‘Developmental Profiling Approach’

When treating Multiple Psychological Traumas

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This paper reviews the use of the 'Developmental Profiling Approach' (DPA) that has evolved through my work in the treatment of clients with Multiple Psychological Traumas (MPT). I briefly discuss some issues around the classification of traumas, and describe the MPT client, illustrating the complexity of their presentation. Following this, I explain the DPA and its role as a useful strategy when working with clients.

The paper includes case studies which illustrate the techniques used to 1) engage the MPT client and build coping strategies in preparation for the DPA, and 2) implement DPA in the treatment process. Within the case studies used, I highlight points for consideration that will enhance a positive outcome for the client. The case study and examples reported are accurate in the expression of the client profile. However, to ensure client confidentiality and obscurity, the identifying details of the individuals and cases reported have been altered.

There appears to be confusion in diagnosing and classifying issues in psychological trauma. The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition *(DSM-IV* American Psychiatric Association, 1994) handles psychological trauma under the Anxiety Disorders section in the categories of Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD). Acute stress disorder is the result of experiencing an extreme traumatic event with the emotional disturbance lasting from two days to a maximum of four weeks. Though diagnostic criteria for ASD are similar to that for PTSD, it is if the symptoms persist after four weeks that a diagnosis of PTSD could be applied.

PTSD field trials (1990 through to 1992) for the DSM-IV support the concept that trauma, particularly prolonged developmental trauma can have significant effects on psychological functioning greater than that of the PTSD symptoms (Van der Kolk et. al., 2005). In interpreting the Adverse Childhood Experience (ACE), a population based study of over 17.000 middle class American adults, Felitti et. al. (1998) found a significant and clear association for those exposed to childhood abuse, neglect, and family dysfunction with increased levels of depression, suicide attempts, obesity, alcoholism, drug use, domestic violence, physical inactivity and other high risk

behaviours. Van der Kolk (pers. com., 2010) suggested that childhood neglect, separation and emotional abuse may be equal to if not more significant than sexual or physical abuse as traumatic stress antecedents. That is traumatising experiences may be prolonged and covert in their occurrence and nature and in so may have difficulty meeting current diagnostic criteria for ASD and PTSD. Van der Kolk.(2005) argues that the DSM-IV diagnosis of PTSD is restrictive and not developmentally sensitive when describing the impact of multiple traumas: particularly during the early years.

In my practice, there is a clear relationship between prolonged exposure to experiences that produce psychological injury or harm and specific incidents of trauma. The specific incidents are often entwined and create a complex matrix, with many clients listing numerous single experiences that, independently, could leave a typical individual traumatised. Clients, who have been subject to such a life of trauma, frequently report a contiguous disrupted and abusive environment to the extent that such environments have come to be taken as normative. In this report, I use the term 'Multiple Psychological Traumas' (MPT) to define such multiple issues of abuse and disturbance over the course of an individual's development. The aim in working with these clients is to illuminate the developmental background so that there is separation and awareness of the various forms of trauma being played out. The challenge is to identify the most effective entry point for dealing with the trauma, and how to structure the treatment process for each specific client.

For instance a baby (Max) was born to a heroin and alcohol dependent mother. Max and mum lived in relative squalor in an underprivileged district of a major Australian city. Max does not know who his father is, has never met family and lives a fairly isolated life. Mum worked as a prostitute to fund their life style and existence. Mum got into debt with the local drug supplier and at age six Max was offered into the sex industry. By 12 years, Max made his own way, earning his keep through prostitution, drug dealing, and robbery. At 16, Max was a seasoned alcohol and substance user, and had experienced a number of adverse and disturbing life experiences.

At 46, Max is seeking psychological treatment, not however, from his own volition. Max has been an alcoholic, a heroin addict, abused most drugs, a hopeless gambler, incarcerated twice for assault and robbery, has no contact with his two children (from different mothers), is destitute and suffers with a number of debilitating physical complaints including irritable bowel syndrome and chronic back pain. Max is addicted to his medication, unable to work, attend social events or even travel short distances. It requires a large effort from Max to attend our sessions.

The initial point to note in this case is the normalisation of a traumatic environment. Max lists a number of disturbing experiences. Yet for Max, they have become a normative part of his background environment. He reports that from his earliest years, he can remember waiting night after night in the back of the car for mum to come back from seeing clients. Sometimes mum would come back quickly, and at other times she was out till dawn. He never knew when she would return, and says he can remember being frightened when he was about four years old but after that says he was 'OK' with it. Max reports that he would often hide under the blanket and keep still, looking out the window, waiting for the sun to come up. Max's life journey also contains a multitude of singular disturbing experiences, including a) at 5 watching his mother being severely beaten, b) being anally raped and pleading with his mother not to keep sending him back to the house, c) being stabbed in a fight, and d) his mother's death from a drug overdose.

