Working with hacks

Mark Brayne argues that talk therapies that don't proactively address the traumatic root causes of presenting distress can be worse than useless

If a bomb were to go off close to your neighbourhood, which way would most sensible people run? And who would rush in the other direction – towards the explosion? Of course, everyone thinks of the blue-light first-responders – police, firefighters, rescue workers and medics – who would be immediately drawn in, and of the trauma to which they might be exposed. But what about journalists, photographers and news teams – often the very first people to get there when bad things are happening.

In the military, police and firefighting professions, the last couple of decades have thankfully seen a shift away from old cultures of macho denial. But it's only much more recently that media organisations have woken up to the potential for psychological trauma among those they send into harm's way, whether it's a foreign war or what journalists call the 'local death knock': 'I'm sorry that your son/husband/child has died, Mrs Smith, but do you have a good photograph we could use, and how does it make you feel...?'

With trauma support and awareness training programmes in-house, and EAPs now in the background for many leading news organisations, journalists who might previously have turned to drink or drugs to dull their post-traumatic pain are beginning to seek out counsellors and psychotherapists. For those in private practice, including those of us willing to take on even highly traumatised clients for the rapid fire five to six sessions allowed by an EAP, this has important implications for how best to work with intelligent, experienced, well-travelled and perhaps emotionally hard-bitten clients who've taken one of the scariest steps of their life in contacting a therapist.

Working through the 1970s, 80s and 90s as a foreign correspondent and news editor myself, and since 2000 as a trauma psychotherapist with the Dart Centre for Journalism and Trauma and with organisations ranging from the BBC and Reuters to Al-Jazeera and the Russian Union of Journalists, I've been heartened by the changing attitudes of colleagues and bosses towards the normal human vulnerability of the average hack. But I've too often also been saddened by stories I hear of the counselling support that some of them have had. This isn't to criticise my fellow therapists who, with the best of intentions, deploy with these clients the standard person-centred, psychodynamic, Gestalt or whatever approach they've been trained in. But as I've worked in latter years with clients – including what might be termed ordinary human beings as well as professional first-responders – who present with often complex mixes of adult trauma compounding old dysfunctional patterns of childhood attachment, I've become more and more convinced that slow moving, client-led talk therapies which don't proactively seek out and address the almost always traumatic root causes of presenting distress can, I'm afraid, be worse than useless.

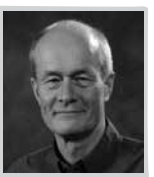
Brain research in the past couple of decades has illustrated increasingly clearly how the roots of most depression, anxiety, and indeed most presenting issues our clients bring lie in what might be termed adverse childhood events (ACE), or, in the Eye Movement Desensitisation and Reprocessing (EMDR) world in which I mostly move, 'small t' as well as 'Big T' traumas. Without identifying and addressing those roots of present distress, therapy – even in the long term – will succeed only in removing the visible weeds without tackling the root system down below. And as the NHS is discovering with CBT and IAPT, the weeds come back, as superficial solutions see up to 50 per cent of clients relapsing – not much better than the natural healing expectation without therapy.

After 10 years of using EMDR, I now – rather controversially perhaps – am coming to believe that any therapy which does not work in a trauma-focused way, ideally with the bilateral sensory stimulation that's at the heart of EMDR therapy (and I scarcely use eye movements any more, just knee taps or headphones and hand- held buzzers) is unethical. Gratifying evidence is building of how EMDR, as if it were the Heineken of therapies, reaches the parts that other psychological approaches do not reach, and of how well EMDR can be integrated with other core models from the psychodynamic to the transpersonal.

I know I am at risk of self-combustion with enthusiasm for the efficacy of EMDR therapy, and also with frustration at the rigidity of the standard protocol as generally trained, as with the paucity of training opportunities in a therapy still tightly controlled by individual commercial companies. With many of my colleagues, I also despair sometimes at the struggle to secure good research that will confirm what we users of it find in our work every day – that EMDR can be stunningly effective for much more than the PTSD for which it is now recommended by the National Institute for Health and Care Excellence (NICE). But the results and testimonials I've had from using EMDR with the widest range of clients – including journalists in sometimes quite short treatment windows – continue, in the vernacular, to knock my socks off. And the impact is enduring.

So, if as a shrink you find yourself approached by a hack, bear in mind that a trauma-focused, proactive response that aims to make an explicit difference as rapidly and efficiently as possible, will do the cause both of psychotherapy and of your own private practice more good than you can imagine.

About the author



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