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Post-Traumatic Adaptation Method

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Abstract

The deferred consequences of trauma include painful, uncontrollable psychological reactions to various traumatic triggers. This article demonstrates how such reactions may lead to negative self-esteem and impair the victims' mental state. A method is presented by which post-traumatic adaptation can be achieved: construct an adequate conceptual framework about the functioning of the human psyche and adjust one's mental state to account for past traumas.

Keywords: Psychological trauma; Psychological adaptation; Self-esteem; Self-support

Introduction

Past trauma limits a person's potential. Whereas physical trauma is easily noticeable and its consequences are evident, the consequences of psychological trauma prove, at times, to be unconscious for the trauma survivor. People who suffer from psychological trauma often fail to take into account their condition; their notions of the functioning of the human psyche are far from reality, causing them to have inaccurate perceptions of their own capabilities and, consequently, a lack of understanding of themselves and negative self-esteem when confronted with their limitations. As Beck [1] demonstrated, one of the reasons for depression is a persistent negative perception of oneself and one's actions. Therefore, for the clinical psychologist dealing with the consequences of psychological traumas, it is especially important to have the opportunity to effectively adjust their client's conceptual framework – their perceptions of the functioning of both the human psyche generally, and of their own psyche, in particular.

The Consequences of Psychological Trauma

When confronted with psychological trauma, the victim's first wish is for none of this ever to have happened! Often this person is in fact trying to live in a way that denies the trauma ever occurred, failing to integrate that past experience and ignoring the psychological consequences of that trauma. Obviously, this may result in very sad outcomes [2]:

a. The image of Actual Self begins to drift farther and farther apart from that of Ideal Self;

b. Any attempt to ignore events that have already occurred, to "erase" the past or devalue it, impairs the testing of reality in the present.

In other words, in such instances the person's mental state is further eroded because he or she is considering neither their own actual condition nor the actual state of the world around them and, therefore, is unable to change either themselves or the actual world, and instead is simply losing touch with the present. In recent years numerous materials have been published proving the neurophysiological effect of psychological trauma. A meta-study by a group of American scientists [3] that includes the analysis of 39 scientific studies of the effect of psychological traumatization and stress on the brain convincingly demonstrated a decrease in hippocampus size as the result of psychological traumatization. A study of identical twins confirmed the palpable influence of psychological traumas on the brain, and not just in those cases when the traumas were life-threatening or associated with PTSD. Even in cases when the individuals subjected to trauma did not have a full-blown post-traumatic stress disorder, the size of their hippocampus was noted to be smaller compared to that of the control group of study participants who had not been subjected to stress, and this effect is seen as well in identical twins compared to their twins who had not been subjected to the stress.

Childhood trauma has an especially pronounced neurophysiological effect: the onset of PTSD as the result of traumasin one's adult years correlates with the presence

of sexual abuse, neglect, harsh treatment, and other kinds of traumatization in the subject's childhood [4-7]. In other words, the existence of trauma in one's childhood case history impairs that person's mental stability in the face of subsequent traumatization. In addition, those who survived harsh treatmentin childhood proved to be 6%-14%smaller than the norm in various parts of the hippocampus, compared to those individuals who had not experienced violence, even if they had no diagnosed disorders. If disorders were present, even those clients' successful psychotherapy had not resulted in the size of the hippocampus being restored. In other words, the existence of early psychological traumas changes the brain at the physiological level in such a way that is makes the organism less stable against a later stress.

Features of Childhood Traumatization

The above allows us to conclude that encountering a traumatic event in childhood may result in a substantially lower tolerance for stress or certain types of stress as an adult, manifesting itself as helplessness in certain situations, a physical inability to take constructive actions, or a return to a helpless, childlike state. Unfortunately, there are in fact measurable, physiological implications for such exposure to stress. Psychotherapeutic intervention methods must account for such circumstances, providing resource support for the client's processes. Regrettably, in the way trauma is handled, methods popular in certain modalities of "returning responsibility to the client" for his/her reactions may, at times, do more harm than good, since they view volitional behavior as the antithesis to the power of actual needs and impulsive desires, and not as a means of supporting one's own intentionality and ensuring the benign satisfaction of one's own needs.

