

CLINICAL EXPERIENCES IN TREATING PTSD PATIENTS BY COMBINING INDIVIDUAL AND GROUP PSYCHOTHERAPY

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SUMMARY

PTSD is a complex psychobiological disorder that causes dysfunctionality in many areas. In treating PTSD different models have been applied, however, no general consensus on the method of treatment has yet been achieved. At the Clinic for Psychological Medicine we have developed the model of combined treatment for PTSD patients that involves outpatient individual psychotherapy, psychopharmacotherapy and group psychotherapeutic techniques introduced within repeated day-hospital treatments. In this paper the efficiency of the above mentioned model has been explored. Three PTSD patients have been presented. We assessed changes in psychological functioning of our subjects on the basis of clinical observation and analysis of the session protocols. The model of combined and long-term treatment of PTSD in which the approach to traumatized patients has been mostly supportive, including supportive psychotherapeutic interventions and psychopharmacotherapy, has proved to be efficient in achieving integration of traumatic experiences and consolidation of the traumatised Self. Combination of individual and group approach facilitates the analysis of traumatic transference, whereas more mature defence patterns become stronger and integration of traumatic experiences improved. Consolidation of the Self leads to better socialization.

Key words: PTSD - model of long-term combined treatment - individual and group psychotherapy

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INTRODUCTION

Several research studies have suggested the effectiveness of different psychotherapeutic techniques and psychopharmacotherapy available for PTSD. Having obtained insights into a large number of studies Robertson, Humphreys and Ray (2004) found that different treatments had been effective in alleviating PTSD symptoms. Meta-analysis of a number of treatments, that was carried out by Van Etten and Taylor (1998) and that included different models of psychotherapy and psychopharmacotherapy, indicated that the effectiveness of all types of psychotherapy amounted to 1.17 in comparison with the effectiveness of medications which stood at 0.69. The dropout rate that occurred as a result of psychopharmacotherapy was 32%, whereas psychotherapy accounted for 14%.

However, data collected so far do not clearly indicate when and for which patients specific psychotherapeutic interventions are the most effective. In other words, there has been no consensus on a standard psychotherapeutic paradigm in treating PTSD that would define which psychotherapeutic techniques seem to be the most appropriate for different cases and when to apply them.

Model of treating psycho-traumatized patients at the Clinic for Psychological Medicine

At the Clinic for Psychological Medicine we have developed the model of combined treatment for PTSD

patients that involves outpatient individual psychotherapy, psychopharmacotherapy and group psychotherapeutic techniques introduced within repeated day-hospital treatments. Within this model, the psychotherapeutic approach to traumatized patients is to be supportive over a longer period of time, whereby occasionally some psychotherapeutic interventions that intensify anxiety may also be introduced. At the beginning our primary (psycho dynamically-formulated) goal in treating traumatized patients is prevention of deeper regression and disintegration of the patient's psychological instances achieved by creating a safe and contenting therapeutic environment, by strengthening positive transference and more mature defence mechanisms. In later stages of treatment the goals refer to improvement and rehabilitation of social, interpersonal and professional functioning.

Patients that continuously undergo individual psychotherapy are referred to interviews for admission to day hospital by their psychotherapists. During day-hospital treatment, individual psychotherapy is not terminated. Patients are involved in continuous individual supportive psychotherapeutic treatment by being repeatedly admitted to the day hospital for treatments provided in a group setting. When registering for the day hospital treatment patients are allowed to choose between a heterogeneous or homogenous group. The basic psychotherapeutic orientation in the day hospital treatment is supportive.

Day hospital practice has been organized according to the principles of therapeutic community with the

elements of milieu therapy. The psychotherapy in day hospital treatment is based on group psychotherapy, either in small or large groups. Each day two one-hour group sessions are held with a half an hour break between them. After each session therapists join in discussion for half an hour. A male-female pair of psychiatrists conducts a dynamically oriented large group once a week.

By presenting the following case studies we would like to draw attention to the particularities of working with psycho-traumatized patients, and to difficulties in developing trust and creating safe environment so that therapeutic interventions could lead to improvements.

