Treating complex trauma: Using emotive writing to facilitate posttraumatic healing

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Objectives

- Each participant will demonstrate an ability to differentially diagnose complex posttraumatic stress disorder.
- Each participant will identify ways to apply emotive writing strategies in the treatment of complex posttraumatic stress disorder.
- Each participant will demonstrate an ability to assess posttraumatic growth outcomes in the treatment of complex posttraumatic stress disorder.

Emotional Intelligence

1. **Definitions**
   - Emotion is a brain phenomenon that is vastly different from thought.
   - Different memory systems have been located in relation to emotions.
     - One stores consciously processed information about events
     - The other stores the actual emotional experience of the event
     - For many trauma victims, these two systems do not communicate
   - Automatic emotional responses occur before on can stop it and in some situations it is clearly adaptive to respond quickly, whereas at other times better functioning results from the integration of cognition into the emotional response.
   - Emotions are signals worth listening to.
     - Emotions give people important information related to their well-being; they tell people when their needs or goals are being reached or frustrated; gut feelings guide decisions by rapidly reducing alternatives to be considered.
   - Emotions are most noticeable as changes in a readiness for action; they respond to changing circumstances by changing the person.
   - Emotions follow a natural course of rising and passing away, swelling and fading.
   - Emotions come and go if people let them and do not try to block the emotions or avoid them.

Emotional Intelligence

1. **Emotional Experiences**
   - Each emotional experience is a combination of bodily feeling and thoughts
     - Emotions provide the very first evaluation of events.
     - We then engage in a second-level cognitive evaluation where we determine whether felt emotion is adaptive and healthy
     - This cognitive processing helps to make sense of the emotion and/or to regulate it
     - Integrating the prompts of the emotional brain with the guidance of reason leads to the greatest adaptive flexibility

2. **Communicative Role**
   - Emotions are the primary communicative signals in intimate and non-intimate relationships and our interactions with various circumstances and environment.
   - To understand this communication, patients need to use their higher level brain centers, not to control emotion but to consciously recognize the message being sent from the amygdala and then act to calm the activation.
   - Deactivation of a maladaptive emotion is achieved by accepting the emotion, experiencing self-empathy, and by providing cognitive, affective, and physiological soothing.

Emotional Intelligence

1. **Higher level thought or reflection on emotional prompts is a crucial part of emotional intelligence**
   - Adaptively, people need emotions to tell them, without thought, that something important to their well-being is occurring, and they need their thinking capacities to work on the problems that emotions point out and that reason must solve
   - The reported story of the emotion (the conscious narrative flow of evaluations, interpretations, and explanations of experience) often comes only after the emotion is experienced
   - Developing and applying this capacity is one hallmark of emotional intelligence
2. **Emotional intelligence involves the skillful use of emotions, feelings, and moods to cope with life and solve problems**
3. **Part of emotional intelligence is the ability to regulate emotionality so that one is guided by it but not compelled by it**
   - Emotions set up relational themes that become central organizers of relationships between people and between a person and the environment
   - Empathy is the response choice to feelings; recognizing others feelings requires that one first becomes sensitive to one' own feelings; validating feelings makes people and others more human
   - Gaining consciousness of feelings by symbolizing them in words is where the integration of head and heart begins.

Premise

Putting experience into language helps *the patient* to overcome trauma. The capacity to describe emotionally traumatic experience allows *patients* to make sense of their experience. Before, they had not coded the experience in language, and the experience remained as sights, sounds, and images in emotion memory. Now, in a safe environment, being able to put the traumatic experience into words enables *the patient* to think about and describe *his* traumatic memories and thereby gain some control over the terrifying experience. *He becomes* the *author* of the experience rather than the *victim* of it. This process of naming emotions helps marry the verbal and nonverbal parts of the brain and creates an integrated experience in which *the patient* can both feel and think about *his* experience simultaneously (Greenberg, 2002, p. 90, italics mine).

Complex Trauma

As early as 1985, it was recognized that certain forms of trauma (especially prolonged or multi-faceted trauma, or when it occurs in situations where there is no escape, or where gang violence is endemic) lead to specific long-term effects that lay outside those formerly associated with posttraumatic stress disorder (PTSD). Herman (1992b), for example, discussed the inadequacies of the current diagnostic categories for describing survivors of extreme situations. She identified three broad areas of disturbance that, she claimed, transcended simple PTSD (Herman, 1992a).