In such instances willpower is viewed as something that runs counter to human feelings: this is precisely the understanding of will that we often encounter in individuals who, in their reactions, have been confronted with the psychological consequences of a traumatic event. Usually they are already brutally self-critical, if not self-effacing. Such a relationship to oneself and to the objective, psychological trauma-related features of their own psyche lead directly to the development of pathological guilt and toxic shame for their own "lack of will". That said, it must never be said that such individuals lack will; rather, their will is focused on refusing to satisfy their own needs, and thereby deprives them of the possibility of self-support, thus provoking behavior that they themselves would generally deem unconstructive. This is precisely why, in dealing with trauma, the first thing that must be done is for the client to create an adequate representation of the normal functioning of the psyche.

The picture of emotional-volitional self-regulation arising as the result of childhood trauma may be compared to thin ice covering a deep water body: even just a small stressor in a situation that somehow reminds that person of the traumatic situation may result in an incommensurate emotional inundation and, consequently, adverse behavioral reactions. As though the ice is cracking and this adult, who in all other matters is fully in control, falls into an abyss of emotions that are similar to childhood emotions, have the same intensity and generalization, and make it difficult to stay in touch with current reality, in which he/she is an independent adult. For the traumatized individual, coping with such experiences is difficult and, at times, even impossible [8]. It is precisely this interconnection that often becomes a reason to avoid situations that are somehow reminiscent of traumatic ones, but extensive experience with such avoidance shows us clearly how limited this method is. A person who has been traumatized finds themselves between two fires, essentially: on the one hand, the desire not to be flooded with traumatic recollections, and on the other, a desire to rectify what happened.

Common sense and primitive medical analogies suggest that "the place of the trauma needn't be disturbed" in the hope that the trauma will heal itself using the body's healthy resources. And at times, in the case of traumas experienced as an adult, when mature and adaptive psychological defenses have already been formed, such an approach actually works. But it never works for childhood traumas, and from what has been said, it is completely clear why: because in childhood, mature defenses and coping strategies have not yet formed, and if, in a difficult situation, no adult comes to the aid of that child, mature strategies are still not formed, and survival will be ensured by overstressing the immature defenses that had already formed by then.

That said, the trauma survivor usually has a conscious or unconscious desire to rectify or re-experience what happened. It is precisely because of this that they often say that "trauma has a way of repeating" [9,10]: with the perseverance worthy of a better cause, that person ends up time after time in situations reminiscent of the traumatic one, and more often than not, alas, always with the same traumatic outcome: the person has not changed their behavioral patterns, has not reconsidered their own assessments and actions, has not mastered any new coping strategies – and so, naturally, the result for them will be the same: trauma or re-traumatization. This only further hardens the person's conviction that "there is nothing you can do in situations like that, those situations simply must be avoided" – even though, in reality, the point is not that no useful experience can be derived from such situations now and then, but rather that, in order for such situations to be utilized constructively, not just one's own actions, but from time to time even one's convictions and values must be reconsidered.

Features of Cognitive Psycho Correction of the Consequences of Trauma

It is precisely in this that the principal danger of working with trauma generally, and particularly with childhood trauma in adults, is rooted: only in the easiest cases can the person on their own, using resources that emerged thanks to experience gained in related situations, find a new way out of situations

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reminiscent of a traumatic one. Usually this new experience is not gained as the result of avoiding such situations, but this requires a specialist (psychotherapist or psychologist), who in this case serves as a carrier of a healthy Ego, i.e. plays the role of a caring and explaining defender for the distraught and traumatized client, including defending the client from his/her own attacks on himself/herself. Without this, if so-called "analytic neutrality" is preserved, or if the impact is inaccurately calculated, working with trauma may be fraught with re-traumatization and may even make the client's condition worse. From a behavioral perspective, an event that is traumatic for the psyche leaves behind a noticeable strain and is a factor that, time after time in similar conditions, provokes the launch of a general non-specific stress reaction of the body [9].

