Trauma therapy: What place for humanistic approaches?

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Introduction

In this article I will present the National Institute for Health and Clinical Excellence (NICE) Guideline 26 for Post Traumatic Stress Disorder (NICE, 2005) together with some of the underlying philosophical and theoretical assumptions upon which the guidelines are based and consider whether their claim to promote truly innovative practice is justified. I will also suggest that person-centred counselling is an available yet little considered alternative in working therapeutically with traumatised clients. The person-centred approach is able to provide a theoretical explanation of distress following trauma and a theory of therapy, both of which are highly supported by recent neuroscientific findings (Lux, 2010; Rutherford, 2007). Further, it provides an account of growth following adversity that can also explain the higher levels of functioning reported by some people following trauma (Joseph, 2005). Despite these benefits person-centred therapy remains largely on the periphery of a professional context that privileges those approaches specified within NICE guidelines.

I work in a busy university counselling service and offer person-centred therapy to both students and staff. Some clients report experiences resembling symptoms in the DSM-IV-TR (DSM, 2000) diagnostic criteria for Post Traumatic Stress Disorder (PTSD) yet are not subject to a diagnostic process or treatment protocol. This allows for an approach to working with trauma which fits the therapy to the client, rather than fit the client to the treatment.

I have become increasingly aware of a changing dynamic in my consulting room. Clients' expectations, questions and requests are increasingly reflecting changes in society and the nature and delivery of mental health services. A growing phenomenon is of people coming forward for therapy expecting specific treatment

cures. A growing and alarming number of people of all ages are being prescribed anti-depressants as first line treatment for a whole range of experiences, including trauma. Some clients within our service report that they find no relief from medication or CBT delivered through the Increasing Access to Psychological Therapies (IAPT) programme yet do respond well in a range of counselling approaches, including person-centred therapy. However, this work and perhaps any non NICE approved therapy are being undermined by the current emphasis on specific treatment guidelines.

What strikes me is the lack of regard given to the client's own views, needs, preferences, and the matter of informed choice. On occasions the GP might refer a client to our service for support whilst waiting to access the 'treatment of choice'. It seems that the implicit and explicit messages being given are that following trauma, specific treatments based on the presenting symptoms are necessary and little recognition is given to natural human healing processes or other non NICE approved therapies.

What is traumatic stress?

Brewin (2003) a leading author on trauma traces the origins of the study of traumatic stress back to the mid 19th century and describes the controversy over what constitutes trauma and its aetiology. He emphasizes the social and cultural contexts in which people mediate their way through traumatic events and experiences and recognises the experience of trauma as an integral part of what it is to be human. It is helpful to note the distinction between *developmental trauma,* an interruption in normal development, which may result from child deprivation or abuse and *traumatic shock or stress,* a sudden event overwhelming a person's normal capacity to cope and causing an extreme activation of the nervous system (Eckberg, 2000).

In person-centred theory traumatic stress is seen as estrangement from oneself, incongruence between experience and the self-structure where significant experiences are denied to awareness or are inaccurately symbolised. From a phenomenological perspective a definition of trauma would be descriptive and include the individual meanings for the client.

Post Traumatic Stress Disorder (PTSD)

PTSD was formally recognised when it was entered into the Diagnostic Statistical Manual of Mental Disorders (DSM) in 1980 and has since undergone numerous revisions. Initially it was defined as a consequence of a specific

and recognisable traumatic event ‘outside the range of normal experience’. However, since then many studies have shown that an event in itself, even though it might objectively be seen as one which would ‘evoke significant symptoms in almost everyone’ (DSM-III), does not always lead to significant or long-lasting symptoms (Cash, 2006). As a result the focus has shifted to include an event which involves a death or serious injury or threat of the same which at the same time evokes *feelings of intense fear, helplessness or horror* (Brewin, 2003). For PTSD to be diagnosed these criteria together with criteria from three symptom clusters broadly classified into re-experiencing phenomena, avoidance and increased arousal need to have been present for at least a month.

In many ways the admission of PTSD into the DSM and the shift in focus towards people’s *response* to trauma has been helpful in validating and accepting as normal peoples’ experience following trauma. More resources have been dedicated to the study of trauma and to understanding peoples’ subjective experiences and the biological basis of a number of distressing symptoms. Van der Kolk and colleagues maintain that this has helped to re-contextualise trauma by focusing on a person’s experience and the meanings they give to them and away from the concrete definitions of disorders as’things, in and of themselves’. (Van der Kolk et al, 2007)

PTSD: the management of PTSD in adults and children in primary and secondary care.

