Narrative Exposure Therapy (NET): A Short Term Treatment for Traumatic Stress Disorders

NET Training | 2022

What is Narrative Exposure Therapy (NET)?

NET – an intervention for the treatment of complex traumatic stress in children and adults.

- ✓ short-term
- ✓ field-oriented
- ✓ culturally sensitive
- ✓ science-based
- ✓ therapeutic &
- ✓ human rights

Narrative Exposure Therapy (NET)

Combination of behavioral exposure and testimony therapy (Lira and Weinstein)

Diagnostic Assessment and Psychoeducation

Exposure to traumatic events

Documentation of biography

Use of the narration for human rights work or personal use of the client

Narrative Exposure Therapy (NET)

TWO GOALS:

1. Reduction of PTSD symptoms by confronting/exposing the client with the memories of the traumatic event.

EXPOSURE: Imaginative reliving, emotional processing, reweaving hot and cold memory.

2. Construction of a consistent document.

NARRATION of the client's biography, especially the consequences: survivor testimony.

Relevant Mechanisms

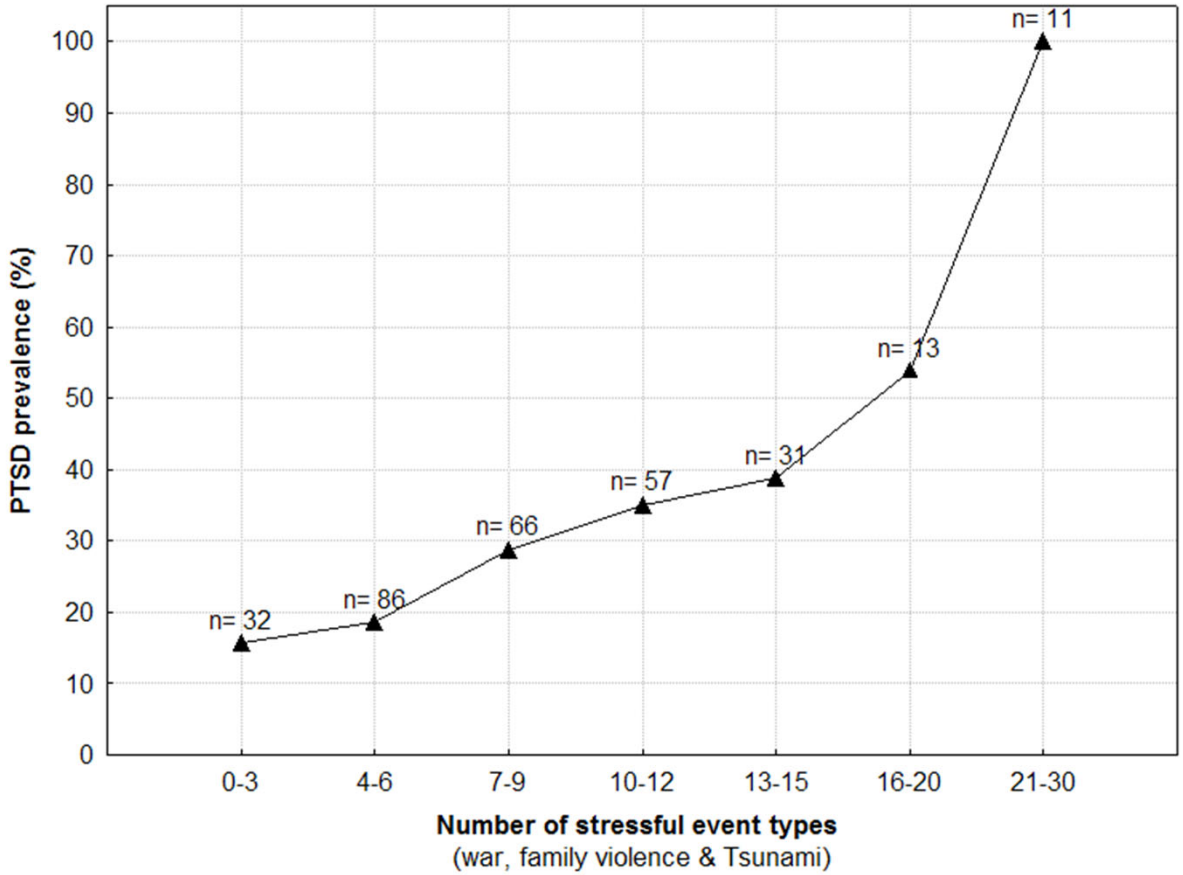
- *Chronological* reconstruction of the autobiographic/episodic memory

- Activation of the fear network through exposure to modify the emotional network

- Meaningful integration of hot and cold memories

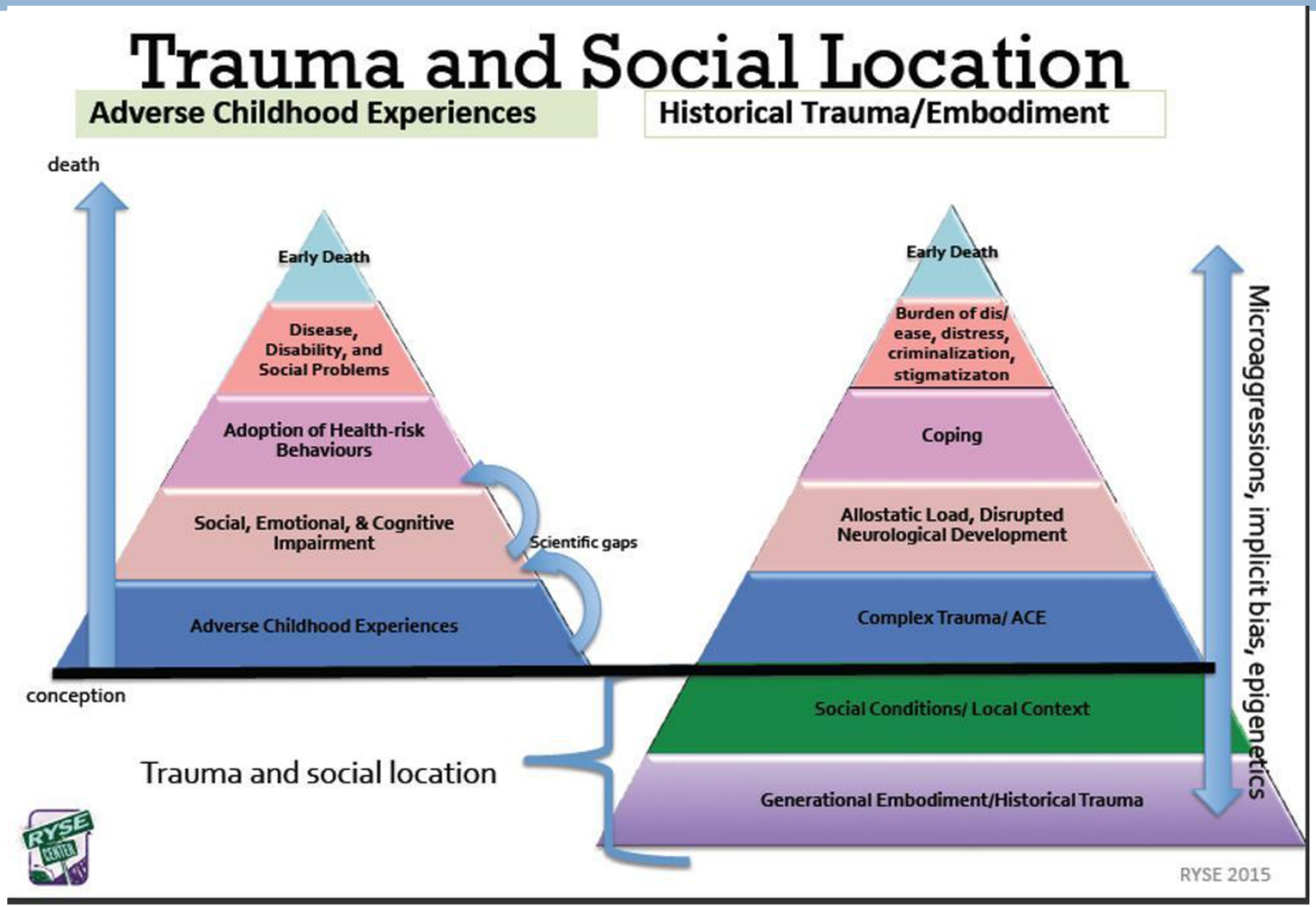
- Reinterpretation of the memories; regaining a sense of dignity and the need for acknowledgement

Cumulative Effect of Traumatic Events and Adverse Life Experiences



- More different types of stressful events, the more likely someone is to develop PTSD

(Catani et al., 2008, BMC Psychiatry)


Trauma and Social Location
Adverse Childhood Experiences
Historical Trauma/Embodiment
death
Early Death
Disease, Disability, and Social Problems
Adoption of Health-risk Behaviours
Social, Emotional, & Cognitive Impairment
Adverse Childhood Experiences
Scientific gaps
conception
Early Death
Burden of dis/ ease, distress, criminalization, stigmatizaton
Coping
Allostatic Load, Disrupted Neurological Development
Complex Trauma/ ACE
Social Conditions/ Local Context
Generational Embodiment/Historical Trauma
Microaggressions, implicit bias, epigenetics
Trauma and social location
RYSE 2015

NET, KIDNET, & FORNET: The Evidence

Effective Treatments for PTSD

- Cognitive behavioral treatment
- Trauma-focused CBT (TFCBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Stress management
- Prolonged Exposure

Trauma-focused psychological treatments are most effective.

Randomized Controlled Trials of NET

- Refugees, internally displaced persons (IDPs), asylum seekers
  - Romania, Uganda, Rwanda, Germany, Norway
- Living in their original homes, camps in their own countries, neighboring countries, or far from original home
- Individuals across the lifespan
  - Children ≥ 7 years
  - Adolescents
  - Adults
- Simple and complex trauma

Effectiveness of NET

Lely et al. (2019)

Table 1. Characteristics of the included studies.

Study name	*N* NET	Age	Male participants (%)	Treatment dose	Professionals	Outcome	Language	Migration	Dropout NET	Control
Alghamdi et al. 2015	17	28.7	100.00	360	1	SR*	1	0	0.00	WLC*
Al-Hadethe et al. 2015	20	17.5	100.00	300	1	SR	1	0	0.05	EFT*
Bichescu et al. 2007	9	68.9	100.00	600	1	DI*	1	0	0.00	PED*
Ertl et al. 2011	29	18.66	44.8	840	0	DI	1	0	10.34	Catch-up*
Hensel-Dittmann et al. 2011	15	36.4	57.14	900	1	DI	0	1	20.00	SIT*
Hijazi et al. 2014	41	47.6	36.59	225	1	SR	1	1	4.88	WLC
Jacob et al. 2014	38	40.0	10.53	960	0	DI	1	0	2.63	WLC
Morath et al. 2014a	17	27.29	58.82	1080	1	DI	0	1	0,00	WLC
Morath et al. 2014b	19	28.7	67.65	1080	1	DI	0	1	21.05	WLC
Neuner et al. 2004	17	31.9	41.18	420	1	SR	0	0	5.88	SC*
Neuner et al. 2008	111	34.4	49.55	540	1	SR	1	0	3.6	TC*
Neuner et al. 2010	16	31.6	68.75	1055	1	SR	0	1	12.5	TAU
Schaal et al. 2009	12	19.42	38.46	540	1	DI	0	0	0.00	IPT*
Stenmark et al. 2013	51	34.51	66.67	900	1	DI	0	1	25.49	TAU
Zang et al. 2013	11	56.64	22.72	360	1	SR	1	0	0.00	WLC
Zang et al. 2014, NET* 2014	10	53.5	6.67	300	1	SR	1	0	0.00	WLC
Zang et al. 2014, NET-R* 2014	10	56.5	6.67	270	1	SR	1	0	0.00	WLC

Catch-up, academic catch-up programme; DI, diagnostic interview; EFT, emotional freedom techniques; IPT, interpersonal psychotherapy; NET, narrative exposure therapy; NET-R, NET – revised; PED, psychoeducation; TC, Trauma Counselling; SC, supportive counselling; SIT, stress inoculation training; SR, self-report; TAU, treatment as usual; WLC, waiting-list conditions.

Effectiveness of NET cont.

Nose et al. (2017)

Table 1. Selected characteristics of included studies.

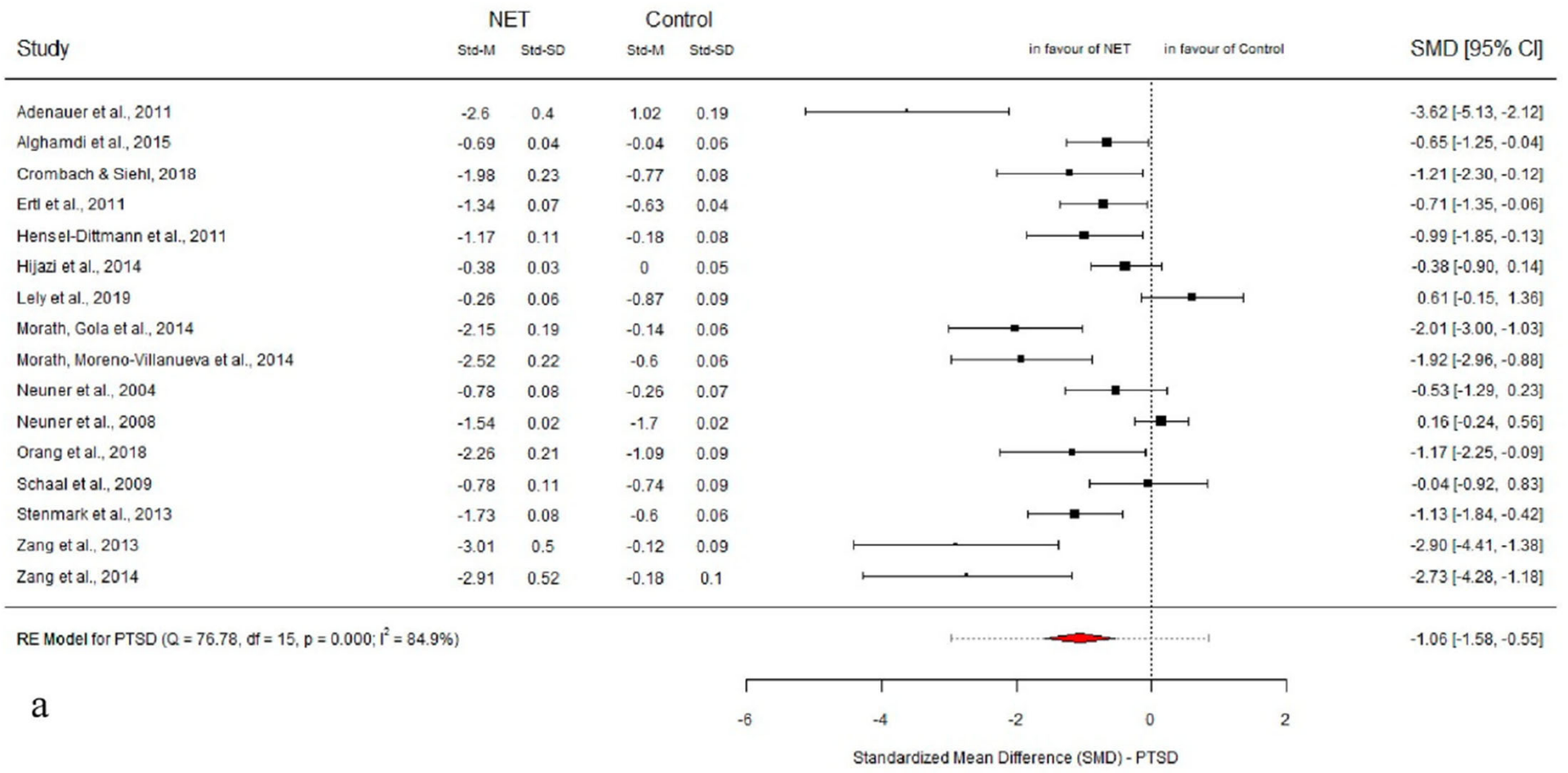
Study	Country	Country of origin	Intervention (No of sessions)	Control	N	Design	PTSD measure	Follow-up (months)
Adenauer 2011	Germany	Africa, Middle East, Balkans	NET (12)	Waiting list	33	RCT	CAPS	3
Buhmann 2016	Denmark	Iran, Iraq, Afghanistan, Balkans	CBT (16)	Waiting list	142	RCT	HTQ	6
Drozdek 2010	Netherlands	Iran, Iraq, Afghanistan	TFP (85)	Waiting list	82	CCT	HTQ	12
Hijazi 2014	USA	Iraq	NET (3)	Waiting list	63	RCT	HTQ	2
Hinton 2004	USA	Vietnam	CBT (11)	Waiting list	12	RCT	HTQ	3
Hinton 2005	USA	Cambodia	CBT (12)	Waiting list	40	RCT	HTQ	3
Kruse 2009	Germany	Bosnian	TFP (25)	TAU	70	CCT	HTQ	12
Liedl 2011	Germany	Balkans, Turkey	CBT (10)	Waiting list	36	RCT	PDS	3
Morath 2014	Germany	Africa, Middle East	NET (12)	Waiting list	34	RCT	CAPS	4
Neuner 2010	Germany	Turkey, Balkans, Africa	NET (9)	TAU	32	RCT	PDS	8
Otto 2003	USA	Cambodia	CBT (10)	TAU	10	RCT	CAPS	
Renner 2011	Austria	Chechnya	CROP (16)	Waiting list	56	RCT	HTQ	4
Stenmark 2013	Norway	Iraq, Afghanistan, Africa, Middle East	NET (10)	TAU	81	RCT	CAPS	6
Weine 2008	USA	Bosnia	FGI (9)	TAU	197	RCT		6

Abbreviations: NET: Narrative Exposure Therapy; CBT. Cognitive Behavior Therapy; TFP: Trauma Focused Psychotherapy; CROP: Culture-Sensitive Oriented Peer; FGI: Family-Group Intervention; TAU: Treatment as usual; RCT: Randomised Controlled Trial, CCT: Controlled Clinical Trial; PTSD: Posttraumatic stress disorder; CAPS: Clinician-Administered PTSD Scale; HTQ: Harvard Trauma questionnaire, PDS: Post Traumatic Stress Diagnostic scale.

doi:10.1371/journal.pone.0171030.t001

Effectiveness of NET cont.

