Assessment and Treatment of Post Traumatic Stress Disorder

By Lorraine Winkler, LCSW

Presented by CEUSchool
**Brief Bio**

Originally a Registered Nurse from 1963-1978, Ms. Winkler MSW, LCSW, BCD returned to school and received a Masters in Social Work from Rutgers University in 1980. She is currently licensed to practice as a private practitioner in Virginia, Maryland and Washington DC and Florida. Ms. Winkler has gained extensive experience in various inpatient, outpatient and agency settings, has worked as private practitioner for the eighteen years and as a supervisor for the past five-years. Specializing in Post Traumatic Stress Disorder, a large portion of her work is directed toward helping clients who have a history of emotional, physical and sexual abuse. Ms.Winkler has received certifications in sex therapy and hypnotherapy. She is and has been a social activist working with community to address problems of drug/alcohol abuse, domestic violence, general problems of violence, offering educational seminars on domestic violence and anger management. She was the Editor of *The Practitioner* The Florida Society of Clinical Social Work’s newsletter. She is a member of The National Association of Social Workers, The Academy of Certified Social Workers and is Board Certified through the American Board of Examiners. (BCD)

**Writers Comments:**

I can vividly recall the infamous day of 9/11 when I watched the Twin Towers going down. I was watching it on TV. At first, I though it was some programming done in really bad taste. When it did finally did sink in, that this was for real, I found myself unable to wrap my mind around what I my eyes recorded. In the days that followed I operated on automatic pilot attending to the details of my life but essentially feeling dazed and numb.

At the time the Twin Towers was hit, I lived in Virginia, an easy ride from the Pentagon. It was a ride I both dreaded and was compelled to take. I saw the charred wing of a landmark government building. I saw people sitting out on the lawn by roadside memorials weeping and I too was flooded with emotion. But, years of programming were in place and I felt and believed that I had to be strong in order to help others. I found out soon enough that even as I and my fellow professionals tried to reach out to the community, we too, found ourselves feeling stricken and helpless. After finding myself struggling with bouts of anxiety, episodes of crying and inability to sleep I realized that I was courting a full blown post traumatic reaction. I learned that being a professional clinical worker specializing in trauma did not grant me or my colleagues any special immunity or protection.

Those of us who work within the confines of a traumatic event helping trauma victims must know how to self monitor for a stress reaction. It is imperative that critical debriefing begin within no more than a week of the event, (the sooner the better), in order to do the necessary damage control. This is best accomplished in a group setting in which the participants can share and reach out to each other for support. In my case, I had to go to my supervisor and insist that a group be formed. I am hoping that through increased awareness of the long term negative effects of an untreated trauma that that this will be offered as a matter of course in the future but, because we cannot count on this. We must be vigilant and guard our own mental health.
**Brief Course Description:**

This course will provide the mental health professional with a broad knowledge base of the emotional and neurophysiologic implications of Post Traumatic Stress Disorder (PTSD). An opening segment of this course discusses how we as practitioners are affected by treating trauma victims and what we must do to protect ourselves. Monitoring for safety issues that include assessing for self destructive behaviors and/or ideation, self-mutilation, suicidal/homicidal thinking and addictive behaviors are critical issues that are addressed. The varied symptoms of PTSD as dictated by the type and nature of the trauma the victim suffers will be described as well as diagnostic criteria. There are various treatment modalities available. This course will discuss the treatment modalities and how to tailor those modalities either alone or in combination with others to meet the client's needs. How to interact with a client who is in a state of crisis in order to provide a stabilizing influence is a key factor.

**Course Objectives:**

After completing this offering, the participant will be able to:

1. Recognize the risk factors through diagnosing covert and overt safety issues and intervening in a timely and effective manner.