Regel & Joseph (2007) point out that the NICE full guideline for PTSD at 167 pages long is relatively comprehensive yet contains some contentious issues and ambiguities. For example, the section on early interventions provides ambiguous guidance leaving treatment options open to interpretation. In the guideline the identified symptoms of the disorder are thought to be normal in the first month and so treatment would not normally be offered during this time, unless the symptoms are severe. After this the guideline recommends 8-12 sessions of between 60-90 minutes on a weekly basis of trauma-focused CBT or EMDR. Anti-depressant medication is also recommended if CBT doesn’t work or a person doesn’t wish to have CBT. More than 12 sessions may be offered for multiple traumas or one resulting in the death of a close relative or friend or a disability (NICE, 2005).

Notably, person-centred and experiential therapies - referred to as non-directive therapy - (as well as relaxation, hypnotherapy, psychodynamic therapy and systemic psychotherapy and for children, play therapy, art therapy and family therapy) are singled out for negative consideration as appropriate ‘treatments’

(NICE, 2005) and are excluded from the guideline preferences stating PTSD sufferers "should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD" (1.9..2.8). Further to this no mention is made of, for example, Shiatsu, acupuncture, yoga therapy, or bio-energetic or somatic psychotherapy.

NICE claim that its recommendations for treatment are based on the best available evidence, but actually are very selective in focusing on 'objective and scientific evidence', valuing mainly evidence from Randomised Controlled Trials (RCTs). In the summer of 2007 the British Association for Counselling and Psychotherapy (BACP) delivered to a House of Commons Select Committee enquiry into NICE, a comprehensive submission outlining concerns that NICE's evaluation processes disadvantage particular groups by the use of a rigid hierarchy of evidence, that there is serious under-funding of systematic review of psychological therapies with the exception of CBT and that recommendations for practice are based on a very limited range of evidence (BACP, 2007).

The full guideline acknowledges the importance of knowledge gained through clinical experience and service user input and views, and the limitations of the research evidence on which it draws. It acknowledges that there is research evidence to support the argument that a good therapeutic relationship can be more important than the specific treatments offered. NICE also states the intention of the guidelines as 'not a replacement of clinical knowledge and skills' and yet in practice the emphasis on hard 'scientific' facts leads to recommendations for treatment which tend to de-value clinical experience and the detailed study of individual cases (Williams & Garner, 2002). However, all this is lost or superseded in the shorter NICE guideline which is the version most people will read, including those responsible for commissioning services and prescribing treatments and "what is presented as the facts is highly questionable, even within its' own terms" (Learmonth, 2007; p16).

Sally Aldridge (2007) indicated that vested interests were operating in the funding of research into psychological therapies by the Department of Health quoting 98% of funds made available for research in the space of 2 years went to research into CBT. If this is accurate is it any surprise that there is as yet 'no convincing evidence for a clinically important effect' of other forms of psychological treatment (NICE 1.9.2.8). It is interesting to note that Aldridge also pointed out that 5 out of 5 of the most recent research recommendations from NICE on issues related to mental health and classified as essential or high priority are for RCT's with CBT being the main focus (www.nice.org.uk). It is widely believed that the Pharmaceutical industry has a lot of influence in setting research agendas

(Summerfield, 2004), however, it would seem that this is not the only industry influencing research agendas.

Practice-based evidence has always played a significant part in the development of theory and practice but is given little weight in the NICE guidelines. In practice, there are many alternative models for working with trauma. Many of these are profoundly person-centred and provide an environment of deep respect for the individual and a recognition of the healing and growth that happens through relationship and community (Howe, 2007). They have their own evidence base for effectiveness with their own ways of validating knowledge which are equally rigorous (Bohart et al, 1998). Moreover they are being chosen by and helping many people.

A good example is Kid's Company, an organisation that understands and responds to the complexity of the needs of severely traumatised young people. Here therapeutic relationships are considered essential in building the safety required to work through the trauma many of these children are growing up with in severely deprived and increasingly violent areas of our cities. The children themselves rated the service over 95% in terms of success. The model, which is holistic, has been recommended for national replication but no funding or structure has been put in place by the government to take this forward (Batmanghelidjh, 2000).

The medicalisation of distress and pathologisation of everyday life

The short NICE Guideline 26 focuses on the treatment and management of disorder and are grounded in the medical model. In brief, the medical model views human distress as illness or abnormality, and a maladaptive symptom is seen as having a biological base rather than something to be understood (Snell, 2007). Sanders (2005) points out that a list of mental illnesses based on similarity of symptoms is not the same as being based on aetiology. The patient's symptoms are matched to diagnostic criteria for a specific disorder and then an appropriate treatment applied (Bohart et al, 1998). An effective outcome of the treatment is the elimination or at least a reduction in the symptoms. Treatments must then be shown to cure the disorder through rigorous scientific research, which within the medical model, is synonymous with the randomised control trial (RCT) methodology (Freeth, 2007). Once support has been found for a therapeutic model claims are then made for scientific support, findings are presented as facts and therefore reliable and rational (Freeth, 2007). Once a 'disorder', and the treatment specific therapeutic regime gains legitimacy in this way a vast

array of resources for further research can be commanded producing plenty of 'evidence' to reinforce the initial claims of effectiveness.

