Vega, L. A., et al., (2023). *J Rehab Pract Res* 4(2): 146
https://doi.org/10.33790/jrpr1100146

Journal of Rehabilitation Practices and Research

Transcending Trauma: Treatments' Caveats, Construal, and Cultural-Context

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Article Details

Article Type: Research Article
Received date: 18th June, 2023
Accepted date: 25th July, 2023
Published date: 27th July, 2023

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Citation: Vega, L. A., Agabao, M., Franco, A., Estrada-Rodriguez, Z., Gomez, F., Selene, N., Lee, Y., Gonzales, A., Wu, K., and Niestas, A. S., (2023). Transcending Trauma: Treatments' Caveats, Construal, and Cultural-Context. *J Rehab Pract Res, 4*(2):146. https://doi.org/10.33790/jrpr1100146

Abstract

We examined evidence for the view that trauma transcendence should be operationally defined as a process rather than an *end goal* and considered caveats in individual differences of construal and contextual-cultural influences. The focus was on the role of therapy treatments used in trauma transcendence and the extent to which evidence-based information, theory, and generalizability are—can/should be—involved. *Our methodological analysis and theoretical discussion of extant research evidence* focused on (a) models of trauma transcendence, (b) the multivariate, scientific nature of evidence-based therapy treatments/outcomes, (c) the need to have tailor-made trauma treatments that allow for individualized patient variability, (d) therapists' skill-limitations/strengths, and (e) the need for methodical, systematic approaches to trauma transcendence. Our conclusions show that evidence-based approaches are needed, but limits remain in generalizability of findings. We also recognize a need for multipronged approaches to trauma transcendence, from trauma-informed approaches, to reducing the shortage of therapists, increasing methodological-clinical sophistication in the public sphere, and addressing the multivariate nature of trauma. Finally, we suggest that navigating trauma transcendence should be a process that goes beyond the homeostatic state.

Keywords: Trauma-transcendence, Evidence-based therapy, Assessment-treatment validity, Trauma-informed approaches, Construal-and-context in therapy outcomes; Multicultural competence

Introduction

Transcending trauma is crucial today, considering catastrophic events ranging from the COVID-19 pandemic, natural disasters, human dislocations, the ubiquity of gun violence in many societies, to ongoing wars. In 2021 alone, the number of people seeking mental-health care in the United States was 42 million [1], or about 12 percent of the US population of 331.4 million [2]. To help with trauma transcendence, our research group has shown that we must first understand how a person's *affect, behavior, and cognition*-also known as the ABC *tripartite model* in social psychology [3]need to be considered [4]. In specific, Zamora et al. showed that different types of trauma treatments, such as the 12-steps approach program used by Alcoholics' Anonymous, Kübler-Ross [5] six-stages of grief, as well as the *broaden-and-build theory* of emotions [6], all involved aspects of *Affect, Behavior, Cognition* (ABC). Vega et al. [7] further extended Zamora et al.'s [4] work by showing that transcendence needed to not only involve all aspects of the *ABC tripartite*, but must also be a proactive approach, requiring monitoring of trauma through a 5Rs model (*trauma* -reduction of wellbeing, -relapse, -resiliency, -recovery, and -realization), as well as having a good definition of trauma, an opaque endeavor. In this paper we further offer clarifications to the *5Rs* model, as well as review and propose continued improvements to trauma transcendence based on methodical, systematic approaches.

Transcendence Trauma Model: Methodical Refinements

We have argued that transcending trauma required a proactive approach, where the status of trauma could be monitored according to the 5Rs model, and that this required ongoing efforts of gradual improvements that went over and beyond the homeostatic state [7]. Also, we stated that trauma *uniquely and differentially* affected individuals—on a severity continuum of no- to high-harm trauma-experience for a similar event across individuals. That is, an event that is traumatic for one person may not be for another. Furthermore, a person's definition and experience of trauma is influenced by context and personal construal or interpretation. We offered that

using standardized approaches and more scientific norming, when appropriate and available was a necessity. Here, we propose to embed our model in a more contextual setting, with varying paths to emulate how people may possibly navigate trauma. Figure 1 presents our modifications, with hyphenated arrows showing that transcendence can be nonlinear, and that context, circumstances, and culture, as examples, should be embedded through the system affecting trauma transcendence (shaded oval).