2. Recognize the varied signs and symptoms of Post Traumatic Stress Disorder, (PTSD)

3. Gain an understanding of the neurophysiology of PTSD

4. Assess the client’s specific needs as dictated by the nature of the trauma.

5. Identify and integrate various theoretical approaches tailoring it to the client’s specific needs.

6. Understand and apply the concepts of critical debriefing

7. Understand the needs of the client and be able to join with the client in a meaningful way in order to defuse the presented crisis and create a therapeutic alliance.

8. Monitor for and prevent a post traumatic reaction as the treating therapist.
INTRODUCTION:

Post traumatic Stress Disorder is often misdiagnosed because it incorporates so many symptoms but PTSD is essentially a cluster of symptoms that involves multiple subsets of diagnoses such as depressive disorder, anxiety disorder, mood disorders and dissociative disorder. If PTSD is not correctly diagnosed the clients may find themselves trying multiple medications and wondering why they do not help or only provide partial relief. This is because treatment for PTSD requires interventions that are specific to that disorder. Not finding relief to the intense anxiety experienced only adds to the client’s feelings of helplessness and desperation essentially rendering the good intentions of the treating practitioner counterproductive and even destructive.

The importance of the practitioner recognizing and making a timely diagnosis of PTSD cannot be overstated. The therapist must be a stabilizing influence to a client who is crisis, firstly, monitoring for safety issues and then providing pertinent information about the symptoms of PTSD in order to provide the always needed reassurance that he/she is not going crazy.

Monitoring for safety:

Clients are frequently not open about their safety issues. In fact, there is a very real possibility that the client will not be completely open or willing to discuss their level their self-destructive behaviors or ideations.

- Clients may view suicide as their only out and want to keep that option open.
- Clients find relief through self mutilating because of the endorphins released into their blood stream reduce the emotional pain and wish to keep that option open.
- They are often veterans of a mental health system that has failed them and feel distrustful. They know how to manipulate the system, the right words to use, what information to
give and what information to withhold in order to achieve a desired end such as preventing hospitalization or acquiring a prescription for an addictive drug that they use.

- They have secrets that create feelings of shame and guilt often associated with sexual trauma and prefers not to advertise.
- They are protecting an abuser.
- They are afraid of being viewed as crazy.

**Monitoring for safety:**

There are specific questions that should always be asked in order to elicit the presence and severity of suicidal, homicidal or self destructive behaviors and/or ideation. They are as follows:

**Monitoring for suicidal risk:**

Do you have any current suicidal thoughts and, if so, you have a plan?

Have you ever attempted suicide and, if so, when and how?

Have you acted self-destructively in any way such as speeding excessively and not wearing a seat belt or placing yourself in other dangerous situations?

Have you now or in the past inflicted any self injury such as cutting, hair pulling or burning yourself?

What medications are you taking and have on hand?

Do you have a psychiatrist overseeing your case?

What is your psychiatric history, including hospitalizations and reasons for hospitalizations?

Were you ever involuntarily committed to a hospital?
Do you self starve, or purge?

Are you sexually active and if so how often in what manner?

Do you use protection when engaging in sexual intercourse?

Do you abuse drugs or alcohol?

Are you engaged in any other addictive activities such as gambling, relationship or sexual addiction?

Would you be willing to sign a non-destruct contract and, if so, do you believe you can maintain control?

**Monitoring for homicidal ideation and the potential for violence:**

Have you ever had thoughts of wanting to hurt or kill someone and, if so how?

Do you feel that you have wronged or treated unfairly by someone and want revenge?

Do you have a history of violence?

Have you ever been arrested?

Do you have a legal record, (Rap sheet)

Do you have a gun or a weapons collection of available to you?

**Monitoring for the impact of psychosocial issues on safety:**

How did your family of origin manage angry feelings?

If applicable, how do you and your partner manage angry feelings?

Do you live alone and if so, what kind of support system is available to you?

What is the attitude of your spouse or partner toward what you are experiencing?

Do you have any health problems?

Do you have any financial problems?
Do you have any children, and, if so, what are their ages.
Are there any parenting problems?

