Psychotherapeutic Strategies for Healing Trauma

Wheeler, Kathleen

PURPOSE. The Adaptive Information Processing Model (AIP), originally developed by Shapiro (2001), provides a model for understanding how trauma affects the brain and how healing occurs.

CONCLUSIONS. The effects of trauma are thought to be much broader than the diagnosis of PTSD and overlap with many other diagnostic categories. Recent physiological research supports the complexity of neurobiological responses to childhood stress and trauma.

PRACTICE IMPLICATIONS. The Treatment Hierarchy, AIP model, and evidence-based treatment framework presented here provide the context and a compass for holistic PMH-APRN practice for working with traumatized patients.

Search terms: Adaptive information processing, disorders of extreme stress (DESNOS), healing trauma, posttraumatic stress disorder (PTSD)

Trauma is an inescapable part of the human experience and affects all dimensions of the person. Psychological trauma has been posited to underlay or contribute to a wide range of psychiatric disorders and medical problems (Hennessy, Ford, Mahoney, Ko, & Siegfried, 2004; Morrison, Frame, & Larkin, 2003; Scaer, 2005; Teicher, Polcari, Andersen, Anderson, & Navalta, 2003). Trauma disconnects the person physiologically, emotionally, spiritually, cognitively, interpersonally, and socially. The National Comorbidity Study found that 60.7% of men and 51.2% of women interviewed reported having experienced at least one major traumatic event in their lifetime (Kessler et al., 1999), and of those exposed to trauma, the prevalence rate for posttraumatic stress disorder (PTSD) is approximately 25% overall in the United States (Foa, Keane, & Friedman, 2000).

Findings (Arnsel & Marshall, 2003) from the World Trade Center disaster indicate that many people did have significant symptomatology afterward, such as insomnia, irritability, general anxiety, vigilance, and impaired concentration. However, those problems that people sought help for did not fit into the diagnostic categories of the DSM-IV-TR. Van der Kolk (2003) says that single incident traumas account for those diagnosed with PTSD but that most adults who seek psychotherapy have had numerous traumatic events and suffer from a variety of psychological problems, most of which do not fall within this diagnostic category. Broadly speaking, these fall into problems in aggression, self-hatred, dissociation, somatization, depression, distrust, shame, relationship problems, and affect regulation.

The Effects of Trauma Beyond PTSD

The effects of trauma are thought to be much broader than the diagnosis of PTSD and overlap with many other diagnostic categories. This is true for adults as well as children. One study (Teicher et al., 2003) found that almost two thirds of children with documented abuse do not suffer from PTSD but from a variety of other psychiatric disorders, such as dissociative disorders, borderline personality, bipolar and unipolar depression, substance abuse, eating disorders, oppositional defiant disorder, and attention deficit disorder.

An individual's vulnerability to trauma depends on the developmental stage, genetic vulnerability, gender, past experiences, preexisting neural physiology, cognitive deficits, emotional maturity, coping skills, hardness, relationships with others,
sociocultural factors, and a host of other factors (Antai-Otong, 2002). If the trauma is particularly prolonged and/or severe and/or the person is vulnerable, pervasive personality problems develop. The person may then develop complex PTSD or disorders of extreme stress not otherwise specified (DES Nos) (Herman, 1992). Although not a DSM-IV diagnosis yet, six deficit areas for DES Nos have been delineated, which include: dysregulation of affect and impulses, disorders of attention and consciousness, disorders of self-perception, distorted interpersonal relationships, distortions of systems of meaning, and somatization of external stress manifesting in the body as disease or physical disorders (Dworkin, 2005). These individuals, referred to as the chronically disempowered by Chu (1998), are often survivors of childhood abuse and require long-term treatment extending over several years.