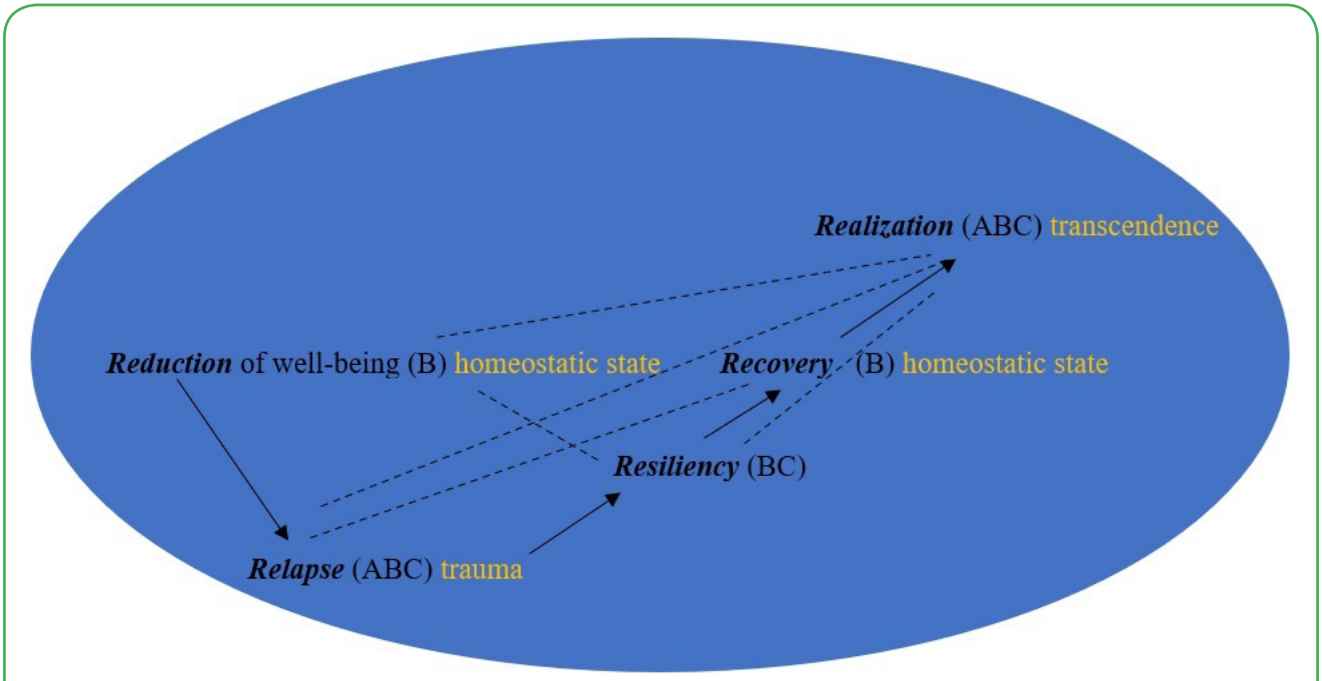

Figure 1: Reframing Zamora et al.'s [4] and Vega et al.'s [7] Transcendence Theory and the 5Rs Model

Source: Vega et al. [7]. J Rehab Pract Res 2(2), 122. https://doi.org/10.33790/jrpr1100122 -[*hyphenated arrows added*].

The main points of the model in Figure 1 are that transcending trauma requires attention to four foundations. First, trauma affects a person's emotions, actions, and thinking, which are denoted as affect, behavior, and cognitions (i.e., ABC) at each step. Second, the 5Rs (*trauma* -reduction of wellbeing, -relapse, -resiliency, -recovery, and -realization) operationally define locations of trauma transcendence in relation to the homeostatic state. Thus, *relapsed* connotes a negative influence of trauma, whereas *resiliency* connotes a positive one. Third, how a person progresses through trauma transcendence, or each of the 5Rs, does not have to be in the outlined sequence, for it could be non-linear (dashed lines)—so some people who are not affected by a traumatic effect, may be able to access transcendence and wellness of positive emotions, thoughts, and actions (or positive outcomes of ABC). Finally, implicit in Figure 1 is that being in a homeostatic state, as one was before a traumatic event, is not as ideal as transcending into a higher state of wellbeing. Further, as Vega et al. [7] showed, trauma transcending is a process that requires ongoing, proactive effort to not re-live, or stagnate with negative effects of past trauma. Therapies and treatments may not be explicit in these foundations, but our research goal is that they should be if we are to rely on evidence-based analysis for the effectiveness of therapy.

