POSITIVE PSYCHOTHERAPY IN APPROACHING PSYCHOLOGICAL TRAUMA

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Abstract

Domain literature suggests that the cyclical nature of psychological trauma may lead, on a long term, to long term effects on the individuals and those around them. This paper sets out to examine the opportunity of using positive psychotherapy in approaching the effects of potentially traumatic events. Although trauma therapy is a less explored approach of positive psychotherapy, a review suggests that positive psychotherapy could bring a significant contribution when working with people exposed to potentially psychotraumatizing events, even in the phase of crisis intervention

Key words: *psychological trauma, posttraumatic stress, positive psychotherapy, the balance model in psychotrauma therapy, conflicts, soldiers.*

INTRODUCTION

A traumatizing incident is an emotionally shocking and overwhelming situation, where we personally experience or perceive a threat to the physical and/or psychological integrity of ourselves or of a significant person resulting in a reaction of intense fear, helplessness or terror. (DSM IV Tr., 2003). The fact that such experiences may lead to psychological problems, labeled as posttraumatic stress disorder symptoms, is mentioned ever since ancient times (Sumerian documents – Ben Ezra, 2001, quoted in Grey, 2007). More recently, the acts of terrorism such as the attacks from 9.11.2001 on the USA, the military actions in Iraq and Afghanistan as well as the natural disasters such as the 2004 tsunami in SE of Asia or the 2005 Katrina hurricane have multiplied the statements regarding psychological trauma among professionals and the mass-media alike. Thus, trauma is gaining more and more acknowledgement both as a specialty domain and particularly as a fundamental aspect of human experience.

Stolorow (2007) made a personal philosophical reflection on the psychological and emotional impact of trauma, defining it as an ”unbearable emotional experience” in a context where there is ”a lack of adaptation and an individual incapacity of appropriately reacting to painful emotional stimuli” (p.9-10). The reactions to traumatic events vary considerably, ranging from relatively low intensity responses, which lead to minor disturbance in the person’s life, to severe and debilitating reactions. It is common for those exposed to traumatic events to experience intrusive thoughts and images accompanied by avoidance attempts, emotional numbness and increased nervousness. It is equally common to relive the trauma, which occurs in the form of self-destructive behaviors (van der Kolk & McFarlane, 1996). The effects of trauma are seen over time in increased rates of psychiatric diagnoses which include the major depressive episode and alcohol and drug addiction (Wainrib, 2006). Increased rates of comorbidity between trauma and psychosis are also highlighted in the domain literature.

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV-Tr., 2003) emphasizes, as a characteristic of the post traumatic stress disorder, maintaining the distress symptoms for more than a month after the exposure to a traumatic event. Foa et al (2008) argue that this diagnosis frame is restrictive and call for an increasing multimodal intervention consensus. It is argued that the posttraumatic stress disorder is not a neutral concept, but a social construct (Maddux et.al, 2004, quoted in Joseph, 2010) which could improperly pathologize normal and natural reactions to traumatic events. Therefore, Joseph (2010) believes that posttraumatic stress disorder diagnosis status and medication of the reactions to trauma denies the existential nature of searching for answers and represses people’s capacity to emotionally process their experiences in a significant manner.

In general, the literature approaching the traumatic reactions amongst soldiers after a traumatizing event makes immediate intervention recommendations in order to avoid maintaining and developing the distress symptoms which could prevent the subjects in question from returning to their duty.

These are a few arguments which make me consider that using the positive psychotherapy specific techniques – as prophylactic tools – offers a new perspective in assisting the persons exposed to psychotraumatizing events with the aim of accessing inner resources.

POSITIVE PSYCHOTHERAPY

Positive psychotherapy was developed in 1968 in Germany by Nossart Peseschkian, and at the beginning it was called differential analysis. N. Peseschkian defined his method as a ”transcultural psychotherapy method”, a short-term therapy oriented towards conflict and resources. His method is based on transcultural observations from over 20 cultures. The positive psychotherapy specific techniques may be used as therapy and treatment methods but can also easily be used in education and prevention.

