PTSD and Evidenced Based Treatment Available at the VA

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PTSD DSM-5 DIAGNOSTIC CRITERIA

• Criterion A: stressor

• The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (1 required)
  • 1. Direct exposure.
  • 2. Witnessing, in person.
  • 3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  • 4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.
**Criterion B: intrusion symptoms**

The traumatic event is persistently re-experienced in the following way(s): **(1 required)**

- Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.
- Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
- Intense or prolonged distress after exposure to traumatic reminders.
- Marked physiologic reactivity after exposure to trauma-related stimuli.
• **Criterion C: avoidance**
• Persistent effortful avoidance of distressing trauma-related stimuli after the event: *(1 required)*
• Trauma-related thoughts or feelings.
• Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
• **Criterion D: negative alterations in cognitions and mood**
  
  Negative alterations in cognitions and mood that began or worsened after the traumatic event: *(2 required)*
  
  • Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
  
  • Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
  
  • Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
  
  • Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
  
  • Markedly diminished interest in (pre-traumatic) significant activities.
  
  • Feeling alienated from others (e.g., detachment or estrangement).
  
  • Constricted affect: persistent inability to experience positive emotions.
DSM-5 DIAGNOSTIC CRITERIA

• **Criterion E: alterations in arousal and reactivity**
  • Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: *(2 required)*
    • Irritable or aggressive behavior.
    • Self-destructive or reckless behavior.
    • Hypervigilance.
    • Exaggerated startle response.
    • Problems in concentration.
    • Sleep disturbance.

• **Criterion F: duration**
  • Persistence of symptoms (in Criteria B, C, D and E) for more than one month
DSM-5 DIAGNOSTIC CRITERIA

• Criterion G: functional significance
  Significant symptom-related distress or functional impairment (e.g., social, occupational).

• Criterion H: exclusion
  Disturbance is not due to medication, substance use, or other illness.

  Specify if: With dissociative symptoms.
  In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

  - Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

  Specify if: With delayed expression.
  Full diagnosis is not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.
• Prolonged Exposure Therapy
  – 10 to 15 individual therapy sessions lasting 90 minutes in length

• Cognitive Processing Therapy
  – 12 sessions of treatment conducted either in individual sessions, group sessions, or both group and individual.
PTSD- Non-Recovery

• All who experience life-threatening events have some aspects of ASR. (Re-experiencing and hyperarousal)
• “Non-Recovery” explains the development of prolonged symptoms in some people
• Treatment focuses on resetting the recovery process
What causes Non-Recovery

- **Avoidance**
  - Thinking about the event, emotions associated with the event, triggers, detached feelings, and people or places that are reminders/anxiety provoking.

- **Presence of unhelpful thoughts**
  - Thoughts about the event, the world, yourself, or other people.
What does avoidance look like?

- Avoid places, smells, people, or anything that activates the trauma memory
  - Iraqi’s, driving, large crowds, small spaces, nighttime, trash, etc...

- Avoid situations where you feel in danger
  No strangers behind them, can’t have back to the door, stay inside all the time, doors must be locked at all times, etc...
What does avoidance look like?

- Try hard not to feel feelings associated with the event
  Angry, drink to feel numb, keep self distanced from family, no intimacy, don’t respond emotionally to tragedy/sad events, etc...

- Try hard not to think about it
  Workaholic, alcoholic, don’t want to talk about it, constantly try to distract from thoughts of the memory, keep busy, etc...
Erroneous Cognitions Underlying PTSD (Unhelpful thoughts)

- The world is extremely dangerous
  - People are untrustworthy
  - No place is safe
  - To stay safe, I need to control things.

- I am extremely incompetent
  - PTSD symptoms are a sign of weakness
  - Other people would have prevented the trauma
What is Prolonged Exposure Therapy

Evidenced based treatment for PTSD which was created by Edna Foa over 20 years ago. PE has been clinically evaluated to be effective over numerous scientific clinical trials.

