PTSD: Traumatic Sensitization & Iatrogenic Amplification: Therapeutic Antitheses

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December 13, 2019

Trauma’s Intrinsic Perversity

1. Knowledge normally empowers, but
2. for trauma, it’s SENSITIZED us →
3. Fear of fear itself (“Traumatophobia”) ↑
   - “Try to avoid trauma, at any cost!”
   - vulnerability to most stressors
4. Attempted Solutions Fail
   → MORE TRAUMA! How? Why?
   WHAT TO DO? Indiv, Group, Society?

Institute of Medicine (2003) ¹²

1. Psychological Vulnerability
   (a) urgent societal priority post-9.11
   (b) terrorists knowingly exploit this
2. Challenge to Society:
   (a) shore up our defenses:
   (b) Δ → RESILIENCY (we’re failing)
3. Questions: Potential Therapist Role?
   (a) what to do, how, at what levels?
Strategic Reasoning

1. **PROBLEM?** how, for whom, what level?
2. **ATTEMPTED SOLUTIONS?** How failed?
3. **GOAL?** Whose? Conflict & incongruity
4. **CLIENTS’ “LANGUAGE”?** shaping from bottom up and top down
5. **STRATEGY?**
   (a) problem → goal
   (b) versus attempted solutions
   (c) framing in client’s language
   (d) MHE: rapport, modify, change
   (e) Weakland: focus ≠ identified clt.

Who’s the Client?

1. **INDIVIDUAL = Locus of Control for**
   (a) identity, (b) motor behavior, and (c) primary treatment contracting
2. **FRIENDS or INTIMATES** ↑↑ & ↓↓ effects
   (a) alternative narratives
   (b) support, leverage (e.g. Al Anon)
   (c) tx. of one party → Δ another
3. **SOCIETY as either Client or 3rd Party?**
   (a) affects clients’ sx, language
   (b) traumatogenic social milieu

Under-Attended Factors

1. **Helplessness:** not a defining stressor
2. **Re-enactment:** not a defining “positive sx”
3. **Hypnotic contagion:** not listed
4. **Altered identity (personal, social):**
5. **Concealed agency:** inattention leads to
   (a) posttraumatic polarization
   (b) iatrogenic regression
   (c) escalating symptomatic coercion
6. **Societal enabling** of active traumatizing
1. Why Attend to Helplessness?

1. Logically Negates AGENCY (“free will”)
2. Helplessness before
   (a) a mortal threat = TRAUMA!
   (b) posttraumatic sx → help-seeking
3. Posttraumatic = Infantile Helplessness
   both call on others to rescue & defend
4. ≠ Infants: AGENCY INTACT, HIDDEN
   (a) misdirection → amplification
   (b) accessing → positive tx. result
   Tx. challenge = RESTORE AGENCY

2. Why Focus on Re-Enactment?

1. Spiritual nutriment of traumatic sx.
2. Its perversity perplexed Freud, Terr
3. Neurobiology = chemical addictions
   adrenergic sensitization → opioid addiction
   ↑↑↑ sx
4. Conscripts persons/groups into service
   (a) disguised, rationalized, defended
   (b) fuels reinforcers & amplifiers
   Voluntary ABSTINENCE → EXTINCTION

3. & Hypnotic Contagion?

1. Spontaneous Hypnosis, Hypnotizability
   → epidemics, crusades, witch hunts
2. Third Party FRAMING → Δ FORM of Sx
3. Hypnotic skill is potentially useful
   (a) to recognize, reframe & redirect
   (b) from symptomatology to healthy agency
4. but perilous. USE WITH CAUTION!!!
   (a) polarizing and regressive effects
   (b) paradox: Δ hypnosis → NON-hypnosis
   AVOID RESCUE, ACCESS AGENCY
4. & **Altered Identity?**

1. **Trauma marks one’s sense of identity**
   (a) not necessarily worse, just different
   (b) “false self” serves traumatic re-enactment

2. **Social identity also shaped by trauma**
   (a) “chosen traumas” (e.g., slavery, Civil War)
   (b) “sociodynamics” are under-explored

3. **Redefining identity = tx. challenge**
   (a) seemingly fixed & heavily defended, but
   (b) socially malleable & **reframable** → offers a
   **PATH OUT FROM TRAUMAS’ THUMB**

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5. **Agency Remains Intact**
   **But Hidden, Unlike Infants**

1. **In infants**, (a) helplessness is total, and
   (b) nurturance is essential for health

2. **In trauma**, pre-developed agency persists
   (a) often concealed, disguised, defended
   (b) = “dissociation”, “false selves”

3. **Non-recognition &/or misdirection**
   can paradoxically amplify, via ≥ 3 routes

4. **TX**: activate all citizens’ responsibilities

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5(a). **Traumatic Polarization**

1. **Shared Interests Pull Apart**, e.g.,
   child protection tx. for trauma ↔ family
   integrity & presumption of innocence

