VETERANS HAVE FEELINGS TOO: THE OVERLOOKED EMOTIONAL WORLD OF COMBAT PTSD

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DISCLOSURES

- No financial disclosures
- The views and opinions in this presentation are those of the presenter and do not necessarily reflect, and should not be taken as, official policy of the US Department of Veterans Affairs

LET'S GET TO KNOW EACH OTHER (POLL #1)

"JOHN" – COMBAT VETERAN, PRE-THERAPY

- "I just wish I didn't feel this way"
- "I want to be better for my wife and my sons" (not for himself)
- "I don't want to talk about what I did for the Army"
- "I just want to be normal"
- Anger causes anxiety and in combination is frightening

High hyperarousal, fear of anger, avoidance, frequent re-experiencing

CPT AND PE CAN BE HELPFUL, BUT AREN'T ALWAYS ENOUGH

JAMA Psychiatry editorial, Hoge et al, 2016:

More importantly, this study highlights the limitations of current evidence-based trauma-focused PTSD treatments. In this trial, approximately 50% to 60% of participants retained the PTSD diagnosis 2 weeks and 6 months after treatment, even among those who completed the full course of individual CPT.[2] The mean decrease in PCL scores (range, 17-85) at 2 weeks and 6 months was only 6.3 and 6.5 for group CPT, respectively, and 12.6 and 10.7, respectively, for individual CPT. These are clinically small changes, confirming concerns raised in recent reviews and editorials that health care policies emphasizing time-limited trauma-focused treatments are insufficient to meet the needs of veterans with chronic PTSD and comorbid trauma-related conditions.[3,5,6] Compounding this issue is high study attrition, which highlights the ongoing struggle to retain servicemembers and veterans in trauma-focused treatment.

JAMA review by Steenkamp et al, 2015

sistent and remains an empirical question. Potential reasons why treatment outcomes may be worse among military and veteran populations include the extended, repeated, and intense nature of deployment trauma[65] and the fact that service members are exposed not only to life threats but to traumatic losses and morally compromising experiences that may require different treatment approaches.[66-68] A recent meta-analysis comparing trauma-

"Other strategies are urgently needed to effectively address remaining research and clinical gaps concerning the health care needs of combat veterans." – Hoge et al, 2016

SO WHAT ELSE CAN WE DO?

- EMDR holds promise but does not have many RCTs to support its use
- Complementary and Alternative therapies like Yoga, Mindfulness-based Stress Reduction, Tai Chi, Meditation, etc
- CBT, cognitive therapies, have dominated the psychotherapy evidence world for many years, which is both positive and negative (Leichsenring and Steinert, 2017)
- The nature of the trauma probably matters (Gerger et al, 2014) and needs to be taken into consideration when thinking about therapies

WHAT ABOUT THERAPY TARGETING FEELINGS?

- DSM-5 PTSD has negative thoughts and feeling cluster
- Numbing and negative emotion are cleared linked to many adverse outcomes (Hassija et al, 2012)
- Is fear of emotions playing a role? (see Simpson et al, 2006, Tull et al, 2007)
- MDD is highly comorbid with PTSD
- Emotion regulation difficulties can predict PTSD symptom severity (Sippel et al, 2015)

EMOTIONAL DEFICITS

- Numbing is closely tied to sexual dysfunction in Veterans with PTSD (Nunnink et al, 2010)
- Have consequences for intimacy with YOU and with loved ones
- Numbing cluster predicted presence of comorbid depression (Kashdan et al, 2006), and PTSD presence after 2 years (Malta et al, 2009)
- Anhedonia and alexithymia are problematic (Frewen et al, 2008)

ANGER

- The pattern of readily accessible anger feelings in post-trauma populations is more likely to be present if a traumatic event was caused by humans as opposed to natural disasters such as an earthquake or flood (McHugh et al, 2012).
- Anger can be explosive in PTSD patients, escalates quickly, can be dissociative in nature, and violent (Novaco, 2015)
- Anger tends to be a cover/placeholder for other feelings
- PTSD + MDD -> higher anger levels than PTSD alone (Gonzalez et al, 2016)

ARE WE AS CLINICIANS EQUIPPED TO WELCOME THE DISCLOSURE OF PAINFUL/SHAMEFUL FEELINGS?

- Shame is grossly under-addressed in most therapies and in therapist training
- Clinicians aren't necessarily aware of their own shame
- Shameful topics tend to be those most actively avoided by patients
- Perceived perpetrations of moral transgression are clearly linked to shame and guilt, emotions which may mediate the onset of PTSD and MDD (Nazarov et al, 2015)

From Taylor, 2015

Fig. 1. Compass of shame-avoidant behaviours and masking emotions (Webb, 2010, developed from Nathanson, 1992).