Siehl et al. (2020)



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KIDNET: Randomized Controlled Trials with Children and Adolescents

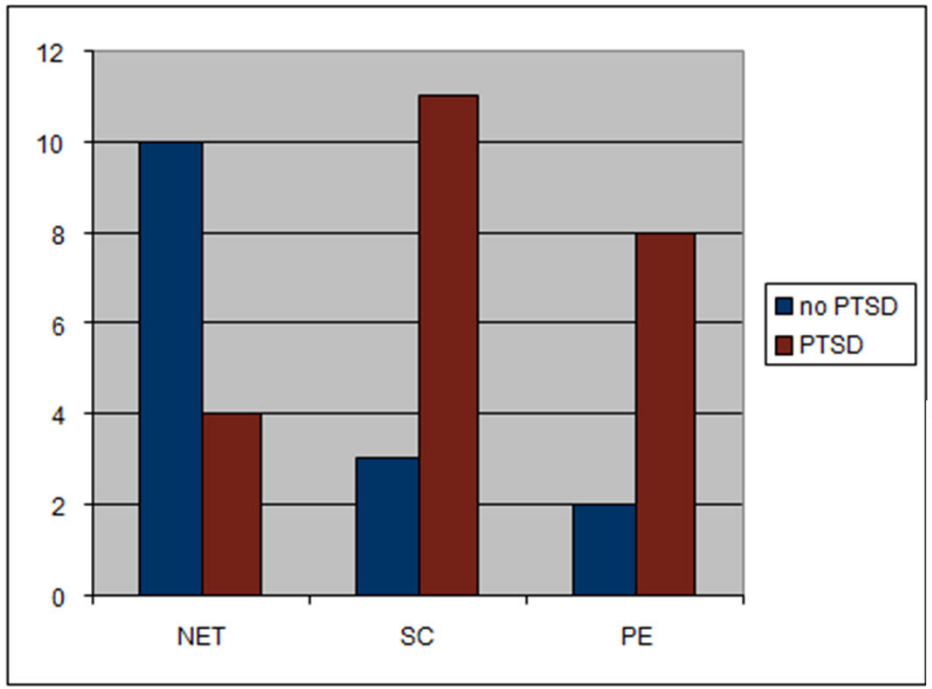
- Children with PTSD of asylum seekers in Germany

  Ruf et al., Journal of Traumatic Stress (2010)

PTSD severity (UPID score)	pre	6 months post	1 year follow-up
KIDNET *Effect sizes*	42.33	18.08 *d= 1.85*	18.92 *d=1.74*
Waiting-list	38.31	33.77	

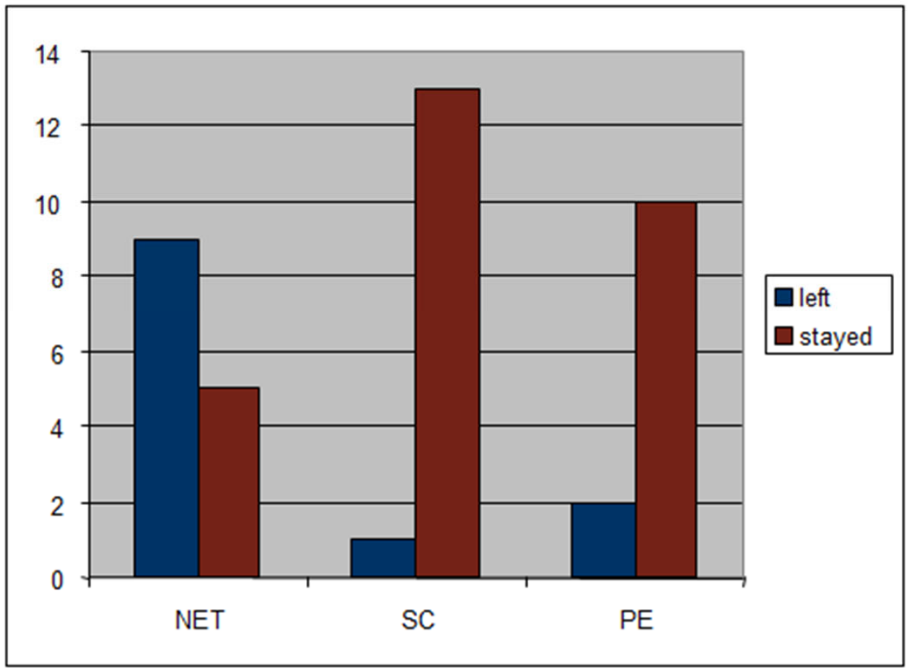
- Tamil children traumatized by war and Tsunami treated by trained local counsellors (former school teachers) *Catani et al. (2009), BMC Psychiatry*
- Former child soldiers treated by local counsellors *Ertl et al. (2011), JAMA*

NET with Sudanese Refugees Imvepi Camp, Uganda



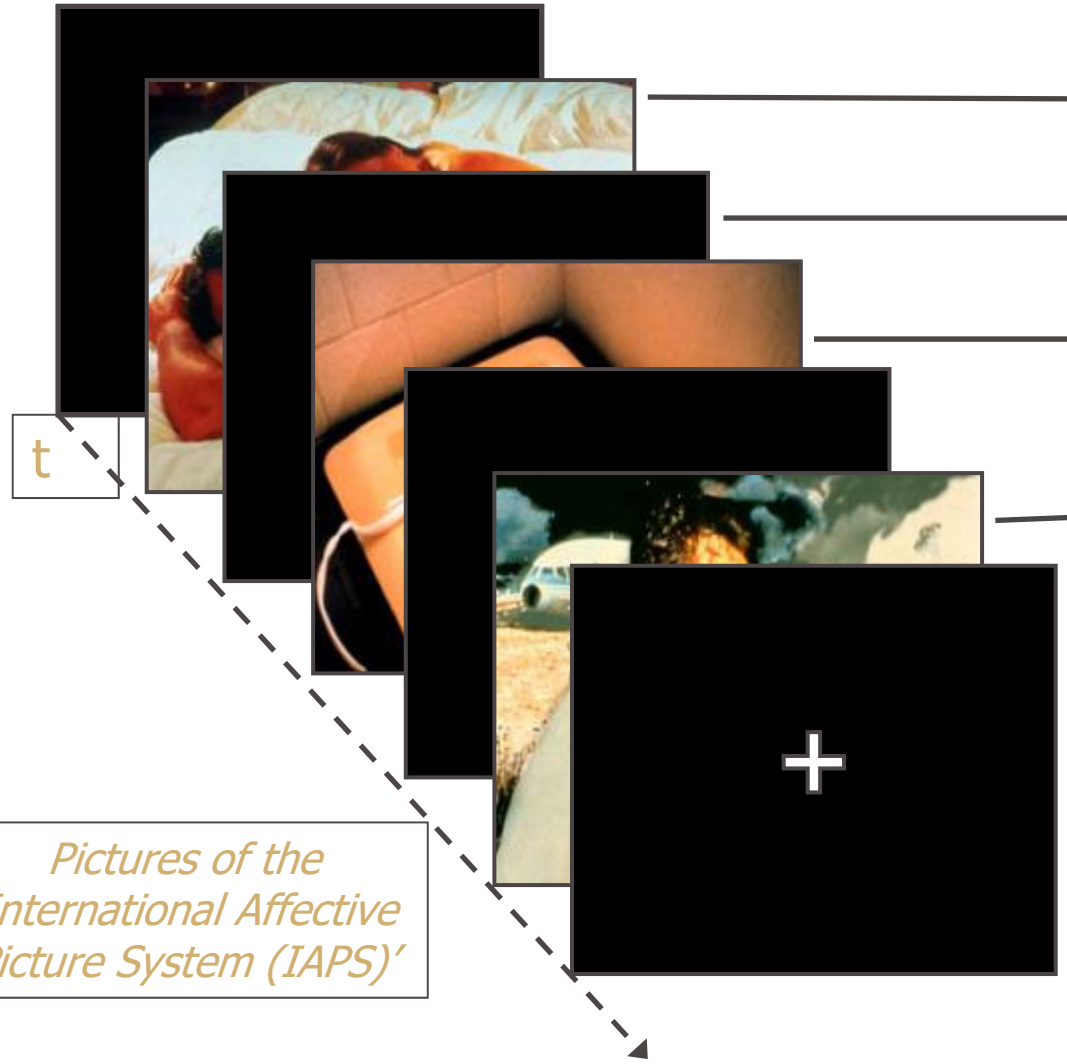
PTSD diagnosis:
1 year follow up

"leaving the camp"



Neuner et al., JCCP 2004

Affective Picture Processing in PTSD



Pleasant picture (4 s)

ISI & fixation (6-8 s random)

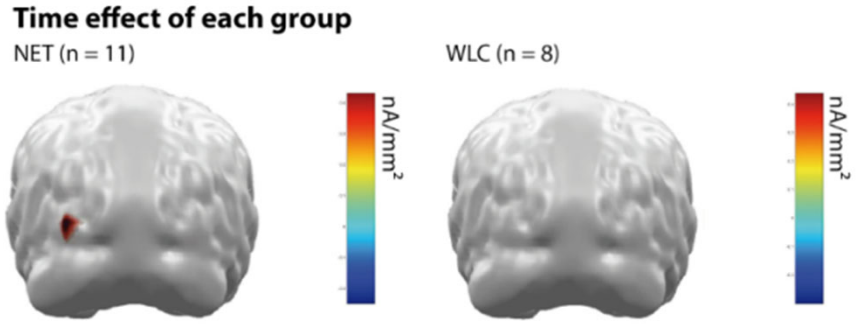
Neutral picture (4 s)

Unpleasant picture (4 s)

Pictures of the 'International Affective Picture System (IAPS)'

Pictures are presented in a flickering mode of 10 Hz
(40 on-off cycles) each

Effects of NET on the Brain

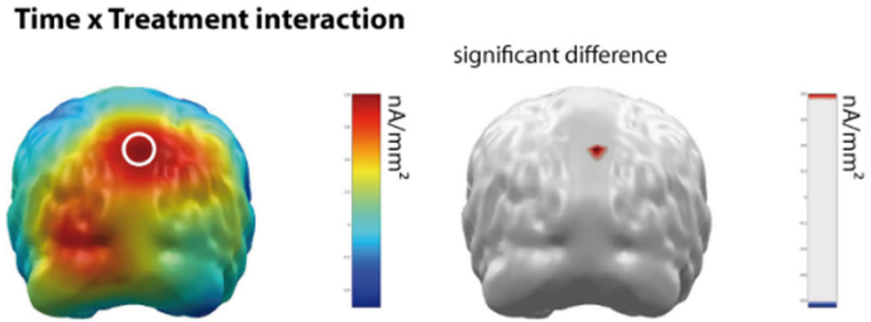


Changes within the group (pre-post):

Significant increase of left occipital activity selectively towards threatening cues

NET vs Waiting-list:

Significant increase of superior-parietal activity in the NET group selectively towards threatening pictures.



(Adenauer et al., BMC Neuroscience, 2011)

Processing of Aversive Stimuli in PTSD

- rapid and strong reaction of the autonomic nervous system
- very early frontal activation ("alarm")
- Reduced processing in posterior brain areas ("avoidance")

Narrative Exposure Therapy

- enhanced activation in occipital cortical areas
  ➔ increased visual processing

- enhanced activity in parietal areas
  ➔ selective attention and episodic memory retrieval – evaluation of the situation by taking into account the actual context
  ➔ reduction of the fear response

Refugees Becoming Therapists

- Therapies with Sudanese and Rwandese refugees in Nakivale Refugee Camp, Uganda
- Training of refugees without any medical/ psychological background as NET therapists
- Randomized controlled trials comparing NET, "Trauma Counseling" and a "Monitoring Group"

(Neuner et al. 2008)

Kaltenbach *et al. BMC Psychiatry* (2020) 20:312
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BMC Psychiatry

RESEARCH ARTICLE Open Access

Trajectories of posttraumatic stress symptoms during and after Narrative Exposure Therapy (NET) in refugees

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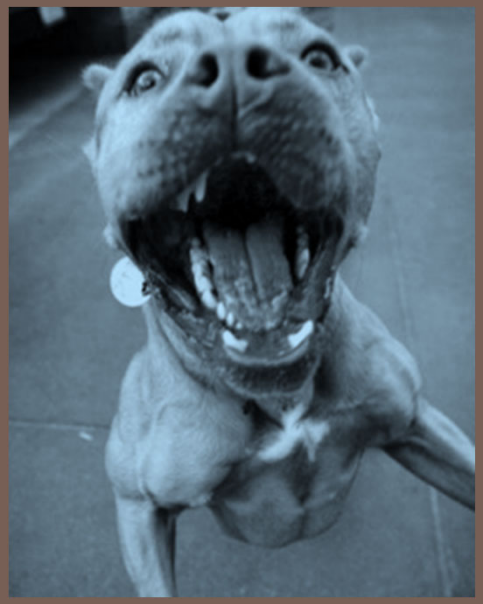
vivo international



Traumatic Stress and Posttraumatic Stress Disorder

Etiological Model and Diagnostic Aspects

Traumatic Event (DSM-5) Criterion A. Stressor

- Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following:
  - Direct experience
  - Witnessing, in person
  - Indirectly (to close family member or friend)
  - Repeated/extreme indirect exposure to aversive details:
    - Through professional duties (e.g. first responders, treatment providers)
    - Not via media, TV, movies etc.

Source: APA, 2013

The Function of Fear

- Brain takes cues from environment and activates body for an appropriate response to potential danger/threat
- Quick response to threat is evolutionarily adaptive
- Brain triggers the secretion of stress hormones and prepares body system for rapid (alarm) response to threat:
  - FLIGHT or FIGHT

https://www.youtube.com/watch?v=i3aqHe02aPo

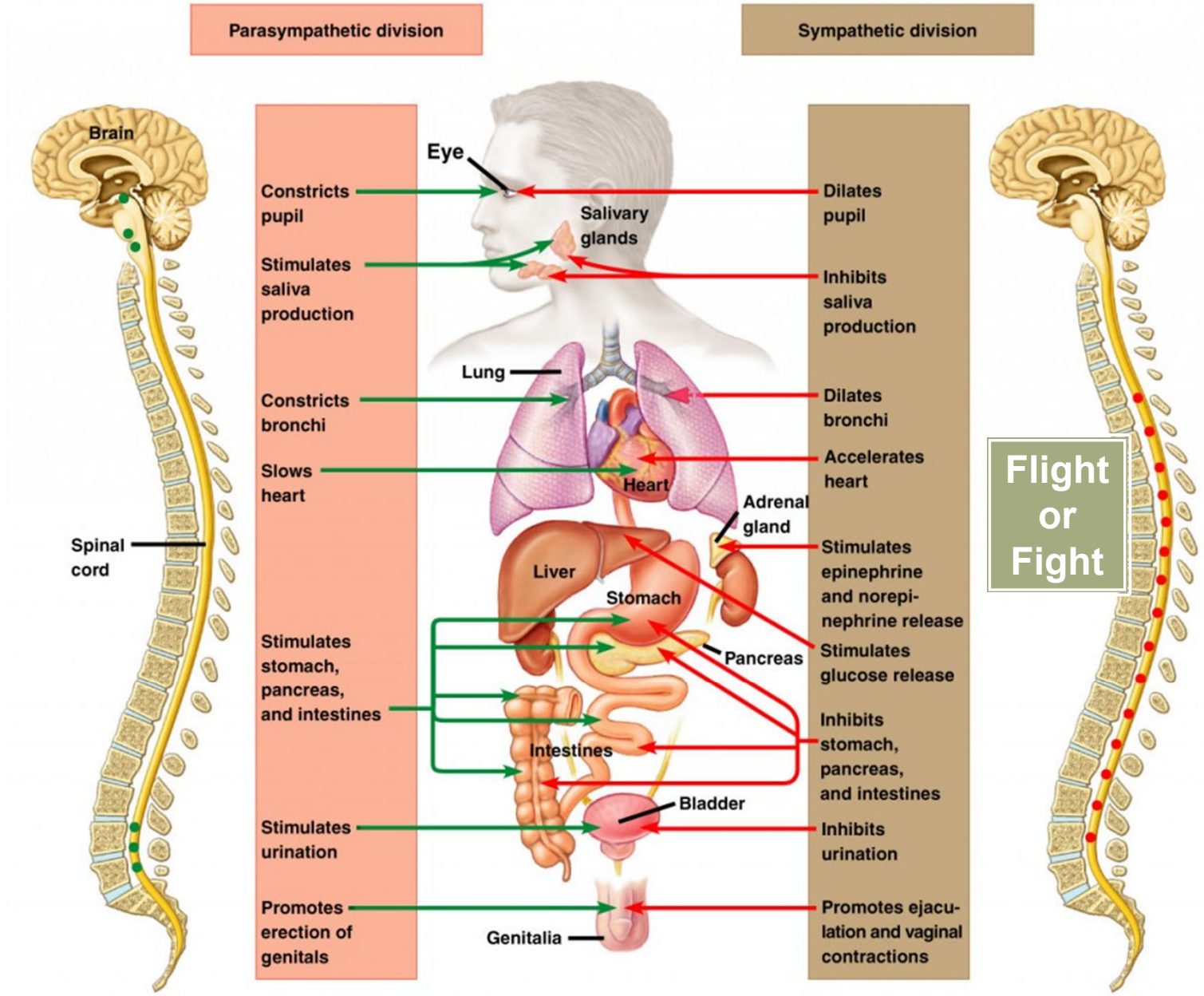
https://www.youtube.com/watch?v=17LdW2KQCSE

