Trauma
Working with PIT

PSYCHODYNAMIC INTERPERSONAL THERAPY
PIT-UK

Overview

- Work of Russell Meares and the Australian group
  - The trauma system
  - Processing trauma
  - Integration and Dissociation
  - The Australian Conversational Model
- Managing arousal level
  - Yerkes Dodson curve
  - Managing hypoarousal
  - Hyperarousal and grounding techniques

Practical ways of working with trauma

- NICE Guidance:
  - Medication
    - Some evidence for SSRIs
  - CBT for trauma
  - EMDR

- Poor outcome once consolidated leading to long-term changes in “personality”
- Complex PTSD
- Link with Borderline states
- New possibilities e.g. MDMA and therapy

Conversational model.au

- Work of Russell Meares,
  - with Jane Haliburn,
  - Nick Bendit,
  - Anthony Korner,
  - Dawn Mears,
  - David Butt
- Damage to the self and its repair

The Trauma System

- Disruption of personal being
  - Micro-dissociations – “prickly”, “sensitive”
- The Uncoupling of Consciousness
  - The 3 “Js”
    - Pierre Janet,
    - Hughlings Jackson, William James (“The duplex self”)
    - “I” and “Me” dislocated
- Dissolution
- Stimulus entrapment
  - And narrowing of the field of consciousness

The Trauma System II

- Trauma and “attacks on value”
  - “Attacks upon the positive feeling, the sense of well-being, which is at the core of a personal reality which has developed under “good-enough” conditions are major but neglected traumata.”[Intimacy and Alienation, p71]
  - This type of trauma is akin to repeated invalidation- in development this is a failure to respond to the immediate experience of the child (see Winnicott, M & E Balint, Kohut, HS Sullivan)
- “A child who lacks feeling-based experiences of others, connected with their own immediate experience, are left with a persistent dysphoria involving emptiness and deadness.”
- “...direct attacks on what Sullivan called the “tender emotions” ...When their expression meets with a devaluing response such as ridicule, the developing person “may be literally hurt”...exposure risks the experience of shame. In extreme circumstances shame is devastation, associated with a loss of personal worth.”

Working with the trauma system

- “The therapist must be able to manage and balance the two imperatives: the fear of disclosing and the fear of avoiding disclosure”
- “Therapeutic zeal in the hunt for traumatic experience [runs the risk of] retraumatization”
- Evidence of intrusion of unconscious traumatic memory

Processing Trauma

- Repair of disjunctions and restoration
- Failure in processing
- Difficulties processing trauma
  - Impasse
  - Attachment to the trauma and dependency
  - Aloneness, fear of abandonment and separation anxiety

Concepts: 1. Integration

- Development of Narrative and Symbolic Transformation
- The Capacity to remember traumatic events without fragmenting
- Integrating affects and regulating the Self
- Integration expressed as relatedness
- Changing maladaptive coping styles
- The ability to adapt
- Integration of split-off aspects of Self

2. Dissociation

- Dissociation, depersonalization and derealization
- DID
- Somatization
- Blanks in memory
- Discontinuities
- Prompts:
  - Having flashbacks related to your PTSD
  - Feeling that you are briefly losing touch with events going on around you (similar to daydreaming)
  - “Blanking out” or being unable to remember anything for a period of time

Dissociation

- “Unable to integrate traumatic memories, they seem to have lost their capacity to assimilate new experiences as well. It is ...as if their personality has definitively stopped at a certain point, and cannot enlarge any more by the addition and assimilation of nnew elements”.
  - Pierre Janet

3. Avoidance

- Emotional numbing symptoms are part of the avoidance cluster of PTSD symptoms. Emotional numbing symptoms generally refer to those symptoms that reflect difficulties in experiencing positive emotions.
  - A loss of interest in important, once positive, activities.
  - Feeling distant from others.
  - Experiencing difficulties having positive feelings, such as happiness or love.
  - Being cut-off in the session

4. Negative thoughts

- Self-blame
- Survivor guilt
- Negative thoughts about self
- Distortions of self-image

Adherence to the Conversational model working with trauma (Meares)

- From Borderline PD and the CM : A clinician's manual (Russell Meares, 2012,New York: Norton)
  - Immediacy
  - Inner speech (right hemisphere language)
  - Mutuality
  - Positivity
  - Representation
  - Reflection
  - Changing the chronicle
  - Processing trauma

Adherence to the model II

- Immediacy
  - T response coupled closely in emotional tone (mirroring)
  - Uses the words actually used by P
  - Responds to what is most “alive” in what is said
  - T uses present tense usually
  - Trauma is processed as if in the present
- Inner speech (right hemisphere language)
  - T uses inflections and avoids direct questions at these times
  - Uses sentences without pronouns and may be incomplete with a “reshaping” intent
- Mutuality
  - T uses P’s language
  - Speculative and tentative
  - Careful listening evident and does not “translate”
  - T “stays with” evolving theme

Adherence to the model III

- Positivity
  - T amplifies positive tone, and affirms +ve affect
  - T responds to what is spontaneous and stays with +ve affect
- Representation
  - Uses empathic imagination to put immediate experience into words
  - Tone of voice represents emotional core experience
  - Uses metaphor & figurative language, with sensory aliveness
- Reflection
  - T potentiates reflective awareness in P
  - Uses proper syntax with pronouns at these times
  - Shows collaborative effort

