

When trauma therapists dissociate
—
A new approach to Secondary Traumatization



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Secondary Traumatization

Current state of research:

- We have gathered extensive proof of typical posttraumatic symptoms in populations that were not directly affected by the traumatic incident itself
- The occurrence of these symptoms without direct sensory confrontation cannot be explained by the theoretical approaches published to date
- So far, no convincing predictors of secondary traumatization have been established
 - training, work load, experience, therapy setting etc. have been included in different studies as predictors, but did not yield coherent results
- Current research projects:
 - Possible means of traumatic transmissions need to be explored
 - Individual differences in the processing of the trauma material need to be used as predictors

Aetiology

Peritraumatic Dissociation is

- the most important predictor of PTSD in people who were confronted with a traumatic situation (Ozer et al., 2003)

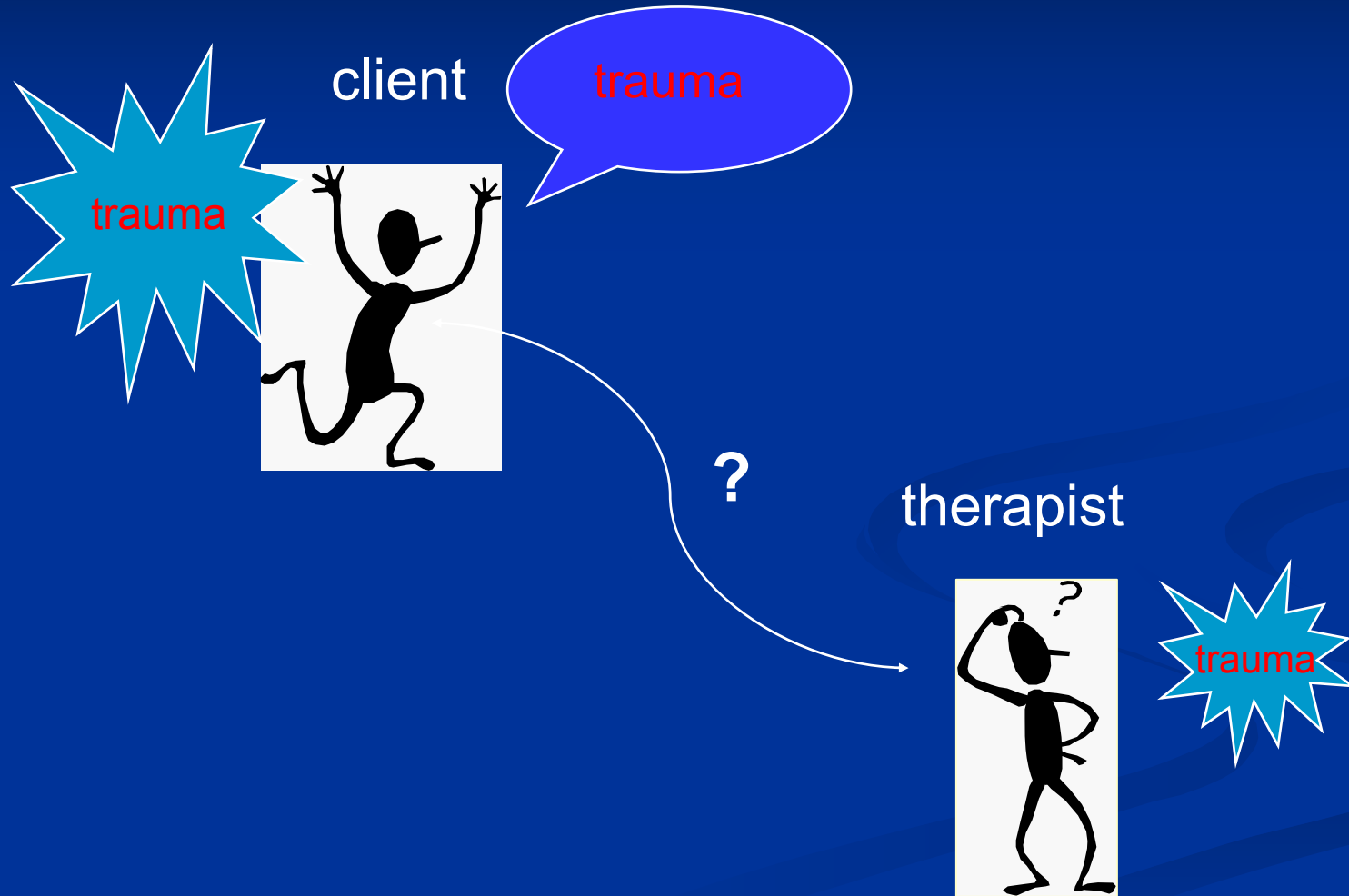
Dissociation was once seen as

- a survival mechanism
- solely elicited in moments of acute threat
- New studies show that it might be best described as
 - a stress reduction mechanism
 - elicited when the physiological arousal reaches a threshold
 - which might occur even in objectively harmless situations
 - which can be come conditioned and thus automatic
- It represents an active stress coping mechanism of our organism, rather than a passive disintegration

Aetiology

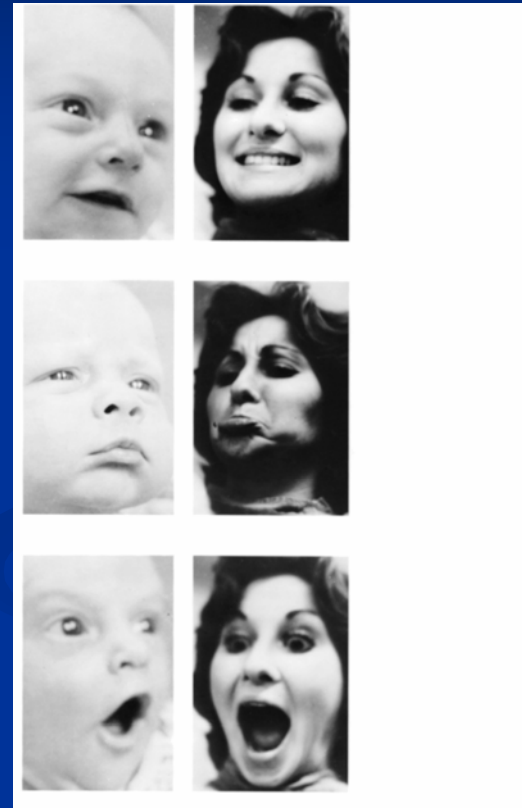
- The presented theory explains how
 - dissociative processing can arise in trauma therapists how dissociation can become an automatic defense mechanism in the therapy setting
 - and why this can lead to secondary traumatization

How does the trauma reach the therapist?



