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To cite this article: Marina N. Rosenthal, Kristen M. Reinhardt & Pamela J. Birrell (2016) Guest editorial: Deconstructing disorder: An ordered reaction to a disordered environment, Journal of Trauma & Dissociation, 17:2, 131-137, DOI: 10.1080/15299732.2016.1103103

To link to this article: http://dx.doi.org/10.1080/15299732.2016.1103103

Published online: 15 Mar 2016.

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Guest editorial: Deconstructing disorder: An ordered reaction to a disordered environment

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ARTICLE HISTORY Received 10 September 2015, Accepted 17 September 2015

This special section of the Journal of Trauma & Dissociation offers three theoretical perspectives on the important and understudied topic of psychology’s potential to pathologize reactions to trauma rather than emphasize the central importance of healing. This tendency to pathologize directs all our attention to the victim of the trauma and leaves our violent misogynist culture unexamined. Time has come for a change.

The authors of the three theoretical articles featured in this special section each offer important insights into what it means to pathologize in the context of trauma practice and research. McLean and Follette (2016) articulate psychotherapy’s history in medicine and the medical model, stating aptly that the treatment of trauma typically focuses on the eradication of distressing thoughts and feelings, generally seen as deficits located in the individual. Gómez, Lewis, Noll, Smidt, and Birrell (2016) expand this perspective, noting that psychiatric diagnoses have historically neglected to distinguish between interpersonal and non-interpersonal traumas, thus failing to account for the well-researched and consistent exacerbating effects of betrayal on posttraumatic outcomes. Hoover, Luchner, and Pickett (2016) further argue that returning the individual to a perceived normal state is a fundamentally pathologizing goal frequently communicated to psychology’s newest pupils, undergraduate students enrolled in abnormal psychology courses.

Although the authors featured in this special section differ in their theoretical orientations, they align in their shared definition of what it means to pathologize survivors of trauma. We distill their messages to three main points. First, human experiences leave predictable and understandable marks; trauma in particular, and interpersonal trauma more specifically, impacts survivors’ minds, bodies, and spirits. Second, these scars do not constitute psychological disorder but instead are the natural and expected consequences of abnormal events, including betrayed trust, violated bonds, and broken boundaries. The effects of trauma are indeed just that—effects of an event—and as such are causally related to the trauma and not to the harmed individual. And third, when psychology and mental health professionals draw that causal path incorrectly, when the field fails to place the
dysfunction solidly on the shoulders of individual and societal wrongdoing, survivors of trauma are thus reduced to a single experience that was enacted on them. They end up shouldering the burden. This, in essence, is pathologizing—the assumption that because individuals exhibit certain sets of symptoms, they are themselves disordered.

It is exciting that the authors of the three excellent articles featured in this special section all write from slightly different theoretical orientations. Hoover and colleagues (2016) offer a perspective rooted in psychodynamic and feminist multicultural theory to describe how abnormal psychology courses can be sites of intervention against pathologizing attitudes and beliefs commonly bolstered in academic settings. They provide useful guidelines for how instructors can counteract pathologizing conceptualizations of trauma, providing a powerful mechanism of social change. Gómez et al. (2016) orient their perspective in relational cultural therapy, a modality that focuses on the context of trauma (i.e., the social or cultural setting or background) and highlights the potential for therapeutic relationships to disrupt betraying and traumatic relational scripts learned through trauma. McLean and Follette (2016) examine the utility of acceptance and commitment therapy in moving beyond symptoms of disorder and instead focusing on the functionality of various behaviors, thus empowering clients to face and accept pain in the service of moving toward their values and cultivating the life they desire.

In presenting these three articles, we hope not only to provide valuable insight to the field but also to spark important questions and discussions in which we can collectively engage. For example, are certain kinds of interventions more likely to pathologize trauma survivors? Is pathologizing always and inherently negative or counteractive to treatment? Is the likelihood of pathologizing rooted in the intervention or in the practitioner? Are diagnoses always pathologizing? We invite readers of the journal to write letters of response to this special section to further progress in the field of trauma psychology as we strive to heal and help rather than harm. We also acknowledge that the question of whether specific interventions are likely to be pathologizing incites controversy; we would like to highlight this potential for controversy by transparently illustrating differences even among the three authors of this editorial. Following is a snapshot capturing each of our beliefs on the topic of nonpathologizing treatment for trauma survivors. We contend that these differences in orientation, experience, and ideology constitute a positive context for discussion and dialogue as we continue to strive to understand how to better resist societal injustices like sexual violence and better serve trauma survivors in the aftermath of unspeakable hurt.
Therapeutic words have the power to be pathologizing (Reinhardt)

