Understanding Trauma

Forensic and Military Cultural Aspects of PTSD and Effective Solutions

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Acknowledgements and Disclosures

- The views expressed in this presentation are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government, Federal Bureau of Prisons, or United States Pretrial or Probation Services.

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Conference Overview

- Brief Introductions
- Why are you here?
- Whiteboard
- Defining PTSD
- PTSD and Family
- Break
- Video—brothers in arms
- Incarceration
- Individual Consequences of cumulative exposure / complex trauma
- Impacts on relationship functioning and community reintegration
- Treatment options that work
- Post Trauma Growth

Questions? Ryan.Sanft@va.gov

- First Handout Perceptions

What is Posttraumatic Stress Disorder (PTSD)?

What is PTSD?

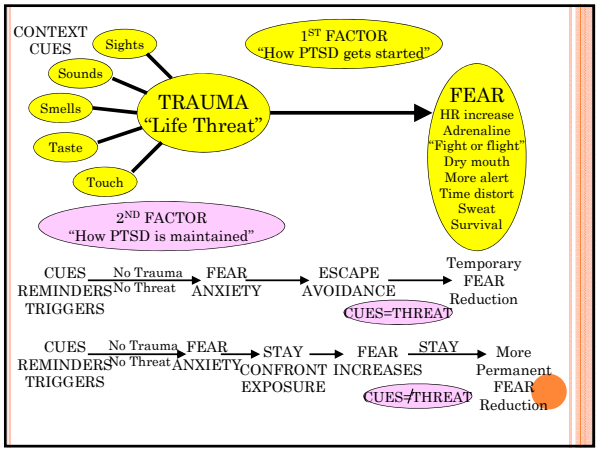
- PTSD in a mental health condition that can occur after a person has been through a traumatic event.
- A traumatic event is something terrible and threatening that you see, or that happens to you.
  - ***Sudden** and **uncontrollable** exposure to actual or threatened death, serious injury, or sexual violence.*

Examples of Traumas

- Combat
- Sexual assault in childhood and/or adulthood
- Military Sexual Trauma (MST)
- Serious accidents
- Natural disasters
- Sudden death of a loved one
- Witnessing or experiencing violence/physical assault
- Terrorist attacks

PTSD: Two-Factor Model

- How does PTSD develop?
- How is it maintained?



Common Stress Reactions After a Trauma

- Re-experiencing the trauma
  - **Memories**, sensations, images of the traumatic event can come back at any time.
  - You may have **nightmares** related to the trauma.
  - You may act or feel like you are going through the event again: have a "**flashback**."
  - You may **feel** the same **fear** and **horror** you did when the event took place.
  - "Triggers" - something you may see, hear, or smell, - may cause significant anxiety.

Common Stress Reactions After a Trauma

- Avoidance
  - You may avoid distressing memories, thoughts, or feeling about the traumatic event. Including:
    - Avoiding talking or thinking about the event.
    - Keeping very busy or avoiding seeking help because it keeps you from having to think or talk about the event.
  - You may try to avoid reminders (people, places, conversations, activities, objects, situations) that trigger memories of the traumatic event.

Common Stress Reactions After a Trauma

- Changes in mood/thinking
  - Negative beliefs about yourself, others, and the world (e.g., "I am bad," "No one can be trusted").
  - Unrealistic thoughts about the trauma that hinder your recovery and keep you stuck.
  - Frequent negative emotions (e.g., fear, horror, anger, guilt, or shame).
  - Loss of interest in activities you previously enjoyed.
  - Feeling detached from others.
  - You may find it hard to experience positive emotions like love and joy.

Common Stress Reactions After a Trauma

- Arousal
  - Unprovoked irritable or angry behavior (e.g., verbal or physical aggression).
  - Self-destructive behavior (e.g., dangerous driving, excessive alcohol/drug use).
  - Hypervigilance – remain alert and the lookout for danger
  - Startle Response- Intense reaction to an unexpected event (i.e., "hit the ground" when you hear a loud noise)
  - Difficulty with concentration.
  - Sleep problems.

Common Example of living with PTSD

PTSD and the Family

PTSD and the Family

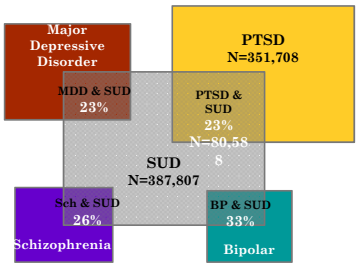
- Compared to Veterans without PTSD, Veterans with PTSD:
  - Have more marital troubles and increased divorce rates.
  - Tend to have shorter relationships.
  - Share less of their thoughts and feelings with their partners.
  - Report more worry around intimacy issues.
  - Are more likely to have sexual difficulties and/or decreased sexual interest.
  - Have lower relationship satisfaction.