Utilizes treatment approaches of:

- Education and explanation of the post-traumatic syndrome.
  1. What maintains PTSD
  2. The need to process the event and the emotions associated with the event.
  3. Treatment interventions
  4. What the symptoms of PTSD are like generally and specifically for the individual
What is Prolonged Exposure Therapy

➢ Imaginal exposure
  • client closes their eyes and recalls the memory of their trauma in the present tense over and over.
  • This assists the veteran with recalling the memory and feeling emotions associated with the event.

➢ In-vivo exposure
  • client identifies situations that they have been avoiding and systematically approaches these situations until their anxiety decreases.

➢ Breathing retraining
  • Slows down the fight or flight response
10-12 Weeks of 90 minute Individual Therapy sessions.

Treatment Outline:

Week One- Overview of the program, discuss treatment procedures, education on how treatment helps PTSD symptoms, trauma interview, teach breathing retraining, assign h/w.

Week Two- Review homework, education on common reactions to trauma, discuss in-vivo treatment rational, introduce the SUDS Scale, construct the in-vivo hierarchy, assign h/w.

Week Three- Review h/w, discuss rational for imaginal exposure, conduct imaginal exposure, process imaginal exposure, assign h/w.

Week Four through Nine or Ten- Review h/w, conduct 30-45 minutes of imaginal exposure (start doing hot spots somewhere in session 5-9, returning to full trauma prior to ending treatment), process imaginal exposure, discuss in-vivo exposure, assign h/w.

Final Session (approx. week 10-12 Last session will occur when SUDS have decreased with imaginal exposure to a sufficient level)- Review h/w, conduct imaginal exposure for 20-30 minutes, review progress and make suggestions for continued practice, terminate therapy.
Additional Session Necessities

• Each client is evaluated for symptoms weekly or every other week using the BDI and PCL-C and this is reviewed with the client.
• Education is provided about a slight increase in symptoms being a positive sign that treatment is working and thus improve recovery results.
• Each client is evaluated for alcohol/drug use and if a prior problem, checked on weekly to ensure they are not using this to avoid during treatment.
• Each client is asked to bring a taping device so that the session is taped and the imaginal is taped. The client will take these recordings with them and will listen to the imaginal tape daily and the session tape once per week.
• Asking specifics about homework to ensure they are not using techniques to help them avoid emotions or do homework at a time that would cause unnecessary exacerbation in symptoms.
Emotional Processing Theory

All of us have Fear Structures

- A fear structure is a program for escaping danger
- It includes information about:
  - The feared stimuli
  - The fear responses
  - The meaning of the stimuli and responses

The Trauma memory has its own Fear structure that develops
Schematic Model of a Memory Shortly After Combat Trauma

Afraid
- I-Me
  - Helpless
  - Yell
  - Scan
- PTSD symptoms

Uncontrollable
- Combat
  - driving
  - dark
  - crowd
  - fire
  - noise
- IED
  - trash

confused
incompetent
dangerous
Early PTSD symptoms

- Trauma reminders in daily life activate the trauma memory and the associated perception of “danger” and “self incompetence”

- Activation of the trauma memory is reflected in re-experiencing symptoms and arousal

- Re-experiencing and arousal motivate avoidance behavior
Recovery Processes

- Repeated activation of the trauma memory (emotional engagement)
- Incorporation of corrective information about “world” and “self”
- Activation and disconfirmation occur via re-experiencing trauma reminders (e.g., thinking about and contact with trauma reminders)
- Corrective information consists of the absence of the anticipated harm
Schematic Model of a Trauma Memory After Natural Recovery

Afraid
- I-Me
  - Scared
  - Yell

Helpless

PTSD symptoms

Uncontrollable

Combat
  - Driving
  - Dark

IED
  - Crowd
  - Fire
  - Noise
  - Trash

Dangerous

Confused

Incompetent
Chronic PTSD

- Persistent cognitive and behavioral avoidance prevents change in the trauma memory by:
  - Limiting activation of the trauma memory
  - Limiting exposure to the corrective information
  - Limiting articulation of the trauma memory and thus preventing organization of the memory.
Schematic Model of Pathological Trauma Memory (Chronic PTSD)

- Afraid
- I-Me
- Uncontrollable
  - Combat
    - driving
    - dark
    - crowd
    - fire
    - noise
    - trash
  - IED
    - crowd
    - fire
    - trash

- Helpless
- Yell
- Scared
- PTSD symptoms

- Confused
- Incompetent
- Dangerous
How does PE work?

