Response to Commentaries on "Back to the Future": Narrative Treatment for Post-Traumatic, Acute Stress Disorder in the Case of Paramedic Mr. G

Prepared and Still Surprised

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ABSTRACT

Farnsworth and Sewell (2010) and Currier (2010) have provided commentaries on our case study of paramedic Mr. G, who was suffering from Acute Distress Disorder and whom we treated employing our "Back to the Future" therapy (BFT) model. These authors identify and discuss a number of important issues raised by our case study. In this response to their commentaries, we focus on three of their important points: how the therapist balances directive versus collaborative roles in working within the BFT model; whether in therapy to address or not to address the "traumatic nucleus" of an ASD victim's initial memories of a traumatic experience; and the types of clients for whom the BFT model is particularly applicable. Our responses to these issues are designed to generally illuminate the BFT model, to make it more applicable for much-needed further research study, and to provide additional guidance for clinicians considering whether and how to employ it with their clients.

Key words: Acute Stress Disorder (ASD); narrative therapy; traumatic nucleus

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We very much appreciate the thoughtful and stimulating commentaries of Farnsworth and Sewell (2010) and of Currier (2010) on our article, "'Back to the Future': Narrative Treatment for Post-Traumatic, Acute Stress Disorder in the Case of Paramedic Mr. G" (Palgi & Ben-Ezra, 2010). We would like to respond to some of the points they raised about the Back to the Future therapy (BFT) model in three areas: how the therapist balances directive versus collaborative roles in working within the model; the nature and function of the "traumatic nucleus" of a victim's initial memories of a traumatic experience; and the types of clients for whom the BFT model is particularly applicable.

THE THERAPIST'S ROLE: DIRECTIVE OR COLLABORATIVE?

Farnsworth and Sewell (2010) raise an important question: Is the therapist's role in a narrative therapy like BFT "directive or collaborative"?

> On one hand, if the therapist fails to respect the client as the primary author for her/his own narrative, how can that same therapist argue that the client has developed resiliency (as opposed to simply becoming dependent upon the therapist to create meaning for her/him). On the other hand, neglecting to acknowledge the inherent power differential within a client-therapist relationship permits the therapist's power to influence the client without conscious and thoughtful prior consideration as to how such influence should be directed (p. 28).

We agree that using active narrative psychotherapy sounds almost like an oxymoron, potentially leading to role confusion within the therapist and within the therapeutic relationship when the therapist appears to become the writer of the patient's narrative. In actual practice, the therapist strives to balance two different stances. At times, the therapist holds the roles both of an audience member and a co-author, while at other times the therapist encourages the patient to be the protagonist of his or her life story.

It is important to remember that in almost all the techniques for treating ASD, the therapist is active and has a conception of what the best way for helping the patient is. This approach is most dominant in cognitive approaches like prolonged exposure (PE), where the whole story of the patient's traumatic life experience is known from the beginning. In BFT, the therapist is not the one who writes the patient's narrative, although the therapist has basic assumptions in regard to the way people prepare themselves for future adverse events (Palgi & Ben-Ezra, 2010). The assumption is that human nature compels people to prepare for future events, that is, people are "programmed" to construct and organize coherent self-narratives that are in line with their life outlook (Neimeyer, 2004). The amygdala alerts us for future dangerous events, and the prefrontal cortex prepares us for these occurrences (LeDoux, 1996). The therapist's role in BFT is to stimulate turmoil and unrest in the client about the original traumatic story by challenging the traumatic narrative so that a patient's natural striving for coherence leads him or her to a revised self narrative that can incorporate elements from the patient's pre-trauma life experience.

Thus, following the intake stage, the therapist in BFT suggests a preparedness narrative based on the patient's own narratives. It is true that this active intervention results to some extent in the therapist assuming the role of a story teller. Just as a parent intervenes when he finds a child playing with electricity and intervenes, the BFT therapist takes responsibility for intervening with clients in the early, ASD stage of their traumatic reactions. The therapist cannot give the patient the time to rewrite his or her life story while exposing the patient to the risk of developing PTSD. It can be said that the patient in such cases is like a log in the river that has been stuck in an eddy. The therapist cannot help the patient choose his or her trajectory in the stream, but the therapist can help the individual to get out of the eddy.

It is a myth that people can always reconstruct and rewrite their traumatic narrative on their own, especially in the aftermath of a trauma. During the very first days after an individual have been exposed to a trauma, the state of shock and bewilderment still exist in his or her life

narrative (Campbell, Baumeister, Dhavle, & Tice, 2003). Patients need direction, support, a sense of safety, calming, and hope to take the first steps towards rewriting their new story, and hence facilitating recovery (Hobfoll et al. 2007). Some individuals develop depressed and stressed narratives, which may consolidate during this time (Dudai, & Eisenberg 2004). Since consolidation time is limited, we believe that every narrative—either therapist-directed or patient-self –authored—is better than the traumatic narrative.

