BASIC EMOTIONAL NEEDS: A KEY CONCEPT IN THE ASSESSMENT AND TREATMENT OF TRAUMA

MATTHIAS MENDE, PHD, CLINICAL PSYCHOLOGIST/HYPNOSIS-PSYCHOTHERAPIST

ABSTRACT

An acute trauma represents a momentary rupture in the experiential flow. The world, as the traumatized person used to know it, does not seem to exist any more. The clinician faced with an acutely traumatized patient on-scene or later on in therapy needs to assess the psychological situation of the victim quickly to derive appropriate measures of stabilization. The ecology of the basic emotional needs may be utilized as a framework to assess the severity of an emotionally upsetting experience: during acute psychological and/or physiological trauma, the patient is bereaved of his or her needs to feel autonomous, related, competent, and oriented.

Depending on the nature of the traumatic situation and the victim's response, each basic emotional need may be affected to a varying degree. A quick assessment of the damage done to each basic emotional need can be used as a criterion for psychological triage on-scene in major disasters to discern heavily traumatized persons from slightly traumatized ones and from non-traumatized persons with regular emotional responses.

Here I will illustrate how the basic emotional needs to feel autonomous, related, competent, and oriented can be gratified by hypnotic communication in the psychological treatment of victims during the acute stress response and by hypnotherapeutic interventions for regaining safety and stability in the treatment of posttraumatic stress disorders. The approach integrates psychodynamic and resource-oriented features and is easily expressed in operational terms. It is suited for discussion with the traumatized for the sake of therapeutic transparency and reorientation in a chaotic environment.

Key words: trauma, emotion, hypnosis, posttraumatic stress disorder, psychotherapy

BASIC EMOTIONAL NEEDS IN ACUTE TRAUMA

What is a trauma? A physiological trauma is created by a life-threatening violation of the integrity of the body. A psychic trauma, on the other hand, is much more difficult to assess than a physiological one. Subjective experience is what makes the difference. An emotional trauma is defined by the experience that life has been threatened and control has been lost, resulting in a feeling of helplessness. The sheer magnitude and suddenness of the critical event intensify the traumatic experience. The view of the world that has existed so far has been shattered to the bone. There has been a severe rupture in the natural flow of experience. Life does not seem to be the same any more.

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As will be shown the original definition of a trauma blends easily into the theory of emotional needs. According to this theory, an alignment of four different needs to feel specific emotions will result in a state of well-being and will support any emotional salutogenetic process (Mende, 2006).

1. The need to feel autonomous signifies the need for an individual to feel self-determined, respecting the self and its needs, and freely making decisions in a self-reliant manner.
2. The need to feel related means the need to feel the protection and warmth of a relationship, the feeling of belonging and being appreciated by others.
3. The need to feel competent means the need to feel in control, capable of influencing the environment to a sufficient degree, and being able to utilize one's resources and capabilities.
4. The need to feel oriented means the need for sense and meaning, for setting worthwhile goals, and working towards these goals, once they have been found, and perceiving that the goals can be reached by justifiable efforts.

In the peritraumatic experience all of these needs are badly violated, if not suspended.

To take an example: just think of someone working at the counter of a bank being victimized by a bank robber and having a gun pointed at her face. This incident took place in Salzburg—and it happens probably by the minute around the globe. Imagine the suddenness of the experience in this incident. The bank robber storms into the bank and in a flash instantly creates a totally new situation for the bank employee—a life-threatening situation. It is obvious that this experience will violate an individual's need to feel oriented: the employee is completely disoriented, because the working environment as she knew it has changed dramatically without warning. The suddenness and the traumatic intensity of the event will result in a feeling that orientation has been lost (loss of orientation).

As the bank robber is pointing the gun at the employee's face, she is also losing the feeling of autonomy instantly. There is nothing she can do in a self-determined way at that moment. This will result in a feeling that autonomy has been lost (loss of autonomy).

At the same time the employee may be struck by the feeling that there is absolutely nothing she can do about the robbery. She may feel that she cannot meet the responsibility to protect the money of her clients. The situation may even result in the cognition: 'My life is threatened, maybe I will die and there is nothing I can do about it.' This will result in a feeling that she has lost control and is disconnected from all her capabilities, competences, and resources (loss of control and competence).

Finally, even though there may be others around, such as colleagues or clients on the other side of the counter, the employee is being stopped from establishing contact with peers in this traumatic situation. The person is disconnected and isolated from important relationships. The only thing the employee is focusing on is: this bank robber is carrying a gun. Consequently, most likely the victim is struck by a feeling of being isolated and deprived of her need to feel related to others (loss of relatedness). Even though this is a pretty common experience around the world, it doesn't lose any of its severe impact on the individual who happens to be a victim of such a robbery.

