Post-Traumatic Stress Disorder

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OVERVIEW AND KEY POINTS

This chapter outlines the following:

- Definitions and relational conceptualization of Post-Traumatic Stress Disorder (PTSD)
- Offers a case study from therapeutic practice and a model of working from a relational perspective with PTSD from assessment to ending
- Offers an illustration of the types of skills and strategies the approach utilises in working with PTSD.

From our professional experience we have noted that for many clients accessing therapy, the profound psychological distress they present with often arises from the combined impact of life's stress, existential challenges, or experiences of trauma. The American Psychological Association (APA) define trauma as "*an emotional response to a terrible event like an accident, rape, or natural disaster"* (APA, 2022). Furthermore, for some, post-traumatic stress may ensue following a one-off traumatic experience or multiple experiences over time. Given the magnitude of the subject area of psychotraumatology, and the word limitation of this chapter, our focus will be on a relational approach to conceptualizing and working with trauma, and in particular post-traumatic stress. To start with, however, we offer a definition of Post-Traumatic Stress Disorder.

ASSESSMENT AND UNDERSTANDING

Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder was first officially defined in 1980 when the American Psychiatric Association published the 3rd edition of the Diagnostic and Statistical Manual of

Mental Disorders (DSM-III) (APA, 1980). Rather than outline and repeat the criteria for both the DSM-5 and the International Classification of Diseases 11th Revision (ICD 11) for PTSD in this chapter, all of which are available in the diagnostic manuals in detail, we will focus on the core symptoms for PTSD common to both the ICD 11 (WHO, 2019) and the DSM-5 (APA, 2013) criteria.

These are:

- Intrusions or re-experiencing of the event (such as intrusive memories; repetitive play in which the events or aspects of it are expressed; nightmares, flashbacks, or distress triggered by reminders of the event or events).
- Avoidance (such as avoiding thoughts, feelings, or memories of the event or events; or avoiding people, places, conversations, or situations that are associated with the event or the events).
- Arousal and reactivity or sense of current threat (such as irritability, being overly vigilant, being easily startled, concentration problems, or sleep problems).

In Table 1.1, we offer a summary of the PTSD Diagnostic criteria. The criteria presented in this chapter is in line with the DSM-5 (2013) criteria applying to adults, adolescents, and children older than 6 years.

Table 1.1 Summary of PTSD Diagnostic criteria.

PTSD (DSM-5, 2013)	**PTSD (ICD-11, 2018)**
A. **Exposure to actual or threatened death, serious injury, or sexual violence in one (or more ways)** i.e. direct exposure;	▪ Exposure to extremely threatening or horrific event or series of events.

witnessing trauma; learning that a relative or friend was exposed to trauma; experiencing repeated or extreme exposure to aversive details of trauma.	
B. **Re-experiencing of intrusive symptoms** i.e. distressing memories; nightmares; dissociative reactions such as flashbacks; or emotional or distress or physiologic reactivity after exposure to traumatic reminders. C. **Avoidance of stimuli associated with the event** i.e. trauma-related thoughts or feelings or external reminders. D. **Negative changes in cognitions and mood that began or worsened after the trauma** i.e. memory loss; overly negatives thoughts and assumptions about oneself or the world; exaggerated blame of self or others for causing the trauma; feeling isolated. E. **Alterations in arousal & reactivity that began or worsened after the trauma** i.e. irritable behavior or aggression; reckless or destructive behavior; hypervigilance; exaggerated startle response, difficulty concentrating; difficulty sleeping.	▪ Re-experiencing ▪ Avoidance ▪ Persistent perceptions of heightened current threat.

F. **Duration.** Symptoms last for more than 1 month.	▪ Must last at least several weeks.
G. **Functional significance.** Symptoms cause clinically significant distress or functional impairment (e.g., social, occupational).	▪ Significant impairment in personal, family social educational, occupational, or other important areas of social functioning.
H. **Exclusion.** Symptoms are not due to medication, substance misuse, or other illness.	