PTSD and the Family

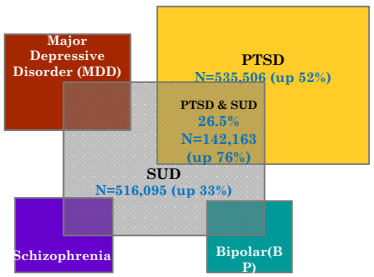
- PTSD can affect the lives of a Veteran's partner and children.
  - Partners of Veterans with PTSD experience:
    - Lower levels of happiness
    - Less satisfaction in their lives
    - More demoralization (discouragement)
  - Children of Veterans with PTSD:
    - Have more behavioral problems.
  - Family members may experience a wide range of emotions about Veteran's difficulties including:
    - Sadness/depression, worry, anger, fear, etc.

PTSD AND COMORBID DISORDERS

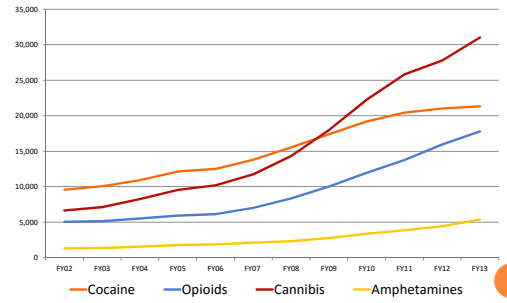
FISCAL YEAR (FY) 2008 PREVALENCE OF CO-OCCURRING CONDITIONS IN VETERANS SEEKING TREATMENT IN VETERANS HEALTH ADMINISTRATION (VHA)



FISCAL YEAR (FY) 2013 PREVALENCE OF CO-OCCURRING CONDITIONS IN VETERANS SEEKING TREATMENT IN VETERANS HEALTH ADMINISTRATION (VHA)



VHA Trends in Diagnoses by Drug for Veterans with PTSD and SUD



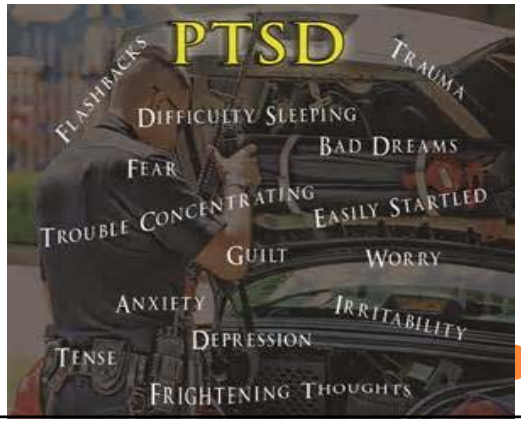
Screening For PTSD

DSM-5 Validated Measures

With the release of DSM-5, the National Center for PTSD is working to revise and validate a number of PTSD assessments.

Currently, the following measures have been updated to include DSM-5 criteria for PTSD:

- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5).
- PTSD Checklist for DSM-5 (PCL-5)
- Life Events Checklist for DSM-5 (LEC-5)
- The measures below are still being developed:
- Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
- The Primary Care PTSD Screen (PC-PTSD), which will also be available in Spanish



Incarceration and PTSD

Epidemiology and prevalence in prisons

First Study:

- Black American Adults in Prison Populations

Epidemiological associations between posttraumatic stress disorder and incarceration in the National Survey of American Life.

[1]Department of Psychology, University of Wisconsin-Milwaukee, Milwaukee, WI, USA.

Authors: Anderson RE[1], Geier TJ[1], Cahill SP[1]

Journal: Crim Behav Ment Health. 2015 Mar 1. doi: 10.1002/cbm.1951

- **METHODS:**
- Conducted analysis of data from the National Survey of American Life sample of 5008 Black American adults in the USA. Multivariate logistic regression analyses controlling for demographic factors including age, gender, home region and education were conducted to examine whether incarceration status was independently associated with PTSD.

Results

- Incarceration was significantly associated with trauma exposure, PTSD in the 12 months prior to interview and lifetime PTSD, even while controlling for demographic covariates.

CONCLUSION:

- Incarceration, trauma exposure and PTSD share a significant number of risk factors and co-vary frequently in some populations, including the one of Black Americans investigated in this study. Interventions that can reduce shared risk factors for incarceration and PTSD and/o condition have the potential to make a large positive impact among r facilitate successful treatment of the established incarcerated and formerly incarcerated people.

