

Post Traumatic Stress Disorder (PTSD): Impact on Children, Families and Communities, and Hopeful Treatments

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Objectives

- To learn about PTSD (diagnostic & historical overview)
- To identify impacts on individual, family, communities
- To learn about special treatment issues and proven treatments
- To learn about and share helpful resources



Outline

- **PTSD overview**
- **Impact on individual, family, community**
- **Treatment considerations (Children, Youths, Adults, Women, Veterans)**
- **Effective Treatments: PE/CPT**
- **Treatment reviews: 2 veterans/families**
- **Resource sharing (Handouts)**

What Is PTSD?

- Experienced or witnessed event(s) involving death or serious injury, or threat of death or serious injury, threat to physical integrity
- Responded with intense fear, horror, and/or sense of helplessness
- Re-experiencing symptoms (eg, intrusive memories, distressing images, upsetting dreams, flashbacks, physical reactions)

What Is PTSD?

- **Avoidance of trauma reminders.**
Situations, people, things, memories etc.
May include emotional numbing etc.
- **Hyperarousal. Watchful, on guard, alert for signs of danger, startle. May affect sleep/concentration.**
- **Symptoms last over a month**
- **Symptoms cause significant distress, impairment**

Trauma Examples

- **DV, sexual abuse (experiencing/witnessed)**
- **Suicide, homicide**
- **Violent crime (eg, robbery, shooting, rape)**
- **Death or serious illness of loved one**
- **War (combat, MST, etc)**
- **Medical events**
- **Accidents (eg, car and plane crashes)**
- **Natural disasters (hurricane, earthquake)**

Traumas (Children/Youths)

- Accidents (MVA's, drownings)
- Normal risk taking
- Violent crimes (kidnapping, rape/murder of parent, sniper fire, school shootings)
- Death or injury of loved ones
- Peer suicide
- Other violence (bullying; sexual, physical, emotional abuse; assault)

Physiological Responses

- **Fight, flight, freeze**
- **Brain/body response during trauma and post trauma**
- **Physiological changes (eg adrenal)**
- **Body-mind mind-body impact**
- **“Normal reactions to abnormal event”**
- **→ “Tunnel vision” → Survival**

Anxiety Triggers (Examples)

- Intense responses to predictably safe cues (conscious and out of awareness)

- Anniversary dates

- Events (retirement, new war)

- Smells, sounds, sights, taste, touch

- Clothing articles

- Appearance: male/female, age

[overpass-trash-bbq-food-kids-roof-news
cologne-planes-festival-funeral-humidity]

PTSD Progression

- **Adaptive → survival**
- **Coping → short term relief → long term overreaching impact**
- **For example:**
 - identity, self esteem, safety,
 - relationships, family, parenting
 - work, finances, school, social life
 - community health and well being
 - medical and psychological conditions
 - spirituality, foreshortened future

PTSD Progression

- **Acute stress response**
- **Some clients recover naturally; others may develop partial/full PTSD**
- **Avoidance/thoughts can maintain PTSD**
- **Impact: thoughts-emotions-behaviors**
- **Internal and external reinforcement**
- **Risk for physiological habituation**
- **“Life is small, everywhere is dangerous”**

Other Factors

- **PTSD may occur at any age**
- **Children's expression vs. adults**
- **Intensity, frequency, proximity of trauma**
- **Trauma type (interpers/natural disaster)**
- **National, community, family, individual, response can help prevent PTSD and interrupt progression (address neglect)**
- **Treatment can jump start recovery that diminishes/resolves symptoms**

Diagnostic Challenges: Symptom Overlap With Other Disorders

- **Avoidance (lack of interest in activities)**
- **Emotional numbing, blunted affect**
- **Detached, disassociated**
- **Anger, irritability, outbursts**
- **Guilt, worry, shame, sadness, blame, self blame, etc.**
- **Poor sleep**
- **Sexual dysfunction**
- **Memory and concentration problems**

PTSD Rates (United States)

- **Variable reports (1-3% general, 30% Vietnam vets etc)**
- **8% in general population, APA (2000)**
- **97.7 million American adults**
- **Challenges in data collection**