- The first was symptomatic, the symptom picture in survivors of prolonged trauma often appearing to be "more complex, diffuse and tenacious" (p. 379) than in simple PTSD. Categories of symptoms that did not readily fall within the classic diagnostic criteria for PTSD were the psychological fragmentation, loss of coherent sense of self, and the dissociative and affective sequelae of prolonged trauma.
- The second was *pervasive insecure or disorganized attachments* and characterological, survivors of prolonged abuse developing recognizable personality changes, including "deformations of relatedness and identity" (p. 379, italics mine).
- The third area involved the survivor's vulnerability to repeated harm, both self-inflicted and that received by others.
- This previously undefined syndrome may co-exist with simple PTSD, but extends beyond it" (p. 387).

In summary, six clusters of symptoms characterized C-PTSD: (a) alterations in regulation of affect and impulses; (b) alterations in attention or consciousness; (c) alterations in self-perception; (d) alterations in relations with others; (e) somatization; and (f) alterations in systems of meaning.

The Experience of Suffering

A core symptom of complex posttraumatic stress disorder is mental death, characterized by loss of core beliefs and values, distrust, alienation from others, shame and guilt, and a sense of being permanently damaged that threaten the psychological integrity of the victim.

- Cassell (1982) defined suffering as "a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity" (p. 639). This definition identifies an end state ("severe distress"), operative conditions ("loss" or "threat of loss"), and substantive qualities ("integrity intactness, cohesiveness, or wholeness).

- Michael Kearney (1996), an Irish psychiatrist and hospice physician, provided a synergistic definition of "soul paint" (his term for suffering) as "the experience of an individual who has become disconnected and alienated from the deepest and most fundamental aspects of him or herself" (p. 60).

- The psychiatrist Victor Frankl (1997) specified these "deepest and most fundamental aspects" as the matrix of beliefs and expectations that give meaning to life. Hence, he asserted that: "Man is not destroyed by suffering; he is destroyed by suffering without meaning" (Swenson, 2005, p. 52).

Posttraumatic Growth

There is a long tradition in psychiatry, reaching at least back to World War I, of studying the response of people who are faced with traumatic circumstances and devising ways to restore their integrity and psychological health.

The kinds of positive changes individuals experience in their struggles with trauma are reflected in models of posttraumatic growth (Calhoun & Tedeschi, 1998) and in measures of posttraumatic growth (Tedeschi & Calhoun, 1996).

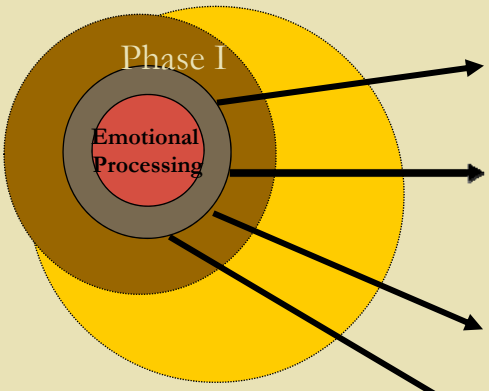
- These changes include improved relationships, new possibilities for one's life, a greater appreciation for life, a greater sense of personal strength and spiritual development.
- There appears to be a basic paradox apprehended by trauma survivors who report these aspects of posttraumatic growth: Their losses have produced valuable gains (Tedeschi & Calhoun, 2004).
- An important caveat here is a reminder that posttraumatic growth occurs in the context of suffering and significant psychological struggle, and a focus on this growth should not come at the expense of empathy for the pain and suffering of trauma survivors.
- For most trauma survivors, posttraumatic growth and distress will coexist, and the growth emerges from the struggle with coping, not from the trauma itself.

Posttraumatic Growth

A central theme of the life challenges that are the focus of traumatic experience is their seismic nature.

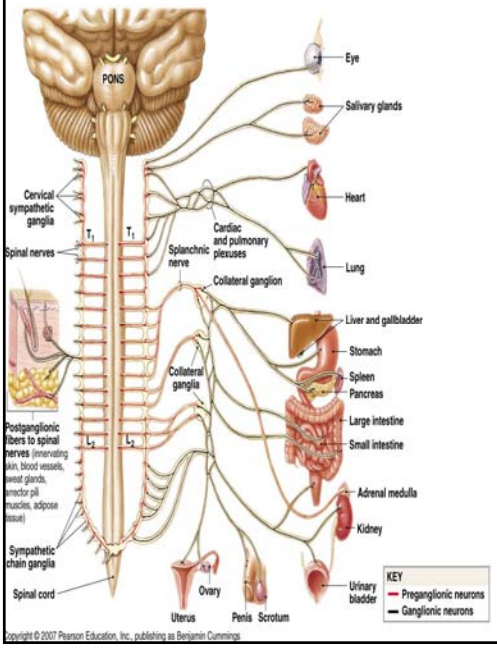
- Much like earthquakes can impact the physical environment, traumatic circumstances, characterized by their unusual, uncontrollable, potentially irreversible and threatening qualities, can produce an upheaval in trauma survivors' major assumptions about the world, their place in it and how they make sense of their daily lives.
- In reconsidering these assumptions, there are the seeds for new perspectives on all these matters and a sense that valuable--although painful--lessons have been learned (Chamberlin, 2012).
- As the individual comes to recognize some goals as no longer attainable and that some components of the assumptive world cannot assimilate the reality of the aftermath of the trauma, it is possible for the individual to begin to formulate new goals and to revise major components of the assumptive world in ways that acknowledge their changed life circumstances.
- The individual's cognitive engagement with and cognitive processing of trauma may be assisted by the disclosure of that internal process to others in socially supportive environments . At some point, trauma survivors may be able to engage in a sort of meta-cognition or reflection on their own processing of their life events, seeing themselves as having spent time making a major alteration of their understanding of themselves and their lives. This becomes part of the life narrative and includes an appreciation for new, more sophisticated ways of grappling with life events.

