online events

Resources

#TATuesdays

Contact After Contact: TA and the Treatment of Combat-Related PTSD

David Harford

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David has worked in private practice in Edinburgh since 2008; his clinical work evenly divided between the provision of TA counselling and psychotherapy to Scottish armed forces veterans experiencing combat-related PTSD and a similar service for “civilian” individuals and couples from premises located in Leith.

In conjunction with Mark Widdowson at the University of Salford, David has recently published extensive quantitative and qualitative research into the effectiveness of TA in the treatment of combat-related PTSD in the International Journal of TA Research (IJTAR), which is also available on his practice website. Current projects include assisting in building a service to provide therapy for veterans of the current conflict in Eastern Ukraine.

CONTACT AFTER CONTACT: AN INTEGRATED TA APPROACH TO DIAGNOSIS, TREATMENT AND RESEARCH WITH VETERANS OF COMBAT-RELATED PTSD

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Etiology and Diagnosis of PTSD

(DSM-IV, American Psychiatric Association, 2000)

A: Exposure to a traumatic event involving: (a) actual or threat of injury, death, or loss of physical integrity to self or others; (b) a response to the event involving intense fear, horror, or helplessness.

B: Persistent re-experiencing in the form of recurrent and intrusive: a) flashback memories, b) distressing dreams, c) subjective re-experiencing of the traumatic event(s), d) intense negative psychological responses or physiological reactivity to any objective or subjective reminder of the traumatic event(s).

C: Persistent avoidance of stimuli associated with the trauma and numbing of responses in the form of: a) avoiding thoughts or feelings, or talking about the trauma; b) avoidance of behaviours, places, or people that might lead to distressing memories; c) inability to recall major parts of the trauma(s); d) decreased involvement in significant life activities; e) detachment from others; f) restricted range of feelings; g) sense of a foreshortened future.

D: Persistent symptoms of increased arousal not present before the trauma in the form of: a) difficulty falling or staying asleep, b) irritability and anger; c) loss of concentration; d) hypervigilance; e) increased startle response.

E: Duration of symptoms for more than 1 month.

F: Clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Etiology and Diagnosis of PTSD

Pomeroy, 1998

Table 1
Ego State Thinking Characteristics

	Neocortex (Adult)	Limbic System (Child and Parent)
Functions: executive power for . . .	Coordination of all brain structures to categorize incoming information, weigh a range of options, anticipate consequences, make complex long-term and here-and-now decisions	Self-preservation Procreation Parental care Play
Thinking Characteristics	Thinks before acting, thinks about feelings, able to maintain emotional control Processes relevant information from past and present in the here and now Objective reality more important than perception Uses intuition in balance with logic Complex thinking • takes time to be accurate • able to make fine distinctions, discernment • able to see others' perspectives • uses logic, problem solving, reason, strategizing to make complex decisions and evaluations that may differ from previous beliefs (Goleman, 1995)	Acts and feels before thinking Reacts to the present as though it were the past Perception more important than objective reality Highly associative, symbolic, creative Simplified, streamlined thinking: • sacrifices accuracy for speed • categorical (good-bad, always, never) • personalized (it's about me) • self-confirming (selective memory confirms prejudices and beliefs) (Ekman, 1992, 1994; Goleman, 1995)
Transactional analysis ego state thinking descriptions	"The neopsyche is principally concerned with transforming stimuli into pieces of information, and processing and filing that information on the basis of previous experience" (Berne, 1961, p. 37).	"The archeopsyche tends to react more abruptly, on the basis of pre-logical thinking and poorly differentiated or distorted perceptions" (Berne, 1961, p. 37) "child-like, archaic" (Stewart & Joines, 1987, p. 11).

