

## PSYCHOTHERAPY OF POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder occurs when an individual is exposed to a traumatic experience that is severe enough to overwhelm the usual coping mechanisms. PTSD can be divided into two types: simple acute PTSD and chronic complex PTSD. Simple acute PTSD typically follows single incident traumas such as car accidents, workplace violence, rape and sudden life threatening medical illness such as heart attack. Treatment is brief, usually spanning 4-8 sessions. Chronic complex PTSD results from ongoing recurrent trauma as in child abuse, domestic violence and war. Treatment may require months or years.

Individuals suffering from both types of PTSD can experience dissociation as a spontaneous coping mechanism. Research shows that high degrees of dissociation result in more complicated and prolonged treatment. Dissociation can be easily measured by use of one of the self-administered instruments such as the 28 item Dissociative Experiences Scale (DES), or administration of the Structured Clinical Interview for DSM-IV Dissociative Disorders (SDID-D).

Dissociation is basically the mind's way of fragmenting experience into pieces and then putting the pieces behind dissociative barriers. Whenever the individual confronts triggers of the original trauma he or she will be susceptible to experiencing breakthrough of those memory fragments. Memory fragments can break through in four ways: 1) as behavioral re-enactments (eg. not wanting to go to bed, compulsive showering) 2. as affective experiences (eg, bouts of anxiety, angry explosions) 3. as body sensations (eg, episodic abdominal pain or vaginal burning) 4. as knowledge of the event, usually experienced as visual images (eg, seeing bathroom tiles flash through the mind). People experiencing memory fragment breakthrough usually do not know what is happening to them and are often afraid they are "going crazy". If this condition is misdiagnosed by medical or mental health professionals the patient is generally started on a variety of psychotropic medications. This can lead to tranquilizer dependency. Patients may seek out other numbing agents such as recreational drugs or alcohol.

Once the diagnosis is made it is helpful to explain it to the patient. Individuals often feel immediate relief when they learn that they are experiencing memory breakthrough from

a previous trauma rather than having a “breakdown”.

Treatment of PTSD is stage-specific. Hypnotherapy is integrated into a cognitive and dynamic psychotherapy. The three stages of treatment are: 1) stabilization, 2) memory processing and 3) cognitive restructuring. The same approach is used for both types of PTSD. If dissociation is high it may be necessary to work with integral ego states.

It is recommended that each patient sign a hypnosis consent form after appropriate discussion about hypnosis, trauma and memory has occurred. The therapy then quickly moves into the stabilization phase. This is a skill building phase in which the patient learns how to use and integrate specific hypnotic containment skills. It is essential that all patients have a firm foundation of hypnotic containment skills in place before moving into the memory processing stage. Some of the more useful hypnotic skills we use at our center are listed in the accompanying handout. It is not necessary for each patient to utilize all of these skills. Specific skills can be matched to the needs and capacities of each specific patient.

Centering and grounding techniques are important to enable each individual to stay in the present and not be swept back into the trauma. Spontaneous abreactions (complete flashbacks) are counter-therapeutic and must be prevented. Patients quickly learn the self-hypnotic skills of diaphragmatic breathing for tension reduction, safe place, lock-up, and affect dial.

Some patients find it useful to chain tension reduction skills together as a deepening experience. Diaphragmatic breathing can progress to clouds for soothing (floating and rocking on soft white clouds) to entering a hypnotically-imagined safe place. Time distortion can be used to enhance the tension-reducing power of a safe place. Unwanted traumatic images or feelings can be locked up into hypnotically-visualized inside containers (eg. lock boxes or safes). The “key” may be left in the therapist’s office, and the traumatic contents opened and examined at the right time in the presence of the therapist. Affect dial can be particularly effective in reducing unwanted and painful affects (eg, shame) or body sensations (eg, vaginal burning). The patient in hypnosis visualizes the dial with numbers from 0 to 10. Colors may accompany the numbers. The dial measures the intensity of the feeling at the moment and then the patient experiences turning the dial up and down, mastering the ability to control the sensation.

In many cases of chronic complex PTSD occurring from recurrent childhood trauma there may be ego states present which hold chunks of traumatic material. The therapy then engages these parts of the patient’s mind and the containment skills are taught to the ego states.

After stabilization has been adequately achieved the therapy proceeds to the memory processing stage. In simple acute PTSD it may be possible to process the traumatic event in a few sessions. In chronic complex PTSD this stage may proceed gradually over

months, augmenting containment skills whenever necessary.

Memory processing can be undertaken with the patient telling the story of the trauma from beginning to end while under hypnosis. The attendant affects, body sensations and visual images are all experienced and integrated. Emotions or sensations which are anticipated to be too powerful to cope with initially can be “fractionated” out by using affect dial. For example, the shame dial is turned down as close to zero as possible while the patient narrates the memory the first time. The next time the memory is worked on the shame dial might be set at 5. In patients with chronic complex PTSD who have ego states it is necessary to process the memories contained in each ego state with the patient and the other ego states listening, absorbing and integrating the material.

Symptoms and susceptibility to triggers will have markedly diminished or disappeared at the completion of the memory processing stage. It is then possible to move into the final stage of treatment which facilitates cognitive restructuring. Working with the patient’s negative cognitions usually occurs as part of the therapy throughout the first two stages of treatment, but now the focus shifts fully in this direction. At this stage patients come to terms emotionally and cognitively with the impact of knowing what happened to them and how they have survived. The individual before the trauma is not the same as the individual after the trauma. A new identity emerges which must be integrated. Negative cognitive assumptions are explored and give way to new beliefs and self-perceptions. Hypnotic ego enhancement techniques can be useful at this stage. In simple acute PTSD this may require only one or two sessions whereas in chronic complex post traumatic stress disorder this stage may require months or years. With appropriate treatment recovery from both types of PTSD can be complete and lasting.

Charles H. Rousell, M.D.