**Monitoring for safety: Diagnosing dissociative reaction:**

Dissociative reaction is often part of the PTSD syndrome. This is caused by repression of memory and the ability to numb one’s feelings allowing the client to separate experience from when the client is in a fugue (blackout) state. I have had to treat such clients in a hospital setting making it safe enough for me do the necessary uncovering work in order to prevent future occurrences.

- Involves feelings of depersonalization, e.g. feeling like you are the outside of your body watching yourself.
- Substance abuse is often found as it is a form of self numbing and helps block out memories.
- Involves self medicating in an effort to reduce anxiety and depression
- Alcohol worsens depression since it is a central nervous system depressant.

While still controversial in some circles, dissociative identity disorder also known as multiple personality disorder is now a recognized diagnostic entity. I personally have treated four such clients and was amazed by the distinctness of the different personalities right down to having different handwriting. In the case of a multiple with five different personalities, one personality had an acute allergy to mold and dust while the other personalities did not have any allergic symptoms. Suffice to say, that I believe this is a real diagnosis with very specific safety issues attached to it. Of primary importance is recognizing the presence of persecutory personality.
This personality is self-destructive making it imperative to contact and work with that personality as soon as possible in order to develop a safety contract. This safety contract should involve as many helpful personalities as possible in order to achieve a counterbalance. In screening for dissociative disorder here are suggested questions that should be asked. They are as follows:

Do you hear voices telling you to harm yourself?
Do the voices come from inside your head or outside your head? *
Do you find yourself losing time?
Do you find yourself in strange places and not know how you got there?
Do you have episodes of blackouts during which you inflict self-injury but have no memory of doing so?

Note* Internal voices that is the voices of the different personalities are indicative of a dissociative identity disorder. External voices or auditory hallucinations indicate the presence of psychosis.

http://www.webmd.com/mental-health/dissociative-identity

The non-destruct contract:
This contract should be simple, to the point and on your letterhead or your agency’s letterhead. Here is a sample:
In order to be treated in an outpatient setting by--------, I hereby agree to not harm myself or others in any way. Instead, I agree to call -------- (Provide phone numbers and names). I understand that if I am not able to control my impulses, for the sake of my safety and/ or the
safety of others, I will be hospitalized. I agree to keep all appointments and see my psychiatrist for medication overview.

Signature: ______________
Date: ________________
Witness: ________________

Note* The treating psychiatrist and, if possible, an available family member should be contacted and advised of the situation and recommendations. Better yet, have a family member present to witness the contract. In Multiple Personality Disorder the contract should be signed by as many personalities as possible in the early stages of treatment and as new personalities emerge they, too should sign the contract.

Know your Statutes:
If there are any doubts regarding danger to self or others, hospitalize. It is always better to lean toward the conservative. It is important that the practitioner know the laws governing involuntary commitment of their State or Country as they will vary. For example, in the State of Florida, The Baker Act allows the practitioner to commit a person if he/she feels the client is a danger to self or others and the client can be involuntarily committed for a 72 hour observational period.

Under the Tarasoff Law the practitioner has a duty to warn a potential victim and police should be contacted, as well. Be able to tell the police if there are any weapons available.

Tarasoff law  http://www.jaapl.org/cgi/reprint/30/3/417.pdf
Even though danger to self or others allows us to breach confidentiality, it is still a good idea to have releases of information signed. This allows the clinician to talk freely to the specified individuals without having to be concerned about what information to give and what to withhold.

**PTSD (DSM 309.81)**

Being able to make a diagnosis of Post Traumatic Stress Disorder in a timely manner is critical to maintaining the client’s safety and in injecting some stability into a crisis situation. Despite the reluctance or difficulty the client has in sharing information, it is still possible to make that diagnosis as there are certain easily recognizable components to this disorder.