Shapiro (2001) expanded the concept of trauma from what we traditionally consider Big T events, such as natural disasters, terrorist attacks, war, incest, physical abuse, car accidents, and other major lifethreatening events, to include small T traumas. Small T traumas are those that occur often and to most people, such as emotional neglect or indifference, humiliation, and family issues and do not rise to the level of a Big T trauma, yet may create problems and long-term sequelae, both physically and emotionally. For example, childhood experiences such as caregiver depression, chronic mother-infant misattunement, being bullied, chronic loneliness, separation from parents, feeling stupid and humiliated in the classroom setting, significant physical illness, relationship and/or personality problems between parents, economic hardships, family instability, frequent moving and/or change of school, taking care of an alcoholic parent, and many other life events impact the developing child's brain.

Recent physiological research supports the complexity of neurobiological responses to childhood stress and trauma (Stien & Kendall, 2006; Teicher et al., 2003). Of course, adults, too, are affected by small T events, especially if they have experienced many small T childhood events because the cumulative effects of trauma on the developing brain are apt to be profound and long lasting, particularly in those with a genetically encoded vulnerability. Traumas, both big and small, can significantly compromise functioning and lead to psychiatric problems and disorders.

Adaptive Information Processing Model

The Adaptive Information Processing Model (AIP), originally developed by Shapiro (2001), provides a model for understanding how trauma affects the brain and how healing occurs. AIP hypothesizes that humans have an inherent information processing system that usually processes experiences to a physiological adaptive state where information can be taken in and learning will occur. This model posits that there is a self-healing quality in all persons and that negative experiences can inhibit innate neurophysiologic functions. Memory is stored in neural networks that are linked together and organized around early events with associated emotions, thoughts, images, and sensations. Interconnected neuronal and biochemical patterns are developed as templates for future experiences through interaction with others, and specific profiles emerge that may be adaptive or nonadaptive. Healthy functioning is reflected in the optimal integration and coordination of these neural networks.

In trauma, the experience is so overwhelming that the event is not fully processed and instead is stored as it was at the time of the disturbing event in a state-specific form and does not get linked to other networks in an adaptive way (Shapiro, 2001, 2002). Intense affect occurs, and the experience may be isolated with the thoughts, emotions, and sensations locked into the memory network. Trauma dysregulates integrated neural processing of information in these networks (Cozolino, 2002). Later, similar experiences may then activate this material. The response to trauma that was adaptive at the time it occurred is now, in the present, compromising functioning.

Psychotherapy facilitates information processing so that painful memories are integrated with other more adaptive memories. Processing dysregulated information to an adaptive resolution and connecting subcortical areas with cortically mediated higher brain functions changes dysfunctional symptoms (Cozolino, 2002; Shapiro, 2001, 2006). Emotional arousal and novel
sensory experiences activate implicit memory that is necessary in order to access these state-dependent memories and link these neural networks in the brain to more adaptive, positive, information networks. Accessing traumatic events marked by sadness, anger, or fear activates all areas where the emotional memory is stored, recreating all dimensions of the experience, and thus provides an opportunity to facilitate restructuring neural networks.

A Framework for Treatment

Given the complexity of responses to trauma, a framework for using psychotherapeutic interventions needs to address the bewildering symptoms and deficits that result, particularly when there has been severe and prolonged trauma. The Treatment Hierarchy outlined in Figure 1 is based on research and theory developed by numerous clinicians (Briere & Scott, 2006; Chu, 1998; Davis & Weiss, 2004; Najavits, 2002; Shapiro, 2001). This is a phase-oriented treatment model: Phase 1, safety and symptom stabilization, involves increasing external and internal resources, and Phase 2 is aimed toward processing the painful memories so the person can move toward enhancing future visioning and self-actualization. This framework is based on neuroscience underlying the AIP model. Cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing (EMDR) interventions can be used for both Phase 1 Stabilization to enhance internal resources and Phase 2 Processing.

