

## **More to the Story: Synthesizing Narrative Therapy with the Adaptive Information Processing Model**

Claudia M. Fletcher<sup>1</sup>

Georgia Boxer

Alexis V. Ambeau

Sarah DeMarais

Loyola University, New Orleans, Louisiana, United States

*Narrative counselors emphasize the social context and storytelling rights of the client, which contributes to the theoretical base for trauma work. However, the traditional narrative approach typically addresses the cognitive aspects of the story and relies less on the associated emotional and somatic responses. The authors synthesize the objectives of narrative therapy with the Adaptive Information Processing (AIP) model to conceptualize how the dominant narrative consists of the proposed interrelated cognitive, emotional, and somatic sub-narratives. The authors also describe how creating unique outcomes emerges from developing congruency among the three sub-narratives. Clinical recommendations for narrative counselors are provided.*

*Keywords: trauma, narrative, AIP model*

Narrative therapy provides a theoretical lens for counseling practice based on postmodern philosophical concepts, whereas the research-driven Adaptive

---

<sup>1</sup> The authors give special thanks to Dr. Thomas Foster, Department of Counseling, Loyola University New Orleans, for valued support and consultation in the critique and preparation of this manuscript. Address correspondence to Claudia M. Fletcher. Contact: claudia.mackenzie.fletcher@gmail.com

Information Processing (AIP) model conceptualizes how individuals digest memories of trauma on cognitive, emotional, and somatic levels. Synthesizing narrative therapy with the AIP model addresses the American Counseling Association's (2014) *ACA Code of Ethics* standard related to application of research to practice (Standard C.7.a), in addition to the Council for Accreditation of Counseling and Related Educational Programs' (2015) *CACREP Standards* emphasis on clinical mental health counselor competence when working with trauma cases (Standard D.2.h). Furthermore, this synthesis provides a comprehensive theoretical lens to the AIP model through which to facilitate trauma narrative development. The authors chose the AIP model over other trauma models, because its focus on memory construction and the effect of storied memories on everyday life best fits with narrative therapy's constructs of storytelling and problematic internalization. This approach synthesizes narrative therapy with the AIP model to create a multilayered conceptualization of trauma that involves cognitive, emotional, and somatic narratives.

### **Needs for Trauma Informed Counseling**

The American Psychological Association (2016) defines trauma as “an emotional response to a terrible event like an accident, rape or natural disaster”, which may cause individuals to respond with intense emotional feelings that can range from normal responses such as fear and helplessness to the development of a mental health disorder. More recently, the counseling field expanded how they interpret what constitutes as trauma to include verbal and emotional abuse in addition to life-threatening and dangerous events (Gondolf, 1987; Shepard & Campbell, 1992; Straus, 1979). While the most commonly associated diagnoses with trauma are Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder, trauma can serve as the etiology for problems related to substance use, depression,

and anxiety disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

A substantial portion of the United States population reported experiencing trauma at some point during their lifetime. Regarding life-threatening or dangerous events, 30% of military personnel stationed in war zones meet the criteria for PTSD, while an additional 20-25% report PTSD symptomatology (Nebraska Department of Veterans' Affairs, 2007). Approximately 15-25% of women report a history of sexual abuse as a child or adult (SAMHSA, 2015), while nearly 300,000 individuals report being sexually assaulted annually (Truman & Langton, 2015). Additionally, one in three women and one in four men experience physical violence by an intimate partner within their lifetime (Black et al., 2011). Verbal and emotional abuse is similarly widespread, as 26% of female adolescents disclosed repeated verbal abuse and 20% reported being threatened by their significant others (Safe Voices, 2016), while the national prevalence rate for reported childhood emotional abuse is 11% (Felitti et al., 1998).

Due to high prevalence rates and the substantial impact of trauma, counselors must adjust their practice to include a holistic approach. Typically, the application of narrative therapy focuses primarily on the narrative content, not exploring in-depth the emotional and somatic responses when compared to trauma models. The authors propose to enrich traditional narrative therapy by synthesizing it with the Adaptive Information Processing (AIP) model to integrate the emotional and somatic aspects of trauma into the narrative. In the following sections, a case vignette is presented, followed by narrative therapy and the AIP model before describing a new narrative therapy trauma model.

