OVERVIEW OF TREATMENT
PTSD

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INITIAL PHASE I

- Establish therapeutic alliance
- Insure patient safety
- Address immediate needs
- Normalize and validate the patient's experiences
- "Commend" the patient for distress
- Educate the patient about PTSD and treatment
- Nurture hope
- Collaboratively generate treatment goals: Motivate the patient to change

PHASE II - SKILLS BUILDING

- Address target symptoms of PTSD (Intrusive ideation, hyperarousal, avoidance, dissociation)
- Address symptoms of comorbidity
- Teach coping skills - Stress Inoculation Training
- Address adherence issues ("Homework", medication)

PHASE III - "MEMORY WORK" AND FIND MEANING

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- Address issues of memory and meaning
- Use Exposure Procedures (Imaginal and In vivo)
- Use "Rethinking" activities: Cognitive Restructuring (e.g., case of guilt)
- Transform trauma - help the patient find meaning: Use rituals, journaling, letter writing
- Help the patient develop and mobilize supportive relationships
- Involve significant others as part of treatment: Nurture "connectedness"

PHASE IV - TERMINATION

- Attribution training - ensure that patients "take credit" for improvement
- Conduct relapse prevention: Consider possible anniversary effects
- Build in follow-up and ongoing assessments

SPECIFIC THERAPY TASKS TO BE ADDRESSED IN TREATING PATIENTS WITH BPD

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I. Initial Phase of Therapy

1. **Pretherapy interventions**-- both individual and group

2. **Establish a therapeutic alliance**. Use the "art of questioning" (see PTSD Handbook). Place emphasis on developing a supportive, collaborative, trusting relationship, since the alliance established by the third or fourth session is a good predictor of therapeutic outcome (Garfield, 1994). The therapist should not act as a **surrogate frontal lobe** for the patient. (Possible assessment measure of the therapeutic relationship - Working Alliance Inventory, Horvath & Greenberg, 1989; Helping Alliance Questionnaire, Luborsky et al., 1996.)

   A. Therapeutic strategies should maximize mutually informed decision-making.

   B. Patient should feel respected and "empowered".

   C. See **Checklist of Therapist Behaviors**

3. **Co-construct Case Conceptualization Model**

   A. Assess both "deficits" and "strengths"

   - assess current presenting problems and comorbidity
   - assess developmental and current stressors (e.g. use timelines, genograms). Obtain developmental history and consider "family or origin" issues, "incompatible" environments. Consider the patient's ways of thinking, feeling and behaving and how got that way
   - assess "strengths," treatment history, and potential barriers
   - provide feedback and collaboratively generate an agreed-upon treatment plan and treatment tasks

4. **Validate and normalize the patient's feelings and experiences** 66

   A. Validate trauma experiences, but avoid abreaction in the early phase of treatment.

   B. Help the patient understand why they behave as they do - rescript narrative; why feel as intensely as they feel (concepts of secondary emotions and coping solutions)

5. **Address suicidal behaviors** -- conduct a careful suicide assessment, conduct a moment by moment chain analysis of behavioral and environmental events that preceded, accompanied and followed suicidal behavior; consider alternative solutions, use journal writing, telephone contacts. Search for less damaging alternative behavior (see Leibenleft et al., 1987; Linehan, 1993a; Linehan et al., 1989, 1993). Also see Meichenbaum, 1994, pp. 212-228 for description of assessment and treatment approaches.

   A. Treatment includes:

      Helping the patient view suicide as a problem-solving attempt. ("Not in suicide prevention business, but in life promotion business." Linehan, 1993)

      Help patient structure activities; keep mood log;

      Focus on thinking patterns ("Should" statements, overresponsibility, implicit rules- if this rule applied to others what advice)

      "Emotional mind" - emotional reasoning - feeling something and using feeling as confirming evidence. Addressing guilt in terms of "hindsight bias."

      Use coping words - think of how respond to friend with same feelings

      Thought record - "reasoning mind"

      Tolerate distressing feelings - reframe as "warning signs" for hopelessness and suicidal risk

      Back-up plans

Elicit commitment statements 67

"I know that hurting yourself has been a long-standing way of coping and that you may not feel that self-care is important. However, if we are to get anywhere in this therapy, you will have to make a commitment to work very hard to take care of yourself, even when you may not want to." (Chu, 1992, p. 3.)

EXAMPLE OF COPING CARD

"I know I am feeling overwhelmed, but I have felt this way before and it always passes. I do not have to respond to my feelings. I am working with my therapist to get better at fighting off my depression an not giving into it. I refuse to be victimized by my depression. I am going to look at my list of activities and begin working my way through the list until the feelings pass. if George was telling me about feelings like this, I would reassure him that he has gotten through it before and he will again. I would tell him to remember all of the things he has successfully accomplished." (Reilly, 1998, p. 30)

6. **Educate the patient about the BPD disorder** -- share the definition and the conceptualization of the patient's problems. Involve and educate significant others and family members about BPD.

7. **Nurture "hope"**

   A. View "strengths" as a series of adaptations

   B. Help the patient make sense of current coping efforts in light of past experience.

   C. How to learn from the past so the history does not repeat itself.

8. **Discuss therapist availability** in terms of possible telephone consultation and intersession contacts. Gunderson (1996) suggest that:

   A. the therapist should only be contacted if a crisis arises or in the event of an emergency

   B. during the phone conversation the therapist should identify the reasons for intersession contact. Ensure patient safety.

   C. on the telephone or in the follow-up session the patient and therapist should discuss how the patient had thought the therapist might be of help, and secondly, what the patient thought was helpful.

   D. help the patient engage in problem-solving

   E. during the call the therapist can offer specific suggestions "Read...," "Think about...," "Distract yourself by ...,"

   F. in subsequent sessions the therapist can help the patient to perspective take by discussing such issues as "How did you think I would feel about your call?", or "What did you imagine I'd be doing when you called?" Do not raise these questions at the time of the emergency.

   The goal of these guidelines is to eventually have the patient come to act as her own therapist. As Gunderson observes, the therapist should behave in a way that leads the patient to conclude that after a few calls that her therapist "isn't very good on the phone" (p.754). Nurture patient independence.

9. **Address therapy interfering behaviors and potential barriers**. Work on possible "ruptures" to the therapeutic alliance.

10. **Address issue of taking medication**-- consider adherence counseling and attributional processes. (Encourage the patient to attribute improvement to what the medication allowed the patient to achieve. Able to "notice, catch, plan, interrupt, cope in spite of difficulties," etc.)

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11. **Consider treatment options**- individual, group, psychoeducational (consider issues of the treatment setting and the length of treatment). Engage in collaborative goal-setting. Give the patient as much choice and control as possible.

12. **Treat comorbidity such as substance abuse**. Employ relapse prevention procedures (see Linehan et al., 1999; Linehan & Dimeff, 1995; Marlatt & Gordon, 1985; Meichenbaum, 1994; Nigam et al., 1992)

    Build supportive relationship early, be nonjudgmental, view substance abuse as solution to problem.

    Use harm-reduction strategies - use transitional maintenance replacement. Replace illicit stimulants with prescribed methylphenidate and opiates with methadone.

    Use relapse prevention model - se *Irvin* et al., 1999.