Any one of the many development issues Max reported could cause an individual to be traumatised. Yet Max says that his developmental years were not really so different to that of other kids. He loved his mother, and she did the best she could under the circumstances. Max reports receiving counseling and professional health care services since he was 13. He says he has been hospitalised with a number of physical and mental conditions, has attempted suicide a couple of times, but is now successfully off heroin, and cannot afford to gamble. Though he 'says' he is not an alcoholic he reports that he still needs a drink to get through the day and often wishes his life would end.

Max's case provides a clear example of MPT. He is also the type of client whose potential recovery can be enhanced by the use of the Developmental Profiling Approach.

Developmental Profiling Approach

The Developmental Profiling Approach (DPA) is a process that helps record a client's verbal self-report of their life, from as early as they can remember to the current situation. The DPA gives structure to their life story, allowing the discernment of disturbing situations, and the differentiation of traumatising single episode events from a normalised traumatising background. This is important because the two types of experiences often require separate processes to resolve. DPA will also illuminate positive events and experiences that can be used towards developing positive life style choices.

Engaging the MPT Client

From my experience, most clients present with the symptoms of unresolved trauma such as substance and alcohol abuse, gambling problems, depression, anxiety and a myriad mental health issues. I have never experienced a situation where a client will come straight out and say that they are seeking help to resolve some very painful developmental experiences. Clients will generally have these feelings well contained and/or even blocked out of their typical interactions.

Further, MPT clients often present as unresponsive and disillusioned with the prospects of another attempt to 'get themselves sorted'. This is often illustrated by the necessitated repetition of 'their' story (disclosure), which can appear dissociated from them as the story becomes a 'function' of their identity as it is repeated. At the same time they are desperate to find peace in their lives.

Such clients are generally savvy and well seasoned when it comes to health care service providers. Unfortunately, many MPT clients have been subjected to unspecialised services, under-resourced and under-qualified Non Government Organizations, and/or inappropriate government services. As well they have often been

abandoned by private service providers usually due to lack of funding and limitations in the Medicare service or just put in the too much trouble box. Many MPT clients' harbor issues of trust and confidentiality and quickly evaluate the efficacy of the therapeutic alliance. If they are not comfortable, they will leave after one or two sessions confirming and reinforcing their own negative self-beliefs. Counselors often unquestioningly justify this action by reporting that the client was 'simply' not ready.

The client counselor interaction from the very first session is paramount in forming a trusting therapeutic alliance. I tend to favor psychologist Carl Rogers, 'Client Centered' approach where the therapist creates a comfortable, non-judgmental setting by demonstrating congruence (genuineness), empathy, and unconditional positive regard. I also believe a level of personal disclosure and finding some common ground is essential.

My clinical experience has shown that by the time they present, MPT clients have often experienced numerous and, varying levels and competencies of counseling services and their feelings of confidence and safety in therapy have been compromised.

For example, John (38) with a disruptive and abusive developmental history attended counseling sessions to address a gambling problem and anger issues. John reports that from when he was 18, he had been receiving counseling services and is currently seeing counselors for anxiety and depression. John says he has been to rehabilitation and overcame his heroin addiction at 24. But he then started smoking marijuana (approximately 60 cones per day and on occasion when stressed or 'in the mood' up to 100) and when he could afford it, drinking lots of alcohol. John further reports that he has difficulty in forming relationships and that most of his relationships have been volatile, short term and with women who have bigger problems than he has.

John's case confirms many of the ACE study (Felitti et. al., 1998) findings that MPT clients do have increased levels of depression, suicide attempts, obesity, alcoholism, drug use, domestic violence, physical inactivity and sexually transmitted diseases. John sought counseling for drug and alcohol abuse, and though he has stopped using marijuana he has increased his alcohol use. John is working on his alcohol problem

and is cutting down, but has now developed a serious gambling problem that is ruining his life. John reports that he felt overloaded with counseling and was beyond help, 'a hopeless useless loser'.

When such individuals present, it is important to keep in mind that the MPT client has a totally different developmental history to the typical population. They have a different way of thinking and responding, and most often come from a completely different cohort and cultural setting. Thus the MPT client can appear notoriously unreliable and difficult until properly engaged. This is often tied to the reality that MPT clients may never have experienced trust, reliability, security or somebody genuinely interested in their welfare: this requires time and flexibility. Understanding these differences and changing your own expectations as the counselor will often be crucial to achieving a sound therapeutic alliance.