Etiology and Diagnosis of PTSD

Pomeroy, 1998

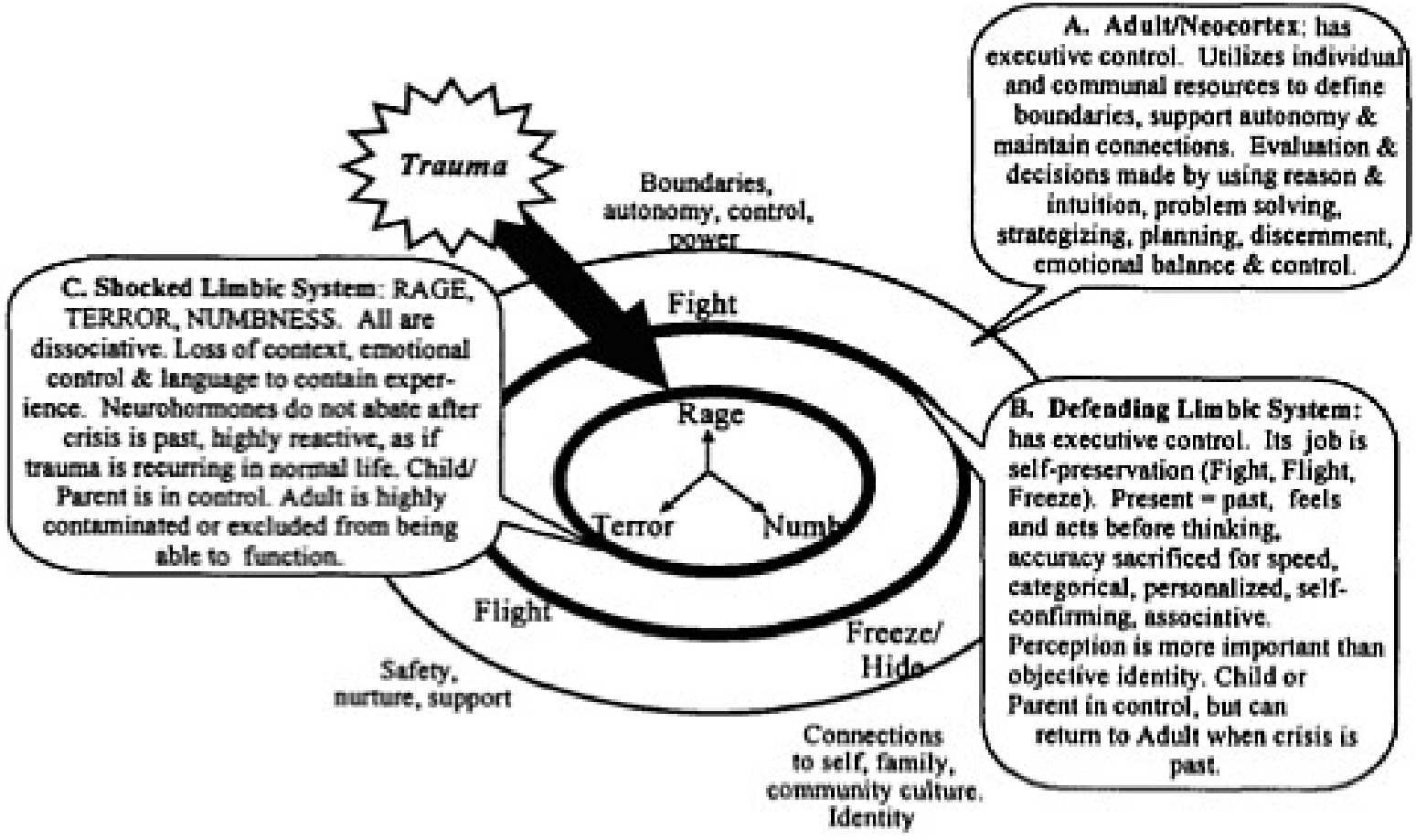


Figure 1
Human Systems of Defense, Resource, and Response to Threat

Etiology and Diagnosis of PTSD

Pomeroy, 1998

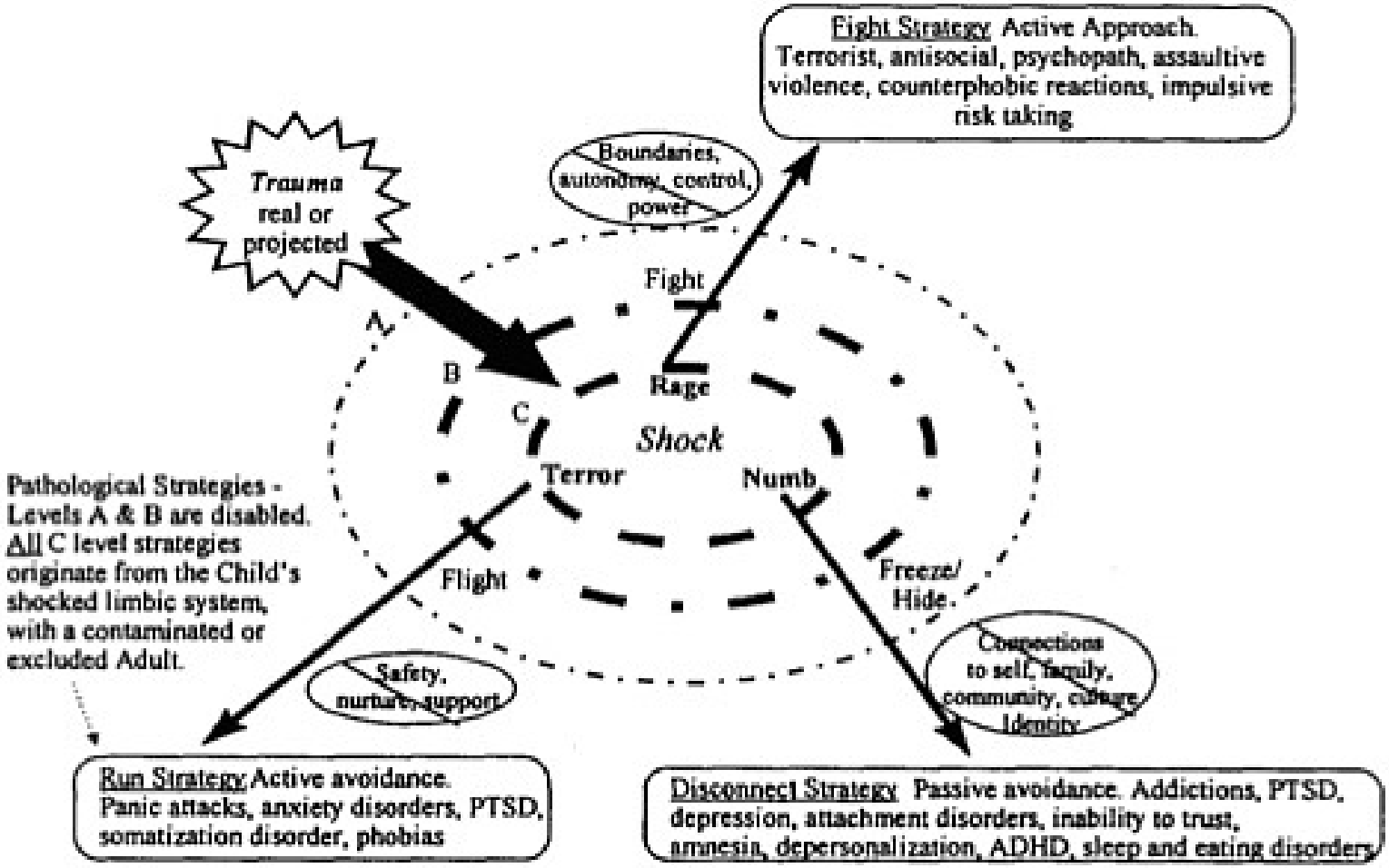
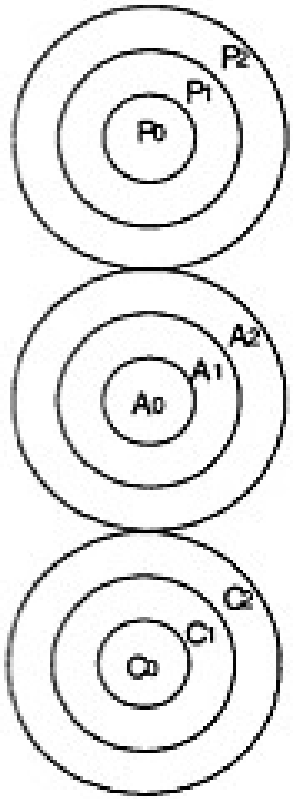


