brought privately to mind**
  - **Eye movement desensitization and reprocessing (EMDR)**
  - **Counting method (Ochberg)**
  - **Human givens - rewind technique**
  - **Emotional Freedom Techniques (EFT) - Meridian tapping**
- **Trauma is brought; or comes metaphorically, or metonymically to mind**
  - **Transference**
  - **Dream work**
  - **Stories**
  - **Clean language / metaphor**
  - **Art therapy**

EMDR (Shapiro *et al*., 2004)

- **Short term treatment**
- **Possible for therapist to avoid explicitly entering the trauma**
- **Adaptive information processing (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 post trauma 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 (2011)**
- **Allan Turner (2012)**
- **Ambiguous loss – Pauline Boss (1999, 2006)**

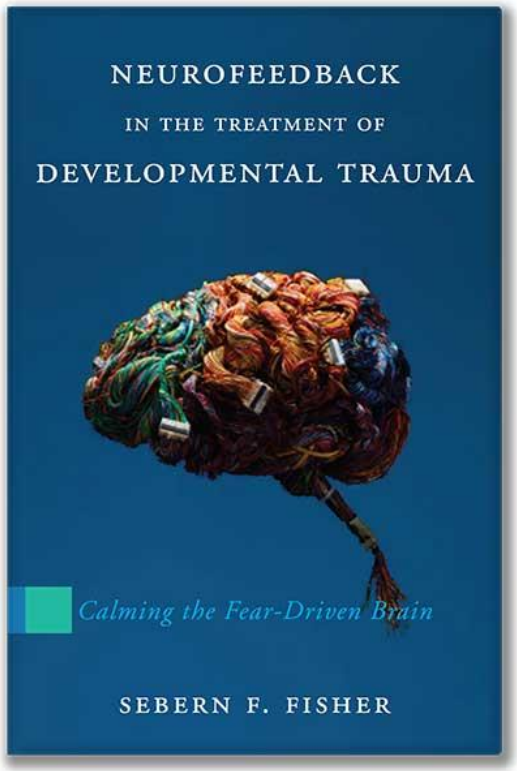
Group versus individual

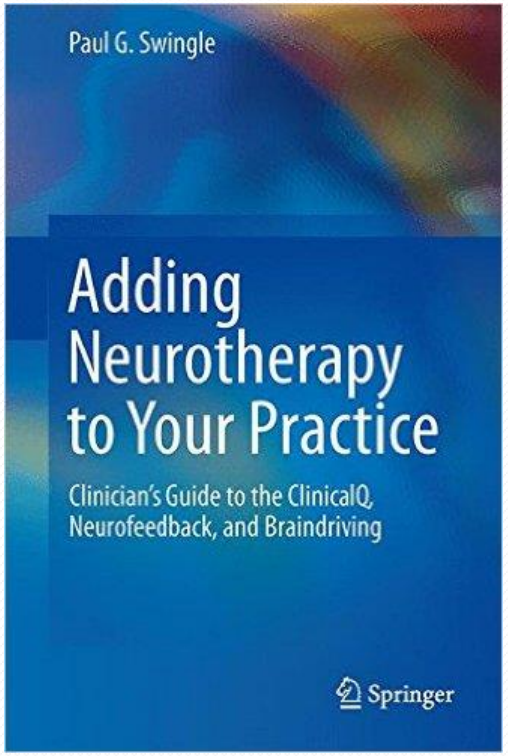
- **Practical limitations**
- **Evidence of effectiveness after disasters or group traumas**
- **Many documented treatments include a combination of individual and group work**
- **This is also seen in manualised treatments like Mentalization for Borderline Personality Disorder – arguably a medicalised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

