Treatment of Post Traumatic Stress Disorder

Reactions to Unrelenting Stress

- Ability to integrate (rare)
- Pre or during stress reactions
  - Most able to integrate
    - Denial
  - Serotonin based responses
    - Anxiety, panic, or phobic reactions
    - Depression/psychosis/OCD/etc (predisposition)

- Conflicted responses
  - Conversion Disorder
  - Hysteria (i.e., dysmorphia or hypochondriasis)
  - Dissociation
- Internalization responses
  - Shock (immediate)
  - Acute Distress Disorder
  - Post Traumatic Stress Disorder

Theory Base for PTSD

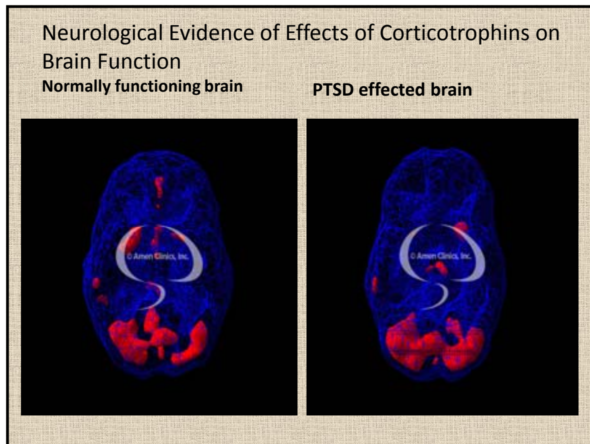
- Behaviorist explanation most practical
  - Easily explains chain of events internally
  - Congruent with tested theoretically based clinical applications
- Emotional learning
  - Experience of traumatic event
  - Internalization of immediate response teaches ongoing response to future cues
  - Generalizes to most environmental factors present at event
  - As individual reacts to environmental cues, reinforced learning for further generalization to array of potential triggers

Neurological explanation of effects of PTSD on the brain

- Research as early as the 1990s made a direct link between PTSD and corticotrophins, particularly cortisol (stress hormones) in the limbic system of the brain.
- Linked with earlier death (10 years), hypertension, diseases of lung, heart circulatory system, cancer, digestive system, joints, earlier sexual maturation in preadolescent girls, poorer decision making skills

Immediate Effects of Cortisol

- Stressor causes adrenalin rush which fades quickly but concurrent introduction of corticotrophins lasts up to 72 hours.
- During this period symptoms occur.
- Internalization of trauma without preventive measures increases chances that other non-trauma related environmental triggers will cause a “PTSD attack”.
- The body and mind condition to presence of cortisol and automatic thoughts and behaviors ensue.



Assessment of PTSD

- Research indicates decision tree assessment (ruling out) of disorders is only 60% accurate and cumbersome
- Most accurate and efficient diagnosticians rely on multiple hypothesis, also known as “problem solving diagnostic procedures” (ruling out rather than ruling in)
- PS changes the diagnostic interview from specific, assumptive questioning to rule to general, reflective, invitations to share experience of problems.

Symptoms of PTSD

- **Re-experiencing the traumatic event**
  - Intrusive, upsetting memories of the event
  - Flashbacks (acting or feeling like the event is happening again)
  - Nightmares (either of the event or of other frightening things)
  - Feelings of intense distress when reminded of the trauma
  - Intense physical reactions to reminders of the event (e.g. pounding heart, rapid breathing, nausea, muscle tension, sweating)

- **PTSD symptoms of avoidance and emotional numbing**
  - Avoiding activities, places, thoughts, or feelings that remind you of the trauma
  - Inability to remember important aspects of the trauma
  - Loss of interest in activities and life in general
  - Feeling detached from others and emotionally numb
  - Sense of a limited future (you don't expect to live a normal life span, get married, have a career)
  - Depersonalization
  - Derealization

PTSD symptoms of increased arousal

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance (on constant "red alert")
- Feeling jumpy and easily startled
- Outbursts
- Homicidal ideations