Adherence to the model IV

- Changing the chronicle
  - T listens intently even with a boring account
  - T finds what is most “personal” and capable of imaginative development in the account
  - T helps elaborate and enlarge this part of the account
  - T finds some unifying image in the clatter of details presented
- Processing trauma part 1
  - T responds to intrusion of traumatic material
  - Does not proceed with trauma processing when P is not ready for it
  - T acknowledges his/her part in triggering the disjunction

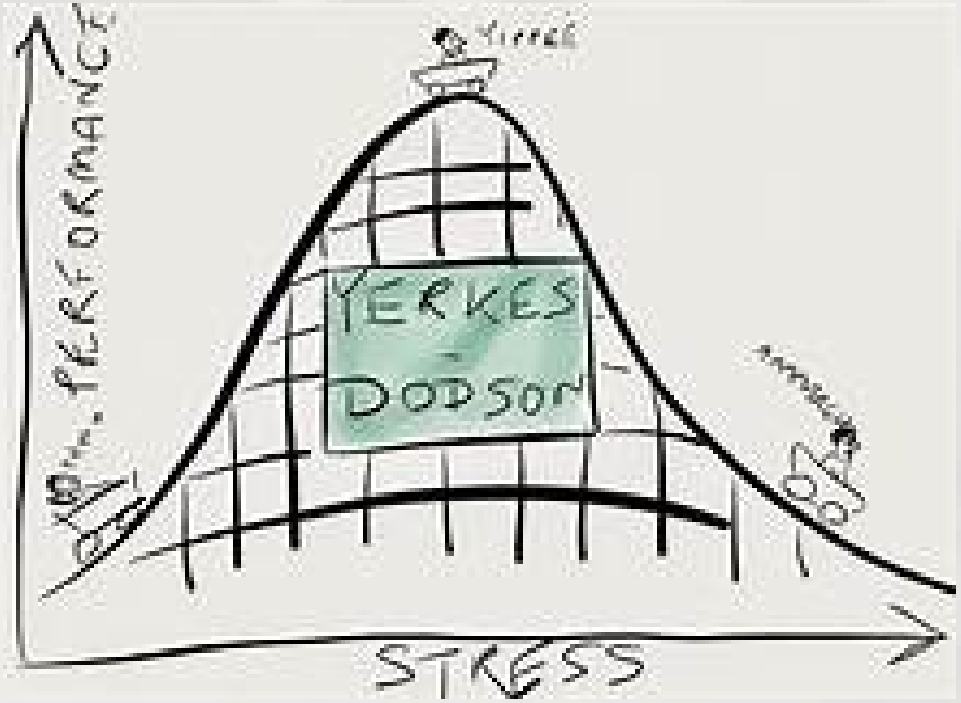
Adherence to the model V

- Processing trauma part 2
  - T and P together build up of the scene of the traumatic intrusion into the therapeutic conversation
  - T and P build up the “scene” of traumatic memory affecting a relationship outside therapy (including detail: feelings, self-attributions, responses, expectations, voice and posture and demeanour of patient
  - Move towards changing the script when the script and scene has been well laid out

Recognising PTSD

Managing over-and under-arousal
"The window of tolerance"

- Yerkes-Dodson curve (see Forms of Feeling)



Mindfulness Exercise

- “Find a comfortable position either lying on your back or sitting. If you are sitting down, make sure that you keep your back straight and release the tension in your shoulders. Let them drop.
- Close your eyes.
- Focus your attention on your breathing. Simply pay attention to what it feels like in your body to slowly breathe in and out.
- Now bring your attention to your belly. Feel your belly rise and expand every time you breathe in. Feel your belly fall every time you breathe out.
- Continue to focus your attention on the full experience of breathing. Immerse yourself completely in this experience. Imagine you are "riding the waves" of your own breathing.
- Anytime that you notice your mind has wandered away from your breath (it likely will and this is completely normal!), simply notice what it was that took your attention away and then gently bring your attention back to the present moment - your breathing”.

Hypo-arousal

- Hypoarousal is characteristic of dissociative disorders and PTSD. Hypoarousal is associated with the freeze response in mammal mediated by the dorsal vagus nerve when they face a threat to life which they cannot avoid by fighting or fleeing.
- Hypoarousal is manifested by features like amnesia, emotional and/or physical numbing, depersonalization (feeling estranged from oneself), and derealization (feeling as if the environment is unreal or dreamlike).
- Hypoarousal makes it difficult or even impossible to experience feelings of love, pleasure or interest.

- Hypoarousal-Related Symptoms:
- Flat affect, numb, feels dead or empty, “not there” Cognitively dissociated, slowed thinking process Collapsed posture, psychomotor retardation
- Disabled defensive responses, victim identity
- Secondary traumatisation
  - [for client and therapist!] may need to be addressed at all levels: self care, case load, and support.

Thank you

- References:
  - Borderline PD and the CM : A clinician's manual (Russell Meares, 2012,New York: Norton)
  - A Dissociation Model of Borderline Personality Disorder (Russell Meares.2012, new York: Norton)
  - Intimacy and Alienation: Memory, trauma and personal being (Russell Meares, 2000, London, Routledge)
  - The Metaphor of Play: origin and breakdown of personal being (3rd Edn) (Russell Meares, 1992, London, Routledge)
  - The Poet's Voice in the Making of Mind (Russell Meares, 2016, London, Routledge)
  - An Integrated Approach to Short-term Dynamic Interpersonal Therapy,(Joan Haliburn, 2017, London, Karnac)