# *PTSD & TRAUMA: AN OVERVIEW OF EVIDENCE-BASED TREATMENTS AND COMPLICATING FACTORS*

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## OVERVIEW

- Brief Overview of PTSD
- Three Evidence-Based Treatments for PTSD:
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye-Movement Desensitization and Reprocessing (EMDR) Therapy
- Treatment Comparisons and Brief Case Example
- Complex Trauma & Complicating Factors

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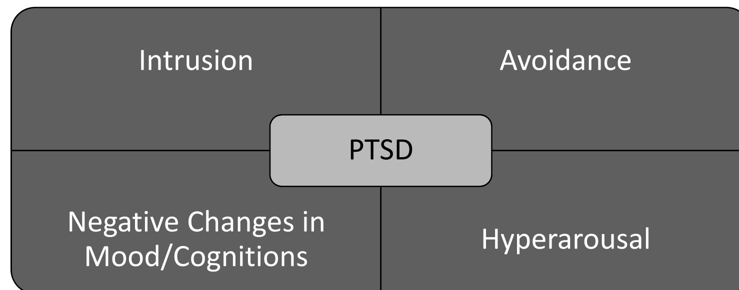
## OVERVIEW OF POST-TRAUMATIC STRESS DISORDER (PTSD)

- Criterion A – Threatened death, actual or threatened serious injury or actual or threatened sexual violence
  - **Direct** exposure
  - **Witnessing** the trauma
  - Learning that a **relative or close friend** was exposed to a trauma
  - **Indirect exposure** to aversive details of trauma, usually in the course of professional duties (e.g., first responders, nurses, 911 dispatch operators)

## PTSD "TRAUMATIC EVENT" VS. NON-PTSD STRESSORS

## POST-TRAUMATIC STRESS DISORDER (PTSD): FOUR SYMPTOM CLUSTERS




## EVIDENCE-BASED TREATMENTS FOR PTSD

- There are 3 Main Evidence-Based Treatments for PTSD:
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye Movement Desensitizing and Reprocessing (EMDR) Therapy

## PROLONGED EXPOSURE (PE)

- Theory – PTSD is caused by:
  - (1) **avoiding thoughts and feelings** about a traumatic event
  - (2) **avoiding people, places, things, situations**, etc. that remind the client of a traumatic event
  - (3) **unhelpful and inaccurate thoughts and beliefs** about the traumatic event
- Treatment components (lots practice work outside of treatment):
  - Psychoeducation regarding PTSD, exposure, avoidance, etc.
  - In vivo exposure (i.e., doing safe things that have been avoided)
  - Imaginal exposure (i.e., talking about the event)
  - Cognitive processing

## PE – IN VIVO RATIONALE (FACING FEARED SITUATIONS)

- **Avoidance**
  - Prolongs and worsens PTSD reactions and prevents new learning
- **Process of "Habituation"**
  - Repeated exposure to anxiety-producing situations actually results in decreases in anxiety
- **New Learning ("Differentiation")**
  - E.g., veterans may learn that blue bins on the road Winnipeg are not explosive devices. With new learning, the body learns to adapt and becomes less anxious (i.e., "Maybe blue bins in Winnipeg are safer than I thought")
- **Gradual/Hierarchical Approach**
  - In vivo exposure works best when exposure targets are identified and listed in order of difficulty/distress and tackled from easiest to hardest

## PE – IN VIVO EXPOSURE FEAR HIERARCHY

| Item | Situation | Distress Level (X/100) |
|---|---|---|
| 1 | Going to the dog park and talking to other dog owners | 25 |
| 2 | Not doing a perimeter check of my yard when I wake up in the morning | 40 |
| 3 | Going to Safeway by myself on a weekday | 55 |
| 4 | Sitting at Tim Horton's on a weekday with my back to the crowd | 65 |
| 5 | Letting my daughter go out at night without tracking her with my GPS | 70 |
| 6 | Watch documentary on Afghanistan | 85 |
| 7 | Eating lunch at Polo Park food court by myself on a weekend | 90 |