Phase 1: Stabilization

To begin the healing process, decisions are made regarding where to target interventions based on a comprehensive assessment of the strengths and resources the person already has. What coping skills have worked for the person in the past? A thorough history of the patient and an accurate assessment includes selected appropriate assessment tools that help the Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN) formulate a plan. In general, the lower the patient falls on Maslow’s hierarchy of needs, the more active the therapist must be. For example, the patient who abuses substances, is hungry, and is homeless must first have physiological needs of safety met. Safety is always a priority in the stabilization phase, and crisis intervention may be needed. Many clinicians recommend treating comorbid disorders simultaneously, that is, both PTSD and alcohol abuse together, because of the interdependent relationship between the person’s problems (Briere & Scott, 2006; Expert Consensus Guideline Series, 1999).

Since dissociative disorders frequently co-occur with PTSD, every patient should be screened with the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) (see Table 1). Patients who score highly on this scale should be further evaluated by the Structured Clinical Interview Schedule for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1994). If a dissociative disorder is present, the patient should be treated by a clinician who is skilled in the treatment of these disorders, as the patient may rapidly destabilize. These patients may need a prolonged period of stabilization and may never be able to tolerate Phase 2, Processing, but will still improve functioning significantly. Some indicators that the person is ready to move to Phase 2 include: the patient is able to establish a useful distance from the traumatic event, there is no current life crisis, there is a support system in place, patient’s mood is stable even if depressed, the person can self-soothe and manage emotions, there is no major dissociation, and living conditions are stable.

Goals of Treatment

Patients with significant trauma histories come to treatment with a range of disturbing symptoms and present significant diagnostic and treatment challenges. The complexity of symptoms and multiple diagnoses confuse and challenge clinicians who care for this population. In general, the goals of treatment for PTSD can be applied to those who suffer from other trauma-related diagnoses. These are delineated in The American Psychiatric Association Practice Guidelines for PTSD (2004) and include reducing the severity of symptoms, preventing or treating trauma-related comorbid conditions that may be present or

emerge, improving adaptive functioning and restoring a psychological sense of safety and trust, protecting against relapse, and integrating the danger experienced into a constructive schema of risk, safety, prevention, and protection. Clinical signs of recovery include being able to talk about the trauma without feeling upset or numb, functioning in daily life, having feelings of being safe and confident, participating in healthy relationships without feeling vulnerable, taking pleasure in life, having the ability to rely on self and others, experiencing minimal dissociation, having the ability to manage emotions, feeling deserving, and being able to plan for the future and expand one’s focus beyond the self.

Symptom measures used for assessment can track progress during treatment as well as help determine whether the goals of treatment have been met. See Table 1 for a selected list of some of the most commonly used instruments. The Impact of Event Scale (IES-R) is a screening tool for a specific trauma (Weiss & Mannar, 1997), while the Modified PTSD Symptom: Self Report Version (MPSS-SR) measures severity of trauma symptoms (Falsetti, Resnick, Resnick, & Kilpatrick, 1993), and the Clinician Administered PTSD Scale (CAPS) is a structured interview tool (Blake et al., 1995). Although these measures target specific symptoms, the effects of trauma are wide ranging and affect all dimensions of the person: emotional, intellectual, physical, relational, spiritual, vocational, environmental, and psychological. Holistic outcome measurements rather than symptom-specific instruments may more accurately reflect healing. Example of measures reflecting holistic outcomes might include quality of life, self efficacy, overall health status, connection to others (e.g., a sense of belonging or social support), spiritual well-being, and resilience.

The Therapeutic Alliance

The importance of safety in the therapeutic relationship cannot be overemphasized. The therapeutic alliance cultivates a healing environment for emotional safety and allows the patient to continue and benefit from treatment. Traumatized patients may have particular difficulty forming a therapeutic alliance, and trust issues are often fraught with anxiety. The term traumatic transference was coined to refer to the particular transference constellations that form for those who have suffered childhood abuse (International Society for the Study of Dissociation [ISSD], 2005). According to the Guidelines for Treating Dissociative Identity Disorder in Adults, therapy itself:

may begin to erode dissociative barriers and defenses leading to greater intrusion of traumatic memories. This may engender additional fears of loss of control due to increased awareness of extreme affects and disturbing cognitions. Feeling vulnerable, patients may manifest more difficulty with trust, fearing that they will be abused or manipulated as they were in childhood. (ISSD, p. 23)

