Feature Article: The Reconstruction of Trauma: A brief overview.

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The Constructivist and PTSD

The need for an integrative theory has been noted by many prominent writers in the study of traumatic stress reactions (Baum et al., 1993; Wilson, 1994; Wilson & Raphael, 1993). Some writers have attempted to integrate some very disparate theoretical traditions to generate viable clinical treatment models (Briere, 1992; Loo, 1993; Marmar & Horowitz, 1988; McCann & Pearlman, 1990a; Scurfield, 1985). These workers have developed sensitive and comprehensive analyses of the processes of traumatisation. They have suggested sequential, concurrent, contextualised and multiple treatment interventions which not only acknowledge individual differences but also the complexity and the human suffering associated with traumatic stress reactions. However, the assumptions underlying these clinical treatment models are very dissimilar. Such eclecticism is understandable when many traumatised people report severe difficulties in so many areas that are central to their well-being. The problem is that technical eclecticism has been accepted by these writers at the cost of theoretical integration. Scant attention has been paid to the fact that these diverse interventions have competing views of individual circumstances, of capacities to change, and of people’s ability to influence the outcome of events (Bannister & Fransella, 1986; Harter, 1988; Karst, 1980; Mahoney, 1991; Neimeyer, 1988; 1993; Neimeyer & Harter, 1988; Winter, 1992).

A constructivist conceptualisation of traumatic stress reactions provides a rationally integrated meta-theoretical framework that can subsume the technically eclectic range of strategies that are frequently used to treat traumatised people. The relationships between the personal, trauma and recovery factors which appear to influence mental health outcome following exposure to life events are explored within this framework. The model emphasises the purpose and protective value of certain behaviours
within traumatic environments and after survival. Emphasis is given to the creativity and value of reactions and choices rather than to their deficits, weaknesses and erroneous assumptions.

**The Model**

The model encompasses the spectrum of negative and positive sequelae following traumatic events, including PTSD. The differential severity of symptoms in people is examined as is the presence of significant psychological distress in some individuals but not others experiencing similar trauma. A parsimonious yet eloquent explanation for recent research bearing on these issues is provided. The model provides a testable conceptual framework which can assist in efforts to prevent and treat the debilitating effects of unresolved traumatisation. A developmental process linking the past, present and future of traumatised people is proposed without prescribing individual solutions for any particular life event. Aspects of this constructivist model of traumatic stress reactions have been successfully tested with the cooperation of two large samples of police and attest to the predictive utility of the model (Higgins 1995a; 1997b). The clinical utility and implications of this model for risk assessment and the effective management of critical therapeutic process issues when working with people who have survived prolonged and repeated traumatisation has also been elucidated (Higgins, 1997a).

Way back in 1955 George Kelly's said a diagnosis was: "all too frequently an attempt to cram a whole live struggling client into a nosological category" (p. 775). PTSD is a medical diagnosis and the use of this term has legal and compensation implications. The use of a nosological category has placed traumatic events and their consequences within a scientific classificatory model and that has provided considerable advantages for some traumatised people in terms of their access to treatment and compensation. However, the diagnostic criteria for PTSD also have severe limitations and they suffer from various anomalies (Herman, 1992; 1993; Higgins, 1995a; March, 1993; van der Kolk, 1994). Classification systems inspired by the medical model have sometimes encouraged a view of traumatic stress reactions where the survivor is seen as sick and needing to be cured, rather than as playing a critical role in their own healing process. In general, biological explanations for traumatic stress reactions have often been used as alternative rather than as complimentary to psychological explanations. Such explanations have frequently diverted attention away from the meaning of a traumatic life event for a particular person. The pathogen host process of internal medicine is simply inadequate to explain the multiplicity of personal, trauma, and recovery factors which influence the ongoing emotional and physical health of traumatised individuals (Higgins, 1995a; 1997a; van der Kolk, McFarlane, & Weisaeth, 1996).

In a constructivist model, traumatisation is defined as a threat to the core processes of an individual, organisation, community or society (Higgins, '1995). These core
processes are concerned with identity or self, sense of reality, value or worth, power and fundamental social roles (Mahoney, 1991). Traumatisation, depending on its severity and its unique psychological proximity for an individual, is accompanied by threat, anxiety, fear, guilt, shame, and anger. These emotions have very specific definitions in this model and are explained as teaching people something about the adequacy of their attempts to make meaning from their experiences (McCoy, 1981; Neimeyer, 1993).

