Real world psychological therapy for Post-Traumatic Stress Disorder (PTSD)

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Welcome!!

Session today

1. Introduction to PTSD and basic theory into practice
2. Impacts of PTSD and evidence-based trauma-focused cognitive behavioural therapy approach (tfCBT)
3. Emphasis on real-world practice not academic, NDPP ☺
4. Balancing the conversation between the professional perspective and Nick's (more important!) lived experience
5. Q and A

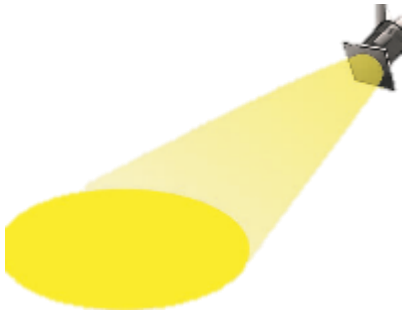
Aims

- ✓ Enable you to reflect on your own views about PTSD and hear a lived experience perspective
- ✓ Provide you with introductory insights into some of what trauma focused therapy for PTSD entails (focus on CBT approach with adults)
- ✓ Enrich your awareness of what our clients actually will go through in psychological therapy
- ✓ Today's workshop is obviously **not** sufficient to equip you to provide direct trauma interventions. It is of course a heavy and emotive topic

Areas discussed:

PTSD, clinical theory, military veterans, engagement/trust building, emotion regulation and safe place, Ehlers & Clark CBT model, hotspot memories and restructuring beliefs, repeated exposure, reclaiming your life

Keeping Safe



Focus in on the here and now

Limit distractions (e-mails/ phones)?

Give yourself permission to just focus on this

Respect for everyone

Respect

Confidentially

Safety

Please take responsibility for what you need.

Take care of yourself

Clip (3 min 30)

Reflection point – what are our pre-existing beliefs about PTSD?

Please **click here** and take a few minutes to watch this video

- PTSD – is it still synonymous with 'weakness' of some kind?
- Arguably remains one battle many sufferers face themselves or from others' attitudes, alongside '*am I going mad*'
- Certainly it is something that can be misdiagnosed, but PTSD is very real and distinct

Ways that trauma can happen

Being directly harmed

Witnessing harm to someone

Living in a traumatic environment

Affected by community trauma

One-off **OR** ongoing events

Defining PTSD

- Concept of emotional disturbance following exposure to trauma has existed for over 100 years “Shell shock” but no official diagnosis until 1980 in 3rd edition of the DSM
- DSM-III-R (1987) refined trauma definition as an event that was “*outside the range of usual human experience*”
- DSM – IV (1994) definition of trauma modified to include the subjective response of the individual …. “*the person’s response involved intense fear, helplessness or horror*”
- DSM-V (2013) no longer categorised as an anxiety disorder but a trauma/stressor related disorder

*Now also a helpful diagnosis of Complex PTSD in ICD-11(2022)

Defining PTSD ctd.

- Essentially based around the presence of 3 core symptom clusters: re-experiencing/intrusions, avoidance, increased arousal.
  (important 4th cluster in DSM-V is *negative alterations in cognitions and mood)*