Key Brain Structures

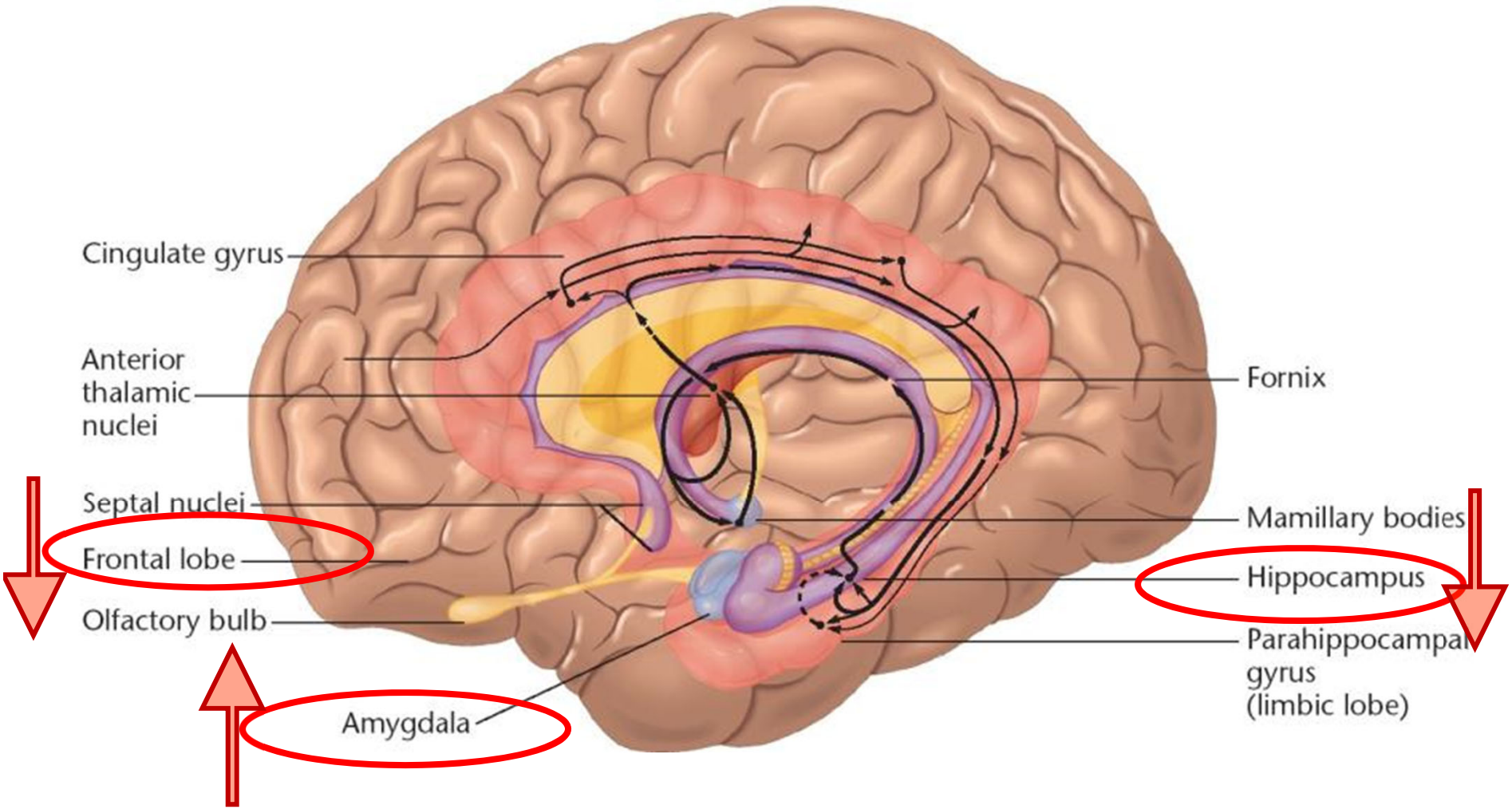
- *Thalamus:* relay station between midbrain to cortex, sleep/wake, arousal
- *Hypothalamus:* Central to neuroendocrine functioning, hormones, HPA Axis activation
- *Association cortex:* higher order cognition, complex
- *Prefrontal cortex:* executive functions, personality, emotion regulation
- **Hippocampus**: episodic memory (autobiographical), consolidation of short-term to long-term memory
- **Amygdala**: emotion facilitated memory, memory consolidation
- *Anterior cingulate gyrus:* modulates emotional expression

Slide credit: Mandi Burnette, PhD, University of Rochester

The Alarm Response to Stress



(Suggested) Effects of Stress/Trauma on Brain Structures



Remembering the Trauma

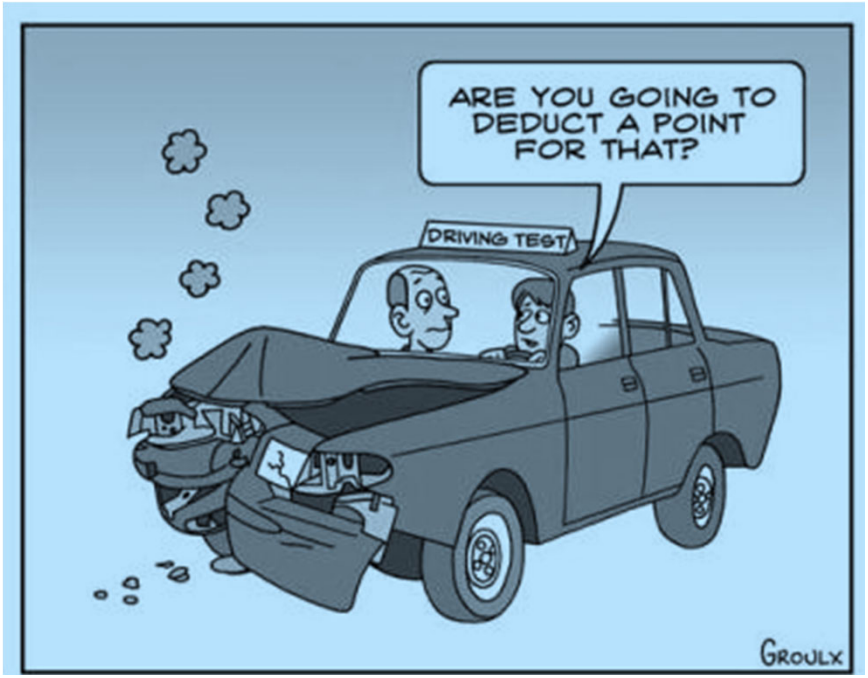
Formulate a short narrative about one of the following topics

"First time I rode a bicycle …"

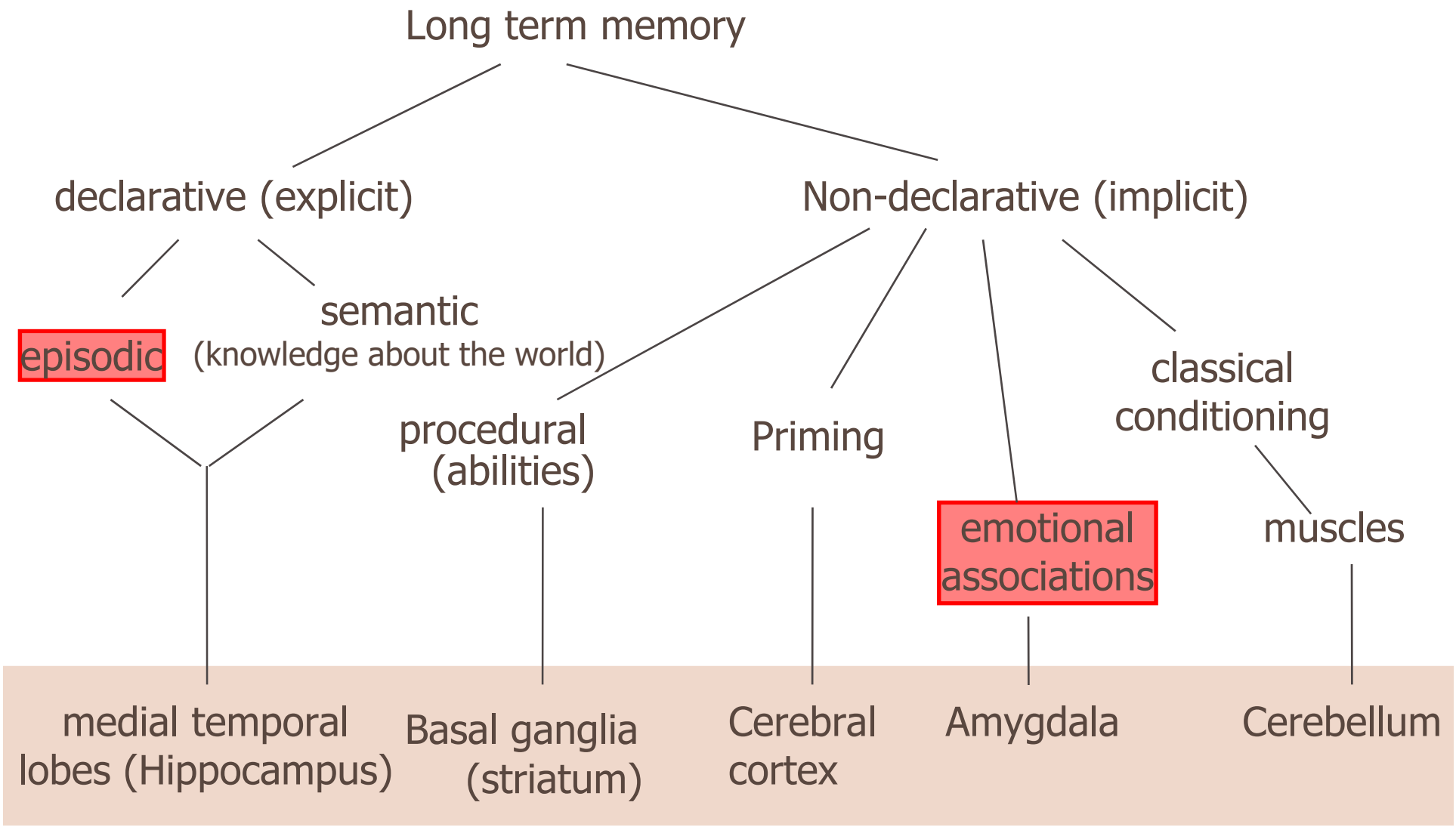
"First time I drove a car/ driving license exam…"

"My first public presentation…"

"My first romantic kiss …"



Taxonomy of Memory



Memory Theory

Non-declarative memory (Hot Memory)

- Automatically activated by cues
- Sensory, emotional & physiological perceptions
- Fragmentary reports
- Sensation of "Here and Now"

Amygdala

Declarative memory (Cold memory)

- Deliberately retrievable
- Knowledge about the event in the context of life, time & space
- Chronological report

Hippocampus

Autobiographic Memory

Knowledge about life time periods

Knowledge about general events

Knowledge about specific events

Cold Memory

Event specific emotional-sensory network

Hot Memory

Narration

Knowledge about…

I can remember that it was a warm day in spring. It was near my parent's house, someday in the 80s, I was not yet going to school. I had a blue bike, it was a friend's bike who lived next to us at this time. My father was pushing me and I can remember well the feeling I had when I started rolling on my own.