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In my view, the intensity of a peritraumatic and posttraumatic experience can be assessed by measuring the degree to which the four basic emotional needs have been violated. In this sense, the intensity of the trauma may be somewhat lower if the victim had managed to press the alarm button without the bank robber noticing. In this case the need to feel competent would still be gratified to some extent. The same would be true if the employee had just recently finished an emergency training programme that would have prepared her for bank robberies. If some plan can be retrieved of how to behave in such intrusive situations, the feeling of orientation will not get lost completely.

Here are some questions for the on-scene emergency psychologist by which she or he can easily assess the intensity of a peritraumatic experience. Questions like this may be used to estimate the degree to which the basic emotional needs have been violated.

BASIC EMOTIONAL NEEDS AS INDICATORS OF TRAUMA INTENSITY

To what degree:

1. Did you feel isolated from others who might have been supportive? (relatedness)
2. Did you feel threatened by another person? (relatedness)
3. Did you feel incapacitated? (competence)
4. Did you feel helpless? (competence)
5. Did you feel lost? (orientation)
6. Were you unable to find out what was going on? (orientation)
7. Did you feel detached—as if you were outside of yourself? (autonomy)
8. Did you feel unable to decide for yourself? (autonomy)

Quite often the trauma victim will be in no position to answer these questions. In many cases the emergency psychologist will have to rely on observational cues.

A quick on-scene assessment of the degree to which the basic emotional needs are violated can be used for an *emergency psychological triage* to separate victims who are seriously affected emotionally (but not traumatized) from traumatized victims who require immediate professional attention by an emergency psychologist.

The paradigm of the basic emotional needs is also the basis for outlining a quick strategy for on-scene help. From the diagnostic exploration, the psychologist can determine:

1. Which emotional need is affected the most?
2. Which emotional need can be gratified most easily by an on-scene intervention?

RE-ESTABLISHING THE BASIC EMOTIONAL NEEDS

In most cases, the easiest need to be re-established will be the need to feel oriented. This need can be gratified by the emergency psychologist putting the incident into words for a victim. Within the hypnotic framework you would call that 'pacing the situation' for the victim: explaining the situation that he or she finds him or herself in and describing and normalizing his or her responses on a behavioural, cognitive, and emotional level. Next, the

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story of what has just happened will enhance the readiness of the central nervous system to transfer these intrusive experiences and preverbal imprints into the regular episodic memory.

Following this, the peritraumatic responses of the victim are explained as being normal autonomous reactions to utterly un-normal experiences meant to protect the individual from the massive impact of the trauma. Thus, the peritraumatic responses can be reframed as being automatic and autonomous protective measures of the self. This way, the need to feel autonomous is also gratified: even if they are unexpected and unknown, the peritraumatic stress responses can be seen as expressions of the autonomous self.

The need to feel related will be reinstalled mostly by establishing rapport in the hypnotic sense. A simple way of doing this is by avoiding all communications that are incongruent with the victim's perceptions of the world and of herself in this particular stressful moment. This can be done by abstaining from any communication meant to calm the victim down by reassuring them that everything is going to be all right again. Nothing is all right at that particular moment. In the sense of strengthening rapport, it is much more appropriate to emphasize that, yes, there is a crisis, something terrible has happened, something out of the ordinary which constitutes a real crisis. Acknowledging the crisis means facing the patient's perception of the situation which means strengthening rapport. And having rapport with the psychologist will gratify the victim's need to feel related.

To gratify the victim's need to feel competent, the psychologist can find a simple activity or assignment the victim will be able to perform. This will be helpful, even if it includes just very basic things like holding on to something, making a fist, or inhaling and exhaling deeply once. Another way to re-establish the victim's feeling of competence is to explore competent behaviours exhibited during the critical event. In most cases the competence shown in the peritraumatic phase will be quite obvious to the psychologist. The victim however will be unaware of it.

In order to support the victim's need to feel autonomous again, the psychologist can offer simple choices, stimulating the victim to make decisions again. The feeling of being autonomous will also be supported, if the measures being taken are explained and the victim is asked for his or her consent, if possible.

I did not come up with these interventions. They are available in the emergency psychology literature (e.g. Bengel, 1997; Lasogga & Gasch, 2004; Fischer, 2008). However, all these interventions make much more sense within the paradigm of basic emotional needs, as they can be easily assigned to one of the four basic emotional needs which they will be supporting in the peritraumatic phase.

BASIC EMOTIONAL NEEDS IN POSTTRAUMATIC STRESS DISORDERS – SINGLE TRAUMA

The framework of the basic emotional needs also applies to posttraumatic stress disorders that have developed after a single trauma or as a consequence of a long-term complex relational traumatization.

