Making Sense of the Unfamiliar World of Trauma Related Disorder Treatment

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Lessons Learned: Unfolding the story of PTSD
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Post Traumatic Stress Disorder and Acute Stress
Stigma of PTSD and related disorders

- Loss of career ("unfit for duty")
- Embarrassment
- Label of "ill" or "sick"
- Loss of Confidentiality
Treatment
Differences between Mental Health Clinicians

- Counselors/Therapists (Master’s Level)
  - Licensed Clinical Social Workers (LCSW)
  - Licensed Professional Counselors
- Psychologists (Doctoral Level)
- Psychiatrist (MD)
Debriefing immediately following trauma is NOT necessarily effective

- Individual therapy
- Group therapy
- Outpatient vs. Inpatient
Pharmacotherapy

- Antidepressants
- Anxiolytics
- Antipsychotics
- Mood stabilizers
- Medications – antidepressants, mood stabilizers, beta-blockers, Clonidine, Prazosin, Gabapentin, Propanolol
General treatment approaches

- EMDR (Eye Movement Desensitization Reprocessing Therapy)
- In-vivo therapy with Response Prevention
- Prolonged Exposure Therapy
General treatment approaches

- Cognitive Processing Therapy
- Psychotherapy-Cognitive Behavior Therapy
Therapy with PTSD Video

60 Minutes Advanced PTSD Therapy
EMDR-Eye Movement Desensitization Reprocessing Therapy
EMDR as a Trauma Treatment

- Uses the natural processing of the brain (arm injury analogy)
- Minimizes re-traumatization of the traumatized person
- Avoidance versus processing
- Traumatic memory fragmentation
- Actually treats trauma at a biological brain level
- Memory storage: “hot memory” vs. “bad memory”
- Processing occurs at a heightened speed, not all elements are discussed as in talk therapy
- Board analogy – targeting sequence plan
- Three-pronged approach: Addresses the past memory, current trauma reminders, and future anticipation of trauma reminders
Is EMDR Effective?
Research & Evidence Base

• EMDR is widely recognized as an acceptable and appropriate treatment methodology for trauma
• A wide research base exists
• A comprehensive list of clinical trials can be found at: EMDR Institute: The Efficacy of EMDR
EMDR Video
Cognitive Processing Therapy
Cognitive Processing Therapy (CPT) for PTSD

STRUCTURE OF CPT SESSIONS

Individual CPT
- 12 x 50-minute structured sessions
- Participants complete out-of-session practice assignments
- Sessions typically conducted weekly or bi-weekly
- Includes a brief written trauma account along with ongoing practice of cognitive techniques

Group CPT
- 12 x 90-120 minute structured sessions
- Participants complete out-of-session practice assignments
- Typically conducted by 2 clinicians
- 8-10 Veterans per group
- Includes a brief written trauma account component, along with ongoing practice of cognitive techniques
Cognitive Processing Therapy (CPT) for PTSD

THE ESSENTIAL COMPONENTS

- The Impact of the Event
- Identifying Stuck Points
- Identifying and resolving assimilated beliefs
- Challenging and balancing overaccomodated beliefs.
- Use of Socratic Questioning
- Processing natural emotions related to the trauma
The individual sessions are:

- Session 1: Introduction and Education
- Session 2: The Meaning of the Event
- Session 3: Identification of Thoughts and Feelings
- Session 4: Remembering the Traumatic Event
- Session 5: Identification of Stuck Points
- Session 6: Challenging Questions
- Session 7: Patterns of Problematic Thinking
- Session 8: Safety Issues
- Session 9: Trust Issues
- Session 10: Power/Control Issues
- Session 11: Esteem Issues
- Session 12: Intimacy Issues and Meaning of the Event
Exposure Therapy
Empirical Support for Exposure Therapy

► For Chronic PTSD:
► 22 Published randomized studies on exposure therapy alone
► 25 Published randomized studies on exposure therapy with other interventions (Stress Inoculation and/or Cognitive Restructuring)
Exposure therapy is a set of techniques designed to help patients confront their feared objects, situations, memories, and images (e.g., systematic desensitization, prolonged exposure, flooding).
Theoretical Rationale for Exposure Therapy

Combination of:

- Classical conditioning (traumatic event), e.g., little Albert
- Instrumental conditioning
  - Memory of trauma is paired/conditioned to current, unrelated events, e.g., crowds, restaurants, movies
  - Engagement of avoidance activities to reduce anxiety
  - Result is world starts to shrink
Imaginal reexposure to memory of trauma in a safe setting results in desensitization/habituation of conditioned associations between traumatic memory and negative emotions.
Two Essential Ingredients in Emotional Processing of Trauma:

- Accessing the fear structure (fear activation)
- Availability of corrective information
Two Exposure Models

- Flooding (Keane)
- Prolonged Exposure or PE (Foa)
- Both Keane and Foa models use systematic repeated imaginal exposure to memory of the trauma
Keane’s Flooding Model

- Once through in 60 min. session
- Therapist-guided
- Therapist asks questions on senses (seeing, hearing, smelling, thinking, feeling) for each step in the trauma
- Therapist slows story down at worst points
- Repeated imaginal exposure in subsequent sessions
- Rating of SUDs (Subjective Units of Distress) on 100 point scale
Foa’s Prolonged Exposure

Highly developed protocol
- Imaginal exposure
- In-vivo exposure

Prolonged (imaginal) exposure:
- 10-15 90 minute sessions, more as needed
- 60 min of repetitions in 1st session, 45-30 in subsequent
- Patient instructed to describe event as many times within allotted time
- Little or no therapist intervention
- Later sessions address “hot spots”
- Assess SUDS level (scale of 1 to 100) every 5 min.
Cognitive Behavioral Therapy
Cognitive Behavioral Therapy

Cognitive techniques address thoughts and thought patterns which may be ‘unhelpful’ and may trigger and/or increase anxiety.

Behavioural techniques address behaviours which may be used by a person to reduce their anxiety or avoid it altogether.
A person’s environment, emotions, thoughts (cognitions) and behaviours are all linked. Our thoughts, ideas, mental images, beliefs and attitudes can sometimes be ‘errors’ which are unhelpful and lead to emotional disturbances and physical reactions.
WHAT IS THE AIM OF CBT?

- To increase self-awareness
- To encourage a better self-understanding
- To help us recognize the ‘negative traps’ or ‘vicious cycles’ we get caught in (see fig. 3)
- To improve self-control by developing more appropriate cognitive and behavioural skills
THE NEGATIVE CYCLE

Confirms negative thought

Negative thoughts

Create doubts/worries

Produce unpleasant feelings

Make you feel sad, depressed, anxious and uptight

Affect what you do

Feel disinterested, unmotivated

Stallard, P. 2002

Fig. 3
Treatment Resources
Questions