Beyond reliving in PTSD treatment: Advanced skills for overcoming common obstacles in memory work

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Challenges in trauma-focused CBT

- Reluctance to engage in trauma memories
- Poor imagery ability
- Excessive shame, guilt, anger
- Numbing and dissociation
- Over-engagement with memories and images
- Slow rates of “extinction”
- Ineffective with multiple/sustained/early traumas
- Take too long
- Move patients too quickly

1(1) Over-engaged with memories

1(2) Under-engaged with memories

1(3) Dissociation

2. Multiple trauma memories

3. Head-heart lag
Cognitive processing during trauma

Characteristics of trauma/sequelae
Prior experiences/beliefs/coping

Nature of traumatic memory

Discriminate

Elaborate

Triggers

Sense of current threat
Intrusions
Arousal
Strong emotions

Dysfunctional behaviours/cognitive strategies

Appraisals of trauma and/or its sequelae

Identify and modify

Give up

S-Reps
Raw sensory data

C-Reps
Representations of sensory data

“Raw” sensations

Nimbus 2000

Contextual information

Higher order meanings

Understanding of events

Representation of sensations

Thoughts

Images

Emotions

Physical Sensations

Proprioception
CAUTION
NO DATA AHEAD
Necessity is the mother of invention

- Don’t reinvent the wheel – start with what works
- Apply basic principles to understanding individual presentations and obstacles
- Develop and test solutions with rigorous creativity

Problem 1: Over or under-engagement with the memory
Therapeutic window

http://www.estss.org
Optimising the volume level

Too quiet – can’t make out details

Too loud – overwhelming and can’t think straight

Optimal – all the details, can still think
S-reps lacking c-reps: uninhibited sensory fragments

Contextual information

Higher order meanings

Understanding of events

Representation of sensations

Thoughts

Images

Emotions

Physical Sensations

Proprioception
S-reps with partial c-reps, lack context and/or distorted meanings

Contextual information

Higher order meanings

Understanding of events

Representation of sensations

Thoughts

Images

Emotions

Physical Sensations

Proprioception

Nimbus 2000

John Williams
Problem 1: Over or under-engagement with the memory (cont.)

PART 1: UNDER-ENGAGED
Case 1: Jane
Distress/arousal too high to allow processing

Distress/arousal too low to allow processing

THERAPEUTIC WINDOW
THERAPEUTIC WINDOW

Distress/arousal
The trauma means I’m bad

I’ll be overwhelmed

I’ll be judged negatively

Intentional numbing
“Soldiers don’t cry”

Google Images – 10,200,000
Emotional schemata

Low imagery ability

Peri-traumatic numbness

Unintentional numbing
Turning up the volume

- Intensify reliving
- Focus on affect and sensations
- Introduce triggers
- Site visit/in vivo reliving
Problem 1: Over or under-engagement with the memory (cont.)

PART 2: OVER-ENGAGED
Case 2: Sarah
THERAPEUTIC WINDOW

Distress/arousal
Meaning of memory e.g. “I’m going mad”

Comorbid panic disorder

Meaning of trauma e.g. “I’m a killer”

Alexithymic

High imagery capability
Turning down the heat

- Reduce intensity of reliving
- Focus on cognitions
- Written narratives
- Imagery exercises for distancing
- Birds eye view/board game reliving
Problem 1: Over or under-engagement with the memory (cont.)
Case 3: Amy
THERAPEUTIC WINDOW
<table>
<thead>
<tr>
<th>DSM-5 Dissociative Disorders</th>
<th>ICD 10 Dissociative Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative amnesia</td>
<td>Dissociative amnesia</td>
</tr>
<tr>
<td>Depersonalisation/derealisation disorder</td>
<td>Dissociative convulsions</td>
</tr>
<tr>
<td>Dissociative identity disorder</td>
<td>Dissociative stupor</td>
</tr>
<tr>
<td>Dissociative disorder, other specified</td>
<td>Dissociative fugue</td>
</tr>
<tr>
<td>Dissociative disorder, unspecified</td>
<td>Dissociative loss of movement or sensations</td>
</tr>
<tr>
<td>Dissociative motor disorders</td>
<td>Dissociative anaesthesia</td>
</tr>
<tr>
<td>Dissociative trance and possession</td>
<td>Dissociative disorders</td>
</tr>
<tr>
<td>Mixed dissociative disorders</td>
<td>Other dissociative disorders</td>
</tr>
<tr>
<td>Dissociative disorders, unspecified</td>
<td>Dissociative disorders, unspecified</td>
</tr>
</tbody>
</table>
DISSOCIATION