Consider another case example: recently another bank employee, female, 25 years old, suffered from a posttraumatic stress disorder. In this case the disorder had developed from a single secondary traumatization, when the only child of her best friend had died in a sudden infant death. The mother of the child, her best friend, was devastated and that got her

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psychological treatment right away. The psychological trauma was so serious that she had to be hospitalized. The patient was traumatized by experiencing that mother becoming traumatized.

She never would have considered something like a child's instant death in her immediate environment of significant relationships. This experience crushed her former belief in an orderly world (loss of orientation). Moreover, she was experiencing a feeling of complete helplessness. As for the child's death, there was nothing *anyone* could do about that any more (loss of competence). Neither was there anything *she* could do in order to comfort the mother (loss of autonomy). The secondary traumatization included the experience of a secondary loss of a significant relationship—the relationship between the mother and child. Above that, the relationship with the mother as her best friend was shattered due to the experience of not being of any help to her friend (loss of relatedness).

The secondary traumatization included severe damage to the self-perception of her friend as a caring mother into a bereaved mother laden with feelings of guilt with regard to the death of a child which could not have been prevented.

The symptoms the patient developed soon after the incident were centred on the fear that her body might develop a serious illness. The patient focused on her body and started searching for tiny abnormalities underneath the skin that might be indicators of a threatening illness: always finding something that should not be there and had not been there before. She was constantly checking to the point where her concentration at work deteriorated so she could not meet her responsibilities any more and had to file in sick.

In this constant checking she didn't trust herself any more—an expression of having lost her feeling of autonomy in the course of secondary traumatization. She didn't trust that she, for herself, could determine if a tiny bump underneath her skin was normal or indicated alarming change. To compensate for her violated feeling of autonomy and weakened self-determination she got other people involved in checking her body for signs of sickness. Her parents, close friends, doctors, and therapist were asked to do the checking for her and confirm that everything was all right.

The treatment plan, along the lines of supporting the basic emotional needs, set off with restoring the feeling of orientation: the therapist would not confirm that everything was all right. Nothing was all right any more. Not with her body or with a significant part of her emotional and physiological life. Out of the blue, the body of a baby was wasted, her best friend's baby. The first part of the therapeutic work was dedicated to establishing the recognition of the traumatic dimension of this incident, even if it *only* concerned her best friend. If a best friend suffers a crisis, there is often a tendency to downplay the impact of the incident on one's own emotional life in order to remain stable enough to help the friend in need.

After normalizing the stress responses, trance work started to support acknowledging that the posttraumatic stress responses were actually attempts by the unconscious mind to deal with an unbearable crisis. This type of reframing is a very helpful way of arriving at reality constructions which re-establish the patient's feeling of being oriented and competent: the symptoms may be seen as directed at stabilization, as measures set by the competent unconscious mind and not as expressions of disorientation and helplessness.

The following interventions were designed to re-establish the patient's feeling of autonomy. In hypnosis, the relationship to the unconscious was strengthened. The unconscious

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was introduced as a wise, competent, highly attentive bodyguard, responsible for governing body processes, detecting abnormalities, and producing obvious signs if something was out of the ordinary. This work helped the patient to do without having others check her body for hidden abnormalities. Later on she was able to reduce her self-checking behaviour considerably and finally gave it up.

The need to feel related was first addressed in the context of re-establishing the relatedness to her inner self. Her unconscious had forced her to focus on herself intensively, as if to say: look after yourself, take care of yourself! The agreeableness of this message was secured during trance and the unconscious was engaged in searching for pleasant, creative ways for how this might be done in the future. This kind of work gratified the patient's need to feel related to herself again. As she felt comfortably related to herself, she once again could open up for the relationship to her best friend. The feelings of guilt and helplessness—because there seemed to be nothing she could do to help her friend—had dissolved, without being addressed specifically.

As this example shows, focusing on the basic emotional needs will be of help in the structuring of therapy planning in the treatment of posttraumatic stress disorders. It may be used as an itinerary for planning and conducting therapy with patients suffering from posttraumatic stress disorders.

BASIC EMOTIONAL NEEDS IN POSTTRAUMATIC STRESS DISORDERS – COMPLEX TRAUMA

Focusing on gratifying and aligning the lost balance of the basic emotional needs may also serve as a guide for therapy planning in cases with complex relational traumatizations suffered over a longer period of time.

A woman aged 37 suffered from a complex trauma administered by her emotionally malignant mother, in combination with having an absent father. The patient herself was married and had a 2-year-old son. Her mother was an educated person, working as a university professor at a German language department in a city far away from where the patient lived. The mother took up the habit of constantly punishing her daughter, who was her only child, for unpredictable reasons. As a young child, these punishments constituted a loss of the feeling of competence. Thus, the most significant relationship a child has, the one to the mother, was perverted into one of constant fear. Searching and finding strategies for self-protection became vital for the child. Of course, she constantly wondered why her mother was so malignant because she noticed other children were treated with love and affection by their mothers (loss of orientation).