The application of the medical model to mental health has been criticised vociferously for decades both within psychiatry and other professional disciplines such as psychology, sociology, counselling and psychotherapy. Firstly, this model is only one way of explaining a problem and only one method of helping and as such presents one view of what it means to be a person, of what it means to suffer and of what it means to recover (Summerfield, 2004). The tenacity with which the medical model is taken for granted in our society and has maintained its position within health discourses is staggering. Pete Sanders (2005) explains,

"It has become a 'given' to be taken for granted - that which we think *from,* rather than we are able to think *about.* The thought that human distress might not be an 'illness' is not merely radical, it is inconceivable." (p26)

This '*thinking from'* is dominant in the western world; evident within a lot of literature on PTSD, debate amongst professionals, and in clients' narratives. The dominant presence of the medical model view becomes particularly problematic when authoritative guidance requiring healthcare workers to follow recommended treatments as best practice is based on the illness metaphor whilst claiming to be based on fact. Sanders (2005) points out the suggestion of another view, or even a desire to debate the issue, is met with incomprehension and with challenges on meeting responsibilities associated with managing risk, safety and a 'duty of care' towards vulnerable people. These issues might be considered defensive attempts to discredit anyone questioning the prevailing paradigm of the day.

The groups formed to select evidence for the development of NICE guidelines rarely demonstrate representation of practitioners from person-centred or the humanistic paradigm. The result is that guidelines are often formed in thinking *from* the medical model. Understandably, the final guidelines report with authority encouraging both an arrogant attitude towards people who hold differing views and a perceived philosophical naivety amongst some to whom it is disseminated. Sanders (2007) urges those with alternative views to the medical model, be it academics or practitioners, not to continue to refer to it or accept it without question or else risk weakening any chance of having alternative perspectives being taken seriously.

A significant objection to the medical model is advanced in what has come to be known as the 'medicalisation of human distress' (Sanders 2005). It is argued that giving someone a diagnosis of a disorder is to assign them a *sick role*

encourages clients to *look outside* to the professional for a cure and to give up or lose faith in their own capacity to understand themselves. In this way passivity and dependence are encouraged. I observe this in practice when clients, for instance, even though taking medication still feel lost or confused and in a worse state than when they started. Furthermore the helper who takes the role of expert maintains distance from the client whilst receiving all the benefits of his or her status.

Contrary to managing risks for the client such power over relations create different risks regarding the misuse and abuse of power that might result in re-traumatising a client. Such abuse can be explicit but is most often hidden and subtle which may be harder for the client to defend themselves against, especially in the face of such an 'expert'. In this way, mental health services based solely on the illness metaphor can lead to perpetuating the suffering they lay claim to cure. Those within the anti-psychiatry movement have for a long time suggested that objectifying and labelling people mentally ill has led to the justification of inhuman treatments leading to punishing 'deviants' in society as a means of social control. That which is seen by many as problems of living is reduced to biology, a dysfunction in someone's brain. Young (2003) believes we have abandoned the study of human subjectivity and now face "a massive contemporary illusion: that we can understand our suffering through some version of biological determinism" (p107).

Technical interventions aimed at removing symptoms, take little or no account of the personal and cultural meanings of someone's experience of trauma. This is never more evident in my clinical practice when clients feel unable to take time off work or to defer their studies to rest, recover and heal from a variety of serious traumatic events in their lives. An unempathic social environment is often a source of 'secondary victimization' (Scharwachter, 2005) and as well as causing further pain creates a barrier to integrating the traumatic experience. It also reveals itself in clients' complaints about themselves, not living up to their own expectations to be able to cope or letting other people down. They may find themselves in painful conflict within themselves, already compromised by developmental trauma in their capacity to accurately symbolise powerful emotional experiences. These difficulties are often a source of greater anxiety and stress than the event itself and serve as a barrier to being able to acknowledge and process the impact of the trauma on their lives. Equally, clients often report therapy as hugely life-changing and therapeutic whilst not being symptom-free (Totton, 2007).

Modern and so called empirically supported approaches to therapy might not be all they are heralded to be. Spinelli (2006) suggests the current evidence–based practices, such as trauma-focused CBT, EMDR, may be creating worse psychological problems for clients by further internalizing underlying conflicts so that they become more diffuse and general rather than focused on a specific symptom or event. Others agree that when working with people affected by trauma not taking into consideration the whole person, focusing only on cognitive restructuring or cathartic release can leave physiological and emotional underpinnings untouched. This risks re-traumatising the client as he or she relives the trauma and is once again left feeling totally helpless and out of control (Eckberg, 2000).