Positive psychotherapy is a humanistic, transcultural therapy, being part of the psychodynamic psychotherapy family, where the focus is on solving the intra-psychic conflicts. One of the most influential modern theories regarding trauma is the one belonging to Mardi J. Horowitz, in which are emphasized: negation, abreaction, catharsis and recovering stages. The aim of therapy is to solve the intra-psychic conflict resulted from the traumatic experience. The therapy is focused both on exploring the self and on the conflict induced by the trauma, containing common elements with the cognitive-behavioral and existentialist interventions. At the same time, positive psychotherapy (like any other psychodynamic psychotherapy) pays much attention to aspects related to transfer, counter transfer and the therapeutic relationship. It is said that a strong therapeutic alliance helps create a safe environment in which the assisted person may come to understand the impact of the trauma on the self. Moreover, such an environment may help reduce the strong emotional component associated to the trauma and facilitate the integration of the trauma in the beliefs and future expectations of the person.

The term of ”positive psychotherapy” derives from the word ”positum”, that is ”which is actual and given”. Just like in the universe there is the law of duality and the good/bad dichotomy, for positive psychotherapy every person bears a positive and a negative side of personality which should preferably reach a balance, so that these two polarities make room for harmony in the human being. It is known that it’s not an event per se that determines a certain thought, emotion or behavior, but the way in which we interpret it, the way in which we give an event meaning and significance. Thus, any negative event as well as our conflicts can be reassigned a positive meaning, for example: ”aggressiveness – the ability to react spontaneously, emotionally and uninhibited to certain facts or situations; depression – the capacity to deeply emotionally react to conflict; fear of loneliness – the need to be around other people; anxiety – the capacity to notice risks that most people don’t notice” (N. Peseschkian et. al, 2010, p. 42-43) etc.

N. Peseschkian (who set the foundation of positive psychotherapy and turned it into a science) argues that positive psychotherapy is based on three essential principles, the first one being the ”principle of hope” which is based on the positum. He believes that by focusing on the positive aspects of the disorder, we encourage the patient to give up the symptoms and face the conflict which lies behind these symptoms. Positive psychotherapy lays its account on the development of human potential and on the person’s self-help capacity, through the mobilization of his/her inner resources in facing the crisis and problems he/she deals with.

The second basic principle of positive psychotherapy is the ”balance principle”. ”In positive psychotherapy we try to answer the question: What do people have in common and what differentiates them?”; the answer laying in the inventory of the conflict contents (N. Peseschkian, 2010). These contents are strong and are to be found both in the family and in society, being divided into four areas: health (body/senses), environment (achievement/work), family (relationships) and fantasy or future. These are in the same time four ways of coping with conflicts and ways in which our primary and secondary capacities manifest (loving and knowing).

Everything begins with the relationship between ourselves, as physical bodies, and the environment: the biological forces that harmonize our body/senses area. The social dimension refers to our social, professional and cultural network (the work and contact/communication areas) through which we relate to others and finally our relationship with the future, fantasy and belief, in which we can experience and conceive the world from a spiritual perspective.

In the therapeutic process, the client's confrontation with his/her own trauma is not approached as a hard-set aspect. In positive psychotherapy, the accent is both on the process (how it happened) and on the content (what happened). When we deal with problems such as exposure to trauma, this balance becomes unbalanced, because we develop our own adapting mechanism and we escape from one area and go into another, according to our defense mechanisms, psychological destructuration, temperament and previous life experiences. Thus, four "escaping mechanisms" emerge (N. Peseschkian, 2010). People's conflicts are to be found in somatic disorders (somatic forms of the disorder), in professional activities (as adaptation and performance problems caused by the disorder), in society (through disturbed relationships and changes in the social behavior induced by the disorder) and in fantasy, religion (worries, phobias, panic attacks, perception disorders, loss of meaning.)

