

## Values and visions for the field of psychological trauma, from brain to re-moralization and social transformation

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I write this editorial from my experience as a 54-year-old psychologist who has studied psychological trauma and dissociation from many perspectives, ranging from research on neurobiology and memory, to male victims and perpetrators of violence, and the interventions of EMDR and MDMA-assisted psychotherapy. I have also worked to educate lay audiences and to foster institutional, social, and cultural transformation via my website, engagements with the media, and training of police, prosecutors, judges, military commanders, higher education administrators, legislators, and many others. Over 30 years in those varied endeavors, I believe that I've gained some valuable knowledge and insights, and hope that sharing a few here will be helpful to *Journal of Trauma & Dissociation* readers and others who find this editorial.

Here are my central messages: We must understand the essentially *moral* nature of human beings, especially traumatized people, in order to foster the individual, relational, institutional, and social transformations that can reduce trauma and bring genuine healing, happiness, and well-being to as many people as possible.<sup>1</sup> And we must understand and leverage the centrality of human values at every level of analysis and intervention.

### A New Perspective on the Brain: Centrality of the “Seeking Circuitry”

In recent years, the conventional neurobiological wisdom among academic researchers and clinicians in the field of psychological trauma has focused on the amygdala or “fear circuitry” and regulation of those by the prefrontal cortex; on fear extinction and memory reconsolidation; and on “interpersonal neurobiology” and “polyvagal theory.” Some of those perspectives have more scientific support than others, but all have been found helpful by substantial numbers of research and clinical professionals, which accounts for their popularity and staying power.

The framework for understanding traumatized brains and healing that I'm offering here, as in prior writings (Hopper, 2014, 2017),<sup>2</sup> is largely

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<sup>1</sup>Spirituality is just as central, I have found, but addressing that is beyond the scope of this editorial.

<sup>2</sup>See also the “Brain, Healing & Happiness” section of my website, [www.jimhopper.com](http://www.jimhopper.com), especially the page, “Cycles of Suffering, Healing & Happiness.”

compatible with and complementary to conventional ones. However, it has different intellectual and empirical roots and, more importantly, a different moral (and spiritual) vision at its core. It also has implications for theory, research, and practice – including practices of institutional and social transformation, not just clinical intervention.

Most readers have heard of the brain’s “reward circuitry” from addiction research and the media’s popularization of dopamine’s functions (actual and imagined). Unfortunately, the term “reward” often obscures more than it reveals, in part because the reward circuitry can be parsed into two key subcomponents: a *seeking circuitry* that is primarily dopaminergic and associated with anticipatory pleasure, wanting, expecting, craving, longing, and motivated behavior; and a *satisfaction circuitry* that is primarily (mu) opioid and underlies experiences of consummatory pleasure, physical and psychological contentment, safe and loving interpersonal connection, and fulfillment of various kinds. (The term “seeking circuitry” was coined by Jaak Panksepp [1998; Alcaro & Panksepp, 2011]; “satisfaction circuitry” by me [Hopper, 2014].)

The seeking circuitry underlies all motivated thinking and behavior, and can be seen as the “lifeforce” manifesting in our brains. It innervates the prefrontal and anterior cingulate cortices, and through those pathways contributes to deliberate choices and effortful seeking, while its other major output, via the dorsal striatum, is associated with habitual seeking that is conditioned and automatic (Balleine & O’Doherty, 2010; Salamone & Correa, 2012; Walton & Bouret, 2019).

How is this relevant to psychological trauma, aside from the well-established link between trauma and addiction? There have been decades of research, writing, and talk about “emotion dysregulation” in trauma and PTSD, complex PTSD, and dissociative disorders. But few have focused on the fact that most behaviors conceptualized as “emotion dysregulation,” which happen when people get “triggered,” are *habits*. Not only are they habits, but like all habits, they are *habits of seeking* – specifically, habits of seeking to avoid and escape unpleasant and unwanted thoughts, memories, feelings, and body experiences (including those associated with dissociative states).

The recognition that emotion dysregulation mostly runs on the brain’s seeking circuitry is essential to understanding the neurobiology and psychology of trauma. And it is essential for linking neurobiology to more than emotion regulation, fear extinction, memory reconsolidation, and other conventional visions of healing and recovery that focus on individual “psychopathology” and are thereby not only socially and culturally decontextualized but disconnected from human values (and spirituality).