To overcome this I find an environment of loosely structured meeting times is important to build up a sense of support and trust. I find keeping in telephone contact and providing client drop in times without an appointment is a great help. From there, when the client is more familiar and comfortable, a more structured and time-framed appointment scheduling approach can be attempted. This is the first stage of engagement for the next steps.

Preparing the MPT Client

Following from this, the paramount issues of confidentiality, consistency, and trust can be approached. From my experience indicates that MPT clients are hypersensitive to any inconsistencies. An open, straight forward, and honest collaborative approach is essential in building the therapeutic relationship, and it often takes many sessions to achieve confidence and comfort. The client will be entering an extremely confronting and stressful period and will be hyper vigilant to any opportunity to reduce the uncomfortable feelings and discontinue the service. Rushing the therapeutic relationship can result in losing the confidence and interest of the client. During this time the client needs to be advised of the treatment process- including DPA.

These early sessions are also about stabilising the client and the practical aspects of safety and security. This time includes collaboratively establishing some routines, developing and implementing positive life style changes and alternative coping strategies.

Many are available, suggestions include:

- teaching and practicing relaxation techniques (such as diaghram breathing);
- establishing a suitable exercise program;
- learning to play and do fun things;
- investigating a vocation change or further education;
- developing more positive social activities and support; &
- establishing the possibility of a different future and purpose.

During this stage it is important not to focus on the client's issues or be rigid in your expectations as a therapist. Focus on engaging the client and slowly implement lifestyle changes and alternative coping stratergies. If the client is open to it, a diary can be kept and tasks can be set each week. I also like to get some early assessments for comparisons as treatment progresses. This can be as simple as asking the client to rate how they feel on a scale of 1 to 100 about some special concern and then monitor the change.

As the client stabilises and becomes more familiar and safe, I have found they will start to enquire as to when they can start to look at dealing with some of their deeper issues: they can become increasingly receptive to change and keen to progress.

Using the Developmental Profiling Approach

Dealing with these deeper issues begins with the DPA. It starts with both the counselor and client being in the present, relaxed, and calm. Generally, the client is prepared by having practiced the breathing and focusing techniques. I then ask the client to close

their eyes and to think back to their earliest memory. I ask the client to tell me what was notable about that memory and I record the client's response. From this point we slowly move forward through the life span. These memories become a thorough account of the relevant moments in the client's life. The number of sessions this takes will depend on the complexity being revealed.

During the narration it will be come clear which life experience or events have registered more strongly. As a counselor, it is important to be vigilant, note these situations, but continue to move on with the story. Do not be tempted to investigate issues as they arise: simply acknowledge the issue and direct the client to continue when they are comfortable. Often the more painful experiences or areas of restraint are only expressed non-verbally like an abrupt change in facial expression, fidgeting or intonation in the voice. The client will often remember additional information between sessions or at a later date, and this should be added, in the correct chronology, to the story.

At the end, the more significant positive and negative events and experiences can be collated. The client and the therapist will be aware of which events are more troubling than others. Emphasise to the client that it is their decision as to which issues to work on. I generally recommend 'feeling the ground' with the lesser issues and working towards the more significant. Ultimately, the deep traumatic background experiences are dealt with as well as any single traumatising events.

Case Study - Diane

Diane (54) was directed to seek help for a gambling problem. She presented with debilitating gambling addiction, long standing substance and alcohol abuse and depression. She reported that she is a long term, regular abuser of cannabis, tobacco and alcohol, and further admitted that she has been a problem gambler most of her adult life. Over the last 5 years, she gambled away her $160, 000 inheritance, and is now $40,000 in debt. Dianne reported that she hadn't worked for 12 years; was most often broke, and was sleeping on a mattress in the back of her van. She is continually chased by creditors, has had lengthy periods of depression, and often thought of ending

her life. Like many MPT clients, she had a considerable history with counselors and therapists, her first contact being at 7 years old when she was hospitalised with hysteria.

The first few sessions were given to developing a trusting therapeutic relationship, safety and security, and briefly outlining the treatment program. This included 'for the hundredth time' giving a very general life history and acknowledgement that she had been hospitalised on other occasions with chronic depression and suicide ideation. Diane was on medication for depression.

As outlined previously, the following steps were taken to prepare Diane for therapy. We collaboratively developed alternative coping strategies. For her, this included relaxation techniques, regular walking, enrolling in a personal development course (Adult Education Course), socialising in a healthier environment, which would include community work and playing (building sand castles on the beach). She kept a daily diary of her activities and also recorded her thoughts. We agreed that when she was ready, we would investigate her life story in detail using DPA.