THE BODY/SENSES AREA

The client's manifestation in the area body/senses refer to body, health and physiological symptoms. The therapist's focus on this area will help him/her better understand the client's world in the physical sense and the impact of the traumatic event. During the course of our entire lives, our main physical survival challenge remains the constant concern with continuous threats, van Deurzen (1997) pointing out that our existence is regulated by physical, biological and natural forces. Similarly, the psychological trauma leads, among others, to an increased feeling of physical vulnerability. Jacobsen (2006) conceptualized the crisis as a term we sometimes use as an alternative to trauma, this being associated to three dimensions: loss, adversity and meaning of life. At an individual level, crisis means losing something, confronting adversity and brings the opportunity to redefine our lives, even to the deepest level. In Jacobsen's (2006) conceptualization, "the crisis as a loss" may involve direct and physical loss which cause pain. Jacobsen (2006) notices that when something is lost, it's like part of the person's self was attached to that thing. Therefore, this feeling of loss as a result of trauma may be perceived as an unfamiliar environment which intensifies the physiological sensations of the person by the simple awareness of their mortality. Trauma may induce a series of physical consequences. Kendall-Tacket (2009) show that people who went through traumatizing experiences have later been recorded with serious illnesses, such as: cardiovascular diseases, diabetes, gastrointestinal diseases, cancer. Tarrier (2010) emphasizes the existence of interaction between physiological and psychological disorders which appear because of a trauma, proving how a physical prejudice can maintain a post traumatic stress disorder by constantly triggering memories of the traumatic event and its consequences (Jenewein et. al, 2009; Sharp & Harvey, 2001).

CONTACT/COMMUNICATION AND WORK/ACHIEVEMENT AREAS

The psychological trauma, seen through the perspective of these two areas, refers to our usual responses to trauma, to the way we instinctively respond to threat, and to the social and professional impact of trauma. Denham (2008) describes different ways in which people experience, build and transmit the traumatic experiences along generations in the American Indian families, showing that trauma and stories about trauma in the history of the families have a significant function in the culture and identify of these families. The same aspect is also noticed by N. Peseschkian in his transcultural studies form over 20 cultures. He believes that the stories "reflect the rules, concepts and behavior norms accepted in a certain culture…reinforce and offer security…the content suggest accepted solutions within a culture" (2005, p. 30).

This process is related to another one, eliminating the emotional barriers and those who oppose the unknown ways of thinking and behaving, making new things be perceived as aggressive and threatening.

From the point of view of positive psychotherapy, the therapist's work includes helping the client become more authentic, more aware of his/her own existence and of the background passed on from generation to generation regarding the way of approaching conflict and problems, which generally includes exploring the two areas. Undoubtedly, the psychological trauma affects these areas as well. Our fight for survival requires us to make the difference between what protects us and what threatens us and, when it is the case, to activate our own social involvement system.

The fact that psychological trauma has an impact on our social and professional life is also proved by Maercker's researches (2009), who showed how some combinations between certain dimensions of the posttraumatic symptomatology and certain personal factors may induce increased social exclusion, which can represent an additional emotional factor for the trauma victim. The posttraumatic stress disorder is often accompanied by psycho-social and professional dysfunctions, McFarlane and Van der Folk (1996) arguing that symptoms such as repression, denial and dissociation are both social and individual consequences. In the same time, the social dimension of trauma reflected in these two areas emphasizes once more the positive psychotherapy's concern with process-orientation and therapeutic alliance.

THE FUTURE, RELIGION/FANTASY AREA

Van Deurzen (1997) suggests that we shape our relationship with the divinity according to our life experiences. Trauma may cause an alteration of our life philosophy and may include spiritual beliefs. During the exposure to trauma, the client may experience a high level of awareness of his/her own death, which allows him/her to experience more clearly and more awarely the joys, meanings and values of life (Frankl, 2009; Yalom, 2010). Trauma offers the psychotherapist the opportunity to help the client discover a respect for life which emerges, paradoxically, as a response to being close to death, identified by Frankl (2009) as being "final meanings". Moreover, trauma may result in growth, insofar as the adversity and distress may determine someone to develop. Parkes (1971) describes traumas as being "psycho-social transitions", explaining that "individuals must restructure the way they see the world and their plans of living in it " (p.101). Research suggests that a series of traumas, such as cancer (Cordova et.al, 2001), HIV infection (Schwartzberg, 1994), mourning (Lehman et. al, 1993) and natural disasters (McMillen et.al, 1997) may positively precipitate personal development. The crisis become existential and may become crucial and landmark moments, bringing along new life possibilities (p. 46).