The therapeutic relationship can offer a corrective emotional experience through collaborative support and connection. Meta-analytic reviews of research studies have found that the therapeutic alliance is itself therapeutic and crucial for the successful outcome of psychotherapy no matter what model of treatment is used (Martin, Garske, & Davis, 2000). Maintaining firm boundaries, setting limits, and explaining to the patient the inherent difficulties the person may encounter in trust are essential in order to promote a safe environment, especially for severely traumatized patients. General strategies for initiating and maintaining the therapeutic alliance are important and include: (a) asking detailed questions about the patient’s main concern, (b) validating affect, (c) explaining the therapy process as it unfolds, (d) listening empathically without minimizing or offering "fix it" statements, (e) reminding the person that we are working together toward "our" common goal, and (f) pointing out the person’s strengths (Bender & Messner, 2003).

Internal Resources

Along with shoring up external resources, internal resources often need to be increased prior to processing. Internal resources are less tangible than external resources and include the person’s ability to manage both positive and negative emotions (i.e., affect management), symptom control, spiritual beliefs, a sense of inner strength (i.e., ego strength), and a belief in oneself.
Indicators that the person has sufficient internal resources include the person’s ability to self-soothe, control impulses adequately, identify stressful triggers, stabilize mood, reach out to supportive people, and communicate and be honest in reporting. Strategies for stabilization include strengthening and/or creating internal resources. These strategies assist the person in managing the state changes required prior to processing (Shapiro, 2006).

Evidence-Based Interventions

Empirical research supports the efficacy of CBT and EMDR as sole treatment interventions for PTSD (Davidson & Parker, 2001; Rauch & Cahill, 2003). A multidimensional meta-analysis revealed that the majority of patients treated with either CBT or EMDR improved significantly (Bradley, Greene, Russ, Dutra, & Westen, 2005). Practice guidelines for both PTSD and Dissociative Identity Disorder include CBT and EMDR as effective treatment modalities (American Psychiatric Association, 2004; Department of Veterans Affairs & Department of Defense, 2004; ISSD, 2005). CBT and EMDR are both widely used for other trauma-related disorders as well, such as anxiety, mood, eating, somatic, and dissociative disorders (Wheeler, in press). Psychoeducation is a key component throughout all phases and involves education about trauma; how the fear response develops; and information about sympathetic nervous system arousal, depressive symptoms, panic, and education about the psychotherapeutic process itself. For a more in depth discussion about psychoeducation, please refer to Phoenix’s (2007) article in this issue. Medication to decrease hyperarousal may be indicated and help the person to manage emotions and control symptoms. Please refer to Dowben and Keltner’s (2007) discussion of psychopharmacological management for PTSD in this issue.

Cognitive Behavior Therapy

CBT is based on the premise that the individual’s view of self and the world are central to the determination of emotions and behaviors, and thus by changing one’s thoughts, emotions and behaviors can be changed (Freeman & Freeman, 2004). Dysfunctional (or maladaptive) thoughts relating to self, world, and/or others are based on irrational or illogical assumptions. Clinical strategies are utilized to help the individual recognize the dysfunctional nature of their thinking patterns and to assist the individual to change their interpretations of situations. Behavioral interventions have been integrated with cognitive strategies in CBT, and these combined techniques contribute to better outcomes. CBT enhances coping skills by teaching strategies such as diaphragmatic breathing, thought stopping, covert rehearsal, guided self-dialogue, and role playing (Falsetti, 2003). Seeking Safety: A Treatment Manual for PTSD and Substance Abuse by Najavits (2002), The Anxiety and Phobia Workbook by Bourne (2005), and The Posttraumatic Stress Disorder Sourcebook by Schiraldi (2000) are excellent resources for the PMH-APRN to use in order to assist the person in developing these skills.