As I contemplated the question “What does it mean to be pathologizing?” within the context of my training in clinical psychology, I realized that finding the answer was no easy task but a multistep process. First, I needed to step back and acknowledge my gut response to this question, which is this: I strongly believe that the therapies in which I have training (cognitive behavior therapy and dialectical behavior therapy) can be practiced in a nonpathologizing way. Second, I needed to define for myself what non-pathologizing treatment entails: an approach that does not locate the problem in the trauma survivor but rather places the blame and problem with the perpetrator (individuals, society, or both). Nonpathologizing approaches recognize that there is nothing abnormal about the way in which a survivor reacts to trauma but rather that the survivor is responding the best he or she can to a set of abnormal circumstances. My third step was to question where my perspectives came from: my theoretical orientation. My theoretical orientation has been most heavily informed by training in cognitive behavior theory. This theory, as I understand it, focuses mostly on what the individual can do to modify his or her own thoughts and beliefs about events, other people, and society. In that way, I find the theory very empowering: Therapists offer tools to clients to examine how their thoughts impact the way they feel and how they behave. All along the way, therapists remind clients that they are the experts on their own cognitions and on their own lives. From this vantage point, I find cognitive behavior theory and the therapies it has informed (e.g., cognitive behavior therapy, dialectical behavior therapy, mindfulness-based cognitive therapy) to be highly nonpathologizing. I am of the mind that cognitive therapies for trauma survivors are, on the whole, nonpathologizing treatments.

There are elements of these therapies, however, that can be pathologizing if not navigated skillfully. I believe that pathologizing elements of cognitive therapies are related to the language that is sometimes used in therapy. Here I focus on the concept of dysfunctional beliefs. Dysfunctional beliefs are described as beliefs that disrupt or get in the way of a desired level of human functioning. For example, a common core belief of a rape survivor is “I am damaged.” This belief is labeled dysfunctional because according to cognitive theory, it negatively impacts the way a person behaves and feels, thus impeding his or her level of functioning. The belief “I am damaged” might lead a rape survivor to then only recognize automatic thoughts that fit with this core belief, such as “I’m the only one who doesn’t understand what the teacher is saying.” Informed by the core belief, this thought may impact the survivor’s actions, leading her to stay silent in class or even avoid attending (“What’s the point of my going? I’ll never understand, because there’s something wrong with me.”). Conceptualizing how a client’s thinking
is impacting his or her behavior makes sense to me and, in my experience as a clinician, also makes sense to clients. What I find pathologizing, however, is the word *dysfunctional*. Let us consider where that core belief may have come from: Following the experience of sexual assault, it is likely that a survivor cannot initially make sense of why she was raped. One of the thoughts that may help her understand what happened would be “He would only rape someone who is already damaged. Therefore, I am damaged.” If that line of thinking helps the survivor comprehend what happened, then it is actually not dysfunctional but may *help* the survivor function at the time, albeit from a very hurt and ashamed place. The thought is not actually dysfunctional but functional and understandable. Replacing the term *dysfunctional belief* with *belief that gets in the way of you living the life you want* may serve to reduce pathologizing and enhance understanding of clients’ reality. In developing such a belief, they were simply doing the best they could with the tools they had at the time.

I believe that many cognitive therapists would agree with what I have written here, and yet many cognitive therapists photocopy and hand their clients blank homework sheets that read “Dysfunctional Thought Record” or “Maladaptive Belief Record.” Although I do believe that *all* cognitive therapies can be performed in a nonpathologizing manner, small details such as these subliminally contribute to hurt and shame instead of liberation and healing. Given that, let us be mindful of small details and modify our language as we work with trauma survivors.

**Rethinking the field: A radical approach (Birrell)**

When I began my career as a psychologist more than 30 years ago, there was little emphasis on trauma. The *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM–III; American Psychiatric Association, 1980), had been published in 1980 with the then recently rediscovered posttraumatic stress disorder, an updated version of the gross stress reaction described in the *Diagnostic and Statistical Manual of Mental Disorders, First Edition* (DSM–I; American Psychiatric Association, 1952). The DSM–III represented a huge shift in how psychiatry, psychology, and therefore our culture views mental health and mental disorder. It was a shift from a biopsychosocial descriptive approach to a medically based research model (Wilson, 1993). As the medical model widened, so did the thinking that the mental disorders were brain disorders or chemical imbalances (Peschosoldo et al., 2010).