Emotional Processing



1. **Facilitate an Understanding of the of How Emotions Affect the Sympathetic Nervous System**
2. **Facilitate an Understanding of the Parasympathetic Nervous System in Promoting Harmony**
3. **Teach skills to Activate the Parasympathetic Nervous System**
4. **Facilitate the Use of Positive Emotions to Activate the Parasympathetic Nervous System**

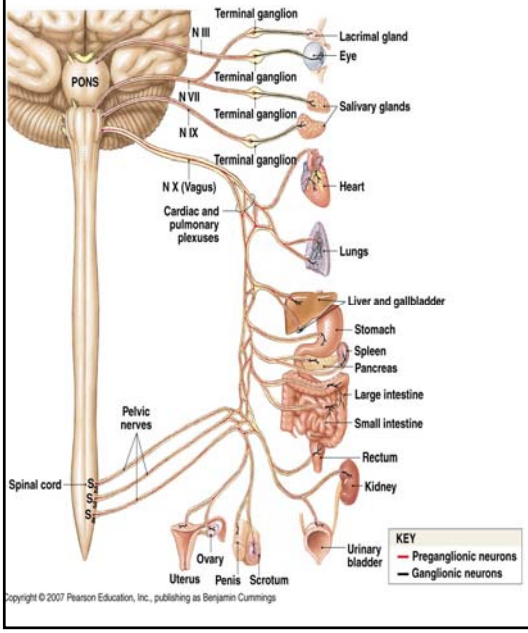
Activities of the ANS



Effects of Sympathetic Activation -"fight, flight, or freeze" response (energy expenditure or inhibition):

- increased cardiovascular & respiratory activity
- increased blood flow to brain (increased alertness), skeletal muscles, heart muscle, lungs
- increased visual acuity (pupil dilation)
- release of energy reserves from adipose, liver, & skeletal muscles
- decrease in "non-essential" functions (i.e.. digestion)
- release of Epi & NE from adrenal medullae to continue effects

Activities of the ANS



Effects of Parasympathetic Activation -"rest & repose" response (conserve & restore energy):

- decreased cardiovascular & respiratory activity
- increased GI motility & enzyme secretion
- pupil constriction
- nutrient uptake & energy storage into adipose, liver, & skeletal muscles (glycogen)

Promoting Emotional Regulation to Achieve Inner Peace and Harmony

- **Meditation**
- **Deep, Rhythmic Belly Breathing**
- **Music**

- **Singing Bowls**
- **Affirmations and Creative Visualizations**
- **Aromatherapy**

- **Spending Time in Nature**
- **Light Therapy**
- **Laugh Often**

- **Listen to Natural (unstructured) and Free-Flowing Sounds Like Running Water or Wind Chimes**
- **Starting and Ending Your Day by Arousing a Pleasant, Positive Emotion**
- **Deep Muscle Relaxation**

- **Attention to the mastery of these skills must be interspersed throughout the model.**

Emotive Writing

Each patient explores figuratively the relationship between a self, struggling to find and sustain an identity—sometimes at the very edge of abandonment, fragmentation, and annihilation—in relation to the world of inner objects that sometimes nurture, sometimes haunt, and often threaten the fabric of the self and its tenuous cohesion.

The figure in each patient's poems that needs healing and transformation is a man who is abandoned, rejected, and abased: *the abandoned male persona.*

He is in this respect a scapegoat, a victim, and he seeks others with whom to unite in order to repair the damaged self and to ignite his creative potential (Graves & Schermer, 1998).

Emotional Categories

Table 1: Emotional Categories

The following emotion categories are frequently explored in emotive writing sessions.