Therefore, I suggest that we continually ask ourselves and at least partly work from these questions: What do the seeking circuitries of traumatized people’s brains seek? What are their *values* – especially their actual lived values, as evidenced by their dominant thoughts and behaviors? What can bring traumatized people

and their brains – and their loved ones, and the institutions, communities, and cultures in which they live – genuine healing, satisfaction, and well-being?

Those questions are important not just in reference to traumatized brains, but for each topic and level of analysis in our research, clinical work, and efforts at institutional and social transformation. They are questions that address the moral (and spiritual) dimensions of trauma and healing, not just the biological and psychological ones.

### **Brain Values, Hard-Wired and Learned**

Evolution has shaped our mammalian and human brains to value and seek some things and experiences over others. As many declare these days, we are “wired for connection.” We can’t help but need safe and supportive relationships, because they’re inherently good for our brains and bodies (Beckes & Coan, 2011; Coan & Sbarra, 2015). A great deal of research has found that we can’t help but need and value relationships and interactions that support our autonomy, competence, and relatedness (Deci & Ryan, 2008; Ryan & Deci, 2001). When we feel safe to do so, we can’t help but seek to meet those innate needs and values. In brain terms, those are hard-wired needs and values that our seeking circuitries inescapably want and seek (Panksepp, 1998; Panksepp & Biven, 2012).

Of course, beyond formative influences from genetics and temperament, what our brains value and seek are also greatly shaped by relationships and experiences in our families, communities, institutions, and cultures. Indeed, we can be conditioned to value and seek all kinds of things, not only the healthy objects and ideals that emerge in unique cultures and subcultures but also what can be very unhealthy and harmful to ourselves and others. The latter range from addictive drugs, environmentally destructive consumer products and ways of exploiting others for profit and power, to many other things associated with posttraumatic dysregulation, including habits of dissociative avoidance and escape.

### **Fear of Moralizing, Moral Inarticulacy, and Inescapable Selves in Moral Space**

All non-reflexive behavior is *motivated*, and thus inescapably involves values and seeking. Unfortunately, and to all of our detriment, fear of acknowledging the role of values, particularly a fear of “moralizing,” has prevented neuroscience, psychology, and other social sciences from understanding and making use of this reality: the centrality of *seeking what is valued* to the functioning of our brains and to cognition, emotion, and behavior. This state of affairs makes sense, because in Western culture since the late 18th century instrumental

reason and the sciences – including medical and behavioral sciences – have been embraced as counters to and even replacements for religious authorities vulnerable to judgmental and destructive moralizing.<sup>3</sup>

However, as the philosopher Charles Taylor has explained in his magisterial book *Sources of the Self* (Taylor, 1992), fear of such moralizing has rendered us *morally inarticulate*, that is, unable to recognize, name, and draw upon the moral values that actually underly our identities and motivated behavior. This despite the fact that, as Taylor shows, we humans *can't help* but be “selves in moral space” – continually evaluating whether we are moving toward or away from valued ways of being (a parent, partner, scientist, therapist, etc.), and continually evaluating, even if only implicitly, how close to or far from those ideals we are. Indeed, whether we realize it or not, our values<sup>4</sup> are a major foundation of our selfhood and identity, and articulating our highest ideals can support our efforts to embody them.

### Values in Psychotherapy and Addiction Theory and Treatment

For decades humanistic, transpersonal, and religiously affiliated psychotherapists and theorists have articulated the importance of moral values in human suffering, healing, and flourishing. But with a few notable exceptions, including Acceptance and Commitment Therapy (ACT; Follette & Pistorello, 2007; Harris, 2009; Hayes, Strossahl, & Wilson, 2016) and motivational interviewing (Miller & Rollnick, 2012), mainstream clinical theorists, researchers, and practitioners have largely ignored the centrality of values in psychological suffering, therapeutic and healing processes, and happiness and well-being.

Addiction is an important realm of clinical theory, research, and practice in which the central role of values has been particularly feared and avoided. In the 20th century, with the best intentions – and largely in reaction to traditional religious and folk psychological views of addictions, which have judged and stigmatized addiction as “moral failure” and “bad choices” – most of those who studied and treated addictions embraced the medical model. Most still authoritatively proclaim that addiction is “a disease, not a choice,” a slogan common in statements and policies of the National Institute on Drug Addiction (NIDA) and on posters found in addiction, mental health, and medical clinics around the country.