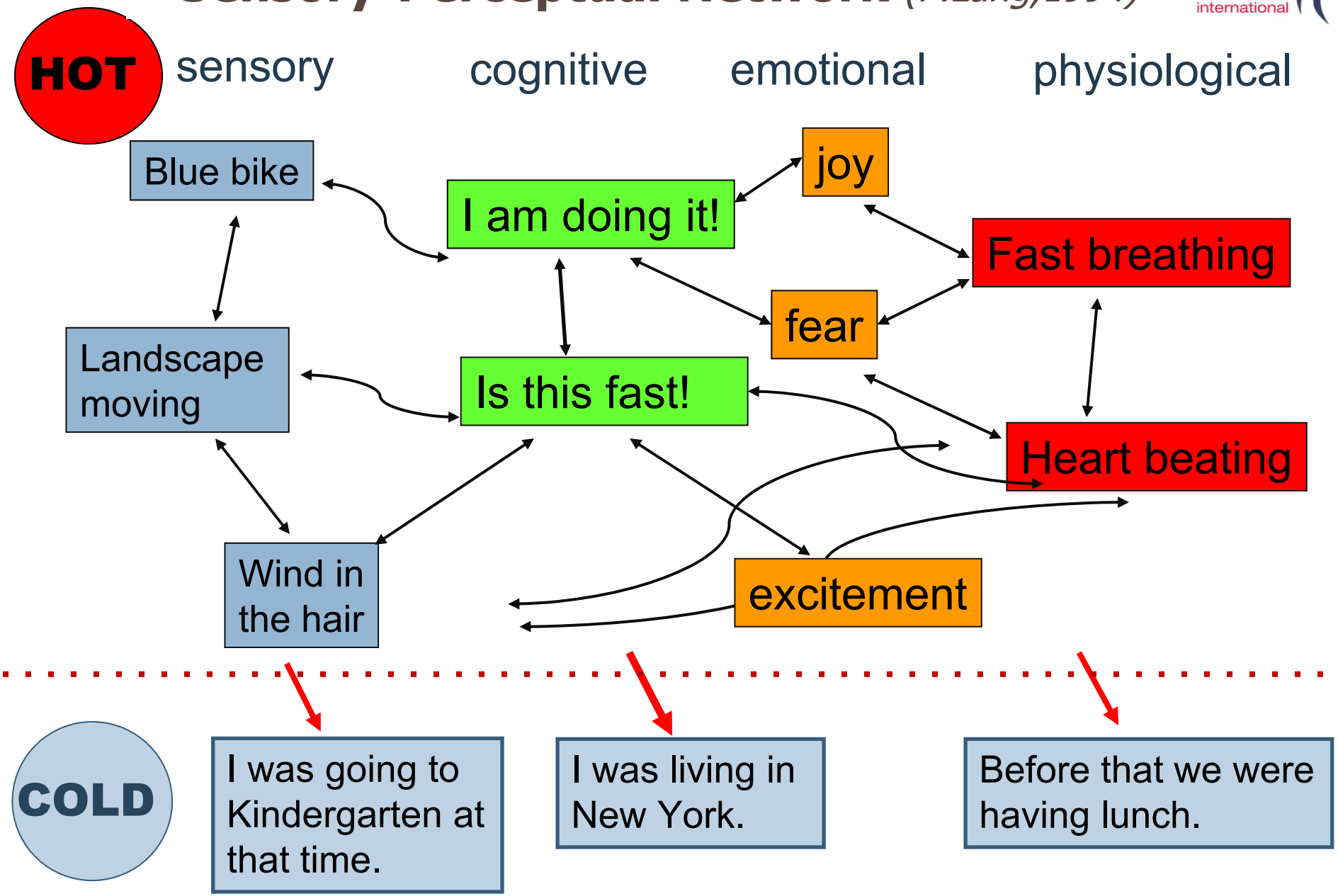
Lifetime periods

General Events

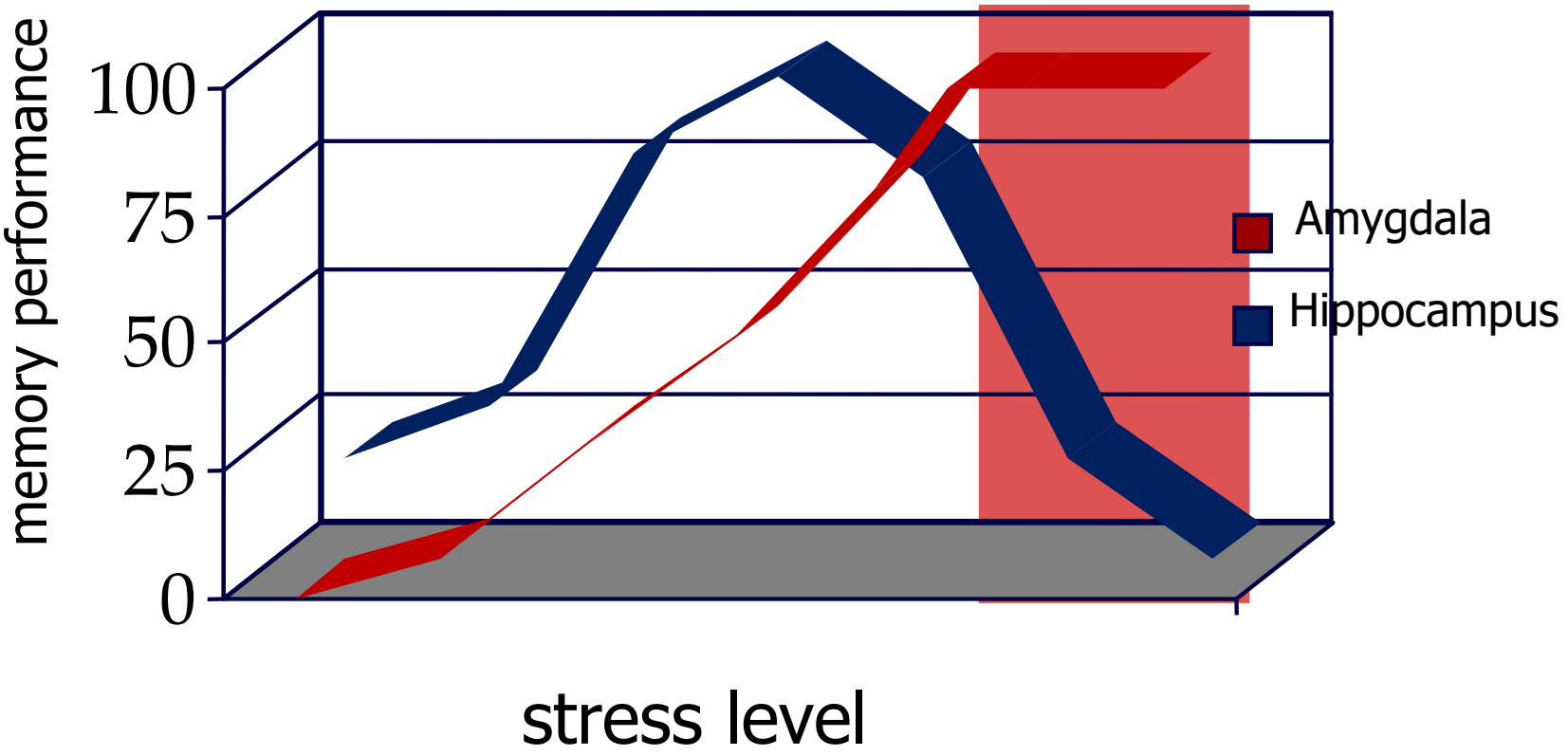
Specific event

Emotional/Sensory Network

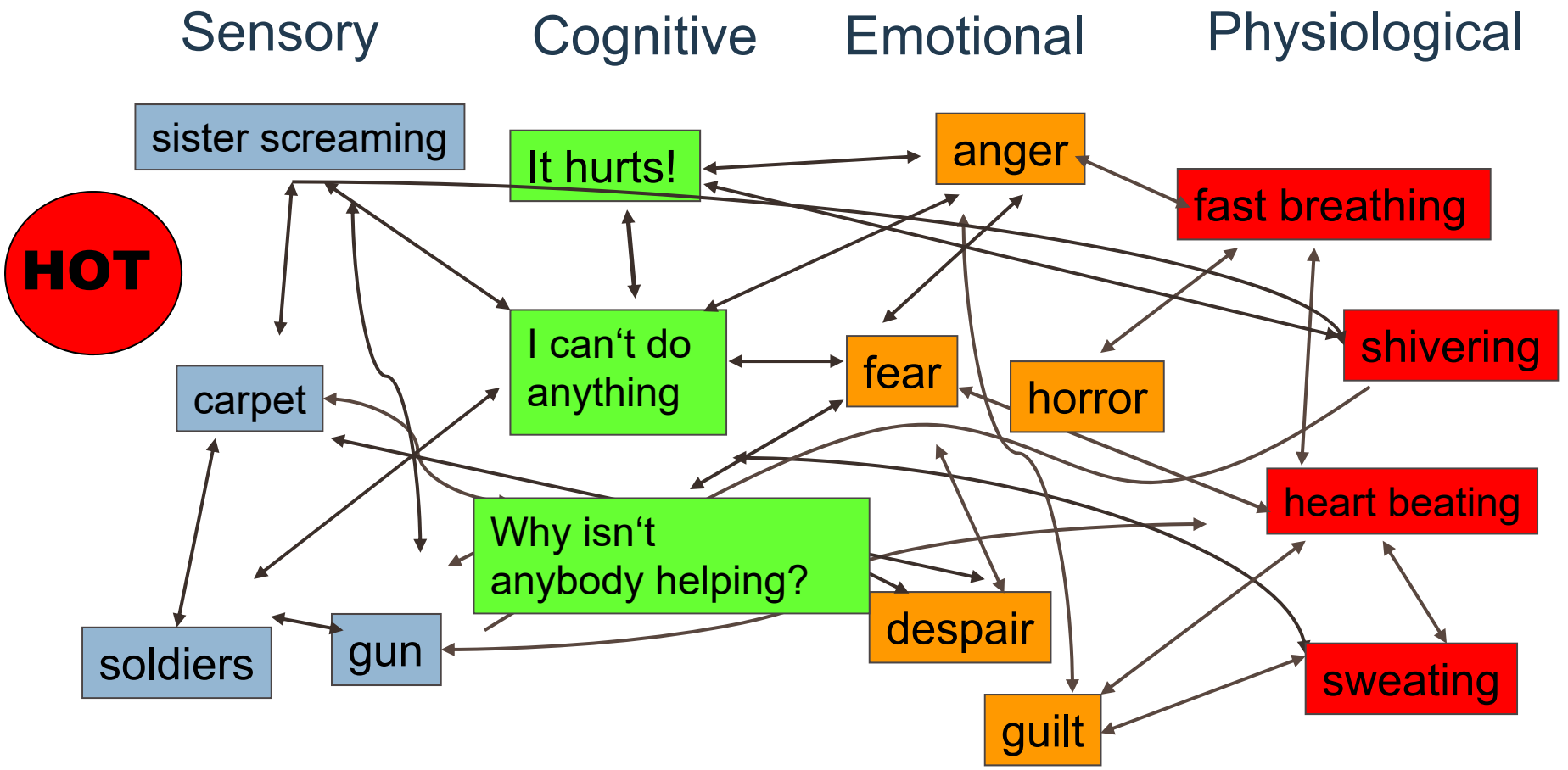
Sensory-Perceptual Network *(P.Lang,1994)*



Stress and Memory



Fear Network of a Traumatic Event



COLD

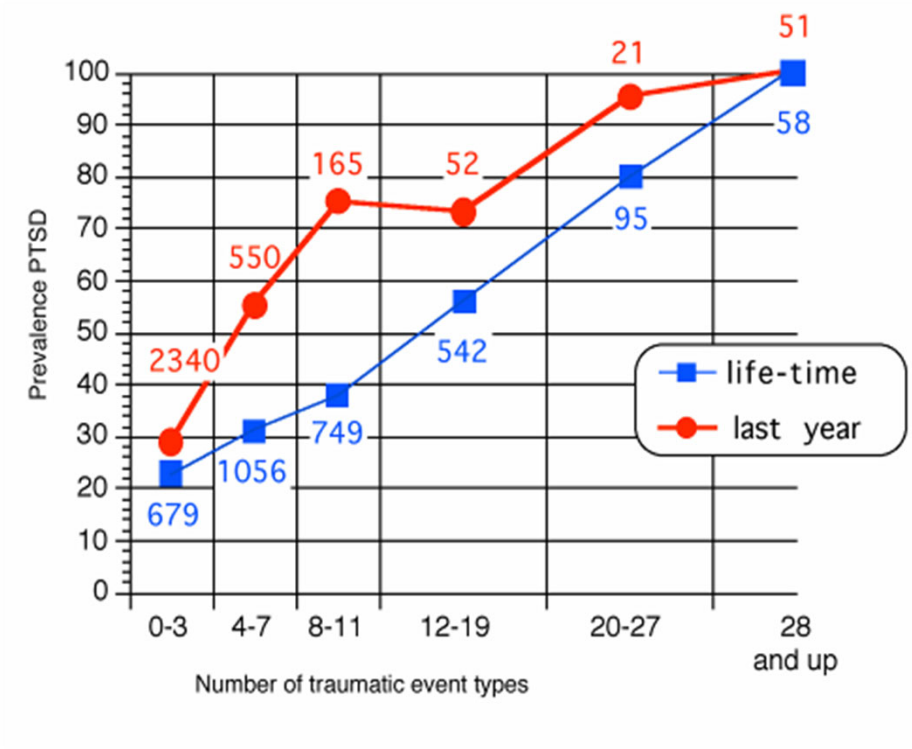
I was living in Mogadishu.

It happened during the afternoon.

Before that I’ve been to school.

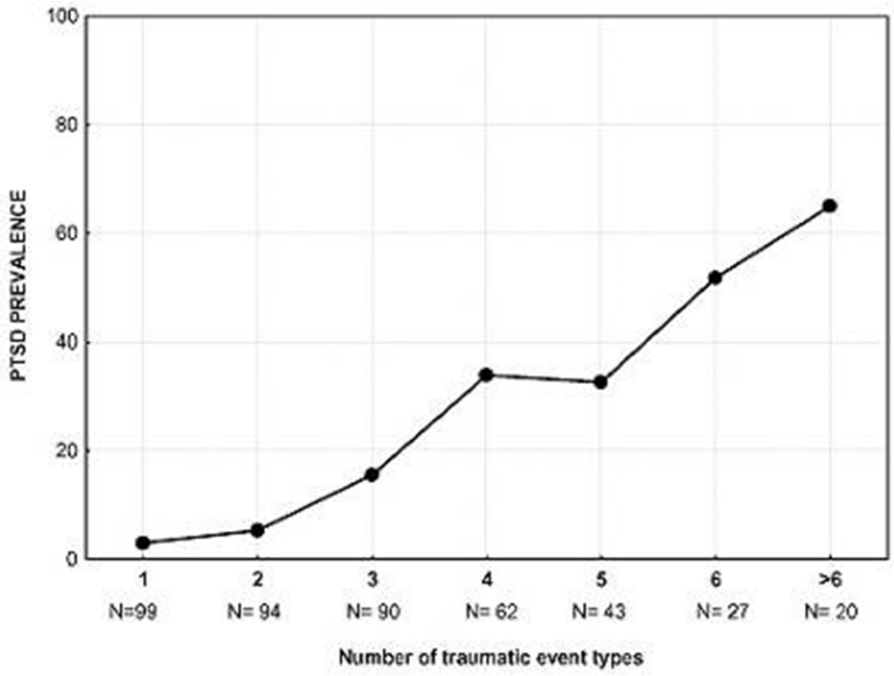
Source: Vivo (2013)

Dose-Effect of Traumatic Stress



Sudanese refugees, Imvepi refugee camp, Uganda

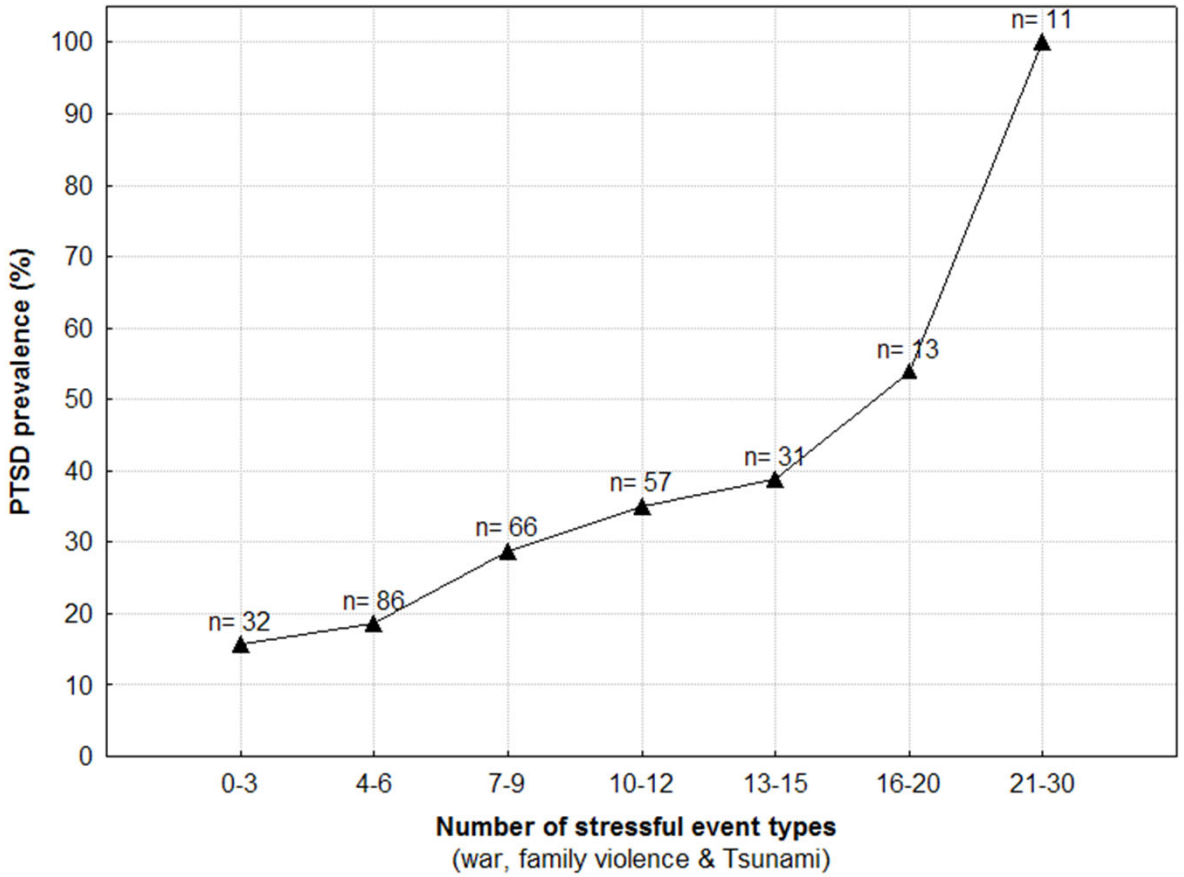
(Neuner et al. 2004, BMC Psychiatry)



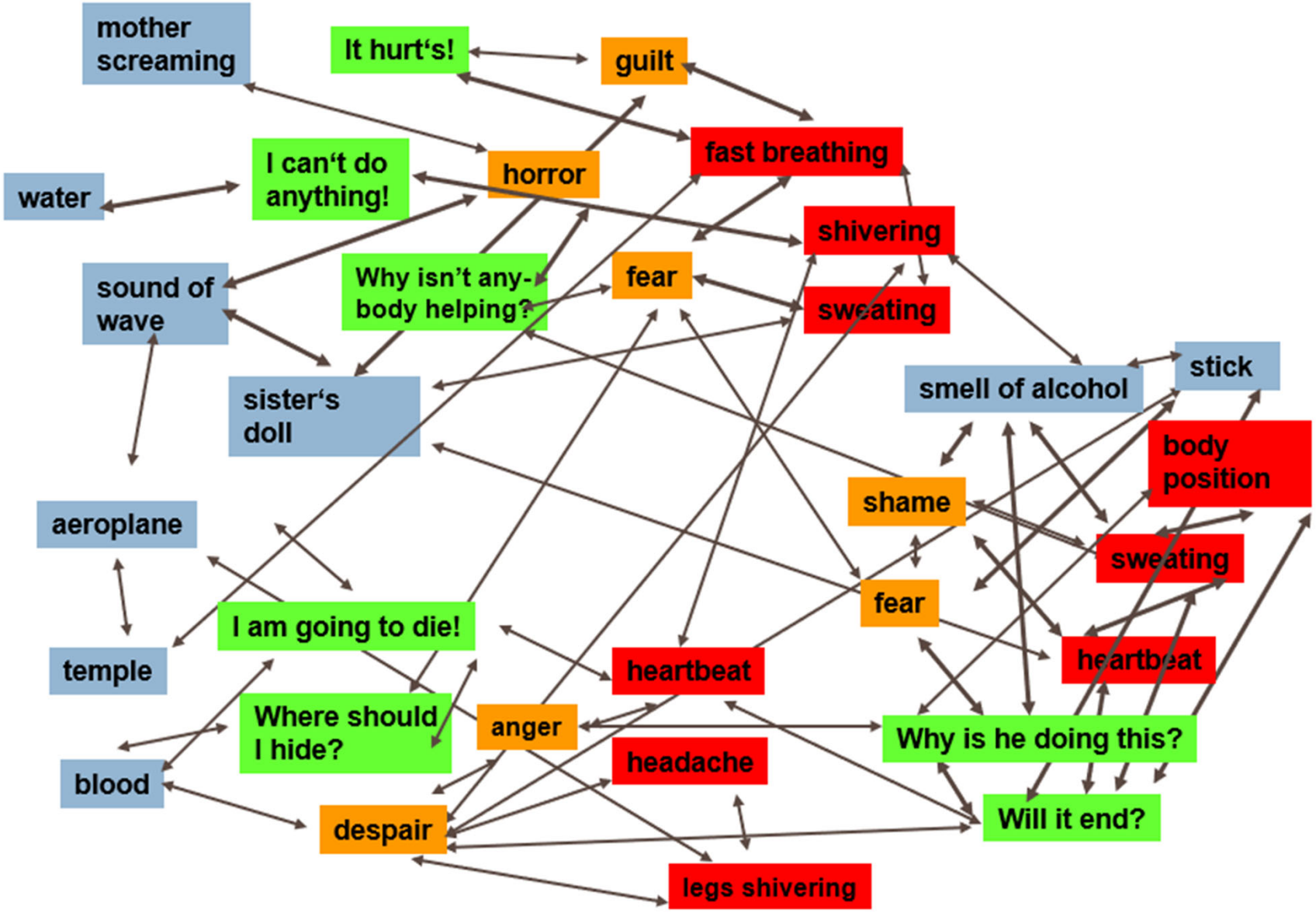
Tamil school children, North-East Sri Lanka

(Catani et al., 2005, ESTSS)

Cumulative Effect of Traumatic Events and Adverse Life Experiences



(Catani et al., 2008, BMC Psychiatry)


mother screaming
It hurt's!
guilt
fast breathing
horror
I can't do anything!
water
shivering
sound of wave
Why isn't any-body helping?
fear
sweating
stick
smell of alcohol
sister's doll
body position
shame
aeroplane
sweating
fear
I am going to die!
temple
heartbeat
heartbeat
Where should I hide?
anger
Why is he doing this?
blood
headache
despair
Will it end?
legs shivering

Posttraumatic Stress Disorder (PTSD)

- DSM-5: "Trauma-and Stressor Related Disorders"
- 8 diagnostic criteria
- Enduring reaction to trauma
- "Stuck" in this past traumatic memory

- Unable to integrate sensory, cognitive, emotional, and physiological aspects of the experience into the particular declarative memory of the event

Criterion A.