1. Sadness
2. Pain/Hurt
3. Hopelessness/Helplessness
4. Loneliness
5. Ander/Resentment
6. Contempt/Disgust
7. Fear/Anxiety
8. Love
9. Joy/Excitement
10 Contentment/Calm/Relief
11. Shame/Guilt
12. Pride/Self-Confidence
13. Anger and Sadness (both present simultaneously)
14. Pride (Self-Assertion) and Anger (Both present simultaneously)
15. Surprise/Shock

Goals

1. **Emotive Writing**

   – There are several goals that guide emotive writing:
   - To promote higher levels of functioning and to help the patient learn rather than to treat a deficit or disease.
   - To create a partnership of co-exploration in a growth-promoting process aimed at helping a patient achieve goals of emotional awareness, regulation, and transformation.
   - To assist the patient in developing abilities to self-soothe involves activation of the parasympathetic nervous system to regulate heart rate, breathing, and other sympathetic functions that speed up under stress.

2. **Emotional Fitness**

   - Awareness of emotion involves overcoming avoidance and promoting emotional processing.
   - Emotional processing involves the patient's need to feel his emotions before he can change them; the patient needs to understand that he cannot leave a place unit he has arrived there first.
   - Once patients have felt an emotion, he is more able to transform it or let it go.
   - Change also involves assimilating nonverbal emotional meaning into conscious narrative structures and regulating sensation as well as replacing or integrating old emotional responses with newly activated and more adaptive experiences

Emotive Writing

Toward alleviating suffering, trauma survivors must be allowed to tell the truth about their experiences, and members of the sufferer's community must be encouraged to listen, to remember, and to repeat the story to others.

- Virginia Woolf said that the moments of profound insight that come from writing about our soulful, thoughtful examination of psychic wounds should be called "shocks", for they force us into an awareness about ourselves and our relationships to others and our place in the world (Albini, 2007; Rossy, September, 2010).

- This therapeutic writing process contains tremendous potential, both for healing and for cultivating the quality of absorption or integration of the traumatic experiences.

- Writing also regularly fosters resilience - a quality that enables people subjected to trauma and disaster to thrive despite their experiences.

- The process through which emotive writing, particularly through the use of metaphors, leads to healing is quite simple, yet undeniably profound. This is because honest expression opens the door to insight, clarity and understanding. There is also an additional dimension of healing when these activities are undertaken in healing communities.

Emotive Writing and Suffering

It is instructive to view the use of emotive writing, in light of the three phases of suffering described by Warren Reich (1989).

When a person is first confronted by catastrophic illness or loss, he or she responds with silence and immobilization (freeze response). The sufferer is not only struck dumb, but cannot make informed decisions—or sometimes any decisions at all—because the sense of loss overwhelms agency.

Autonomy is diminished, and imagination gives out; it is not up to the task of creating meaningful images. Reich calls this phase "mute suffering," the experience of being speechless in the face of one's own suffering.

Obviously, mute sufferers are unable to express their experience in poetry, prose, visual arts, or any form of imaginative communication.

Emotive Writing and Suffering

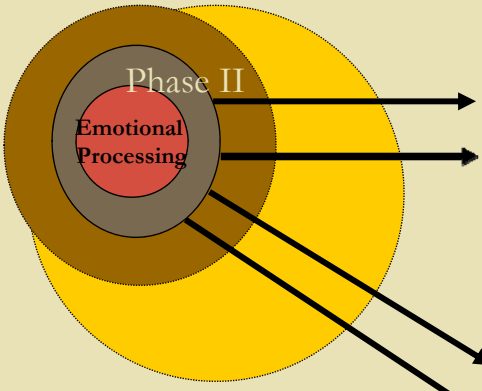
"Expressive suffering" is the second phase, in which the sufferer seeks to understand the experience by finding a language to express it (Reich, 1989).

- Some accomplish this by writing personal journal entries, while others go through a more structured process of creating poems that are intended to communicate with a larger audience.
- The expressive sufferer can also respond in his own style and learn to articulate his deepest fears and sense of loss to family members, or to a chaplain or health professional, in a way that encourages conversation.

Reich's third and final phase is called "new identity in suffering," where the sufferer discovers a new self, or a new understanding of self, that in essence overcomes suffering by preserving personal integrity.

- The old self may have been destroyed, but a new self, a new character, has emerged. According to Reich, this process requires the participation of others, if only as listeners.

Emotional Processing



5. **Promote Awareness of Emotions**
6. **Facilitate a Welcoming and Acceptance of Emotional Experience**
7. **Promote Putting Emotions into Words**
8. **Identify the Patient's Primary Experience**

Using Metaphors to Describe Emotions

A metaphor is something relatively more concrete or conceivable which stands for something more elusive. There are at least three communicative functions that metaphors might serve.