Figure 2
Regression in Response to Trauma: Fragmentation

Etiology and Diagnosis of PTSD

Stuthridge 2006

Table 1 The Narrative Self	
A_0	Subsymbolic, affective, sensorimotor stories of self. Present at birth (Cozolino, 2002, p. 178). Implicit memory systems.
A_1	Simple symbolic, verbal stories of self. Present from 18 months (Schore, 1994, p. 487). Explicit episodic memory.
A_2	Complex symbolic stories of self and reflective capacity. Present from 4-5 years (Fonagy, 2002, p. 245). Autobiographical memory.



P_0, P_1, P_2—Parent ego states encoded in implicit, explicit, and autobiographical memory

A_0, A_1, A_2—Adult ego states encoded in implicit, explicit, and autobiographical memory

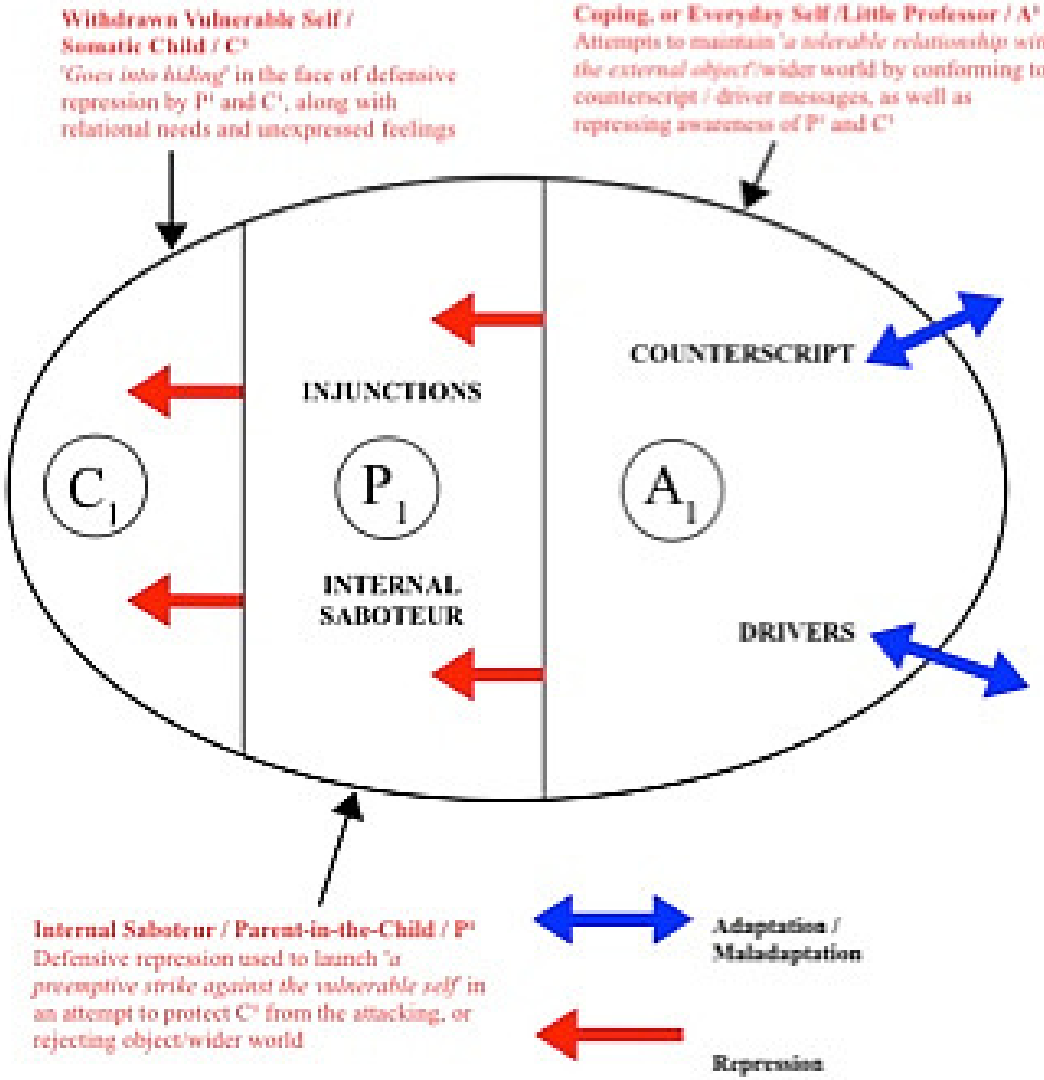
C_0, C_1, C_2 —Child ego states encoded in implicit, explicit, and autobiographical memory