Exposure to actual or threatened death, serious injury or sexual assault through ONE of the following:

- Directly experiencing the event
- Witnessing the event in person as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)

Source: APA, 2013; Photo credit: Center for Mental Health

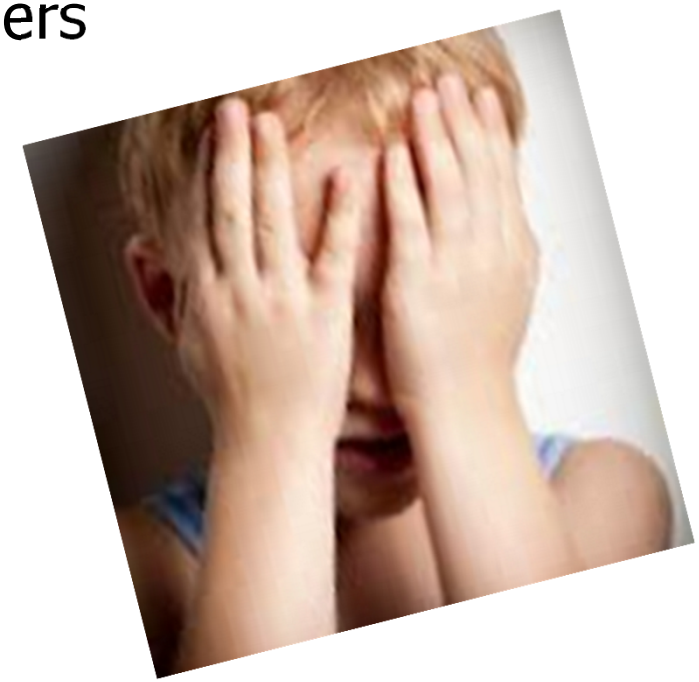
Criterion B. Intrusion Symptoms

- Event is re-experienced (at least ONE)
  - Recurrent, involuntary, intrusive memories
  - Traumatic nightmares
  - Dissociative reactions/flashbacks
    - Vary from brief to full loss of consciousness
  - Intense distress after exposure to reminders
  - Physiological reactivity after exposure to reminders

Source: APA, 2013; Photo credit: anxietytreatmenthub.com; Slide credit: Mandi Burnette, PhD, University of Rochester

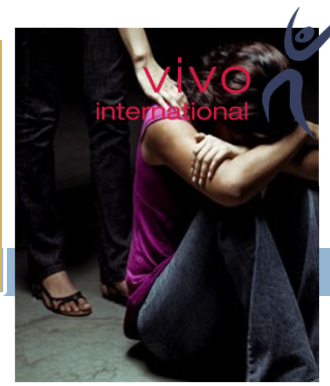
Criterion C. Avoidance Symptoms

- Persistent effortful avoidance of distressing trauma-related stimuli (at least ONE)
  - Trauma-related thoughts or feelings
  - Trauma-related external reminders (e.g., people, places, things)



Source: APA, 2013; Photo credit: Psychcentral.com
Slide credit: Mandi Burnette, PhD, University of Rochester

Criterion D. Negative Alterations in Cognition & Mood



- Negative alterations in cognitions and mood that began or worsened after the trauma (at least TWO)
  - Inability to recall key features of event (not due to head injury, alcohol or drugs)
  - Persistent (often distorted) negative beliefs and expectations about oneself and the world
  - Feeling alienated from others
  - Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, shame)
  - Markedly diminished interest
  - Constricted affect: inability to experience positive emotions

Source: APA, 2013; Photo credit: anxietytreatmenthub.com; Slide credit: Mandi Burnette, PhD, University of Rochester

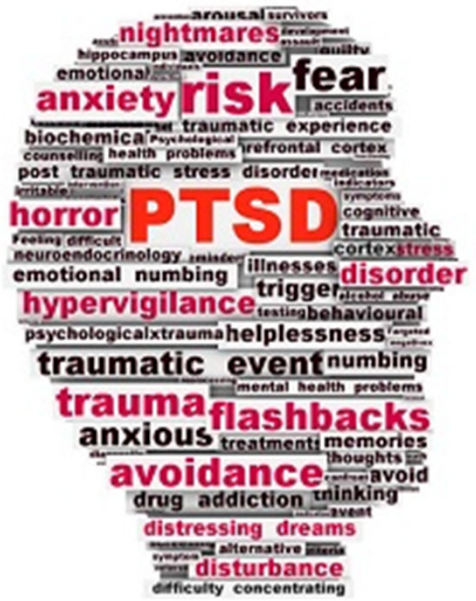
Criterion E. Alterations in Arousal and Reactivity Symptoms

- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (at least TWO)
  - Irritable or aggressive behavior
  - Self-destructive or reckless behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems in concentration
  - Sleep disturbance

Source: APA, 2013; Photo credits:Psychcentral.com
Slide credit: Mandi Burnette, PhD, University of Rochester

Other Criteria

- **Criterion F.** Duration of symptoms is more than 1 month.
- **Criterion G**. Causes clinically significa distress or impairment in the individua
  - social interactions
  - capacity to work
  - or other important areas of functioning.
- **Criterion H**. Not the physiological res of another medical condition, medicati drugs or alcohol.



Source: APA, 2013; Slide credit: Mandi Burnette, PhD, University of Rochester

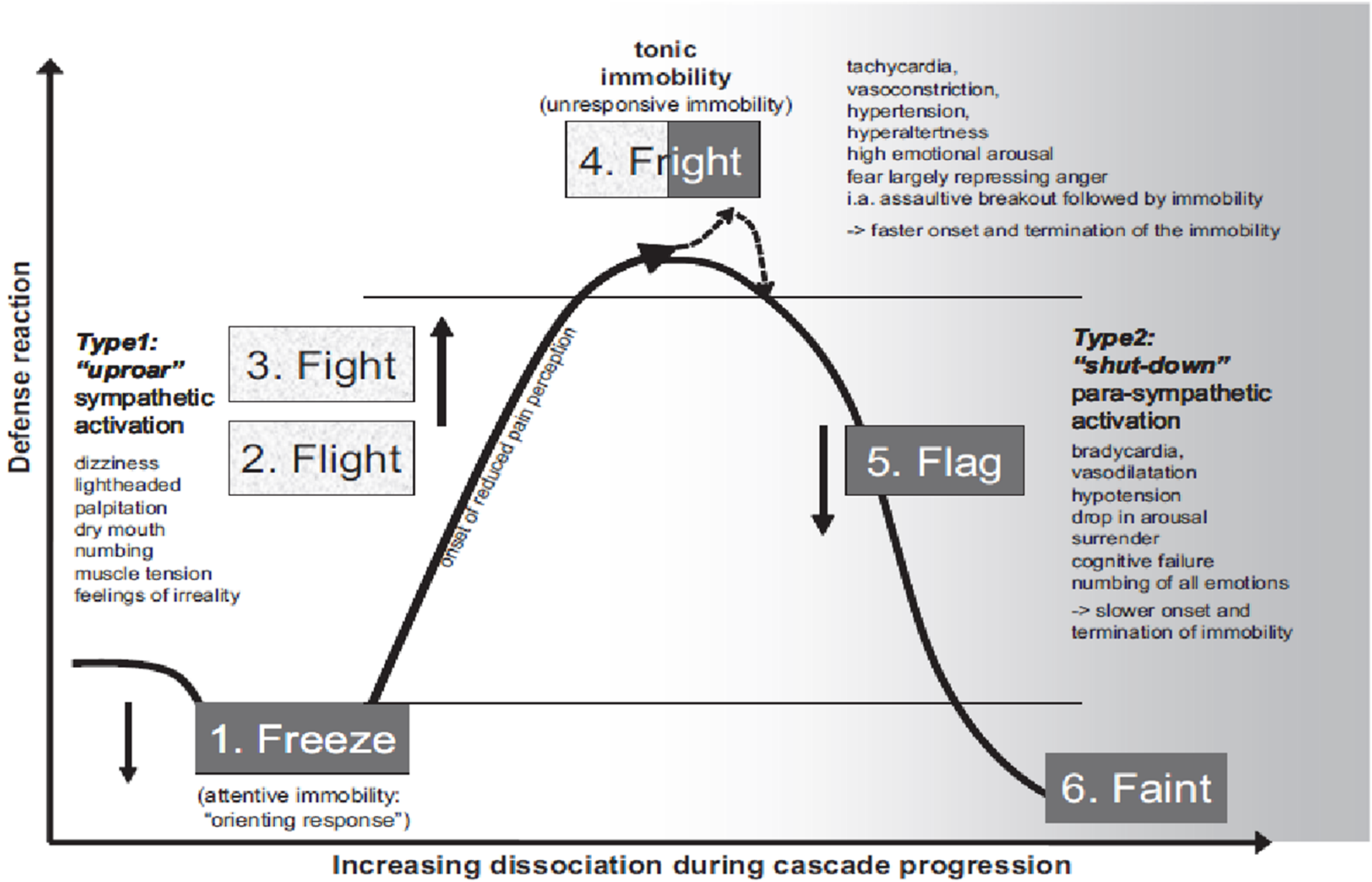
Specify whether…

- With dissociative symptoms:
  - Depersonalization: experience of being outside observer of or detached from oneself (feeling as if this were a dream)
  - Derealization: experience of unreality, distance, or distortion
- If happens more than 6 months after trauma – called *delayed expression*

Source: APA, 2013; Photo credit: anxietytreatmenthub.com; Slide credit: Mandi Burnette, PhD, University of Rochester

The Defense Cascade

Schauer & Elbert (2010). Dissociation Following Traumatic Stress, Journal of Psychology



Characteristics of Events That May Elicit Dissociative Fright, Flag, or Faint

- Imminence of threat/aggressor and total helplessness (e.g., direct body contact with perpetrator, being constrained, and danger of skin penetration by sharp objects
- Rapid arousal peak and startle response due to unexpected and sudden proximity of threat or aggressor
- Presence of fresh blood or mutilated bodies
- Being contaminated and contact to infectious material (e.g., body fluids, sperm, feces)
- Anal, vaginal, or oral penetration of the victim
- Severe pain being inflicted on the victim

(Schauer & Elbert, 2010)

PTSD Prevalence Rates in the U.S: The National Comorbidity Survey (NCS)

(Kessler et al., 1995; NCS, Kessler et al., 2008)

	Women	Men
"lifetime prevalence" (7.8% on average)	10.4 %	5.0 %
development of PTSD after confrontation with a traumatic event (depending on trauma type)	20.4% up to 48.8% (rape)	8.2 % up to 38.8% (war combat)
most frequent trauma types	- sexual violence - physical assault - being threatened with a weapon - childhood physical abuse	- participation in a combat situation - childhood physical abuse
Comorbid disorders present?	79%	83%
Types of comorbid disorders	anxiety disorders, substance abuse, mood disorders	

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PTSD in Survivors of Organized Violence

Population	*n*	PTSD
Sudan	664	49%
Uganda	1419	19%
Sudanese refugees in Uganda	1240	48%
Rwandese refugees in Uganda	959	31%
Somali refugees in Uganda	527	51%
Tamil children in Sri Lanka	425	24%
Sri Lankan children after Tsunami	265	18 - 41%
Afghan children in Kabul	287	19%
Asylum seekers in Germany	40	40%
Children of Asylum seekers in Germany	120	20%

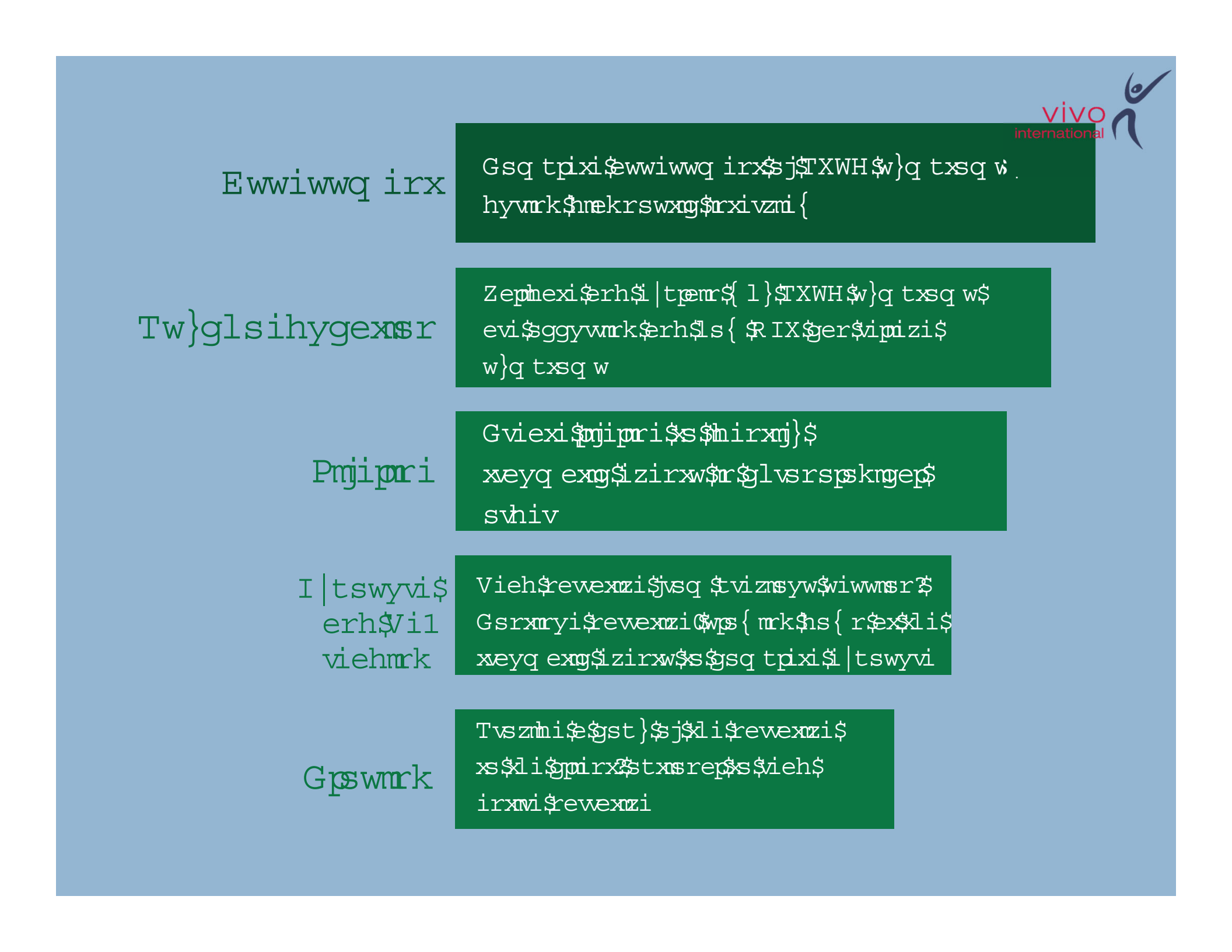
Disorders Frequently Comorbid with PTSD in Adults (National Comorbidity survey)

diagnosis	lifetime prevalence (women vs men)
major depressive disorder	48%
dysthymia	22%
GAD	16%
simple phobia	30%
social phobia	28%
panic disorder	13 vs 7 %
alcohol abuse	28 vs 52 %
drug abuse	27 vs 35%
conduct disorder	15 vs 43 %

Kessler et al. (1995)

TREATMENT OF PTSD with NET

Overview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Diagnostic Assessment

Assessing PTSD in Adults

Self-report measures

Impact of Event Scale (IES)

Impact of Event Scale – revised (IES-R)

Posttraumatic Stress Diagnostic Scale (PDS)

Penn Inventory for Posttraumatic Stress

Clinical Interview (specific for PTSD)

Clinician Administered PTSD Scale (CAPS)

Structured Interview for PTSD (SI-PTSD)

PTSD Symptom Scale-Interview

Tools for specific populations:

Mississippi Scale for Combat-Related PTSD

PTSD-Scale – Military

Standardized Clinical Interview (general)

Composite International Diagnostic Interview (CIDI)

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID)

Mini International Neuropsychiatric Interview (M.I.N.I.)