OUR OWN RESEARCH: CASE REPORTS

Case 1: Svebor, aged 40, married, has an adopted son. Soon after the outbreak of the war in 1991, Svebor joined the Croatian Army as a volunteer. He terminated his full-time studies that he had been pursuing until then. After the war he stayed with the army and transferred to a two-year study program that he finally managed to complete with great difficulty. In his words education made no sense and he also had difficulty concentrating. It was then that the first symptoms of entero-colitis occurred, but at the beginning he ignored them. Also, he felt increased tension and sleep disturbances.

His military physician referred him to a psychiatrist. He was placed under observation with symptoms related to PTSD and depression, complete loss of interest, joylessness and social isolation. During supportive outpatient individual psychotherapy in combination with psychopharmacotherapy he partially gained insight into his disorder but at the same time created high expectations of his therapist (e.g. he expected his therapist to be omnipotent and heal his psychosomatic disturbances and improve his social status). When he was confronted with reality issues his condition worsened. He was disappointed with his therapist since the therapist was not a powerful mother who could solve his problems and protect him from suffering. Since the therapist could not fulfill the task, the patient's condition aggravated. In such a regressive relationship in which there was no satisfaction and expectations were high, there could be no improvement. At that time day hospital treatment started and besides having an individual therapist, the patient got a group therapist as well. During day hospital treatment, the patient's mood was significantly improved, and isolation reduced. By entering the group led by a male therapist who was in transference perceived as a father by the patient, the patient returned into the 'modified military environment', in which the father was less authoritative and made it possible for his sons to react competitively. The illusion of comeback into the 'military environment' was also maintained by the homogeneity

of the group, which was made up of war veterans. Such a setting shifted the patient back into the period of trauma when he felt strong and powerful, which led to symptomatic improvement.

In Lindy's opinion (1989), also confirmed by our own experience, a specific type of transference – traumatic transference develops during treatment of patients suffering from PTSD. Emotional responses to authority have changed due to experiencing fear and helplessness that occurred during the traumatic experience. The patient found them very difficult to cope with and he expected that he would be presented with 'almighty' solutions. In the case of Svebor, the absence of the gratification of idealized expectations led to depression. Joining the group reduced transference pressure because it influenced dispersion of transference reactions to other group members as well. However, in our opinion it was the support of the group that was the most important factor in initiating this positive move. The identification with the group members led to better reality testing not only within the group itself, but also in the external environment. Svebor is now better able to cope with everyday tasks.

Case 2: Mladen, aged 34, a Homeland volunteer, retired, married, with two children. In 1991, at the very beginning of military actions, Mladen served his regular military service in Belgrade. He had just come of age when he escaped from Belgrade and remained hidden for some time in Slovenia. Yet, his wish to be involved in the defence of his homeland was so strong that he came back to Croatia and joined the volunteer armed forces in which he was actively engaged until the end.

As an eighteen year old young man he was the youngest in his unit. At the beginning he was referred to as the 'baby of the unit', but due to his outstanding devotion and courage he was soon promoted to the officer rank and became an authority figure for his fellow-soldiers.

Since 1995 he has been treated at our Clinic with individual psychotherapy and psychopharmacological treatment as well as being involved in day-hospital treatment. From the very beginning anxiety occurred as the most obvious clinical manifestation and sometimes it became overwhelming with frequent acting out reactions, followed by guilt feelings and withdrawal caused by depression.

Due to external circumstances (retirement of the therapist that had treated him for 9 years); Mladen had to change his therapist. At the beginning Mladen was reluctant to share much of the group contents with his new individual therapist. It was obvious that he was trying to overcome splitting; the group and his group therapist were a 'good object', constant and safe, whereas the new therapist had to deserve his trust. From the group therapist and day-hospital staff, the individual therapist used to gather information on Mladen's activity in the group and on his need to help other people. As had been the case during the war, despite his age, he

was the kind of a group member that the whole group placed great trust in, and who took on the role of an 'experienced member'.

