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Trauma Science in the context of human connection: $p < .05$

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The EBT movement: a little history


- Richard McFall, 1991, gives a Presidential Address, entitled "A Manifesto for a Science of Clinical Psychology."
- "Clinical psychologists cannot justify marketing unproven or invalid services simply by pointing to the obvious need and demand for such services, any more than they could justify selling snake oil or remedies by pointing to the prevalence of diseases and consumer demand for cures."

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History


- Division 12, under the leadership of David Barlow, formed the Society for the Science of Clinical Psychology.
- The Society came up with a list of "well-established treatments" and "probably efficacious treatments" in 1995.
- These were dubbed the empirically supported treatments.

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History


- This produced a firestorm of controversy
 - Some of the controversy was over who made the list and who did not.
 - Other critics targeted the research itself: which patients were left out of the research protocols, for instance, or who dropped out.

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History


- Others called on APA to “impose sanctions including expulsion if necessary,” against those routinely failed to practice the EST’s (Lohr, Fowler, & Lilienfeld, 2002, p. 8)

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The Presidential Task Force on Evidence Based practice


- EBPP (in 2006) was defined as “the integration of the best research with clinical expertise in the context of patient characteristics, culture and preferences.”

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PE in the community

- o Becker, Zayfert, & Anderson (2004) found that 28% of those in private practice reported training in exposure treatments.
 - But of those with training, 46% still never used it.


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Therapy outcome: Lambert (1992)


Variance in outcome

Factor	Percentage
Client	40%
Technique	16%
Relationship	30%
Expectation	15%

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Therefore, empirically supported therapy must include understanding of factor that support and harm relationship, factors that influence expectation, and factors that predict and maintenance or healing of ruptures, as well as techniques for patient education and change (CBT, PE, ACT).

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How I learned what is wrong with the countertransference literature from my digital camera manual

- o Instructions not to do things that it would never occur to me to do
 - Do not immerse in water
 - Do not disassemble
 - Do not sleep with your patients
- o Instructions not to do things that I only do by accident and would never do consciously.
 - Do not drop
 - Do not unintentionally violate the emotional boundaries of your patients
- o Instructions that need instructions
 - Do not overfocus
 - Create safety for your patients.

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The countertransference survey


- o Interviews of clients who had completed trauma therapy
- o Asking about difficult points in therapy, including
 - Emotional reactions to therapist response
 - Therapist mistakes
 - Therapist countertransference

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Boundary survey studies


John is a 35 year old abuse victim who is having trouble controlling his anger. One session, when you are a few minutes late, John shouts at you as you enter the waiting room. How would you respond?

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Psychotherapy in real time research: Fawcett & Dalenberg, 2009


- o Use of actors and analogues do not create the sense of real therapy or elicit real therapy behaviors.
- o Use of real psychotherapy patients do not allow manipulation of relevant variables.
- o In the TRI patient process paradigm, actors are coached to use a true but nontraumatic event in their life as a foundation to create a realistic trauma scenario.
- o Therapist participants believe that they are interacting with a real patient.
- o The cover story for the study is that we are researching the possibility of whether therapy conducted serially across several therapists can have positive effects on the client.

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The Trauma Narrative


- o Event #1: "A couple months ago my mom had a stroke and was taken to the hospital. The doctors couldn't tell us how bad it was, so we just had to wait. We didn't know anything for almost 24 hours, when we finally found out that she was going to be ok. She has been having health issues for a while, but I thought for sure this was it."
- o Event #2: "There was a guy that I was hanging out with around that same time. About a week after the stroke happened, I went to see him because I felt safer with him for some reason. Somehow we started making out that night. I suddenly realized that I didn't feel comfortable and tried to tell him to stop. He didn't stop, he just kept telling me "It'll be all right." He pinned me down so I couldn't move and kept touching me all over, trying to undress me. I'm pretty sure he would have raped me if I didn't fight him off and get away."

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Premises of our work

- o Therapists may not be the best, and certainly are not the only accurate reporters of relevant therapist alliance behavior.
- o Connection/alliance is important.
- o Therapists are often pulled out of their best beliefs about correct therapist behaviors by the connection to the patient.


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Premises II

- o Therapist theoretical sophistication is important.
- o Therapists need help in directing the path out of a connection-related rupture or a technique related rupture.

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Listening to trauma


P: She [her therapist] just would not listen. She kept shifting the subject. I would be trying to figure out how to tell her something and she would cut me off. It hurt so much


Int: How would she cut you off?

P: She would not let me speak. She would ask me about something else. I think she must have thought I was to blame for the rape (Begins to cry)

Int: Did she say anything like that, that you were to blame?