Construction of traumatic experience

Traumatisation represents an overwhelming psychological assault to the meaning structure of a particular individual. This meaning structure “is the sum total of all the conclusions you have drawn and are always drawing from your experience, all your ideas, attitudes, expectations, opinions, and beliefs. You and your meaning structure are one (Rowe, 1995 p.38)”. When we are traumatised we discover that the world is not as we interpreted it to be and we are utterly helpless and powerless in the face of some life events. We experience terror at the prospect of physical or psychological annihilation. The “symptoms” that traumatised people experience may be the only ways they can find to prevent their entire meaning structure from crumbling. Some of these “symptoms” may serve a useful purpose until people are able to find a way of understanding their traumatising event and to fully experience powerfully uncomfortable feelings and bodily sensations from a safe place.

Overwhelming emotional pain, powerlessness, shame, rage, guilt and terror are associated with finding that your meaning structure has been entirely inadequate to predict or control such life events (Higgins, 1995a; Rowe, 1995).

The theoretical traditions informing psychodynamic, cognitive behavioural and information processing, biological, and socio-cultural theories of traumatic stress reactions have very different views on human nature, individual plasticity, personal power to influence the outcome of events, the self, adaptation, and the change process. In contrast to other formulations of traumatic stress reactions, a constructivist model of traumatisation emphasises lifelong development and considerable plasticity within individual limits. In this model, there is considerable opportunity to influence the outcome of events by virtue of behavioural choices but these exist within the constraints of individual contexts. The development of self is seen as essential to all viable personal change. Adaptation is seen as organising individual activity in coordination with constantly variable opportunities and confinements. The process of change results from repeated experimental efforts to gain dynamic equilibrium (Higgins, 1995a; Mahoney, 1991).

Treatment implications

In this model, people who develop trauma symptoms have a right to treatment opportunities that respect their efforts, acknowledge their courage, recognise their simultaneous strength and fragility, and empathise with the difficulty of their
struggle. Such interventions attend immediately to urgent safety and survival issues. Treatment is highly individualised and acknowledges the fluid and reciprocal relationship between people, their context, and their behaviours. Interventions are characterised by trust and confidentiality. Helping relationships are ethical, collaborative, gentle, and provide clear and consistent support. The traumatised person is able to freely experience and express all feelings at their own pace (Neimeyer & Harter, 1988). Individuals seeking help are empowered with resources and abilities to choose their own life course. Helpers facilitate a sense of continuity between the past, present, and the future of the traumatised person (Higgins, 1995; Kelly, 1955; Mahoney, 1991; Neimeyer, 1993). The therapeutic strategies used to facilitate this process can be technically eclectic providing they are both integrated and consistent with the assumptions of a constructivist model of traumatic stress reactions. For example, the exposure based treatments of the conditioning theorists can be seen as graduated trial and error experiments in formulating new meanings for traumatising events. The free association of psychodynamic formulations could be used, in collaboration with a trauma survivor, as a way of gently loosening constructs formed in traumatic environments (Bannister & Fransella, 1986; Neimeyer, 1988; Winter, 1992). Such an approach allows for both treatment versatility and theoretical coherence (Harter, 1988; Neimeyer, 1988; 1993).

Successful constructivist trauma treatment addresses immediate physical and psychological safety issues, conducts comprehensive medical and psychological assessments and is cognisant of the unique nature, opportunities and dangers of therapeutic relationships. Systems for the primary therapeutic worker to proactively take full responsibility for their own self-care are established and closely monitored. Clear lines of communication and responsibility with the multiple professionals involved are established. Therapeutic relationships and goals are collaboratively negotiated with regular joint reviews of progress within negotiated time frames. Personalised and culturally relevant strategies to constructively express and reclaim powerful feelings and bodily sensations associated with traumatising events are collaboratively identified and developed. Currently unhelpful ways of thinking that may have been viable and/or developmentally appropriate in traumatic environments are identified and gently but firmly challenged. Suggestions for reconstruction of traumatising events are repeatedly offered but never imposed. Strategies to safely experiment with alternative ways of being in and acting upon the world are rehearsed and enacted.

Healing and reassociation

The quality and quantity of existing social supports are strengthened and a balance between focus on current life events and reassociating traumatic material is repeatedly re-negotiated. The therapeutic relationship constructively addresses both
transference issues and
countertransference issues.
It is my view that successful and healing
trauma reassociation work is not about
lancing boils or learning (or being
medicated) to remain unfeeling in the face
of extreme human devastation and horror.
The aim is not re-traumatisation or the
production of robot like responses to very
real and very tragic events. Trauma work
is about developing a current way of
understanding traumatic events which fully
acknowledges and embodies the profound
emotional impact of traumatising events
but no longer enables the expectations,
feelings, bodily sensations and behaviours
developed and validated in traumatic
events to dominate either the present or
the future of the traumatised person.

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