

# Trauma: Treatment Issues

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Psychology 607, Trauma as Etiology  
2 June 2003

## Pharmacotherapy

### ***A Pill for What Haunts You***

#### *Key ideas:*

1. Medicine may be able to prevent PTSD by altering brain chemistry
2. Gene therapies may be able to make people less vulnerable to emotional injuries

#### *Key concerns:*

1. Reducing suffering alters what makes us human.
2. Prozac went from treating severe depression, to helping well people feel better (even pets).
3. At what point do we decide someone should or should not take the drug(s)?
4. Would making the horrors seem not so horrible make us complacent about crime and war?
5. "Isn't human suffering more than a matter of chemistry?"

*What about the possibility for misuse or abuse?*

# Pharmacotherapy

## ***Against Depression, A Sugar Pill Is Hard to Beat***

### *Key Ideas:*

1. Time spent with patients may be important to helping them get well.
2. Drugs are prescribed by primary care doctors who see patients for only a short time.
3. Many research trials show that placebos work as well (or better) than anti-depressant drugs.
4. Nobody seems to know how or why anti-depressants or placebos work.
5. Placebos work in some of the same places of the brain as anti-depressants (prefrontal lobe)

# Pharmacotherapy

## ***Against Depression, A Sugar Pill Is Hard to Beat***

### *Considerations:*

1. "Activation in prefrontal cortex" is non-specific
2. Possible that anti-depressants work in a bottom-up direction rather than top-down direction
  - Does this matter?
3. When told they were on placebo, functioning deteriorated

### *Other findings:*

1. Changes in brain function in and symptomatology in OCD and depression have been found after successful CBT (Baxter et al., 1992; Brody et al., 2001; Schwartz et al., 1996)

# Pharmacotherapy

## ***Against Depression, A Sugar Pill Is Hard to Beat***

### *Questions:*

1. Is it the therapy that works, or the belief that the therapy works?
  - Related to expectation and motivation
2. If placebo changes brain function, is it a placebo or an active treatment?
3. Is medication automatically more active than "talk therapy"?
  - Should medication be the implicit "gold standard?"
4. Placebo PTSD pill?
5. Ethical to not disclose placebo condition if patient improves?

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

### *The Writing Paradigm*

1. Spend 15-30 minutes writing about deep emotions and thoughts about an emotional issue.
2. Time and duration varies from once a day for 3-5 days, to once a week for a month.

People write about a great variety of topics, and seem to take the assignment seriously.

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

### *Results of Writing Studies*

*(Benefits to writers of emotional experiences)*

1. Less visits to health center
2. Improved immune functioning, changes in autonomic and muscular activity
3. Long-term improvements in mood
4. Significant reductions in stress
5. Less absences from work
6. Getting a new job more quickly after being laid off
7. Improvements in grades

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

### *Considerations:*

1. *Improvement does not appear to be a result of improved health habits such as more exercise or less smoking (except one study showed less alcohol consumption.)*
2. Talking and writing about emotional experiences both seem to work better than writing about superficial topics.
3. Few individual differences are found to influence who benefits from writing (e.g. personality, education, language, culture.)

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

*Why does it work?*

1. Perhaps active inhibition involves psychological work, and disclosure reduces that workload.
2. Perhaps building a coherent story about a trauma improves health by reducing flashbacks and ruminations.
  - Individuals who have benefited most from writing began with poorly organized descriptions and progressed to coherent stories

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

*Coding:*

Computation of percentage of negative emotion words (sad, angry), positive emotion words (happy, laugh), causal words (because, reason), and insight words (understand realize)

*General Results:*

1. More positive emotion words related to better subsequent health
2. A moderate number of negative emotion words predict health (very high and very low negative emotion correlated with poorer health)
3. An increase in both causal and insight words over the course of writing was strongly associated with improved health
  - This increase in cognitive words covaried with ratings of coherence

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

### *Activity:*

1. Small-group coding of narrative from "Exiled Voices" article using Pennebaker's system (%pos, %neg, %causal, %insight)
2. Develop an alternative system for coding written narratives
  - May build on Pennebaker's system or may be a completely different approach

