Restoring Trauma Victims’ Agency and Accountability
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13th International Congress on
Ericksonian Approaches to PTx
December 15, 2015

AGENCY = “Free Will”

1. Illusory as a Causal Force
   (a) hypnotic suggestion redefined
   (b) conceptual primitive: \( A \approx \text{Not-A} \)

2. = Self-Defining Locus of
   (a) identity, “selfhood” (“Cs”)
   (b) motor control (“Volition”)
   (c) social accountability (& Law)

Not-A I. “Active Unconscious”

1. Normally Hidden Co-Consciousness
   (a) \( \rightarrow \) sleep, sex, mood regulation
   (b) spontaneity in complex activities

2. Failed A/Not-A Coordination
   (a) “Be spontaneous!” paradoxes
   (b) failed executive function,
       “falling into” life decisions,
Not-A II. Post-Traumatic Ucs.

1. Purposeful, Often Symptomatic
   (a) “false self” serves re-enactment
   (b) distressing sx., impaired sociality
   (c) disguised, as in Bernian “games"

2. ≠ Healthy Negatives
   (a) anger when challenged
   (b) grief over losses
   (c) anxiety if hungry cougar nearby

Not-A III. Social Entanglement

1. Agentic Narratives often post hoc
   (a) Moll (1890) PHS rationalized
   (b) “minds” ← shared self-deception?

2. Paradox of Psychotherapy
   (a) only clients have locus of control
   (b) but tx. “works” from outside in

3. Mutual Influence
   (a) Bernian “games”, synchronicity
   (b) changing one person via another

HYPNOSIS = Basic Science

1. A/Not-A: Hypnosis ≈ Non-Hypnosis
   (a) universally relevant to waking Cs

2. Paradigm: Soc. Influence, Therapy
   (a) how we influence one another
   (b) paradigmatic for psychotherapy

3. Perilous: How, Why, & What to Do?
   (a) polarizing, regression, escalation
   (b) goal = NON-hypnosis, AGENCY
HELPLESSNESS Negates Agency

1. Helplessness before a mortal threat defines psychosocial “TRAUMA”
2. Helplessness before SYMPTOMS motivates psychiatric help-seeking
3. Restoring Clients’ Sense of Agency = GOAL of psychotherapy, and MEANS of therapeutic change

Traumatic Affect Resembles Infantine Helplessness

1. Both activate similar neurobiology
   (a) adrenergic arousal = aversive to all
   (b) nurturance → opioids = attractive to all
2. Both call on others to provide relief
   (a) relieve associated distress
   (b) defend innocent parties
3. Extend through hypnotic contagion to victim protection norms. BUT → 3 CX

1. Posttraumatic Polarization

1. Shared Interests Pull Apart, e.g., child protection tx. for trauma ↔ family integrity & presumption of innocence
2. Trauma Marks Poles’ SALIENСE
   (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
2. 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

3. Symptomatic Coercion

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

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

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

Therapist Responsibilities
Amplify These Pitfalls

1. Gaining Therapeutic Alliance
   \( \approx \) ratifying victim narratives

2. Helping, e.g., tx Δ pts’ brains
   \( \approx \) temptation to “rescue”

3. Duties to Protect
   \( \approx \) symptomatic coercion

All Confuse the LOCUS OF CONTROL
WHO IS IN CONTROL OF WHAT?

1. Clients: subjective experience, brain physics, and muscle control
2. Therapists do what only clients do: change others' brains, from the outside in. HOW THIS PARADOX?
3. Third Parties: narrative, framing
   - re-enacting &/or mitigating
   = powerful therapeutic adjunct

ACCESSING HIDDEN AGENCY

1. Δ Nurturance → Challenge
2. Interpersonal Game Antitheses
   (a) yes, but → What's your PLAN?
   (b) NIGYSOB → Correct Behavior
   (c) 3rd party leverage (Al Anon)
3. Symbolic, e.g., “tidying up”
4. Holding Responsible
   (a) legal: DID & coercion cases
   (b) defining one's personal identity

Strategic Self-Therapy (SST)

1. Limited Intensity
   (a) life itself = therapeutic arena
2. Client = Own Therapist
   (a) therapist = catalyst, consultant
   (b) independent system
   = crisis resource
3. Redefining Personal Identity
   = Vehicle for Therapeutic Change
Essential Messages
1. “I Can’t Change You, and Won’t Try”
   (a) instead, challenge client’s life plan
   (b) ↑↑↑ boundaries, locus of control
   (c) VS role diffusion, regressive sx.
2. “Can You Be Trusted?” with
   (a) behavioral safety? & to
   (b) abstain from destructive behav?
3. “Who Are You?” (answering ≈ Δ)
   (a) “What do you stand for?”
   (b) “Where are you headed?”

Therapist Burdens
1. Empathic Rapport w Clt’s Distress
   (a) → treatment alliance
   (b) perceived on same side of court
2. Frame Client’s Sole Responsibility as Self-Evident
   (a) sole locus of control, legal criteria
   (b) no playing pretenses otherwise

Client Burden: Trustworthiness
1. Contracting for Behavioral Safety =
   (a) precondition for most psychother.
   (b) made explicit in SST
2. Assess, Confirm and Document
   (a) client’s understanding & agreement
   (b) evidence of capability & good faith
3. Client Violation → protection, BUT
   (a) NOT defined as extra “tx”
   (b) must re-establish trustworthiness
Specific Indications

1. Recurrent Traumatic Sx & Re-Enactment
   (a) complex trauma, subj. non-volition
   (b) behavioral risk to self or others
   (c) high regressive potential
2. “Help Me, But I Won’t Let You”
3. Confused Personal Identity
   (a) who’s responsible, for what, to whom?
   (b) “d/o’s of the will” (BPD, dissociative d/o)
4. Practical Issues: e.g., cost, tx-avoidance