Figure 1
Second-Order Structural Model: An Alternative Configuration of Ego States

Etiology and Diagnosis of PTSD

Schizoid Process

Harford, 2012 – after Little, 2001



Etiology and Diagnosis of PTSD

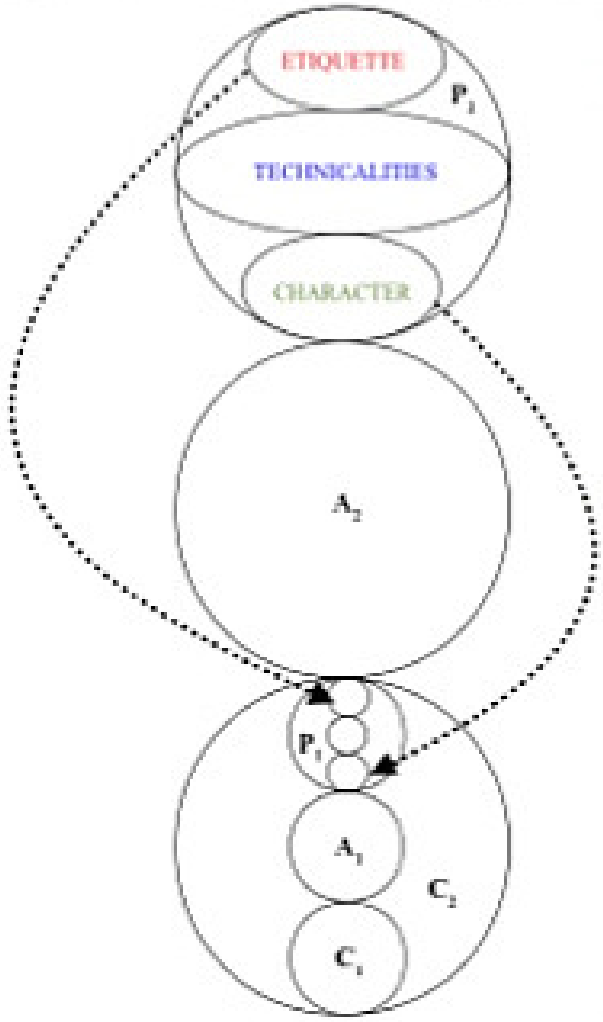
General Observations

1. Disruption of chronology and conflation of events in veterans' testimonies (Stuthridge, 2006)
2. Complex co-morbidity: mood disorders, personality adaptations
3. Influence of addictions and other lifestyle problems
4. Childhood trauma as predisposing factor in combat-related PTSD (Stuthridge, 2006, 2012)
5. Role of poor social support and lack of reparation (Schnurr & Friedman, 1997)
6. Ethnocultural bias in the diagnostic criteria and available research (Schnurr & Friedman, 1997)
7. Cultural Parent (Drego, 1963) influences from the military as an alternative parent figure
8. The veteran as the expert on their phenomenological experience

Etiology and Diagnosis of PTSD

Military Cultural Parent

Harford, 2014 – after Drego, 1983



ARMY ETIQUETTE

Never question orders, never challenge authority, soldiers are superior to "civvies", stiff upper lip, importance of loyalty, punctuality, orderliness, rigid structure and presentation, rituals of inspection, punishment and reward.

ARMY TECHNICALITIES

Hierarchy by rank, army structure (platoons, regiments), army housing, Official Secrets Act, army contract, security protocol, wages, specialist terminology and acronyms, weapons, uniforms and equipment.

ARMY CHARACTER

Never show feelings "inappropriate" to being a soldier, doubt and anger towards superiors is insubordination, crying is a sign of weakness, put the army's needs ahead of personal needs, black humour, drink alcohol to forget, death or glory.

CULTURAL SHADOW INFLUENCE

Breathing Exercise

Treatment Planning and Clinical Considerations

TA Treatment Plan

(Harford 2014, after Pomeroy, 1998)

1. STABILISATION – establishing safety; return executive control to the Adult ego state / neocortex; psychoeducation about the limbic response; identify and verbalise emotional states; grounding techniques; setting boundaries; problem-solving; re-engage with physical and social activities.
2. EMOTIONAL PROCESSING – repattern the traumatic experiences; deconfusion of the traumatised Child ego state; controlled exposure experiments; memory reactivation; working through transferential phenomena; addressing unmet relational needs; relational TA approach to the therapeutic relationship.
3. INTEGRATION – updated identity which integrates traumatic experiences; address biological hungers; restore meaning and purpose to life; reconnection with lost personal skills and resources; building relationships in the wider community; supporting access to training and work

Treatment Planning and Clinical Considerations

Psychoanalytic Treatment Plan

(Harford 2014, after Davies & Frawley, 1994)

1. **CONTAINMENT** – techniques taught to enhance client control, mastery and competence; deep relaxation exercises; strengthening Adult / neocortex.
2. **RECOVERY AND DISCLOSURE OF TRAUMATIC MEMORIES AND FANTASISED ELABORATIONS** – working with transference between therapist and client; bearing witness to the client's story and memories of traumatic experiences.
3. **SYMBOLISATION AND ENCODING OF MEMORY AND EXPERIENCE** – making sense of the traumatic experiences; finding new words and coherent meaning; increasing client's self-reflective capacity (neocortex / Adult); bringing together dissociated fragements of experience.
4. **INTEGRATION OF DISPARATE SELF AND OBJECT SYSTEMS AND OTHER REALITY-DISTORTING DEFENCES** – bringing together split-off and dissociated aspects of self, the other and sensory experiences; increase awareness of defence mechanisms.
5. **INTERNALISATION OF A NEW OBJECT RELATIONSHIP** – updating client's template of relational expectations; increase client capacity to form safe and trusting relationships.