Emotional Processing Must Occur

- Emotional Processing During Therapy requires:
  - Accessing of the fear structure (memory)
    - Imaginal exposure and in-vivo exposure give the client access to the fear structure
  - Availability of corrective information
    - Memory becomes more accurate, dangers become more accurate, and erroneous cognitions clear up.
How do the treatment approaches help?

• “Relive the Event” through flooding
  – Develop habituation of the fear
  – Symptoms lessen as habituation occurs

• Develop a clear trauma memory
  – Erroneous cognitions clear up
  – Remember clearly the real dangers
  – Flight or fight becomes activated less often

• Approach fears/Stop avoiding
  – Learn to differentiate between event and remembering
  – Learn that anxiety will go down if no real danger
  – Develop sense of competency and positive self cognitions
Schematic Model of a Trauma Memory After PE therapy

Afraid
- I-Me
  - Helpless
  - Yell
  - Scan

Uncontrollable
- Combat
  - driving
  - dark
- IED
  - crowd
  - fire
  - noise
  - trash

PTSD symptoms
- confused
- incompetent
- dangerous
Schematic Model of a Trauma Memory After Natural Recovery

Afraid
- I-Me
  - Helpless
  - Scan
  - Yell

Uncontrollable
- Combat
  - driving
  - dark
- IED
  - crowd
  - fire
  - trash
  - noise

PTSD symptoms
- confused
- incompetent
- dangerous
Who can you use PE treatment with?

- PTSD diagnosis and other co-existing disorders (e.g., depression, other anxiety disorders, substance abuse or Axis II disorders)
- Must have some memory of the trauma
- People with cognitive impairments
- Must be committed to homework outside of therapy sessions
- Not actively abusing drugs/alcohol
- Not actively self-harming or suicidal
- Not actively psychotic or dissociative identify disorders
- Can have multiple traumas. Must identify the index trauma in these circumstances. (The memory that disrupts them the most or the one that has the most faulty cognitions associated.)
Watch and Discuss VA video about PE
Questions......
What is Cognitive Processing Therapy?

• A short term evidenced based treatment for PTSD
• A specific protocol treatment, that is a form of cognitive behavioral treatment
• Utilizes treatment approaches of:
  – Education and explanation of the posttraumatic syndrome
    • PTSD symptoms
    • Fight/flight and freeze response
    • How our beliefs are formed and change with time.
    • Difference between natural and manufactured emotions and the need for emotional processing.
    • Stuck points and the importance of accommodating new information correctly into our belief system.
What is Cognitive Processing Therapy?

– Challenges unhelpful thoughts (also called “Stuck Points”) with Socratic questions and rational thinking.
  • Beliefs are looked at and challenged using worksheets so that the beliefs change to match the actual experience (Accommodation)
– Can utilize a written account to engage client in the trauma memory, but does not have to.
– Focuses on 5 areas of life that are affected by trauma, safety, trust, power and control, esteem and intimacy
  • Don’t trust anyone or groups of people/or can trust too much (Rare)
  • Don’t feel safe in places, with people, feel life will be cut short
  • Try to control everything or feel they have no power over their life
  • Don’t hold themselves in high esteem or/and others
  • Struggle with intimacy with other people
Tools used in CPT

- Provides tools that client can use to challenge their own unhelpful thoughts

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A-B-C Worksheet

ACTIVATING EVENT
A  "Something happens"

BELIEF
B  "I tell myself something"

CONSEQUENCE
C  "I feel something"

Are my thoughts above in “B” realistic?