Other common symptoms of post-traumatic stress disorder

- Anger and irritability
- Guilt, shame, or self-blame
- Substance abuse
- Depression and hopelessness
- Suicidal thoughts and feelings
- Feeling alienated and alone
- Feelings of mistrust and betrayal
- Headaches, stomach problems, chest pain

Approaches to Treatment

- Original (traditional) approach
- Eye Movement Desensitization and Reprocessing (EMDR)
- Prolonged Exposure Therapy
- Cognitive Restructuring Therapy
- Symptom Abatement Therapy
- Group-based Interpersonal Psychotherapy for Post Traumatic Stress Disorder

Traditional Approach

- Continuous debrief of incidents
  - Assumes desensitizing factor by discussing what happened and how it affected life quality
  - Similar, both in procedure and outcome, to abreaction with dissociative disorders: neither diffused emotional trauma nor increased coping mechanisms in the present

EMDR

- Based on observation of client fixation
- Intervention is methodical, progressive sequence
- Advantages
  - Easily learned
  - Reliable within limits
- Disadvantages
  - Deals exclusively with singular events effectively
  - No therapeutic range
  - Research on effectiveness range done by EMDR specialists

Prolonged Exposure

- Based on earlier work with desensitization
- Geared to lowering stress using behaviorist desensitization procedures, reliving traumatic event
- Advantages
  - Easily learned
  - Reliable with limited range of clients
  - Reduces re-experiencing, avoidance, and hyperarousal

- Disadvantages
  - Only some clients respond favorably, others do not at all
  - Assumes all clients willing and able to revisit original trauma
  - Does not address full range of clinical problems including emotional discontrol, irritability, depression
  - Reliability range low

Cognitive Restructuring

- Cognitive Behavioral intervention
- Deals with automatic thoughts by means of Socratic Dialogue, Psychoeducation, and other Cognitive skill sets
- Advantages
  - Addresses emotional discontrol, irritability, depression
  - Deals with misperceptions that taint memories of traumatic events

- Disadvantages
  - Invites psychoeducation to take the part of counselling
  - Does not reduce re-experiencing, avoidance, and hyperarousal
  - Only some clients respond favorably
  - Invites resistance on the part of some clients
  - Reliability range low

Group Interpersonal Psychotherapy for PTSD

- Based on attachment and communication theories
- Developed to respond to the three psychological areas not addressed by other forms of counseling
  - re-experiencing
  - Avoidance
  - hyperarousal
- Process group model is central theoretic base of group
  - Present oriented
  - Confrontive
  - Interactive between participants

- Advantages
  - Good reliability in treating contemporary life responses, interactional skills, lessening overactivation behaviors, increases immediate interactional successes
  - Can address several clients simultaneously
  - Limited duration
- Disadvantages
  - Time limit does not address more severe reactive PTSD symptoms
  - Does not address issues from origin of PTSD, discontrol, irritability, or depression
  - Excellent group facilitator skills required for effectiveness

Symptom Abatement Therapy

- Theory base: Several theories converge to formulate this integrated intervention
  - Cognitive
  - Behavioral
  - Communication (Kiesler)
  - Attachment (Bowlby)
  - Psychodynamic
  - Person-centered (humanistic)

- Advantages
  - Addresses the composite of symptoms across past and present
  - Fluid: allows the counselor to start where the client starts
  - Provides immediate relief, reinforces client compliance and interest
  - Builds ongoing tools for self evaluation and growth
- Disadvantages
  - Requires grasp of several counseling applied theory bases
  - Not a "structured, sequential" type of therapy, concrete therapists might have difficulty applying skill sets

Some Basic Rules

- Activation and Overactivation
  - Some activation has to occur to produce desensitization
  - Find the therapeutic window
    - Don't overactivate or miss the opportunity to process when the client can tolerate and retraumatize (intensity control)
    - Intrinsic processing only as tolerable
  - Overactivation brings traumatic responses
    - Avoidance
    - Dissociation
    - Tension reduction behaviors