It is important that we keep a holistic view of trauma transcendence, so that we can make processes, procedures, and practices of transcending trauma, transparent. For example, an individual's cultural background needs to be considered in how that person will navigate trauma transcendence. This is essential because a person's cultural background may be a strength in their journey to transcending trauma. Lilienfeld [8] has shown that psychological treatments at times can cause more harm than good, and this can be particularly the case in multicultural settings [9]. According to Sue et al. [10], this is especially true when we lack cultural humility to acknowledge issues of multicultural competence—costumes, language, values, world views and the intersectionality of issues of social justice which include historical oppression, discrimination, racism, sexism, and many other -isms. A more detailed account of how therapy may cause harm is offered by Curran et al. [11], who showed that in addition to a lack of cultural competence, a negative therapeutic process like unresolved alliance raptures [therapist-client], therapists' practices of rigidity, over-control, lack of knowledge, can all derail trauma transcendence.

Thus, as Cronbach [12] once stated, understanding the full person within their psychology necessitates an account of explained- and unexplained-variance, experimental approaches that account for variance between treatments and within individuals, and putative multivariate (correctional) influences, identifiable or not. It is essential that we examine and meet both statistical/methodological assumptions of treatment validity and generalizability, as well as consider any omitted variable(s) and basic measurements of constructs. This is similar to data scientists worrying about violations of their models involving curvilinearity, existence of outliers, heteroscedasticity (unequal error residuals), and omitted X variables in their regression models [13]. Or, experimentalists, who must worry about demand characteristics, progressive error, experimenter biases, and even what to call the control group (baseline, comparison group, placebo;[14]). Hence, the importance for being methodical and systematic in treatments to trauma transcendence is of utmost importance for research on mental health treatments and outcomes as it is for data scientists and experimentalists obtaining valid results.

Evidence-Based Trauma Transcendence Treatments

That we must treat trauma is not debatable, but who can treat trauma has been the subject of scrutiny in public discourse and professional associations. Baker, McFall, and Shoham [15] published concerns that practitioners of psychological services often failed to

base treatments on scientific evidence. They traced this issue to the training of doctoral students, with Philosophy Doctorates (PhD) trained in laboratories, research, and clinical practice settings perceived as more adept at applying scientific rigor and evidence-based approaches. In contrast, the degree of Doctor of Psychology, with persons earning this degree known as PsyDs, are perceived to mostly be trained more for clinical practice and less for laboratory and research practice— more science-based approaches. Adding to this perception is the fact that many PsyD programs are for-profit programs, with Baker et al. [15] arguing that just like in medicine in the early 1900s, when personal experience was valued higher than scientific research, psychology must now adopt to scientific application in accreditation, as medicine once did.

One result of this debate is a bifurcation of accrediting bodies. The American Psychological Association (APA) used to be the sole body offering accreditation to clinical training institutions, with some PsyD graduate programs meeting their standards. Because the Association of Psychological Science (APS), which split from the APA in 1989, has focused on stricter scientific rigor, they now offer an accreditation to doctoral-level clinical programs, known as PCSAS (Psychological Clinical Science Accreditation System), and it excludes PsyD degree programs. This process of gatekeeping aims to infuse science into licensure of clinicians [16].

The aims of infusing science into clinical practice are important and it may lead to similar advances for mental health as medicine did for medical practice and treatment. However, it must be noted that the emergence of therapy is recent and ongoing, with Freud anticipating current debates. According to Dominus [1], writing in the New York Times on the effectiveness of therapy, Freud himself was "famously uninterested in submitting his innovation [psychoanalysis] to formal research." Even though some of his findings were finding scientific support, Freud strongly believed that "…the wealth of reliable observations on which these assertions rest make them independent of experimental verification." Thus, if we are to examine the record on the usefulness of therapy in helping the transcendence of trauma, reconciling scientific, political, and practical considerations need to be explicitly examined. We attempt to provide insight into this perspective by discussing issues of theory-making (inductive approach), and theory-testing (deductive approach) as these apply to trauma transcendence.