The DSM IV describes the components to having acute stress reaction as follows:

1. **“The victim must be exposed to a traumatic event that threatens life or physical integrity.”**
   - The treating therapist may not always be able to ascertain the occurrence or details of such an event because of the presence of partial or complete amnesia.
   - Memories may be too fragmented to present a clear picture.
   - The event may have happened in infancy- a preverbal stage of development, early childhood when verbal skills and the ability to grasp and verbalize abstract concepts are not yet available.

2. **“The victim must have a reaction of fear, horror or helplessness.”**
   - Clients will describe feelings of dread and helplessness,
   - Clients will offer the suspicion that something happened even though the details are not available.
• Feelings of horror and helplessness can be caused by a triggering event that brings upon a full blown stress reaction. The client may or may not be able to make a conscious connection to the original traumatic event.

• Clients will describe feelings of acute distress due to flashbacking, recurrent nightmares

• Clients can have unexplained physical sensations ranging from the pleasurable to unpleasant or painful in nature.

• Clients can be in an intensely numbed state and be unable to tolerate closeness or intimacy often alienating people.

• Clients show a distinct intolerance for authority.

• Clients will complain about feelings of depersonalization, e.g. watching themselves form outside themselves like in a movie.

3 “The victim will have a recurrent re-experiencing of the event. ”

• Flashbacking, essentially the reliving a horrifying event(s) over and over again, is a hallmark of PTSD. Flashbacking is more than just the access of memory. It is the reliving of physical and emotional sensations that accompanied the trauma literally transporting a person back in time. Experiencing the array of distressful emotional and physical sensations is called an abreaction. Since, an abreaction blocks out the here and the now, it can be viewed as a hallucinatory experience; however, it is distinguished from a true psychosis because the victims always returns back to present day reality. It is important for the client to know that flashing, however distressing, is a fleeting experience.
• Flashbacking can occur in the waking state or the sleeping state, (night terrors). Night terrors are described as being vivid, undisguised and are easily recalled unlike normal dream state.

• Flashbacking can be splinters of memory disconnected from the actual event or fragments of the actual event or a reliving of the entire event.

• Flashbacking does not necessarily happen immediately after the traumatic event since the victim, by virtue of the necessity to gain distance from painful memories can successfully repress the memories from conscious mind until a triggering event occurs.

**Physical body memory:**

Physical body memory recalls the traumatic event through experiencing physical sensations with or without conscious memory attached to but nonetheless recalls what was happening to the victim’s body during the actual event. The mind body link cannot be broken apart. Because the mind and the body are inextricably linked, it is entirely conceivable that the initial injury to the body has carried itself over to become a physical illness. The physical etiology of an illness must, of course, first be addressed, but a true cure or alleviation of symptoms cannot occur unless a client is treated holistically. Examples of the physical sensations that have been described to me are:

- numbness or tingling of a body part
- a sense of heaviness or being pressed down
- pain in any body part
- a lump in the throat,
- a sensation of gagging or choking or a sore throat or difficulty in swallowing
This, of course is an incomplete list as the body can relive any number or types of traumas and any body system can be affected.

**Note** Physical causes of symptom complaints must be ruled out first by the patient’s physician.

4 *The victim will avoid evocative stimuli.*

If the symptoms of PTSD can be *temporarily* avoided through the mechanisms of dissociation, repression, suppression, and memory blocking then the symptoms of PTSD can be precipitated when these self protective mechanisms are overridden by a triggering event. A triggering event can be anything, a sight, a sound, a smell. In one case, a client’s symptoms were triggered by a billboard on a roadside. In another case, a client was triggered when her child celebrated her fifth birthday, the age when she was traumatized. It is very important for a client to understand this concept because, unless sources of trauma are addressed, the client will literally be held hostage to the often unpredictable triggering of a series of distressing symptoms that seem to come from nowhere and substantially impair the client’s ability to function.