### **Case Vignette**

Alicia, a 32-year-old multiracial woman, began seeing a narrative counselor after experiencing several panic attacks at work. Alicia tells her counselor that she worries these attacks will undermine her professional reputation and social relationships outside of work. During therapy, Alicia discloses several traumatic childhood memories, such as parental separation, abandonment by her father, and verbal and emotional abuse by her mother. As Alicia and her counselor explore stories from her childhood, she experiences both emotional and visceral reactions. For instance, while rationally she recognizes her mother's verbally abusive messages as false, emotionally she feels worthless and unlovable. In addition, as Alicia recalls these memories her face begins to flush, her palms sweat, and she fidgets with her clothes; her counselor notices these reactions but does not investigate them.

Alicia also describes multiple sexual assaults she endured during high school and college. While Alicia attends to her narrative of these traumas with her counselor, Alicia feels degraded and overwhelmed by shame and guilt. Frustrated by these feelings of self-blame, she becomes angry with herself and those who hurt her in the past. Furthermore, Alicia experiences extreme nausea, tension throughout her body, and an intense sensation to move her legs and arms. The counselor reflects to Alicia that she appears tense to ensure that she does not become too overwhelmed in their session regarding her traumatic past. Alicia confirms that she is able to continue discussing her traumas, as she is familiar with experiencing these reactions.

After several months of narrative therapy, Alicia and her counselor successfully identified the problem, mapped its influence, and deconstructed the negative aspects of her identity by adding context to her traumatic experiences. Ideally, Alicia can now re-author her narrative; however, Alicia feels escalated anxiety, experiences increased panic attacks, and her triggers have generalized to experiences outside of her traumatic memories. While she made great strides to

cognitively externalize the identified problem, her emotional and somatic reactions continue to reinforce her maladaptive narrative. Alicia and her counselor both agree that great improvement was made in externalizing her problem narrative, but her emotional and somatic state need additional description for context.

### **Narrative Therapy**

White and Epston (1990) developed narrative therapy from postmodern philosophy that asserts how political and scientific institutions create cultural norms that objectify people through dividing practices and scientific classification. Through repeated social encounters under the dominant cultural narrative, individuals shape their identity over time by integrating a socially sanctioned view of the self with their personal experiences (Madigan, 2011). Geertz (1973) used a text analogy to describe how individuals use storytelling to depict themselves and derive meaning from these stories. These meanings can serve to empower or oppress individuals by means of their own subjectification (Foucault, 1977). Specifically, internalizing the problem as an aspect of their identity results in a maladaptive dominant narrative.

People who experienced significant trauma may represent a vulnerable population who could develop a problem saturated narrative, as their trauma symptomatology might not be in accordance with their own dominant narrative or the culture's dominant narrative. The trauma event and resulting symptomatology is only one aspect of their lived experiences, and through problem externalization, individuals can re-author a preferred narrative by adding context to lived experiences that contradicts the maladaptive narrative, known as a unique outcome (White & Epston, 1990). In order for therapeutic change to occur, unique outcomes need to take two forms: reconceptualization of past experiences and creating new experiences that align with the preferred narrative (Matos, Santos, Goncalves, &

Martins, 2009; White & Epston, 1990). However, people who experienced trauma may be unable to forge new unique outcomes due to unprocessed emotional and somatic responses to triggers, therefore impeding the process for therapeutic change.

Findings from empirical studies demonstrated that narrative therapy is effective across developmental levels with various issues, including depressive disorders, substance use disorders, self-harm behaviors, and autism spectrum disorder (Cashin, Browne, Bradbury, & Mulder, 2013; Gardner & Poole, 2009; Hannen & Woods, 2012; Vromans & Schweitzer, 2011). Within trauma work, counselors often help the client to sequence the traumatic experience into a narrative (Hoecker, 2014). However, one notable limitation may be the sole focus on cognitive reconceptualization, as clients with high levels of posttraumatic stress symptomology demonstrate impaired cognitive processes in therapy (Jaeger, Lindblom, Parker-Guilbert, & Zoellner, 2014). Given the high level of arousal inherent in trauma, clients may struggle to verbally describe and re-author their narrative without triggering emotional and somatic sensations, causing re-traumatization and interfering with the therapeutic process (Lopez, 2011; Ogden, Minton, & Pain, 2006).

### **Adaptive Information Processing Model**

The AIP model proposes how new information consolidates into long-term memory and becomes adaptive within the neural network. When an individual encounters new information, they unconsciously react to and integrate the content on cognitive, emotional, and somatic levels (Van der Kolk & Van der Hart, 1991) where they are connected to and stored within existing memory networks. MacLean's (1990) triune brain theory substantiates the AIP model's use of the cognitive, emotional, and somatic levels through the evolutionary anatomical

mechanisms controlling these reactions: (a) the forebrain, which accounts for cognitive processing; (b) the limbic system, which is responsible for emotional processing; and (c) the hindbrain, which regulates somatic processing. The AIP model uses these levels to describe memory storage and thus how an individual responds to similar, new information (Cory, 2003; Shapiro & Lalotis, 2010).