STUDY #2

"Does PTSD occur in sentenced prison populations? A systematic literature review"

Goff A[1], Rose E, Rose S, Purvess D.
Psychology Services, New Horizons, Berkshire Healthcare NHS Foundation Trust, Slough, Berkshire, UK.
ashley.goff@berkshire.nhs.uk

Journal: Crim Behav Ment Health. 2007;17(3):152-62.

- **METHOD:**

Literature databases EMBASE, Medline, PsychInfo, PILOTS and SIGLE were searched. The Journal of Traumatic Stress was searched manually. Preliminary screening was conducted by reading abstracts of hundreds of papers. Ten exclusion criteria were then applied to the screened selection. Reference sections of all accessed papers were searched for any further studies.

RESULTS

One hundred and three potentially relevant papers were identified after preliminary screening. Four met all criteria for inclusion and suffered none of the exclusion criteria. PTSD rates ranged from 4% of the sample to 21%. Women were disproportionately affected.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE:

- All four papers suggested that the prevalence of PTSD among sentenced prisoners is higher than that in the general population, as reported elsewhere. Overall the findings suggest a likely need for PTSD treatment services for sentenced prisoners.
-

STUDY 3: POSTTRAUMATIC STRESS DISORDER IN INCARCERATED WOMEN: A CALL FOR EVIDENCE-BASED TREATMENT.

- **Author information:** Harner HM[1], Budescu M[2], Gillihan SJ[3], Riley S[1], Foa EB[3].
[1]School of Nursing and Health Sciences, La Salle University.
[2]Department of Psychology, Temple University.
[3]Center for the Treatment and Study of Anxiety, University of Pennsylvania.
Psychol Trauma. 2015 Jan;7(1):58-66. doi: 10.1037/a0032508. Epub 2013 Jul 15.

RESULTS:

The majority of women who enter the criminal justice system, most of whom are poor and women of color, have suffered from significant lifetime trauma exposure that can lead to posttraumatic stress disorder (PTSD)..

It is essential to identify the prevalence of PTSD among this population in order to identify treatment needs

The findings add support to the link between PTSD and comorbid physical and mental health conditions and suggest that many women with PTSD are not receiving mental health treatment that is likely to benefit them.

Because prison has become the mental health safety net for some of the nation's most vulnerable women, it is imperative thatmprisons provide evidence-based PTSD treatment during incarceration.

- Hand out How to catch a monkey
- Autobiography in 5 chapters

BREAK

Tracking Present Emotions

Centering exercise

TREATMENTS THAT WORK

- **Evidence Based PTSD Treatments (EBP)***
- Cognitive Processing Therapy (CPT)
- (Group and Individual Formats)
- Prolonged Exposure Therapy (PE)
- EMDR
- **General Symptom Management Groups**
- Coping Skills
- Seeking Safety (Substance Use + PTSD)
- Acceptance & Commitment Therapy (ACT)
- Nightmare Management (IRT)
- Mantram Repetition
- Mindfulness

- (EBP)* These treatments have been researched extensively and have been shown to give you the best chance of recovering from PTSD.

Cognitive processing therapy

Cognitive Processing Therapy

- A 12 session protocol, developed in 1988
- Predominantly a trauma-focused cognitive therapy, with or without written accounts of worst traumas
- The protocol is very specific session-by-session and teaches the clients to challenge their own thoughts
- Can be implemented individually, in group or a combined format
- Recovery-focused based on collaboration and informed choice

COGNITIVE PROCESSING THERAPY (CPT) IS…

- a short-term evidence-based treatment for PTSD
- a specific protocol that is a form of cognitive behavioral treatment
- predominantly cognitive and may or may not include a written account
- a treatment that can be conducted in groups or individually

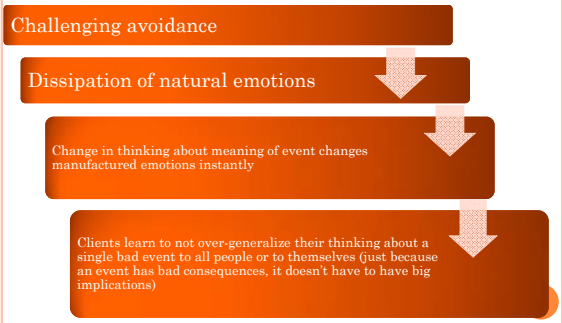
A FOCUS ON COGNITIVE THEORY OF PTSD

- Throughout their lives, people are taking in information through all of their senses.
- We work to organize all of that information (words, categories, schemas, etc.) in an attempt to understand, predict and control.
- Most people are taught the "just world belief" (good behavior is rewarded and mistakes/bad behavior is punished) by parents, teachers, religions, culture.
- In the face of trauma, we often revert back to the just world belief.