What can you tell yourself on such occasions in the future?
```

C6
### Challenging Beliefs Worksheet

<table>
<thead>
<tr>
<th>A. Situation</th>
<th>B. Thought(s)</th>
<th>D. Challenging Thoughts</th>
<th>E. Problematic Patterns</th>
<th>F. Alternative Thought(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the event, thought or belief leading to the unpleasant emotion(s).</td>
<td>Write thought(s) related to Column A. Rate belief in each thought below from 0-100% (How much do you believe this thought?)</td>
<td>Use <strong>Challenging Questions</strong> to examine your automatic thoughts from Column B. Is the thought balanced and factual or extreme?</td>
<td>Use the <strong>Patterns of Problematic Thinking Worksheet</strong> to decide if this is one of your problematic patterns of thinking.</td>
<td>What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Emotion(s)</th>
<th>E. Problematic Patterns</th>
<th>F. Alternative Thought(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%</td>
<td>Jumping to conclusions:</td>
<td></td>
</tr>
<tr>
<td>Evidence For?</td>
<td>Evidence Against?</td>
<td>Exaggerating or minimizing:</td>
</tr>
<tr>
<td>Habit or fact?</td>
<td>Interpretations not accurate?</td>
<td>Diaregarding important aspects:</td>
</tr>
<tr>
<td>All or none?</td>
<td>Extreme or exaggerated?</td>
<td>Oversimplifying:</td>
</tr>
<tr>
<td>Out of context?</td>
<td>Source unreliable?</td>
<td></td>
</tr>
<tr>
<td>Low versus high probability?</td>
<td>Based on feelings or facts?</td>
<td>Over-generalizing:</td>
</tr>
<tr>
<td>Irrelevant factors?</td>
<td>Emotional reasoning:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G. Re-rate Old Thought(s)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-rate how much you now believe the thought(s) in Column B from 0-100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**H. Emotion(s)**

| **Now what do you feel? 0-100%** | | |
Throughout our lives we take in information through all our senses.

We work to organize all of that information in an attempt to understand, predict and control our environment.

Most people are taught the “just world belief” by society

  – So, we tend to believe that good behavior is rewarded and mistakes are punished.
  – When contradictory information comes in, this belief system is challenged.
• Traumas that lead to PTSD are schemas (beliefs) incongruent with prior positive beliefs and/or schema congruent with previous negative beliefs.
• Intrusive symptoms occur as a result of the inability to accommodate the information.
• Three options for adjusting our beliefs to make the trauma fit:
  – Beliefs are changed to match experience and belief is incorporated (Accommodation)
  – They change their view of the world/themselves/memory to incorporate the new information (Assimilation)
  – They change too much and interpret everything in light of this new information. (Over-accommodation)
Identifying Stuck Points

- Undoing, (“if only, should have) guilt or blame about the trauma
- Conclusions, implication of trauma ("never, always, no one" all regarding the 5 theme areas)

Assimilation (About the past/trauma) → Over-accommodation (about present and future)
Five Core Areas of Life that Trauma Effects

Safety
Trust
Power/Control
Esteem toward self and others
Intimacy
Stuck Point Examples

- If I had done my job better, then other people would have survived. (assimilated)
- Other people were killed because I messed up. (assimilated)
- Because I did not tell anyone, I am to blame for the abuse. (assimilated)
- Because I did not fight against my attacker, the abuse is my fault. (assimilated)
- I should have known he would hurt me. (assimilated)
- It is my fault the accident happened. (assimilated)
- If I had been paying attention, no one would have died. (assimilated)
- If I hadn’t been drinking, it would not have happened. (assimilated)
- I don't deserve to live when other people lost their lives. (over-accommodated)
- If I let other people get close to me, I'll get hurt again. (over-accommodated)
- Expressing any emotion means I will lose control of myself. (over-accommodated)
- I must be on guard at all times. (over-accommodated)
- I should be able to protect others. (over-accommodated)
- I must control everything that happens to me. (over-accommodated)
Stuck Point Examples Cont.