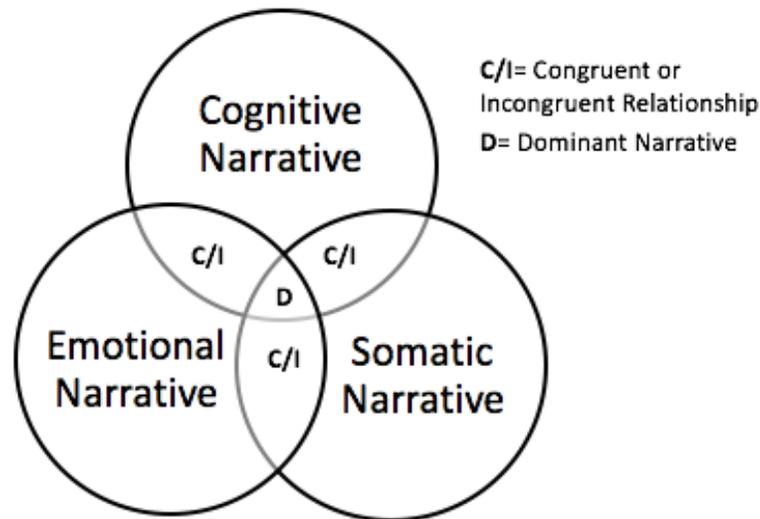
Though the brain typically filters nontraumatic experiences, consolidating adaptive information into long-term memory storage and making connections to existing memories within the neural network, trauma often obstructs new information from fully processing and adjoining to existing memory networks (Crawford, 2010; Shapiro, 2001; Wesselman & Shapiro, 2013). Under these circumstances, the automatic neural filtering of non-useful information and subsequent reactions becomes disrupted. When a traumatic memory does not move into long-term storage, all of the original cognitive, emotional, and somatic reactions that occurred during the trauma remain intact and active (Clark, Tyler, Gannon, & Kingham, 2014; Wesselman & Shapiro, 2013). The disruption can shape and trigger future maladaptive responses to similar experiences (Brewin, 2014; Shapiro, 2001; Stocks, 2007) and can set the foundation for how an individual views the self, others, and the world (Clark, Tyler, Gannon, & Kingham, 2014; Stocks, 2007).

Following a traumatic event, disruptions to the cognitive, emotional, and somatic processing of the triune brain can trigger a maladaptive, self-preserving reaction to a non-dangerous situation (Crittenden, 1997). For example, when Alicia verbally described her sexual assault to her counselor, cognitive processing of the forebrain was activated, which in turn triggered fear (an emotional response of the limbic system) and the urge to move or free her unrestrained legs and arms (a somatic response of the hindbrain). Though Alicia was not currently in danger while recalling the traumatic memory, the unconsolidated cognitive content of the traumatic memory remains connected to unprocessed emotional and somatic

responses, thus triggering her self-protective behavior. Furthermore, trauma-caused disruptions to the limbic system, regulating emotional response, and hindbrain, regulating somatic response, can cause an individual to continuously and unconsciously re-live the emotional and physical experience of the trauma (Clark, Tyler, Gannon, & Kingham, 2014). Alicia's experience, again, provides an example: Alicia has gained professional success and is generally confident in her professional ability, yet her confidence is overshadowed by the enduring effects of the verbal and emotional abuse Alicia experienced as a child by her mother. The cognitive content associated with Alicia's childhood emotional and verbal abuse remains unconsolidated, her emotional and somatic responses unprocessed, and manifests as panic attacks.

### **Synthesizing Narrative Therapy with the AIP Model**

The authors incorporated narrative therapy with the AIP model to provide counselors with a comprehensive conceptualization of their clients struggling with trauma, specifically with the intent to foster therapeutic growth by creating new unique outcomes that align with their preferred dominant narrative. It was proposed that the dominant narrative consists of three sub-narratives: the cognitive narrative, the emotional narrative, and the somatic narrative. These sub-narratives act both independently and dependently of one another, constructing a congruent or incongruent state between the sub-narratives.