Treatment Planning and Clinical Considerations

Other Treatment Plans

(Korol, 1998)

1. To become aware of and accept disowned parts - i.e. ego states
2. To become able to contact other people while maintaining a sense of self

(adapted from Rothschild, 2003)

a) Establish safety
b) Establish a good relationship
c) Learn to apply the brakes
d) Identify and build on a person's internal and external resources
e) Defence mechanisms are [self-protective] resources
f) Always work to reduce pressure, never to increase it
g) Provocation is never a useful strategy for traumatised individuals
h) Each client is unique and will respond differently to you and the therapy

- Take things slowly, explain all interventions clearly

Treatment Planning and Clinical Considerations

The Transferential Field

(Summers & Tudor 2000)

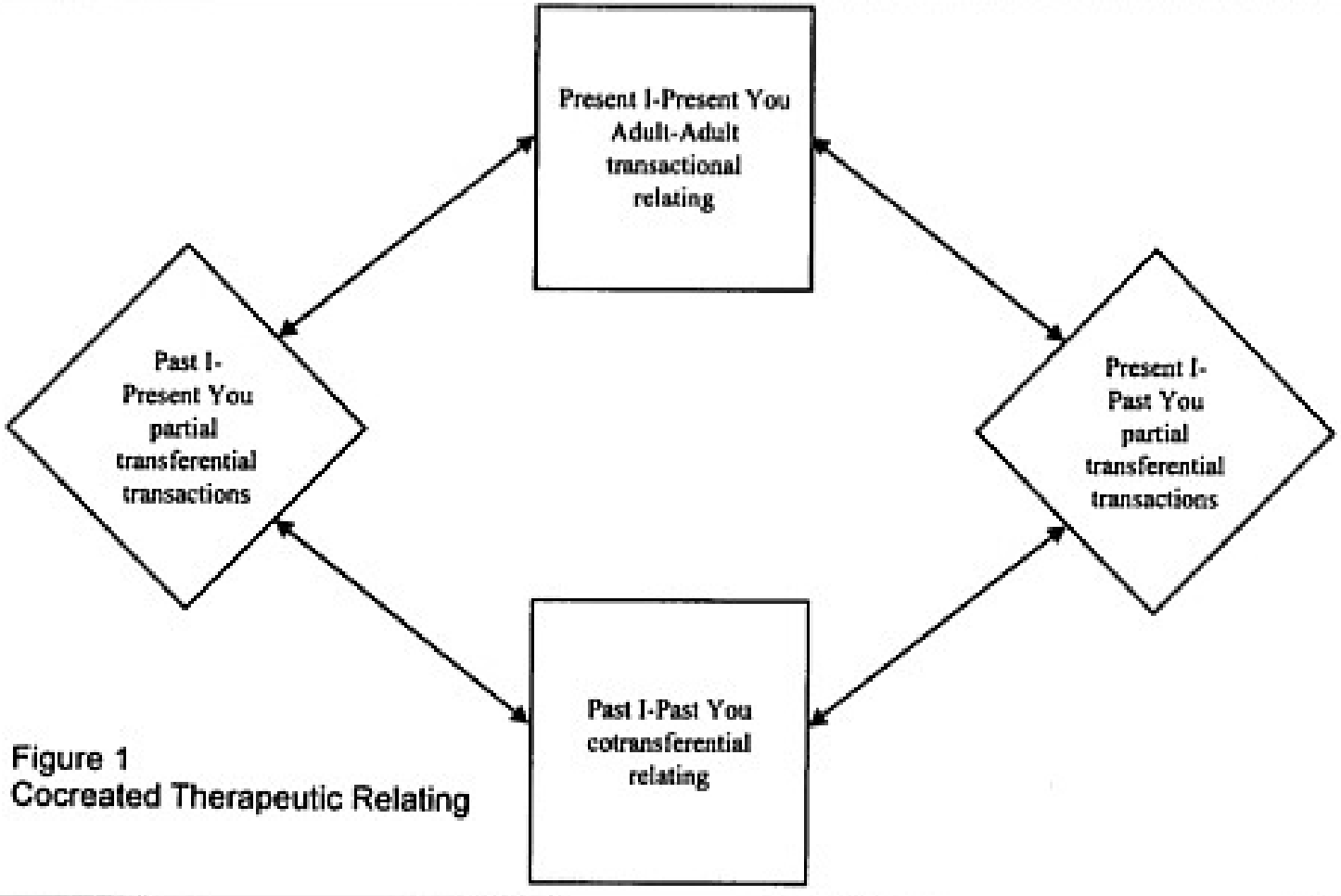
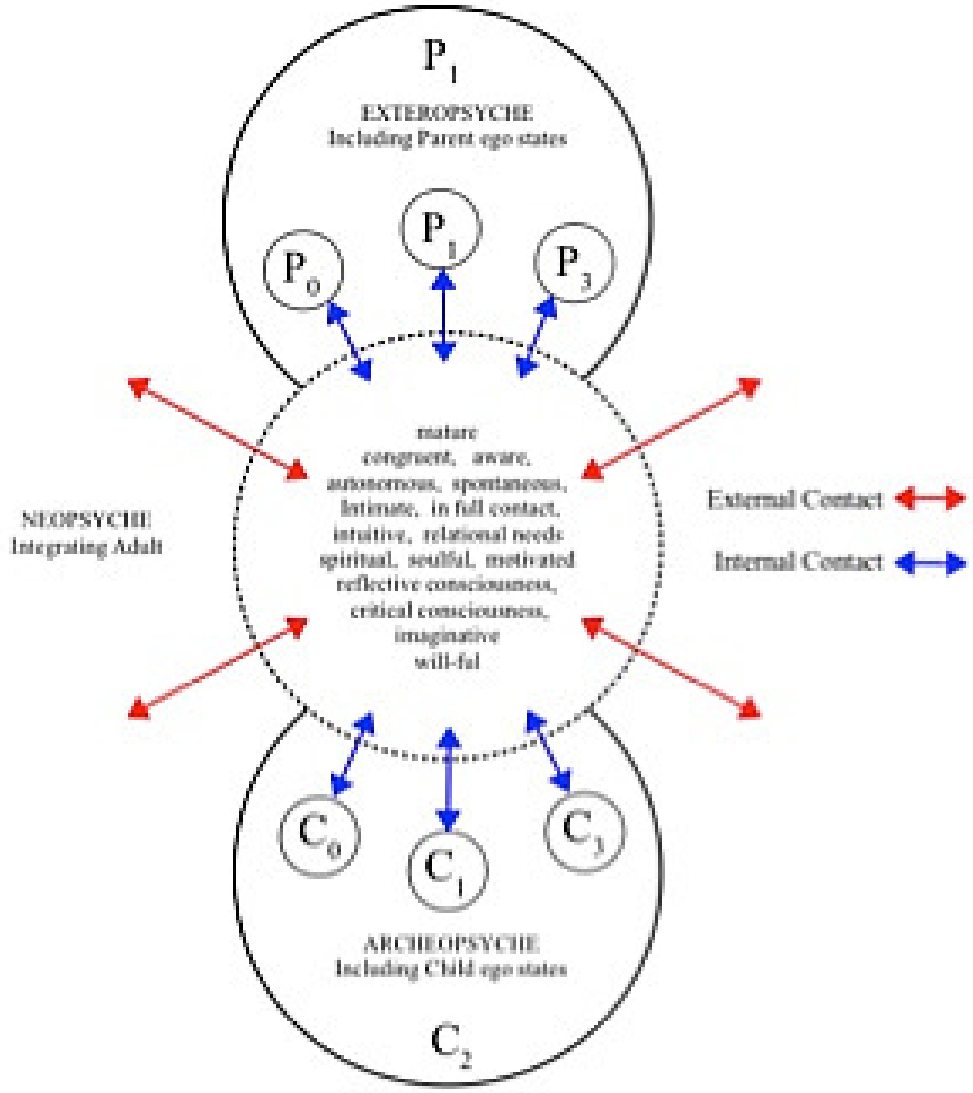