CASE STUDY

In my personal experience I offered psychological assistance to several soldiers who had been exposed to potentially traumatizing events, such as the case of an improvised explosive device that exploded, leading to several deaths and serious injuries. The aim of the intervention was to reduce the negative reactions following the traumatic incident and speeding the recovery process in order to return to normal functioning. In such cases, using only psychotherapy is, unfortunately, insufficient for covering the psychological needs of those involved. Therefore, crisis intervention, sometimes designed as a form of "psychological first-aid" is recommended for dealing with the psychological needs following traumatizing events. Such interventions can serve as a means to facilitate the access to traditional psychological assistance services and psychiatric assistance, if needed.

The subject, aged 30, while in a mission on a military operation theatre, witnessed the explosion of an improvised explosive device which caused the death of two of his comrades.

The psychological intervention was performed inside the military base where we were dislodged (not a hospital or other medical facility) according to the specific protocol for such

situations but using the means and techniques of positive psychotherapy. The main focus of positive psychotherapy being conflict resolution, the intervention, in this case, focused on identifying and solving the conflicts resulted from the traumatizing experience.

1. **OBSERVATION-DISTANCING** (1 group session)

Ten hours after the incident, the subject, together with other survivors attended a DEFUSING session, a crisis intervention method for small groups. The objectives of this method are: reducing stress and emotional tension; normalizing the post-traumatic reactions, speeding the recovery process in order to return to normal functioning; identifying the individuals who might need further assistance.

While listening to everyone's story, I noticed that almost all of them avoided talking about the emotions experienced during the explosion, or at present. I was aware that the absence of such reference following special events is far from being a sign of "psychological strength" but it rather is, more often than not, the result of a "voluntary denial", caused by the need to preserve the self-image, and by the fact that they were facing a person towards whom one should not show vulnerability. The programmatic promotion of an ideal model, a soldier "immune" to danger, contributes significantly to this attitude.

Therefore, taking into consideration the double role I had back then (as a psychologist and as colleague of those involved in the incident) I used the personal model of "self-disclosure", talking about my own emotions and experience towards the death of our two colleagues. This seemed to be a moment they have been waiting for, that triggered a wave of emotion, tears, expression of anger, sadness, and helplessness. Our subject alone confined himself to giving a technical description of the facts, avoiding the description or showing of emotion or any particular experience. His non-verbal behavior clearly emphasized the fact that he did not wish to make further disclosures within the group.

I closed the session with the story "The Sun-Crier" ("Oriental Stories as Tools in Psychotherapy, N. Peseschkian) then announced the group that, starting the next day, I would hold individual sessions with each of the survivors. I approached the subject, thanked him for attending the session and we scheduled an individual session the next day.

2. **INVENTORING** (1 group session and three individual sessions)

The group session ended in a written evaluation. I applied the Impact of Events Scale (*I.E.S*, Horowitz et all, 1979). The scale comprises 15 items which measure the subjective distress experienced after traumatizing events, by means of two sub-scales: the intrusive symptoms scale (intrusive thoughts and experiences, nightmares) and the avoidance symptoms scale (avoiding recalling, apathy, avoiding emotions, experiences, situations or talks related to the incident). This scale is appropriate for repeated application over time, being responsive to the changes in the clinical status of the respondents and useful in monitoring the progress in psychotherapy. One can get a score between 0 and 21 for the intrusive symptoms scale and between 0 and 24 for the avoidance symptoms scale. Following the studies undertaken, the authors suggest that a total score of over 26 (of the total of 45) indicates a moderate to severe impact. The higher the scores are, the greater the level of subjective disorder.

It is important to note that our subject obtained a total score of 26, this translating in a moderate psychological impact of the traumatizing event.