At the beginning of the therapy Mladen put his new therapist to the test. The group in the day hospital treatment had a role of a constant, good object, whereas, on the other hand, Mladen needed his new therapist only for one reason – to recommend him for day hospital treatment. The day-hospital was a constant object for him and, under the given circumstances, it served as a transference object.

Two years after he had started individual therapy, Mladen showed trust in his new therapist in that he asked him to start treating his acquaintance.

In individual treatment, transference shifted in a positive direction. The homogenous group with well established cohesion among its members who all shared similar traumatic experience, encouraged the patient to experience again, through multiple transference, his traumatic war situations, which, in turn, led to consolidation of the Self. Therapy in the homogenous group paved the way for the patient to socialize in outer reality, i.e. in his own words: 'to survive and stay alive' in this ghostly peaceful everyday routine'.

Case 3: Slobodan, aged 37, married, with two children. He had fought in the Homeland war since 1991, on the front line, and had been exposed to different traumatic experiences (being injured, taken prisoner, experienced death of his fellow soldiers and loss of friends and relatives). In 2001 he came to our Clinic for the first time and started participating in outpatient individual psychotherapy sessions in combination with psychopharmacotherapy. The dominant symptoms were high tension accompanied by multiple somatic complaints, sleep disturbances with traumatic dreams (haunting war contents), occurring every night, and impulsive aggressive behaviour attacks during which he used to throw objects all over the house. He felt misunderstood by his surroundings and his family, whereby in relation to his traumatic experiences he suffered from survivor guilt, described by Lindy (1985). By the time the patient presented himself to our Clinic he had been followed up by another psychiatrist and several times admitted to the psychiatric hospital in the area where he lived. In individual psychotherapy the patient developed positive transference that made it possible for him to gradually open up and work through his traumatic experience. During treatment, insights were gained into the patient's basic over-sensitive personality structure that had been exposed to war traumas over the delicate period of his adolescence.

Lack of understanding and acceptance shown by his surroundings that, in the patient's view, were related to the fact that he had been of different nationality, as well as lack of empathy expressed by the members of his immediate family obstructed the process of integration of traumatic experiences in individual therapy. That is,

in this case we are dealing with the patient who, during therapy, was diagnosed with complex PTSD, described by Terr (1991), Goodman and Weiss (1998), where trauma in adulthood more intensively damages a person whose psychological structure is, due to infantile traumas, more vulnerable and less resistant. Therefore, we decided that our patient should receive adjunctive day-hospital treatment. During his first stay in the day-hospital, despite support provided by the group therapist and group members, Slobodan was hardly able to tolerate tension developed in the course of group therapy sessions. He was verbally inhibited and instead of verbalizing, he reacted in a number of acting outs and tended to leave group sessions frequently. Gradually, during repeated day-hospital treatments and as a result of experiencing acceptance by the group, the patient's capacity to tolerate frustration increased and he started to participate in group sessions more actively. A sense of security with the group therapist and group members started to develop. A simultaneous treatment consisting of combined individual psychotherapy and group psychotherapy in the day-hospital made it possible for the patient to elaborate and work through traumatic experiences, to integrate traumatic experiences with other parts of his personality and to integrate Self which would result in better socialization.

DISCUSSION

The effect that PTSD has on the patient depends on the severity of the disorder, associated co morbidity, and on the duration of the disorder, with all these factors determining the use of different psychotherapeutic approaches and psychopharmacotherapy. According to McFarlane and Yehuda (2000): 'New symptoms appear in time, chronic ones are fluid, so it is important to consider use of various therapeutic interventions in various stages of illness.' Relief of PTSD symptoms or even, much desired full elimination of these symptoms is the first goal of different therapeutic approaches. However, very soon the clinician finds it necessary to treat adjunctive disorders related to object relationships and social functioning and to solve medico-legal problems that are frequently of higher subjective importance for the patient.

According to Herman (1992) the treatment of psycho traumatized patients has three phases:

1. security;
2. remembering and mourning;
3. establishing connections.

For Van der Kolk et al. (1996) the third phase is 'rebuilding of secure social connections and interpersonal security'.