Assessing PTSD in Children

PTSD Instruments

Self report: UCLA Child PTSD Index (UPID)

PTSD interview: CAPS-CA

Clinical Interview: M.I.N.I. KID

Instruments to assess childhood trauma (family violence)

- Early Trauma Inventory – ETI (Bremner, 2000)
- Childhood Trauma Questionnaire – CTQ *(Bernstein, 1994)*
- Conflict Tactics Scales Revised – CTS *(Murray Strauss)*
- Event Checklist for Family Violence *(Catani, 2008)*

Posttraumatic Stress Diagnostic Scale (PDS-5)

- 49 item self-report instrument based on the DSM-IV diagnostic criteria for PTSD
- allows diagnosis of PTSD and provides a severity rating of PTSD symptoms

DSM IV – Diagnosis

1) Event list
2) Worst Event & A-Criterium
3) Criteria B, C & D:
   - Intrusions (5 Items)
   - Avoidance (7 Items)
   - Hyperarousal (5 Items)
4) duration & onset of symptoms
5) level of impairment in functioning

Severity rating

Frequency of symptoms:

0 = not at all / only one time
1 = once a week / once a while
2 = 2-4 times a week / half the time
3 = 5 or more times a week/ almost always

Cut-offs for symptoms severity rating categories:

<10	= mild
> 11 and <20	= moderate
> 21 and < 35	= moderate to severe
> 36	= severe

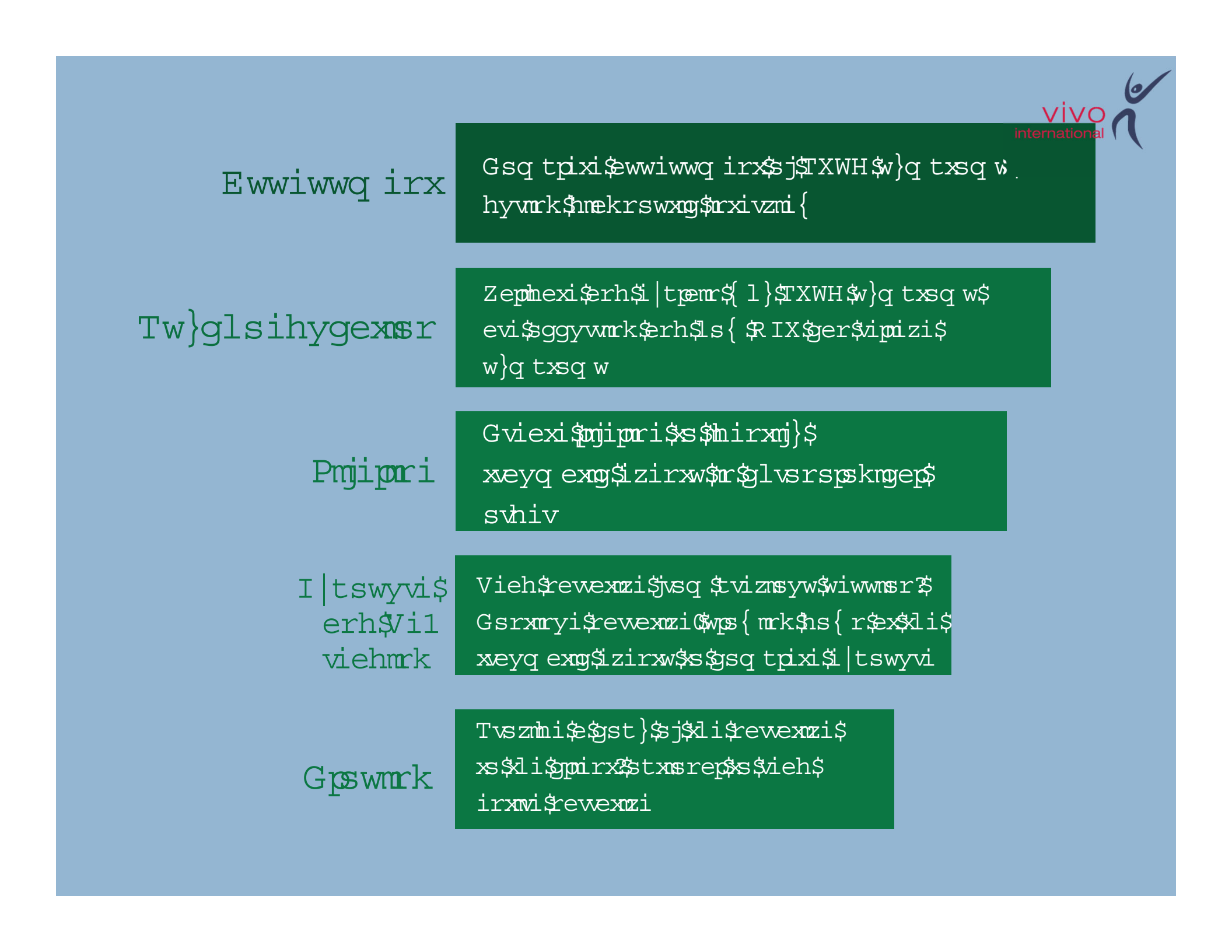
Foa et al. (1997). Psychological Assessment

Diagnostic Assessment: Tips

- Acknowledge the client's worst fear
- Sensitivity and trust
- Remember: The clinician is asking the client to take a tremendous risk and abandon avoidance and protection
- Ask clients to let you know when interview becomes upsetting
- Keep clients informed – psychoeducation, why you are doing this
- Confidentiality

TREATMENT OF PTSD

Pyschoeducation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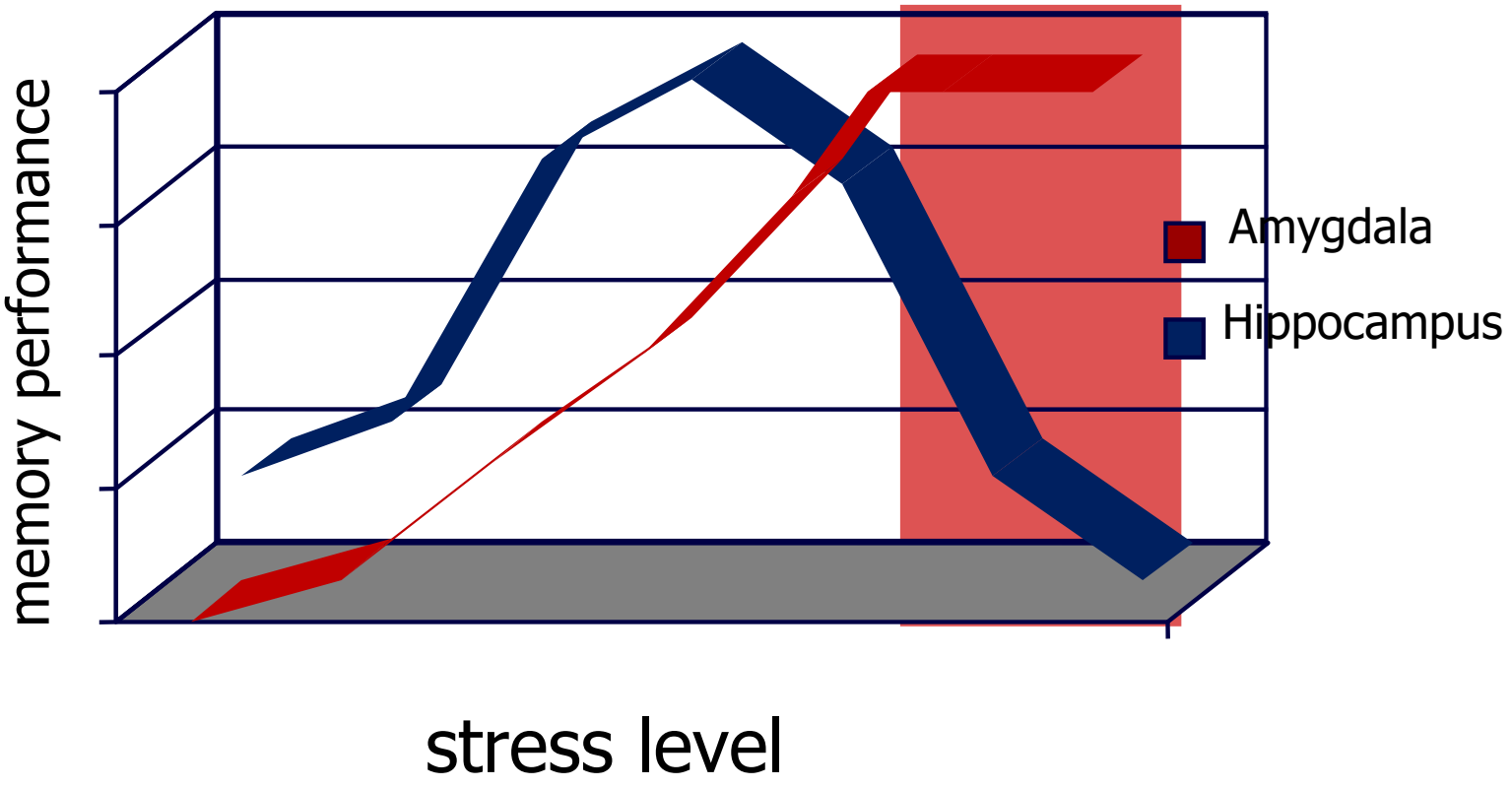
Psychoeducation

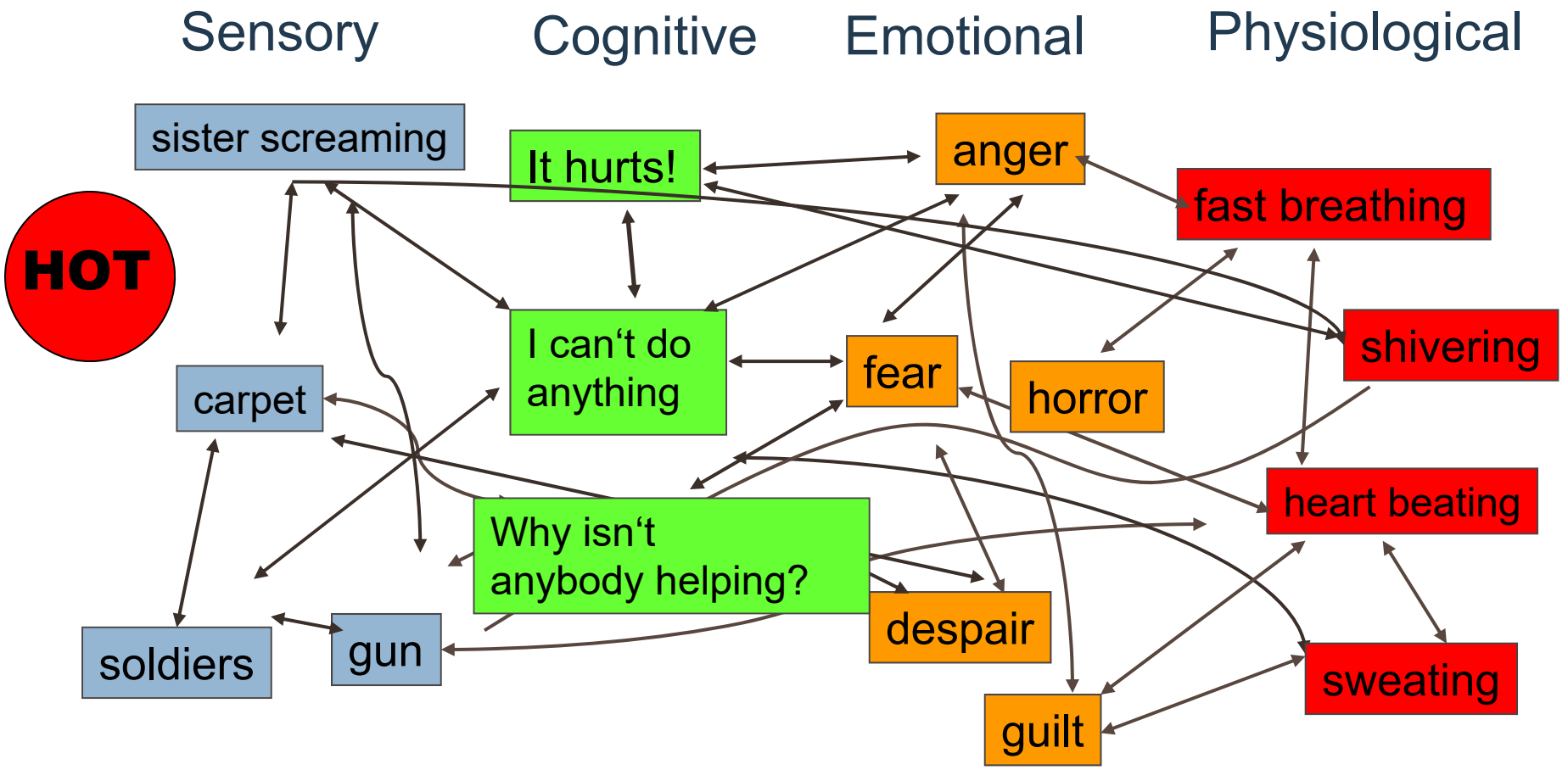
Part 1

1. What is PTSD?
   a. Connect to client's symptoms
   b. Normalize
   c. Legitimize

Stress and Memory



Fear Network of a Traumatic Event



COLD

I was living in Mogadishu.

It happened during the afternoon.

Before that I’ve been to school.

Source: Vivo (2013)

Psychoeducation

Part 2

Introduce NET

a. Explain the process, imaginative exposure, written narrative
b. 70-80% effective at decreasing symptoms
c. Symptoms may get worse before they get better
d. Some relief right away, some after 3-6 months
e. Stress importance of coming regularly and following through on process

Why does NET work? - Therapeutic Agents

- Active chronological **reconstruction** of the autobiographic/episodic memory
- Prolonged **exposure** to the 'hot spots' and full activation of the fear memory in order to modify the emotional network
- Meaningful linkage and **integration** of psycho-physiological and somato-sensory responses to the time-, space-, and life-context
- The **cognitive re-evaluation** of behavior and patterns, as well as reinterpretation of the meaning-content through reprocessing of negative, fearful and traumatic events
- Regaining of survivors dignity and satisfaction of the need for **acknowledgement**. Explicit human rights orientation of 'testifying.'

