imagined reliving/revisiting for ptsd

this handout with internet links was posted to www.stressedtozest.com on 25.05.12

This is the sixth post about this workshop on CBT memory-focused treatment for adults with PTSD. Earlier posts have looked at the workshop overall, discussed treatment structure, explored application for "non-PTSD trauma" like grief & loss, and application for anxiety/depression, personality disorders & complex PTSD, as well as looking in detail at the use of written trauma narratives. Nick Grey, the workshop facilitator, highlighted that he used four different ways of working with trauma memories. I have already discussed written narratives. In this post I want to focus on imagined exposure/reliving, and then in the final post about the workshop I'll more briefly discuss site visits & discrimination of triggers.

"Exposure/reliving" is likely to be the first of these approaches that is used in trauma therapy. Actually it seems to me that "revisiting the memory" might be a less daunting descriptor for clients than "reliving the memory" (although maybe "reliving" is more accurate). As I've described in the earlier post on treatment structure, typically therapy begins with one or two "assessment sessions". "Therapy sessions" proper then starts (although assessment/orientation may well already have engaged the client and begun to give them hope). The first "reliving" intervention would typically be at the second or third therapy session (e.g. at session three to five if one also counts the assessment meetings). Good client orientation before starting this process is, of course, crucial. I've talked about this in the earlier post on written trauma narratives saying *"Traumatic experience can be like a wound that has been bandaged up, but that still causes real difficulties in one's life. It is as though the wound has never been fully cleaned, has never had a chance to mend properly. Typically one did the best one knew at the time to move on from what happened, but in many ways one continues to be powerfully affected by these past experiences. The wound is now a bit like an abscess. It can still be badly stirred up, producing very real distress and interfering with fully living one's current life. This "cleaning out an old wound" metaphor is one way of understanding the importance of emotional processing for many old traumas. Another useful model is the "Factory metaphor" (see the associated handout). Restacking a badly packed cupboard or filling in an only partly completed jigsaw puzzle are other potentially helpful ways of seeing this type of processing work. The trauma may have been a single dreadful experience, or a series, or whole periods of one's life. In all these situations it may be important and very helpful to go back and re-process what happened, take the bandage off for a bit, clean the wound out better, and allow fuller healing."* See too the "PTSD assessment, images, memories & information" page on this website for more handouts that can be used for client orientation.

In describing trauma written narratives, I have suggested *"If one is writing about a single dreadful traumatic experience, it's likely to be best to begin the description from just before things started to go wrong, and then to continue through to where one has emerged from the trauma and largely come out the other side. There isn't a cut-and-dried, right-or-wrong way of deciding exactly what period of time to include in one's writing but, for single traumas, it's typically from before things became unsafe to after one has emerged and the worst has passed. Similarly there isn't a definite right-or-wrong about writing in the present tense or in the past tense. Sometimes describing the trauma in the present tense - as if one is going through the experience as one writes - may help in making the description fuller and more vivid. This is likely to be helpful therapeutically. The main thing though is writing a full, detailed and emotional account of what happened, and it's OK to do this writing in the past tense if this is what feels best for you. If in doubt, first try writing in the present tense."* Certainly Nick comments that he encourages the client to go through what happened in their imagination 1.) making it as realistic as possible. 2.) telling the story in the first person. 3.) using the present (rather than the ***[Cont.]***

past) tense. 4.) describing what was experienced through all the different senses. He suggests that the therapist is supportive and also watches out for avoidant behaviour. Ratings of vividness, now-ness and emotion may be helpful. See this *"Post imagery questionnaire"* that I have put together for areas it may be worth looking out for. The questionnaire can be filled in with the client very soon after they have gone through the imaginal reliving/revisiting intervention. Copies can also be given to them to fill in, as homework, when they have listened to the recorded reliving/revisiting sequence at home. Nick commented that if the client went through the memory with little emotional engagement, he might ask them to go through it again almost immediately afterwards ... this time encouraging them to really allow themselves to be there more vividly and to feel more what they felt at the time. Remember at the trauma therapy centre where Nick works, therapy sessions are typically 90 minutes long.

In the subsequent week after this reliving/revisiting experience, the client is asked to listen to the session recording 3 or 4 times ... maybe once for the full session and 2 or 3 times just for the reliving/revisiting section. See the *"Introduction & monitoring"* page of this website for more details about session recordings. Typically it will also be at this stage (after imaginal reliving/ revisiting) that the client will be asked to write a description of the trauma experience – see the blog post on this and the linked handout providing writing suggestions that can be given to the client (after adapting it if you want to). At the risk of overloading them with handouts, I would also give them a copy/copies of the *"Post imagery questionnaire"* to record how they experience listening to the recording (and to encourage them to really engage with reliving/revisiting the memory).