Having presented a summary of the diagnostic criteria for PTSD, we acknowledge that the presentation of more complex responses to trauma have been argued to fit in a separate category of Complex Post Traumatic Stress Disorder (cPTSD) (Herman, 1992). These types of traumatic experiences involve additional cognitive, emotional, behavioural, relational, and characterological changes beyond the symptoms of PTSD, thereby implying a need for adapted models of understanding and treatment (Karatzias et al., 2019; Dyer & Corrigan, 2021).

Diversity of Practice Guidelines and Modalities for Working with PTSD

There are several primary unimodal approaches recommended for PTSD. The evidence for their effectiveness in PTSD populations has been well-established in gold-standard meta-analyses and randomized control trials (RCTs). These for example include therapies such as Cognitive Behavioural Therapy (CBT), Cognitive Processing Therapy (CPT), Cognitive Therapy (CT), Prolonged Exposure Therapy (PE), Narrative Exposure Therapy (NET), and Eye Movement Desensitization and Reprocessing (EMDR) (Dyer & Corrigan, 2021). There have continued to be developments in different modalities in addition to these, for example

psychodynamic psychotherapy for posttraumatic stress disorder, which considers the impact of trauma on the psyche and on ego function; and other orientations that focus on specific imaginative and resource-oriented techniques or draw on humanistic-existential principles around reframing a new self-concept following trauma and developing the capacity for posttraumatic growth (Murphy, Elliott and Carrick, 2019).

In addition to these, there is a plethora of literature which has highlighted the centrality of the therapeutic relationship in working with PTSD and complex or relational trauma (Dyer and Corrigan 2021; van der Kolk, 2014). This contemporary body of literature and research primarily argues that longer-term work with PTSD requires deeper therapeutic relationships and trust for the client to feel safe, contained, and psychologically held to enable them to process their trauma (Lord, 2019). Thus, the section that now follows will offer the relational protocols we are proposing can inform therapists of diverse modalities in working with PTSD. Additionally, the case vignette offered illuminates the ways in which this happens in practice.

Relational Principles, Assumptions and Central Ideas

A relational approach explores the role relationships play in understanding self and maintaining who we are (Finlay, 2016; Paul and Charura, 2014). As human beings we all have an inner drive for connection and attachment with others. The relational approach posits trauma happens in and through relationships and it can therefore also be argued that processing trauma, change, and growth can occur through the co-creation of the therapeutic relationship. Through the co-construction of shared meaning, the aim of therapy is to increase awareness of an individuals' way of relating to self and other (intellectual insight) and how this relates to PTSD. A safe and supportive relationship can provide the opportunity for an individual to experience a positive 'self with other' experience as well as develop a new and

more productive model of relating (Finlay, 2016; Paul and Charura, 2014). Individuals who experience PTSD can often loose trust in self and in others, making it difficult to connect on a relational level (van der Kolk, 2014). Shame and self-blame/doubt can be particularly toxic and difficult to confront the in the presence of another. It is no surprise therefore that it takes time to address experiences of PTSD.

RELATIONAL WAYS OF WORKING WITH PTSD

In this section we will focus on a relational approach which can be applied in all modalities. To preserve confidentiality of the clients we work with the following case study is a fictitious composite but is based on our own experiences and those of the individuals we have worked with.