# To Speak or Not To Speak

## **Pennebaker's Writing Paradigm**

### **Compare with coding of Adult Attachment Interview**

AAI (Grice's Maxims of rational or coherent discourse):

1. Quality: be truthful, and have evidence for what you say
2. Quantity: be succinct, and yet complete
3. Relation: be relevant to the topic at hand
4. Manner: be clear and orderly

# To Speak or Not To Speak

## **From AAI Classifications – how might these map onto coping with trauma?**

- Secure: discussion and evaluation of attachment experiences are reasonably consistent, clear, relevant, and succinct. Results in high coherence score
- Dismissing: parents described in positive terms that are unsupported or contradicted. violation of maxim of quality (no evidence for what they say); many also described as being excessively succinct, violating quantity maxim by using statements like “I don’t remember.”
- Preoccupied: violate maxims of relevance, quantity, and manner. Relevance violation: tend to wander from topic to topic or move away from context for the query; quantity violation: usually too much – embroiled in excessively lengthy descriptions of past or current problems; manner violation: use of vague speech (e.g., sort of), excessive use of psychological jargon
- Unresolved/disorganized: lapses in metacognitive monitoring. Brief slips in monitoring of thinking during discussion of loss or other traumatic events. Lapses in reasoning include incompatible ideas (simultaneously alive and dead) and state shifts.

# To Speak or Not To Speak

## **Repression Possibly Better Than Your Therapist?**

### *Key Ideas:*

1. Some psychologists believe that people who talk about a traumatic event appear to get worse, or at least fail to get better.
2. A study with heart attack victims showed that those patients who minimized, denied and distracted had better outcomes than those who thought about, worried about, and processed their experience.
3. A study of widows and widowers, and another with sexual abuse survivors showed better adjustment among those who said that they were not depressed, but had elevated heart rates.
4. Perhaps repression is an effective coping style that leads to “the power of positive thinking.”

# To Speak or Not To Speak

## **Repression Possibly Better Than Your Therapist?**

### *Key Ideas:*

5. The trauma field has a history of encouraging people to talk about their trauma—perhaps they have something to lose by paying attention to repression research.
6. Repression may seem “anti American” because of the emphasis on expression in our country.
7. Maybe different types of people are best treated by different methods—repression may work for some, but not for others
8. Maybe we don’t know much about repressors because they don’t show up for treatment.

# To Speak or Not To Speak

## **Repression Possibly Better Than Your Therapist?**

### *Discussion:*

- Catharsis (“rambling”) vs. structured disclosure
  - Catharsis not related to change without cognitive component
- Disclosure on own time vs. “coerced” disclosure
- Is style of disclosure related to self-regulation?
  - Article talks about “ramblers” – which may imply poor regulation/organization
- High vs. low neuroticism (constant worry wears out immune system? General Adaptation Syndrome—Selye)
  - Article states “high anxiety and low defensiveness [thinking about it, worrying about it, processing it] had far poorer outcome than their stiff-lipped counterparts”



# Relational Models

## **The Core Trauma of Incest: An Object Relations View**

*Main "mysteries" of the behavior of incest victims*

1. Why can't (or don't) they prevent the abuse?
2. Why do they keep it secret? (or deny it after revealing it?)
3. Why do they seem to have an intensive attachment to the perpetrator?
4. Why do they get involved in further abusive relationships?
5. Why do they sometimes become abusers themselves?
6. Why do some children appear to be asymptomatic, when others have high levels of pathology?

*Traditional Psychoanalytic view:* children have a desire for incestual gratification.

*Object-Relations view:* Much of the victim's behavior is an attempt to remain attached to caretakers.