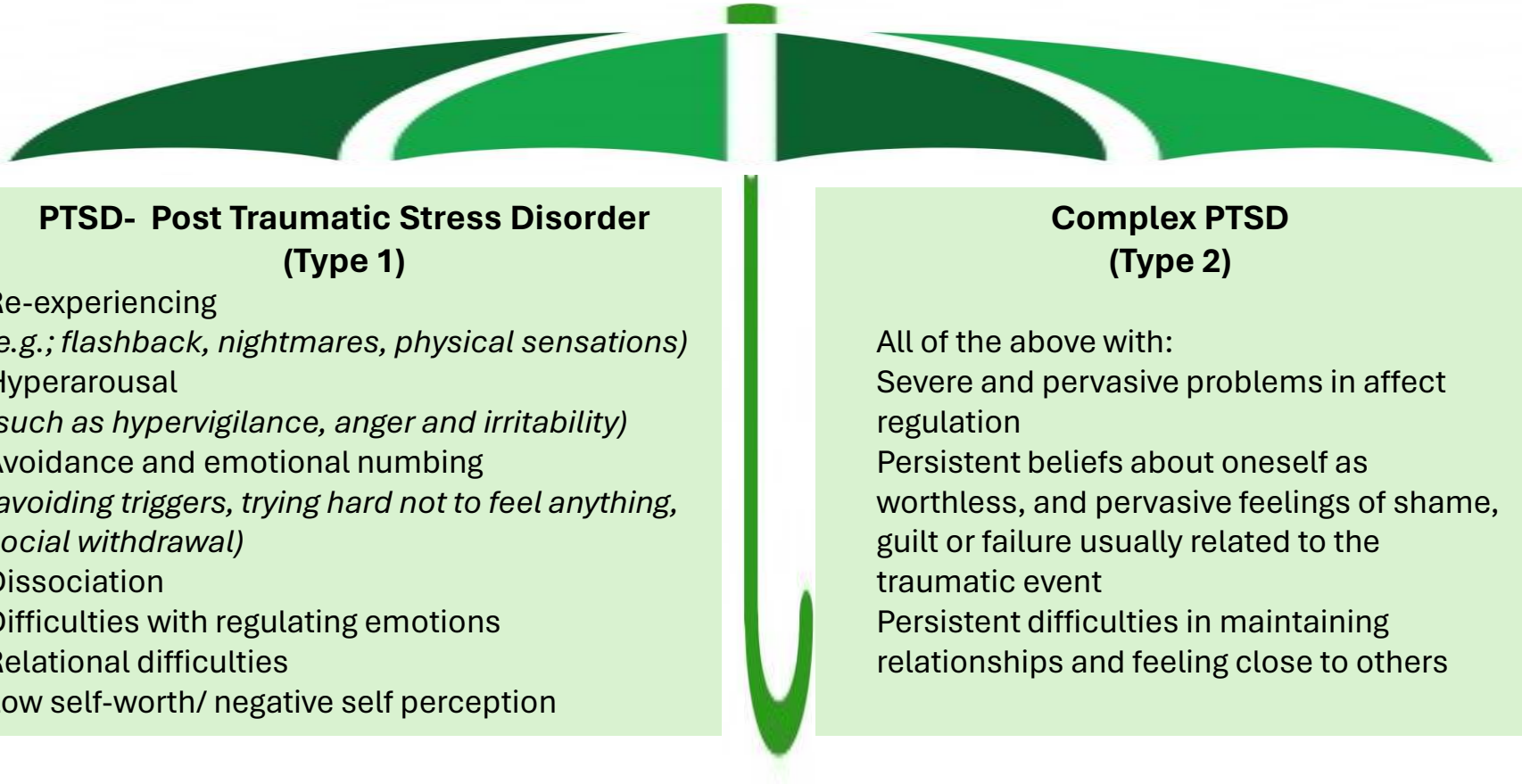
- Hallmark *here and now* quality to the affect. Sense of current threat despite consciously knowing event is in the past

- Acute stress disorder <4 weeks
  - ❖ *normal reaction to an abnormal event*
  - ❖ watchful waiting

- **PTSD**>1 month (3 months), **PTSD** with delayed onset**; Complex PTSD**

- Can be extremely debilitating and have a huge impact on the person and those around them

PTSD



PTSD- Post Traumatic Stress Disorder (Type 1)

Re-experiencing
(e.g.; flashback, nightmares, physical sensations)
Hyperarousal
(such as hypervigilance, anger and irritability)
Avoidance and emotional numbing
(*avoiding triggers, trying hard not to feel anything, social withdrawal)*
Dissociation
Difficulties with regulating emotions
Relational difficulties
Low self-worth/ negative self perception

Complex PTSD (Type 2)

All of the above with:
Severe and pervasive problems in affect regulation
Persistent beliefs about oneself as worthless, and pervasive feelings of shame, guilt or failure usually related to the traumatic event
Persistent difficulties in maintaining relationships and feeling close to others

Nick

- Background
- Military service
- How things were coming into therapy and where things had got to – what life was like with the difficulties
- Particular events that had ‘got stuck’
- Impacts on mental health, ripple effects

Knowing the theory

- Particularly key in working with PTSD as it provides the rationale for an otherwise aversive, counter-intuitive approach
- Often described in analogies (memory ‘filing’ system, cupboard overflowing)
- Clinical model provides the roadmap for tf-CBT

Key point into clinical theory and therapy

- Prevalence rate of PTSD estimate at 4% in UK (previous lifetime prevalence found to be 7-8%) and of course it varies across groups.