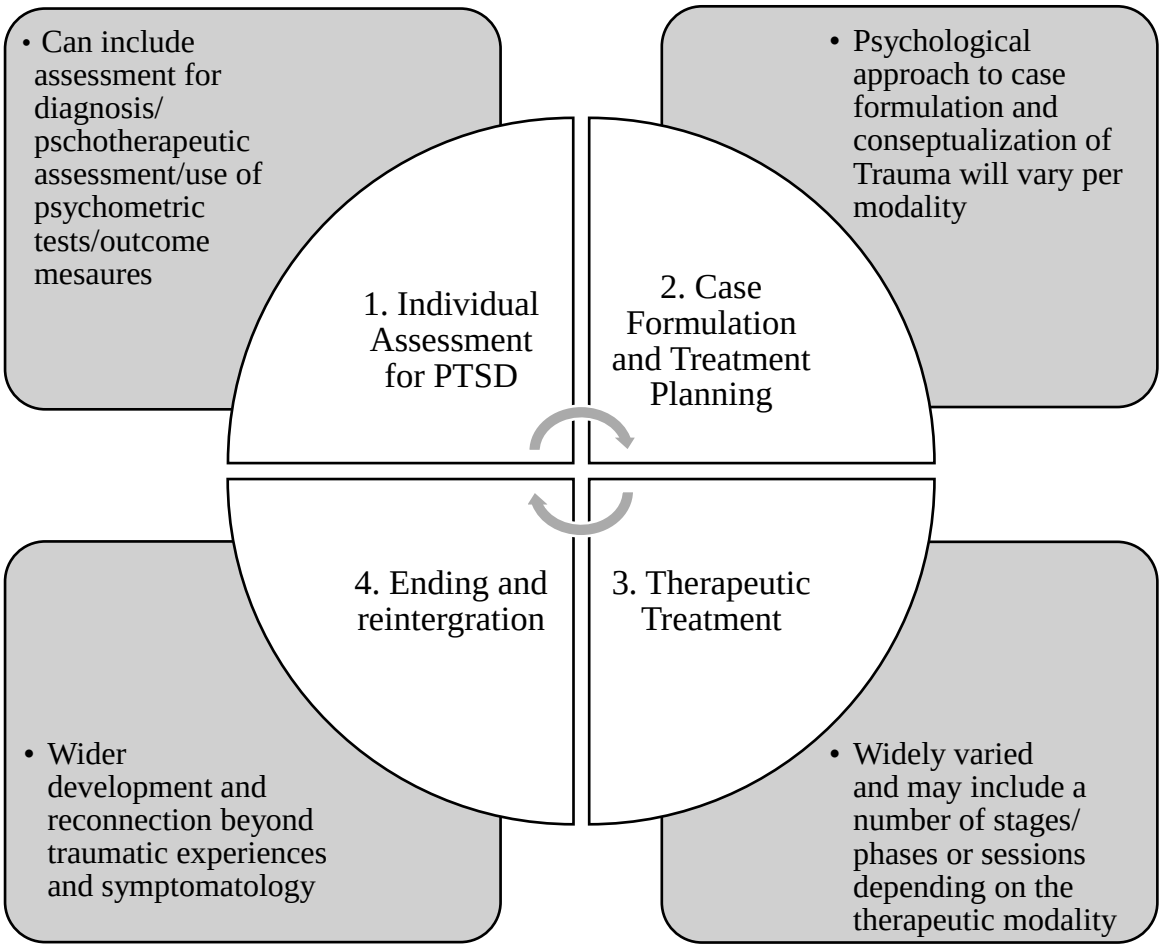
Case Example: Sam is a 30-year-old who presents for therapy with symptoms of PTSD (see Table 1). In the assessment phase of the therapy Sam describes to the therapist numerous traumatic experiences from childhood through to adulthood including childhood abuse, neglect, and bereavement. A "recent experience" has triggered re-experiencing of intrusive symptoms, exacerbated by media coverage of a high-profile case involving survivors of abuse. Sam describes that when intrusive memories of the traumatic experiences emerge distressing nightmares, flashbacks, and panic set in. As a result, Sam has withdrawn from social contact, feels isolated, and overwhelmed. This has resulted in what Sam describes as a "dark cloud" and "low mood". Sam is now signed off work due to the magnitude of the impact of the re-experiencing and intrusive suicidal ideation.

Table 1.2 Pause for reflection: The therapeutic approach.

Pause for reflection on the therapeutic approach
• *Given Sam's presentation as described in the above case example how would you approach working with Sam from your own therapeutic modality.*

In discussing this case study, we will offer a brief four-stage pathway/strategy which includes: (i) Assessment; (ii) Case Formulation and Treatment Planning; (iii) Therapeutic Treatment; and (iv) Ending and Reintegration (Figure 1.1).

Figure 1.1 Four-stage pathway of working with PTSD.



At the centre of this proposed four-stage pathway of working with PTSD as noted in Figure 1.1 are skills central to the therapeutic process which include contracting, asserting the importance of confidentiality, holding boundaries, naming limitations, and potential contraindications of engaging in trauma therapy. Of equal importance is the capacity of the therapist and client to engage in an ethical, collaborative, therapeutic relationship in which there is trust, commitment, containment, and openness. For illustrative purposes to each stage, we will offer an example of a psychological approach, but this model can be adapted accordingly to each practitioner's way of working. In our practice of working with PTSD, we include for example a 3-step recovery plan (Herman, 1992/1997) and we will expand on this in the sections that now follow. We commence here with an exploration of what is included in assessment and move through the stages to ending and re-integration.