Eye Movement Desensitization and Reprocessing

EMDR training began in the 1990s as a behavioral treatment for PTSD. In EMDR processing, all dimensions of the memory, the image, the thoughts, the emotions, and the body sensations are accessed while the patient focuses on a dual attention bilateral stimulation, with either eye movements, auditory tones, or tapping, while at the same time paying attention to the disturbing event (Kuiken, Bears, Miall, & Smith, 2001-2002; Shapiro, 2001). In between bilateral sets of stimulation, the patient free-associates, according to protocols, in order to elicit information and associational memories. Patients process painful memories and integrate new information. The exact mechanism of action is unclear, but it is thought that the dual attention that is required during EMDR facilitates interhemispheric connection, thus disrupting the traumatic memory network. The accessing of adaptive information and the integration of memory networks has been linked to the processes of REM sleep. There is some empirical support for this explanation for EMDR (Christman, Garvey, Propper, & Phaneuf, 2003; Stickgold, 2002).

Internal resources can also be developed and installed with specific protocols using EMDR that combine imagery, safe place,
therapeutic interweaves, and/or containment exercises with bilateral stimulation (Leeds, 2001). Three general types of resources identified by Shapiro (2001) include: mastery resources such as patient’s memories of past coping, relational resources such as memories of positive role models or supportive others, or symbolic resources from dreams, nature, religion, music, future positive image, etc. Often skilled clinicians use both CBT strategies and EMDR to enhance internal resources. An important point about these strategies is that nothing works for everyone all the time and that some things work better than others for certain patients. Accurate assessment of the person’s coping skills coupled with collaboration, trial and error, and patience guide the PMH-APRN in identifying what will work best for this person at this time so that the patient can have a repertoire of resources readily available when needed.

Stages of Change

When working with the patient, consideration should be given to where the person is in the change process in order to aim interventions toward behavioral change. Prochaska and Norcross (2002) provide a model upon which to match therapist intervention to the patient’s stage of readiness to change (see Table 2 for the Stages of Change). The therapist assesses the person’s motivation through open-ended questioning and techniques that are specific for each stage of readiness. For example, techniques used to assess precontemplation would be exploratory about the person’s lifestyle, such as “Where does alcohol fit into your daily schedule?” Requesting the person to measure the amount of alcohol and keep a log of what they drink for a week raises consciousness about the reality of the problem behavior. Observation and confrontation are useful communication techniques for consciousness raising and increases information about the self and the problem. Bibliotherapy also helps the person to progress to contemplation. Another technique useful for both precontemplators and contemplators is to draw a line vertically down the middle of a paper and ask the person to list the good things about the behavior on one side and the not so good things on the other side. Allowing time for the person to think about this and then verbally summarizing without judgment are important so the person can explore their own ambivalence.

Imagery can also be useful in moving toward contemplation and assist in self-reevaluation by asking the person to imagine themselves doing the positive behavior or change. Along with this process, the person may experience dramatic relief through experiencing and expressing feelings about the loss of changing. However, the PMH-APRN should help the person modulate the intensity of the experience by naming the experience and rating the level of disturbance (0-10 scale) but not encourage detailed remembering of the trauma. Once the patient has moved into the contemplation stage, the therapist helps the person to focus on the discrepancy between now and the way the person would like things to be. This can be accomplished through exploring questions, such as “How would you like things to be different in the future?” “What’s keeping you from doing things you want to do?” and “How does your current behavior fit into your future goals?” These strategies gently lead the person to their own change.

Phase 2: Processing

Once stabilization has been achieved, the person is ready to move to the next phase, that of Processing. Processing reflects access of all dimensions of memory; behaviors, affect, sensations, cognitions, and beliefs associated with the trauma. Processing involves assisting the person in constructing a narrative through the exploration of the meaning of significant small and large traumas that impair functioning, and through this process, new learning can occur so that trait changes are possible (Shapiro, 2006). Changes in physical and emotional responses that occur as components of the dysfunctional memory are integrated with other more adaptive networks. Once processed, the event no longer increases emotional arousal. Implicit memories are accessed and this must occur in the context of a safe therapeutic relationship with adequate resources in place. Ensuring safety and stabilization are priorities during emotional arousal so the person is not retraumatized and the information is integrated and not further dissociated (Shapiro, 2001).