**FIGURE 1**

**Relationship Between the Three Sub-Narratives of the Dominant Narrative**

*Figure 1. The cognitive, emotional, and somatic narratives that together make up the dominant narrative. This figure illustrates the relationship between the three sub-narratives, specifically the role of congruency.*

When the sub-narratives are in a state of incongruence, new unique outcomes cannot be fully realized due to the internal conflict. For example, an individual who experienced trauma could possess a positive cognitive narrative about the event, but still experience somatic symptoms such as trembling hands and increased heart rate, resulting in an inability to create new experiences that are not affected by their maladaptive somatic sub-narrative. In this case, the preferred cognitive sub-narrative has been contradicted by the problematic somatic sub-narrative.

Incongruence between any of the sub-narratives results in a problematic dominant narrative. An adaptive dominant narrative can only be achieved when each of the sub-narratives are congruent and support the preferred narrative,

yielding new unique outcomes. Next, each sub-narrative is described using the AIP model and include Alicia's story as an example.

### **Cognitive, Emotional, and Somatic Sub-Narratives**

Proponents of the AIP model propose that non trauma-related memories consolidate into adaptive memory networks and become part of long-term storage. Trauma-related memories can impede this process, leaving the memory unprocessed and kept in its original cognitive, emotional, and somatic state. This disruption of memory consolidation allows these three parts to both stand independently of one another and reinforce each other. Thus, when an unprocessed traumatic memory is triggered within an individual, they experience the same thoughts, feelings, and somatic responses they felt at the time of the incident. This re-experiencing is what contributes to and supports the cognitive, emotional, and somatic sub-narratives.

**Cognitive sub-narrative.** The cognitive sub-narrative includes cerebral skills, such as verbal ability, logic, and reason, and is regulated by the forebrain. This sub-narrative defines what people believe about themselves, others, and the world in general. For instance, Alicia's sexual assault might lead her to believe she is unsafe, that others cannot be trusted, and the world is dangerous. The cognitive sub-narrative typically involves the traditional aspects of narrative therapy, such as identifying the problem, plotting the problem's influence, deconstructing negative aspects of the problematic dominant narrative by adding context to the problem, and externalizing the problem (Madigan, 2011; White & Epston, 1990). Once an individual can separate their problem from their identity, they create a space through cognitive processing from which they can re-author a preferred narrative. Complications develop when addressing only the cognitive sub-narrative with

unprocessed trauma, as the associated emotional and somatic reactions emerge to both contradict the preferred cognitive sub-narrative and reinforce the problematic cognitive sub-narrative. Thus, this conflict can prevent creating a space from which a preferred dominant narrative may be re-authored.

In Alicia's case, she had gained perspective about her maladaptive cognitive sub-narrative, but her unresolved emotional and somatic reactions prevented her from creating new experiences that align with her preferred narrative. Alicia can make progress in therapy as it relates to her cognitive sub-narrative by verbally identifying ways in which her traumas have affected her life, however, her emotional and somatic sub-narratives remain unaddressed as evidenced by her anxiety and panic attacks. These sub-narratives will continue to challenge her new cognitive sub-narrative and prevent her from constructing a preferred dominant narrative.

**Emotional sub-narrative.** The emotional sub-narrative involves the experience of feelings, attachment, and affect regulation, and is regulated by the limbic system. This sub-narrative associates emotions to events people experience and memories that emerge. When a traumatic memory cannot be successfully consolidated into long-term storage and made adaptable, the distressful thoughts and emotions from the trauma remain intact and connected to that memory. For instance, Alicia's sexual assaults might lead her to develop the cognitive sub-narrative that she is unsafe in social settings, and her emotional sub-narrative would support this through the experience of anxiety and fear. As with the cognitive sub-narrative, any emotions associated with an unprocessed traumatic memory remain attached to that memory and activate when the memory triggers.

Thus, the emotional sub-narrative consists of emotional patterns that activate when an unprocessed traumatic memory triggers. These emotional patterns become habitual reactions for the specific traumatic memory and also may

generalize to other experiences that are less or completely unrelated to the memory. This generalization of the problematic emotional sub-narrative to other experiences could magnify and support the problematic cognitive sub-narrative and further complicate the preferred dominant narrative.

In Alicia's case, as she talks about her traumatic memories in counseling, her problematic emotional sub-narrative triggers. Despite the fact that Alicia recognizes her mother's verbally abusive messages as inaccurate and can add context to the story, she still cannot help feel unlovable and worthless, making it difficult to resolve her problematic cognitive sub-narrative. Additionally, memories of her multiple sexual assaults elicit an emotional pattern of degradation, shame, and guilt, resulting in anger. These triggers generalize to other experiences over time, and Alicia now feels anxiety in situations that evoke her problematic emotional sub-narrative.