Assessment

In trauma therapeutic work, the assessment process is an important part of conceptualising the client's experience and in formulating an understanding of the therapeutic work that will ensue.

Table 1.3 Pause for reflection: Assessment.

Pause for reflection on assessment
• *What would be your therapeutic approach to assessment with Sam?*

A relational approach to assessment from a trauma informed perspective, focuses on "what happened to you" rather than "what is wrong with you". It is also holistic, meaning assessment is of the bio-psycho-social-sexual-spiritual domains to ensure that it captures the diversity of PTSD experiences. It begins with an invitation to share the trauma narrative/experience and gathers information that includes:

- An understanding of the persons conceptualisation of their life at present “the here and now” as impacted by the trauma “the there and then” (this could include DSM-5 Criterion A & B)
- An exploration and identification of the changes that they notice in themselves and in the ways of relating with self and others post trauma (this could include DSM-5 Criterion C & D)
- A perception of the impact of trauma on psychological functioning and social activities of daily living (this could include DSM-5 Criterion E & G)
- A discussion of how long they have been experiencing symptoms and difficulties (this could include DSM-5 Criterion F)
- An assessment of risk to self and/or other.

Assessment is a continual process and can be revisited as new information emerges and changes in the therapeutic relationship and the client’s life occur. As part of assessment depending on the professional’s approach numerous psychometric PSTD assessment screening and outcome measures may be used. In other orientations however, focus is on the therapeutic relationship and functionality reported by the client over time rather than pathologizing or interpretating their experiences based on measures.

Case Formulation and Treatment Planning

Several mental health professionals use formulation as a key therapeutic tool that enables a greater understanding of an individual’s difficulties. Information collected might include presentation, experiences of trauma, exploring what maintains the trauma cycle, and identifying protective factors. It may also include any other information that enable both patient/client and therapist to make links with regards to emotions, thoughts, behaviours, memories, and functionality. From a relational perspective, formulation is conducted in collaboration with the patient/client and is an organic process that can change over time,

hence, if new information comes to light interventions can be refocused accordingly. Through this process both the therapist and patient/client can make sense of the PTSD experiences and begin to identify what maintains certain behaviours and responses to engage in the therapy, process the trauma, and make changes in the future. At this stage, the plan and goals for therapy are collaboratively set. Processing trauma requires openness and trust in the therapeutic relationship; thus, the treatment plan offers a map of how to navigate the terrain of difficult traumatic process. Processing in this context includes stabilization, grounding, and developing a capacity for tolerance of heightened emotional arousal that will inevitably emerge in the process. In line with this, Herman (1992/1997) offered three fundamental milestones which can be considered in treatment planning. These are namely: (i) establishing safety; (ii) reconstructing the trauma narrative; and (iii) restoring relational connection.

Table 1.4 Pause for reflection: Formulation and treatment planning.

Pause for reflection on formulation and treatment planning
• *What would be your approach to formulation and treatment planning with Sam?* • *What alternative approach to formulation and treatment planning could you take?*

Therapeutic Treatment

(i) Establishing safety

Establishing a safe environment can be a complex time-consuming process and often involves rebuilding the patient/client's ego functions, as well as key discussions around their capacity for self-care and self-soothing strategies (Herman, 1992/1997). Trauma can have a devastating effect and ranges from experiencing single overwhelming events to more complex and prolonged psychological pain. Thus, the therapist's commitment to the task of

ensuring safety is crucial to PTSD work. Setting appropriate boundaries and working within the patients/client's capacity to tolerate and manage emotional dysregulation is therefore key when establishing safety.