## PE – IN VIVO EXPOSURE LOG

- Situation Practiced – "Going to Safeway by myself on a weekday"

| Date & Time | Pre | Post | Peak | Date & Time | Pre | Post | Peak |
|---|---|---|---|---|---|---|---|
| April 1 at 1:00PM | 60 | 40 | 80 | April 4 at 9:00PM | 30 | 30 | 40 |
| April 2 at 11:00AM | 70 | 50 | 70 | April 4 at 3:00PM | 30 | 20 | 35 |
| April 2 at 3:00PM | 55 | 40 | 60 | April 5 at 12:00PM | 25 | 20 | 30 |
| April 3 at 1:00PM | 40 | 30 | 50 | | | | |

## PE – IN VIVO EXPOSURE

- In vivo exposures are faced at the client's own pace where the difficulty of the exercise increasing each week
- Gradual exposure – e.g., fear of crowds
  - (1) Week 1 – go to Safeway weekday mornings **with spouse**
  - (2) Week 2 – go to Safeway weekday mornings **without spouse**
  - (3) Week 3 – go to Safeway Friday night after work by self
  - (4) Week 4 – go to Safeway during peak periods (e.g., on weekends)
  - (5) Week 5 – go to Costco, etc.

## PE – IMAGINAL EXPOSURE

- Imaginal exposure involves talking about the traumatic event in vivid detail (i.e., eyes closed, spoken in the present tense, including as many images, thoughts, emotions, sounds, smells, etc. as is tolerable)
- The goal is not to "erase" the trauma, but rather, to confront memories that generate anxiety and avoidance until they become less emotionally painful.
- Initially, imaginal exposure involves talking about the **whole traumatic event** (e.g., 30-40 minutes in length)
- Later, the client focuses on a few "hot spots" which are highly emotional **parts of the traumatic event** (e.g., 2-minute piece that is retold 10 times in a row)
- Imaginal exposure is audio-recorded so the client can listens to it daily between sessions.

## PE – IMAGINAL EXPOSURE RATIONALE

- **Emotional Processing**
  - Repeated exposure helps organize the traumatic memory and clients learn that it is not dangerous to feel anxious or think about the trauma
- **Habituation**
  - Repeated exposure actually decreases anxiety about the trauma
- **Remembering is not the same as being retraumatized**
  - Clients learn that remembering the trauma is not the same as experiencing the trauma
- **Increased Self-Confidence and Mastery**
  - Repeated exposure enhances clients' sense of self-control and personal competence as they stop avoiding and begin mastering their fears

## PE - IMAGINAL EXPOSURE LOG

- Imaginal Exposure: IED Tank Explosion (Tape 1)

| Date & Time | April 8 at 7pm | April 9 at 5pm | April 10 at 4pm | April 11 at 10am |
|---|---|---|---|---|
| Distress Before (Pre) | 80 | 80 | 70 | 40 |
| Distress After (Post) | 70 | 70 | 50 | 60 |
| Peak Distress | 90 | 80 | 75 | 65 |

## PE – COGNITIVE PROCESSING

- Two main "erroneous cognitions" targeted for change:
  - "The world is extremely **dangerous**" (safety/threat concerns)
    - E.g., I always have to be on guard, I cannot trust others, etc.
  - "I am extremely **incompetent**" (self-competence/self-confidence concerns)
    - E.g., I am weak and incapable, I can't do things on my own, etc.
- Possible Issues:
  - Cognitive processing is often overlooked or de-emphasized
  - Time constraints with other components to complete
  - Lack of clarity for clinician re: how to do this? Need to weave into sessions

## COGNITIVE PROCESSING THERAPY (CPT)

- Theory – PTSD is caused by:
  - **Negative beliefs** that block natural recovery from PTSD and keep clients stuck in avoidance
- Treatment components (lots of practice work outside of treatment)
  - Psychoeducation regarding PTSD, different types of emotions, how the brain processes information, avoidance, etc.
  - Identifying clients' "stuck points" and how clients make meaning of the traumatic event
  - Learning how to identify thoughts, emotions and the connections between them
  - Learning to challenge/reframe negative thoughts and beliefs (i.e., "stuck points")
  - Processing five core PTSD themes: Safety, Trust, Power/Control, Esteem and Intimacy