According to Lindy (1996), clear consensus exists, which is also in line with findings based on the author's (2000a, 2000b) own experience in treating psycho-traumatized patients in day-hospital and with individual psychotherapy, that one of the primary and basic goals in treating traumatized patients is creating a safe and contenting therapeutic environment.

The psychotherapeutic approach to traumatized patients is therefore in the first phase, which can last for a very long period of time, mostly supportive with possible occasional psychotherapeutic interventions that intensify anxiety. The aim of the supportive psychotherapy is to strengthen the patient's positive transference and more mature defence mechanisms so that a deeper regression and personality disintegration can be prevented.

Koller, Marmar and Kanas (1992) believe that group therapy is the method of treating traumatized patients. According to Catherall (1989) group treatment creates a supportive environment and makes it possible for patients to identify with others who share similar traumatic experiences.

From the cases described above it can be seen that for all the patients treated within the day-hospital program the most important was the feeling of support developed within the group.

The aim in the first phase of recovery is to build trust. As can be seen from Mladen's case, a change of the therapist led to a loss of trust in the health care system. Unfavorable external circumstances traumatized the patient again and abused his trust in therapy and therapist, which is a necessary prerequisite for the therapeutic procedure. Being in the group with his equals helped him, despite a temporary regression, to reconsolidate his ego strength.

As is well known, when a patient experiences narcissistic injury, splitting occurs as a manifestation of regression, which is inevitable. Creation of a safe environment, such as the group, makes narcissistic injuries heal faster, which, in turn, raises possibilities for continuing the recovery process. Psychotherapists decide to include patients in day-hospital treatments when it is not possible to stop regression and relieve pain resulting from narcissistic injuries. Thus, according to Courtois (1988) and Yalom (1970) group treatment enables confrontation with equals, helping others; it diminishes feelings of shame and offers the possibility of checking one's own experience. In all three of the cases described above the transformation of splitting and reintegration occurs later.

The integration of the traumatic experience takes place partly within the group and partly within the individual setting.

The course of the treatment of psycho-traumatized patients, as evident in the above presented cases, is a long term one. The capacity of the traumatized ego is significantly limited, as can also be recognized in all of the described examples. There is a very weak conscious motivation for working on the symbolic meaning of the traumatic experience and on the analysis of representation of the Self based on war merits. Thus, when split into parts, the story is a source of narcissistic gratifications and of secondary gain that psycho-traumatized patients are reluctant to "give up" because they do not have a source of narcissistic gratification in

their community, sometimes not even in their exhausted family (as in the case of Slobodan). Due to all the reasons mentioned so far, a considerable number of traumatized patients are not so willing to accept treatment in heterogeneous groups because in that case they would have to give up their war superego and recreate their civil superego.

The aim of the therapeutic procedures with psycho-traumatized patients is to gain a new understanding of trauma as well as of reactions during trauma. Integration of traumatic stories leads to a change in attitude towards psycho-trauma and creates the possibility of returning to the family milieu, to civilian everyday life, which means: to carry the burden of trauma and repeated traumas with detachment, supported by the observing ego, to find one's own place in the family, to come back home psychologically, to accept reality as it is and to learn again from everyday experience. Prognosis does not depend only on treatment methods, but on the degree of changes in the personality structure and support of the environment (community and family) during and after trauma.

In individual psychotherapy we work on the symbolic meaning of the traumatic experience, on building ego strength, healing narcissistic injury and providing support to efforts made in the process of adjusting to civilian life.

The focus of group psychotherapy is on the readjustment to everyday life situations and a psychological return home. Very often repeated traumas are treated as well, whereas working elaboration and working through of original traumatic events is not put forward because it frequently leads to precipitation or aggravation of PTSD symptoms. The patient's traumatic experience is recognized and evaluated; efforts are made to return traumatic responses to normality. The presence of other patients with the same history of trauma contributes to the development of the feeling of psychological safety and allows group members to build up trust. Bonding with the 'equals' in a supportive environment is necessary to re-establish trust.

In such patients tolerance to the activity during trauma is developed.