During DPA, Diane recalled a number of positive and negative events and experiences. By the time Dianne had completed her DPA we were alerted to many significant issues that could leave a person traumatised. Collaboratively we put these significant issues in an order of importance.

Circumstances included (but not in order of importance):

- Being adopted at 3;
- Molested by her adopted uncle from 4;
- Hospitalised at 7 with hysteria;
- Secretive meetings with her natural father;
- Regularly abused from 11 by her older adopted sisters husband (e.g. constant sexual innuendo and bullying like being held under the water at the beach whenever he could get his hands on her);
- Fear of the ocean to the point where she would not venture past the ankles;
- An abrupt ending of the relationship with her natural father;
- Being abandoned by her foster parents;
- Violent rape by three teenagers and left in a ditch when she was 15;
- Rape by another teenager while hitchhiking; &

- Meeting her natural mother and finding out she was the only one of four children who was adopted.

Further, Diane listed difficulty relating to her natural mother, being chronically depressed for long periods during her life, being sexually indiscriminate, and difficulty settling down, and maintaining relationships as factor that troubled her.

The efficacy of DPA in highlighting the traumatic issues was clear. Diane attended to and found resolution with each of the listed events, though some she had previously resolved in other counseling sessions. However, it became evident two issues played heavily on her psyche. Firstly, being hospitalised at 7 with hysteria was confusing and troubling to her, and secondly, coming to terms with being the only child in her natural mother's family to be adopted. As the sessions progressed, an understanding of the family dynamics and her mother's mental health issues at the time of the adoption began to have context, and Diane was able to accept the pain of being adopted and have forgiveness.

However the issue of hospitalisation with hysteria was not resolved. Diane knew she was in hospital. When released Diane had been required to stay in bed for a further 3 weeks recuperating at home. She did not know why. At first she could not remember anything. Diane had appeared to have blocked out this memory (disassociation). However, between sessions Diane slowly recalled the details of the hospitalisation. During the next session Diane revealed that she was hospitalised with hysteria and a bleeding vagina due to her adopted uncle's penetrative rape. Diane was told by the family to keep quiet about this and pretend it never happened. She had shut the memory from her mind.

By using DPA and then listing the issues in hierarchical order Diane was able obtain separation and order while maintaining control over the sequence in which she felt comfortable processing and resolving her issues. As Diane processed the lower order issues she grew in confidence, and gained in her ability to find resolution. Of note is that Diane gave up gambling the same week she resolved the penetrative rape issue by her

adopted uncle. Over the months after resolution, she also gave up smoking cannabis and tobacco (aided with anti- smoking medication), drinks moderately on social occasions, and has started work 3 days a week. Diane also completed a 12 week adult education course, moved into her own rented apartment and is developing a healthier set of social contacts. Diane relapsed once about 4 weeks after resolving the adopted uncle rape issues, but suggested this relapse may have been due to a high expectation when rekindling an old love (boyfriend), Christmas time blues, and not having developed adequate social support. Her new awareness allowed her to minimise the impact and stay on track with her new lifestyle.

This case study illustrates the use of DPA in the resolution of Diane's MPT. The DPA uncluttered the jumble of concerns, and enabled her to work through her issues systematically, and in emotionally manageable and safe sections. Her issues were no longer a scary uncontrollable mass, but a number of separate issues that were investigated and resolved.

One limitation when using the DPA can be the limited number of sessions deemed necessary or funded (through health care agencies) to achieve a successful outcome. Diane's case presentation was complex and took 35 sessions over 9 months. Some of her story was recalled deep in treatment, many sessions after completing her initial story via the DPA. Client's safety and wellbeing can be compromised (to the point of re-traumatising) if the opportunity to extend treatment is not available.

In Conclusion

MPT clients are often confused, unsettled and have difficulty stabilising their lives. The Developmental Profiling Approach (DPA) enables the MPT client to accurately identify and isolate each emotionally troubling situation giving it structure, clarity and separation. This facilitates a collaborative approach to the treatment plan while giving order to the treatment process and the capacity for the client to clearly identify their most troubling issues and progress through them at their own pace and safety.

I have found the DPA useful in working with multicultural and indigenous populations and a variety of client presentations from eating disorders, problem gambling,

agoraphobia, depression, drug and alcohol, anger issues through to self harmers, essentiality any client who has unresolved issues and has had difficulty making sense of their emotional state.

I thank you for taking the time to read this paper and welcome your comments and feedback .Please feel free to contact me on clinicdirector@byronclinic.com.au .

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