Figure 1
Cocreated Therapeutic Relating

Treatment Planning and Clinical Considerations

The Integrating Adult

(Harford 2012, after Tudor 2003)



Treatment Planning and Clinical Considerations

Possible Factors Important to Successful Treatments of PTSD

(Wampold et al, 2010, p.931, reproduced with permission)

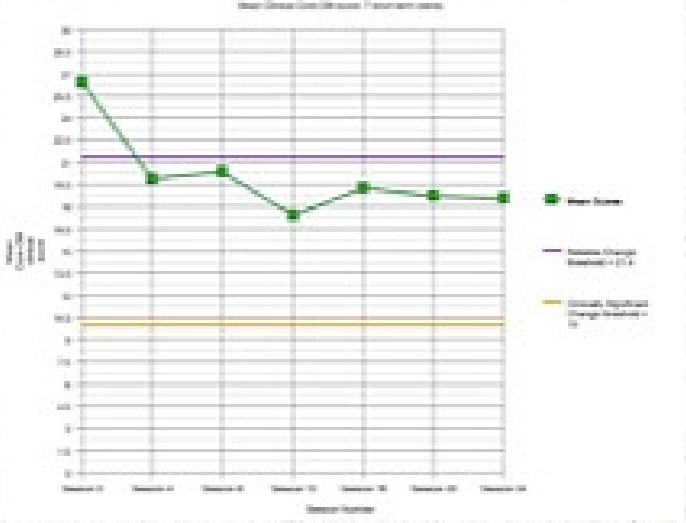
- Cogent psychological rationale that is acceptable to patient
- Systematic set of treatment actions consistent with the rationale
- Development and monitoring of a safe, respectful, and trusting therapeutic relationship
- Collaborative agreement about tasks and goals in therapy
- Nurturing hope and creating a sense of self efficacy
- Psychoeducation about PTSD
- Opportunity to talk about trauma (i.e., tell stories)
- Ensuring the patient's safety, especially if the patient has been victimized as in the case of domestic violence, neighbourhood violence, or abuse
- Helping patients learn how to avoid revictimization
- Identifying patient resources, strengths, survival skills and intra and interpersonal resources and building resilience
- Teaching coping skills
- Examination of behavioural chain of events
- Exposure (covert in session and in vivo outside of session)
- Making sense of traumatic event and patient's reaction to event
- Patient attribution of change to his or her own efforts
- Encouragement to generate and use social supports
- Relapse prevention