During the individual sessions with our subject, I combined the inventory and the situational encouragement stages. After each inventory taking stage we went through situational encouragement by means of stories and positum, until I managed to identify the primary and secondary capacities in order to increase the capacity of self-reflection. I alternated the two stages, facing two therapeutic objectives: reducing the symptomatology and returning to duty as soon as possible (maximum 2 weeks); preventing the development of a post-traumatic stress disorder. These objectives did not

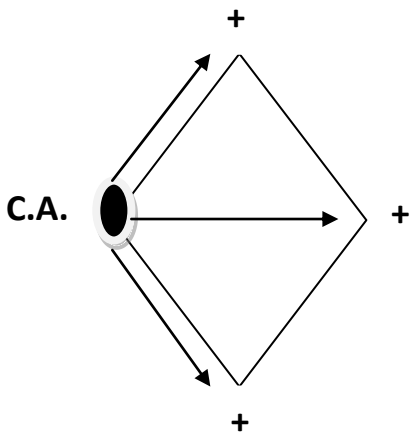
belong to the subject, but to the therapist, in this case the subject considered that by avoiding talking about the trauma, it will disappear by itself.

During the inventory stage, since it was a crisis intervention, I only used those instruments that could offer me information about the present, having access to the data from the previous psychological assessments regarding his personal history and evolution. Therefore, based on the projective test and on the balance model, I extracted the actual conflict, the key conflict and the inner conflict. Being a crisis intervention, it is not absolutely necessary to identify the basic conflict, this being useful especially in case the subject might have developed PTSD.

The projective test was a crucial moment for the subject's self-disclosure. Talking about the personal interpretation of the four drawings, he started to offer information about the feelings and thoughts he was facing.

The balance model is the primary instrument used for obtaining information about the present situation. In our case, it revealed the fact that our subject only uses 95% of his energy, which might indicate depression, the most developed area being "future/fantasy" (40%) – which suggested the presence of certain symptoms specific to anxiety disorders. Other data obtained using the two instruments:

- **Actual Conflict** (AC) located in the "future/fantasy" area.
  Content: "Confronting death",
  Fantasizing on the theme of death
- **Symptoms** on all the areas:
  - Body/Senses:
    - insomnia, nightmares,
    - tachycardia, exaggerated reactions
    - psychomotor agitation, irritability
  - Work/Achievements:
    - Incapacity of focusing attention
    - Intrusive thoughts
    - fatalism, communication difficulties
  - Contacts: isolation
  - "Future/Fantasy": Depression, guilt



- **Capacities involved in the Actual conflict:**
  - Secondary: justice, responsibility, achievement, orderliness, obedience
  - Primary: hope, faith/meaning, trust (God does not love us anymore; the hope that God protects us is gone, etc.)
- **Inner Conflict**: the conflict between obedience and meaning: „*I was obedient, as a soldier I did everything I was asked to, and still, two people died."*
- **Defense mechanisms**: dissociation; escaping in Future/Fantasy: (watching movies, excessively playing computer games); denying („I don't have any problem"), altruism („It is my fault"), psychotic projection („God does not love us anymore, he turned his face away from us"), avoidance ("I want to be left alone").
- **Key conflict**: I only observed the way our subject reacted to the actual situation, the way in which the subject adapted to the trauma. I was less interested in his general pattern of reaction. In this case, even though the subject had a general increased sincerity and low politeness, in the traumatic situation he reacted by ***increased politeness.***
- As mentioned above, in such situations of crisis intervention we do not investigate the **basic conflict** because we do not have the time to investigate the "Model dimension."

3. **SITUATIONAL ENCOURAGEMENT** (combined with the inventory stage and continued for another 5 individual sessions).