Nick said that over the whole sequence of therapy sessions with a client, he would typically get them to repeat imaginal reliving/revisiting twice more in addition to this first time through. Remember a typical course of trauma treatment at his centre involves one or two initial assessment sessions, then up to twelve weekly therapy sessions, and finally up to three follow-up sessions (so a total of ten to seventeen appointments, each of ninety minutes duration). The first imaginal reliving intervention would occur at the second or third therapy session (the third to fifth visit if one includes the one or two initial assessment meetings). Following this first reliving intervention there is likely to be important time spent on processing what has been experienced. Reactions & judgements made during the original trauma are likely to have got "frozen" and it may be very important that the client allows themselves to take on board new information & understanding that they didn't have at the time of the original event. This reminds me of Garnefski & Kraaij's fascinating work using the *"Cognitive emotion regulation questionnaire (CERQ)"*. There are numerous research studies showing its relevance across many different life stresses. Again and again the same findings emerge ... there are three cognitive emotional responses that are routinely associated with worse subsequent outcomes and one that is routinely associated with better subsequent outcomes. The three associated with worse are the usual suspects. They are responses involving rumination, catastrophizing and self-blame. And the response that is so often associated with better outcomes? It's *"Positive reappraisal"* with affirmative answers to the four questions *"I think I can learn something from the situation", "I think that I can become a stronger person as a result of what has happened", "I think that the situation also has its positive sides"* and *"I look for the positive sides to the matter"*. I wonder here about the possible value of giving clients the *"Posttraumatic growth inventory"* and asking them to fill it in a.) as they have currently experienced their trauma, and b.) as they would like eventually to have experienced their trauma if they become able to learn & grow from it as they would most hope to. This notion of possible "posttraumatic growth" needs to be approached carefully and sensitively and it's not going to be appropriate for all trauma sufferers. See the blog post (and handout) *"Writing (& speaking) for resilience & wellbeing: personal growth"* for more on this.

It's important to work with the client to clarify what new information/understanding/attitudes to their traumatic experience they would want to take on board. The second imaginal ***[Cont.]***

reliving/ revisiting intervention would follow about three sessions after the first (at approximately the sixth therapy appointment). This time Nick said that he would typically incorporate/rescript the imaginal reliving to add in the new information/understanding/attitudes. This is a very interesting area that the day long workshop didn't have time to go into in any depth. Ougrin's recent study *"Efficacy of exposure versus cognitive therapy in anxiety disorders: Systematic review and meta-analysis"* stated *"No statistically significant difference in the relative efficacy of CT (cognitive therapy) and E (exposure) was revealed in Post Traumatic Stress Disorder."* However Arntz et al, in their earlier paper *"Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting"* wrote *"We tested whether the effectiveness of imaginal exposure (IE) treatment for posttraumatic stress disorder (PTSD) was enhanced by combining IE with imagery rescripting (IE+IR). It was hypothesized that IE+IR would be more effective than IE by (1) providing more corrective information so that more trauma-related problems can be addressed, and (2) allowing patients to express emotions that they had been inhibiting, such as anger. In a controlled study 71 chronic PTSD patients were randomly assigned to IE or IE+IR. Data of 67 patients were available. Treatment consisted of 10 weekly individual therapy sessions and treatment evaluation was conducted post-treatment and at 1-month follow-up. Results show that when compared with wait-list, treatment reduced severity of PTSD symptoms. More patients dropped out of IE than out of IE+IR before the 8th sessions, 51% vs. 25%, p=.03. Completers and intention-to-treat analyses indicated that both conditions did not differ significantly in reduction of PTSD severity. IE+IR was more effective for anger control, externalization of anger, hostility and guilt, especially at follow-up. Less strong effects were found on shame and internalized anger. Therapists tended to favor IE+IR as it decreased their feelings of helplessness compared to IE. Results suggest that the addition of rescripting to IE makes the treatment more acceptable for both patients and therapists, and leads to better effects on non-fear problems like anger and guilt."*

At present I would go with incorporating new information & imagery rescripting (sometimes guided by exploration of possible posttraumatic growth) as worthwhile interventions to be able to add to straightforward exposure style imaginal reliving. However I would also try to be a little cautious & humble about rushing in too quickly with rescripting. Working at the great emotional depth that is often the challenge and the profound privilege of trying to help people suffering from PTSD reminds me of something a sculptor friend once said to me. I was asking him about how he worked with a block of stone to carve out the eventual shape he had in mind. He said that yes he would chisel in knowing what figure he hoped would emerge, but he also tried to be sensitive & responsive to what evolved as he worked with the stone. This is my experience in strongly emotional phases of therapy. I try to be soft, sensitive, aware as the "emotional spray is whipping into my face". At times the most creative, helpful changes emerge spontaneously from the client, with new healing insights & directions coming out of the reliving/revisiting journey (no doubt helped by the discussions we have had about how & what we're trying to achieve thera-peutically before we dived into the emotional rapids). Rightly or wrongly, I suspect that some cognitive-behavioural therapists are a bit awkward in situations of high emotion and may slap on pre-programmed additional information/rescripting too quickly & formulaically. There's an interesting research question here that will probably never be explored. See the posts *"... cathartic work from the inside"* and *"... cathartic work from the outside"* for more on this. For practical suggestions about how best to go about working with imagery in PTSD treatment there are many good resources. Examples include *"A casebook of cognitive therapy for traumatic stress reactions"* (edited by Nick) and the *"Oxford guide to imagery in cognitive therapy"*. Nick commented that he might well then run through a third & final reliving/revisiting late in the course of the therapy sequence (possibly four or five sessions after the second reliving session – at appointment ten or eleven if one is simply counting the up to twelve weekly therapy sessions).