Treating Traumatic Stress in Adults

The Practitioner's Expressive Writing Workbook

Stephanie Field and
Kathy McCloskey

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Treating Traumatic Stress in Adults

Treating Traumatic Stress in Adults is a resource for therapists of all disciplines for use in the treatment of adults suffering from post-traumatic stress. By reading this unique synthesis of information on the most current trauma treatments and expressive writing exercises, practitioners will gain an integrative and practical set of tools for treating post-traumatic stress. Also included are numerous diverse case vignettes, exercises for building trust in the patient/client relationship, and sections dedicated to exploring the client's thought patterns and emotions to provide an opportunity for exposure, healing, and restructuring maladaptive beliefs.

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On that glad night
in secret, for no one saw me,
nor did I look at anything
with no other light or guide
than the one that burned in my heart.
—St. John of the Cross, "*The Dark Night*"

To the patient souls whose secrets are unwritten and unspoken. It is for those looking for their light at the edge of darkness to illuminate that which is hidden from others and most importantly from themselves.

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Part I

Introduction

Integrating Expressive Writing Into Trauma-Related Treatment Approaches

Given the prevalence of violence and trauma within the U.S., psychologists have become increasingly involved with treating individuals who are suffering from traumatic stress. The effects of trauma pose a problem of great magnitude due to their far-reaching impact on society. Suggesting that trauma has costly intergenerational effects, Widom and Maxfield (1996) found that half of those arrested for criminal offenses by the age of 32 had been the victims of abuse and neglect (as cited in Streeck-Fischer & van der Kolk, 2000). In support of the link between trauma history and substance abuse, Ford and Smith (2008) found that 91% of 231 men and women in outpatient substance abuse disorder treatment met criteria for Post-traumatic stress disorder (PTSD). This suggests that trauma has profound and costly consequences for society.

Current treatments for trauma (e.g., cognitive-behavioral, body work, psychodynamic, narrative therapy) share various elements. Schottenbauer, Arnkoff, Glass, and Gray (2006) found a great deal of commonality in trauma treatment approaches used by therapists from divergent self-identified orientations (i.e., cognitive-behavioral or psychodynamic). This commonality may be partially due to the finding that there was a great deal of heterogeneity in how treatment was conducted among therapists from a particular orientation. Therapists who identified as coming from solely a cognitive-behavioral or psychodynamic background reported using more integrative therapy with clients suffering from PTSD. Commonality in treatment approach was not only found among therapists of different theoretical orientations, but also within treatment for clients reporting different trauma histories. Schottenbauer et al. found that treatment did not differ due to the type of trauma reported (e.g., single vs. complex). It seems that therapists tend to practice in certain ways regardless of theoretical orientation or types of trauma history.

What does this suggest about the future of psychotherapy for trauma? Because therapists have an overall propensity to blend techniques (including when treating trauma patients), it seems that deliberately integrated

treatment may be an attractive and optimal approach. Schottenbauer et al. (2006) argue that treatment may need to be more broadly focused than the previously developed manualized therapies in order to optimize patient care. Therefore, there seems to be a need for integrative treatment that allows therapists to deliver more comprehensive services.

The present effort brings to bear the world of artistic expression to current treatments for traumatic stress so as to create an integrative, unified approach. Artistic expression in the form of expressive writing is a multifaceted tool in the treatment of traumatic stress. Expressive writing provides information on client thoughts and emotions (Chavis, 2011), allowing the reassessment of maladaptive beliefs (Hynes & Hynes-Berry, 2011). Writing is not only an avenue for emotional catharsis and healing post-trauma; it can serve as an excellent vehicle with which to deliver exposure to past traumatic stimuli, as well as the associated cognitions and emotions with which many clients deal.