## CPT – STUCK POINTS (MAIN FOCUS OF CPT)

- Stuck points are analogous to negative core beliefs
- They are created or exacerbated by traumatic events
- Interfere with natural recovery from PTSD (i.e., they keep clients "stuck" and unable to move foward)
- Stuck points are beliefs that are:
  - Negative
  - Extreme, black and white
  - Based on opinions
  - Often global or generalized

## CPT – EXAMPLES OF STUCK POINTS

- "I should have known he would hurt me" (blame)
- "If I had been paying more attention no one would have died" (blame)
- "If I have a happy life, I'm dishonouring my friends who died" (survivor's guilt)
- "I must be on guard at all times" (safety)
- "Other people cannot be trusted" (trust)
- "Mistakes are intolerable and cause serious harm or death" (control)
- "I am damaged forever because of the rape" (esteem)
- "If I let people get close, I will just get hurt again" (intimacy)

## CPT – IMPACT STATEMENT

- "Please write at least a one-page statement on ***why*** **you think** your most distressing traumatic event occurred. You are *not* being asked to write specific details about this event. Write about what you have been thinking about the ***cause*** of this event. Also, consider the ***effects*** this traumatic event has had **on your beliefs** about **yourself, others, and the world** in the following areas: **safety, trust, power/control, esteem, and intimacy**."

HANDOUT 6.3C

**Sample ABC Worksheet**

Date: ________ Client: ________

| Activating Event<br>A<br>*"Something happens"* | Belief/Stuck Point<br>B<br>*"I tell myself something"* | Consequence<br>C<br>*"I feel something"* |
|---|---|---|
| I build a porch and the railing comes loose. | "I can never do anything right." | Anger at myself and sadness |

Are my thoughts above in column B realistic or helpful? No. It wouldn't hold up in a court of law, because I do some things right.

What can I tell myself on such occasions in the future? "There are some things that I do all right. It is not true that I 'never do anything right.'"

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HANDOUT 8.1B

## Sample Challenging Beliefs Worksheet

| A. Situation | B. Thought/Stuck Point | D. Challenging Thoughts | E. Problematic Patterns | F. Alternative Thought(s) |
|---|---|---|---|---|
| Describe the event, thought, or belief leading to the unpleasant emotion(s). | Write thought/Stuck Point related to situation in section A. Rate your belief in this thought/Stuck Point from 0 to 100%. (How much do you believe this thought?) | Use **Challenging Questions** to examine your automatic thought from section B. Consider whether the thought is balanced and factual, or extreme. | Use the **Patterns of Problematic Thinking Worksheet** to decide whether this is one of your problematic patterns of thinking. | What else can I say instead of the thought in section B? How else can I interpret the event instead of this thought? Rate your belief in the alternative thought(s) from 0 to 100%. |
| *I led my company into an ambush, and many of my men were killed.* | *I should have prevented it.—100%* | Evidence for? *People were killed.*<br>Evidence against? *There was no way to know that there was going to be an ambush—that's the nature of an ambush. To think I should have known it was coming is to ignore the fact that it was an ambush.*<br>Habit or fact? *A habit. I have been saying this for years.*<br>Not including all information? *It was an ambush. We had no intel that there were insurgents in that area.*<br>All-or-none? *No one else would have led their company into an ambush.*<br>Extreme or exaggerated? *Extreme to say I should have prevented it when I didn't know.*<br>Focused on just one piece? *That I am responsible for my men.*<br>Source dependable? *I am the source of the self-blame. No one else blamed me.*<br>Confusing possible with likely?<br>Based on feelings or facts? *Feelings.*<br>Focused on unrelated parts? *That I was their leader. I couldn't predict the future.* | Jumping to conclusions: *That I could have prevented it.*<br>Exaggerating or minimizing: *Exaggerating my control in the situation.*<br>Ignoring important parts: *I haven't been paying attention to the fact that it was an ambush. There was no way I could have known.*<br>Oversimplifying:<br>Overgeneralizing:<br>Mind reading:<br>Emotional reasoning: *Because I feel guilty, I am guilty.* | *There was no way to see it coming at the time.—85%*<br>*I did the best I could, given the circumstances.—90%* |
| | **C. Emotion(s)**<br>Specify your emotion(s) (sad, angry, etc.), and rate how strongly you feel each emotion from 0 to 100%.<br>*Guilty—100%*<br>*Helpless—100%*<br>*Anxious—75%* | | | **G. Re-Rate Old Thought/Stuck Point**<br>Re-rate how much you now believe the thought/Stuck Point in section B, from 0 to 100%.<br>*10%*<br>**H. Emotion(s)**<br>Now what do you feel? Rate it from 0 to 100%.<br>*Guilty—40%*<br>*Helpless—80%*<br>*Anxious—40%* |