Contrasted with the excessive demands they place on themselves, trauma survivors underestimate their own capabilities in real-life situations. For example, a person who five minutes earlier had easily and calmly declined, say, an appointment time that was not convenient for him, now asserts about himself: "I can never say no to anyone." That is, his perception of himself as "weak" does not jibe with reality and attests to traumatic dissociation of personality: when speaking of his weaknesses, such a person seems to overlook his strengths, and vice versa.

Traumatic dissociation does in fact make a person weaker. Occasionally this occurs unnoticeably, and the trauma survivor himself does not notice it, until he is confronted with his own strange behavior. Then certain logical questions arise for him: Why do I not notice my own strength? How is it I failed to notice that I was able to say no? Why is someone else's weakness irritating? All of these events may be viewed as the result of encountering a traumatic situation in the past, but often the person begins to view them as intrinsic to their own personality, as a result of which he perceives of himself more and more negatively and more and more forcefully tries to "pull himself together" and quash his own mental reality. Such a split between Actual Self and Ideal Self results in persistently negative self-esteem, and this, in turn, may provoke anxiety, a depressed mood, and even depressive disorders.

To rectify such consequences, the first thing that must be done is to return to the person an understanding of himself and his reactions and of the cause-and-effect relationships in his behavior – relying in part on scientific information about the actual, not ideal, mechanisms for the functioning of the human psyche. Useful in this may be an educational conversation presenting information on a wide range of matters, and dialogs that allow for objective information to be linked with subjective perceptions and beliefs, so that the client can improve his awareness of his own mental reality. In order to help the specialists not to miss any important aspects, we suggest using the following method, which covers basic understandings of oneself and of the world, which may suffer in a trauma situation.

Post-Traumatic Adaptation Method

This method includes eight primary aspects, each of which may require a separate, detailed discussion. Fortunately, each individual aspect may remain untouched by the trauma and be deemed sound; but even in this case, according to our observations, clients are grateful to receive confirmation of their own views during the conversation:

i. Assessment of the situation as traumatic

ii. Differentiation of fault and responsibility

iii. Conceptualization of the normal functioning of the psyche

iv. Restoring intentionality

v. Separating self-esteem from behavioral assessment

vi. Training to recognize re-traumatization

vii. Appropriate assessment of existing capabilities

viii. Expansion of coping strategies

Assessment of the situation as traumatic

If trauma is present in a person's case history, that person is often sincerely certain that what happened was, as it were, "normal" and occurred naturally, due to his own fault: he alone should have contrived somehow so it did not happen. That is, often what is missing is a critical perception of the overall situation and of the behavior of others, while excessive demands are made of him related to control over uncontrollable events or other people. ("I should have behaved in such a way that mom didn't get mad"; "I should have been able to resist the rapist"; "I should have been able to save the other fighters in my unit") In this case the specialist must make every effort to clearly label the traumatic situation as abnormal. This is what in the future can restore a sense of basic safety: a relationship to the world as generally a safe place intended for living, not surviving.

Fortunately, cognitive effort is often sufficient for restoring this aspect of one's worldview. In the case of childhood traumas, for example, it may be helpful to review pedagogic literature on the subject of "What is the correct thing to do?" following the birth of one's child. Often for those seeking help, this question has already been answered. It is useful to respond to questions in this way: how should that situation have unfolded in the normal world? How could the negative consequences have been avoided? What should normal adults have done in those circumstances? If the traumatic event still occurred: how could its impact – what there is to explain, what there is to help with – have been lessened? Who should have done that – adults, the police, the administration? Who theoretically could have come to your aid in this situation?

Differentiation of fault and responsibility

From the item above it is evident that any attempt to perceive the traumatic situation as normal has a kind of secondary benefit:

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preserving an internal locus of control. Fortunately, in actuality this does not require blaming oneself for all one's failures – it is sufficient to recognize your responsibility for your life going forward. It often happens that a person may have no guilt for what happened, and yet a sense of responsibility still remains: it is his life and he must answer for whatever occurs in it. No one else. Guilt presupposes deliberate harm, whereas responsibility involves: whatever happens to you, you alone must deal with the consequences. Even if you yourself are in no way to blame for them: this is the reality of life. Therefore, in actuality, taking responsibility is a path to freedom.