**Somatic sub-narrative.** The somatic sub-narrative, regulated by the autonomic nervous system, consists of a pattern of physical reactions in response to memories and the environment an individual experiences following a trauma. These physical responses, like the cognitive and emotional sub-narratives, are stored as part of the memory of the trauma and may include such things as rapid heartbeat, shortness of breath, sweating, nausea, and psychomotor agitation. Similarly, the somatic sub-narrative may also generalize to experiences other than the traumatic memory, reinforcing the problematic cognitive and emotional sub-narratives, and also the maladaptive dominant narrative.

Although Alicia and her counselor gained perspective and verbally re-authored her preferred cognitive sub-narrative, her unprocessed emotional and somatic sub-narratives continued to reinforce the dominant maladaptive narrative. Therefore, although she may be able to add context to past experiences, she cannot create new unique outcomes to substantiate her preferred narrative that does not

blame herself for her history of verbal abuse and sexual assault due to her emotional (e.g. worthlessness, shame) and somatic reactions (e.g., fidgeting, tension, nausea, sensation to move). Alicia's emotional reactions influenced her cognitive and somatic sub-narratives: her feelings of shame and worthlessness reinforced her beliefs that the world is not safe and she is not lovable, which also trigger negative somatic reactions, such as tension and fidgeting with appearance, that support such beliefs. So while Alicia can verbally tell her counselor that she knows she is safe and worthy of love, she cannot help but feel she is not safe, unlovable, and continues to react physically.

Not only can Alicia not create unique outcomes, but her new experiences reinforce her problematic cognitive, emotional, and somatic sub-narratives. Specifically, as Alicia's anxiety and panic attacks become more generalized, their deleterious effect on her ability to align with the preferred cognitive sub-narrative increases. For example, although Alicia wants to believe that her somatic symptoms (e.g., panic, sensation to move) were once an adaptive response to a real threat, the recurrent panic attacks are now triggered by a number of seemingly innocuous situations that reinforce feelings of anxiety, self-blame, and shame. These feelings become internalized and support the belief that she is flawed due to her inability to control her panic attacks, ultimately leading to new experiences that will substantiate these distressful emotions.

## **Recommendations**

Four recommendations are provided, two of which are mindfulness-based, for narrative counselors to address a client's cognitive, emotional, and somatic sub-narratives. Mindfulness techniques have been employed by narrative counselors to facilitate the re-authoring process and expand the concept of self (Gregg Blanton, 2007; Percy, 2008). Furthermore, the practice of mindfulness following trauma

exposure may result in greater resiliency, whereas dissociation and emotional disengagement potentially exacerbates trauma symptomatology (Thompson, Arnkoff, & Glass, 2011). Therefore, it is suggested that counselors begin with mindfulness-based recommendations, as these techniques have successfully been employed by both narrative counselors and by counselors to specifically address trauma.

When traumatic memories remain unconsolidated into long-term storage, emotional and somatic responses that were adaptive within the context of the trauma later become triggered in similar situations wherein they are now problematic. The recommended techniques are used to process traumatic memories by expressing the emotional and somatic sub-narratives through their own nonverbal language (e.g., feelings, sensations, movement), in addition to integrating these sub-narratives with the cognitive sub-narrative. Once the sub-narratives are processed and congruent, the client can create unique outcomes that support the preferred dominant narrative.

### **Grounding and Relaxation**

Prior to addressing the emotional and somatic sub-narratives through guided activities, mindfulness-based grounding and relaxation techniques need to be established in order to prevent the client from experiencing severe hyperarousal or hypoarousal throughout the session. Learning to regulate breathing serves as a foundation for more complex relaxation techniques. After the client establishes regulated breathing, they can begin to create a calm, safe place used to prevent entering a state of hyper- or hypoarousal during therapy. Many similar methods exist to regulate arousal; this model provides two specific grounding and relaxation techniques

**Breathing.** Given that posture affects breathing, start by asking the client to notice and describe their current posture (e.g., slumped, stiff) and breathing style (e.g., shallow, quick). Then, request they lengthen their spine by sitting up straight, hold the crown of their head up, relax their shoulders, plant their feet on the ground, place a hand on their chest and abdomen to feel their breathing. The client should describe any noticeable changes in breathing that accompany this change in posture. Encourage them to take slow, deep breaths while maintaining the change in posture.

Breathing activities help clients both be mindful and regulate their breathing through a series of directives (e.g., attempt to push your hand out with your abdomen when you inhale; breathe in with your nose and out with your mouth; breathe in for 3-4 seconds, pause for one second, and breathe out for 3-4 seconds). The counselor is encouraged to perform these breathing activities along with their clients in order to demonstrate and normalize these exercises for their clients. How many times during a session breathing exercises should be performed depends upon how often the client needs to regulate their arousal.