- First, they allow one to express that which is difficult or impossible to express if one is restricted to literal uses of language
- A second possible function of metaphors is that they may constitute a particularly compact means of communication
  - Although conscious experience is continuous in form, the linguistic system we use to talk about it is comprised of discrete elements. As such metaphors may enable us to convey a great deal of information in a succinct manner.
- Finally, metaphors may help capture the vividness of experience.
  - If metaphors convey chunks of information rather than discrete units, they can paint a richer and more detailed picture of our subjective experience than might be expressed by literal language.

This seems to be the case with the quality of unobservable internal states like emotions, as evidenced by research showing the predominance of metaphorical language during descriptions of feeling states as opposed to actions, especially when those states are intense.

Metaphor and Emotions

Lakoff (2008) offers an analysis of *anger* in his famous book *Women, Fire, and Dangerous Things*. The analysis essentially claims that without metaphor, our knowledge of emotion concepts would be tremendously weak.

The analysis begins with the "common folk theory of the physiological effects of anger," which include: increased body heat, increased internal pressure, agitation, and interference with accurate perception. These physiological effects increase as anger increases, and we look to these physiological effects to determine whether someone is angry. The physiological effects of anger therefore stand for anger.

Lakoff provides the following metaphors for anger based off this principle, each of which indicates the occurrence of anger through its physiological effects:

- Body heat
  - –Don't get *hot under the collar.*
  - –Billy's a *bothead.*
- Internal pressure
  - –Don't get a *hernia!*
  - –When I found out, I almost *burst a blood vessel.*
- Agitation
  - –She was *shaking* with anger.
  - –You look *upset.*
- Interference with accurate perception
  - –She was *blind with rage.*
  - –I was beginning to *see red.*

10 Metaphors for Life

Life is……

- 1. ……a game. Things can't get you down that much, cuz it's all just a game. This is a good thing. Another empowering thing about this metaphor is that in any game, there are cheats and bug exploits
- 2. ……a dream. "Row row row your boat, gently down the stream. Merrily merrily merrily, life is but a dream!"
- 3. ……a movie. Bring the popcorn, this is the most awesome blockbuster ever set on the silver screen! Sit back and enjoy the drama of life.
- 4. ……a dance. The dance representation of life puts social interactions and other players in the foreground. The measure of life is the way we interact with everyone around us.
- 5. ……a battle. Not all metaphors for life are "positive". The battle perspective is often assumed by people who feel like the whole world is against them. If you hold this school of thought, you're very liable to experience a lot of stress, anger, and conflict.
- 6. ……a song. All the things you create and imagine and give birth to contribute ultimately toward one giant work of genius: and that's what the "song" here stands for.
- 7. ……a journey. What sort of vessel are you travelling in– a car, a ship, an airplane? And where are you going? We're on a great journey together, following a path with many twists and curves. Most people around us are going on autopilot, but since we've woken up to the reality of things, we have the power to grab the wheel and take control!
- 8. ……a mystery. This is often a "transitional" model, held by people whose previous reality has been shattered, while they try to explain the mysteries surrounding them with another model. To actually solve the riddles of the mystery model, you must shift to another perspective. The answer you reach will depend on which perspective you assume.
- 9. ……a party. While this may sound shallow at first, it's actually refreshingly honest. If you subscribe to the party perspective, you're just being more forthright about the quest for fun and pleasure.
- 10. ……an opportunity. Whatever our time in this world might be, it's an opportunity. An opportunity to grow, to learn, to change, to develop, to create, to enjoy.

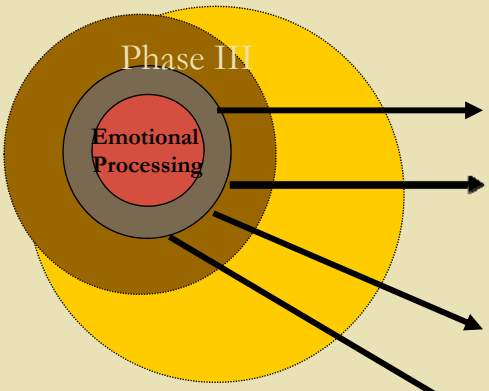
Phase II: Arriving: Facilitating Emotional Awareness

1. **Core Feelings**
   - Having arrived at a feeling, the therapist assists the patient in determining whether he has arrived at a core feeling.
     - People recognize a feeling as core because it is fresh and new.
     - It is a vital feeling that often leaves the patient feeling very open and perhaps vulnerable.
     - When patients arrive at primary emotions, a type of internal bell often rings and tells him "Yes, this is it This is what I most truly feel."
     - Primary feelings feel good. They feel right, even if they are painful (e.g., a core fear or anxiety about being rejected or being unlovable or worthless).
2. **The Essential Self**
   - What the patient unearths initially may be a bitter truth
     - Whatever this wound is, however, it can yield a most delicate part of the self if the patient deals with it using emotional intelligence.
     - With care, this part of a person can transform itself from a bitter experience into a subtle and delicate part of the self, an essence that gives strength.
     - By going into the wounded part of the self, the patient can find the gem of their adaptive, essential self.
     - This healthy essence is a vital part that strives to be connected to others and to be effective.
     - The essential self, however needs safety and encouragement, both from within and without, to help it emerge.