5 *The victim will experience an increased reactivity or hyperarousal.*

Clients with untreated Post -Traumatic Stress Disorder, (PTSD) will be on a constant alert status even though it is no longer appropriate. Because of their heightened anxiety and expectation that something bad will happen they are in a perpetual fight or flight stance and easily subject to misreading or misperceiving events as well as abusing drugs and alcohol. Behaviors can be volatile and erratic. Depression, substance abuse, thoughts of suicide, extreme anxiety to the point of panic, and explosive out-bursts of anger are part of the emotional profile victims of PTSD may suffer.
Hyperarousal is over-reactivity to stimuli. Examples of this are:

- Rage reaction and general loss of control leading to violence.
- Increased startle reflex
- Panic attacks
- Mood swings
- Deep depressive episodes
- Onset or increase of addictive disorders

To understand the mechanism of hyperarousal it is important to understand the neurological and physiological changes that occur when one is traumatized. The brain is composed of a vast network of cells known as neurons. These neurons communicate by virtue of bio-electrical impulses being transmitted from neuron to neuron. Neurons fire electrical impulses to each other as the brain integrates, processes and responds to sensory input. The point of contact where one neuron contacts another neuron is known as a **synapse**. Chemicals present in the brain called **neurotransmitters** affect the manner in which the neurons communicate thus affecting the routing of messages, the speed in which messages are sent and received and the subsequent responses of its owner. Environmental influences, genetic pre-disposition, medication, drug and/or alcohol abuse and, of course, traumatic events will exert a substantial effect on how the brain synapses and routes messages.

In response to a trauma our brain reroutes its messages by bypassing the neocortex, the center of reasoning and intellect, instead routing messages through **amygdala**. The amygdala is an almond shaped structure, located at the base of our skull and is responsible for fight or flight reactions.
causing messages to be routed through our limbic system, the primitive part of our nervous system. Signals are then sent to the body via the sympathetic nervous system which activates the pituitary and adrenal gland. When the pituitary and adrenal glands are alerted by the brain they produce chemicals such as adrenaline and cortisol that pour into the bloodstream and affect the client emotionally and physiologically.

Some studies have shown that the neurological changes associated with hyperarousal responses occurring in infancy and early childhood are not considered reversible and will translate itself into a conduct or personality disorder due to failure to attach later in life; however, the author believes that while the early childhood programming cannot be deleted in can be overwritten, at the very least, allowing the client to modify his or her responses and therefore does not necessarily seal the client’s fate.

_Perry, Bruce. Childhood Trauma, the Neurobiology of Adaptation and Use-Dependent Development of the Brain. How States become Traits. Texas: Baylor College of Medicine, 1996._

6 “The victim will experience distress and impaired functioning.”

- While the client may have been able to successfully repress or block of traumatic events for long periods of time, PTSD once triggered greatly impairs a victim’s ability to function.
- Victims will be overwhelmed with intense feelings such as rage or panic. Some will be able to connect feelings with memory. Other victims will be blindsided and will not understand what is happening to them.
- Victims will be thrown into a state of crisis.
- Victims can relapse, start or accelerate substance abuse.
- Victims may consider suicide seeing it as the only way out.
• Victims often believe they are going crazy and try to hide their symptoms without success.


Types of Trauma and implications for treatment:

Trauma can be caused by a single event, multiple events or ongoing traumatic experiences.

Single events:
Examples of single are accidents and natural disasters. This type of trauma responds well to prompt debriefing. Medication may or may not be necessary or may be used only temporarily. Hypnotherapy in order to induce relaxed and block flashbacks has also proven to be very helpful.

Multiple events:
This kind of trauma is more deeply seated and can have an enduring effect on a client’s life unless treated. Because it is not possible to debrief immediately after the event treatment will take more time and it will require the client to be able to recall at least some of the events and the associated feelings.

Children who come from abusive backgrounds often experience a series of multiple events of trauma. A prime example of this is a child living with an alcoholic parent who has violent outbursts when drinking. While this child may experience periods of calm between explosions,
the child has been placed on a constant alert status literally waiting for next explosion. One adult
I worked with complained of a nagging back and neck ache. Once the body memory was
connected to the actual events and emotional responses, the client was able to see that he was
literally bracing himself for next onslaught, this even after years had passed since he left his
parent’s home.