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## CPT – THE 5 PTSD THEMES ADDRESSED IN TREATMENT

- **Safety**
  - Believing that you cannot protect yourself from harm or believing that others are dangerous and intend to cause harm, injury or loss.
- **Trust**
  - Believing that you have poor and unreliable judgment or that the promises or behaviours of others cannot be relied upon (e.g., fear of betrayal).
- **Power/Control**
  - Believing that you are completely helpless and cannot solve problems or that you need rigid control over others and your environment.

## CPT – 5 PTSD THEMES ADDRESSED IN TREATMENT (CONT'D)

- **Esteem**
  - Believing that you are bad, worthless, permanently damaged, etc. or that other are inherently selfish, uncaring, evil, indifferent, etc.
- **Intimacy**
  - Believing that you cannot comfort yourself, are "dead inside", etc. or that you always need to need to isolate and disconnect from others.

## EYE MOVEMENT DESENSITIZATION & REPROCESSING (EMDR)

- Theory – PTSD is caused by:
  - Insufficient processing of the traumatic memory
  - Unprocessed trauma is like a "foreign object" that blocks our natural recovery system
- Treatment components (i.e., "Adaptive Processing Model"):
  - Thinking about disturbing images, feelings and sensations to process the event
  - Therapist facilitates rapid eye movements or similar strategies to aide with processing
  - Client processes whatever thoughts, images, emotions and physical sensations come up
  - Therapists are **supposed to be "non-interfering"** so clients make their own connections
  - Clients works to build new ways of thinking of the trauma and themselves
  - Generally, no homework in EMDR!

## EMDR – THREE PRONGED APPROACH (PAST/CURRENT/FUTURE)

- "Three-pronged approach". When addressing a traumatic event, EMDR addresses:
  - (1) **past** experiences that have laid the groundwork current dysfunction related to the trauma
    - E.g., aversive childhood experiences, moments of powerlessness, etc.
  - (2) **current** events that create distress (i.e., usually memory of the traumatic event itself)
    - E.g., imagining the worst traumatic aspects of an event and processing whatever comes up
  - (3) **future** stressors – to enhance relapse prevention and long-term recovery
    - E.g., imagining an anticipated future "trigger" and mentally rehearsing a process of coping with it effectively

## EMDR – WHAT DOES PROCESSING LOOK IN IN A SESSION?

- Clients imagine an **image** that represents the "worst part" of the trauma
- Clients identify a **negative belief** that goes with the trauma (e.g., "I am a failure")
- Clients identify a **positive belief** they would rather believe when remembering the traumatic event (e.g., "I am a capable person")
- Clients identify and rate negative **emotions** and **physical sensations** associated with the trauma (e.g., "Anxiety rated as 8/10 in my chest")
- Then, therapist asks clients to think and feel all the above and engage in **rapid bilateral eye movements** (e.g., "Bring everything to mind and follow my hand")
- Clients think and feels about whatever comes up **until they no longer feel any distress** and they believe the more positive belief