Organismic growth as an alternative paradigm for traumatic stress

Rogers (1951) believed diagnosis led to a loss of personhood and impeded psychological growth and developed his client-centred approach as counter to this. Since then the importance of the relationship has taken centre stage in the development of many theories of healing and helping. At the heart of the person-centred approach is a genuine encounter between therapist and client, a deep valuing and respect for the client and a trust in the client's capacity to make sense of his or her own experience without the need of an expert. Rather than formulating hypotheses and seeking to change the client the focus is on exploring the actual lived experiences of the client (Cooper, 2007).

In contrast to the illness metaphor and medical model, person-centred theory uses an *organismic growth* metaphor, which instead encourages self-determination, empowerment, self-respect and growth. Joseph & Linley (2006) proposed focusing on resilience and growth rather than illness and disorder. Rogers' personality theory provides an understanding of the process of breakdown and disorganisation of a person's self-structure when under threat that also accounts for understanding the phenomena described in PTSD and is consistent with much of the current trauma theory (Joseph, 2005). A wide range of experiences following trauma can be understood through person-centred theory.

The person-centred approach offers a comprehensive theory of therapy and a number of different methods to facilitate the safe processing and integration of traumatic experiences; focusing (Gendlin), process-orientated therapy (Rice & Greenberg) and Rogers' theory of a facilitative environment for personality development (Kirchenbaum, 2007). Practitioners within this approach are also integrating learning from recent neuroscience (Rutherford, 2007). All these approaches differ significantly to the directive approach of trauma focussed CBT by locating change processes as taking place as a result of the social environment

leaving the client free to move toward integration and growth. Person-centred therapy can facilitate growth meaning the client functions at a higher level than before the trauma. This is in stark contrast to the medical model view which aims merely to return clients' functioning to pre trauma levels.

An alternative paradigm also needs to address our existential condition, to ask what does it mean to be a person and to suffer when faced with trauma? It is common for clients to want to engage with such questions and find ways to make sense of their experiences. After a trauma, we are required to find a way to live life after things have fundamentally changed forever. When our assumptions about the world are seriously called into question there is a need to adapt cognitive schema to assimilate or accommodate the traumatic events (Joseph & Linley, 2006). It is in considering these questions and in facilitating growth that humanistic and person-centred therapies are in a unique position to help.

Concluding thoughts

It is hard to see how the psychiatrists (Critical Psychiatry Network) and psychologists (the positive psychology movement) within the system of the NHS can hope to uncouple themselves from the medical model especially when it is perceived and experienced as highly threatening to question the status quo. However, it has never been more necessary for the wide range of therapeutic approaches that fall under the broad umbrella of humanistic psychology to assert themselves as valid alternatives to the conventional medical model approaches currently being advocated. Sanders (2007) strongly encourages the emerging psychotherapy profession to go it alone and not associate with such an outdated and damaging system as represented by the medical model. He recommends that we "should constitutionally fix ourselves in the domain of the psychological, social and existential theories" (p38).

In 2005 opposition from psychoanalytic therapists in France succeeded in securing the withdrawal of an INSERM (the French equivalent of NICE) report claiming to offer its public information about the most effective, evidence based treatment for mental health problems (again CBT). At that time the Minister of Health made a public declaration that psychic suffering was 'neither measurable nor open to evaluation' (Snell, 2007). Unfortunately, history suggests that such a revolution is unlikely in the UK. Whether the person-centred approach can live up to its name as the quiet revolution remains to be seen.

It would be progressive indeed if NICE could take on the responsibility of informing people of the wide range of possible responses to trauma, acknowledge models of

resilience and growth, people's innate capacities to heal and their moral right and capacity to take charge of their own healing. This would go a long way to promoting a fairer distribution of funding for research and could then lead the way to provide a system of equal access to a whole range of therapies. Ironically, in a time when the drive to regulation claims to have public interests at heart a continuing reliance on the medical model in mental health has a huge capacity to oppress us all. National guidelines concerning public health representing only one view or group in our society might be considered an undemocratic abuse of power.

As Carl Rogers suggested a very long time ago "it appears to me that the way of the future must be to base our lives and our education on the assumption that there are as many realities as there are persons, and that our highest priority is to accept that hypothesis and proceed from there" (Rogers, p. 46; in Kirchenbaum & Henderson, 1989). By failing to stand in opposition to the dominance of the medical model and to the march of evidence-based practice and managed care we perhaps risk further traumatisation of whole generations. Maybe, humanistic practitioners can join together to promote their services and continue to demonstrate through case studies how numerous approaches to trauma can help clients. We might otherwise be in danger of losing contact with our own human nature and our trust in our natural capacity for healing and growth following trauma.

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