2. **Trauma Marks Poles’ SALIENCE**
   (a) e.g., child abuse → **pro-victim**
   (b) broken families → **pro-defense**

3. **Selective Affiliation → CONFLICT**
   e.g., defend victims VS falsely accused
   **Re-Enactment = Interim Victor**
5(b). Regressive Dependency

1. **Conflicted Relationship of Clt & Ther**
   \[\uparrow \text{sx} \rightarrow \uparrow \uparrow \text{rescue} \rightarrow \uparrow \uparrow \uparrow \text{acting out}\]

2. **Vicious Circle Model**
   (a) surface-level dependency
   (b) threatens concealed agency
   (c) \[\rightarrow \uparrow \text{anxiety} \rightarrow \uparrow \uparrow \uparrow \text{SX}\]

3. **TX: Access and Challenge Clients’ Hidden Strengths, Responsibilities**

5(c). Traumatic Coercion

1. **Appeasing \rightarrow ESCALATION**
   (a) clt’s symptomatic coercion
   (b) coercive social sensitivities

2. **Counter-Traumatizing \rightarrow same**
   (a) \[\approx \text{fighting fire with gasoline}\]

3. **“STANDING FIRM” = antithesis**
   (a) difficult, as is vs. re-enactment

Therapist Responsibilities Amplify These Pitfalls

1. **Gaining Therapeutic Alliance**
   \[\approx \text{ratifying victim narratives}\]

2. **Helping**, e.g., tx Δ pts’ brains
   \[\approx \text{temptation to “rescue”}\]

3. **Duties to Protect**
   \[\approx \text{symptomatic coercion}\]
   All Confuse the LOCUS OF CONTROL
6. Societal Trauma-Amplifying

1. "Enabling" = Collusion, Complicity
   (a) against social systems’ duties
   (b) enabling of false trauma narratives?  
2. Media Sensationalism
3. Selective Non-Responsibility
   (a) victim responsibilities = sensitive
4. Coercive Information Control
   (a) sensitivities nullify problem-solving

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e.g., Recovered Memories I

1. Apparent Consensus, 1993 APA Forum
   (a) victim memories necessarily true
   (b) alleged abusers presumed guilty
   (c) safety & recovery require therapists
   (d) corrective research data are seditious
2. MASSIVE AMPLIFICATION
   (a) social polarizing, death threats
   (b) iatrogenic regression, massive scale
3. RE-ENACTMENT = Interim Victor

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RMC II: Society Self-Corrects

1. Advocacy: Pro-Family, -Innocence
2. Memory Research: Newer Data
   (a) traumatic memory malleable
   (b) debriefing & reliving = problematic
   (c) memory requires physical evidence
3. Post-2000: Psychiatric Tx. Shifted to
   build on patients’ strengths
   BUT SX AMPLIFIERS PERSIST IN MUCH
   CLINICAL PRACTICE & SOCIAL TRENDS
Third Parties = Deciders

1. *Neither Agents Nor Targets of Trauma*
   but interact with others in ways that
2. *Modulate the Trauma Response*
3. *Implicit Suggestion can Amplify*
   e.g., non-responsibility, dependency
4. *Changing One Party via Another*
   e.g., Bernian “games”, Weakland
5. *Determine the Prevailing Narrative*
   e.g., 3rd party rulings → decisions

Mitigating I: Interdicting Traumatic Re-Enactment

1. **Identification:** Is there a focal pattern?
2. **Preparation:** (a) within locus of control?
   (b) can one recognize it, and
   (c) accept responsibility over it?
3. **How Can Third Parties Facilitate?**
   (a) balance support and challenge
   (b) respectful reframing = focal

Mitigating II: Within-Treatment

4. **More Information → New Narratives**
   (a) 3rd party collaterals, other sides
5. **Access Patients’ Sole Loci of Control**
   (a) alliance, contracting parties’ roles
   (b) game antitheses: A rescuing to challenge, e.g., “yes, but” to “what’s your plan?”
   (c) redefine one’s personal & social identity
Standing Firm @ One’s Locus of Control

1. General Principle:
   (a) identify one’s locus of control
   (b) act here, to optimize probabilities
   (c) stand firm vs being pushed off course

2. VS Trauma Re-Enacting Interactions:
   (a) decline counter-tx client demands
   (b) moral stand + mobilize social support
   (c) withstand traumatizing accusations

Societal Mitigation

1. 3rd Party Impact, e.g., principled juror
2. Study Enabling
3. Defend All Parties’ Responsibilities
   (a) legal duties of psychiatric patients
   (b) appropriate risk-taking parameters
3. De-Catastrophize
4. Open Constructive Discourse →
Δ Traumatophobia → RESILIENCE

Unresolved Challenges

1. Optimizing Our Therapeutic Influence
   (a) while respecting clients’ L.O.C.
2. Protection ↔ Holding Responsible
   (a) ↓ victimizing ↔ ↑ accountability
3. Re-Opening Free Speech
   (a) without traumatizing hate speech
4. Who is Responsible?
   (a) for what? to whom? at what levels?
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