

EFFECTIVE TREATMENT OF PTSD

Jennifer McGrail (University of Melbourne) & Grant J. Devilly (Swinburne University of Technology)

What is PTSD?

Posttraumatic stress disorder is an anxiety disorder caused by exposure to an intensely traumatic event. It is characterized by reexperiencing the traumatic event in recurrent intrusive recollections, nightmares, or flashbacks, avoidance of trauma-associated stimuli, generalised numbing of emotional responsiveness, hyperalertness and difficulty sleeping, remembering, or concentrating.

According to the theoretical models outlined above, two conditions are required to reduce PTSD symptoms:

1. The fear structure must be activated; and
2. Information incompatible with its pathological elements must be incorporated (corrective information must be provided).

This can be achieved through the use of exposure techniques or cognitive therapy approaches. Exposure therapy comprises a set of techniques designed to help the patient confront, in a safe environment, feared objects, situations, memories and images. The two forms of exposure most commonly used to treat PTSD are *imaginal exposure* and *in vivo exposure*. *Imaginal exposure* helps the patient emotionally process the trauma by vividly imagining the traumatic event and describing it aloud, in the first person, present tense, accessing affective as well as cognitive schemas. *In vivo exposure* works by encouraging confrontation with external situations, places or activities that are avoided (but realistically not dangerous) and that trigger trauma-related fear and anxiety. Both of these aspects of exposure therapy are administered by experienced therapists in such a way that the patient feels in control of the whole process.

The following case example outlines the use of exposure techniques to treat PTSD.

Case Example – Mary

Mary is 35 years old, has been married for four years and works full-time as a personal assistant. One day, walking home from work through parkland, she was confronted by three teenage boys who approached her and demanded that she give them her handbag. Mary became frightened and told the boys that she would give them the money she had in her handbag but that the bag was a gift from her husband and she asked to keep it. The boys became agitated and one of them produced a knife from the pocket of his jacket. He told Mary to give him the handbag and her money. Mary handed over her bag to the boys and the boys ran away through the park. Mary walked through the park to a coffee shop and told the shop assistant what had happened and asked for help. The police were called and Mary was taken to the police station and questioned about the incident.

It has been seven months since this incident and Mary sought help for the difficulties she has subsequently experienced. She reports overwhelming anxiety and fear, a sense of helplessness and hopelessness, and is consumed with thoughts about what happened.

'I have nightmares every night. It takes me hours to get to sleep and I frequently wake throughout the night having had a nightmare. The content of my dreams varies, but usually I dream about death and that I am being pursued by people. As a result I constantly feel exhausted. I find it difficult to concentrate at work and follow conversations with friends. I have only spoken to close friends and family about what happened to me that day, but they all tell me to not think about it and put it in the past. I try not to think or talk about it but I still get flashes of what happened coming into my mind. For instance, I was at work the other day putting together a document and suddenly the image of a knife came into my head. I became shaky and my heart raced. I had to run to the bathroom because I was afraid I would start crying or faint. I'm trying to push those thoughts and images out of my head but I can't. As a result, I find that I am not concentrating at work and am constantly forgetting things.

I get scared at things that never used to worry me. For example, the other day when I saw a group of teenagers I was overcome with fear and terror. I felt that I was in danger. My heart was pounding and I was worried I would 'lose it', 'go mad' or have a heart attack.

My husband now goes to the supermarket for me because I don't like being around crowds. I used to be a member of a walking group but I haven't been attending because I do not like being in public, particularly near parkland. I feel safest at home and I don't go out very much. I used to be such a busy and active person, but now I like to stay home where I feel safe. I feel that the world is no longer a safe place and that I can't trust anyone – including my own decisions. My husband now drives me to work and drops me right outside the building; he then picks me up at the end of the day'.

Treatment

Psychoeducation

Engaging Mary in the treatment process requires that she understand her symptoms and the treatment rationale. Psycho-education for Mary will include a discussion of her PTSD symptoms, an explanation and normalisation of her anxiety response and the biological basis of anxiety. This helps to outline the treatment rationale with particular emphasis on explaining the principles of exposure.

In Vivo Exposure

Following psycho-education, Mary, in consultation with the therapist, will develop an 'exposure hierarchy' which outlines the situations that are anxiety provoking for her and those that she avoids. These feared situations are placed in order from the least distressing (e.g., reading a newspaper) to the most distressing (e.g., walking through a park during the day). Mary is required to systematically complete tasks outlined on this hierarchy, starting at those that she rated as least anxiety provoking (e.g., walking to her letterbox during the day). She moves up the hierarchy completing tasks for homework towards the more anxiety provoking task (e.g., visiting a skateboard park – during the day).

In vivo exposure tasks are completed for homework. In therapy sessions Mary will begin her *imaginal exposure*. Mary is instructed by the therapist that:

'I'm going to ask you to recall the memories of the trauma. I'll ask you to close your eyes so you won't be distracted. I will ask you to recall these painful memories as fully and as vividly

as possible. I don't want you to tell a story in the third person, but to describe it in the present tense, as if it were happening now, right here. However, you are perfectly safe here. You will close your eyes and tell me in detail what you see and feel. We'll work together on this. If you start to feel too uncomfortable and want to run away or avoid it by leaving the image, I will help you stay with it. We will tape it so you can take the tape home and listen to it. Every few minutes I'll ask you to rate your anxiety level on a scale from 0 to 100. Please answer quickly and don't leave the image.