Normal dissociation e.g. daydreaming

Compartmentalisation

Detachment ‘Tuning out’ – general

‘Tuning in’ e.g. flashbacks

‘Tuning out’ Dissociative amnesia Conversion disorders

Depersonalisation

Derealisation

Dissociative amnesia/fugue

PTSD

DDNOS

Dissociative identity disorder

Braun, 1988

Holmes et al. (2005). Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. Clinical psychology review, 25(1), 1-23
Dissociating ‘in’ – flashback?

Re-experiencing peri-traumatic dissociation?

General dissociation?

Learnt dissociation?

Turn down heat

Create visual code

See emotional numbing!

Turn up heat

Managing dissociation

- Psychoeducation
- Detective work
- Use all ‘turning down the heat’ options
- Plus practiced grounding
- And stimulus discrimination
I am safe
I am in... I can see...

Physical

Sensory

Attential

Verbal
<table>
<thead>
<tr>
<th>Trigger</th>
<th>Intrusion</th>
<th>Intensity (0-100)</th>
<th>Grounding method</th>
<th>Intensity (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Man who looks like ex</td>
<td>Him holding me down on floor</td>
<td>100</td>
<td>Looked around</td>
<td>90</td>
</tr>
<tr>
<td>Smell of aftershave</td>
<td>‘Christmas incident’</td>
<td>90</td>
<td>Smelling salts</td>
<td>50</td>
</tr>
<tr>
<td>Anthony giving me a hug</td>
<td>Being held down on bed</td>
<td>100</td>
<td>Looked at Anthony Moved around</td>
<td>40</td>
</tr>
<tr>
<td>Headache</td>
<td>Being punched in head</td>
<td>70</td>
<td>Smelling salts Stroked hair</td>
<td>30</td>
</tr>
</tbody>
</table>
Stimulus discrimination
<table>
<thead>
<tr>
<th>Then – Screams in prison</th>
<th>Now – someone shouting on street</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shouting</td>
<td>Shouting</td>
</tr>
<tr>
<td>Inside</td>
<td>Outside</td>
</tr>
<tr>
<td>In a cell</td>
<td>On street</td>
</tr>
<tr>
<td>Someone in fear/pain</td>
<td>Shouting to a friend</td>
</tr>
<tr>
<td>Couldn’t escape</td>
<td>Can walk away</td>
</tr>
<tr>
<td>Musty smell</td>
<td>Fresh smell</td>
</tr>
<tr>
<td>Screams in French</td>
<td>Shouts in English</td>
</tr>
<tr>
<td>Can’t see who is screaming</td>
<td>Can see who is shouting</td>
</tr>
<tr>
<td>Wearing rags</td>
<td>Wearing jeans, trainers, coat</td>
</tr>
<tr>
<td>Temperature is hot</td>
<td>Temperature is cool, raining</td>
</tr>
<tr>
<td>Am in danger</td>
<td>Not in danger</td>
</tr>
</tbody>
</table>
Kaur, M., Murphy, D., & Smith, K. V. (2016). An adapted imaginal exposure approach to traditional methods used within trauma-focused cognitive behavioural therapy, trialled with a veteran population. *The Cognitive Behaviour Therapist, 9*
Table 2. Similarities and differences in approach to traditional TF-CBT methods

<table>
<thead>
<tr>
<th>Stage of treatment</th>
<th>Similarities</th>
<th>Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking through the narrative</td>
<td>Stabilizing client using grounding to manage anxiety</td>
<td>Greater focus on multiple sensory grounding for highly dissociative clients, e.g. movement, air temperature, textures, noise</td>
</tr>
<tr>
<td></td>
<td>‘In vivo’ exposure to the trauma memory</td>
<td>Greater focus on developing a 3D spatial plan of the image that the client can walk around</td>
</tr>
<tr>
<td>Manipulating the perspectives</td>
<td>Challenging cognitions and developing alternative cognitions</td>
<td>Considers the trauma image from multiple viewpoints to readjust the spatial relationships between objects</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develops the contextual factors to create a dynamic memory rather than fragmented image</td>
</tr>
<tr>
<td>Restructuring the narrative</td>
<td>Cognitive restructuring and updating of the memory</td>
<td>None</td>
</tr>
</tbody>
</table>
3D Reliving - Methods and Benefits