## EMDR – 3 TRAUMA THEMES CONSIDERED IN TREATMENT

- **Responsibility**
  - "It's my fault it happened"; "I should have prevented it"; "I should have done… "
- **Safety**
  - "I am total vulnerable"; "I am weak"
- **Power/Control**
  - "I am helpless", " I have to be perfect", "I always need to be in control"

- "Cognitive interweaves" – when clients get really stuck, therapists can ask provocative questions, make statements for consideration, offer actions to elicit further information needed to continue learning

## EMDR – POSSIBLE ADAPTIVE CHANGES IN CORE BELIEFS

- When traumatic injuries are successfully processed, thoughts about the traumatic event should shift:
  - "I should have prevent it" → "It wasn't entirely my fault"
  - "I am totally vulnerable" → "I can protect myself"
  - "I am powerless" → "I can control what I can"
  - "I have to be perfect" → "I can accept myself as I am"

  - These are "discovered" by the client through adaptive processing

## TREATMENT COMPARISONS

| | PE | CPT | EMDR |
|---|---|---|---|
| **Session Length** | 60 or **90** minute sessions | 60 minute sessions | **60** or 90 minute sessions |
| **Treatment Length** | 8-15 sessions | Average of 12 sessions | 12-15 sessions |
| **Focus** | Facing avoidance & fears to increase sense of control | Changing negative beliefs to get people “unstuck” and recover | Processing “blocks” to let mind naturally heal itself |
| **PTSD Themes** | Safety & Incompetence | Blame, Safety, Trust, Power/ Control, Esteem & Intimacy | Responsibility, Safety & Power/Control |
| **Homework?** | Yes | Yes | No |
| **Consider When** | Strong avoidance, more concrete behavioural approach | Strong guilt/blame, thoughts & beliefs more negative | Low tolerance for homework; strong developmental origins |

## BRIEF CASE EXAMPLE – “JIM”

- “Jim”, 52 year old male, long-haul truck driver
- Involved in serious motor vehicle collision (MVC)
- Sustained serious physical injuries, but recovering well
- No prior history of mental health issues
- Other driver “distracted driving” (i.e., texting while driving)
- Primary symptoms: nightmares, intrusive thoughts, anger/irritability, “terrified” to drive again, avoids driving or talking about the incident, avoids driving, blames self for not having reacted faster

## BRIEF CASE EXAMPLE: PE TREATMENT

- **In vivo exposure*** (i.e., facing feared situations)
  - Gradual approach: Jim looks at pictures of long-haul trucks, sits in truck without driving, driving around parking lot, drives on non-busy streets, drives on busier streets, etc.
- **Imaginal exposure*** (i.e., talking about the MVC)
  - Jim talks about the MVC in session (e.g., 30 minute detailed account), talks about “hot spots” (e.g., moment of collision, paramedics removing from vehicle), listens to audio recording of exposure daily between sessions, tracks distress levels between sessions.
- **Cognitive processing**
  - Jim is asked… What has the exposure taught him? What has he learned about tolerating anxiety, the dangerousness of driving, what he can or cannot control?, etc.

* usually, the primary focus

## BRIEF CASE EXAMPLE: CPT

- **Psychoeducation & Impact of Trauma**
  - Jim learns about PTSD and writes an impact statement. He states that the MVC happened because he’s a bad driver, driving is super dangerous, and he is helpless to control anything on the road. Jim identifies a number of “stuck points” to address in treatment (e.g., “Driving is completely dangerous”, “You can never trust other drivers”, “I am powerless to prevent MVCs”)
- **Learning to Challenge and Change “Stuck Points”**
  - Jim completes worksheets to get better at identifying his own thoughts and feelings. He completes more worksheets to learn new strategies to question, challenge and evaluate his stuck points. He works hard to find more accurate, balanced and helpful ways to think about his traumatic MVC
- **Processing the Trauma with the 5 Core CPT Themes**
  - **Safety** – Is driving really completely dangerous? **Control** – What are some things that you have when driving? **Esteem** – Does one accident really make you a “bad driver” for all time? **Blame** – Who was the one texting and driving? Could the ice storm and poor visibility have been a factor? What else other than you could be responsible for the outcome?

