Trauma & Resilience through the Postmodern Lens

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Collaborative Learning Experience

Relational approach to presenting

Knowledge is not the possession of one person (McNamee, 2007)

What are you hoping to learn that might be different than what you’ve learned in the past?
Learning Objectives

- Define the concepts of trauma and resiliency through the lens of social construction, the postmodern lens, and within the context of history.
- Deconstruct the current socially constructed understanding of trauma and resilience and consider the ways that this might aid or impede healing or growth.
- Demonstrate skills for participants to consider alternative frames for the experiences and behaviors commonly thought of as trauma and resilience and reflect on the ways that these alternative frames might aid or impede healing or growth.
- Teach participants the ways in which the postmodern and strengths-based psychotherapeutic stance could be used in their work with clients, touching on Narrative, Collaborative, and Solution-focused approaches.
Trauma as human experience

Experiencing trauma is an essential part of being human: history is written in blood (emphasis added).

– Fredrike P. Bannink, 2008
Why this topic for us?

1. We are postmodern therapists and we think it is important to have an alternative voice on this topic.
2. Concern about not being able to see the people we are working with because we have been hypnotized by consensus reality.
What is the postmodern lens?

Social construction – an epistemology that understands language as the vehicle/means by which we construct reality

The construction development by social means of social things (Bohanon, 2019)

Language enables people to describe and organize their experience
The postmodern two-step

Deconstruction – awareness of own assumptions (e.g., cultural, linguistic, etc.) – horizon of understanding – forestructure of understanding in place (Gergen, 1996)

Reconstruction – co-creating a working understanding of an idea or concept in collaboration
Client/Extratherapeutic Factors (87%)

Feedback Effects 15-31%

Treatment Effects 13%

Alliance Effects 38-54%

Model/Technique 8%

Therapist Effects 46-69%

Model/Technique Delivered: Expectancy/Allegiance Rationale/Ritual (General Effects) 30-7%
What is trauma?

Activity – ‘examples’

What does our language imply?
History of Trauma

- Ambroise Tardieu publishes *Un etude medicolegale sur les Attendats aux Meours*

- Pierre Briquet begins to link the symptoms of hysteria to childhood stories of trauma.

- Freud writes on the nature of hysterical attacks in "Physical Mechanism of Hysterical Phenomena".

- Pierre Janet undertakes some of the first systematic studies of the relationship between trauma and psychiatric illness.

- Sandor Ferenczi's "The Confusion of Tongues Between the Adult and the Child: The Language of Tenderness and the Language of Passion is published".

History of Trauma

1941
- Abram Kardiner publishes *The Traumatic Neuroses of War.*

1940s-1970s
- Amnesia in the field.
- Focus on blaming psychopathology on poor genes and poor mothering.
- Mardi Horowitz's *Stress Response Syndromes*
- Lenore Terr's papers on the children of Chowchilla
- Henry Krystal's "Trauma and Affects"

1970s
- DSM III includes PTSD.
- Research focused on trauma.

1980s-1990s

“Trauma” in context.

In Western societies, there is an ever increasing fusion of distress with “trauma” (Summerfield, 1999).

Diagnostic expansion/ concept creep (Conrad, 2007).

“Trauma industry.”

A particular person, at a particular time, in a particular culture.
“Trauma” in context.

Shifting narratives around rugged individualism.

Trauma unique to contemporary “postmodern culture” (Bracken, 2001).

Decline in psychoanalytic approach.

Emergence of political movements.

Developed by professionals, adopted by the public.
“Trauma” in context.
An act of nature becomes a social problem (Echterling & Wylie, 1999).

Events inspire interpretation and meaning making.

Individuals and groups shape the issues emerging in the aftermath of a disaster.

Framing of disasters as mental health issue.

Need for clinical services rarely increase following a disaster.
“Trauma” in context.

The performance of “trauma” (Shotter, 2016).

Approaches, labels, models, and diagnoses act to orient us in any given situation, and along with the situation impose on us requirements or, “‘involvement obligations.”

Our reactions, words, and thoughts to fit step-by-step expectations.
Medicalization (Conrad, 2007)

- The *process* through which a problem or experience comes to be known in medical terms.
- Problems are not viewed as pathological until they are defined as such.
- Diagnostic expansion.
- With regard to trauma and resilience, who or what are the agents of medicalization? ...for what purposes? What do they have to gain (Hubble & O’Hanlon, 1992)?
What is resilience?

Activity - ‘examples’

What does our language imply?
What is resilience?

Client and extra-therapeutic factors.

When the Red Cross sends an army of mental health professionals – what is implied about the resiliency of that particular community/group of people?

There is no uptick in needs for psychological intervention after a disaster (Echterling & Wylie, 1999).
What is resilience?

Latin: Resilio, resilire
To leap or spring back
To rebound
To recoil
To shrink (back again)
Resiliency - Popular Discourse

‘Children are resilient’

Victim/Survivor

Transgenerational Trauma Resilience

Posttraumatic Growth (Tedeschi and Calhoun, 2004)

Wabi-sabi and Kintsugi – Japan aesthetic
Cultural/gender discourses.