The Rise of Talk Therapy as an Inductive Approach to Trauma Transcendence

On the footsteps of Darwin's [17] observational work and findings on natural selection, it is likely Freud may have sought to make similar inroads through observational inference into the psyche of fellow humans. Many of his observations on early parental experiences have passed scientific scrutiny, as psychoanalysis and associated talk-therapy has become *less-libido-focused* [1]. Others on his footsteps, such as Carl Jung's [18] *association method*, and Carl Roger's [19] *client-centered approach* have all been bottom-up approaches, demonstrating the usefulness of transcending trauma as part of the 5Rs (*trauma* - reduction of wellbeing, -relapse, -resiliency, -recovery, and -realization; [7]). These have all involved aspects of affective, behavioral, and cognitive (ABC) approaches. Expressive writing— a recent, behaviorally-primed approach to therapy— has also been a serendipitously bottom-up approach [20].

Interestingly, that talk-therapy works is supported in the literature [1, 21] - with effect sizes measurable—and yet, unconventionally, therapy outcomes often lie on the skills of the therapist(s), and their techniques, as well as the patient-therapist bond [22]. This begs the question on the distinction of the effectiveness between PhD versus PsyD credentialed therapists. While (inductive) skills derived from practice and experience for PsyDs may be shown to be effective, qualitatively measuring these effects is not always done, and at times when it is done, the qualitative methodology—such as action research which investigates the issue as it is solved—is not acknowledged to have the same scientific rigor as evidence-based [deductive], experimental conclusions required of PhD programs. Moreover, outcome effectiveness due to patient differences such as gender, comorbidities, cultural background, and many others have not been fully examined [1]. Consequently, evidence-based data will be crucial as we form theories that are supported and valid, if we are to avoid the *Dodo Bird effect*[1] in therapy [23], so that we do not fall into the trap of assuming therapies and patients are all the same.

Therapy is inductive in nature, with the therapist and even the patient, observing patterns, trends, and grouped characteristics that imply a diagnosis, or that lead to resiliencies and improvements. But to be able to generalize these observed outcomes, the purported trauma transcendence treatments must be tested methodically and systematically, so we do not start from ground zero with every patient. Testing our inductively derived theories will help us standardize our treatments, even if to the chagrin of the late Freud [1].

Directed and Deductive Approaches to Trauma Transcendence Therapy

Predicting trauma transcending therapeutic outcomes necessitates that we have good theories. One drawback is that if we only focus on metric outcomes, then we may over focus on the effects, not the causes. Caveats can be found in the medical model where "magic pills" have brought immediate relief with treatment, but not a cure, and where the roots of the ailment can remain. Mental health practitioners, with psychologists in specific and researchers too, have not been immune to the debate [24], of using magic pills or prescribing drugs for mental health ailments. To be fair, chronic problems can be true of mental health as they are of physical health, and pharmaceutical therapies may be required [25].

And yet, the pressing nature of mental health problems often requires reactive approaches, with a focus on symptoms rather than causes. The fact that trauma and mental health issues are imbued with myriad, multivariate causes, makes it difficult to distill and isolate individual variables for analysis. Still, Dominus [1] shows that causal variables can be of focus, through simple questions like, "is talk therapy better than no therapy?" which can be addressed using randomized studies. Glass and Smith [21] answered this question in the affirmative, showing that persons who suffer from neurosis and psychosis benefited from talk therapy. In their study, the researchers compared untreated to treated individuals. Their results showed that 75 percent of those treated with therapy manifested statistically significant improvement on the outcome measures, compared to no-treatment individuals. In fact, to answer the question Glass and Smith had to create a new statistical technique called meta-analysis, which quantified impact, and answered the question of generalization across therapies—all worked regarding *talk therapy*. It should be noted that therapy having beneficial outcomes since Glass and Smith's [21] study has been shown to be overall true for patients with anxiety, depression, and other psychological disorders [1].