Psychoeducation on Lifeline and Exposure

- **Safety** within the client/therapist contact
- Treatment and therapist behavior is **transparent** and **predictable**
- **Physical integrity** is respected
- Therapist shows **compassion**
  - Understanding and non-judgmental acceptance
- **Confidentiality**

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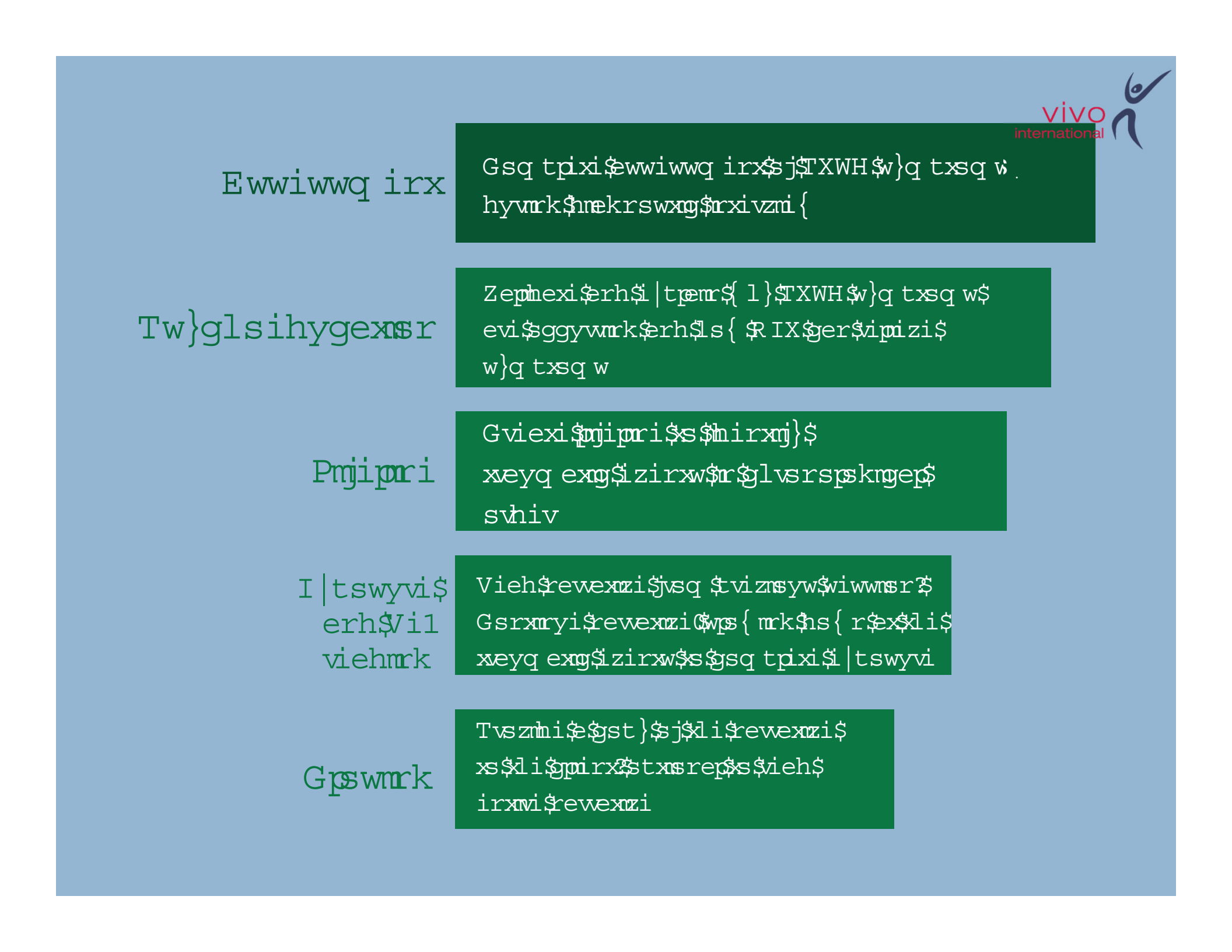
The Lifeline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Flow of sessions

Session #1:

- Assessment and psychoeducation

Session #2:

- Psychoeducation and Lifeline

Session #3 - ? (end of lifeline):

- re-read preliminary narration
- fill in more details
- continue with narration
- slow down whenever you approach a traumatic "stone"

Last session:

- re-read the entire narration for the last time (maybe add hope for the future)
- signing ritual and handing over of narration (if appropriate)

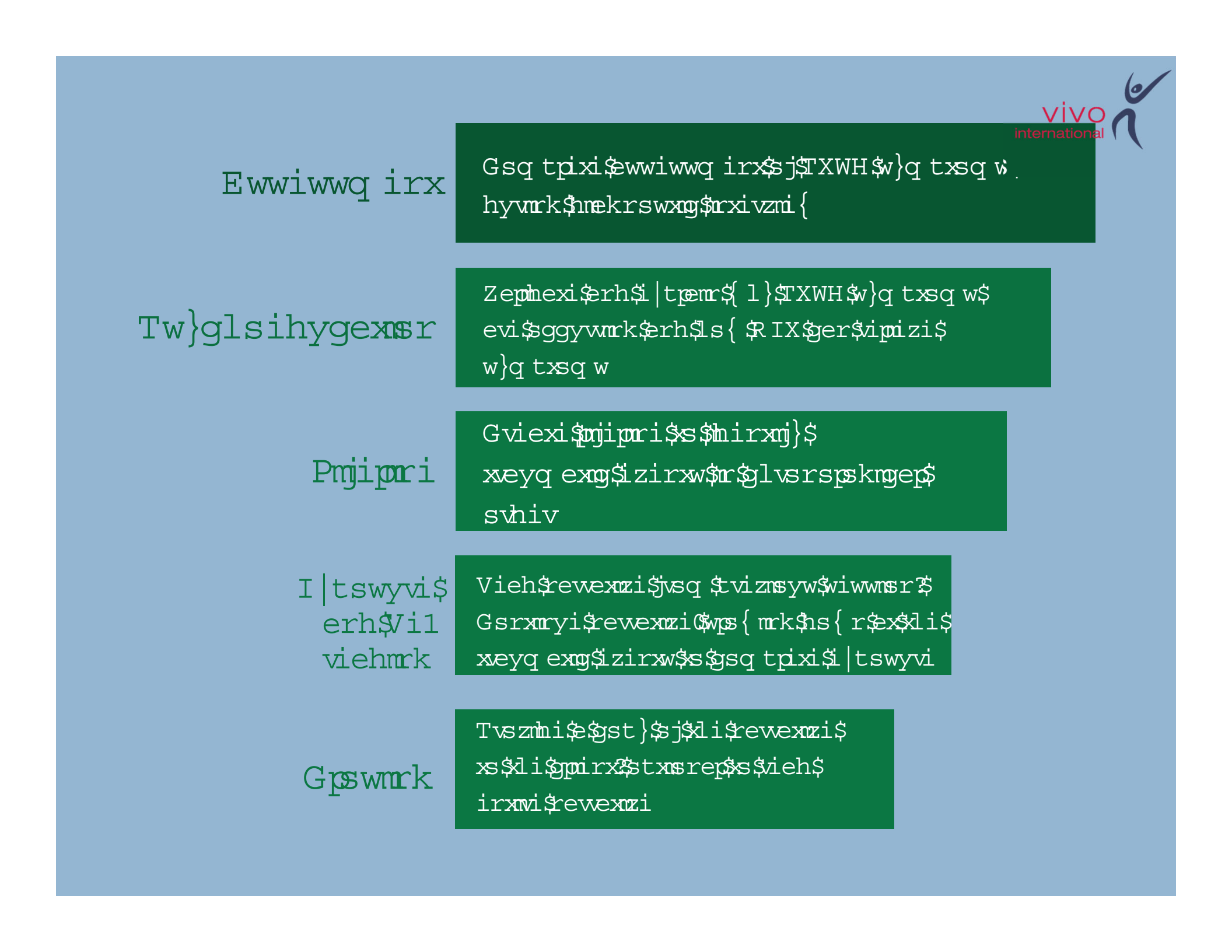
Lifeline

1. Create a “map” of significant life events on the rope, using flowers and stones to identify traumatic events in chronological order
   a. Rope as symbol of life
   b. Flowers as symbols for joyful/happy/good events
   c. Stones as symbols for horrific/painful/bad events

Lifeline

- Only asking for a “headline” for each significant event
  - No elaboration
- Ask for main thoughts and feelings of each event
  - If it is a clear traumatic event, do not ask for main thoughts and feelings b/c it risks client becoming overwhelmed/dissociating

Re-reading and Exposure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Re-reading and Exposure

1. Start at the beginning of lifeline and develop the narrative
   a. can pause briefly at non-traumatic events to ask if they would like to change or add to what was written down in the lifeline

1. Exposure: Slow down at each/most traumatic events to complete an exposure session
   a. Typically, one traumatic event exposure occurs in each NET session

1. At the following session - re-read narrative from previous exposure session and continue forward on the lifeline until the next traumatic event/exposure

Flow of sessions

Session #1:

- Assessment and psychoeducation

Session #2:

- Psychoeducation and Lifeline

Session #3 - ? (end of lifeline):

- Exposure sessions: One for each traumatic event
- 2nd exposure session and on: Re-read preliminary narration and make corrections if applicable
- Continue with narration
- Slow down whenever you approach a traumatic "stone"

Last session:

- Signing ritual and handing over of narration (if appropriate)
- Optional: Re-read the entire narration for the last time (maybe add hope for the future)

Beginning an Exposure Session

- Start to slow down and try to get a clear picture about the situation **before** the hot spot happened (e.g., two hours before)
- Know or observe that you are approaching a hot spot
  - Client becomes impatient, aroused and tries to speed up
  - Story gets fragmented

Exposure - Overview

- Create a very detailed “movie” of the event by:
  Weaving the hot and cold memories together in the hot spot

- While weaving, reinforcing reality by:
  comparing **“then” and “now”**

Exposure - Overview

- Hot Memory (Associative memory)
  - Automatically activated by cues
  - Sensory, emotional, and physiological perceptions
  - Sensation of the "here and now"
    - located in the Amygdala
- Cold Memory (Context memory)
  - Deliberately retrievable
  - knowledge about the event in the context of life, time, and space
  - Chronological report
    - located in the Hippocampus

Exposure: Integrating Cold and Hot Memory

COLD memory

Space: Where did it happen?

Time: When did it happen?

Chronology: What happened?
What happened next?

HOT memory

Cognitive: What did you think?

Emotional: What did you feel?

Physiological: How did your body react?

Sensory: What did you see smell, taste, hear?

THEN

And

Now

Exposure

- Stay in the HOT SPOT until client has experienced at least some relief
- Reinforce reality
  - Constantly compare “then” and “now”
  - Be attentive to prevent
    - ✔ Dissociation
    - ✔ Avoidance
    - ✔ Flashbacks
- If it’s supportive: May use creative tools for exploration (e.g. body position, drawings)

Flow of sessions

Session #1:

- Assessment and psychoeducation

Session #2:

- Psychoeducation and Lifeline

Session #3 - ? (end of lifeline):

- Exposure sessions: One for each traumatic event
- 2nd exposure session and on: Re-read preliminary narration and make corrections if applicable
- Continue with narration
- Slow down whenever you approach a traumatic "stone"

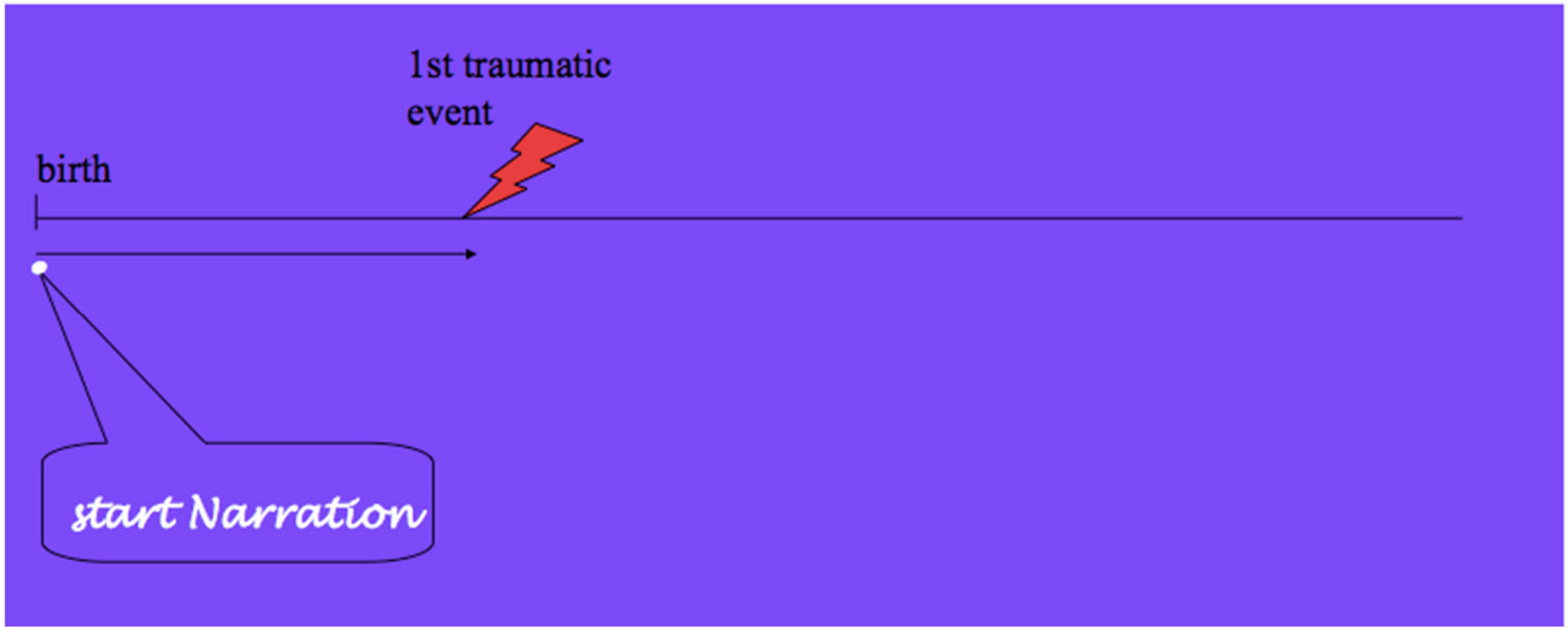
Last session:

- Signing ritual and handing over of narration (if appropriate)
- Optional: Re-read the entire narration for the last time (maybe add hope for the future)

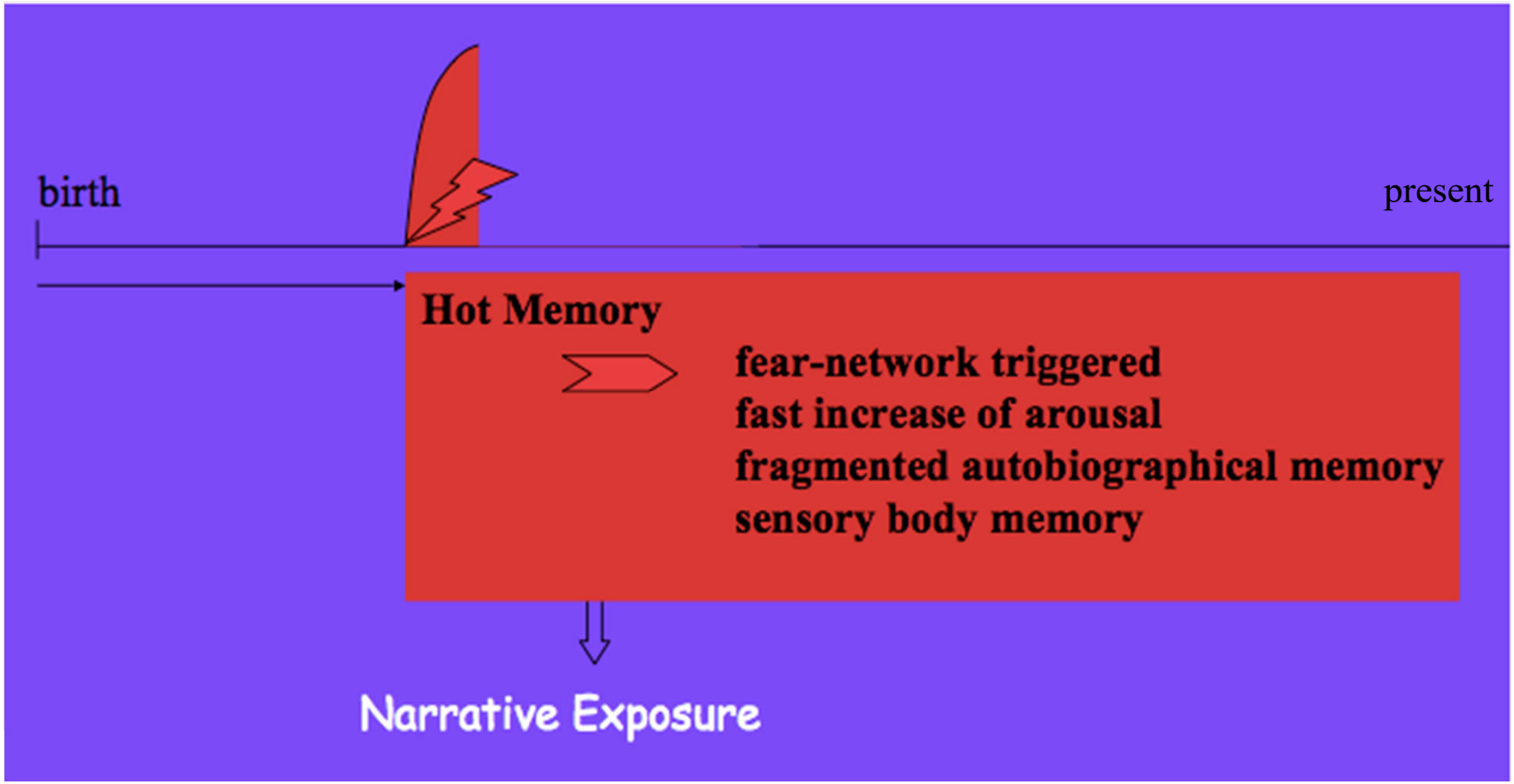
Closing

1. May re-read entire narrative
2. Give the client the narrative (if they would like it)
3. Honor the end of the process however the client would like
   a. Hopes/dreams for the future
   b. Identifying goals for therapy that arose during NET