An integrative therapy workbook is presented for therapists to use in the treatment of individuals suffering from post-traumatic stress. The workbook synthesizes knowledge about current treatment for trauma, and creative exercises used in poetry therapy, producing an integrative collection of writing exercises that treat a variety of aspects of post-traumatic stress reactions. Beginning sections include exercises that create a sense of safety and build therapeutic rapport. For example, these exercises teach clients self-regulation skills, guiding them to reflect on their own physical and affective experiences. Later writing exercises explore and reveal clients' thought patterns and emotions, and provide an opportunity for exposure, healing, and restructuring their maladaptive beliefs. For example, to better foster more adaptive thinking patterns, a client may create a poem using his or her "rational" voice. Exercises of this nature are expected to complement extant methods in the treatment of trauma and to add a creative, holistic, depth-oriented dimension to empirically supported treatments. Writing exercises will provide an opportunity for *imaginal exposure* where clients confront traumatic stimuli (e.g., images and thoughts) mentally with the goal of a decrease in post-traumatic stress symptoms (e.g., hyper-arousal, avoidance).

However, it should be noted that indiscriminate use of exposure may have unintended consequences for trauma survivors (Pitman, Altman, Greenwald, & Longpre, 1991; van der Kolk, McFarlane, & van der Hart, 1996). Re-traumatization and worsening of symptoms can occur when certain conditions for such treatment are not met or if the client is not assessed properly. Later sections will discuss the need for clinicians to develop techniques based on careful assessment of the client's tolerance for exposure to traumatic stimuli.

We believe expressive writing can be the central therapy or major adjunct to therapy in the treatment of traumatic stress. To this end, the first section of this effort will describe/summarize research about how trauma affects the brain as well as emotions, cognitions, and behavior. An understanding

of the effects of trauma will illuminate how expressive writing can be of use with trauma survivors. The second section will summarize major current treatments for trauma and discuss strengths and weaknesses of these treatments. The case will be made for expressive writing as useful in amplifying the strengths of these treatments and buttressing areas of weakness. Current literature will be reviewed on the usefulness of expressive reading and writing in therapy, and how writing can be integrated in the treatment of traumatic stress. Lastly, a clinician's workbook provides ideas and examples of ways expressive writing can be incorporated into the treatment of traumatic stress. Invoking the words of Edward Stainbrook in the opening chapter of *Poetry in the Therapeutic Experience* (Lerner, 1994, as cited in Lerner, 1997), it is hoped that the merger between poetry therapy and current trauma therapies may result in "the revitalizing and remoralizing of the self by providing a wholeness of consciousness—an integration of emotion, cognition, and imagery—with which to create and maintain personal meaning" (p. 11).

Trauma and Its Effects

The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (*DSM-V*; American Psychiatric Association, 2013), has listed trauma and stressor-related disorders including: (a) Acute Stress Disorder (ASD) and (b) Post-traumatic stress disorder (PTSD). Both require exposure to a traumatic or stressful event for diagnosis and involve the re-experiencing of those events, hyper-arousal, and avoidance (Foa, Cahill, & Pontoski, 2004; van Emmerik, Kamphuis, & Emmelkamp, 2008). Symptoms also include negative alterations in cognitions and mood and may include dissociative symptoms (American Psychiatric Association, 2013). It should be noted that reactions to trauma are widespread, and not everyone who is exposed to trauma goes on to develop ASD or PTSD (Foa et al., 2004; van Emmerik et al., 2008). Furthermore, people can often experience many of the symptoms characteristic of the two disorders without meeting full criteria for either.

Herman (1992), Terr (1990), and van der Kolk (2002) have proposed a complex adaptation to trauma that is not captured by the DSM diagnostic criteria for PTSD. Terr (1990) distinguished between Type I and Type II traumas. Type I trauma would be the result of one traumatic event, whereas Type II involves prolonged and/or repeated exposure to traumatic events. Terr described a Type II syndrome characterized by numbing, dissociation, and alternating between behavioral extremes. Herman also suggested that chronic traumatic stressors can result in what she terms *complex post-traumatic stress disorder*. She stated that reactions to trauma can best be thought of as a "spectrum of conditions rather than as a single disorder" (p. 119). The spectrum would range from a brief stress reaction to a short-term traumatic stressor to a complex syndrome in response to prolonged trauma. Herman described complex PTSD as resulting from a "history of subjection to totalitarian control over a prolonged period (months to