2005 National Comorbidity Survey Replication study, nih.gov



Childhood Rates

- **90% of sexually abused children, 77% of children exposed to a school shooting, & 35% of urban youth exposed to community violence, develop PTSD**
- **Some studies report “as many as 100% of children who witness a parental homicide or sexual assault develop PTSD”**

Referenced on va.ptsd.gov



PTSD Rates

- **15-43% girls & 14-43% boys experience at least 1 trauma; of these, 3-15% of girls & 1-6% of boys may have PTSD***
- **Higher rates noted in AI/AN communities**
- **22% of AI/AN population may have PTSD****

**2005 National Comorbidity Survey Replication study, nih.gov*

***Yellow Horse Brave Heart, M. 2003., Journal of Psychoactive Drug, 35, 7-13*

Evolution Of Diagnosis

- **Pre WWI 1880s: nervous shock**
- **WWI & WWII: Stigma → "War neurosis"**
symptoms often described in
medical/physical terms
 - **Combat neurosis**
 - **Shell shock (WWI)**
 - **Battle fatigue (WWII)**
 - **Combat exhaustion, fatigue**
 - **Operational fatigue**

Evolution Of Diagnosis

- **WWI 1918: Psychiatry starts noting emotional factors vs. physiological brain damage (shell shock)**
- **WWII 1930/40s: 37.5% of 800,000 soldiers discharged due to “combat neurosis” leading to “combat exhaustion”**
- **Political influences in diagnosing**



Evolution Of Diagnosis

WWII 1930/40s:

- **Symptoms also noted in survivors of**
 - Atomic bombs**
 - NAZI concentration camps**



Evolution Of Diagnosis

- **Korean War 1950s: 24.2% of 198,380 combat veterans, psychiatric casualties**
- **1952: Gross Stress Reaction (DSM I APA)**
- **Vietnam War 1960s: Diagnosis replaced by “Adjustment Reaction to Adult Life” (DSM II, 1968, APA)**

Evolution Of Diagnosis

- **Vietnam War 1960s/70s: est. 480,000 veterans meet full criteria for PTSD; 350,000 partial criteria**
- **1980: “Post-Traumatic Stress Disorder” DSM III (APA). Event out of normal exp.**
- **1994: Criteria modified in DSM IV, subjective, expanded trauma definition**

Evolution Of Diagnosis

- **Persian Gulf War 1991: Study of 4500. 9% report PTSD symptoms, 34% report other significant psychological distress**
- **Estimated risk from service in Iraq or Afghanistan vary (11%-50%)**
- **2012: DSM V revisions in progress**
<http://www.dsm5.org>

AI/AN Military Representation

- **Early WWI: 16 AI were awarded Congressional Medal, highest honor**
- **WII: Over AI 44,000 served (1941-45), including 800 women**
- **About 99% of healthy AI males (21 to 44) registered for draft**
- **Over 400 employed as “Code Talkers” in Pacific. Navajo, Lakota, & others.**

AI/AN Representation

- **Gulf War, over 3,000 served**
- **Vietnam era (1965-75): Over 42,000 served**
- **PL 101-507: Senator Matsunaga Project, studied PTSD among American Indian Vietnam veterans**
 - high levels of combat exposure
 - high levels of stress and PTSD

AI/AN Representation

- **2005 DOD data: AI “males serve in greater proportion than eligible males in general”**
- **“24,000 among 1.4 million active duty military are American Indians, including nearly 3,900 women”**
- **Data collection flaws: underreporting**

Military Trauma: Trends

- Polytrauma**
- TBI**
- Blast Injuries, survival of soldiers severely injured**
- Wounded Warrior Project**
- Women in war**
- Community involvement**
- Suicidal ideation (SI) and rates**
- Reexposure**



Impact: Individual, Family, Community

- **PTSD affects the person with the disorder and those around them:**

Individual impact (examples)

- anger, impulsivity, irritability**
- substance use (as avoidance)**
- other harm to self/others**
- depression, isolation, shame**
- suicide risk: agitation, avoidance**

Impact: Individual, Family, Community

Individual impact (examples)