Meta-analysis has been a gold standard to show if theoretical predictions hold across studies, using randomized sample designs. Predicted results are not always supported, however, as Cuijpers et al. [26] have found that psychotherapy studies focused on treating depression showed that half of the patients receiving therapy had little or no benefit, with one-third experiencing reduced symptoms to meet being diagnosed as not having depression. Even then, consensus on the value of treatment outcomes and subsequent generalization across populations from samples—even when randomized, and plausible omitted mediator/moderator variables are included-can impact the interpretation and importance of results [27,28]. This is reflected in a registered (predictions made a priory) meta-analysis of studies done in the last two years on the effectiveness of

[1]As Dominus (2023) [1] explains, the effect can be traced to Dodo being asked to judge a race in Alice's Adventures in Wonderland, "[decreeing,] everybody has won, and all must have prizes." This is further seen in the self-esteem literature of the last three decades, where the idea that everyone must be given a medal for participation, was unsurprisingly, nuanced in methodological issues showing that few benefits derived from such premise (Baumeister & Vohs, 2018) [46]. It remains to be seen what the scientific verdict on Dodo Bird effect will be (Wampold, 2015) [22].

psychodynamic therapy by Leichsenring et al. [29], who showed that, "…no single therapeutic approach fits all psychiatric patients, as shown by the limited success rates across all evidence-based treatments" (p. 286).

Adding to the difficulties of assessing the effect of randomized, experimental studies on trauma transcending therapies is the replication crisis that has impacted psychology, and science in general. It is estimated that only 36 percent of psychological studies on average can be replicated [30]. Even highly established, empirically rooted findings that used meta-analysis have been the subject of suspicion under the replication crises [31]. And adding to the limitations of meta-analysis in what is called the *file-drawer effect*—where non-supporting findings are not published, the impact and effect of randomized studies might be more limited than research has shown. As well as data interpretation limitations, factors such as an appropriate control group, where half of the randomized group is put on a waiting list (no treatment), where being in a state of limbo has ethical implications of depriving patients of beneficial outcomes, if any, and where placebo effects—or *nocebo* effects, opposite effects/worsening symptoms [32], can alter or limit the findings.

Trauma Transcendence Tailored Therapy Treatments

The term trauma-transcendence implies being proactive if we are to treat trauma as a process or continuum. This approach seems right, as individuals will differ in their experiences navigating the 5Rs depicted in Figure 1. Advancing trauma transcendence research and practice must continue, as advocated by leaders of the PCSAS and NIMH (the National Institutes of Mental Health) [16], particularly where medical pharmaceutical interventions are needed. Scientific evidence in trauma transcendence requires that we navigate the inductive- (theory building; observations) and deductive- (theory -testing and -revisiting) research cycle that is true of all science [33]. Manifesting and applying evidence-based interventions in the form of norming, standardization of operational definitions, generalizations, and enhanced wellbeing to those experiencing trauma is an ongoing process [1]. Providing tailored therapy treatments is imperative for mental health professionals who must meet the distress demands of our times. If we are to avoid the pitfalls of therapy causing harm [8], we need to be methodical and systematic to narrow the variability where treatments work and are properly tailored to patients' needs.

Extant research provides guidelines for potential ways to tailor therapy to those seeking trauma transcendence therapy. Sue et al. [10] overview issues in counseling the culturally diverse, in a seminal book now in the ninth edition. The myriad issues they discussed are copious, from therapists having cultural humility/competence, to individuals crisscrossing multiple social identities that make them vulnerable to stereotypes, stigmas, and scapegoating (ABC of social psychology). Would be therapists are warned and advised about their limitations or walking in blind when assisting clients in a trauma transcending state. The importance of having a diverse therapists' workforce is also highlighted as important by Sue et al., and a need echoed by minority therapists [34]. Table 1 illustrates a few selected groups Sue et al. [10] cover in their book, with issues that may appear of most concern to the identity space of a group [35], and issues where uninformed therapists can commit malpractice and maligned outcomes [8,11].

Cultural Group	Issues of Importance	Perilous Therapy Traps
Older patients	Geriatric Issues	Child-like talk
African Americans	Issue of Oppression	Victim blaming
LatinX Populations	Cultural familialism	Traditional medicine beliefs
Asian Americans	Collectivism	Impugned identification
White racial consciousness	Antiracist identifications	Privilege

Table 1: Patient Subgroups, their Issues of Importance, and Perilous Therapy Traps in Selected Groups [10].