**Calm/safe place.** Once the client can regulate their breathing, they can begin to create the image of a calm, safe place to think about when they leave the zone of optimal arousal while both in and out of the counseling session. Begin by having the client maintain the desired posture and breathing style from the previous exercise. Next, ask them to close their eyes and guide them through the creation of their imaginary safe place (Shapiro, 2001). This place may be real or imagined, where nothing can harm them. In the case which a client chooses a real place for their safe place, there must be no traumatic associations connected to that place. In the safe place, the client has everything they could possibly need to maintain their comfort (e.g., pet, books, food). Walk the client through describing every aspect of this place using all five senses. After the client has fully developed their calm, safe place, the counselor should encourage the client to name their safe place. When the

client becomes unregulated in session, the counselor can tell them to close their eyes, take three deep breaths, say the name of the place, and visualize it.

### **Body Mapping**

Body mapping is an expressive, storytelling technique where a client artistically responds to a series of questions on a paper outline of their body. This approach has been used among people diagnosed with post-traumatic stress disorder to uncover the emotional and somatic sub-narratives of the traumatic experience without having to verbalize it and thus trigger a severe emotional and somatic response (Crawford, 2010). Prior to beginning the body map, the counselor should provide relaxation and grounding techniques for their client to reduce hyper- or hypoarousal. These techniques help them stay present and aware of their emotional and somatic states throughout the session. A periodic body scan should be initiated by the counselor to monitor the client's ability to regulate themselves during the session.

Once the initial grounding and relaxation techniques are complete, the client traces an outline of their body onto a large paper. The counselor then asks the client questions related to what symbol might represent them, how their body remembers the trauma, and how they remain present, to which the client responds by drawing, writing symbols, or otherwise marking on their paper body, thereby designing a map of the traumatic experience (Crawford, 2010). Typically, this activity takes several sessions to complete. The goal here is for the client to both identify how the three sub-narratives respond to the trauma and learn to regulate each sub-narrative while talking about the traumatic memory, thus preventing the problematic emotional and somatic sub-narratives from negatively influencing the cognitive sub-narrative.

In Alicia's case, her emotional and somatic sub-narratives prevented her from making further therapeutic gains. To address this, her counselor used body mapping to address her sub-narratives of emotional and somatic responses. Prior to beginning the body map, the counselor established grounding and relaxation techniques as needed before, during, and after each session. Using the body map, Alicia explored her emotional sub-narrative by illustrating shame, worthlessness, and anger through symbols and colors. She drew her somatic sub-narrative by where the trauma resides in her body and identified three main areas: nausea in her stomach and restlessness in her hands and legs. Alicia addressed her nausea by coloring her stomach on the outline in shades of red, brown, and black. She glued sand on her stomach to signify the heavy feeling in her stomach. Alicia also illustrated her restlessness in her hands and legs by drawing arrows pointing away from them. She cut her hands and legs away from the body map so she could move them freely when she felt triggered. As she is able to depict the painful emotions, restlessness in her arms and legs, and turmoil in her stomach, she developed a deeper awareness of her traumatic emotional and somatic sub-narratives. After two months, she could regulate all three sub-narratives, as evidenced by her ability to verbally discuss the emotional and somatic reactions depicted on the body map to her counselor without experiencing hyperarousal.

### **Contradictions Between Mind and Body**

Incongruence between the cognitive, emotional, and somatic sub-narratives disrupt the process of creating a preferred dominant narrative. This written exercise helps the client delineate how learned patterns of somatic and emotional responses affected by trauma counters their thoughts, or cognitive sub-narrative, that may support the preferred dominant narrative. For this exercise, the client makes a list of situations that trigger them and writes down what their mind knows about the

experience, how their somatic responses to these experiences might contradict what their mind knows, and their resulting emotional response (Ogden & Fischer, 2015). The purpose of this exercise is to externalize the problem by mapping out the pattern of how the problem operates. By identifying and interrupting the contradictory somatic and emotional responses through the use of the grounding and relaxation techniques described above, unique outcomes can be recognized and initiated.