But must we choose between seeing people who struggle with addictions either as “moral failures” or as having a “brain disease”? Are those really the only options? No. We need not embrace either of those extreme (and invalid)

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<sup>3</sup>Of course, scientists can moralize, sometimes in judgmental and destructive ways, based on values, beliefs, and articles of faith often associated with science yet unprovable with scientific methods (e.g., naturalism, materialism).

<sup>4</sup>Milton Rokeach (1973) helpfully classified values into *terminal*, the primary ends toward which our lives are directed, e.g., personal comfort and security, freedom, God's will; and *instrumental*, general ways of being in the world, some of which can be quite central to identity.

views. Instead, we can see and acknowledge that addiction entails *valuing, seeking, and choosing* substances and behaviors (or experiences associated with their use) despite the negative consequences of doing so, including harming other things that one values.

As Gene Heyman (2009) has shown in his brilliant book, *Addiction: A Disorder of Choice*, addictive behaviors are *voluntary*. They are based on current *valuation* of behavioral options as a function of context and conditions. And they reflect a *local* frame of analysis and prediction (i.e., what will be most rewarding or pleasurable now?) rather than a global one (i.e., what is the best choice considered over time?). (See Heyman, 2009, especially chapters 5 and 6.) Voluntary does not mean unconstrained (by neurobiology), and certainly there are progressive brain changes associated with addiction that increase the probability of valuing, seeking, and choosing addictive things (Volkow, Michaelides, & Baler, 2019), but that doesn't mean addiction is a "brain disease" (Lewis, 2018).

This is important for a variety of reasons. Failure to understand that addiction is indeed partly a function of one's values, seeking, and choices greatly limits our ability to help people who suffer from addictions. Furthermore, there is no good evidence that the brain disease model, with its (demonstrably false) claim that addiction is *not* about values and choices, has delivered on its promises of destigmatizing addiction and increasing treatment seeking (e.g., Haslam & Kvaale, 2015; Kvaale, Haslam, & Gottdiener, 2013; Meurk, Carter, Partridge, Lucke, & Hall, 2014; Wiens & Walker, 2015).

In contrast, decades of NIDA-funded research on addiction and the brain's "reward circuitry" are much better understood (in part) as elucidating *the centrality of brain's seeking circuitry* in addiction. And the seeking circuitry always seeks what people (and their brains) *value* – under particular external and internal conditions, including stressful and traumatic ones – however harmful and self-defeating those values, that seeking, and such choices can be.

## **Psychological Trauma Entails Addictive Patterns of Unhealthy Values and Seeking**

Why have I focused on values and addiction in an editorial on visions for the field of psychological trauma? Because I have become convinced that to advance scientifically, clinically, and in contributions to institutional and social change, the field must recognize that *psychological traumatization entails unhealthy values and addiction*. That is, at every level of traumatization – from severe complex PTSD or dissociative identity disorder to the "healthy" who are still wounded and vulnerable human beings – we all value, seek, and grasp at things and experiences that do not relieve our suffering, except fleetingly, that may only worsen it, and that definitely don't heal our psychological wounds.

Posttraumatic physiological dysregulation can have powerful warping effects on people's values, seeking, and choices. The same is true of the fear, distrust, and hopelessness associated with traumas involving personal or institutional betrayal (Freyd, 1998, 2013; Smith & Freyd, 2014). When one has learned that other people cannot be trusted for love and support, one will value and seek "support" and escape from addictive substances, behaviors, and experiences. When one's daily life is largely focused on survival and coping with overwhelming negative emotions, disconnection from one's own body, emotions, and other people, and/or fragmentation into extreme and polarized subpersonalities or "parts" (e.g., Schwartz & Sweezy, 2019), then what is valued, sought, and chosen is often unhealthy and unsatisfying (Hopper, 2014). The same is true when socialization and enculturation processes, including those associated with gender, have conditioned one to value ways of thinking, feeling, and behaving that limit and harm oneself and others (e.g., Gilmore, 1990; Hopper, 2017; Lisak, 1995).