• If I let myself think about what has happened, I will never get it out of my mind. (over-accommodated)
• I must respond to all threats with force. (over-accommodated)
• I will go to hell because of the things that I have done. (over-accommodated)
• I am unlovable. (over-accommodated)
• Other people should not be trusted. (over-accommodated)
• My hyper-vigilance is what keeps me safe. (over-accommodated)
• If I have a happy life, I will be dishonoring my friends. (over-accommodated)
• I have no control over my future. (over-accommodated)
• The government cannot be trusted. (over-accommodated)
• People in authority always abuse their power. (over-accommodated)
• I am damaged forever because of the rape. (over-accommodated)
• I am bad because I killed others. (over-accommodated)
Stuck Point Examples Cont.

• I am unlovable because of [the trauma]. (over-accommodated)
• I am worthless because I couldn’t control what happened. (over-accommodated)
• I deserve to have bad things happen to me. (over-accommodated).
• Mistakes are intolerable and cause serious harm or death. (over-accommodated)
• No civilians can understand me. (over-accommodated)

Although these are very common stuck points, especially for military trauma, the list is never ending.
Two types of emotions

Natural emotions emanate directly from the event and are hard-wired

- Fight-flight response = fear – anger
- Losses = sadness
- Disgust = withdrawal

Manufactured emotions are produced by thoughts and beliefs

- Self-blame thoughts = guilt
- Blame others thoughts = anger - rage

Therapists goal

- If Natural, encourage and facilitate client feeling these and let it run its course. Natural emotions dissipate quickly.
- If Manufactured, clients need to change their thinking so that the manufactured emotion cease and natural emotion can be expressed.
Diagram of the theory

- Intrusions
- Emotions/Arousal
- Cognitions

event
In normal recovery, intrusions and emotions decrease over time and no longer trigger each other.
However, in those who don’t recover, strong negative affect leads to escape and avoidance.

Intrusions

Emotions/Arousal

Cognitions

Aggression, Self-harm behaviors, substance abuse, binging, cognitive avoidance, behavioral avoidance, dissociation, emotional suppression, social withdrawal, behavioral inhibition, etc.
Successful Avoidance = Chronic PTSD

• This list is exactly like the list of avoidance options discussed with PE, there is no end to the ways that people can escape and avoid.

• Any behavior that serves to escape or avoid negative trauma-related emotions, images or thoughts is functioning as avoidance.
Change Erroneous Cognitions

• Cognitive changes in treatment requires:
  – Identify and challenge assimilated and over-accommodated stuck points by asking Socratic questions and talking about trauma beliefs and beliefs that arise on a daily basis.
  – Client feel natural emotions while in session and completing homework. Educated about the importance of this and it is encouraged in session.
  – Focuses less on the event than the aftermath. Can do a written trauma account, but don’t have to.
  – Provide tools so that clients can challenge their own thoughts outside of treatment.

So how does CPT work?
How does this help?

- As cognitions change, people start to change their actions. (Don’t believe the world is dangerous anymore, so stop avoiding)
- As cognitions change, people stop seeing themselves in a negative light. (It wasn’t my fault, I am not a horrible person.)
- Cognitive changes and decreased avoidance result in a reduction of emotions/arousal and intrusions, thus PTSD symptoms are reduced.
Who can you use this treatment with?

- PTSD diagnosis and other co-existing disorders (e.g., depression, other anxiety disorders, substance abuse or Axis II disorders)
- Clients must have adequate cognitive functioning
- No memory of trauma necessary
- Must be committed to homework outside of therapy sessions.
- Can be done in group to save resources
- Not actively abusing drugs/alcohol
- Not actively suicidal or self-harming
Questions?
Resources

- [www ptsd va gov](http://www ptsd va gov)
References used for this presentation:

• VA Prolonged Exposure Therapy Workshop July 14th, 2009. Minneapolis MN

• Patricia A Resick, Candice M. Monson, and Kathleen M. Chard, 2006.