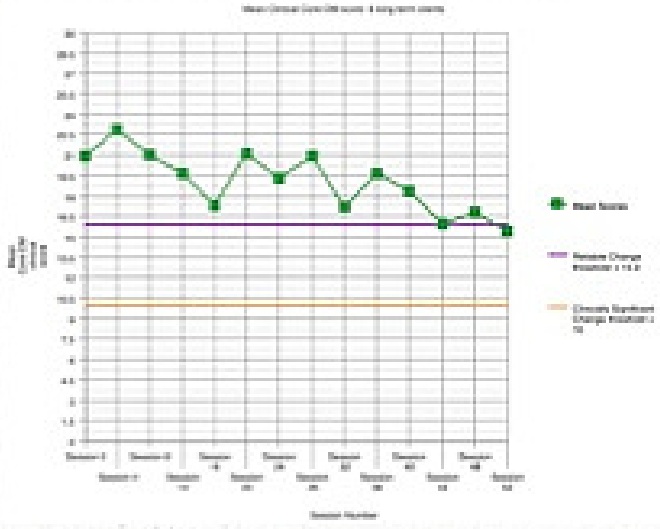
Grounding Exercise

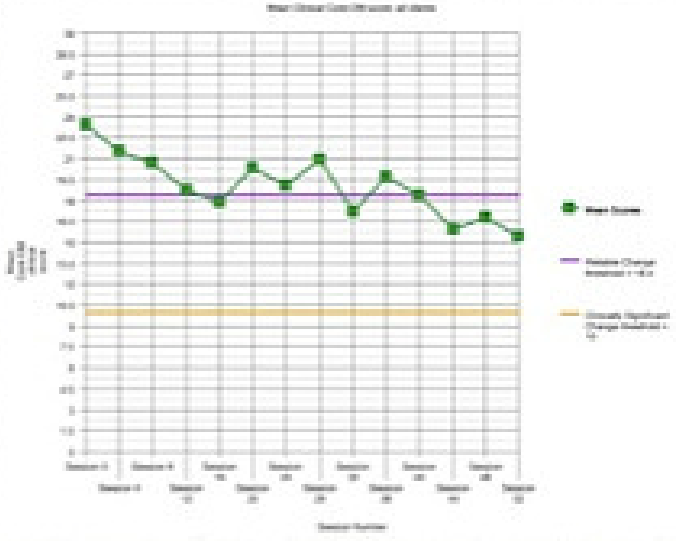
Research

CORE-OM

(Harford & Widdowson, 2014)



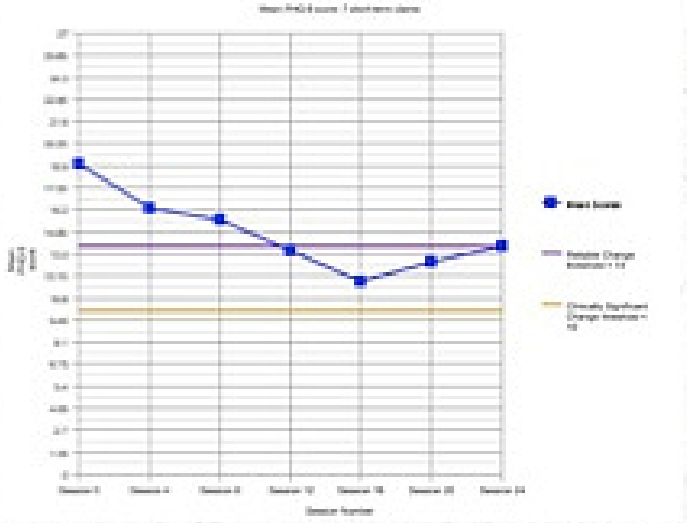


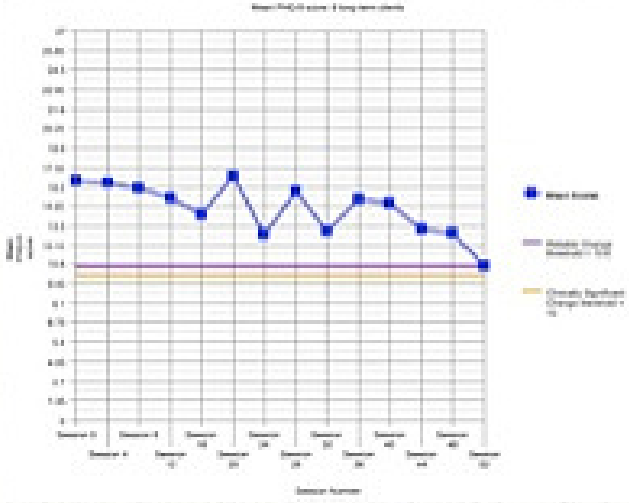


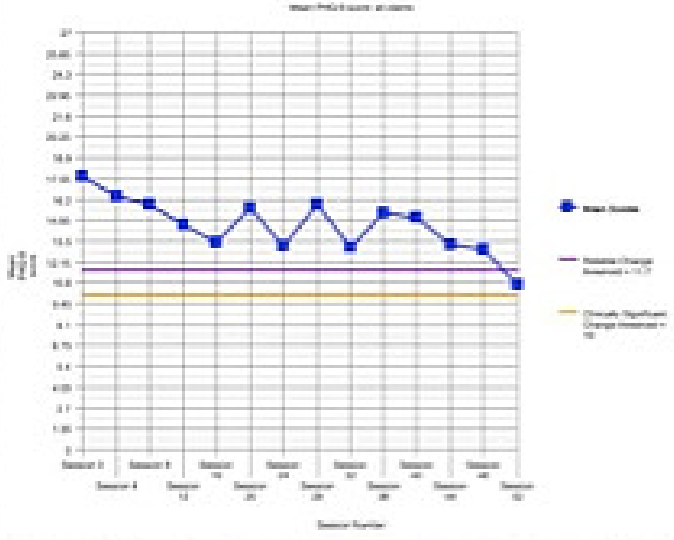
Research

PHQ-9

(Harford & Widdowson, 2014)