Although Alicia cognitively identified her panic attacks and feelings of fear and shame as adaptive responses to a traumatic experience in the past, her continued inappropriate somatic and emotional responses in safe situations challenge her belief that she is in fact safe. During this exercise, Alicia identified that when she walks into a room with men, she cognitively knows that she is not in immediate danger. However, these situations trigger panic attacks that elicit feelings of shame and self-blame. Due to her somatic and emotional response, she cannot fully trust that she is safe. Now that Alicia has mapped out her cognitive, somatic, and emotional sub-narratives when walking into a room of men, she knows when to interrupt her somatic and emotional responses by using breathing exercises and entering her calm, safe place to reduce her somatic and emotional reactions. Over time, she learns to regulate her somatic and emotional reactions in triggering situations, allowing her to believe that she is safe.

## **Discussion**

Trauma affects an individual on many levels, including their thoughts, emotions, and somatic reactions. Narrative counselors who focus exclusively on the cognitive sub-narrative do not address how a traumatic event influences the emotional and somatic sub-narratives. This blended model presents a synthesis of the goals of narrative therapy with the Adaptive Information Processing model to

further conceptualize trauma from a narrative perspective. The use of this model supports a person's naming and storytelling rights of three distinctive but interrelated sub-narratives using verbal and nonverbal methods so they can re-author their dominant narrative. By addressing the cognitive, emotional, and somatic sub-narratives simultaneously, clients can build congruence between these sub-narratives that leads to the construction of their preferred dominant narrative.

While four specific recommendations are provided here, it is advised that counselors using this synthesis appropriately apply specific techniques based on their client's individual needs, which emphasizes the client's autonomy and creative input within the process. However, the authors maintain that mindfulness-based interventions should be implemented prior to expanding to more narrative formulating techniques to reduce trauma-based hyper- or hypoarousal. In order to do so ethically, counselors need to explain possible risks associated with the counseling process (ACA, 2014; Standard C.7.a). During the assessment, counselors should evaluate for readiness to proceed with these interventions as well as any other ethical considerations. Additionally, willingness to participate in this uniquely creative process of counseling as well as other multicultural dynamics should be discussed between counselor and client prior to beginning (ACA, 2014; Standard F.11.c). To promote professional competence, it is recommended that narrative counselors looking to apply the AIP model attend mindfulness training in addition to available workshops on trauma and other somatosensory techniques (ACA, 2014; Standard C.2.a). Lastly, future research recommendations include empirical studies on the application of narrative therapy and the AIP model as well as trauma competence among counselors using narrative therapy.

## References

- American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA: Author.
- American Psychological Association. (2016). *Trauma*. Retrieved from <http://www.apa.org/topics/trauma>
- Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., & Stevens, M. (2011). The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from [http://www.cdc.gov/violenceprevention/pdf/nisvs\\_report2010-a.pdf](http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf)
- Brewin, C. R. (2014). Episodic memory, perceptual memory, and their interaction: Foundations for a theory of posttraumatic stress disorder. *Psychological Bulletin, 140*, 69-97. doi: 10.1037/a0033722
- Cashin, A., Browne, G., Bradbury, J., & Mulder, A. M., (2013). The effectiveness of narrative therapy with young people with autism. *Journal of Child and Adolescent Mental Health Nursing, 26*(1), 32-41.
- Clark, L., Tyler, N., Gannon, T.A., & Kingham, M. (2014). Eye movement desensitization and reprocessing for offence-related trauma in a mentally disordered sexual offender. *Journal of Sexual Aggression, 20*, 240-249. doi: 10.1080/13552600.2013.822937
- Cory, G. A. Jr. (2000). From MacLean's triune brain concept to the conflict systems neurobehavioral model: The subjective basis of moral and spiritual consciousness. *Zygon, 35*(2), 385-414.
- Council for Accreditation of Counseling and Related Educational Programs. (2016). *CACREP standards*. Alexandria, VA: Author.

- Crawford, A. (2010). If 'the body keeps the score': Mapping the dissociated body in trauma narrative, intervention, and theory. *University of Toronto Quarterly*, 79(2), 702-719.
- Crittenden, P. M. (1997). Toward an integrative theory of trauma: A dynamic-maturation approach. In D. Cicchetti & S. L. Toth (Eds.), *Developmental perspectives on trauma: Theory, research, and intervention* (34-). Rochester, NY: University of Rochester Press.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventative Medicine*, 14(4), 245-258.
- Foucault, M. (1977). *Discipline and Punish: The birth of the Prison*. New York, NY: Pantheon Books.
- Gardner, P. J., & Poole, J. M. (2009). One story at a time: Narrative therapy, older adults, and addictions. *Journal of Applied Gerontology*, 28, 600-620. doi:10.1177/0733464808330822
- Geertz, C. (1973). *The interpretation of cultures*. New York, NY: Basic Books.
- Gondolf, E. W. (1987). Evaluating programs for men who batter: problems and prospects. *Journal of Family Violence*, 2, 95-108.
- Gregg Blanton, P. (2007). Adding silence to stories: Narrative therapy and contemplation. *Contemporary Family Therapy*, 29(4), 211-221.
- Hannen, E., & Woods, K. (2012). Narrative therapy with an adolescent who self-cuts: A case example. *Educational Psychology in Practice*, 28(2), 187-214.
- Hoecker, R. (2014). Visual narrative and trauma recovery. *Narrative Inquiry*, 24, 259-280. doi: 10.1075/ni.24.2.05hoe
- Jaeger, J., Lindblom, K. M., Parker-Guilbert, K., & Zoellner, L. A. (2014). Trauma narratives: It's what you say, not how you say it. *Psychological*