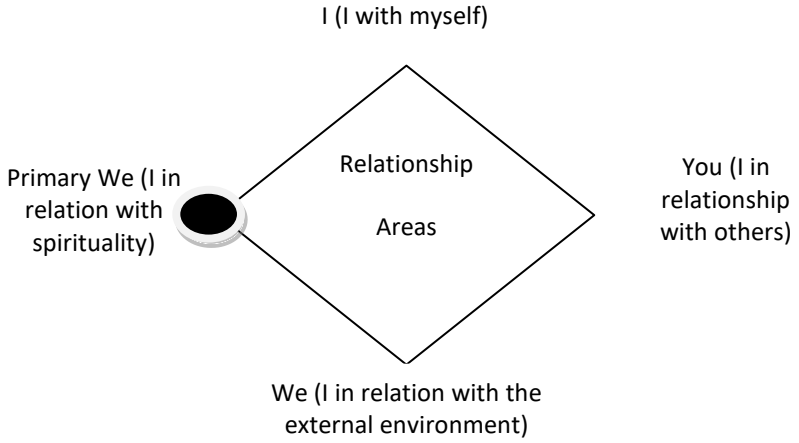
Approached subjects: „Death", „Responsibility" and „Meaning of Life"
Techniques and exercises used:

- Bibliotherapy: „War and Peace" (Lev Tolstoi), the movie „Black Hawk Down"
- The list of stories from "Oriental Stories as Tools in Psychotherapy" (N. Peseschkian):
  - „Give Him Your Hand" and „The Shared Sorrows" – for the refusal of being helped and for denial.
  - „About the Difference" – for accepting those who accuse and blame him
  - „The Sun-Crier" – for the incapacity to see the future
  - "Crisis as Opportunity" and „The Dark Side of the Sun" – for seeing the opportunities brought by a traumatizing situation.
  - „The Healing of the Caliph" – for activating the emotional involvement, expressing emotions, getting out of the emotional numbness.
  - „A reason to Be Thankful" and „The Difficulty of Doing Things Right for Everyone" – for reflection and the feeling of guilt
  - „The Glass Sarcophagus" – for mourning and wail.

I also used the exercise "Who am I?" and the mental imagery exercise „*Imagine your own death*", the dereflection technique and the „engagement", described by I.Yallom (*Existential Psychotherapy*, 2010), autogenous training, „in vivo" exposure.

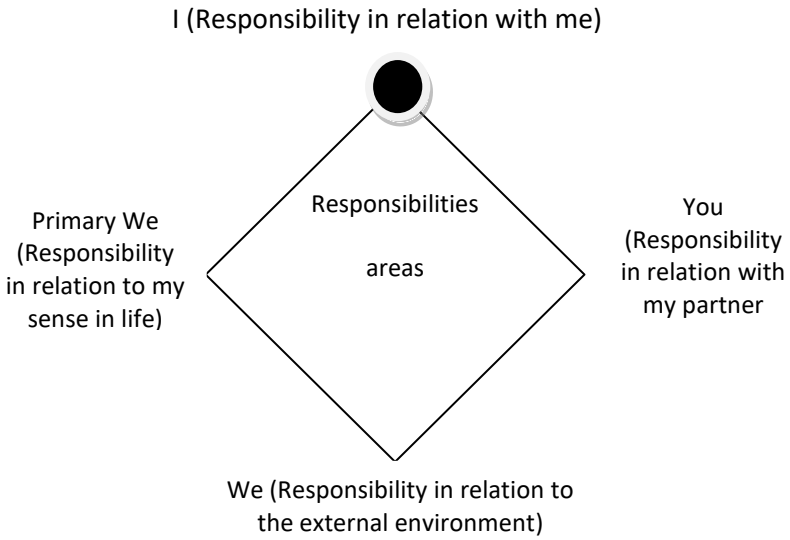
4. **VERBALISATION (**2 sessions)

- Working on the actual, inner and key conflict
- Working on the relationship model in the area „I in relation with spirituality"



5. **BROADENING OF GOALS** (2 sessions).

Work on the responsibilities model, emphasizing the changes that occurred following the event in the relationship of the subject with himself, with his colleagues and with God and meaning in life.



In the broadening of goals stage I also reassessed the specific symptoms of acute PTSD, the results showing a decrease of their intensity, reaching the score of 10. Together with the subject we reviewed all the stages of the intervention, we revised the techniques used, emphasizing the changes that occurred in the relationship with himself, his colleagues and God. The survivors engaged in a project of building a monument in the memory of those killed, subsequently continuing their missions in the areas of their responsibility. The subject himself noticed that he is capable of seeing himself in the future, the state of mourning and sadness was still persisting, which is only natural.