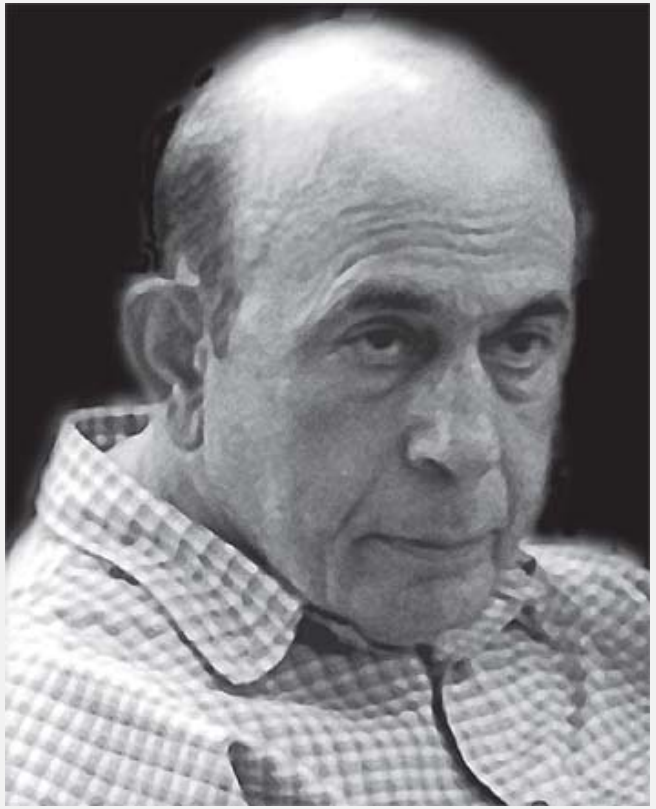
THERAPIES THAT TRY TO TARGET THESE ISSUES

- Acceptance and Commitment Therapy, DBT
- Anger Management, Relaxation, Stress Inoculation Training
- Therapy targeting Moral Injury
- Behavioral Activation (may increase positive emotionality; Jakupcak et al 2010)
- Somatic Experiencing Therapy (Brom et al, 2017)
- Brief Eclectic Therapy, Interpersonal Therapy

POLL #2

INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY (ISTDP)

- Developed by Habib Davanloo, MD as a means for achieving multi-dimensional structural change in patients (1970's)
- Highly active, emotion – and transference – focused psychodynamic therapy
- Videotaped sessions allow for detailed examination of your work with the patient



http://www.psicoterapiaintegrativa.com/therapists/htms/Habib_Davanloo.htm

PUBLISHED STUDIES OF ISTDP

- ISTDP has been found to be effective in the treatment of depression (d=1.51), personality disorders, medically unexplained symptoms, anxiety (d=0.98), panic, and pain (Abbass et al, 2012). Also effective in reducing healthcare costs (Abbass et al, 2015).
- It has not been formally studied in PTSD
- In prep: Healthcare cost reductions and psychiatric symptom improvement in PTSD patients treated with ISTDP, *Roggenkamp et al, 2018*