- developmental**
- memory and sleep problems**
- medical problems (eg diabetes)**
- work, school problems**
- financial**

Family impact (examples)

- see above, and...**
- high divorce rates**



Impact: Individual, Family, Community

Family impact (examples)

- influence on parenting styles**
- intergenerational transmission**
- abuse, neglect, dv**
- relational problems**
- family systems**
- when both parents have PTSD**
- trauma awareness**

Impact: Individual, Family, Community

Community impact (examples)

- see above, and...**
- historical trauma**
- cultural strengths and resources**
- physical environment**
- public health and safety**
- health system shift, telehealth**
- veteran reintegration**

Treatment Considerations: Women And Men

- **Complex trauma, underreporting**
- **Safety assessment and planning**
- **Safety in home and in community**
- **Substance use (treatment interference, physiological risk for women)**
- **Concurrent treatment**
- **Partner/children's responses**



Treatment Considerations: Children And Youths

- **Severity**
- **Parental/community reaction**
- **Physical proximity to event**
- **Exposure (intensity and frequency)**
- **Nature of trauma (interpersonal)**
- **Overlooked signs, timely responses**



Expression In Children

- Time skew
- Omen formation (uncommon in adults)
- Regression, unable to talk
- Somatic complaints
- May refuse to play or go places
- Bed wetting
- Visual flashbacks and amnesia uncommon in children



Expression In Children

- **Posttraumatic play or reenactment**
- **In play, drawings, conversation**
- **Compulsively repeating aspects**
- **Anxiety typically not relieved**
- **Trauma related avoidance**
- **Substance use**



“Tribal leaders...

frequently state that in order to heal one must address the "physical, spiritual, emotional and mental" domains of the self. Treatment programs often address only the emotional and mental components of mental health.” (Trauma in American Indian Communities, A Morsette, Trauma intervention specialist, SAMHSA)

Developing responsive treatments...



PTSD Treatments May

- **“Jump start” recovery processes**
- **Reframe PTSD: “Recovery model” vs. “life sentence of suffering”**
- **Promote concurrent or prioritize care**
- **Advance care coordination**
- **Educate client-family-community-clinician**
- **Empower clients, families, health systems**
- **Encourage spiritual healing**
- **Acceptance and meaning making**

Types Of Treatments (Examples)

- **Symptom management**
- **Prolonged Exposure**
- **Cognitive Processing**
- **Eye Movement Desensitization and Reprocessing (EMDR)**
- **Trauma focused CBT**
- **Groups (normalize, inspire)**
- **Individual treatment (explicit processing)**



Culturally Responsive Care

- **Sweat Lodges**
- **Traditional ceremonies**
- **Medicine wheel**
- **Traditional healers**
- **Smudging, Drumming**
- **“Wellness Garden”**
- **“Honoring Children”/“Promoting Culturally Competent Informed Practice” (Indian Country Child Trauma Center)**



Prolonged Exposure

- **Cognitive Behavioral Treatment**
- **Emotional processing, behavioral exposure: confronts safety behaviors**
- **Individual treatment**
- **Developed by Dr. Edna Foa (Director of the Treatment & Study of Anxiety)**
- **Intentionally approach trauma memory and reminders long enough, often enough to reduce/resolve anxiety (exposure)**

Prolonged Exposure (PE)

- **Involves:**

- PTSD education (normalizing)

- Breathing retraining

- In vivo (real life) exposure (least to most distressing): SUD.

- Imaginal exposure (tapes)

Trauma type and chronicity

Telehealth, hybrids (nonprotocol)



PE Treatment

- **Typically 10-15 90 minute taped, structured sessions (1-2 x week)**
- **Individual sessions**
- **Collateral report**
- **Homework intensive (daily)**
- **Real life and imaginal tape exposures, breathing, etc.**



PE Rationale

- **“Pathological fear structure”**
- **Avoiding (safe but distressing activities, memories etc)
perpetuates avoidance, fear**
- **Therapeutic exposure empowers client to take control back**
- **Explicitly process memory (eyes closed, present tense) → habituate**