Example: Discourse around “the strong black woman” stereotype as schema.

Associated with harmful health outcomes such as overeating, depression, reduced help-seeking and self-care (Watson & Hunter, 2016; West et al., 2016)
Deconstruction in the therapy room

Full disclosure of our own assumptions.

Approaches: SFBT, Narrative, and Collaborative Practices.

General points on the use of deconstruction in psychotherapy.

“How to...”
Solution Focused Brief Therapy & Trauma

Assumptions/Keys: Language matters; questions matter; preferred future (hope); small change(s) create ‘ripple effect’; wholism; trust client’s strengths & competencies

Stance: Present and Future; Both/And; ‘Change is inevitable’

Interventions: First session formula task; exception questions; scaling questions; coping questions; experiment to do more of what is working

(Connie, 2017; DeShazer, 1985; Bannink, 2008; Lee, 2007)
SFBT Guidelines – “Post-traumatic success”

Define goal of treatment.

Ensure client safety.

Do not assume client wants to work through traumatic memories.

Look for resources and strengths.

Look for and identify skills in other areas (e.g., making the decision to start therapy).

Validate and support client’s experience and sense of self.

(O’Hanlon, 1999)
SFBT Guidelines - “Post-traumatic success”

Do not give impression client is ‘damaged’ from trauma. *Change occurs in language.*

Gently challenge self-blaming or invalidating identity stories.

Three C’s of Spirituality

Connection

Compassion

Contribution

Critiques of SFBT

(O’Hanlon, 1999)
Narrative

Chronic PTSD--statistically and clinically significant symptom reduction (Erbes, et al., 2014).

No requirement to recount traumatic event.

The effects of trauma on a person’s identity (White, 2004).

Re-authoring conversations.
Collaborative Practices

- Polyvocal Response to Trauma (Bava, Levin, & Tinaz, 2002)
  - Perspectives change quickly - there are multiple realities
  - Not Pathologizing
    - “Medicalizing reactions to this disaster contributes to the problem”
    - “We should not assume that people need professional help...”
    - “Using a medical or diagnostic model to work with people leaves you interviewing them in a limited context...Questions are informed by purpose, to diagnose and treat the pathology... This keeps you from being able to listen to people the way they want to tell their stories.”
Collaborative Practices

● Polyvocal Response to Trauma (Bava, Levin, & Tinaz, 2002)
  ○ ‘Not Knowing’ about other’s experiences
    ■ “Even if you have done extensive research and are a specialist in trauma relief, or had your own experience with trauma...Approach people with a curiosity about their experience.”
  ○ Being aware of your intentions – avoid ‘psycho-tourism’
  ○ Hearing other’s stories can be difficult – Important to acknowledge when you may be having a hard time listening
Tips for Dialogical Deconstruction

Inviting and sustaining collaborative-dialogue requires a shift in orientation.

Dialogue requires collaborative design.

Dialogue is a natural, spontaneous activity that occurs moment-to-moment.

Differences are critical to dialogue.

Tips for Dialogical Deconstruction

• Speaking, listening, hearing and responding.

• Complete trust and openness to the other and their difference.

• Openness to being questioned, critiqued and not agreed with by the other.

• Carefulness to not assume you know what the other person means and to not fill in the blanks or details of the other person’s story or what is thought to be behind the story.

• Understanding from the other’s sense-making/logic map, not yours.

• Checking-out to make sure you understand the other’s perspective as best you can.

• Understanding does not mean agreement.

• Time for inner and outer talk.

• Time for inner and outer reflections.

• Pauses and silences; they provide opportunity for reflection, inner talk and preparation to speak.

Tips for Dialogical Deconstruction

Actions that do not invite dialogue.

- Trying to persuade the other to understand or agree with you, either explicitly or implicitly.

- Trying to get the other to understand or agree—you are not in dialogue with yourself or the other.

- Asking questions you think you know the answer to or to get the answer you want does not invite dialogue.

- Striving for consensus or synthesis.

- Trying to trace back to a starting point, a significant moment or a person—these are observer punctuations.

Tips for Dialogical Deconstruction

The intent and hope of the inviter of dialogue is:

- To invite and engage one’s self and the other in dialogue.
- To be open to where the dialogue takes you.
- The hope is to create a process of “dynamic sustainability.”
- The process, however, is not duplicable but adapts to the uniqueness of each situation and persons.
- As well, the inviter must not hold onto their intent or hope but must be able to respond in the moment.

Adaptation of Karl Tomm’s ethics model (Selman & Wall, 2017)
Relational activity and reflection.
Contributor impressions?

As participants in this collaborative learning experience, what were you moved by?

Where are you skeptical?

What surprised you?

Other thoughts?

Thank you!
References and Resources

Scan QR code for complete references, updated powerpoint and handouts, and presenter contact information.