In case of childhood trauma, an adult reflecting on it almost always focuses on his guilt over not avoiding that situation: he was behaving badly, was not obeying, or some such thing. Responsibility of this sort is not easily refuted: since he didn't take steps to avoid the consequences, they came, and this is now a fact of his biography. But this does not mean at all that it is specifically that child who is to blame for what happened. Normally, parents or other adults must be responsible for that child. But it is doubtful that, in that moment, they spoke to him of such things – and this is why when working with childhood trauma in adults, we usually encounter a lack of understanding of the rules of causality, since what occurred in the traumatic situation is often perceived, in the best case, as total unprovoked evil and, in the worst case, it may still seem to the client that he and he alone is to blame for everything, even though in the case of childhood traumas it is clear that he was a child in need of help and protection.

Conceptualization of the normal functioning of the psyche

Emotional inundation in stressful situations often provokes unconstructive behavior in a trauma survivor, and that person then begins blaming himself: "cried like a little girl", "behaved like a coward", "threw a hysterical fit". If we are to speak of post-traumatic events, it should be understood that such behavior is a normal reaction in abnormal circumstances, inasmuch as the circumstances of trauma are abnormal! Consequently, triggers that remind of the trauma may result in that person's losing control of his behavior. A person is not a robot and can be prone to emotions; what's more, as we demonstrated above, trauma significantly alters the neurophysiology of the brain, and the capacity to deal with analogous situations will be appreciably lower in a person who has experienced trauma than in a person who has never experienced a traumatic effect. In such cases it is important not to try to demand of oneself "constructive behavior during re-traumatization", but rather to provide an opportunity to protect yourself from re-traumatization in advance, beginning with defending oneself in advance.

When working with childhood trauma, we tend to encounter an inappropriate, "childish" perception of what happened in similar situations. Of course, this is not an excuse for escalating such behavior – but it is certainly a reason to take care of yourself, to learn how to protect your boundaries, to support yourself in challenging situations, to ask for outside support, and not to make excessive demands of yourself. That is, not to remain in a trauma or re-traumatization situation in the vain hope of this time restraining your instinctive reactions, of calmly absorbing the stress, of resisting the rapist, or of doing what it takes for mom to love you, finally, but instead to focus your efforts first and foremost on physically removing yourself from a traumatic or re-traumatizing situation before it occurs.

Restoring intentionality

Intentionality is the capability of a person to have intentions; structure that gives meaning to experience also ensures that consciousness is directed toward the future. In this instance will is understood not as a negation of desire, but as one of the higher-level components of desire. This term has an active connotation and reflects a self-affirmation of deliberate actions: will is the capacity to wish for and achieve something that is desired. Desires are the motor behind our activities, including our self-realization and individuation; therefore, restoring intentionality is essentially a return to one's true desires, which in the case of trauma may be deeply buried under layers of perceptions of "how one should" and are divorced from one's actual needs.

Separating self-esteem from behavioral assessment

It is important that the client's perception of their own imperfections and own unconstructive reactions be translated from an Ego-syntonic to an Ego-dystonic conceptualization. That is, to move away from the position of "I am bad and that is why I am never able to restrain myself" toward a position of "I am good, but the fact that this time I didn't manage to react appropriately is bad". That is, a concerted effort must be made to eliminate the reasons for the unconstructive reactions; in other words, to work through the traumas and create new patterns of behavior, including adequately protecting oneself from getting into stressful situations.

Training to recognize re-traumatization

Unreasonableness and uncontrollability of reactions and a narrowing of perception (the feeling that, with whatever occurred, there can be only one explanation, generally the worst) are fairly reliable signs of secondary trauma. Often at such times the person himself assesses his own behavior as inappropriate, and this serves as an additional trigger for anxiety: if suddenly I am not controlling my reactions, it means that something is probably wrong with me, that I am bad. In this case clarifying the mechanisms of the physiological effect of trauma and using internal guides for the feelings that arose during traumatic and stressful events of the past brings significant, almost instantaneous relief: what emerges is not just an understanding of the mechanisms of what has occurred, but the capacity, too, to predict one's reactions – which means, the capacity to tend to one's well-being in stressful situations in advance.