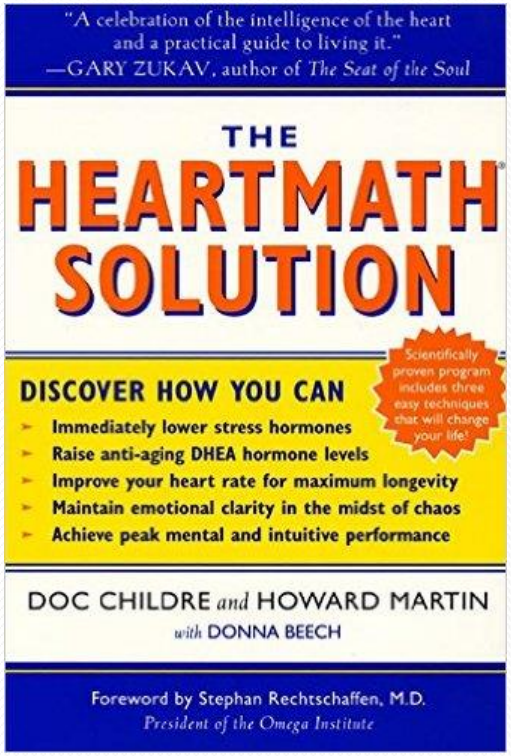
Biofeedback

- **HRV (Heart Rate Variation)**
- **EEG (Electroencephalogram)**
- **HEG (Heamoencephalogram)**