TRIANGLE OF CONFLICT

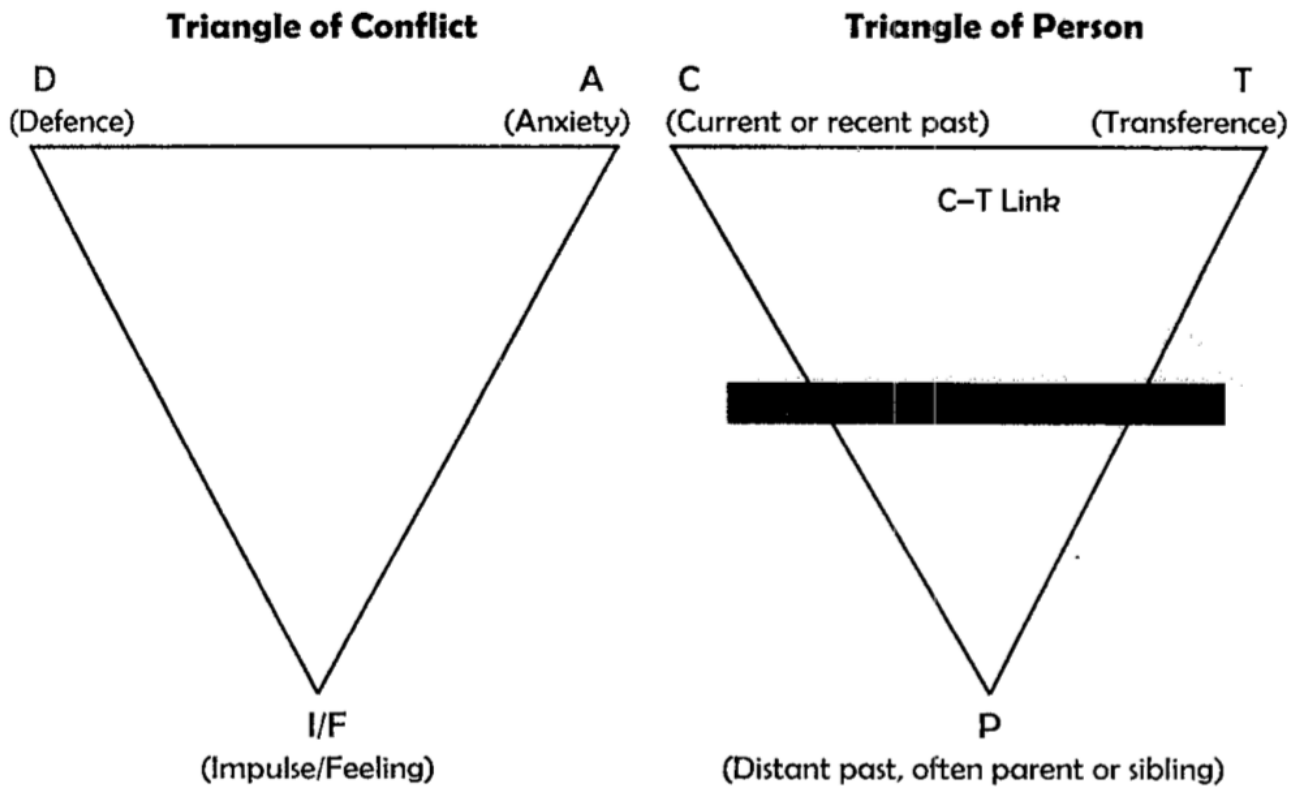


FIGURE 2.1. The two triangles

From Malan & Coughlin, Lives Transformed: A Revolutionary Method of Dynamic Psychotherapy

CLARIFY PHYSIOLOGICAL EXPERIENCE OF FEELINGS

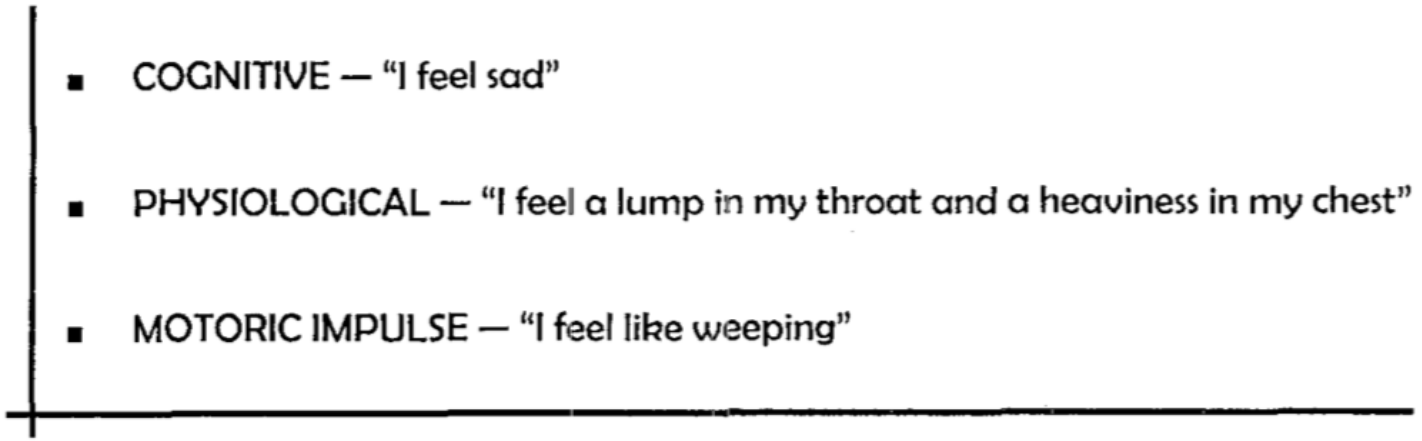


FIGURE 2.3. Components of affect

From Malan & Coughlin, Lives Transformed: A Revolutionary Method of Dynamic Psychotherapy

HOW DO WE EXPERIENCE EMOTION IN OUR BODIES?