Psycho-traumatized patients often have chronic symptoms and co-morbidity particularly with depression (as in the case of Svebor). There are frequent somatic complaints as well as easily observable affective regression, intolerance of emotions (Svebor and Slobodan); joylessness, alexitimia, readiness to trauma from seemingly unimportant stressful events or normal everyday situations.

In their inner world we find internal images of a damaged object world, forms of aggression and victimization as well as "conservation-withdrawal". In the case of Slobodan, the patient had the feeling that he did not belong to any group and that no group could understand him because he was of different nationality. His defences were immature (acting out), which was

partly improved over the treatment period as he got accepted by the group of “warriors“, whereas his family still did not understand him and, thus, did not provide any support. With reference to defence styles, it can be seen from these case studies that splitting occurs more frequently in comparison to acting out, which is rarely present. Accordingly, neither traumatic experiences nor the associated parts of the Self connected to these experiences are integrated. The development and prognosis of PTSD, particularly of the one that has not been treated, may result in permanent personality changes. The indicators involve continuing hostility towards the world, withdrawal from society, feelings of emptiness and hopelessness as well as feelings of constant threat and alienation. The Self has been changed. What is presented in all three cases are changes in the Self that may occur as a result of trauma in the developmental phase (as in the case of Mladen), that may be due to severe trauma (as in the case of Slobodan) or constant repeated traumas (as in the case of Svebor).

In the second generation of the psychotherapeutic approach, which is now more frequently applied within day-hospital treatment, we form heterogeneous groups with focus on differences between psycho-traumatized and non-traumatized patients. These groups build support for family relationships. Also, problems of everyday life, that sometimes take on significance of repeated traumatic experiences for the patients, are discussed. Patients are faced with a tendency towards regressive bonding based on the illusionary feeling that neither difference nor unity among former fellow soldiers exists. The accent is on “here and now“. Efforts are made to motivate patients to make plans for their future. If it can be applied, this second generation therapeutic approach is optimal.

CONCLUSION

PTSD is a complex psychobiological disorder that causes loss of function in many areas of life. Its treatment is often long-lasting and complex. Depending on different factors (such as the therapeutic orientation or education of the psychiatrist and psychotherapist, the number of patients that need to be treated) different treatment models of PTSD have been applied. However, as yet no general consensus about the best model of PTSD treatment has been achieved.

At the Clinic for Psychological Medicine we have developed the model of combined PTSD treatment which includes individual and group psychotherapy and psychopharmacotherapy. In this model the patients are in long-term outpatient individual psychotherapy which includes psychopharmacotherapy and they are repeatedly treated in the day hospital. During repeated day-hospital treatments they are in group psychotherapy. The therapeutic approach to patients is mostly supportive.

In this paper the efficiency of the above mentioned model has been explored. We assessed changes in psychological functioning of our subjects on the basis of clinical observation and analysis of the session protocols. Three clinical cases of PTSD patients have been presented with reference to positive and negative components of this therapeutic approach.

After more than ten years our experience showed that this combination of individual and group approach in long-term psychotherapy stops regression, reduces narcissistic vulnerability, facilitates the analysis of traumatic transference and consolidates traumatic stories. In this way more mature defence patterns become stronger. Improved integration of traumatic experiences enables consolidation of the traumatic Self and better socialization.

However, this therapeutic model seems to be deficient in trying to consolidate the Self as quickly as possible. We realize that for the integration of traumatic experiences and the traumatized Self long-term therapy was needed. During such a long time some events outside of the therapeutic situation can also be frustrating, sometimes even traumatizing for patients. For example, patients feel frustrated by the requirements of the administrative system (recognition of their status), family problems, etc. In long term supportive individual psychotherapy and during repeated day-hospital treatments patients are also exposed to frustrating transference and therapists to counter transference reactions.

The model of combined PTSD treatment which includes long-term outpatient individual psychotherapy and psychopharmacotherapy combined with group psychotherapy during repeated day-hospital treatments in which the approach to traumatized patients was mostly supportive, has proved to be efficient in achieving and maintaining symptomatic improvement based on consolidation of the traumatized Self of our patients as well as improving their social functioning. Therefore it can be one of the valuable treatment models of PTSD.

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