Phase II: Arriving: Facilitating Emotional Awareness

3. **Secondary Feelings**
   - Secondary feelings are global and diffuse and more often are felt in response to situations rather than being about the self.
     - They leave a patient feeling very strident, unbalanced, and tense.
     - They signal that something is wrong, but the patient does not know what is wrong.
     - They are reactions to more primary experiences.
     - They do not define a sense of identity.
     - They can also be part of anger problems, such as feeling hostile, bitter, agitated, or grouchy.

Emotional Processing



9. **Facilitate the Evaluation of Whether the Primary Feeling is Healthy or Unhealthy**
10. **Identify the Destructive Beliefs or Views Attached to the Maladaptive Emotions**
11. **Facilitate Access to Alternative Emotions and Needs**
12. **Facilitate the Transformation of Maladaptive Emotions and Destructive Beliefs**

Phase III: Leaving: Moving on by Accessing Emotions

Table 2: Criteria for Evaluating Emotions

Type of Emotion	Characteristics
Primary Adaptive (organizing)	Fresh and new Felt in the moment in response to shifting circumstances Changes when circumstances change Externally cued ones are rapid and action oriented in response to the environment Internally generated ones are slower Explore until patient feels, "Yes, that's it!" Feel whole, deep

Phase III: Leaving: Moving on by Accessing Emotions

Table 2 (Continued): Criteria for Evaluating Emotions

Type of Emotion	Characteristics
Primary Maladaptive (disorganizing)	A familiar old feeling Patient feels stuck in it. It is overwhelming Each time feels as bad as the last time Don't shift with change in circumstance Difficult, deep, and distressing Often are about the self Part of a person's identity Accomplished by emotion's destructive voice

Phase III: Leaving: Moving on by Accessing Emotions

Table 2 (Continued): Criteria for Evaluating Emotions

Type of Emotion	Characteristics
Secondary (signaling)	Global, nonspecific Include symptoms of depression, agitation Not specifically about the self Obscure a more primary feeling (e.g., anger covering hurt) Might be a feeling about a feeling (e.g., fear of sadness) Thoughts generate the feeling.

Phase III: Second Level Evaluation

- If the patient's core feelings are healthy, they should be used as guides to action. If they are unhealthy, they need to be processed further to promote change.
- This second level reflection involves assessing not the rationality of the emotion but its adaptiveness. If an emotion is adaptive, then it should be followed. If an emotion is maladaptive, then its expression needs to be regulated, and it needs to be understood and transformed.
    - Maladaptive feelings are almost always accompanied by beliefs or views that are hostile to the self of blaming others
    - People often express destructive beliefs as a negative voice in their heads, a harsh, internal voice that has been learned, often through previous maltreatment by others, and is destructive to the healthy self. This internal hostility often leads to vicious self-attacks that leave people stuck in their unhealthy feelings.
- Patients can recognize that a feeling is not helpful to him once it has been accepted fully. The paradox is that if the feeling is judged as not acceptable, as "not me," it cannot be changed, because it hasn't been accepted. Only when a feeling has been accepted can it be evaluated and changed if necessary.
- Assessing maladaptive feelings and identifying destructive beliefs paradoxically facilitates change, first by accessing the state that needs to be exposed to new experience and second by stimulating the mobilization of a healthier side of oneself by a type of opponent process mechanism.

Phase III: Accessing Alternate Emotions and Needs

- Emotions can be changed not by reason but by activating representations of alternatives associated with more positive emotions.
    - For example, in response to feeling the core emotion of shame or fear of maltreatment that is leading a patient to feel worthless, the therapist needs to guide the patient toward his healthy anger at being treated badly that is implicit in his more dominant experience of shame.
    - The anger may be visible in the patient's voice or face or in his phrasing
    - Drawing attention to this subdominant emotion allows the patient to focus on and intensify this subdominant emotion but present emotion expressing how angry he is.
- Bad feelings can also be replaced with happy feelings.
    - This can and does occur in therapy, not in a simple manner by, for example, trying to "look on the bright side," but in a meaningful embodied fashion.
    - In the case of grief, for example, laughter has been found to be a predictor of recovery. That is, being able to remember happy times, to experience joy, can be an antidote to sadness.
    - Warmth and affection similarly are often antidotes to anxiety.
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Phase III: Accessing Alternate Emotions and Needs