Evidence-based CBT interventions in the processing phase are those that involve exposure components, such as writing about...
the cognitive event, imaginal exposure, in vivo exposure to trauma and/or panicrelated cues, and interoceptive exposure to physical symptoms (Rauch & Cahill, 2003). Deciding which exposure component to use depends on the person's presenting problem. If the person suffers from panic anxiety, interoceptive exposure should be considered. This involves exercises such as stair stepping and head shaking that bring on panic-like symptoms. If the person does not suffer from panic, imaginal exposure through writing or talking about the trauma is appropriate. In vivo exposure and constructing a hierarchy of associated fears from the least to the most anxiety provoking and then pairing with relaxation techniques counters sympathetic arousal with the parasympathetic relaxation response.

Processing with EMDR involves targeting the trauma with an eight-phase protocol that guides the person through a description of the disturbing event relating to his or her presenting problem (Shapiro, 2001). The PMH-APRN asks the patient to identify and focus on the image (picture), negative belief about oneself at the time of the trauma, emotions, and physical sensations associated with the traumatic memory. While the person is engaged in some form of bilateral stimulation, he or she is experiencing various aspects of the initial memory or related memories. The practitioner pauses between sets of bilateral stimulation to ensure that the person is processing adequately on his or her own and to get the patient's associations.

During processing, abreaction, which is the intensive discharge of emotions related to the trauma, may occur (Chu, 1998; Shapiro, 2001). During abreaction, the person experiences the same sensations, thoughts, and emotions that occurred during the time of the trauma and becomes immersed in the event. Hyperarousal occurs sometimes with rapid eye movements, increased respirations, and increasing anxiety. Helpful strategies during abreacts include a calm voice, grounding techniques, distraction, asking for clarification, changing the subject, calling the person by name, and orienting them (i.e., "It's ok, Jeanne, this is Kate. You are at my office and can hear my voice. You are upset now but you will be able to calm yourself. Notice the rug, the fabric on the chair, and your feet on the ground. You are right here with me and you are safe.") Don't touch the person or make any sudden moves, and allow for personal space.

Clinically, processing has been achieved once relationships are adaptive, work is productive, selfreferences are positive, there are no significant affect changes, affect is proportionate to events, and there is congruence between behavior, thoughts, and affect (Davis & Weiss, 2004). It is important to keep in mind that periods of processing are sometimes followed by periods of destabilization. The PMH-APRN paces and structures treatment so work on traumatic material alternates with resources, such as grounding and containment. Returning to Phase 1 interventions, such as somatic awareness, safe place, anchors, dual awareness, progressive muscle relaxation, and establishing boundaries is important (Rothschild, 2000). The treatment process often looks more like a spiral, alternating with interventions aimed toward stabilization and then processing leading toward self-actualization and future visioning.

Implications for Nursing Practice

Healing trauma brings together all parts of one's self at deeper levels of inner knowing. Empowerment and autonomy is fostered as the person moves toward self-actualization and into envisioning and planning for the future. The Adaptive Information Processing Model provides the framework for understanding how neuroscience is embedded in holism. Information processing through psychotherapy restores harmony, balance, connection, and integration of neural networks, which are key to healing and reflected in deeper connections with one self and others. The Treatment Hierarchy presented here provides the context and a compass for holistic PMH-APRN practice for working with traumatized patients.

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Kathleen Wheeler, PhD, APRN-BC

Kathleen Wheeler, PhD, APRN-BC, is a Professor at Fairfield University School of Nursing in Fairfield, CT.

Author contact: kwheeler@mail.fairfield.edu, with a copy to the Editor: mary@artwindows.com

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