Responses to multiple events are same as responses to ongoing trauma. Insight therapy, possibly
medication, and hypnotherapy to induce a relaxed state and help the client retrieve memories are
the treatments of choice. EMDR (Eye Movement Desensitization and Reprocessing) has also
proven to be helpful.

Ongoing traumatic event

The results of an ongoing traumatic event is often seen with soldiers who are exposed to ongoing
danger, the constant noise of shelling and artillery and sniper fire, watching their buddies die and
fearing for their own lives. For these men and women there is no relief to the constant state of
anxiety that is experienced. (This is also known as combat fatigue.)

While many veterans celebrate returning home, they soon find out that it can be a very difficult
transition and can in of itself constitute a trauma. There are often huge adjustment issues
returning veterans must face for while their home. Even if their home lives have remained stable
veterans must still deal with the dramatic personality changes they have undergone.

When the veterans returned from Viet Nam and faced a cold response for an unpopular war they
felt betrayed by their country and were further traumatized. Struggling with feelings, of
depersonalization, numbness or rage there was extensive substance abuse, a high suicide rate and
a high divorce rate. Many veterans found themselves unable to adjust, left the mainstream of society to become homeless.

http://veteransinfo.org/ptsd.html

Survivor’s guilt:

Survivor’s guilt encompasses feelings of extreme self-recrimination with the victim finding even inconsequential reasons for self-blame. And, even when the victim rationally knows there was nothing to be done to save a person from harm or loss of live, intense guilt is still engendered by the mere fact that he/she survived. A good example of this was the response of the survivors of the attack on the Twin Towers. One such a survivor, a client of mine, had to watch friends and co-workers die. The client expressed feelings of being torn up inside, feeling both glad he lived and guilty about feeling glad he lived. Victims of survivor’s guilt often adopt self-punishing attitudes that are typified by the belief that they do not deserve any joy or pleasure in life.

(Edward L. Zuckerman Ph.D. 2000)

The Stockholm Syndrome- Hostage Taking:

In a hostage taking situation the hostage begins to identify with the captor. A compelling if not surprising symptom of the Stockholm Syndrome is that the hostages may not be able to fully acknowledge the damage that is done to them instead sympathizing with the captor's cause. Conversely, captors may also develop an often unwanted connection with the hostage or prisoner. (Frank Parkinson 1994)

Bereavement:
Client’s struggling with a loss of a loved one has, in fact, been traumatized. Bereavement and recovery from a single traumatic event parallel each other in that the victim moves through the same stages of grief until resolution is reached. Clients are more accessible as is their memories. There are less trust issues involved than someone struggling with multiple or ongoing traumas. Here the client is actively seeking help and is open about his/her feelings as opposed to feeling forced to seek treatment out of feelings of desperation.

Stages of grief links:

http://changingminds.org/disciplines/change_management/kubler_ross/kubler_ross.htm

http://www.helpguide.org/mental/grief_loss.htm

Treatment Options:

Psychopharmacology:

Many trauma victims initially try to self medicate with drugs or alcohol only worsening their symptoms. In the initial visit and before medications are prescribed, clients should be made aware of the negative interaction between their medications and alcohol or drug taking because it interferes with effectiveness of their medication. Some medication can be addictive. It is important for the psychiatrist and the therapist to obtain a drug and alcohol history in order to avoid inadvertently supporting a drug habit.

Clients with PTSD need medication for anxiety and aggression, at least, until the traumas are worked through. In many cases, but because of the physiological and neurological impact of trauma, medication may be needed permanently. Working closely with a Psychiatrist is a necessity.
Celexa has been widely prescribed by the Veterans Administration for soldiers suffering from PTSD because of its anti-depressive and anti-anxiety properties. “Beta blockers (e.g. Propranolol) and alpha-adrenergic agonists (e.g.) Clonodine have been used with some success for controlling hyperarousal and aggressive behaviors.” Sometimes, antidepressants, mood stabilizers and anticonvulsants are prescribed alone or in conjunction with each other and they seem to help to some extent, “But, there is little reason to expect medications to be a definitive treatment for PTSD although they can helpful along with other treatment modalities.”