Indeed, posttraumatic "emotion dysregulation" largely consists of (repeated) choices to seek avoidance and escape from (anticipated/imminent) suffering in the present at the cost of future unhealthy consequences. It entails addictive habits of valuing, seeking, and choosing. "Grounding," "emotional regulation," and "self-regulation" skills are mostly ways of breaking those addictive habits by deliberately – and eventually habitually – valuing, seeking, and choosing effective and healthy responses to unpleasant and unwanted emotional, bodily, and relational experiences.

Critically, "addiction" need not be a judgmental or moralizing term. It is simply a central aspect of the human condition. We're all addicted to habits of avoiding and escaping unwanted bodily, emotional, and relational experiences. We're all addicted, to some extent, to thoughts and fantasies of avoidance and seeking that are running on components of our brain's default mode network (Buckner & DiNicola, 2019; van Vugt, 2017). (If you haven't observed that yet, just try keeping your attention focused for the next few minutes on the breathing sensations in your belly.)

The point here is not to judge or moralize, and certainly not to heap additional stigma or shame on traumatized people. It is rather to acknowledge and address the real and essential *moral dimension* of psychological traumatization and human suffering more generally. Indeed, it is essential that we acknowledge and address this moral dimension if we are to value and support the inherent dignity of traumatized people, who, like all of us, are inescapably moral beings.

And we must do so with sophistication and subtlety, in ways that address the complexity of how values can shape the self-understandings, behaviors, and well-being of traumatized people. In a recent example of such an approach, Delker and colleagues (Delker, Salton, & McLean, 2019) drew attention to the ways that publicly shared "victim to survivor/advocate" narratives can both resist and reinforce dominant cultural values that are harmful to some traumatized people. On the one hand, such narratives and their public telling can help traumatized

people resist cultural values that silence them. On the other hand, they can reinforce certain dominant culture values, including individualism and redemption, that deny the realities of traumatized people from marginalized groups and reinforce their continued oppression.

## **Healing Psychological Trauma Requires Re-moralization, Cultivating Healthy Moral Values, and Virtues**

Posttraumatic suffering involves valuing, seeking, and choosing things and experiences that are unhealthy and against one's highest values. It is always, to some degree, *demoralizing*. Therefore, healing from trauma – and cultivating genuine happiness and well-being – requires more than reducing symptoms, learning new self-regulation and interpersonal effectiveness skills, enhancing prefrontal cortex control, calming the autonomic nervous system, extinguishing fear or reconsolidating traumatic memories, and the other things on which most trauma treatments focus. For traumatized people, healing, happiness, and well-being also require *re-moralization*.

These ideas are not new, but the roles of values in suffering, healing, and cultivating happiness and well-being are rarely articulated in terms of demoralization and re-moralization. As noted above, motivational interviewing (Miller & Rollnick, 2012) and ACT (Hayes et al., 2016) are “evidence-based” interventions that include eliciting and harnessing moral insight and action to foster healing and well-being, and ACT has been applied to trauma recovery and treatment (Engle & Follette, 2014; Follette & Pistorello, 2007). In *Seeking Safety* (Najavits, 2002) each unit fosters reflection on core values (e.g., with inspirational quotes) and the importance of acting from those values in recovery from trauma and addiction. At the institutional level, the movement for “trauma-informed” organizations (Becker-Blease, 2017; Harris & Fallot, 2001) and Freyd's work on “institutional courage” (Freyd, 2013) – that is, courage to live up to an institution's values – both leverage values to seek not only care and healing but justice, and not only for traumatized individuals but for institutions traumatized and corrupted by betrayal of moral values. As Michael Salter (2019) explicitly and eloquently argued in a recent editorial in this journal:

If we seek to find opportunities for trauma survivors to recover and live well, and if we want to promote the conditions in which people are not traumatised in the first place, then we are necessarily advancing moral propositions about human happiness and flourishing. Research on trauma, recovery and psychological wellbeing consistently finds that human beings thrive when we are embedded in emotionally rich, mutual and equitable relationships. This conclusion furnishes us with a powerful and, I think, very appealing image of a good life – one characterized by dignity, equality, accountability, and shared recognition – that the trauma field should not hesitate in articulating clearly (2019, p. 138).