A FOCUS ON COGNITIVE THEORY OF PTSD

- These beliefs work as long as there is no contradictory information.
- The experience of trauma is so significant that you can't ignore it.
- Intrusive symptoms occur as a result of the inability to integrate the information effectively

So how does CPT work?



Cognitive Processing Therapy

- Sessions 1-4
  - Education and Impact statement
  - Client learns about connections between events, thoughts, and feelings.
  - Client writes detailed accounts of the incident including sensory details, thoughts, and feelings (if CPT-C then no account).

Cognitive Processing Therapy (continued)

- Sessions 5-7: Cognitive therapy
  - Challenging questions for a single belief
  - Learning about patterns of faulty thinking (Problematic Thinking Patterns)
  - Challenging Beliefs Worksheet

Cognitive Processing Therapy (continued)

- Sessions 8-12: Over-accommodation
  - Modules and worksheets challenging beliefs regarding:
    1) Safety
    2) Trust
    3) Power / Control
    4) Esteem
    5) Intimacy
  - Client rewrites impact statement

Take Home Message

- CPT is:
- Effective in group, individual, or combination
- Effective with complex cases

- White board simulation

Prolonged Exposure
Empirical Research

Rationale for PE

- Promotes emotional processing: Learn new, corrective information – trauma memories and related situations are not dangerous
- Discriminate trauma memories from trauma
- Reduce excessive fear and gain perspective on trauma
- PTSD commonly impacts core beliefs about self and world; PE focuses on modifying negative beliefs that maintain PTSD
  - "No one can be trusted"
  - "I am incompetent/weak"
  - "The world is unsafe"

Role of Avoidance

- Avoidance reduces trauma reexperiencing and hyperarousal in short term but prolongs in long term
- Avoid trauma memories → never challenge trauma-related beliefs
- Avoid public → never challenge safety concerns
- Maintains trauma structures
- Avoidance and negative reinforcement: Leaving or initially avoiding feared situation leads to relief, thus strengthening avoidance behavior

Rationale (continued)

- Two types of exposure

1. Imaginal exposure
   - Emotional processing of trauma memory
   - Learning – Memory is painful but not dangerous
2. In vivo exposure
   - Do real-life activities that are avoided
   - Learning – Many situations are safer than I thought

PE Protocol

- 9-15 sessions; averages 10 sessions
- 90-min sessions
- 1: Assessment, treatment overview, PTSD psychoeducation, breathing retraining
- 2: In vivo Exposure (continue throughout)
- 3-5: Imaginal exposure
- 6-9: "Hot Spot" exposure
- 10: Final imaginal exposure, wrap-up

Example of typical PE session (session 4 on)

- Review homework (10 min)
  - In vivo exercises & trauma tape listening
- Conduct imaginal exposure (30-45 min)
- Process imaginal exposure (15-20 min)
- Discuss/implement in vivo exposure (10-20 min)
- Assign homework (5-10 min)
  - Continue breathing practice
  - Listen to trauma tape daily
  - Complete in vivo exercises

Prolonged Exposure (PE) Therapy

- Imaginal exposure: Patients recount the traumatic memories during sessions and listen to the tape-recorded recounting between sessions
- In vivo exposure: Patients confront safe trauma-related situations and objects between sessions, beginning with less fearful situations and moving on to more fearful ones

Foa et al. 1991, 1999, 2005; Resick et al, 2002; Rothbaum et al, 2005

PE IS A TREATMENT FOR *PTSD*

- While PE focuses on trauma, it is specifically designed to treat PTSD
- Not everyone who experienced trauma has PTSD
- PE will not be (as) effective for those who do not meet diagnostic criteria for PTSD
- Potential Problems
  - Lack of/low reexperiencing – poor target for imaginal
  - Low avoidance – few avoided situations for in vivo
  - Not sufficiently distressed to adhere – distress motivates exposure therapy; if patient not very distressed, why would s/he bother?

KNOWING WHEN TO END PE

- Let the numbers tell the tale
  - Have PCL scores dropped sufficiently?
    - 50 is cut-off for PTSD DX; however aim for lower scores
  - Have SUDS levels routinely decreased ~ 50% for both in vivo and imaginal exposures?
- Look for other signs of improvement; PCL *isn't* everything
  - See signs of habituation during imaginal?
    - Tells story with less intense affect, shows behavioral signs of being more relaxed
    - Reports that it seems more like a memory, less like reliving
  - Is patient more engaged with life?
    - Doing more; being more spontaneous; greater emotional range and engagement?