*(Steven Jay Lynn and Judith W. Rhue-Editors 1994)*

**Psychodynamic psychotherapy:**

If I were drowning, I would be forced to trust that person even though I was a basically distrustful person. This is state of mind that a client who has PTSD brings to the first session. The therapist needs to be cognizant of this and utilize the following interventions:

- Work toward establishing a therapeutic alliance through sharing of information, e.g. telling the client what to expect. The client should be made aware of his diagnosis, implications and symptoms.
- Reassure the client that is your job to help him regain control, not take it away.
- Reassure the client that he is not going crazy.
- Reassure the client that whatever traumas need to be explored will be addressed according his state of readiness.
- Reassure the client that PTSD is treatable.
- If need be establish the rules of safety and draw up a non-destruct contract.
• Let the client know when and how you will be reachable.

• Emphasize the importance of consistent attendance in order to achieve positive results

   Note* At least in the beginning stages of treatment two sessions a week may be indicated.

**Behavioral therapy:**

“Improvement produced by behavioral therapy has been more noticeable in symptoms related to depression, anxiety and intrusive symptoms but produces little or no improvement in the symptoms related to avoidance and emotional numbing.” (Steven Jay Lynn and Judith W. Rhue-Editors 1994)

• Often used to help the client improve activities of daily living

• Emphasizes the positive or negative consequences of a particular course of action

• Helps the client regain a sense of order and structure thus helping the client feel more in control of his environment

**Group therapy:**

• The mutual support that participants provide for each other counter feelings of alienation

• Allow for debriefing in a mutually supportive atmosphere

• Provides an opportunity for the therapist to educate participants through the use of lecture, handouts and sharing of experiences.

• Allows for the participants to begin to develop meaningful relationships thus countering the numbness, depersonalization and fear of intimacy.

**Hypnotherapy:**

Clients with PTSD are easily suggestible and thus easily hypnotizable with flashbacks already
a product of being in a trance state. Visualization techniques are often utilized and involve suggesting certain images that are designed to produce a specific result. An example of this is producing deep relaxation through having the client visualize a shady glen with a bubbling brook. Hypnotherapy is very helpful in the following areas:

- Allows the client to access repressed memories.
- Allows the client to stop night terrors through programming dreams.
- Teaches the client deep relaxation techniques that can self induced.
- Allows the patient to view their trauma from a third person perspective as in being in a movie theatre watching the traumatic events on a movies screen. In this visualization the client is also provided with a remote control that allows him to stop the movie. This precursor to learning how to control flashbacks.
- Allows the client to stop flashbacks with the client being taught to visualize sitting in the same audience of the same theatre but this time dropping a heavy, black, sound proof curtain down over the movie screen. (Sean F. Kelly, PhD and Reid J. Kelly ACSW 1985)

**Critical incident Stress Debriefing: (CISD)**

Initially developed for firefighters in 1989 by Dr. Jeffrey Mitchell, University of Maryland Critical incident debriefing allows the victim of a traumatic event to regain emotional equilibrium and closure. It does this through helping and encouraging the client to discuss the specific details of an event in a supportive group atmosphere. In the process of the doing this the victim can work through associated feelings such as survivors guilt, be able to process and integrate physical and emotional responses and restore emotional balance.

- Done in a supportive group setting helps alleviate the effects of a traumatic event.
Critical debriefing should be done as soon as possible while the memories are still fresh and easily available. Involves the discussion of the event and associated feelings.

Prevents misperception or distortion of events as occurs with survivor’s guilt or feeling helpless and inadequate.

Critical debriefing stops the process of reliving the event over and over again because the brain will do this trying to make sense of what happened until the events are clearly understood and placed in conscious long term memory.