- Trauma: Theory, Research, Practice, and Policy*, 6, 473-481. doi: 10.1037/a0035239
- Lopez, G. (2011). Why verbal psychotherapy is not enough to treat post traumatic stress disorder: A biosystemic approach to stress debriefing. *Body, Movement, and Dance in Psychotherapy*, 6, 129-143. doi: 10.1080/17432979.2011.583060
- MacLean, P. D. (1990). *The triune brain in evolution: Role in paleocerebral functions*. New York: Plenum Press.
- Madigan, S. (2011). *Narrative Therapy*. Washington, DC: American Psychological Association.
- Matos, M., Santos, A., Goncalves, M., & Martins, C. (2009). Innovative moments and change in narrative therapy. *Psychotherapy Research*, 19, 68-80. doi:10.1080/10503300802430 657
- The Nebraska Department of Veterans' Affairs (2007). Post-traumatic stress disorder: What is PTSD? Lincoln, Nebraska. Retrieved from: <http://www.ptsd.ne.gov/what-is-ptsd.html>
- Ogden, P., & Fisher, J., (2015). *Sensorimotor Psychotherapy: Interventions for trauma and attachment*. New York, NY: W.W. Norton & Company.
- Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: W. W. Norton & Company.
- Percy, I. (2008). Awareness and authoring: The idea of self in mindfulness and narrative therapy. *European Journal of Psychotherapy and Counseling*, 10(4), 355-367.
- Safe Voices (2016). Abuse Statistics. Retrieved from: <http://www.safevoices.org/statistics.php>
- Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). New York, NY: Guilford Press.

- Shapiro, F., & Laliotis, D. (2010). EMDR and the adaptive information processing model: Integrative treatment and case conceptualization. *Clinical Social Work Journal, 39*, 191-200. doi: 10.1007/s10615-010-0300-7
- Shepard, M. F. & Campbell, J. A. (1992). The abusive behavior inventory: a measure of psychological and physical abuse. *Journal of Interpersonal Violence, 7*, 291-305.
- Stocks, C. (2007). Trauma theory and the singular self: rethinking extreme experiences in the light of cross cultural identity. *Textual Practice, 21*, 71-92. doi: 10.1080/09502360601156971
- Straus, M. A. (1979). Measuring intrafamily conflict and violence: The conflict tactics (CT) scales. *Journal of Marriage and the Family, 41*, 75-88.
- Substance Abuse and Mental Health Services Administration. (2014). Understanding the impact of trauma. *Trauma informed care in behavioral health: Treatment improvement protocol series, No. 57*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from: <http://www.ncbi.nlm.nih.gov/books/NBK207191/>
- Substance Abuse and Mental Health Services Administration. (2015). Trauma and violence. Retrieved from: <https://www.samhsa.gov/trauma-violence>
- Thompson, R. W., Arnkoff, D. B., & Glass, C. R. (2011). Conceptualizing mindfulness and acceptance as components of psychological resilience to trauma. *Trauma, Violence, & Abuse, 12*(4), 220-235.
- Truman, J. L., & Langton, L. (2015). Criminal victimization, 2014. U.S. Department of Justice. Retrieved from: <http://www.bjs.gov/content/pub/pdf/cv14.pdf>
- Van der Kolk, B. A., & Van der Hart, O. (1991). The intrusive past: The flexibility of memory and the engraving of trauma. *American Imago, 48*(4), 425-454.

- Vromans, L. P., & Schweitzer, R. D., (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research, 21*, 4-15. doi: 10.1080/10503301003591792
- Wesselman, D., & Shapiro, F. (2013). Eye movement desensitization and reprocessing. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents* (pp. 203-205). New York, NY: Guilford Press.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W. W. Norton & Company.