years)" (p. 121). Examples include being prisoners of war, concentration-camp survivors, intimate partner violence, and prolonged sexual abuse. Herman also described how complex PTSD involves alterations in affect regulation, consciousness, self-perception, perception of the perpetrator, interpersonal relations, and systems of meaning-making. This constellation of symptoms occurs mainly after exposure to interpersonal trauma at an early age (van der Kolk & Fisler, 1994). The existence of complex PTSD is believed to be a more severe type of PTSD as supported by research such as that of Ford and Smith (2008). Complex PTSD was found to be associated with the co-occurrence of depressive symptoms and more severe levels of trauma than those with simple PTSD (Ford & Smith, 2008). In addition, complex PTSD was found to be co-morbid with substance abuse disorders—they found that of 231 outpatient clients receiving substance abuse treatment, 50% had simple PTSD, while 41% met criteria for both simple and complex PTSD.

Van der Kolk and Courtois (2005) supported the concept of a complex response that results from chronic and/or developmental trauma and define it under the phrase, *disorders of extreme stress not otherwise specified* (DESNOS). DESNOS is conceptualized as alterations in ability to regulate emotions, consciousness, and memory, problematic relations with the perpetrator and others, negative physical/medical status (somatization), and disturbances in systems of meaning-making. A high incidence of such symptoms has been found in individuals with histories of prolonged interpersonal trauma and especially in those with early onset exposure during childhood (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Streeck-Fischer and van der Kolk (2000) posited that disturbances in emotional self-regulation are among the most salient effects of experiencing chronic trauma and lead to problems in other areas such as a lack of self-definition, distrust in others, and difficulties with impulse control.

They suggested that the inability to emotionally self-regulate is linked to a deficit in the ability to describe internal states verbally. According to van der Kolk and Courtois, trauma involves pervasive changes in neurochemistry that have far-reaching consequences for emotional and behavioral regulation. This is thought to be particularly true for those with early exposure to trauma, which can negatively impact patterns of dendritic branching in the brain during development and maturation (Streeck-Fischer & van der Kolk, 2000).

Psychobiology of Trauma

To better understand how treatments are effective, it is important to understand the physiological underpinnings of traumatic stress on the individual. Human behavior and thought are clearly not divorced from the body (Grame, Tortorici, Healey, Dillingham, & Winklebaur, 1999), and more comprehensive and holistic treatment approaches should take this into account. Perry

(1999, as cited in Grame et al., 1999), in describing the response to threat to survival, wrote:

> All areas of the brain and body are recruited and orchestrated for optimal survival tasks during the threat. This total neurobiological participation in the threat response is important in understanding how a traumatic experience can impact and alter functioning in such a pervasive fashion. Cognitive, emotional, social, behavioral, and physiological residue of a trauma may impact an individual for years—even a lifetime. (p. 3)