The patient developed extreme observational skills to find out what could possibly prevent her mother from punishing her (attempting to conserve feeling of competence). She also put a lot of effort into conserving the feeling of autonomy by actively searching for something her mother could not detect in her. And she found that her fantasies were places her mother would never have access to, especially if nothing of the rich inner processes showed on the surface of facial expression or body language. As she grew up through childhood and adolescence, the patient found a silent pleasure in having her own inner life which was unapproachable by her mother's punishments. On the behavioural side, she

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found it was safest never to contradict and always to imitate her mother as closely as possible in her verbal and nonverbal expression behaviour.

When the patient first came to therapy, she still had intrusive images of her mother sneaking up from behind and punishing her without warning in an aggravated and devaluing manner. The patient was always tense, alert, and over-activated with a watchful eye to all sides. Her mother played the role of a malignant introjection denying the patient of any pleasures, forms of well-being, or resources that might help her lead a happy, independent life. The patient had broken any contact with her mother years ago, so she was on the safe side as far as her life in the external world was concerned.

At first the therapy was focused on establishing a sound rapport with the patient to support a parent-like transference and to support the feeling of relatedness towards a significant other. After a trusting relationship had been established and the desire to feel related had been gratified in this respect, the patient was introduced to relevant information concerning trauma dynamics and trauma symptomatology to provide some orientation. The patient fed on this cognitive information emotionally, as it confirmed what she had previously found out and concluded from her own experiences. Her high intelligence had helped her in doing that. Trance work was carefully introduced to help in acknowledging the unconscious as a protective, autonomous entity. The unconscious mind would be involved in taking care of self-protective measures whenever the conscious mind was busy otherwise.

After the stabilization phase, she was able to acknowledge her own resources that had helped her to create protected inner spaces, inaccessible to her mother. In a light trance, the domains her mother had no access to were gradually expanded from the inner circles of fantasy into the outer world. Thus the feeling of autonomy was strengthened. Establishing a safe place, where the patient experienced a special protection for her backside from which her punishing mother had attacked her most times, was possible only after the introjection of the malignant mother had been dealt with. It became possible for the patient to imagine the introjection of her mother as being an animal: a poisonous snake. And it was possible by visualizing another animal that could take care of that poisonous snake: an eagle. In doing so, she was utilizing her abundant observational and fantasy skills to compensate the trauma. In the end, she could employ helpful symbolizations to take care of the introjection of her mother.

This type of work done in a light trance strengthened the patient's feeling of competence and orientation: yes, she could rightfully fend off her mother and was allowed to turn against her. And yes, there were ways of doing it and creatures that were definitely stronger than her mother which could chase her away.

In the course of therapy she started admiring her former self more and more: the way she had kept alive in an environment that she described as hell. She started to take pride in having developed a trusting relationship to her husband and a caring, loving relationship to her child. Thus the feeling of being related was nourished and gratified. Her greatest resource turned out to be the conviction that no matter what, there was a resilient, indestructible, invincible inner self that had protected her in existentially unsafe periods of life and would continue to protect her in a far safer environment from the perils of everyday life.

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In the course of this process the hyper-arousal decreased and the patient found herself taking less and less effort in self-protecting measures. Even though her alertness concerning what was going on behind her back lessened, her feeling of being protected grew stronger.

CONCLUSION

Three examples have been taken from on-scene interventions, simple traumatization and complex relational traumatization. These cases demonstrate how basic emotional needs to feel autonomous, related, competent, and oriented can be utilized in assessing the magnitude of a traumatic experience. Assessing the magnitude of the traumatic experience is useful for psychological triage purposes on-scene and for specific diagnostic purposes in the course of therapy planning.

The framework of basic emotional needs also helps in structuring therapeutic measures for each of these different treatment settings: on-scene interventions in the peritraumatic phase, treatment of acute trauma reactions, and treatment of posttraumatic stress disorders after both simple and complex traumatization.

Until now, it has been a pragmatic approach, a framework derived from clinical practice. The theory is there, waiting to be explored empirically. Since all concepts can be moulded into operational terms, they lend themselves easily for clinical and experimental research. The author, a practitioner of clinical hypnosis, has many researchable ideas but without the resources necessary to conduct research. Certainly creative work could be done with the necessary methodological precision, if existing contacts between researchers and clinicians became stronger.

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Correspondence to Matthias Mende, Taxhamg. 17, A-5020 Salzburg, Austria
Email: Matthias Mende (mende@hypnose.co.at)
Phone: +43 662 433 403
Fax: +43 662 433 403-4

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