- “Walking through the narrative”
- “Manipulating the perspectives”
- “Restructuring the narrative”
- Additional grounding elements and stimuli
- Freedom of movements to create a rich reconstruction
- Facilitate allocentric processing and contextualisation through changing perspectives
- Using the scene to facilitate updating and rescripting
Problem 2: Multiple traumas
Case 2: Moses
Case 3: John
“Montage” memories
Hard to place triggered reactivity
Strongly held beliefs
Long-held avoidant coping strategies
Multiple trauma – multiple memories

It’s not supposed to be easy.

#SASWhoDaresWins
The problem of multiple memories – Foxy

“When it comes to treatment you instantly know what’s not working for you.

I tried Cognitive Behavioural Therapy ... my therapist asked me to pinpoint the exact moment that triggered my PTSD.

When you’ve been in the situations I’ve been in, serving in some of the most intense, high-pressured missions there are, it’s impossible to focus on one exact moment.

In a life of split-second decisions based entirely on survival, how can you specify a single moment?

Instead of helping me to reprocess, it left me feeling constantly frustrated with the lack of progress I was making.”

http://www.theguardian.com/commentisfree/2015/dec/01/ptsd-special-forces-post-traumatic-stress-disorder
Some theory (1): Multiple traumas and memory

- Multiple, especially early, trauma leads to survival focus
- In the longer-term this leads to:
  - Emotional dysregulation
  - Poor information processing
  - Quicker and quicker movement towards perceptual rather than conceptual processing

Some theory (2):
Confirmation vs shattering of assumptions

PRE-EXISTING BELIEFS

I am good
The world is safe
People are decent

TRAUMA-RELATED BELIEFS

I am not good
The world is unsafe
People are bad

GOAL OF THERAPY

I am good enough
The world is usually safe
People are mostly good

I am not good
The world is unsafe
People hurt me

It happened again...
Because I am not good
The world is unsafe
People are bad

I am good enough
The world is usually safe
People are mostly good

Some theory (3): Coping with multiple traumas
Characteristics of trauma/sequelae
Prior experiences/beliefs/coping

Nature of traumatic memory
Multiple, merged, S-reps

Cognitive processing during trauma
Pre-existing vulnerability

Appraisals of trauma and/or its sequelae
Identify and modify

Sense of current threat
Intrusions
Arousal
Strong emotions

Triggers

Dysfunctional behaviours/cognitive strategies
Give up

Pre-existing vulnerability

Long-standing, ingrained

Confirm core beliefs

Elaborate

Discriminate

Highly perceptual

Prior experiences/beliefs/coping

Give up

Confirms core beliefs

Long-standing, ingrained

Pre-existing vulnerability

Checklist for cognitive strategies

Elaborate

Discriminate

Triggers

Cognitive processing during trauma

Appraisals of trauma and/or its sequelae

Sense of current threat
Intrusions
Arousal
Strong emotions

Identify and modify
Adapting treatment (1): Phased approach

- Stabilisation & symptom management
- Trauma-focused therapy
- Reintegration

Judith Herman: Complex PTSD

Stabilisation: Never work without a net

If you are removing the safety net of (unhelpful) coping, build up some healthy strategies first

Rule one: Never work without a net.
Rule two: Specify the type of net.
STABILISATION

Practical

Housing

Legal

Financial

Medical

Pain

Medication

Risk

To self

To others

From others

Drugs/alcohol

Distress tolerance

Symptom management

Sleep

Mood

Flashbacks/nightmares

Comorbidity

Depression

Psychosis

Personality disorder

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

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Drugs/alcohol

Symptom management

Distress tolerance

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Drugs/alcohol

Symptom management

Distress tolerance

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Drugs/alcohol

Symptom management

Distress tolerance

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Distress tolerance

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Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol

Symptom management

Distress tolerance

To self

To others

From others

Drugs/alcohol
TF-CBT: Phased approach

Stabilisation & symptom management  Trauma-focused therapy  Reintegration

Judith Herman: Complex PTSD
Memory work: Deciding where to start (1)

Overall timelining
Narrative Exposure Therapy

(Schauer, M., Neuner, F., & Elbert, T., 2005)
**Deciding where to start (2): Intrusion diaries**

Please use this diary to record intrusive memories of your traumatic event. By ‘intrusions’ we mean memories of the trauma that spontaneously pop into your mind not times when you deliberately think or mull over what happened. Please note down where you were when the intrusions occurred and any triggers. Record what the intrusions were of, and then rate the extent to which it felt as though the trauma were happening again now, and how distressing it was.