Narrative Exposure Therapy Lifeline



Narrative Exposure Therapy Lifeline



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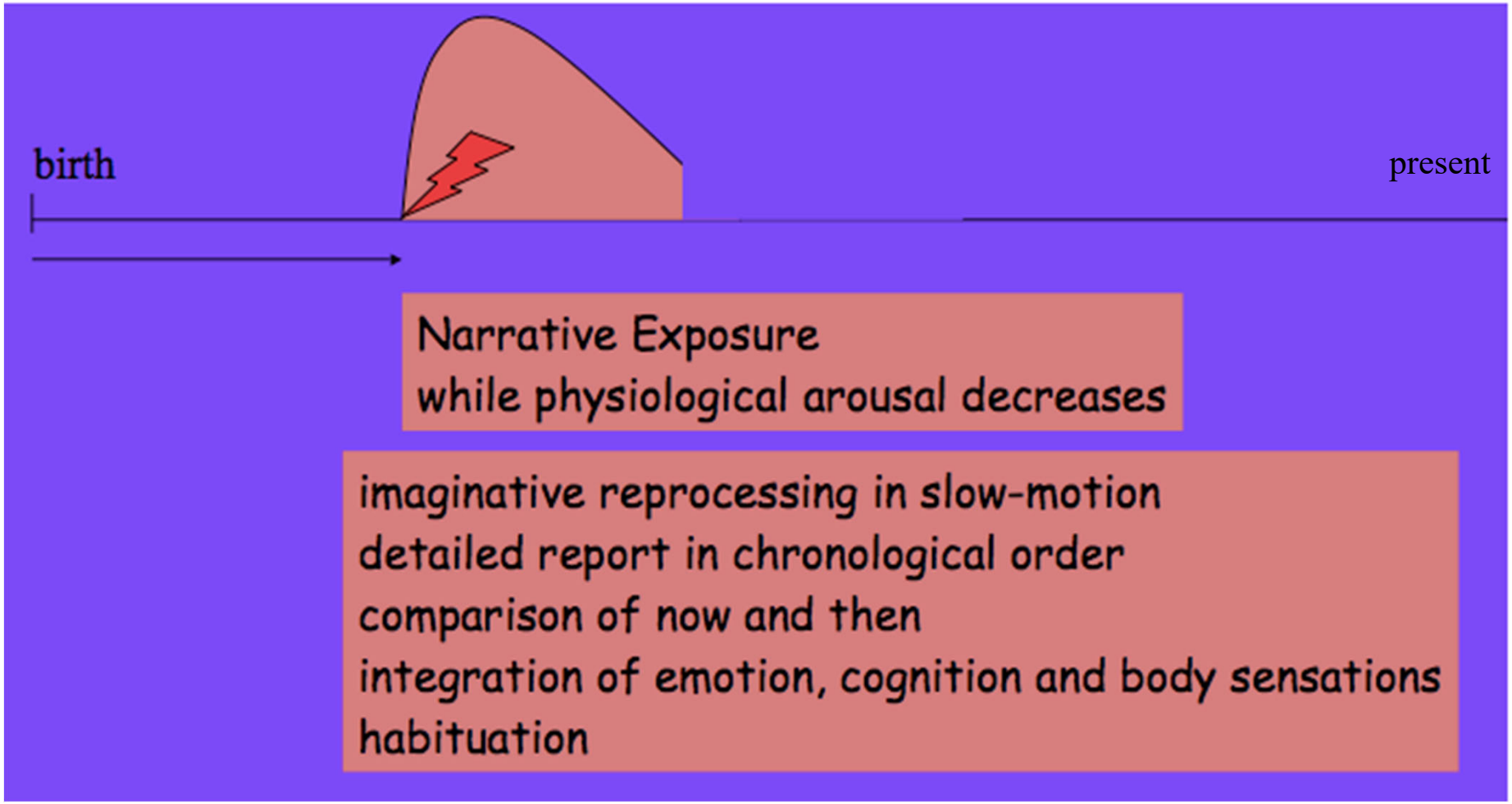

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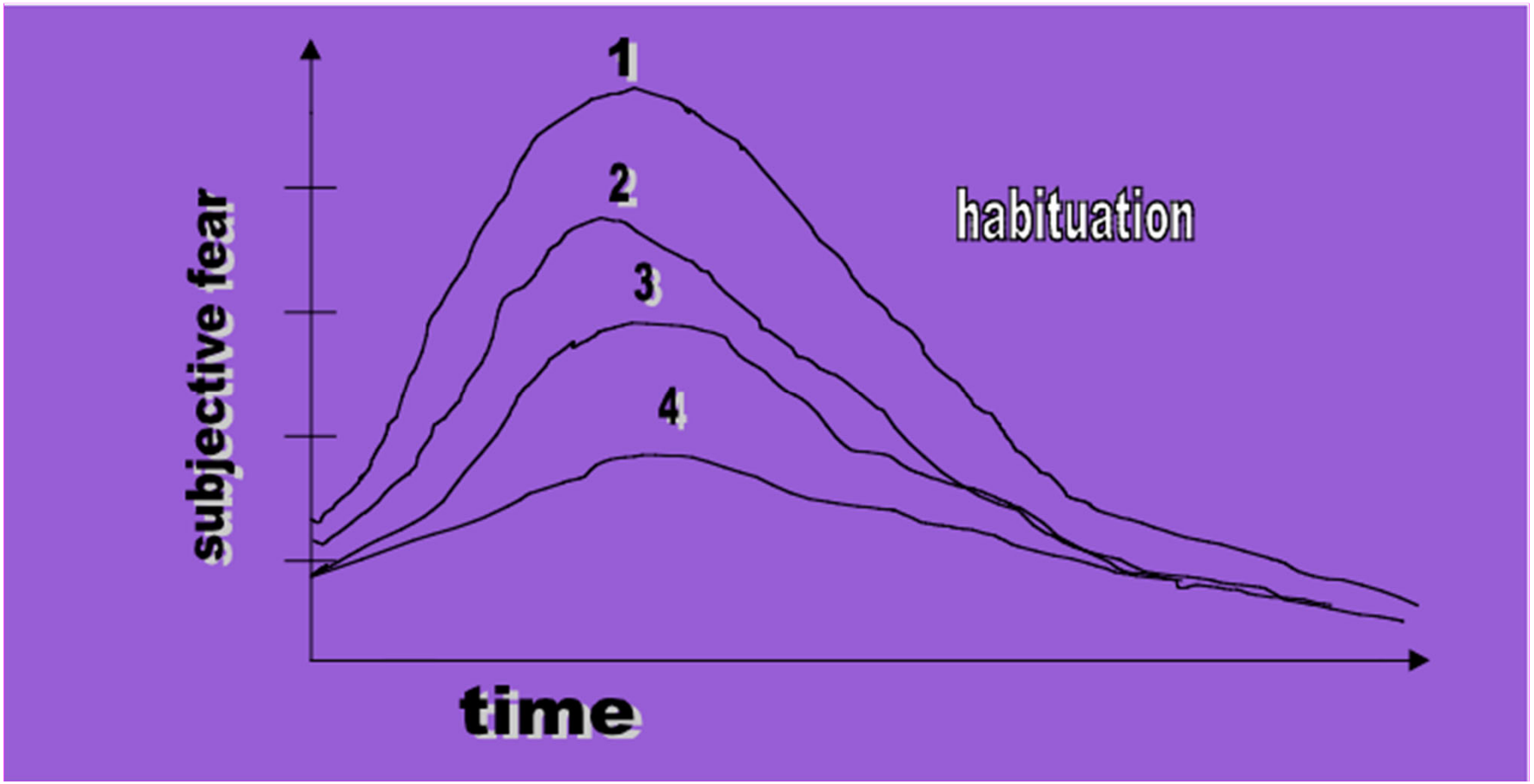

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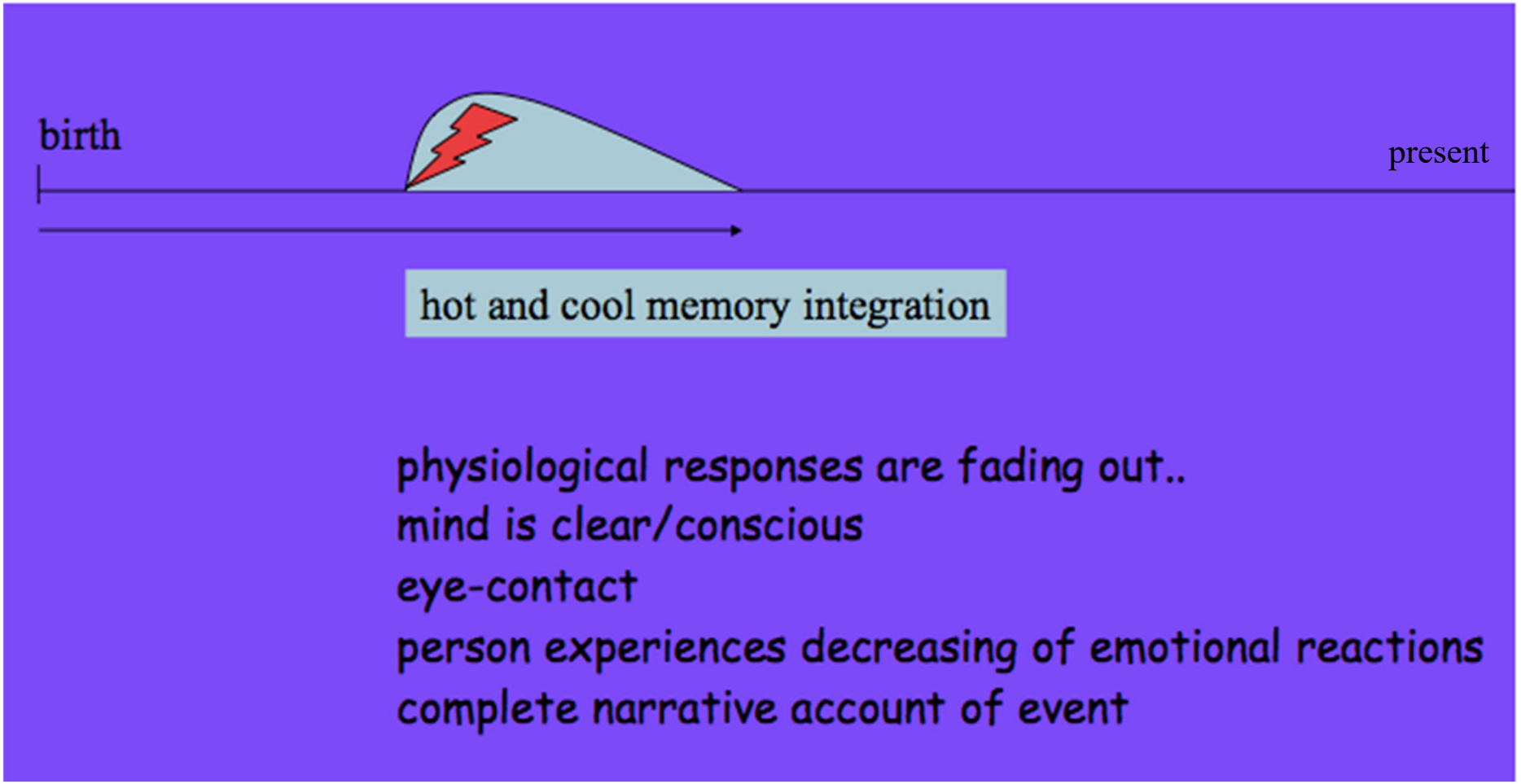

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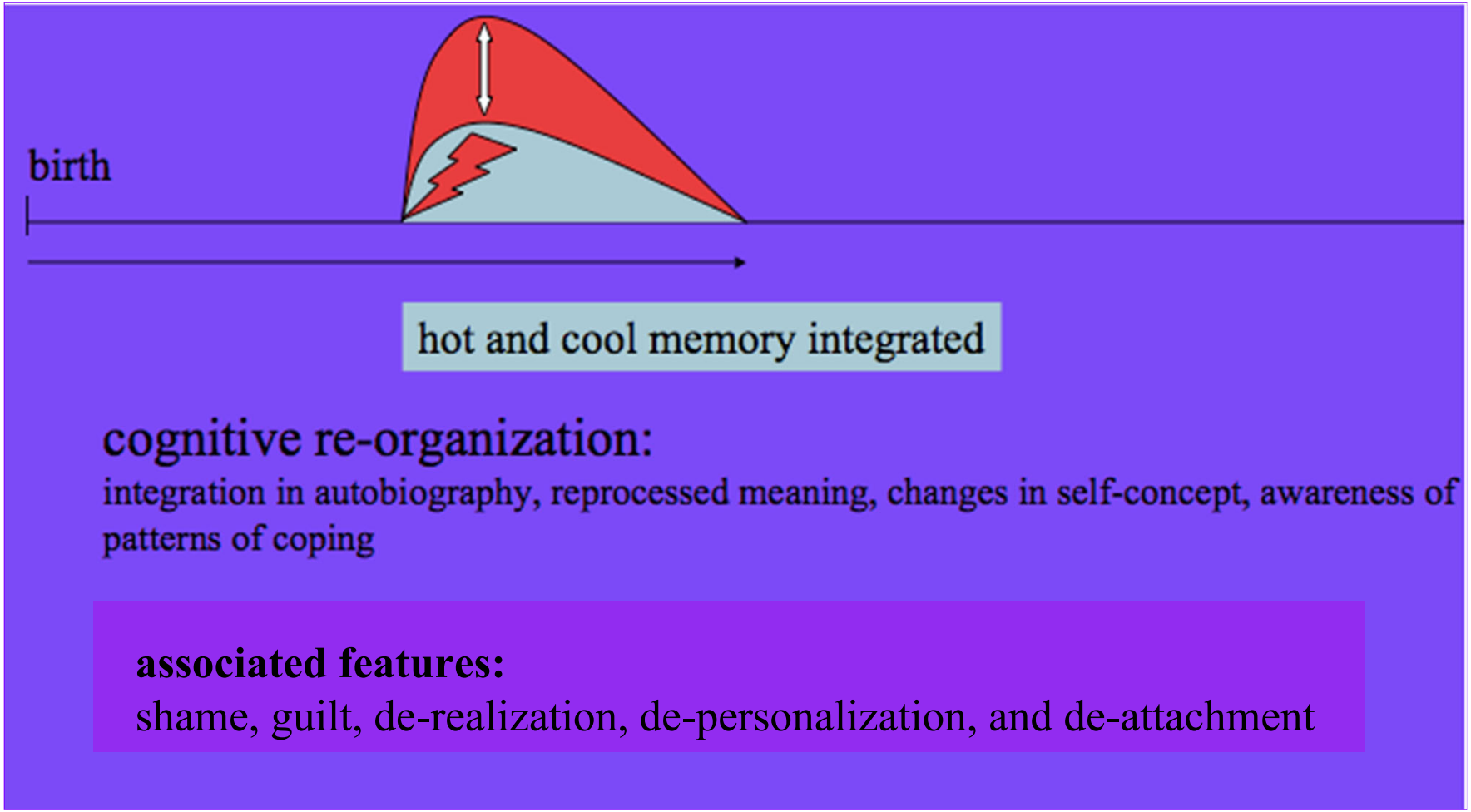
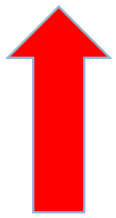


Narrative Exposure Therapy Lifeline

Dealing with Stones: THE WORST MISTAKES

- Stopping at the height if fear
- Allowing de-realization/dissociation and avoidance



Always be clear about the **direction that you are going:** no mixture of exposure and closure

EXPOSURE: arousal and emotions going up

CLOSURE: decrease in arousal, support and calming down

Behavioral Changes Associated With Dissociation ("Shut-Down" Reaction)

- Sensory-afferent signs: person may become unresponsive, with unfocused gaze
- Motor-afferent signs: visible decrease of bodily movements and immobility
  - Bodily numbing and slight paralysis (mainly in legs)
  - Yawning in the middle of the arousing exposure (in order to get blood to muscles and increase heart rate)
  - Dizziness, blurred vision, weakness of the muscles
- Language processing: unclear/confused speech, fragmented sentences, or inability to speak
  - Almost no or delayed response to sounds

(Schauer & Elbert, 2010)

Therapeutic Intervention for Shut Down" Reactions

Sensory-afferent: Stimulate the senses in the here & now, turn on bright, present tactile sensations (e.g., fabric, ice-pack), focus attention to sounds in the room

Motor-afferent: Activate skeletal muscles & enhance blood pressure & muscle tone (e.g., applied tension, physical exercises, leg crossing; body balancing tasks)

Language processing: Emphasize the narration of the PAST traumatic scene, supported by the facilitation of continuous narrative engagement in the PRESENT (e.g., active communication; enhance speech production)

(Schauer & Elbert, 2010)

Things to Avoid (Both PTSD Subtypes)

- Ending exposure session prematurely before the event has been contextualized and integrated into cold memory
- Disengagement from here and now
- Relaxation instead of activation
- Sensory similarities between the trauma context and the therapeutic setting
- Stimuli that are associated with disgust or similar to body fluids and feces
- Threat cues in the here and now (present safety signals instead)
- Semi-darkness in the room and objects for hiding behind (e.g., furniture, large plants)

(Schauer & Elbert, 2010)

Therapeutic Agents of NET

- Active chronological **reconstruction** of the autobiographic/episodic memory
- Prolonged **exposure** to the 'hot spots' and full activation of the fear memory in order to modify the emotional network
- Meaningful linkage and **integration** of psycho-physiological and somato-sensory responses to the time-, space-, and life-context
- The **cognitive re-evaluation** of behavior and patterns, as well as reinterpretation of the meaning-content through reprocessing of negative, fearful and traumatic events
- Regaining of survivors dignity and satisfaction of the need for **acknowledgement**. Explicit human rights orientation of 'testifying.'

Levels of Parallel Processing During NET

- The Incident – what happened then and at the time of the incident?
- Here and now – what happens now during the session?
- Present – What is going on now in the life of the client and how does it influence therapy?
- The narrative of the narrative – during the session and when updating the testimony.
- The therapeutic contact – how are "we" doing during and between sessions?
- The therapist – how am "I" doing during and between sessions?
- Cognitive and emotional reorganization – during and between sessions.
- Admin – timing, appointments, during and between sessions.

Questions to Therapists

- Am I convinced that it is good for the client to be exposed again to the traumatic memories?
- Do I want to hear "it"?
- What about my fear, that "it" will be horrible to listen to?

- Be aware of two snares:

Conspiracy of silence and ***over-identification***