- If overactivation occurs, “grounding “is in order
  - Refocus onto therapeutic process and counselling relationship
  - Deal with internal experience
  - Orient client to external environment
  - Relaxation/breathing
- 5 components of therapeutic window
  - Re-experiencing conditioned emotional responses (CER)
  - Activation (exposing conditioned emotional response)
  - Disparity (discovering the incongruence between CER and reality of trigger)
  - Counterconditioning (positive therapeutic phenomena in existence during CER)
  - Desensitization resolution (breaking the connection)

Therapeutic sequence

- Intake
  - Build rapport
  - Start where the client is most comfortable talking about discomforts that bring him/her to therapy
  - Using reflective skills and Socratic dialogue, build a partial history of client reactive symptoms
  - Seek an area of personal reactive symptoms the client would like to immediately work on (normally the client will wish to alleviate a presently occurring anxiety)
  - Consider that history taking will be an ongoing process as the client seeks further relief

- Each session starts with “check in” about situations that presented anxious responses
  - Evaluate severity
  - Identify triggers
    - Thoughts , feelings, resultant sensations
    - Evaluate stimuli to discover connection to discover reminiscent trauma

- Build Adaptive strategies
  - stress relief tools
  - Avoidance
  - Support
  - self talk
  - Distractions
  - Improve understanding of triggering mechanism to diminish effects
- Reinstitute stress inoculation exercise when needed

Classic Stress Inoculation Therapy

- Use with discretion, if client needs stress training
- Reflectively explore the presenting problem
  - The more realistically the client reexperiences the anxious situation the easier it is to develop a stress hierarchy
- With the client build a 4-5 layer hierarchy of presenting problem related stress levels using Subjective Units of Distress Scale (SUDS levels) with significant detail of stress responses
- Back away from issue and teach
  - Breathing techniques (hot soup)
  - Progressive relaxation
  - Take SUDS levels

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- Reintroduce presenting problem at the lowest level of stressor on scale
- While client holds the “image” of the experience perform stress inoculation procedures
- Take SUDS levels periodically until client notes drop in numerical rating
- Psychoeducation regarding PTSD and the brain, progressive relaxation effects, use as a tool when stressors are present
- Discuss strategies for use and monitoring
- Continue to work on stress inoculation with the SUDS hierarchy recorded with client

Further Assessment

- Since client has experienced some level of relief, more likely to be less defensive and more like to explore
- Continue taking history including
  - Original trauma(s)
  - Precipitating PTSD event(s)
  - Present symptoms of stress reaction

- Psychoeducation/discussion
  - Develop symptom/situation links for client
  - Begin to develop language of PTSD
    - Attacks
    - triggers

More History

- Build symptom/trigger catalogue of issues client wishes to work on and set goals at this point.
  - Classic PTSD symptoms
  - Interpersonal areas of experienced problems: re-experiencing, avoidance, hyperarousal
  - Helpful to use interpersonal problems list developed by IPT
    - Grief and loss
    - Interpersonal disputes
    - Role transitions
    - Interpersonal deficits

"Working Back"

- Working back through history to find original traumas, base for automatic thoughts, issues that supported development of PTSD
- Reframe check-in issue in light of PTSD
- Socratically lead discussion of PTSD history and its effects on "the now"
  - Main skills: reframing, paradoxical intention, confrontation, reflection

Integrating Cognitive Tools

- Escaping versus shutting off ongoing stressor
- Dealing with thoughts & beliefs
  - Learning reframing
- Sorting which triggers to avoid, which are unavoidable, working strategies for each
- Feeling control over symptoms and situations not over fantasy view of events
- Taking on mastery: Learning to "do differently"

Conversations With The World

- Conversations with others involved in triggering PTSD attacks
  - Experiences of PTSD symptoms need to be understood
  - Mutual restrategizing relationship (what is needed for support: minimizing, shortening triggers)
- Transitioning: Changing lifestyle
  - Coping
  - Developing social significance

Final Issues

- Survivor guilt/inability to save others – role related
- Time (PTSD is not a quick cure and client should know and learn to continue self)……
  - Assessment
  - self healing
  - seeking support

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