- Therapists need to help their patient to focus on and feel healthy, adaptive emotions.
  - They need to help the patient to express these adaptive emotions to someone — sometimes to the therapist, to an imagined other in an empty chair, to another part of the self, or to another person.
- Another more active way in which therapists can help patients access their healthy, more resilient emotions *is by focusing them on their needs, goals, and concerns.*
  - Asking a patient the key question, "What do you need when you feel this?" is a good way of bringing goals into awareness..
  - Once people are aware of their goals, then therapists can help them assert their needs and use these needs to challenge their negative beliefs.
  - Focusing people on needs, wants, or goals helps them mobilize themselves to change.
  - Given that an emotion may result from the appraisal of whether a need or goal is being met, goal clarification evokes new emotions and associated action tendencies to facilitate goal attainment.
- Therapists need to help patients focus on their healthy needs for protection, comfort, and affection in response to being maltreated as well as on their needs for autonomy and competence so as to free them from the oppression of their desperate need for approval.
  - Having helped a patient identify what he truly needs, which is usually related to his primary motivational systems (attachment, affection, and mastery), the therapist then needs to ask the patient what he can do to begin trying to get some of what he needs.

Phase III: Transforming Maladaptive Emotions and Beliefs

- Maladaptive feelings are often about a person's sense of self: He feels diminished or ineffective. These feelings do not organize a person for adaptive action; instead, they are disorganizing.
- Maladaptive feelings are associated with primary negative views of the self and with unresolved past hurts and fears. These feelings seem very core to the self; they feel like part of one's identity, but not a healthy identity.
- Maladaptive feelings tend to overwhelm people and suck them into their vortex. Any difficult feeling that repeatedly controls someone, a feeling out of which he cannot shift, is probably unhealthy.
- Examples of maladaptive primary feelings that patients often feel include:
  - A sense of destructive anger;
  - A sad, powerless sense of victimization;
  - A feeling of being weak and invisible;
  - A deep sense of woundedness;
  - A feeling of vulnerability and fear;
  - A basic sense of insecurity
  - A core sense of shame or worthlessness or feeling unloved or unlovable.
- Often these feelings are masked by other feelings on the surface: secondary ones, such as feeling upset, depressed, irritable, or frustrated.

Phase III: Transforming Maladaptive Emotions and Beliefs

- In working to access maladaptive emotions, therapists need to work empathically with patients to access this second-order level of evaluation and bring it into the open.
- Often unhealthy primary emotional responses seem very intense and even meaningful, but what is so characteristic of them is that they do not seem to change, get better, or go away.
- It is important to help the patient see that he is not bad, or even wrong, for feeling this way but that the feeling is not functional, leaves them feeling bad, and does not help him get what he needs.
  - Therapists validate people's feelings but constantly focus on anything the patient says about how the feeling does not work for him or about how it damages him or others;
- Therapists highlight maladaptive emotions mainly by re-entering the problematic state; exploring it and its meanings; and coming to an agreement with the patients that, rather than being an incontrovertible truth, this emotional state is a wound that needs to be healed.
- Half of the battle of change is won when the patient can see that it is their emotional states that are problematic, that they are in conflict, or that they are in part authors of their own distress rather than viewing themselves as victims or believing that fate is to blame.
- This is not to say that the patient is at fault for having an unhealed wound, or for overreacting to something, but helping him to recognize that there is something he is doing in these states that leads to his difficulties and that he need to do something to change is an important goal that is sometimes rather difficult to achieve.

Phase III: Transforming Maladaptive Emotions and Beliefs

- It is not helpful when exploring this type of maladaptive state, to try to demonstrate to people that their thoughts or beliefs are faulty. Rather, what is most helpful is helping the patient get a perspective that this is a temporary, maladaptive, over-reactive state they get sucked into and that this is not all he is or all of what he is capable.
- Also assist the patient to understand that viewing his beliefs, thoughts, or perceptions as faculty is misguided, rather it is his reactions that are problematic and need to be regulated.
- It is important for the therapeutic alliance that the patient feels throughout that the therapist is on his side, validating him and working with him against this problem state.
  - Often patients insist that this (state) is the way they are and that no other reality is true or conceivable. In response, empathize with their frustration and how important it is for him to convince you that this is the case while adding that that this painful place is where he gets stuck and loses all his resources.
  - Recognize this as a real existential moment in which the patient is facing an impasse where he has to figure out how to find his footing. Use the encounter to help the patient find the sense of possibility of change and the will to change.
- A person's old, unsuccessful coping style might have been to avoid the bad feelings or to feel overwhelmed and out of control and sink into despair, numbness, depression, or anxiety. Here the therapist helps the individual make sense of their experience and begin to process more information by identifying their maladaptive emotions, and the associated destructive thoughts, in words and help him bring previously unused internal resources to bear on coping with this distress-producing condition.