PE Rationale

- **Trauma memories and reminders lose power to elicit trauma response, allowing for corrective new learning**
- **PE activates fear response (in safety) to eventually reduce fear/anxiety and integrate new learning**



PE Rationale

Repeatedly approaching memories and (predictably safe) real life fears

- **Promotes habituation**
- **Corrects beliefs that anxiety lasts forever**
- **Blocks short term reward of avoidance**
- **Can lead to further processing**



Repeatedly Approaching

- **Helps survivor differentiate trauma experience from experiences in rest of world**
- **Transforms sense of incompetence to personal mastery**
- **Promotes realization that remembering is not dangerous**



PE: Sessions

- **Trauma intake, breathing retraining, PTSD/PE rationale**
- **In vivo rationale & SUD list**
- **Trauma recounting (3-end)**
- **Processing (each imaginal)**
- **In vivo/imaginal HW review**
- **Progress recorded/reviewed**



Evidence: PE Treatment

- **Over 20 years of research**
- **Has benefitted AI/AN veterans**
- **By 2000, 12 studies tested exposure therapy, all finding positive results**
- **“Rigorous methodology”**
- **Some consider first line treatment**

PE Benefits

- **Decreased anxiety, depression**
- **Increased quality of life**
- **Improved relationships**
- **Improved sleep**
- **Progress evaluated by self/collateral report, clinical tools, staff observation (affect, SUDs, imaginal exp, activities)**



PE Benefits

- Improvements in physical health
- Improved social functioning
- Posttraumatic growth
- Increased sense of possibilities
- Details of daily life, eg resolved SI

Powers et al., Clinical Psych Review 2010; Hageraars et al., JTS 2010; Rauch et al. Depr & Anx 2009



PE Challenges

- **Individual vs. group format**
- **Lack of time & trained clinicians**
- **Cost of competent training, ongoing consultation**
- **Debates about telehealth**
- **PR: “cruel, dangerous treatment”**
- **Adherence to protocol in real life**

Client 1: PE

- **68 y/o, Vietnam Veteran, AN**
- **Alcohol dependence in rem. 3 years**
- **40 years: depression, PTSD (70% SC)**
- **Divorced 3 times**
- **Denies current SI; past attempts**
- **Hx of sexual, emotional, physical abuse by mother and step father**

Client 1: PE

- **Afraid to talk about missions**
- **Trauma interview: multiple events**
- **Avoidance—started w lesser event**
- **Resisted imaginal in session 3: over 90 min session.**
- **“You weren’t there.” Survivor guilt**
- **Couldn’t save soldier who fell from rope he tied. I’m terrible, my fault”**

Client 1: PE

- **Perfectionistic “to make up for it”**
- **“Stupid for running back thinking I could catch him. Sat with him, dead”**
- **Recognized new details through recounting: 200 lb. soldier, carried miles, may have made mistake or not, quality of rope danger to others, trauma, people make mistakes.**

Client 1: PE

- **Early completer (session 8)**
- **“Wife thinks you have stars. She can’t believe the changes.**
- **School, community service group**
- **I told people before about it. PE helped me figure out what to do.”**
- **“I ate a hamburger this big. Do you have any idea what this means?”**

Cognitive Processing Therapy (CPT)

- **Cognitive Behavioral**
- **Natural PTSD recovery process is interrupted by**
 - **Avoidance behaviors (reinforcing)**
 - **Distorted beliefs about trauma (that become)**
 - **Generalized to current life situations**

CPT

- Individual/group formats
- 12 50-min/12 90 min sessions
- Substantial daily practice
- Progress monitored similar to PE
- Studies report benefits similar to PE
- Developed by Drs. Patricia Resick, Candice Monson, and Kathleen Chard
- Original work with rape survivors

CPT Rationale

- **Trauma can dramatically alter basic beliefs about world, self, others**
- **ID/alter unhelpful, inaccurate, often auto thoughts maintaining PTSD**
- **Expands range of emotional response**
- **Worksheets increase awareness of thoughts-behaviors-feelings and automatic thought patterns**
- **Clients learn Socratic questioning**

How to get “STUCK”

Prior beliefs can be disrupted or reinforced by the trauma

EXAMPLE: The Just World Belief

“GOOD THINGS HAPPEN TO GOOD PEOPLE & BAD THINGS HAPPEN TO BAD PEOPLE”



NOW WHAT DO I BELIEVE?????



