

“Particular attention needs to be paid” (van der Kolk, McFarlane, and Weisaeth, 1996p.p. 421-423) to the following issues.

- “Intrusive Re-experiencing” – Flashbacks, affective states, somatic sensations, nightmares, interpersonal reenactments (including transference repetitions), character styles, and pervasive life themes.”
- “Autonomic hyperarousal...the easy triggering of somatic stress reactions causes (people with PTSD) to be unable to trust their bodily sensations to warn them against impending threat and cease to alert them to take appropriate action.”
- “Numbing of responsiveness... after being traumatized, many people cease to derive pleasure from exploration and involvement in activities; they feel that they just “go through the motions” of everyday living.”
- “Learning Difficulties... Physiological hyperarousal interferes with the capacity of concentrate and to learn from experience. Aside from amnesias about aspects of the trauma, traumatized people often have trouble remembering ordinary events as well... They may display symptoms of attention-deficit/hyperactivity disorder.”
- “Memory Disturbances and Dissociation... In addition to hyperamnesia and intrusive memories, chronically traumatized people, particularly children, may develop amnesic syndromes related to the traumatic event... Clients who have learned to dissociate in response to trauma are likely to continue to utilize dissociative defenses when exposed to new stresses.”
- “Aggression against Self and Others...both adults and children who have been traumatized are likely to turn their aggression against other or themselves.”
- “Psychosomatic Reactions...Many traumatized clients suffer alexithymia – an inability to translate somatic sensations into basic feelings, such as anger, happiness, or fear. This failure to translate somatic states into words and symbols causes them to experience emotions simply as physical problems.”

“Comprehensive assessment of the chronology and details of the actual trauma(s) is vital.” This should include a thorough assessment of the affective, cognitive, and behavioral responses present at the time of the trauma. (Foy, 1992, p.9)

Obtaining a “history of prior trauma is critical” as...”previous traumatization may be a powerful determinant of PTSD reactivity through one or more of them.” (Foy, 1992, p.9)

Other potential mediating factors include a family history of psychological disorders and/or significant dysfunction in the family origin. (Foy, 1992)

“...levels of social support intercurrent life events should be assessed, so that current, modifiable sources of potential vulnerability and resilience can be evaluated.” (Foy, 1992, p.9)

Hyperarousal, intrusive memories and numbing or constriction are the three “cardinal symptom(s)” of PTSD. . (Herman, 1992, pp35-47) In particular, the negative constrictive symptoms described by Herman over time become the most prominent symptoms, but the danger is that these symptoms are difficult to recognize and”...may be mistaken for enduring characteristics of the victim’s personality.” (Herman, 1992, p.49)

Clinicians must be alert for the presence of co-morbid conditions such as substance abuse disorders, anxiety disorders and depression. In the case of PTSD, abuse of substances assists the client in achieving some control over “hyperarousal and intrusive symptoms” (Herman, 1992, p 45) “Recent history of addictive levels of alcohol or drug use is an example of comorbidity that requires immediate treatment before PTSD treatment can begin.” (Foy, 1992, p11).

Treatment Guidelines

“Effective treatment needs to proceed in phases, which should include the following (van der Hart, Brown, and van der Kolk, 1989; van der Hart, Stelle, Boon, & Brown, 1993; Herman 1992) (van der Kolk, McFarlane, and Weisaeth,1996, p.426)

1. Stabilization, including (a) education and (b) identification of feelings through verbalizing somatic states.
2. Deconditioning of traumatic memories and responses.
3. Restructuring of traumatic personal schemes.
4. Reestablishment of secure social connections and interpersonal efficacy.
5. Accumulation of restitutive emotional experiences.

- According to Foy (p. 10) “treatment should focus primarily on the nature of the trauma and the survivor’s reactions during and after the trauma.”

- “Traumatized people often are incapable of finding flexible and adaptive solutions; ... Treatment needs to address the twin issues of helping clients (1) regain a sense of safety in their bodies and (2) complete the unfinished past.” (van der Kolk, McFarlane, and Weisaeth, 1996, p17)

- “Clinicians need to be alert to the many ways in which past trauma determines current attitudes and perceptions.” (van der Kolk, McFarlane, and Weisaeth, 1996, p. 77)

- “Psychotherapy must address two fundamental aspects of PTSD: (1) deconditioning of anxiety, and (2) altering the way victims views [*sic*] themselves and their world by reestablishing a feeling of personal integrity and control.” (van der Kolk, McFarlane, and Weisaeth, 1996, p.420)

Examples of treatment techniques:

- Crisis Intervention
- Critical Incident Stress Debriefing (CISD)
- Multiple Stressor Debriefing
- Brief Interventions
- Cognitive-Behavioral Therapy; Bisson and Andrew concluded that trauma focused cognitive-behavioral therapies(TFCBT), individual/group, are effective in the treatment of PTSD (Bisson, J., Andrew M. [Psychological treatment of post-traumatic stress disorder-PTSD, 2005](#))
- Eye Movement Desensitization and Reprocessing (EMDR)
- Dialectic Behavior Therapy (DBT)
- Medications

Medication considerations – one approach:

“...acute trauma is best treated with any of the drugs that decrease autonomic arousal, such as benzodiazepines or clonidine.” (van der Kolk, McFarlane, and Weisaeth, 1996, p 521)

“ Once a person has developed PTSD, a clinician should initially select either an SSRI or a tricyclic antidepressant, with willingness to introduce a second drug (either an anticonvulsant, a mood stabilizer, or a benzodiazepine) after a few weeks if response is only partial. Choice of the second drug should be guided largely by the symptoms profile.” (van der Kolk, McFarlane, and Weisaeth, 1996, P.521)¹

“ In chronic PTSD, in which comorbid psychopathology may be prominent, clinicians can start relying on the studies that have shown different drugs to be effective for such problems a self destructive behavior, impulsivity, and depression. Unfortunately, at this point there is no evidence that any drug is particularly effective in the treatment of dissociative phenomena.” (van der Kolk, McFarlane, and Weisaeth, 1996, p. 521)

¹ (In selecting any medication, consider client’s vulnerability to substance abuse or dependence, including history of suicide attempts and frequency of dissociative episodes.)

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