We are all embodied moral agents. We are all, inescapably, selves in moral space. It is critical that we incorporate these realities into our understanding of traumatized people, and our efforts to help them heal and to transform the relationships, institutions, communities, and cultures in which we all live.

The approaches mentioned above, however, are missing a critical component. This is true even of Salter's vision, which speaks to moral values embodied by relationships, institutions, and cultures that provide a "good life" for traumatized people (and everyone else, of course). What about the moral values that traumatized people can articulate and embody *themselves* – not only for their own healing, happiness, and well-being but for them to participate in creating good lives for everyone else too? I'm referring to the cultivation of *virtues*.

Since the dawn of civilization, religious and philosophical sages have extolled the "good life" and the virtues it entails. Certainly, different visions of the good life and cardinal virtues have been promoted by different religions, philosophies, and cultures. But modern and secular Western culture, including psychiatry and clinical psychology, have been nearly silent on the relationships between virtue and healing, happiness, and well-being. Indeed, many readers of this editorial will not know what is meant by virtue and are likely to see it as an antiquated notion of little to no relevance to the field of psychology, let alone psychological trauma.

As the philosopher Paul Woodruff points out in his enlightening book, *Reverence: Renewing a Forgotten Virtue* (2014), a virtue is "the capacity to have certain feelings and emotions when this capacity has been cultivated through training and experience in such a way that it inclines those who have it to doing the right thing," and, more succinctly, "a capacity to have emotions that make you feel like doing good things" (2014, pp. 55–56). Virtues therefore entail valuing, seeking, and choosing to do good things – that is, things that are genuinely good for you and for others, including because they're good for institutions, communities, and societies. Woodruff helpfully contrasts "virtue ethics" with modern ethics, and notes that modern ethics is "mostly about doing what is right whether you feel like it or not" – that is, following rules. He explains:

By contrast, virtue is about cultivating feelings that will lead you in the right way whether you know the rule in a given case or not. Rules are hard to apply and hard to follow. Feelings, on the other hand, are easy to follow and hard to resist. That's why, from the standpoint of moral education, virtue is best (Woodruff, 2014, p. 56).

Note that Woodruff cites "training" and "experience" as cultivators of virtues. With respect to psychotherapy, interventions that (partly) focus on values and valued action, including motivational interviewing and

ACT, mostly focus on helping people clarify their core values and commit to acting in accord with them. They do not involve explicit, specific practices for cultivating emotional habits that promote actions consistent with those values. That is, they do not deliberately cultivate virtues. However, although not typically referred to as “virtues” (thanks to moral inarticulacy), all therapy approaches cultivate ways of thinking, feeling, and/or behaving that are believed (by that therapy’s adherents) to be particularly curative and generative of well-being. This includes habits of thinking cultivated by cognitive-behavioral therapies, habits of attending cultivated by mindfulness-based therapies, and habits of feeling and relating to feelings cultivated by compassion- and other emotion-focused interventions.

### Promising Directions and Concluding Thoughts

Given space limitations, I can only point to a few promising directions and developments consistent with the vision I’ve presented here.

Nearly 20 years ago, William Miller, eminent researcher and co-creator of motivational interviewing, coauthored with Janet C’de Baca the book *Quantum Change: When Epiphanies and Sudden Insights Transform Ordinary Lives* (2001). I cannot convey the rich data and profound insights it contains, except to say it’s a deep and thoughtful exploration of sudden and unexpected experiences of “quantum change,” which they define as “a vivid, surprising, benevolent, and enduring personal transformation” (2001, p. 4) that involves a massive reorganization, for the better, of one’s *values* (2001, pp.130–132).

The past 10 years have seen a renaissance of research on a treatment approach that is designed to deliberately bring about such sudden and lasting transformations: MDMA- and psilocybin-assisted psychotherapy for PTSD, treatment-resistant depression, addiction, and anxiety and depression associated with life-threatening illnesses (Carhart-Harris et al., 2016; Johnson, Garcia-Romeu, Cosimano, & Griffiths, 2014; Johnson, Garcia-Romeu, & Griffiths, 2017; Mithoefer, Wagner, Mithoefer, Jerome, & Doblin, 2011; Mithoefer et al., 2012, 2019; Ross et al., 2016).<sup>5</sup> In these studies, powerful consciousness-expanding medicines are safely administered within clinical protocols like those used in research on LSD- and other psychedelic-assisted psychotherapies from the 1950s to early 1970s (Mangini, 1998; Pollan, 2018; Richards, 2017).