Day 1 __________  Date __________

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Situation/Trigger</th>
<th>What were the intrusions of</th>
<th>How much did it feel like it was happening again NOW (0-100)</th>
<th>Distress (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afternoon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please tick if you had a sudden memory or nightmare:

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation</td>
<td>✔✓</td>
<td>✔</td>
<td>✔</td>
<td>✔✓✓</td>
<td>✔✓</td>
<td>✔</td>
<td>✔✓✓</td>
</tr>
<tr>
<td>Helicopter attack</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burning village</td>
<td>✔✓</td>
<td>✔</td>
<td>✔</td>
<td>✔✓</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Prison</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Deciding where to start (3): Ranking and pros/cons

- Chronological
- Start with the worst
- Start with a less distressing memory and graduate to worst
- Choose an ‘easy win’ memory
- Choose a representational memory and hope for a domino effect
- A small number of clear memories – relive/update each
- A lot of unclear memories – choose a representational memory, narrative + hotspot work, consider rescripting
Encourage the domino effect

- Highlight cross-over meanings
- Encourage generalisation to other memories
- Teach skills to apply to other memories
Start simple...
Guided discovery, thought challenging, psychoeducation, thinking errors...

Not shifting yet?
Surveys, responsibility pies, behavioural experiments...

Head-heart lag?
See next section... imagery, different modalities...

Core belief?
Schema work, feeder memories, undisclosed memories...
TF-CBT: Phased approach

- Stabilisation & symptom management
- Trauma-focused therapy
- Reintegration

Judith Herman: Complex PTSD
(Re)claiming
• Social
• Occupational
• Relationships
• Interests
• Identity

Adaptations
• Disability
• Pain
• Life changes e.g. country, role
Perpetrators can be predators

PTSD can interfere with help-seeking

Engaging in riskier behaviours

Poorer at picking up cues

Poorer at setting boundaries
Problem 3: Head-heart lag
Case example - Terri

[Diagram with images and symbols]
When head and heart don’t agree (Stott 2007)

- “I know it but I don’t feel it”
- Holding two ideas at once that don’t agree

Updating in Reliving –
Stitching the past and present together

“Standard” verbal updating

Simple:
Hotspot: “I’m lying on the ground and they are stamping on me”
Key Emotion: Terror
Key Meaning: “I’m going to be killed”
Update: “I don’t die here, I’m injured but I survive to tell the tale. This is old stuff.”

Complex:
Hotspot: “I am lying on the ground unable to move and he is on top of me”
Key Emotion(s): Helplessness, disgust, shame,
Key Meaning(s): I’m not fighting back because I’m weak,
His sweaty body is all over me.
(People will think)I’m letting him do this to me and this means I’m disgusting.
Updates: “I’m frozen because my body has gone into freeze mode, this is normal when you can’t run or fight, I was frozen then but I’m not frozen now. There’s not an atom of him on me any more. I don’t want this at all, that’s why he’s had to force me. He is the disgusting one for what he’s doing, not me. Others agree when surveyed that he is the disgusting one.”
Understanding the lag between head-heart-gut

1. Unaware of / unable to articulate meanings and emotions
2. Struggle to connect old and new
3. Meanings and affect may be situation/mood/memory dependent
4. Meanings may reflect endurance of core beliefs or pre-existing schema
5. Uncontextualised memories and images driving distress-source monitoring failure
6. Lack of compassion – self-attack trumps rationality
Basic methods – acknowledge the split

- Avoid simple “belief” ratings
- Elicit, validate, contrast and reflect on the rational vs the emotional
- Use “joining-up” questions
- Consider 2D monitoring charts (Stott, 2007)
1. Unaware/unable to articulate meanings and emotions
S-reps with no c-reps – lacking many of the layers

Contextual information

Higher order meanings

Understanding of events

Representation of sensations

Thoughts

Images

Emotions

Physical Sensations

Proprioception
2. Struggle to connect the old with the new
Amp up your updates!