CPT: Types Of Thoughts

- Identify and resolve “assimilated” beliefs (“I/they/you should have, would have, could have...”)
- Challenge and balance “overaccommodated” (extreme) beliefs (“All [men, women] are dangerous. World is totally unsafe”)
- Goal: accommodation, balanced view

“Innocent people were killed”

Assimilate

- I should have prevented it.
- It was my fault.
- I deserve to have bad things happen to me.
- It didn't really happen.

Accommodate

- Mistakes were made.
- Although lives were lost, many lives were saved.
- Sometimes bad things happen to good people.

Overaccomodate

- Government cannot be trusted.
- Nowhere is safe (I must stay on guard at all times).
- I am powerless.

Areas Interrupted by Trauma

5 major dimensions may be disrupted

- **Safety**
- **Trust**
- **Power and Control**
- **Esteem**
- **Intimacy**



CPT: Preventing Dropout

- MI techniques
- Client beliefs (that gains are possible)
- Ability to tolerate therapy (skills)
- DBT or other pretreatment work
- Desire to approach outweighs desire to avoid—psychic pain as motivator
- Therapist adherence to protocol



CPT Goals

- **Strive for acceptance that the traumatic event occurred**
- **Acceptance does not mean it is “all right” that trauma happened but acceptance of event: impact, thought/emotional processing**
- **Discover ways to successfully integrate experience (meaning)**
- **ID/change PTSD thoughts**



CPT Implementation

- **Daily writing: Multiple worksheets**
- **Impact Statement**
- **Trauma account**
- **Challenging belief worksheets**
- **Patterns of problematic thinking**
- **ABC worksheets**
- **Stuck Point List (worksheet)**



Client 2: CPT

- **30 y/o, vet (Iraq)**
- **Polysubstance dependence in remission x 1 mos**
- **Became homeless in course of tx**
- **Experienced DV during tx**
- **Back and knee pain (vicodin)**
- **Anxiety (benzodiazepine)**

Client 2: CPT

- **No previous PTSD treatment**
- **Trauma: “Kid wandered by nervous, he was a nice kid, we knew him”**
- **“Kid was shaking, clothing covered extensive explosives someone attached to his body”**
- **Bomb specialists spent hours to try to disconnect but could not**

Client 2: CPT

- Witnessed child shot (safety risk)
- Stuck points: “I should have saved him but couldn’t. His parents should have saved him. They are all terrorists and terrible people.
- I am bad luck for kids, I cause harm
- Worksheets helped him process event, gain understanding, integrate

Client 2: CPT

- DV during tx and then homeless
- Stopped tx. Safety planning/housing
- Relapsed to mj use—agreed not to use during practice assignments
- Asked if he wanted to quit therapy. He reported benefit and we cont'd.
- Moved to tent, abuser read HW
- We held worksheets at office

Client 2: CPT

- **Some gains: Was able to watch children play at a store v. leave/avoid**
- **Does one nice thing for himself daily (“ok to be nice to self”)**
- **Homework completion erratic**
- **At end of tx, earned 100 percent SC**
- **Relocated. Recommended inpatient substance abuse tx and recompleting course of CPT uninterrupted**

Assessments (PE and CPT)

- **Can clients attend regular sessions?**
- **Did not locate research on AI/AN and CPT/PE. Success w veterans**
- **No sufficient research to guide treatment matching**
- **Both effective**

Assessment (PE and CPT)

- **Is PTSD primary problem?**
- **Explicit memory of trauma?**
- **Are there significant, more urgent or treatment interfering issues? Imminent risk, rx meds?**
- **Psychosis, SI, substance use**
- **PCL, CAPS, BDI, charts etc.**
- **Perpetrators/antisocial response**

(PE Vs. CPT)

- **Client resonates more strongly with one rationale**
- **Comfort/competence of therapist**
- **Homework preference (writing in CPT vs. tapes/in vivo PE)**
- **Other factors?**



Questions?



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