## BRIEF CASE EXAMPLE: EMDR TREATMENT

- **Past** – Client processes childhood event related to MVC
  - E.g., fell of bike at age 5, broke leg, and felt helpless (i.e., "I had no control")
- **Current** – Client processes MVC event directly
  - E.g., thinks about MVC image of "broken glass", identifies thought "I have no control", describes feelings of terror (rated as 9/10) and physical sensations in stomach. Client processes thoughts, images, emotions and physical sensations of trauma while engaging in rapid eye movements. Processing continues until no distress reported and believes new positive statement such as "I can make choices" (i.e., client has some control)
- **Future** – Client imagines coping effectively in the future
  - E.g., client imagines himself entering his truck, reminding himself that he is competent and has some control, and processes any anxious thoughts/emotions/sensations that come up

## WHAT COMPLICATES AND PROLONGS TREATMENT?

- **AVOIDANCE**

"Forgetting" treatment work at home

Not completing treatment work

Being late for or missing sessions

Excessively talking about personal life

Vague language or saying "I don't know" x 50

Image credit: Mark Anderson (www.andertoons.com)

## "COMPLEX PTSD"

- "Complex PTSD" is **not an official diagnosis**
- There is no formal consensus for how "Complex PTSD" is defined
- When the term is used, various definitions suggest the following possible features:
  - Histories of childhood physical or sexual abuse
  - Alterations in attention and consciousness (e.g., dissociation)
  - Chronic repeated exposure for forms of interpersonal violence (e.g., rape)
  - Prolonged repeated trauma where escape was not possible (i.e., incest, prisoner of war)
  - Highly exceptional traumatic events (i.e., exposure to genocide, sex trafficking, child soldier)

## COMPLICATING FACTORS WITH PTSD TREATMENT

- Younger age at time of trauma
- History of childhood trauma
- History of sexual assault
- Comorbidity (e.g., depression, anxiety)
- Personality disorders (especially antisocial and borderline)
- Alcohol and/or substance use
- Sleep issues (e.g., insomnia)
- Combat-related exposure
- Greater number of traumatic events
- Number and cumulative length of military deployments
- Length of service in the military, police, first responder or similar careers
- Motivation, readiness and engagement
- Low social support

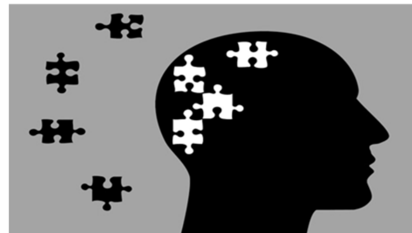
## EFFECTS OF ADDITIONAL COMPLICATING FACTORS

- A greater number of complicating factors may lead to:
  - The need for additional sessions to complete trauma-focused therapy
  - A need for a therapist with greater skill and expertise
  - Lower response to treatment or slower recovery
  - A possible need for additional interventions (e.g., residential treatment, increased social support)
  - Greater need for consultation and collaboration with other professionals

## USEFUL PTSD TREATMENT REFERENCES/WEBLINKS

- Summary of treatment efficacy for PTSD
  - Watts, B., Schnurr, P., Mayo, L., Young-Xu, Y., Weeks, W., & Friedman, M. (2013). Meta-Analysis of the Efficacy of Treatments for Posttraumatic Stress Disorder. *The Journal Of Clinical Psychiatry*, *74*(06), e541-e550. doi: 10.4088/jcp.12r08225

- Prolonged Exposure (PE) - http://pe.musc.edu/ (registration required)
- Cognitive Processing Therapy (CPT) - https://cptforptsd.com/
- EMDR - http://www.emdr.com/



- Thank you :)

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