The problem with the traumatic narrative is that it leads the individual into a vicious circle from which it is almost impossible to escape. The therapist's activity during a patient's bewildered state is crucial for the mental health of the patient, who is not at the stage in which a healthy life story can reconstructed. Yet, it is important to stress out that the therapist does not enforce any narratives on the patient, but rather co-authors with the patient a story of preparedness. At the same time, it should be remembered that every story is built within interaction with the environment. The therapist co-authors different narratives with different patients, even when the therapist uses the same technique. Another way to say this is that the role of the therapist in BTF is to reconstruct the scaffolding of the patient's narratives, but the patient fills in this scaffolding with details. In sum, the therapist's main mission is to change the dark future caused by a traumatic past by going "back to the future."

TO ADDRESS OR NOT TO ADDRESS THE TRAUMATIC NUCLEUS

Currier (2010) examines in detail the question of the advisability of ignoring the "traumatic nucleus," that is, the substantive core of the traumatic experience for the survivor. In this regard, a patient once asked one of us, "If I would not think of it maybe it can disappear?" In the aftermath of a trauma, victims have competitive urges, at both the conscious and unconscious levels, concerning whether to ignore the traumatic nucleus or whether to confront and expose themselves to it by intentionally remembering and talking about it again and again (Shmotkin & Bar-Ilan, 2002). On one hand, exposure elevates the risk of loss of control and chaos. On the other hand, repressing these experiences might cause dissociation between past crucial events and ongoing everyday life (Bromberg, 2003).

We take a risk management approach to these competitive urges: as long as the available narratives enable the patient to regulate the stressful event through repression and similar mechanisms, it is better to strengthen these mechanisms as BFT does. However, at the moment it is clear that these mechanisms are not working and traumatic contents keep penetrating and coloring the patient's narratives, without any improvement, it is time to directly treat portions of the traumatic nucleus.

Note that the traumatic nucleus consists of the subjective feelings the patient gives to the event, and thus it typically consists of the most horrifying, dreadful, and awful moments of the event. Returning to the traumatic nucleus elicits the emotional arousal and associated hormones that enhance the consolidation of the episodic traumatic memory (Henckens, Hermans, Pu, Joels, & Fernandez, 2009; Schwabe, Wolf, & Oitzl, 2010).

Additionally, while professionals frequently frame the clinical situation in all or nothing terms, we do not see it this way. As therapists we know that people can be in touch with some hot-spot areas and at the same time repress others. Therefore even when a decision is made for the patient to speak about the traumatic nucleus, it does not mean that the patient has to speak about everything. We find it very useful to examine exactly to what extent the traumatic nucleus should be described. People need to understand that the therapist knows what they have gone through, but that some descriptions are better not described in detail over and over again. We can speak of a car accident and the bodies inside without talking in detailed, explicit, graphic terms of the smells and sights of the bodies in the accident.

Finally the BFT technique does not prohibit patients from speaking about the traumatic nucleus. It just does not actively encourage them to do so. Therefore, the operational definition of when to start the BFT and when to change it into other therapeutic approaches is based on the condition of the traumatic nucleus in the context of the time period involved, namely, from two days to one month after the traumatic event is the optimal period for implementing a BFT intervention. Once BFT is begun, if after two weeks no decline of symptoms has occurred and the traumatic scenes are uncontrollably at the center of the patient's consciousness, it is desirable to start the conventional interventions, like exposure-based approaches. A useful rule of a thumb in this situation can be how much the patient is haunted by the traumatic scenes in his or her everyday life, and if he or she can have free time from these scenes. Actually, when patients are haunted by scenes associated with the traumatic nucleus extensively, the therapy automatically moves to focusing on the traumatic nucleus. The other interventions can be of course exposure-based ones, but we believe that narrative approaches like those Sewell et al. (2002) have suggested can in many cases be a smoother continuation for BFT interventions due to common ideas and themes.

FOR WHOM THE BELL TOLLS?

A third issue raised by the commentators regarding BFT is the target population to which this intervention applies. Our basic assumption is that we humans prepare ourselves for adversities as part of our core, evolution-based nature. But even when we prepare ourselves for these adversities, we are still surprised when they happen. The clinical goal in a BFT intervention is to connect the sense of prior preparedness to the subjective feeling the patient has about the traumatic event.

In some cases, the connection between preparedness and the event is easier to establish. In these instances, our therapeutic role is to help the patient accept that although he was surprised, still his mind was prepared and therefore we can help him establish a new and healthy narrative. On other occasions—like the generally unexpected 9/11 disaster in the U.S. and the recent earthquake in Haiti—the connection between preparedness and the event is less salient, and the therapeutic role is to make links between the general preparedness and the flexibility of the patient’s mind to use his or her preparedness for other events in order to cope with present event. Addressing guilty feelings for not being prepared and/or a feeling of failure in the face of preparation is the main therapeutic goal. This is what will determine if BFT will be effective or not. This goal helps to combine fragmented narratives by connecting the idealized past with the catastrophic present and the future into one lasting story. A successful narrative is achieved when

patients integrate a first chapter of preparedness, a second chapter of surprise over a traumatic event, and a third chapter of preparation for shocking and painful events in the future.

In sum, we found that the commentaries of Farnsworth and Sewell (2010) on our "Back to the Future" therapy with paramedic Mr. G provided an excellent opportunity for us to clarify the three issues discussed above regarding BFT. In doing so, we hope we have illuminated the nature of this technique, made it more applicable for much-needed further research study, and provided additional guidance for clinicians considering whether and how to employ it with their clients.

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