Reframing Tx. Presumptions

1. Psychological Structure is **Reframable**
2. Change Occurs at **Focal Points**
3. Locale = **Clients’ Life Situation**
4. Therapist Role = **Catalyst, Consultant**
   (a) NEITHER principal change agent
   (b) NOR indispensable crisis resource
5. Client Capabilities: **Hidden, Accessible**

Differential Responsibilities

1. Client = Own Therapist
   (a) goals, pace, plan
   (b) behavioral safety
2. Therapist = Consultant, Catalyst
   (a) 2nd opinion, basic dx & rx functions, channel attention, reframe, inform’n
3. Independent System = Crisis Resource
   *(separation of treatment & protection)*
Engagement Phase I.
1. Consensual Diagnosis and Contracting
   (a) dx. per DSM, frame in client’s language
   (b) to highlight clients’ loci of control
   (c) informed consent, differential responsibility
   (d) tx alternatives, roles, limits of availability
   (e) contingencies and consequences
2. Attitude: Shift from Nurturance → Challenge
   (a) validate: distress & perceived non-volition
   (b) challenge: client’s duties = self-evident

Engagement Phase II.
3. Behavioral Safety Parameters
   - client guarantee of behavioral safety
     = fundamental tx precondition
4. Therapeutic Leverage
   (a) what therapist can’t, won’t, & will do
   (b) standing firm vs. symptomatic coercion
   (c) testing: contingencies, consequences
5. Third Parties: families, consultations
   - alternate narratives, levers

Criteria for Reframing:
1. Positive:
   (a) literally true, if unconventional
   (b) feels better
   (c) implies desirable change
2. Negative (Confrontation)
   (a) behavior is unacceptable
   (b) persisting or escalating
   (c) agency close enough to the surface
Defining Personal Identity

1. **Self-Description** (character in novel)
2. **Value Priorities** (manifesto)
3. **Sense of Direction** (plan):
   - (a) goals
   - (b) **perceived** roadblocks
   - (c) plan for overcoming these

**SST = Ongoing Revision of Personal ID**
- General → Specific, Toward Focal Points

Corollary Tx. Parameters

1. **Re-Do from Discordant Perspectives**
   - (a) DIS-advantages of ther. change
2. **Identify and Interdict Re-Enactment**
   - (a) subtle, relational, ego-syntonic
   - (b) affect containment strategies
3. **Cognitive Projects**
   - (a) pattern identif’n, narrative timelines
4. **Health Maintenance**
   - (a) balance volition & spontaneity

Coping with Healthy Change

1. **Dysphoria: Support**
   - (a) unresolved grief
   - (b) traumatic affect
2. **Social Naivete: Rules of the Game**
   - (a) adaptive deception, face-saving
   - (b) maintaining one’s “edge”
   - (b) politics of everyday living
3. **Consider Rituals:** integration, differentiation, specific role transitions
Strategic Self-Therapy (SST) vs. Exploratory Psychodyn. Tx (EPT)

1. Measures (clinician estimates, 0-4+):
   (a) Regressive Dependency (RDL, operationalized, \( r = +0.89 \))
   (b) Regressive Potential (RPRS, composite estimates, \( r = +0.80 \))
   (c) Pt. Self-Therapeutic Activity (STAL, composite, \( r = +0.71 \))
   (d) Therapeutic Progress (TPRS, composite, \( r = +0.77, 0.82 \))

Comparative Effectiveness

1. Definitions: EPT Differs from SST:
   (a) doubly time-intensive
   (b) therapists accept roles of primary change agent & crisis resource
2. Effectiveness: Equal in Both Modalities
   (a) SST was doubly cost efficient
   (b) but 27% dropouts vs. nil in EPT
3. Tradeoff: Efficiency & Adherence

Regressive Effects

1. Regressive Dependency \(\approx\) Potential
   (a) more in EPT (\( r = +0.74 \)), validating vicious circle model
   (b) less in SST (\( r = +0.45 \)), + the value of challenging patient autonomy
2. Regressive and Therapeutic Effects
   (a) did not correlate at all in either tx.
      (SST = +0.02, EPT = – 0.17),
   (b) thus, they’re separable issues, no need to “get worse” in order to get better
Therapeutic Progress Varies with Clients Helping Themselves

1. TPRS correlated with STAL
   linear, p < 0.001 in both modalities
2. Implications:
   (a) Optimum tx stimulates self-therapeutic effort,
   (b) in any & all modalities
   (c) it can be done

Relevance of Pseudocorrelation

1. STAL & TPRS: Common Elements
   (a) e.g., abstinence from problem-maintaining behavior
   (b) self-advancement activities
2. = Identical, but Experiential Distinction
   (a) experience sx as beyond control, but
   (b) components of STAL subject to agency

Effective Tx = Reframing TPRS as STAL

Miscellaneous Issues

1. Dissimilation ↔ Neural Impairment
   (a) if malingering, also look for medical illness
2. “Doing Projective identification”
   (a) identify, recognize, voluntarily interdict
   (b) neurobehav schema >>> devel lesion
3. Selected Dropouts = Treatment Successes?
   (a) 5/140 intakes = borderline spectrum (3.57%)
   (b) agreed to interdict problem behavior
   (c) failed followup, but no sx on chart review
   (d) was voluntary interdiction done successful?
   (e) res. question: positive non-adherences?
Selected References I.

- Berne E: Games People Play. New York: Grove Press, 1964

Selected References II.

- Pankratz L: Malingering on intellectual and neuropsychological measures, in *Clinical Assessment of Malingering and Deception*. Ed. R Rogers. pp. 105-192, NY: Guilford, 1988

Selected References III.