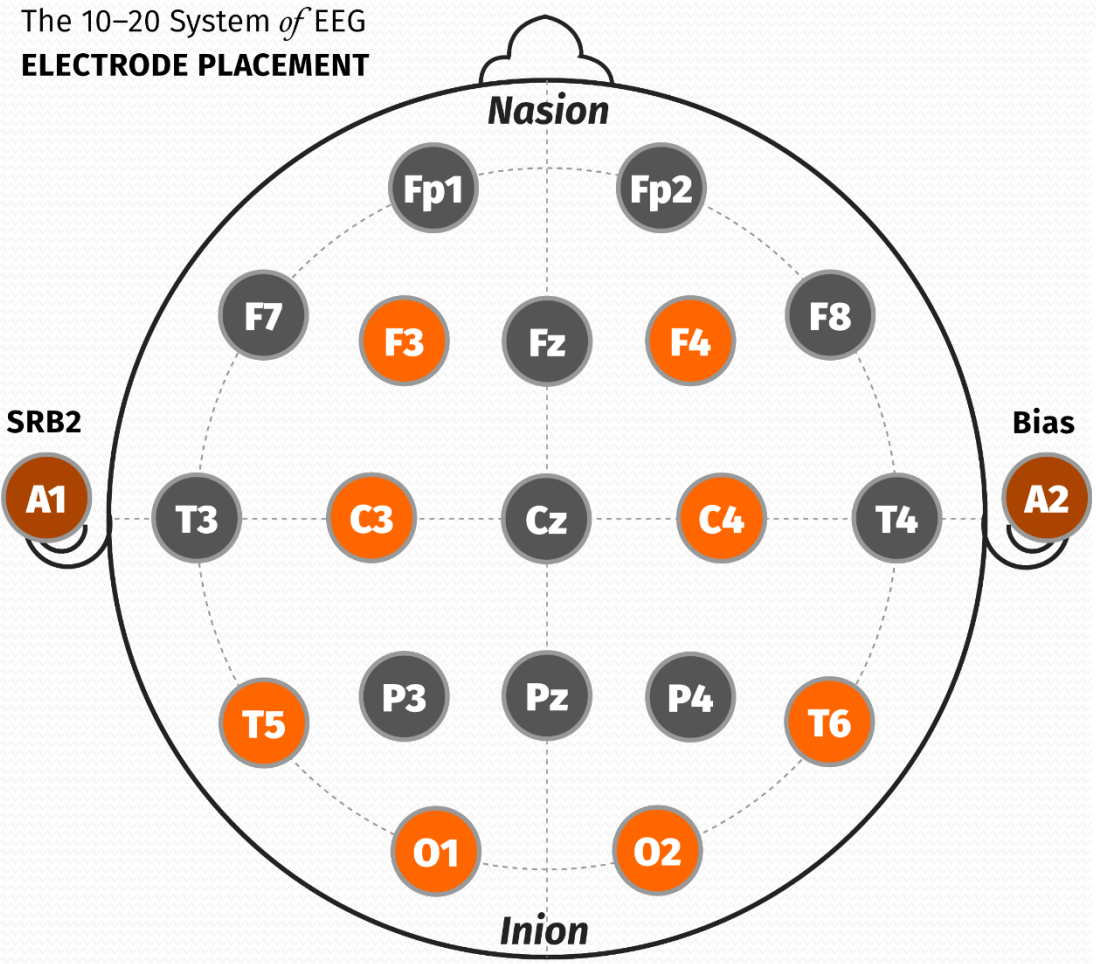
Biofeedback







Medical EEG systems



Neurofeedback

'As Sebern says in her book "Stress never lies with the events that we identify as stressful – it lies in our reaction to them." Neurofeedback raises the brain threshold and generally increases stress resiliency as it increases stability. We are supposed to learn affect regulation during the first few years of life. However, if the system that regulates emotional arousal does not become hardwired in the brain early in life there is little chance that subsequent experience can engage neuroplasticity to such a degree that it can override the critical period of development. Research on monkeys and infants raised with sensory and emotional deprivation in orphanages has shown that it is virtually impossible for the brain to acquire such capacities outside of these critical periods. My meeting with Sebern's patients held out the promise that neurofeedback might be able to accomplish what we have so far failed to do'

van der Kolk (Fisher, 2014)

Film clip 4 min – Sebern Fisher

Sebern Fisher

Sebern F. Fisher, MA, is a psychotherapist and neurofeedback practitioner in private practice who specializes in attachment issues. She trains professionals nationally and internationally on neurofeedback, neurofeedback and attachment disorder, and the integration of neurofeedback with psychotherapy. Her book, *Neurofeedback in the treatment of developmental trauma*, explores the synthesis of Neurofeedback — a powerful modality for retraining the brain — with psychotherapy, specifically in the treatment of developmental trauma and attachment disorder.

Practitioners in action

Video clip of practitioner in action ~20 mins

- **Vote**
- **Necessary to understand clients**
- **‘Horses for courses’**

Practitioners in action

Practitioner	Client	Issue	Approach or technique
Frank Ochberg	'Maya'	Repeated physical and sexual abuse	The counting method +
Fiona Kennedy (Pearson)	'Christina'	Road accident 6 years before	TF-CBT
Peter Levine	'Pete' (veteran of Iraq war)	'Severe PTSD and traumatic brain injury'	'Somatic experiencing'
Tian Dayton	'Sheila	Maternal suicide in childhood	Psychodrama
David Grove	'Anna'	Addiction and consequences	Clean language / Metaphor
Jonathan Lloyd	Volunteer	???	Human Givens Rewind technique

‘Maya’ – Frank Ochberg: Counting Method

- Maya is ~40 years old woman
- Living in US
- Systematically tortured and 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’ – Fiona Kennedy TF-CBT

- **Christina is a woman in 40s, married with two children.**
- **Originally from Latvia – lived in 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 driving.**
- **Husband insisted that she go to GP because she was ‘driving him mad’ – she doesn’t see the problem.**
- **Diagnosis of PTSD confirmed by a clinical psychologist.**

‘Ray’ – Peter Levine Somatic experiencing®

- **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 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**

‘Sheila’ – Tian Dayton Psychodrama

- **Background information on Sheila is limited. No information on assessment and issue emerged in group**
- **Clear it is an established group**
- **Sheila is a woman in her 30s**
- **Mother committed suicide at some stage in her childhood**

‘Anna’ – David Grove Metaphor and clean language

- **Background information on Anna is limited. No information on assessment**
- **Anna is a woman in her 30s**
- **Clear she is a long standing client**
- **Drug user/addict who suffered injuries while under the influence**

Practitioners in action

Practitioner	Client	Issue	Approach or technique
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Jonathan Lloyd	Volunteer	???	Human Givens Rewind technique

Summary of some main points

- 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 the trauma 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