In their study of 27 women with PTSD, Hopper, Frewen, van der Kolk, and Lanius (2007) found that neural activation in different areas of the brain correlated with script-driven trauma imagery and symptoms of re-experiencing, avoidance, and dissociation (Hopper et al., 2007). Specifically, trauma re-experience severity was associated with greater activity in the right anterior insula, an area linked to the somatic aspects of emotional states such as sympathetic arousal (Craig, 2002, as cited in Hopper et al., 2007). In addition, higher levels of trauma re-experiencing were linked with less brain activity in an area associated with the inhibition of amygdala activity and modulation of conditioned emotional responses. Trauma re-experiencing, as well as severity of avoidance and dissociation, was associated with brain activity reflecting less ability to inhibit emotional experience. These findings support the conceptualization of PTSD as a disorder in emotional regulation and a failure over time to extinguish the fear response that has roots in the differential activation of particular areas of the brain. Hopper and colleagues discussed how individuals with PTSD may display pathological emotional over-engagement reflected by hyper-arousal and re-experiencing symptoms or they may display pathological emotional under-engagement involving dissociative symptoms. Other psychobiological changes have been found to be associated with trauma history. These include alterations in cortisol level (Miller, Chen, & Zhou, 2007; Taylor, Weems, Costa, & Carrion, 2009), facial electromyography, heart rate, skin conductance, and blood pressure (Pole, 2007; Wolfe et al., 2000). In addition, changes in vagal regulation have been noted (Porges, 2004). According to Polyvagal Theory, Porges stated that the vagal circuit involves face to heart neural connections where the neural control of the heart is connected anatomically to the neural control of facial and head muscles. Given this connection, disruption to the vagal circuit, as found in trauma, can have a broad impact on emotional regulation and social relatedness by affecting how facial muscles respond to emotional dysregulation. Dale and colleagues (2009) found that women with abuse histories demonstrated less vagal tone (i.e., respiratory sinus arrhythmia) and an inability to quickly re-engage vagal regulation immediately following mild physical exercise. These findings provide evidence for how trauma can affect a person's physiology on a

profound level. It appears that a history of trauma prevents the autonomic nervous system from more easily returning to a baseline state after arousal. This can have long-term health consequences, and is related to the ability to regulate emotions and behaviors, as well as the ability to return to a state of less physiological arousal.

Indeed, Dale et al. (2009) cited that poor vagal regulation may be related to psychological dysfunction including social anxiety (Movius & Allen, 2005, as cited in Dale et al.) and may hinder recovery from depression (Rottenberg, Salomon, Gross, & Gotlib, 2005). Dale and colleagues hypothesized that abuse history alters the vagal feedback loop, and decreases the efficiency of the vagal "brake," which promotes trusting interactions and engagement behaviors. Individuals who have less efficient vagal regulation may experience greater levels of hyper-arousal, and have difficulties in their ability to enter into trusting states and intimate interactions.

Van der Kolk and Fisler (1994) discussed how childhood abuse and neglect can also lead to a diminished ability to self-regulate. Survivors of childhood trauma lose the ability to regulate the intensity of emotions, as well as the ability to control impulses. Streeck-Fischer and van der Kolk (2000) noted that the capacity for representational memory (i.e., internalized representations similar to the idea of 'object permanence') is disrupted by trauma, and that this representational memory is crucial to the development of emotional and behavioral regulation.

Representational memory is a function of a developed frontal cortex; decreased frontal lobe functioning is related to an impaired ability to understand the larger context in which a particular event occurs (Streeck-Fischer & van der Kolk, 2000). Cole and Putnam (1986) posited that the loss of self-regulatory functions in abused children leads to identity disturbance, reflected by: (a) disruption in sense of self, (b) inability to regulate affect and impulses, and (c) insecurity in relationships (as cited in van der Kolk & Fisler, 1994).

As the impact of trauma on the central nervous system is determined by maturational level and severity of abuse, chronic abuse and neglect and trauma at younger ages would seem to have more deleterious effects on the brain than would an isolated traumatic event. The impact of trauma on neurochemistry (specifically the limbic system) can manifest in disruptions of emotional and behavioral regulation, as well as impulse control. Such negative disruptions can result in a host of symptoms, including, for example, an increase in aggressive acts (toward the self and others), eating disorders, and substance abuse (van der Kolk & Fisler, 1994).

Disruptions in Emotion-Identification

As mentioned earlier, abused children often exhibit the inability to identify and express their emotions verbally (Streeck-Fischer & van der Kolk, 2000; van der Kolk & Fisler, 1994). It makes sense that among those with

traumatic stress, the associated emotional over-arousal, inability to self-regulate, and lack of internalized representations would be linked to deficits in labeling and expressing emotions. Traumatized individuals may fail to recognize emotional states because of overall greater levels of hyper-arousal that prompt fight-or-flight reactions (Streeck-Fischer & van der Kolk, 2000; van der Kolk & Fisler, 1994). Nemiah (1991) and Putnam (1991) suggest that lack of awareness concerning internal states may also relate to dissociation and serve as a coping mechanism in the face of overwhelming stress (as cited in van der Kolk & Fisler, 1994). The idea that trauma hinders the ability to identify and label affective states is supported by Schneider-Rosen and Cicchetti's (1984) research showing that maltreated toddlers use fewer words to describe internal states compared to their non-traumatized peers.