At the same time, however, mental health workers began to see the broader implications of this posttraumatic stress disorder, originally defined for returning soldiers, finding symptoms of it in children and women in abusive relationships. Gradually, the field has come to see the central
importance of trauma in many conditions, including psychosis (Kelleher et al., 2013), depression (Shalev, Freedman, Peri, & Brandes, 1998), borderline personality (MacIntosh, Godbout, & Dubash, 2015), and the recent conception of developmental trauma disorder (Rahim, 2014).

We have come now to a time when we need to rethink our basic concepts and the language we use when we deal with trauma survivors. Although someone who breaks his or her leg in a skiing accident is someone in need of care and compassion, this person is not referred to as someone with a broken bone disorder. Broken bones are expectable reactions to hard trauma. Just so, damaged psyches are expectable reactions to psychological trauma and betrayal. They are not disorders but reactions (returning us to the language of the DSM–I). The language we use to refer to those who are traumatized is important, as the long history of social priming has demonstrated (Bargh, 2014).

Finding the middle ground (Rosenthal)

As a therapist with training in both cognitive behavioral approaches and also relational approaches, including relational cultural therapy (see Jordan et al., 1991), I have focused my clinical work thus far on therapy with trauma survivors. Thus, I can compare my own clinical style working with survivors across modalities. As a result of these experiences, I contend that when developing a strong therapeutic alliance is the focus of therapy, relational therapies and cognitive or behavioral approaches look and sound highly congruent. Despite the possible perception that these are very different modalities, I see each approach as a toolbox filled with a variety of strategies to approach treatment. I believe that the core component of doing therapy is creating a growth-fostering relationship in which the client and therapist are both fully present and engaged. Working with trauma survivors highlights the importance of this tenet, as survivors’ relationship histories are so often fraught with betrayal and violation.

In tandem with a strong connection, I see cognitive and behavioral interventions as useful options to offer clients who seek change and are ready and willing to try new ways of thinking and acting. Yet I have also found that many survivors are not initially ready to begin attempting new cognitive and behavioral choices. Approaches like cognitive behavioral therapy may have the potential to pathologize when they insist on, or even gently push toward, measurable change. Going directly at the dysfunctional thought may be initially dangerous for survivors, whose various coping strategies have often been cultivated over time to minimize pain while withstanding unspeakable trauma. As I have had the great privilege of working in various community organizations where longer term therapy (ranging from 6 to 18 months of weekly sessions) is possible, I have learned that cultivating space to just approach and acknowledge a client’s trauma history can be deeply healing and transformative.
Yet many clients do come to therapy hoping to tangibly feel better—to reduce symptoms like flashbacks and nightmares, to improve connection with friends and family, to learn coping skills to handle panic and anxiety. Although only offering these clients skills is not enough, I also argue, when clients come to treatment explicitly desiring skills, cultivating a powerful therapeutic relationship but withholding useful tools is not in line with clients’ stated needs. Excellent case conceptualization and well-delivered interventions cannot heal deep, relational wounds, and a powerful healing connection alone cannot always rebuild healthy strategies for coping and wellness.

I do not see my philosophy of therapy as conflicting with the literature on either cognitive behavioral or relational approaches. Indeed, I see both as powerful modalities to know and use with trauma survivors. Cognitive behavior therapies, as expressed by my coauthor Reinhardt, frequently utilize potentially pathologizing language. I have found that hand-writing individual worksheets (when desired by clients) adapted from but not strictly based on manuals is a useful strategy to avoid pathologizing clients and indeed to demonstrate that I am hearing their words, their struggle, and not merely plugging them into a preexisting equation.

I have found that listening to what clients tell me they want (be it tools, someone to hear their story, reduced symptoms, better relationships) and shaping what I offer in response to their needs often constitutes an important compromise—giving each client what he or she needs. I would argue that this process of asking “What do you want from therapy?” early and often and genuinely respecting the answer is in line with the spirit of cognitive and behavioral therapies, relational cultural therapy, and most other modalities. Indeed, asking and honoring this question ought to be a principal component of all therapy, regardless of orientation. In particular, when working with trauma survivors, who have so often been rendered powerless, respecting the client’s right to decide what therapy should look like is the ultimate path toward nonpathologizing, and ultimately uplifting, treatment.

**Conclusions**

This short special section illustrates a shift from pathology to expectable reactions, from disorder to relationship, from an approach highlighting difference between therapist and sufferer to one emphasizing our common humanity. We offer it in the hope that we can continue to come together in compassion and unity, seeing those who have been betrayed and traumatized as whole human beings rather than as victims with disorders.
References