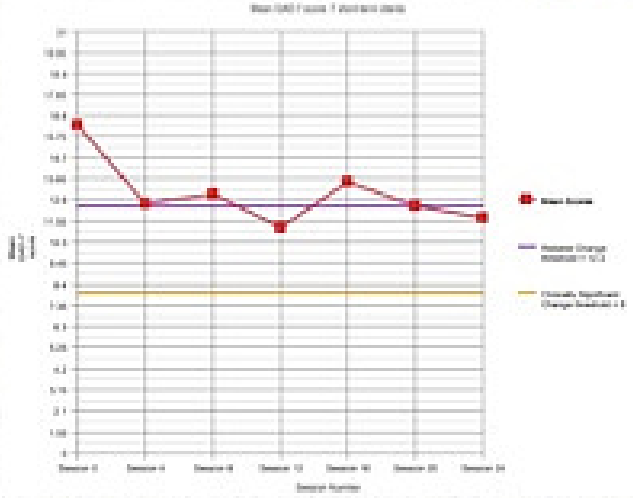


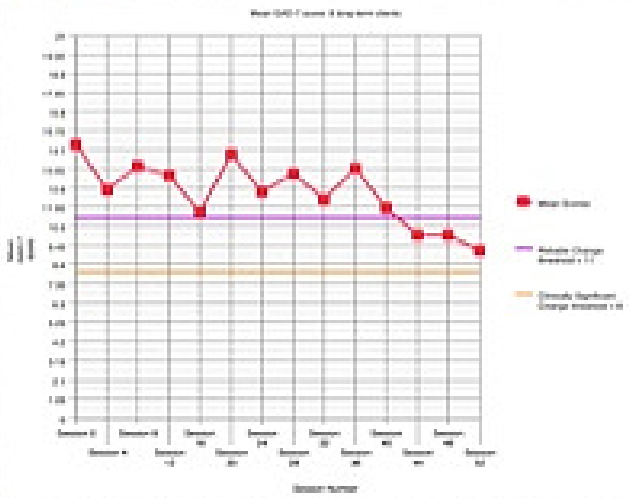


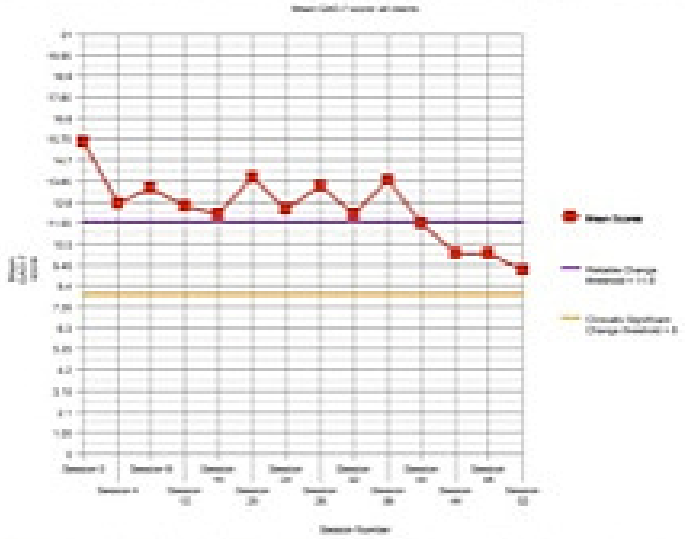
Research

GAD-7

(Harford & Widdowson, 2014)







Research

Conceptual Categories of Change for Eight Veterans' Change Interview Responses

(after Braun & Clarke, 2006)

Note: numbers after the items relate to the number of veterans who specified that particular change

Interpersonal Changes: Increased Assertiveness	**Interpersonal Changes: Improved Communication**	**Interpersonal Changes: Improved Relationships**
Assertiveness and willingness to challenge others appropriately (4)	Improved communication (4)	Improved (sexual) relationships (2)
Asking for what I want and asking for help (2)	Interpersonal learning	Have developed friendships (4)
	Better listening skills	Positive feedback from family about how I'm doing
	Increased openness, empathy and connection with others (2)	Developed trust in therapist
Symptom Reduction	**Improved Coping**	**Increased Well-Being**
Improvement in PTSD symptoms (2)	Improved coping strategies (3)	Increased optimism (4)
Greater understanding of origins of PTSD symptoms	Increased flexibility in responding to life situations	Decreased pessimism
Reduced hypervigilance		Increased confidence (2)
Reduced sense of threat from others		Greater activity and engagement in the world (2)
Made peace with the past (2)		Increased motivation to pursue activities (2)
Reduced depression symptoms		Improved self-care
Fewer disturbing dreams		Ready to move to independent living
Reduced alcohol consumption (2)		
Reduced suicidality		
Reduced hyperactivity		
Increased Affect Regulation	**Improved Cognitive Functioning**	**Self-awareness**
More able to manage anxiety (5)	Thinking more clearly and reduced confusion	Increased self-awareness (5)
Increased ability to manage my feelings	Improved reasoning and making sense of things (2)	Increased self-reflection (2)
Better anger management (3)	Reduced paranoid ideation	Normalisation of symptoms. PTSD symptoms are understandable
More willing to show my feelings	Less jumping to conclusions and black-and-white thinking	
Feeling stronger and more stable (2)	Reduced rumination and dwelling on things	
Increased awareness of emotions (2)		

Research

General Observations

1. Veteran benefits of engaging with research and use of quantitative measures of mental health:

- Providing an approximate measure of treatment progress and hope of further change
- Satisfies structure hunger (Berne, 1961) and offers containment of the fragmented self
- furnishes a means of symbolising / conceptualising fluid phenomenological experience

2. Therapist benefits of engaging with research and use of quantitative measures of mental health:

- Builds professional status and reputation, generating more work opportunities
- Facilitates access to potential funding sources
- Increases competence and stimulates continuous professional development

3. The need for more research into the effectiveness of TA counselling and psychotherapy

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