  * Yet 60% of males and 50% of females report experiencing trauma 1-4 times in their lives *

  So, people normally spontaneously recover, but why others not?

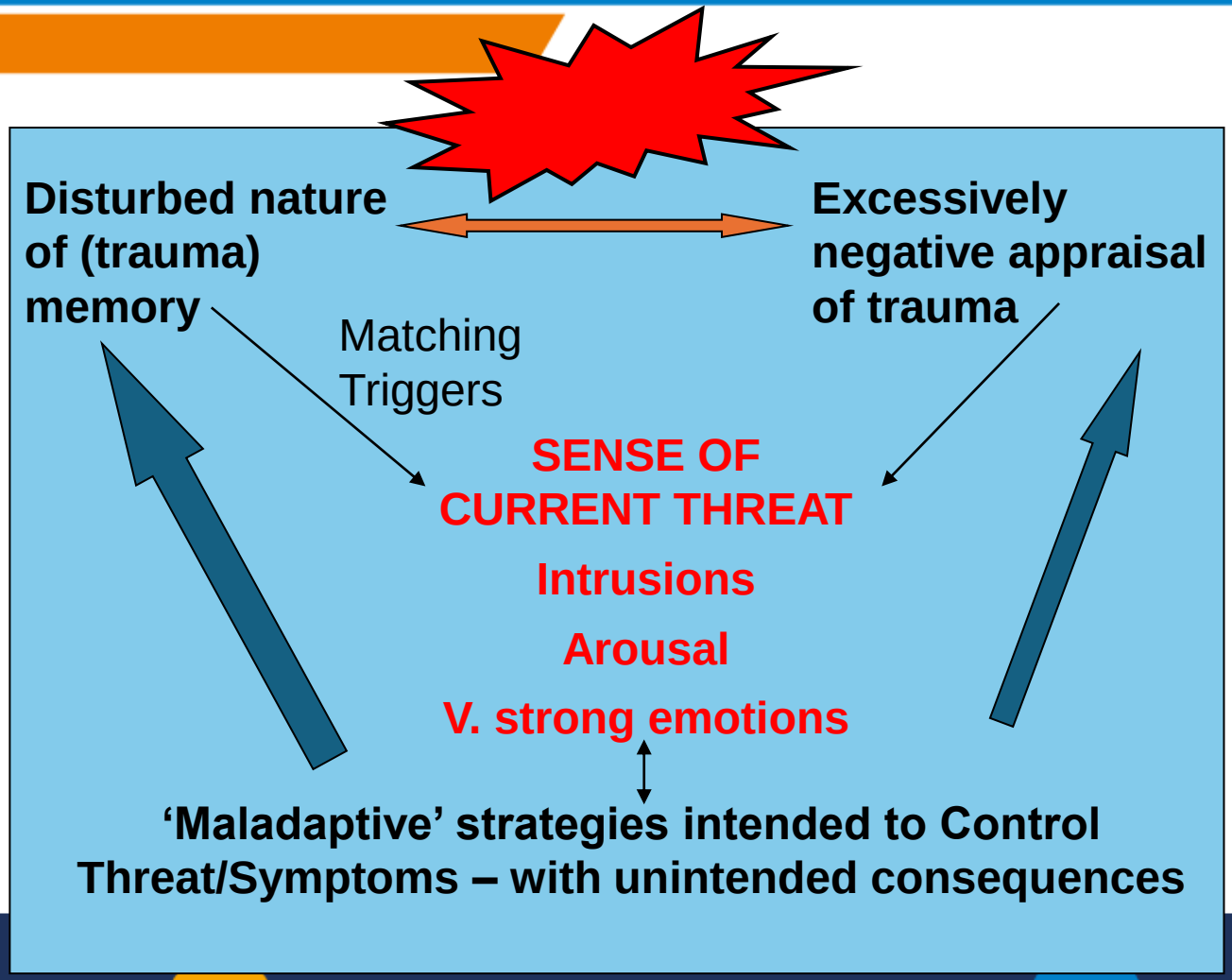
- The core of PTSD: A disturbance in memory