- White board simulation of PE

EMDR

- In VA, most attention has been given to CPT and PE, but
- EMDR is still a recommended first line psychotherapy
- Supported by evidence as reviewed in literature

EMDR: Some History

- Introduced by Shapiro in 1989
  - Reportedly following a personal experience involving distressing memories
- Applied to a series of clinical cases; 1st quasi-controlled experiment by Shapiro (1989)
- Substantial improvement in the quality of research
- Outcomes of treatment have been generally positive
- EMDR classified as empirically supported

Adaptive Information Processing (Shapiro & Maxfield, 2002)

- Objective of EMDR is to assist patients to access and process traumatic memories while bringing them to an adaptive resolution (Shapiro, 2001)
- "If distressing memories remain unprocessed, they become the basis of current dysfunctional reactions"
- Suggestion is that EMDR vis-à-vis the use of eye movements or other "dual attention" stimuli facilitate this information processing
- "As the image becomes less salient, clients are better able to access and attend to more adaptive information, forging new connections within the memory networks (Shapiro & Maxfield, 2002, p.935)"

Description of EMDR

- Incorporates the following 8 stages:
  - Patient history and treatment planning
  - Preparation
  - Assessment
  - Desensitization and reprocessing
  - Installation of positive cognition
  - Body scan
  - Closure
  - Reevaluation

(Shapiro, 2001; Shapiro & Maxfield, 2002)

Preparation

- Therapeutic alliance is developed and fostered
- Patient education regarding trauma is provided
- Treatment is reviewed and explained
- Suggestions are made for coping with trauma reactions
- Perspective-taking in the face of trauma reactivation is also taught

Assessment

- Careful assessment of the trauma memory
- Patient is asked to:
  - Identify targets in memory and associated negative cognitions
  - Identify an alternative positive cognition
  - Rate the validity of the positive cognition
  - Identify emotions that are associated with the trauma memory
  - Rate the subjective level of disturbance associated with the traumatic memory
  - Identify trauma-relevant physical sensations and their respective bodily locations

Desensitization and Reprocessing

- Patient asked to hold the distressing image in mind, along with the negative cognition and associated bodily sensations
- While tracking the therapist's fingers across the patient's complete field of vision in rhythmic sweeps of one full back and forth sweep per second
- At the end of approximately 20 seconds (or 20 back and forth sweeps) the patient is asked to "blank it out"; meaning let go of the memory, take a deep breath
- And to note and provide feedback to the therapist as to any changes in image, sensations, thoughts or emotions that might have occurred
- In successive tracking episodes, the patient concentrates on whatever changes or new associations have occurred

Installation of Positive Cognition

- Once the disturbing images have been desensitized
  - SUDs scale report by the patient indicates little or no distress (0-2 points on the 11 point scale)
- Patient instructed to hold the positive/desired cognition in mind while tracking the therapist's fingers
- Patient not asked to report on changes in thoughts, feelings and images during this phase
- Rather to report on changes in the validity of cognition
  - Utilizing a 7-point scale where 7 is completely valid and 1 is not valid at all

Body Scan

- Patient requested to identify any continuing bodily tensions or discomfort
- If these are reported, the patient is asked to attend to them each in turn as they track the therapist's fingers

Closure

- Patient provided with coping techniques such as relaxation skills or positive visualization to address emergent distressing emotions or memories
- Journaling regarding thoughts, dreams, and feelings is also emphasized as needed

Reevaluation

- Therapist evaluates whether treatment goals are being met and maintained, at each session
- Additional sessions are scheduled as needed to target further trauma memories and/or skill development

Comments on Stages

- Stages 4 – 6 are unique to EMDR
  - Desensitization and reprocessing
  - Installation of positive cognition
  - Body scan
- Other stages may be applicable to many other forms of therapy
  - Patient history and treatment planning
  - Preparation
  - Assessment
  - Closure
  - Reevaluation

Summary of Evidence

- EMDR is an efficacious treatment for PTSD
- Recent comparisons of EMDR to PE indicate that EMDR appears to be roughly as effective as PE
- These conclusions also noted in other PGs:
  - National Institute for Clinical Excellence (NICE)
  - Australian Centre for Posttraumatic Mental Health
  - International Society for Traumatic Stress Studies (Spates et al., 2009)

(ACPMH, 2007; NICE, 2005; VA/DoD, 2003)

Questions?

PRESENT TRAUMA