(ii) Reconstructing the trauma narrative

> *"The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma*."
>
> (Herman, 1992/1997, p.1)

Traumatic events typically occur outside of everyday shared reality, often leaving individuals with a sense that they are harbouring the unspeakable. These secret parts of self, by their very definition, are meant to be kept unknown and unseen by others. In addition, an example of a defence to trauma experiences may be the repression of the trauma and associated memories. However, triggers such as visual, audio, or sensory reminders may result in the emergence of these memories or experiences in consciousness. The discomfort of denial and constant battle to dampen down the re-experiencing of trauma/PTSD symptoms can lead individuals to seek the language to express their pain, bear witness to their lived experience, and feel understood. Many agree that trauma memory processing is a vital part of working therapeutically with individuals presenting with PTSD. The action of retelling a trauma narrative in a safe environment can therefore produce a change in the dysfunctional processing of traumatic memories (Herman, 1992/1997; Paul and Charura 2014).

(iii) Restoring relational connection

Restoring relational connection which allows for a shared understanding and the possibility of finding compassion through working tentatively with felt experiences requires a flexible approach that embodies hope for a future where change, acceptance, and connection can not only be tolerated but also embraced. Being received in this way goes beyond the process of

"speaking your truth" and offers an opportunity for working through traumatic experiences, bodily responses, or felt senses (van der Kolk, 2014) in the "here and now", thus enabling a restoration for relational connection with self and other. In the process of working through traumatic material/memories it is important for therapists to deeply respect the patient/client's trauma experience, the impact on personality, and relationships whilst valuing their difference and diversity (Charura and Lago, 2021).

Table 1.5 Pause for reflection: The therapeutic environment and therapeutic process.

Pause for reflection on the therapeutic environment and therapeutic process
• *What might you do to ensure you establish a safe therapeutic environment for Sam?* • *How might you support Sam with the process of reconstructing or reframing the trauma narrative?* • *Reflect on how you may develop a relational connection with Sam and what some of the challenges may be?*

Ending and Reintegration

Working through an ending stage of therapy could explore strategies for dealing with any pervasive feelings of anxiety, boredom, emptiness, avoidance, unconscious fantasies about the ending of trauma therapy, and/or experienced loss. In some cases, it also requires working through and challenging compulsions to repeat destructive behaviours. An ending phase in which re-integration and relapse prevention strategies, may include re-evaluation of functionality, or capacity for re-engaging in inter/personal relationships. It also includes re-framing the traumatised self in a way more congruent with a meaningful and new functional self and a healthy identity (Paul and Charura, 2014). Additionally, it is good practice where

an unplanned ending emerges or where the practitioners' competences are not aligned with helping individuals presenting with PTSD that they refer to other services.

Table 1.6 Pause for reflection: Reintegration, relapse prevention, and ending therapy.

Pause for reflection on reintegration, relapse prevention, and ending therapy
• *How might you support Sam with the process of reintegration and relapse prevention?* • *What might you do to ensure a good ending to the therapeutic relationship with Sam? (Also reflect on what some of the changes might be?)*

There is a growing body of literature which highlights the concept of post-traumatic growth, (Greenblatt-Kimron, 2021; Nuccio and Stripling, 2021). It is worth us stressing that both of us, as authors and clinicians, have worked with clients who also have reported post-traumatic growth, and this continually gives us hope in our work with those who have experienced Trauma. As has been demonstrated by our chapter, drawn from a relational approach which can be applied to a range of modalities, we would like to conclude by acknowledging how PTSD presents in a range of different ways in different individuals and thus approaches to treatment also must be diverse in contemporary society.

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RECOMMENDED READINGS

Relational Integrative Psychotherapy: Processes and Theory in Practice. (Finlay, 2016).

This essential book outlines a relational therapy model that prioritizes the client and allows for diverse approaches to be integrated within a strong therapeutic relationship.

An Introduction to the Therapeutic Relationship in Counselling and Psychotherapy. (Paul and Charura, 2014).

This key book offers a practical and practice-based evidence guide to all aspects of the therapeutic relationship in counselling/psychotherapy and examines the issues impacting on the therapeutic relationship across a range of models of practice.

The body keeps the score: Brain, mind, and body in the transformation of trauma. (van der Kolk, 2014).

This highly recommend book explores the devastating effect of trauma on individuals, their families, and future generations. Moving away from standard talking and drug therapies, it offers a contemporary paradigm for mind, brain, and body treatment.