In the following stages of reassessment and screening for PTSD (performed regularly at 6 months, one year and two years after exposure to the trauma) no specific PTSD symptoms were found and no clinically significant deterioration was observed in the social, professional or other important functioning areas that could be associated to the PTSD.

As you could notice, one very efficient intervention instrument proved to be *the therapeutic story*. The story addresses one's fantasy and intuition, it can facilitate problem solving and it can heal, because it puts us in contact with our deepest wishes and needs, with our obstacles and our inner, often unknown, resources. Using stories in psychotherapy is securing because it can send messages to the patient, messages that, if communicated directly, would be rejected, especially when talking about painful things such as the traumatic event experienced by the subject.

Finally, I would like to add that this experience was not only a professional one, but also one of self-development, in which I evolved together with the subject, re-evaluating my own relationship with God, which proved helpful later in my life when, after a year, I was diagnosed with cancer. God is neither good nor bad, He simply is. And, as I. Yalom says, "Death reminds us that existence cannot be delayed and that there still is time to live." Alongside the subject, I discovered that we must cherish what we have here and now and not be distracted by thoughts of what we don't have or worries about fame and pride.

Instead of a **conclusion**, here is a story (N. Peseschkian, *Poveşti orientale ca instrumente de psihoterapie*, p. 57-58) – *Crisis as an opportunity*

"There once was a lover who sighed for many years, being separated from his loved one, and he was wasting his life in the fire of solitude. According to the laws governing love, his heart had lost patience and his body was exhausted by the spirit. He was considering life without her to be a mockery and time was consuming him. For so many days he couldn't find his peace, longing for her! For so many nights the pain she caused him prevented him from sleeping! His body was exhausted and the wound in his heart turned it into a mournful cry. He would have given a thousand lives just to taste her presence once more, but this was of no help. Doctors couldn't find a cure and his friends were avoiding him. Indeed, doctors don't have a cure for the lovesick, unless the kindness of the loved one saves him.

Eventually, the tree of his longing bore the fruit of desperation and the fire of his hope turned to ashes. Then, one night, being unable to keep on living, he went out and headed to the market place. Suddenly, a night guard started following him. He started running, with the guard on his trace. Then, more guards joined in and blocked all the roads. Poor him, he was shouting his heart out, running aimlessly and thinking to himself: « This guardian certainly is Izrail, the angel of my death, following me so quickly; or he is a cruel person, trying to do me harm. » His feet kept carrying him, bleeding love, and his heart was weeping. He then reached a garden wall and with incredible pain, the wall being very tall, he climbed it. Once on top, he forgot about his life and let himself fall inside the garden.

There, he saw his lover, holding a lamp and searching for a lost ring. When the lover who had lost his heart looked at his enchanting lover, he breathed in deeply and raised his arms in prayer, shouting: «Oh, Lord! Bless this guardian and bestow richness and long life upon him! For this guardian was Gabriel, guiding this poor soul; or it was Israfil, giving life to this miserable!»

And so it was, his words were true, for he has found a deep guarded secret in the apparent cruelty of the guardian and has seen the mercy hiding behind the veil. Out of anger, the guard had led him who was thirsty in the desert of love, to the sea of his lover and had lightened the night of her absence with the light of reunion. He had led the one who was far away into the garden of closeness and led a suffering soul to the doctor of the hearts.

Now, if the lover could have seen ahead, he would have blessed the guardian from the very beginning, would have prayed for him and would have seen cruelty as justice. But, since the end was hidden from him, he sighed and cried in the beginning. But those who travel in the garden of knowledge, because they see the end from the very first moments, can see peace where is war and friendship in anger.

It is thus the state of the traveler in this Valey; but the people of the Valleys above, they see the end in the beginning, as one; no, they do not see the beginning, nor the end, and they do not see the «before», nor «the after».”

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