Mary is required to recount the incident in the first person, present tense (for instance, 'I am leaving work. I'm starting to feel anxious because I'm running late to meet John. I am looking at all the emails I need to respond to and thinking I must get going – it will wait until tomorrow. I'm shutting down my email programme and now the computer. I'm packing my handbag and walking out the door. I see Amanda on my way through and wave goodbye. I remember I'm meeting with her tomorrow morning...')

During imaginal exposure all relevant details are emphasised including sensory cues and affective responses. Mary will be required to recount the incident for 50 minutes each session. This is the time recommended as being necessary for habituation (anxiety decrease) to occur (Devilly & Foa, 2001).

How does exposure treatment work?

Foa and Rothbaum (1998), drawing on Foa and Kozak's (1986) model, outlined mechanisms thought to be involved in exposure treatment:

- 1) Imaginal exposure promotes habituation to fear provoking stimuli through repeatedly reliving the traumatic event.

Habituation of fear responses involves a gradual reduction of anxiety (self report and physiological measures) through gradual and prolonged exposure to the traumatic stimuli (Foa & Kozak, 1986; Jaycox, Foa, & Morral, 1998). Habituation can occur both within therapy sessions and between therapy sessions. Although Foa and Kozak (1986) initially suggested that habituation within and between sessions is an important step in emotional processing, this is no longer considered the case. Jaycox et al. (1998), using female assault victims suffering from PTSD, found support for the necessity of between session habituation (anxiety reducing over different therapy sessions) but found that within-session habituation (anxiety reducing within the same therapy session) was not associated with improved treatment outcome.

Mary has avoided talking to anyone about the incident since it occurred. It is hypothesised that through having Mary talk about the incident in a safe and controlled environment she will emotionally process the event over several treatment sessions and habituate to its memory.

- 2) Exposure prevents avoidance of the trauma memory being negatively reinforced.

When Mary has a memory of the trauma or is reminded of it, she immediately tries to avoid that situation/memory and subsequently experiences a reduction in her anxiety. However, this reinforces that there is something to be fearful of in the first place. During exposure treatment, Mary is helped to go through the whole event and break the reinforcement cycle.

- 3) Rehearsing the trauma memory in the therapeutic environment promotes incorporation of safety information into the trauma memory.

- 4) Exposure to the trauma memory and associated triggers allows clients to see the traumatic event as a specific case and not one among many examples of a dangerous world.

Following a traumatic event many people report an increase in negative beliefs and safety concerns about themselves, others and the world. For instance, Mary has stated that she does not view the world as safe and as such does not go near crowds of people and no longer participates in activities that she previously enjoyed. Through exposure treatment she is encouraged, in a systematic and safe way, to confront the activities and places she has avoided. Successful completion of these activities provides evidence for Mary that the world is not necessarily a dangerous place at all times.

- 5) Exposure leads to clients experiencing mastery and courage in the face of challenges.

Trauma is often associated with the belief that the event has brought about a negative and permanent change in the self. Mary has expressed that she does not feel she is a strong person anymore, with the implication that she never will be again. More specifically, she used to think she could handle any of life's trials and tribulations but after the event she no longer believes this. Mastery is achieved for Mary through successfully completing the in vivo exposure tasks and talking through the trauma memory during imaginal exposure. Through confronting the memories and places that she fears and has avoided, Mary will achieve a sense of mastery.

- 6) Through reflecting on the event clients examine the evidence and reject false negative evaluations.

For instance, Mary has stated that 'the world is a dangerous place'. As part of treatment this belief will be examined and challenged. Mary's repeated exposure to public spaces and crowds throughout the day, without incident, will result in her realising that it was not the park which was dangerous, but those individuals. She also realises that the probability of being randomly attacked whilst out walking is quite low.

Discussion Questions

1. What barriers do you perceive to using imaginal and in vivo exposure in the treatment of PTSD?
2. What information would you provide to a patient in order to educate them on the process of exposure treatment for PTSD?
3. What changes would you expect to see following successful treatment of a patient with PTSD using exposure therapy?
4. What are ten questions you would ask a patient in order to illicit information about their PTSD symptoms?
5. What is habituation and why is it important in the treatment of PTSD?

References

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Further Readings

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Relevant Internet sites

Australian Victims Website: www.welcome.to/victimservices

Australian Trauma Web: www.welcome.to/ptsd

Australasian Society for Traumatic Stress Studies: www.astss.org.au

The Australian Centre for Post Traumatic Mental Health: www.acpmh.unimelb.edu.au

The American National Centre for PTSD: www.ncptsd.va.gov

Grant J. Devilly PhD & Jennifer McGrail PhD, DPsych (Forensic)

About the Authors: Dr Jennifer McGrail is a Forensic Psychologist. She completed her Doctorate of Psychology (Forensic) at the University of Melbourne. Her thesis was an examination of the treatment of posttraumatic stress disorder in patients with comorbid presentations. Prof. Grant Devilly is the director of the clinical and forensic psychology research unit within the Brain Sciences Institute at Swinburne University. He specialises in the phenomenology and treatment of trauma reactions.