Timely critical debriefing can prevent a full blown, long term PTSD reaction.

http://www.criticalincidentdebriefing.com

GROUNDING:

Clients who are flashbacking can be grounded, that is brought back to the here and the now through asking a few simple questions or making clear statement geared to help the client distinguish between objective reality and what the client is feeling. Examples of grounding questions are:

- Do you know where you are, what color is your shirt, what is today’s date.
- Since flashbacking is a trance like state, hypnotherapy can help bring a client back to the present.
- *Reassuring* statements deliver in a soft, calm voice such as this memory of the past, not present day reality.
- Emphasizing that the client has *control* with statements like you are no longer trapped, you are no longer a child or you are no longer powerless also have the effect of grounding a client.
While flashbacking can be distressing to the client it need only occur once in order to access memory and bring an event into consciousness in order to work it through. In this case, grounding should not be instituted until the event is fully remembered.

Through hypnotic suggestion the client can be told, “You will remember everything that has been said” or conversely, “You will not remember.” The decision to maintain amnesia will be based upon the intensity of the information and the client’s readiness to absorb the information all.


EMDR - Eye Movement Desensitization and Reprocessing

- “EMDR is a comprehensive, integrative psychotherapy approach allowing for processing of information in eight phase approach. It directs itself to uncovering past traumatic experiences.

- The process uses "dual stimulation" that is bilateral eye movements. During the reprocessing phases the client generally experiences insight into the underlying causes of their reactivity.

A Brief Description of EMDR - EMDR Institute, Inc. http://www.emdr.com/briefdes.htm

EMDR involves a technique called flooding. This is also known as an Exposure and Response Treatment. “Exposure treatment purposefully generates anxiety by exposing the patient repeatedly to the feared object or situation, either literally or using imagination and visualization. It uses the most fearful stimulus first. (This differs from the desensitization process because it
does not involve relaxation or a gradual approach to the source of anxiety.) Exposure treatments are can be done all at once, (flooding) or in degrees. (graduated exposure)

- EMDR Induces a trancelike state that causes an abreaction.

- Flooding exposes the person to the anxiety-producing stimulus for as long as 1-2 hours. *

- Graduated exposure gives the patient a greater degree of control over the length and frequency of exposures. In both cases, the patient experiences the anxiety over and over again until the stimulating event eventually loses its effect. Combining exposure with standard cognitive therapy may be particularly beneficial. This approach has helped certain patients in most anxiety disorder categories, including post-traumatic stress disorder.

Note* Since my clients have huge control issues I prefer to use a gradual approach; however, the client may already be flooded. In this case, I find hypnotherapy, relaxation techniques and desensitization along side of insight therapy to be very helpful.

Conclusion:
Post -Traumatic Stress Disorder is treated by the use of various modalities alone or in combination with each other and is directed toward bringing the repressed memories back into the conscious mind thus enabling the client to work through those memories so that they no longer intrude on present day functioning. Treatment modalities are varied and depend upon the type of trauma. The key to effective treatment is helping the client regain feelings of control and establishing a therapeutic alliance. This is done through providing education on the symptoms
and treatments available for PTSD is in a clear and forthright way. Recognition of the client’s ambivalent state, e.g., wanting to know and yet not wanting to know will be a key determinant in the client’s state of readiness and will dictate how and when information and memories are processed. The possibility of flooding whereby the client is overwhelmed with memories is real and therapist must be prepared to use the necessary treatment modalities such as medication, hypnotherapy and psychotherapy to help the client stabilize. Alternative coping skills must be taught in order to replace dysfunctional behaviors, misperceptions and counterproductive behaviors.

Clients often ask me if they are going crazy. They need to know that the coping mechanisms of memory repression, amnesia and dissociation were once needed to ensure emotional survival but now intrude on their ability to live a strong, emotionally rich life. Finally, clients need to know, often repeatedly, that treatment works.

The End
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