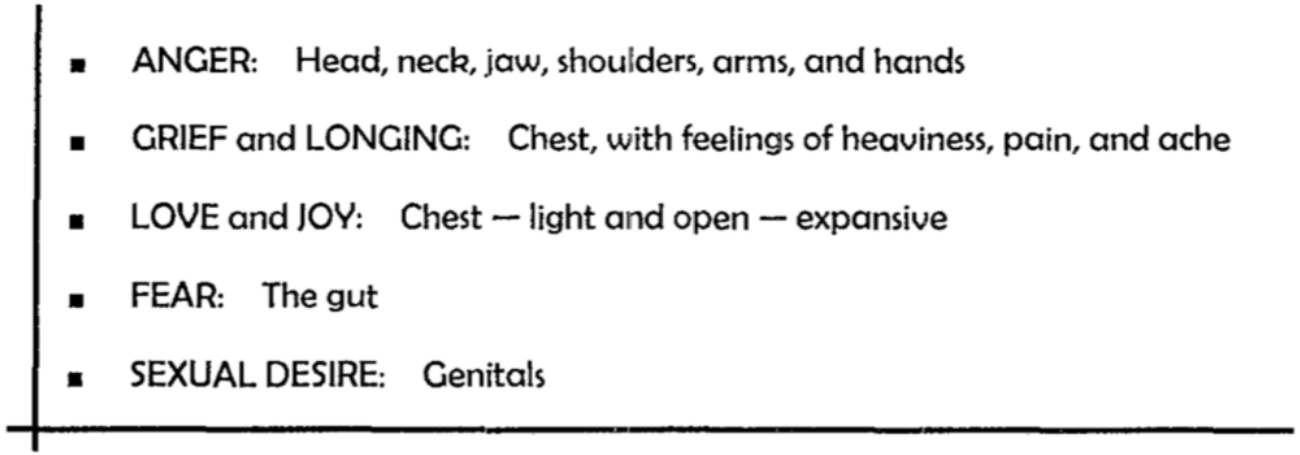


FIGURE 2.4. Map of the body

From Malan & Coughlin, Lives Transformed: A Revolutionary Method of Dynamic Psychotherapy