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<sup>5</sup>For those who seek to learn how MDMA-assisted psychotherapy for PTSD has led the way in this renaissance, I highly recommend Tom Shroder’s excellent (but poorly titled) book, *Acid Test: LSD, MDMA, and the Power to Heal* (2014). It profiles the lives and work of Michael Mithoefer, principal investigator of the phase 2 and 3 FDA-approved trials, Rick Doblin, founder and executive director of MAPS, which sponsors the research, and a Marine Corps combat veteran and participant in the phase 2 trial.

Those protocols include several “preparation” sessions; eight-hour “medicine sessions” with a co-therapist team providing sophisticated clinical support for the client’s “inner-directed healing process”; and several “integration” sessions to help bring into one’s life and relationships the typically profound insights and massive shifts in experiences associated with those medicine-assisted expanded states of consciousness. I can personally attest, as someone closely following this work and a co-therapist in the FDA-approved phase-3 trial of MDMA-assisted psychotherapy for PTSD, to not only the profound healing these treatments can bring to traumatized people but the huge transformations of their values and lives as moral beings.<sup>6</sup> Importantly, those reorganizations of values and re-moralizations emerge spontaneously from within, as part of an “inner-directed healing process” that therapists support but never prescribe or direct.

Those are exciting and promising developments in interventions for individuals,<sup>7</sup> and I encourage readers to familiarize themselves with that work and consider getting involved as researchers, clinicians, or supporters in some other capacity.

The past 10-plus years have also seen an expansion of trauma-informed efforts to transform the understandings, values, policies, and practices of many organizations, institutions, communities. Since those developments are likely familiar to readers of this journal (e.g., Becker-Blease, 2017; Bloom, 2016; Salter, 2019), and more obviously concerned with moral values, I will say no more about them here.

In conclusion, I will briefly summarize and offer a vision for the future of the psychological trauma field. We are all moral beings; our brains have a seeking circuitry that implements our values in emotion, cognition, and behavior; and all forms of traumatization, like psychological suffering in general, involve addictive patterns of unhealthy values, seeking, and choosing, thus demoralization. Therefore, the cultivation of healing, happiness, and well-being are inherently moral processes and require re-moralization – the cultivation of moral articulacy, values, and virtues. These are insights, not judgments or moralizing, nor attempts to impose any values on anyone else.

My vision for the future of the psychological trauma field is that the centrality of values and morality is acknowledged and addressed in our theories, research, and clinical practices, and in our efforts to heal and transform institutions, communities, and societies. This will involve seeing a focus on values and morals as compatible with the (typically implicit)

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<sup>6</sup>Again, addressing the spiritual dimensions is beyond the scope of this editorial. But spiritual experiences can make large contributions to these transformations of values and morality, especially when participants have what researchers define and measure as “mystical” experiences, which are more common with psilocybin and other classical psychedelics than with MDMA. See the comprehensive review by Johnson, Hendricks, Barrett, and Griffiths (2019).

<sup>7</sup>Research has also begun on MDMA-assisted psychotherapy for couples in which one person has PTSD (see Wagner, Mithoefer, Mithoefer, & Monson, 2019).

values of behavioral science, as well as its methods (some of which are virtues). It will involve putting more thought, time, and effort into honestly reflecting upon and articulating our own values, and supporting our colleagues and students, as well as our clinical and institutional clients, to do the same. It will involve incorporating values and morality into our theories, research, and interventions – including by recognizing that “emotion dysregulation” entails unhealthy seeking and values, and by helping ourselves and our clients to recognize and cultivate moral virtues that lead naturally to acting consistent with our highest values. It will involve at least understanding and appreciating, and for some of us participating in, the wave of MDMA- and psychedelic-assisted psychotherapies now poised to revolutionize the treatment of trauma, addiction, and many other forms of psychological suffering. Finally, for many of us, it will require engaging with religious, philosophical, and spiritual traditions and practices that have been around a lot longer than behavioral science – and not just those traditions and practices currently trendy in our field (e.g., Buddhism and mindfulness), but those central to the lives of the individuals, families, institutions, communities, and societies that we seek to serve.

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