# Relational Models

## **The Core Trauma of Incest: An Object Relations View**

*Two critical areas of object relating:*

1. The experience of being connected to others
  - Child must remain connected to caregivers, or risk a state of "objectlessness" which is highly undesirable.
  - Some disappointment with caregivers naturally occurs, and a child can usually incorporate that disappointment into his or her image of "good parent."
  - When severe disappointment or trauma occurs, too much work is required to continue the attachment, so the solution is to "construct an illusory image of a good parent."
  - The child becomes intensely attached to image of "good parent" and has little energy left to form a real relationship.
2. The sense of physical-sensory continuity
  - Childhood is an intensely body-centered experience (the infant is almost all body.)
  - The sense of self is built on skin sensations.
  - A lack of touch can lead to "a feeling of annihilation."
  - There is a feeling of intensity and violation with any bodily damage in childhood.
  - A physical violation damages a child's connection to "good parent."
  - Child must dissociate from "bad parent" knowledge, in order to avoid objectlessness.
  - Dissociation may cause children to appear asymptomatic.

## Relational Models

### **The Core Trauma of Incest: An Object Relations View**

*Why do abused repeat the cycle of abuse?*

1. Reexperience the trauma in the victim, passive aggressor, or active aggressor role
2. See the aggressor in a more positive light (We all do it. We can't all be bad.)
3. Sustain the relationship (I'm like my parents, and therefore we are connected rather than separated)

## Relational Models

### **Betrayal Trauma: Relational Models of Harm and Healing**

*Key ideas of part 1:*

Two types of harm

1. *Life threat*—can result in anxiety, hyperarousal, intrusive memories.
2. *Social Betrayal*—can result in dissociation, numbness, constricted or abusive relationships.

Central organizing construct of the relational model is *the importance of relationships* (for both harm and healing.)

## Relational Models

### **Betrayal Trauma: Relational Models of Harm and Healing**

#### *Key ideas of part 2:*

- Core trauma of incest (as learned previously) is damage to connection to others and to parts of the self.
- Effective treatment must address this damage.
- Careful listening, deep empathy, true compassion, and a mutual relationship are necessary to address “silenced knowings.”
- Listening can be difficult.
- The “believing game” allows a listener to get into the experience of another person.
- Mutuality—both people in the relationship are seen as whole, rather than as a particular label or characteristic.
- Ethics must move beyond avoiding lawsuits into becoming truly therapeutic.

## Relational Models

### **Betrayal Trauma: Relational Models of Harm and Healing**

#### *Key ideas of part 3:*

- Seeing beyond individual suffering
- Human bonds cannot be seen or touched, so they are not considered important.
- The individual is seen as the container of the problem.
- The context does not get examined.

# Relational Models

## **Betrayal Trauma: Relational Models of Harm and Healing**

### *Discussion:*

- Can mutuality be described by someone who has not “been there”?
- Does mutuality consist of some qualities similar to an existential “peak experience” that emerges as a function of the interaction?
  - Characteristics of a peak experience:
    1. Ineffability: Subject to mystical experience-defies verbal expression
    2. Noetic Quality: Intellectual, truth-finding quality of mystical experience
    3. Transiency: Cannot be sustained for long
    4. Passivity: Cannot be actively obtained – when peak experiences are sought or induced, the value of the experience is lost
- How would a person do empirical research on this?
- Is mutuality something that can be measured?

# Personal Experience of Trauma

## *When Racism Gets Personal: Toward Relational Healing*

### *Key Ideas:*

- Racism is described as a socio-historical trauma
- Three types of anxiety: natural, toxic, and sacred
- Toxic racial anxiety can result in problems with both situational and intimate relationships
- Racial anxieties exploit normal conflicts that might otherwise lead to healing and resilience
- Neither family nor sexual intimacy can offer refuge from racial anxiety
- As a result of racial stratification, members on both sides of racial lines are socialized to use disconnection as a survival tool
- (The stories of 3 bi-racial women are presented to illustrate how the Relational-Cultural Model explains racial anxiety.)

# **Notes from class discussion on treatments for trauma**

## **Ideas on how to code narratives:**

1. how much of "self voice" comes out in narrative?
2. does writer "own" the story?
3. is there good use of metaphor or imagery (does it help get the point across?)
4. is the story cohesive and coherent?
5. do the emotion words get expressed implicitly if not explicitly?

## **Other comments from class on the articles in general:**

1. Repression seems to be used to describe several different constructs.
2. Future studies should compare brain activation with psychotherapy compared with anti-depressants (or other drugs) and placebo.
3. A truly scientific study would substitute placebo for "real" drug partway through a drug trial, or vice-versa.