Physical Experience Of Anxiety

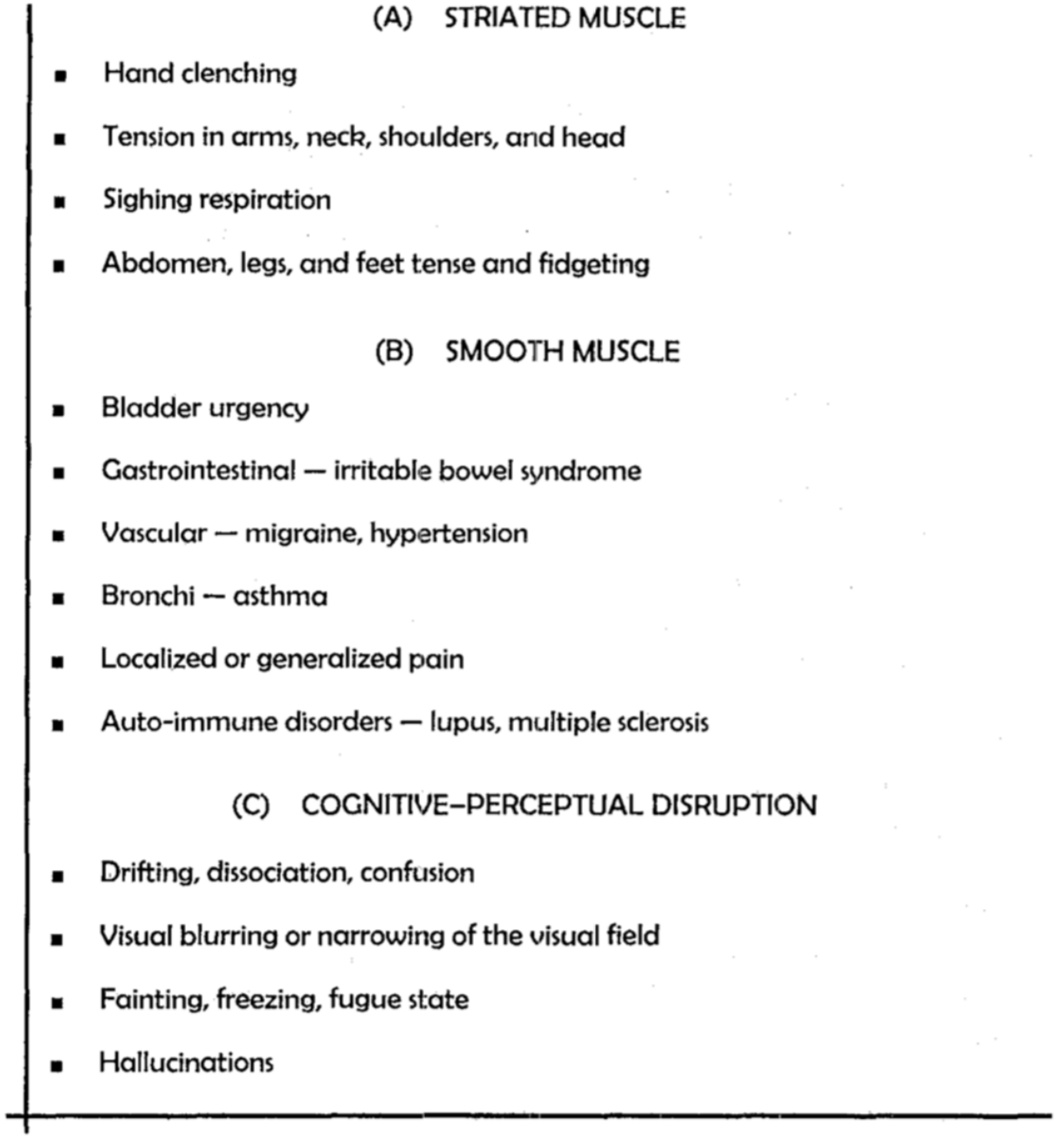


FIGURE 2.6. Unconscious anxiety

From Malan & Coughlin, Lives Transformed: A Revolutionary] Method of Dynamic Psychotherapy

RESISTANCE AGAINST EMOTIONAL CLOSENESS

- A major barrier to progress in therapy – it applies to us!
- Pervasive in all of our patients' relationships
- Not just in PTSD patients, happens in most therapy interactions (unless addressed)
- Patients with moral injury tend to wall themselves off from others

THE ISSUE WITH KILLING

- "Moral injury" – the loss of humanity (see LTC Grossman, *On Killing*, 2009)
- Whom the Veteran killed matters (Maguen et al, 2013)
- How does one recover?
- Can we turn this shame into guilt and grief? What is the difference between these experiences?

https://www.youtube.com/watch?v=BPOXwUgss3I

SELF-COMPASSION

- Closely linked to painful feelings such as shame, anger and guilt
- Needs to be developed in order to have healthy changes
- For John it started with grief about lost time, not wanting to be alone in his suffering anymore

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"JOHN" AFTER A BREAKTHROUGH OF PAINFUL FEELING IN SESSION

- "I want to get better for me"
- "I can feel regret about joining the Army, and I can also be proud of my accomplishments during service. I wouldn't change anything."
- "I cried in front of my wife"
- "I feel closer to everyone: my kids, my wife, my brother-in-law, etc."

Hyperarousal has decreased dramatically, and he is making very positive life changes.

RECOMMENDATIONS

- Help patients clarify feelings vs anxiety vs thoughts
- Try to notice when patients are avoiding feeling in session and help them notice it as well
- Begin to notice anxiety vs feeling within yourself
- Instead of colluding with our patients' avoidance of painful emotions, help them experience it in session
- Try to identify when your patient is showing 'Resistance Against Emotional Closeness'

NEXT STEPS

- ISTDP for PTSD – in progress
- Anger is difficult to manage in civilians, but is even more complicated in combat Veterans- we need to help them with this.
- Could therapy with MDMA or psilocybin help break down inhibitions around feelings?

THANK YOU!

- My patients
- MIRECC presents: James Boehnlein and Christina Garvey
- Murray Raskind, MD and Elaine Peskind, MD (NW MIRECC)
- John Rathauser, PhD and David Wolff, MD (ISTDP supervisors)
- Habib Davanloo, MD
- For your attention

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RECOMMENDED READING

- For patients: "Living Like You Mean It" by Ron Frederick
- For providers: email me for articles.

Books: "Reaching Through Resistance" by Allan Abbass, "Co-Creating Change" by Jon Frederickson.

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