Empathy as Simulation

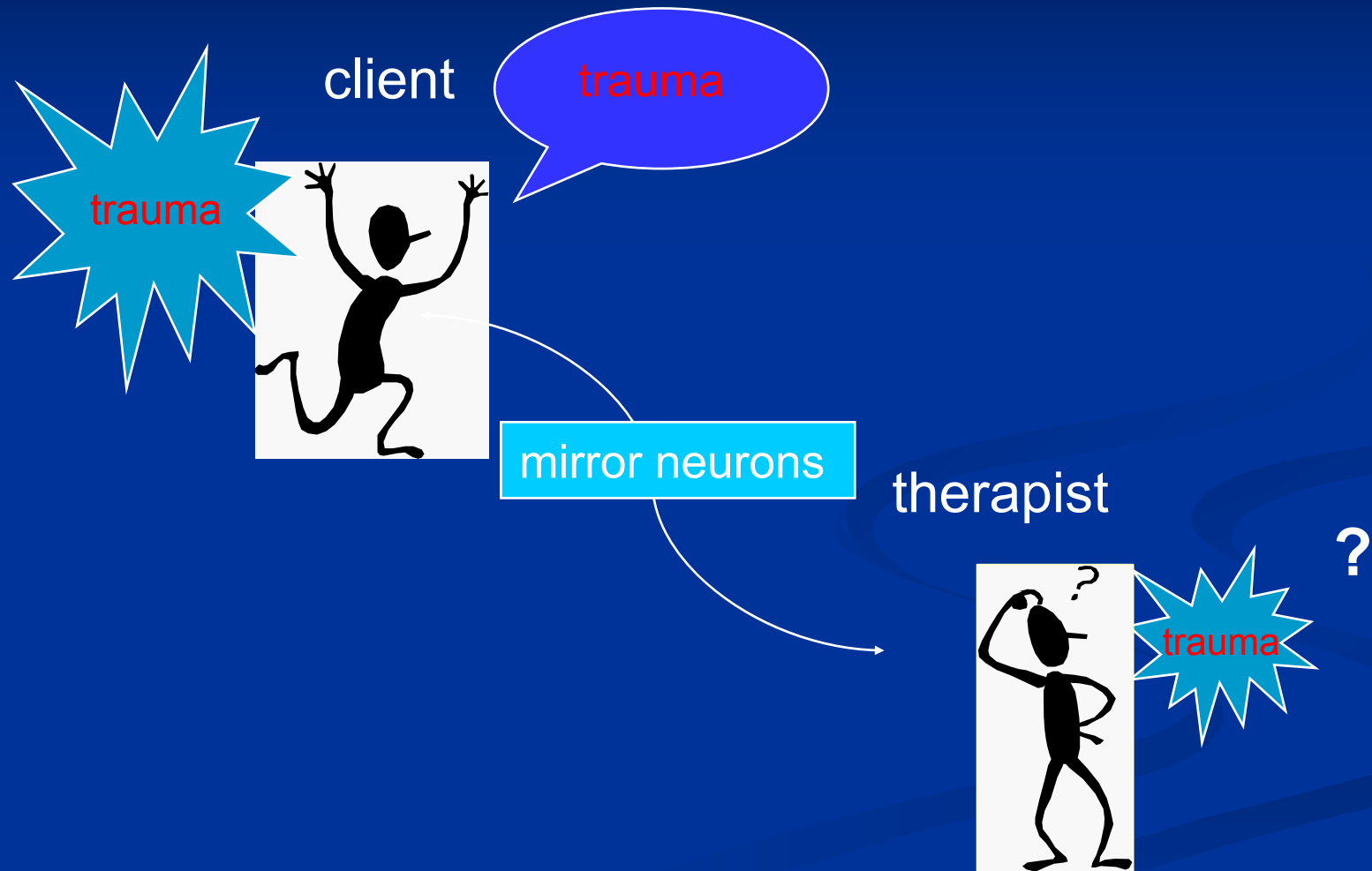
The ability to simulate and imitate another being develops early in humans:



Empathy as Simulation

- The neural basis for simulation seems to lie in specialized neurons called “mirror neurons”
- They seem to mediate resonance in human communication, for example unconscious imitation of posture and facial expression
- Simulation of the other person’s emotions is the background of empathy
- Studies from the 1950’s already showed that the higher the therapists empathy, the more the heart rates of therapist and client synchronized

Why does a simulation lead to a traumatization?