P: She didn't say much at all, really, except for the questions. She was so..silent. That's part of why I think she was ashamed of me.

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Listening to Trauma II: Her therapist speaks


Dr. B: She just couldn't talk about it. I tried to make it easier for her, you know, did all the usual things

Int: What usual things?

Dr. B: I tried to support her defenses while they were still needed. I respected her silence. I could tell the whole thing was too much for her. I actually feel very badly about it. I don't usually have clients leave this way.

Int: I understand. How did you respect her silence?

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Listening to trauma: Therapist continued


Dr. B: I knew that she was not able to talk yet, and I understood that. It was a really terrible rape, from what I could tell about it. I knew she was ashamed. I know I didn't deal with it well.


Int: What do you think you should have done?

Dr. B: Interpreted her resistance, probably

Int: Ok, well, I'm not saying that I think you should have done that, but why didn't you do that?


Dr. B: I felt sort of..incompetent..from being faced with that much pain. It threw me off.

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Why they think you are silent


- o Because you are waiting for them to speak
- o Because you are judging them
 - For their actions at the time
 - For their inarticulation at present

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Why you are really silent


Reason 1:
Because you are vicariously
traumatized yourself

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Why you are really silent


Reason 2:
Because you are trying to think of
something profound to say

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Why you are really silent


Reason 3:
Because you are empathically connected to
the client's wish to avoid

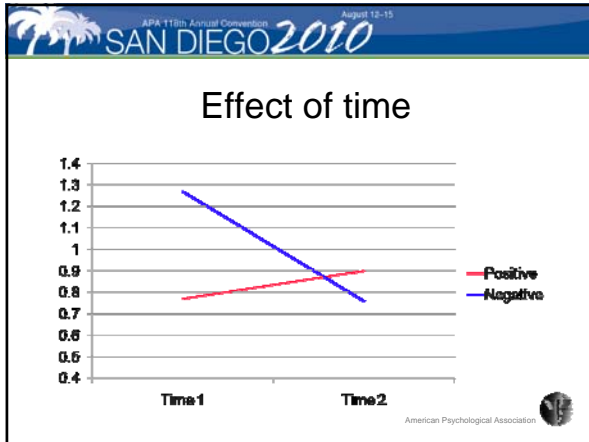
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Joseph F: Participant in Dalenberg countertransference study

- o I guess the most helpful thing my doctor did...well, this is going to sound strange, but he tried to guess what it must have felt like to me as a kid. And when he was groping around for the words he just hit on a couple that worked. And until that happened, I couldn't grip them with my mind, you know? They kept slipping away. His descriptions weren't exactly right, but they were like sandpaper. My own truth stuck to his words well enough for me to trap it and talk about it.

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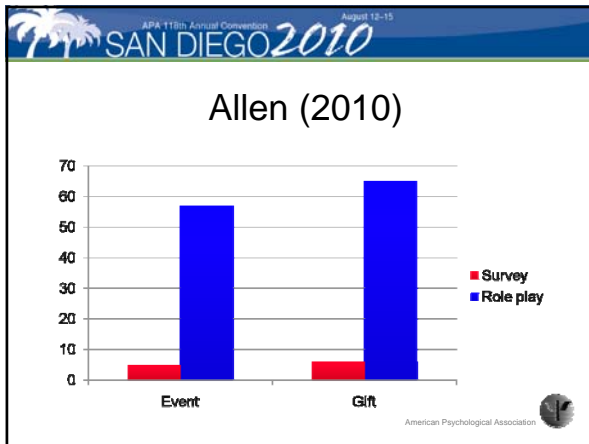


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Allen (2010)

- o Realistic actors making a boundary request
 - The study of two responses
 - The unexpected acquiescence
 - The hostile refusal

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Dalenberg & Dunkerley (2008)


- o 50%-70% of refusals are rated by professionals or patients as hostile
- o You know in my profession we call that a boundary violation. If you can't control yourself and stop asking me to do unethical things I can give you some names of other people.

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Wachtel on the impossible profession


- o Practicing psychotherapy is a difficult—if also rewarding—way to earn a living. It is no profession for the individual who likes certainty, predictability, or a fairly constant sense that one knows what one is doing. There are few professions in which feeling stupid or stymied is as likely to be a part of one's ordinary professional day, even for those at the pinnacle of the field (Wachtel, 1982, p. xiii)

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Training implications


- o It's not enough to tell therapists "here's a list of things you shouldn't do" or "be careful not to exploit your clients."
- o Therapists need to learn when to say yes, and how to say no.

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Training implications II

- o Too little focus has been given to the specific training of the student therapist on the ways in which they can unintentionally harm the relationship
- o Empirically based treatments must include an empirical base for the maintenance of relationship

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And to this year's newest members

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