At that moment then...
What am I *thinking*?
What am I *feeling*?
What *images or memories* are in my mind?
What is *happening*?
What can I *see, hear, taste, smell*?
What *sensations* are in my body?
What is my *body position*?
What am I *doing*?
What do I *want to do*?
What do I *need*?

When I remember it now...
What do I *think* now about it?
What do I *know* about what really happened?
What do I *feel* now when I think of it?
What can I *hear, see, feel, taste* now?
What *sensations* are in my body now?
What *body positions/actions* can I do now?
How are my *needs* met now?
What *sense* have I made of it since
What does it say about *me as a person*?
Where does it fit into *my life story*?
And that now, how does that change what you
Seeing
Hearing
Knowing
Feeling
Doing
Imagining
Remembering
Touching

that now, how does that change what you
Feel
Think
Know
Understand
Think about yourself
Sense you make of it
A simple update not connecting

Hotspot: Lying behind the wall with gunfire all around

Key Emotion: Terror

Key Meaning: “I’m not getting out of this - I’m going to be killed”

Update: “I don’t die here, I survive this.”
Imagery rescripting to enhance updating

“What (else) do you need to happen in the image, to no longer feel that way?”

“Try to imagine that, tell me how it looks. How does it feel now?”

Fear

Meaning: I’m in danger, he’s going to really hurt me
Update: He’s in prison now, I’m safe, this is a feeling from the past
Rescript: Putting him in a comedy jail house
I am in England not in Iraq. I am safe, this is an old memory.
Helplessness

Meaning: I’m powerless and frozen, this means I’m weak

Update: I was 6 years old, I’m an adult now. I’m not helpless any more (to control this memory)

Rescript: I become Gogo Yubari from Kill Bill and take bloody revenge

I’m not helpless any more!
Disgust/contamination + shame

Meaning: He is all over me and, like him, I am disgusting for this happening

Update: Not an atom of him is left on me now. He is the disgusting one, not one atom of him is left on me

Rescript: Mr Shiny the lion comforts and rescues me, he takes me to wash in the magic waterfall and then reminds me who the disgusting one is
3. Meanings and affect are situation dependent
4. Meanings reflect endurance of core beliefs or pre-existing schema
5. Uncontextualised images driving distress
Lack of visual code – imagined horrors
Reconstructed c-reps, s-reps

Contextual information

Higher order meanings

Understanding of events

Representation of sensations

Thoughts

Images

Emotions

Physical Sensations

Proprioception

\[ \text{John Williams} \]

\[ \text{opus 2000} \]
Developing a new visual code

https://www.youtube.com/watch?v=K5kNwYqueUE
6. Self attack trumps rationality
Perfect nurturer and compassionate imagery

Cueing compassionate responses

I need to take care of the cat and tell her she is nice and good and that there is nothing wrong with her, what is wrong is how she was treated.

The cat is not in the cage anymore and I need to care for her so that she knows she is safe again.
Some final thoughts
PROBLEM

- Scores not decreasing
- Dissociation
- Unwillingness to disclose
- High affect
- Low affect
- Self-harm
- Drinking/drugs
- Poor attendance

PROCESS

- Therapeutic window
- Beliefs about trauma
- C-Reps/S-Reps
- Therapeutic relationship
- Therapist beliefs
- Beliefs about feelings
- Lack of coping strategies
- Imagery ability

STRATEGY

- Timelining
- Site visit
- Adapted reliving
- Behavioural experiments
- Amp your updates
- Stimulus discrimination
- Imagery rescripting
- Cognitive restructuring
- Elaborate the memory
- Grounding
In summary...
if the basics aren’t working, revisit your formulation, adapt as minimally as possible

and don’t give up...
"Your fear of being publicly exposed as a fraud is a stress-related disorder called 'Imposter Syndrome.' It's common among people in high-profile authority positions, and, of course, in actual phonies, like you."
Thank you for listening

and thanks to our colleagues and clients for teaching us everything we just said