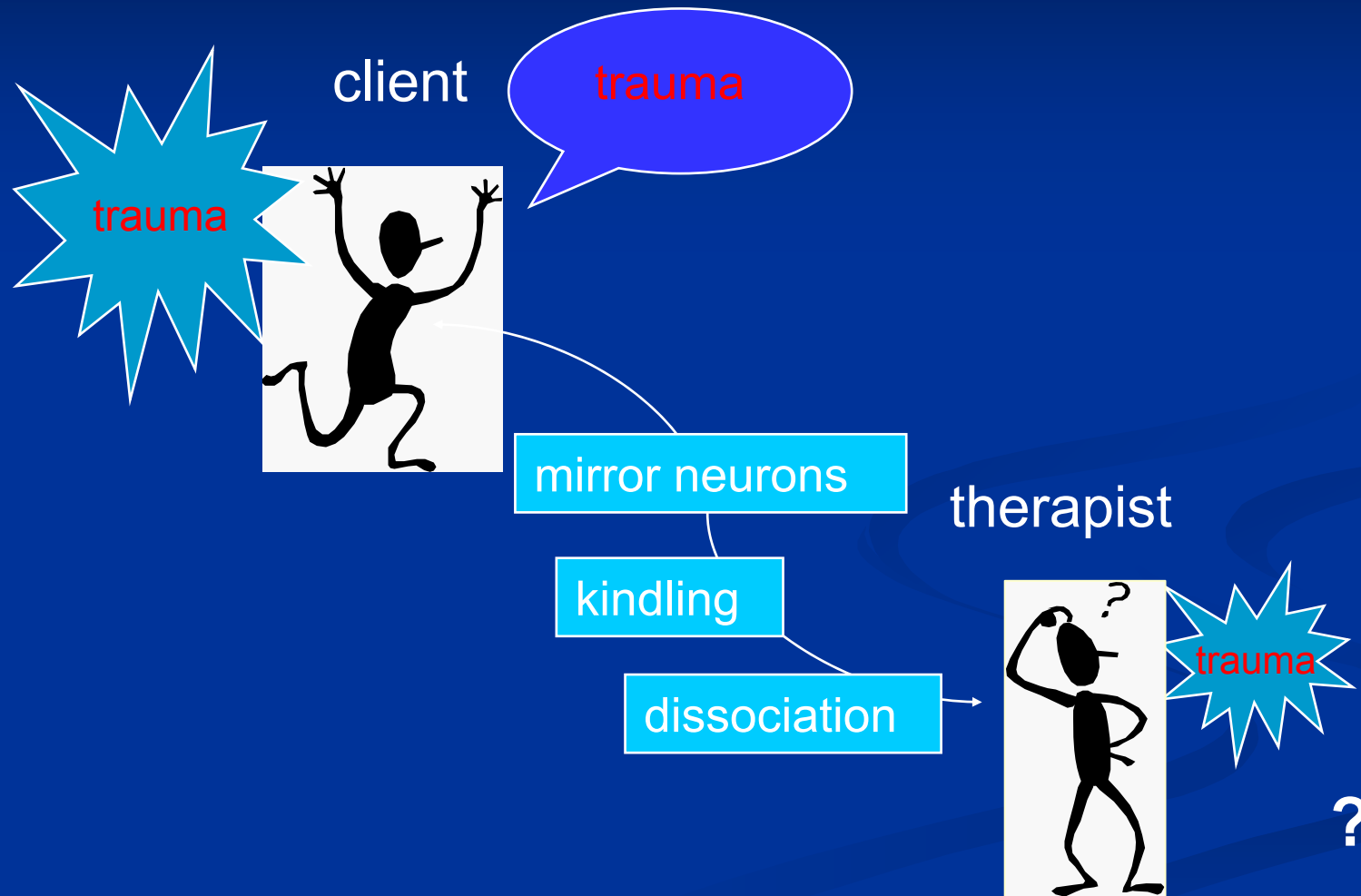
Why does a simulation lead to a traumatization?

- The simulation provokes an activation of the amygdala, which moderates fear and anxiety
- If this happens regularly it results in an increased sensitivity of the amygdala
 - i.e. the threshold gets lower
 - and a stress reaction is achieved more readily. This is called „kindling“.
- If the stress system is already sensitized, for example
 - because of a primary traumatization or an insecure attachment style
 - because of insufficient relaxation abilities
- a stress reaction is achieved even faster

Why does a simulation lead to a traumatization?

- The organisms of mammals (i.e. humans) protect themselves against high stress levels with dissociation
- Dissociation as an active inhibition of “the self“ leads to an encoding of the emotional content of the trauma narrative
 - without space and time information,
 - without differentiation of self and other

Why does a simulation lead to a traumatization?