- 'Dual representation theory' - two separate memory systems involved:

  - Autobiographical memory system that we use to remember the past operates less efficiently, narrowed attention and hippocampus greatly impeded under extreme stress

  - Lower level sensory, image-based – capture lots of sights, sounds, smells. Cannot discriminate between past and present. Mediated by the amygdala – fight, flight, freeze

Clinical Model of PTSD *Ehlers and Clark (2000)*



Arrows show:

- Influences
- Prevents change
- Leads to

Ehlers & Clark (2000) Model

‘EXCESSIVELY NEGATIVE APPRAISALS’ OF EMOTIONAL RESPONSES

Appraisals concerning perceived danger lead to **fear**
(e.g. the world is a dangerous place).

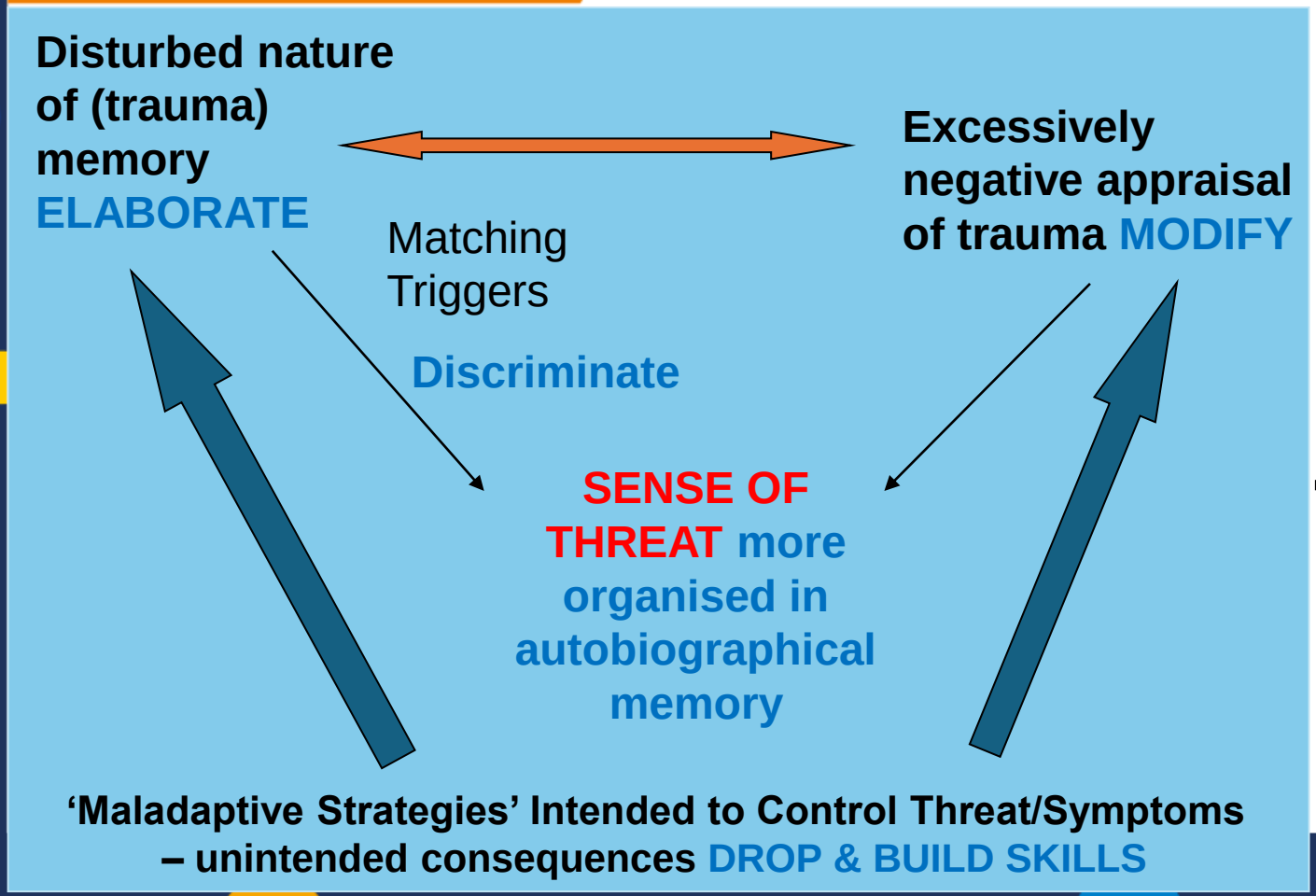
Appraisals concerning others violating rules and injustice lead to **anger**
(e.g. others have not treated me fairly).