Interestingly, Amir, Stafford, Freshman, and Foa (1998) found that the degree of transcribed narrative articulation shortly after trauma was related to the future severity of PTSD symptoms: less richness and verbosity within the trauma narrative is associated with greater PTSD symptom severity. In addition, Foa, Molnar, and Cashman (1995) found that narratives of sexual assault victims with PTSD at the end of exposure therapy were longer and had a higher percentage of organized thoughts (as cited in Amir et al., 1998). Furthermore, greater cohesion in the narratives was associated with a reduction in trauma related anxiety (Foa et al., 1995, as cited in Amir et al., 1998). Impulsive actions and impaired impulse control have also been associated with difficulty putting feelings into words (Fish-Murray et al., 1987, as cited in van der Kolk & Fisler, 1994). As van der Kolk & Fisler stated, "... when the mind is able to create symbolic representations of these past experiences, there often seems to be a taming of terror: a desomatization of experience" (p. 154). Words can provide the coping strategy necessary to increase a sense of mastery and control.

These findings suggest that trauma may have a negative impact on the neural processes involved with language, memory, social interactions, and understanding complex social patterns due to sensory-perceptual disturbances (Streeck-Fischer & van der Kolk, 2000). Overall, traumatized individuals need to improve their ability to put feelings into words; they also need to create an internal narrative of traumatic experiences replete with symbolic meaning to fully integrate memories of the trauma and reorganize distorted beliefs resulting from the trauma. In this way, trauma survivors can abandon maladaptive behaviors that may once have been quite adaptive. In addition, Streeck-Fischer and van der Kolk asserted that treatment needs to involve symbolic linguistic expression, allow the traumatized individual to try out different social roles and outcomes, and help individuals explore how others might have dealt with feared emotions and past situations. Furthermore, treatment for traumatic stress would need to provide a sense of emotional and behavioral containment that was previously unavailable and create a way for individuals to regulate themselves within such arenas (Streeck-Fischer & van der Kolk, 2000). It is suggested here that the process

of expressive writing can provide just such a treatment option to address emotional and behavioral containment for trauma survivors through its structure, pacing, and assistance in self-regulation.

Interpersonal and Cognitive Effects of Trauma

In addition to neurobiological consequences, trauma can negatively affect the interpersonal functioning of individuals on many different levels (Harris & Valentiner, 2002). Traditional talk therapy as an intimate, interpersonal process brings to the fore interpersonal styles and beliefs that have been profoundly affected by trauma. Given this, trauma treatment should take into account the differences and interpersonal limitations of those who are suffering traumatic stress. Specifically, beliefs about the self and the world are altered as a result of traumatic experiences, which can lead to long-term behavioral problems (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Janoff-Bulman, 1989; Janoff-Bulman & Frieze, 1983; McCann & Pearlman, 1990). For instance, problematic thought processes and beliefs can negatively affect how individuals relate to each other in close relationships (Owens & Chard, 2001), such as decreasing the level of intimacy (Fehr, 2004). A decrease in intimacy may have important implications for the overall amount of social support received in close relationships (Sanderson, Rahm, Beigbeder, & Metts, 2005).