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Getting in better touch with reality

A consequence of trauma, particularly of childhood trauma, often is the underestimation of one's capabilities, as in the example presented above with the purported inability to say "no" – and, in this case, to constructively focus that person's attention on the fact that he actually has much greater resources than he thinks he does. Here it is useful to employ techniques during a psychotherapy session that engage directly with what transpired, so that real live examples can be used to show the person how, exactly, he is failing to notice his own achievements – in particular, the ability to say "no" or the unconscious, but distinct protection of his boundaries [11].

Expansion of coping strategies

An effect of trauma is that it begins to seem to the client that there is only one possible way to behave in situations similar to the traumatic one. In actuality, of course, the ways of responding are always significantly greater; the most wide-ranging patterns of behavior are possible, depending on the context, and it is useful to discuss them explicitly, to expand the field of one's conscious options. Fortunately, in a more detailed, abstract consideration of stressful situations for adults, in many instances the client is able to construct independently (or with the help of the specialist) a plan of action appropriate for them, using reasoning and logic, and ignoring emotional involvement.

When working with childhood traumas, it is useful to activate the resources of the adult: moving the client to the meta-position of an adult in a situation analogous to the childhood trauma. The following questions for discussion may be anticipated: If you were to see some other child in an analogous situation, how would you assess what is happening to him? How would you, as an adult, be able to help that child? How would you explain to him what is happening? What actions would you take to protect him? (Here it is good to draw on examples with one's own children, if you have any, or the example of some other child that the client is fond of.)

Conclusion

One should remember the important principles on which work with the consequences of trauma must be built, for physiological reasons:

I. For the work to be successful, the client must be trained to perceive his needs appropriately and to find ways to satisfy them reasonably.

II. It is useful to task the client with small, concrete, easily attainable goals that he would be proud of himself for achieving. In this case a successful result is associated with positive emotions and supports the generation of purposeful activity.

References

1. Beck AT (2005) The current state of cognitive therapy: a 40-year retrospective. Arch Gen Psychiatry 62(9): 953-959.
2. Alloy LB, Abramson LY, Metalsky GI, Hartlage S (1988) The hopelessness theory of depression: attributional aspects. Br J Clin Psychol 27(1): 5-21.
3. Woon FL, Sood S, Hedges DW (2010) Hippocampal volume deficits associated with exposure to psychological trauma and posttraumatic stress disorder in adults: A meta-analysisProg Neuropsychopharmacol Biol Psychiatry 34(7): 1181-1188.
4. Bonne O, Vythilingam M, Inagaki M, Wood S, Neumeister A, et al. (2008) Reduced posterior hippocampal volume in posttraumatic stress disorder. J Clin Psychiatry 69(7): 1087-1091.
5. Lindauer RJ, Vlieger EJ, Jalink M, Olff M, Carlier IV, et al. (2005) Effects of psychotherapy on hippocampal volume in out-patients with post-traumatic stress disorder: a MRI investigation. Psychol Med 35(10): 1421-1431.
6. Bremner JD, Randall P, Vermetten E, Staib L, Bronen RA, et al. (1997) Magnetic resonance imaging-based measurement of hippocampal volume in posttraumatic stress disorder related to childhood physical and sexual abuse—a preliminary report. Biol Psychiatry 41(1): 23-32.
7. Bremner JD, Vythilingam M, Vermetten E, Southwick SM, McGlashan T, et al. (2003) MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and posttraumatic stress disorder. Am J Psychiatry 160(5): 924-932.
8. Mary W Armsworth, Margot Holaday (1993) The effects of psychological trauma on children and adolescents. Journal of Counseling & Development 72(l): 49-56.
9. Rothschild B (2000) The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment. W. W. Norton & Company, USA, pp. 208.
10. Bermant-Polyakova OV (2006) Posttrauma: diagnosis and therapy. M Rech 248s.
11. Gordeeva EG (2016) The influence of clinical transpersonal therapy on indicators of situational anxiety. Scientific and educational bulletin "Health and education in the XXI century No 2.

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