Quantitative Study

- Objective: retrospective assessment of the time with the most intense symptoms
- Online study, N = 1.124 Questionnaires (drop-out rate unknown)
- 2 Questionnaires
 - 31 Items assessing secondary traumatization (FST, $\alpha = .937$)
 - 9 Items assessing habitual dissociative processing
- Goal: To predict secondary traumatization from dissociation scores

Results

- Diagnostic criteria were very stern
- Nevertheless, 29.1 percent were diagnosed as „secondarily traumatized“
 - 19.9 percent were diagnosed as moderately traumatized
 - 9.2 percent were diagnosed as severely traumatized

Duration of Symptoms

Duration of symptoms:

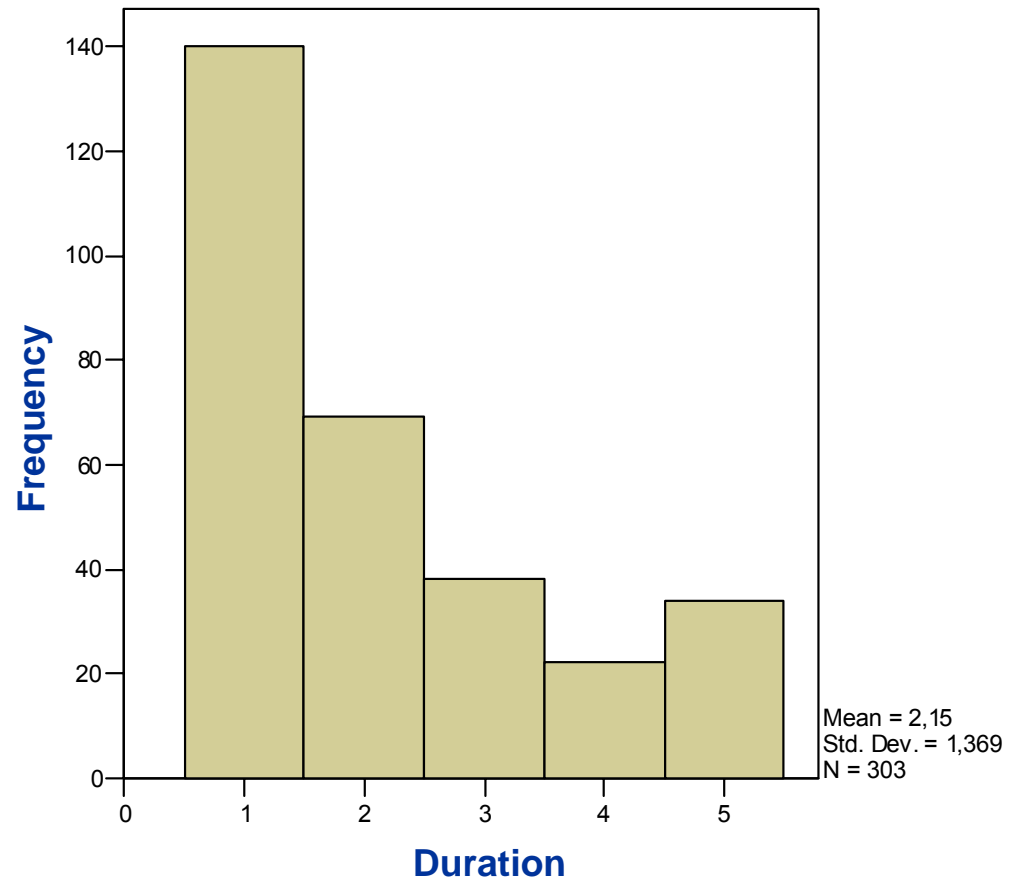
1 = up to 4 weeks (46%)

2 = up to 3 months (23%)

3 = up to 6 months (12%)

4 = more than 6 months (8%)

5 = long-term change (11%)



Results dissociation

- Via a median split, the participants were divided into two groups: high vs. low dissociative processing. Those who use more dissociation while listening to their traumatized clients
 - Show significantly more symptoms
 - Are distressed for a longer period of time
- In a hierarchical regression analysis, scores for dissociative processing predicted symptom scores with $R^2 = .288$

Possible triggers for dissociation

- Too much trauma material
- Dissociation of the client
- Parallels to own person and life
- Personal traumatic incident in current time
- Personal trauma history

Personal dissociative tendencies

- Which situations prompt you to dissociate?
- Which clients or type of trauma prompt you to dissociate?
- Do you picture what the client describes?
 - If yes: How far away is the picture? Is it in color? Can you hear, feel, smell or taste something? Is it possible to move the picture further away?
 - If not: How do you manage to NOT picture it? Can you still feel yourself? Are you grounded? Are you still in touch with the client?

Dissociation stop