Phase III: Transforming Maladaptive Emotions and Beliefs

- Once an experience is clearly accepted and recognized as maladaptive, the therapist needs to help patients identify the destructive beliefs and patterns of thoughts that accompany their unhealthy feelings and access the core negative belief or construal embedded in these feeling.
- The negative belief is much more easily accessible and put into words when the person in experiencing the maladaptive feeling. Thus the therapists needs to work with cognition when it is hot.
  - When a belief is just cold, it is not really accessible to change.
  - People can talk about all kinds of negative views of themselves in an abstract and intellectual way, and they will not change.
  - The person must be feeling what they are saying to make the whole maladaptive scheme amenable to change.
  - Motivated both by their healthy aversion of pain and by their need for mastery and for human contact, comfort, and safety, people will mobilize new resources to cope better.

Phase III: Transforming Maladaptive Emotions and Beliefs

- It is important to note that people are continually changing in light of emerging goals and opportunities.
  - Once they feel their shame at being maltreated, or their fear of rejection, they also can contact their need to be valued.
  - With their attention shifted to the new goal of being valued, they have in essence presented themselves with a new problem to solve: how to feel valued.
  - When people discover that they can do something about their feelings, they can prepare to solve their problems.
  - Motivated both by their healthy aversion of pain and by their need for mastery and for human contact, comfort, and safety, people will mobilize new resources to cope better.
  - In this process, an alternate, healthier part is helped to surface and is then used to challenge and change some of the person's core unhealthy feelings, beliefs, and hostile thoughts.
  - The newness in this process comes from within, by accessing previously unacknowledged healthy feelings and needs, and from without by the affective attunement and confirmation of an empathic other.
- The patient must maintain a working distance for this process to occur, which is why developing emotion regulation skills are taught initially and throughout this model.

Phase III: Accessing Healthy Emotions

- Now that the patient has identified his maladaptive emotion, how does a therapist help him access healthy emotions. A number of different methods in addition to the power of empathetic relational connection for accessing alternate emotions are summarized in the list below.
  - Shifting attention to a background feeling;
  - Asking the patient what he needs when he is suffering and in pain;
  - Use positive imagery to create scenes that the patient knows will help him to feel a positive emotion;
  - Ask the patient to adopt certain emotional stances and help him deliberately assume the expressive posture of that feeling and then intensify it.
  - Have the patient remember a situation in which the positive emotion occurred and then to bring the memory alive in the present;
  - Engage the patient is a conversation about desirable emotions;
  - In some situations, the therapist can express a particular feeling that the patient is unable to express;
- In addition, therapist sometimes need to help people shift out of certain emotions or emotional states. To accomplish this, have the patient describe what they feel at the moment when they recognize a need to shift out of an emotion. This helps them center themselves and gives them a handle that they can pick up later when they are able to deal with the feeling. This ability improves with practice.

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Appendix A

Assessment and Data Collection

Data Collection Instruments

One suggested strategy is that group participants will be administered the following instruments prior to commencement of each twelve week interval (quarter) and at the end of four such quarters.

- Posttraumatic Stress Diagnostic Measure. The Posttraumatic Stress Disorder Checklist-Specific (PCL-S) is one of the most widely used self-report instruments for measuring PTSD symptoms. It was developed at the National Center for PTSD and uses a 17-item self-report format based on the diagnostic criteria given in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. There are three versions of the PCL in existence and are differentiated based on the identified trauma, e.g., "stressful military experience" in the PCL-M, an identified "stressful experience" in the PCL-S, and "stressful experiences" in general in the PCL-C.

- Cognitive Disturbance Measure. As noted in the introduction, complex or sustained traumatic events often produce relatively chronic cognitive symptoms. The Trauma and Attachment Belief Scale measures disrupted cognitive schemata and need states associated with exposure to traumatic events. This instrument taps five related content areas: Safety, Trust, Esteem, Intimacy, and Control. There are reliable subscales for each of these domains, rated both for "self" and "other." In contrast to more symptom-based tests, the TABS measures the self-reported needs and expectations of trauma survivors as they predict self in relation to others. As a result, the TABS is likely to be helpful in understanding important assumptions that the client carries in his or her relationships to others, including the therapist.

Assessment and Data Collection

Data Collection Instruments

- Dissociation Measure. The most popular of such instruments, the Dissociative Experiences Scale (DES) has good psychometric characteristics, including predictive validity for dissociative identity disorder when a cut-off score of 30 is used.

- Posttraumatic Growth Measure. Posttraumatic growth was measured by the Posttraumatic Growth Inventory (PTGI). It consists of 21 items, which evaluate whether a person perceived positive aspects of the traumatic event, such as realizing personal strength, social cohesion and spirituality.