No matter how many evidence-based therapies we have, if there are not enough therapists to tackle the mental health crises of today [36], many individuals who can benefit from trauma transcendence will go unsupported. With millions of individuals in need of mental health care [1], and not enough mental health professionals to meet demand, it is imperative that support systems be in place—such as support groups used by alcoholic anonymous, extended families in many cultures, and community centers tailored to older adults. One effort involves trauma-informing procedures, processes, and programs that can be used by communities, agencies, universities, initiated by the United States Department of Health and Human Services. Their guide is available and accessible to the public [37].

As the above publication notes, a trauma-informed approach requires acknowledging collective trauma imposed not only on individuals, but families, and communities. Many communities have histories of trauma due to historical issues of oppression and discrimination that can cause re-traumatization [37]. One example is the amply demonstrated racial trauma that African Americans have suffered in American society, which according to Tatum [38] is manifested in through hurtful statements such as, *why are all the black kids sitting together in the cafeteria?* to endemic issues of exclusion in housing and employment, to police excessive use of force against this community, all leaving enduring trauma. Thus, not only are there not enough therapists, but victims of trauma involved individuals, families, and communities, which a trauma-informed approach tries to bring into focus for trauma transcending interventions.

Briefly, SAMHSA's [37] efforts are designed to infuse trauma-informed approaches, asking all of us to be *upstanders* rather than bystanders to those living with trauma. This approach seeks to ingrain educational foundations in institutions and populations that are responsive to those in trauma-plight. It seeks to do this by helping potential responders (a) identify trauma conditions, (b) inform on trauma reduction pathways residing within institutional supports and control, (c) use established, proven principles that can be of guidance and application, (d) suggest guidance implementing programs that are trauma informed, and (e) consider trauma in the context and community of those affected.

In addition to the trauma-informed approaches discussed above, it is important to ensure that treatments be individualized for those trying to transcend trauma, depending on the trauma they have experienced. Deindividualization—losing track of the individual's needs-is part of the trauma, and the reason the shaded area in Figure 1 is large.

It is important that support systems to those in the process of transcending trauma allow for non-linear progress of the 5Rs model, that issues (or variables) affecting that person be acknowledged and monitored for progress—where evidence-based approaches can be applied. For example, Kaye [39] proposed a *grief barometer*, where those transcending trauma due to losing a loved one can measure their progress. In other instances, a *relationship tree* [40] has been shown to assess support systems as a person is to engage in trauma transcendence. Another example is *Logotherapy*, where seeking trauma transcendence is pursued through seeking purpose, meaning, and deliberate choice of a positive perspective and reflection. This approach was pioneered by Frankl [41] and is well demonstrated by Southwick et al. [42], who applied it to combat veterans experiencing post-traumatic stress disorder (PTSD). This approach of logotherapy is like *expressive writing*, which is also self-guided and works best with a supportive therapist [20].

Conclusion

As we stated earlier, the field of trauma transcendence is relatively new within Western historical standards. Psychoanalysis traces its roots to 1880-1882 [43], close to the formal establishment of the discipline of psychology in 1879 [44]. We can only hope that in time, trauma transcendence will be a science as medicine is today, and its accrued advances, even though the medical field can be traced back to the Greeks. The plight of those transcending trauma necessitates access to approaches that will work, and to the degree these are methodical and systematic, the better [45]. That more trauma transcending information needs to be made transparent and available to all, has amply been demonstrated in the discussion above. The science cycle of inductive- and deductive-approaches will continue to advance our knowledge. We hope that more methodological literacy approaches can become part of practitioners' tools and treatment repertoires. For example, small N designs are not seen too often in the literature, but these could see more widespread adoption. Myers and Hansen [14] discussed how if we want to see the impact of a new therapy treatment for depression, not enough depressed individuals might be available for a randomized trial. An experiment could still be conducted in which the progress of one or a few individuals could be studied intensively using ABA (i.e., baseline-treatment-baseline progression) variation designs, which can have high internal validity, have baselines, and the individual serves as its own control group—obviating ethical concerns of treatment deprivation, as discussed above in between subjects randomized experiments. Finally, we remain hopeful that science will continue to make progress in attending to the alleviation of those navigating trauma transcendence beyond the homeostatic state and to do so by using the foundations of the 5Rs model covering the ABC tripartite for wellness and wellbeing [4,7].

Competing interests: The author(s) declare that they have no competing interests and express gratitude to two anonymous reviewers whose comments greatly improved this manuscript.

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