A cognitive schema can be defined as a mental framework that confirms a core belief about the self, others, or the world. After a traumatic experience, personal schemas are changed to accommodate the realization that horrific events occur in the world (Cason, Resick, & Weaver, 2002; Foa et al., 1999; Owens & Chard, 2001). Almost two decades ago, Janoff- Bulman (1989) and Janoff-Bulman and Frieze (1983) detailed three specific sets of cognitive schemas that are affected by trauma: (a) perceived benevolence of the world, (b) meaningfulness of life and the world, and (c) worthiness of the self. Similarly, Constructivist Self Development Theory (CSDT) specifies five principal areas of schematic change resulting from abuse as they refer to self and to interpersonal relatedness: (a) safety, (b) trust, (c) control, (d) esteem, and (e) intimacy (McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1988; Pearlman, 2001; Pearlman & Saakvitne, 1995).

There is some agreement that various types of trauma affect different cognitive schemas. Specifically, some traumas mainly change beliefs about the self, while others change beliefs about the world. Foa, Ehlers, Clark, Tolin, and Orsillo (1999) found three sets of schemas that are affected by trauma: (a) negative cognitions about self (general negative view of self), (b) negative cognitions about the world, and (c) self-blame. Owens and Chard (2001) found that female survivors of childhood sexual abuse had altered beliefs regarding self-blame, whereas rape survivors had altered beliefs regarding both self-blame and beliefs about the world. Furthermore, Foa and colleagues found that accident survivors viewed their world more positively than victims of assault because assault was classified as interpersonal

trauma as opposed to an accident. In other words, interpersonal trauma more negatively affects how one perceives the world than accident trauma. In sum, the impact of interpersonal trauma on one's perception of the world may have negative implications for psychological well-being in a different way than the experience of accidents or natural disasters.

Harris and Valentiner (2002) found that disruptions in perceived benevolence of the world, meaningfulness of the world, and worthiness of the self are related to fear of intimacy in relationships and thus play an important role in the interpersonal functioning of individuals. They hypothesized that the belief that the world and other people are unsafe, as well as the belief that the self is unworthy, would lead individuals to avoid intimate relationships (Harris & Valentiner, 2002). Results indicate that the view of one's self and the world, as well as depressive symptoms, did indeed predict fear of intimacy in relationships. Similarly, McEwan, de Man, and Simpson-Housley (2002) found that survivors of rape had greater fear of intimacy than women who had not experienced sexual assault. Davis, Petretic-Jackson, and Ting's (2001) research further indicated that women who had experienced multiple abuse (physical and sexual) during childhood reported greater fear of intimacy than women who had undergone a single type of abuse or no abuse. In addition, women who had reported a single type of abuse did not differ significantly from women who had no abuse history in terms of fear of intimacy, suggesting that the experience of multiple types of abuse is significant in predicting avoidance of intimate relationships (Davis et al., 2001).

Trauma can also disrupt patterns of relating that foster intimacy and relationship satisfaction by altering cognitive schemas and affecting psychological well-being (Harris & Valentiner, 2002). McCann and colleagues (1988) noted a variety of psychological responses as a result of cognitive distortions involving one's self and the world. These included anxiety, social withdrawal, and fear of betrayal, which can greatly hinder social intimacy in the life of the trauma survivor. The World Assumptions Scale (WAS) can assess these changed beliefs by measuring assumptions about the self, others, and the world (Janoff-Bulman, 1989). Subscales on the WAS include: the benevolence of the world (e.g., "The world is a good place"), the benevolence of people (e.g., "People are basically kind and helpful"), justice (e.g., "Misfortune is least likely to strike worthy, decent people"), control (e.g., "Through our actions we can prevent bad things from happening to us"), self-worth (e.g., "I am very satisfied with the kind of person I am"), personal control ("I take the actions necessary to protect myself against misfortune"), and luck ("I am basically a lucky person"). Low agreement with such dimensions on the WAS correlated with depression and fearful attitudes toward relationships, thus pointing toward the role trauma plays in affecting post-traumatic emotions and interpersonal functioning (Janoff-Bulman, 1989; Janoff-Bulman & Frieze, 1983). In Wenninger and Ehlers' (1998) study, highly reinforced patterns of thinking were also related to post-traumatic symptoms in survivors of childhood sexual abuse; for instance, maladaptive