Appraisals concerning one’s responsibility for the traumatic event or its outcome lead to **guilt and shame**
(e.g. it was my fault).

Appraisals concerning loss lead to **sadness**
(e.g. my life will never be the same again)

Most patients’ appraisals will be characterised by these appraisal themes to varying degrees.

Ehlers & Clark (2000) - CBT tasks and purpose



Arrows show:

- Influences more positively
- Allows change
- Leads to

Tf-CBT for PTSD comprises

Bringing it together in a therapy journey

A

- Assessment, relationship/trust building and individual formulation
- Preparatory work: Grounding, parasympathetic/emotional regulation work, psychoeducation of the model: rationale
- Reliving phase (exposure to the trauma using present tense)

B

- Identification of ‘hotspots’ and associated appraisals/beliefs
- Working through and restructuring appraisals/beliefs
- Repeated and in vivo exposure
- Reclaiming life / growth through adversity

CT for PTSD

RELIVING: ISSUES FOR THE THERAPIST

Prepare self, as much as possible, for content of reliving procedure

Identify areas which could be potentially distressing

Ensure adequate time/space to discuss with colleagues/supervisor and identify limits

Nick

What is therapy actually like, through:

- Building trust (esp as a veteran)
- Coping strategies, grounding
- Understanding why PTSD/the theory
- Reliving and recording and repeating exposure

Working with hotspots

Hotspot 1

Image:	Fire destroyed building and bodies
Thought:	This is my fault.
Feeling:	Guilt
Distress/100:	100

Hotspot 2

Image:	Afghan – constant rocket attacks and siren
Thought:	I could literally be killed at any time
Feeling 1:	Terror, ‘survivor guilt’
Distress/100:	100

Hotspot 3

Image:	Seeing the mass graves
Thought:	I could and should have done more
Feeling:	Regret, shame
Distress/100:	100

Working with hotspots

- Dedicated time talking and reasoning through the hotspots
- Photos, maps, historical documents
- Cognitive restructuring
- Arriving at new appraisals outside of reliving (next slide)
- Repeated exposure WITH new appraisals
- Rehearsal and working with blocks

Reliving (with new meanings)

Hotspot 1

Image: Fire destroyed building and bodies

New appraisals: *This is war, there were many things out of my control, it so sad, but* it is not *my fault*

Feeling: Sadness

Distress/100: 50

Hotspot 2

Image: Afghan – constant rocket attacks and siren

New appraisals: *I survived and know that I am not back there. It was terrifying but am now able to see this in a different way – more rationally*

Feeling: Relief. Greater acceptance.

Distress/100: 30

Hotspot 3

Image: Seeing the mass graves

New appraisals: *I really could not have done more and realise that this was sadly happening all over Kosovo. It was not about me specifically*

Feeling: Sadness, loss for the families

Distress/100: 50. Reduced distress, de-personalised

Beyond PTSD / Reclaiming

- So much has been held back
- Purpose and meaning
- Clearly individual to the person
- ‘Giving back’

Nick’s example

Particular therapeutic challenges of working with trauma

- “Won’t this just all make clients worse?”
- Vicarious traumatisation
- Dissociation
- Anniversary reactions
- Avoidance
- Litigation
- Post-traumatic growth

Q&A

Any questions?

Thank you for your time

- Special thanks to Nick

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https://youtu.be/IqkYLRZ0LS0