Invited Address 6

PTSD: What it is and How to Resolve it—and what it isn’t

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Steve Andreas

This article is offered as either a detailed preview of the address, or as a set of notes to be read after the talk.

The term “PTSD” has become so popular that many people apply it very loosely to any unpleasant memory of an event that continues to trouble someone. Having a deprived childhood, repeated failure in school or business, or being dumped by a lover may be very unpleasant, but it is not usually a life-threatening event. The DSM-5 criterion for PTSD is: An exposure to a terrifying life-threatening event, followed by multiple symptoms that persist and don’t resolve over time. (For more detailed DSM-5 criteria, see the footnote at the end of this handout.)

The core of PTSD is a phobic response to a terrifying event that is relived (nightmares/flashbacks) in response to specific sensory triggers or during sleep, created by classical conditioning. Some of the other experiences that may be triggered by the same memories are grief/loss, self-blame (guilt, shame, regret, remorse), other-blame (anger, rage, resentment), anxiety, or disillusionment — the loss or revision of fundamental meanings about the self or the world. Some of these have been described recently as “moral injuries.”

PTSD is usually described and understood as a single problem, and most therapies have a “one size fits all” solution. However, people suffering from PTSD often have one or more of the many different additional aspects mentioned above, each of which requires a distinctly different process for resolution.

Finally, the difficulties of coping with the symptoms described above may result in subsequent problems such as depression, rages, or drug abuse, etc. Someone may also be troubled by questions like, “Why did this happen to me?” or “Why did this not happen to me?” (“survivor’s guilt”) which have no useful answers, distract from resolution and need to be abandoned. These subsequent problems may resolve spontaneously when the more fundamental causative issues are resolved. The account below presents an example of the many different aspects that may accompany PTSD:

Bill was driving the lead Humvee in a convoy in Iraq when an IED exploded by the roadside, killing several men in the vehicle. Ever since this, Bill has had trouble sleeping because of nightmares reliving the explosion,
and frequent daytime flashbacks whenever he hears a loud noise. Since then he has been isolated, drinking too much, feeling depressed, and sometimes exploding into rage.

Bill’s experience satisfies all the DSM-5 criteria for PTSD: The phobic response to the terrifying event can usually be successfully treated using a method in which Bill can quickly learn how to view the event as if he were an uninvolved bystander, calmly seeing himself going through the terrifying experience from the outside. You can view a complete 9-minute videotaped demonstration of this method on YouTube at: http://www.youtube.com/watch?v=mss8dndyakQ (Or search for “Steve Andreas phobia,” and a 4-minute interview with the client 25 years later is also available: http://www.youtube.com/watch?v=TjjCzhrYJDQ (Or search for “25-year phobia cure follow-up.”)

This conditioned terror response is the core of PTSD, and for some sufferers, that’s all there is. The session with John, a Vietnam Veteran in chapter 7 of Heart of the Mind, (pp. 61-63) is an example. One 45-minute treatment with the phobia cure resolved all his symptoms. You can find a 14-minute follow-up interview with John on YouTube at: http://www.youtube.com/watch?v=Ud35xqGc1PQ (Or search for “Rapid PTSD Treatment Interview.”)

However, the many other aspects that Bill experienced are often confused with the core phobic response, even by experts in the field, sometimes using the term “complex PTSD.” These additional aspects are very different from the core phobic response, and each requires a different specific intervention to achieve resolution. Some of these are closely associated with the incident itself, while others occur before or after the traumatic event. Let’s explore Bill’s experience further to illustrate these additional aspects.

Aspects closely associated in time. Bill knew that a pop bottle at the side of the road could be a marker for an IED, but he ignored it, so he feels regret for not stopping, and constantly berates himself for his poor judgment, and feels guilty for the deaths that resulted. Bill’s best buddy was killed in the Humvee explosion, and Bill is grieving this loss. In the frenzy of the attack that followed, Bill shot at anything that moved, including two women and several children, and he feels great shame about having caused their deaths.

Aspects that developed afterward. Bill’s legs were severely
damaged in the explosion, and had to be amputated, so Bill is also grieving this loss of many different treasured sports and activities. In addition he has TBI, and he is depressed by the formidable task of adapting to these disabilities. He was engaged to a woman with whom he was intensely involved. When she found out about his injuries, she dropped him like a hot rock, and it was as if a part of him died, depriving him of love and support when he needed it most. After this he started drinking heavily, and his rages became worse and more frequent.

**Aspects that developed beforehand.** Long before Bill joined the army, he suffered repeated verbal (and some physical) abuse from his father, and he internalized this voice, which constantly criticizes him no matter what he does. Bill had spent almost a year in the red zone, under constant threat of attack 24/7. The constant danger had already made him habitually anxious and hypervigilant, sleeping poorly, and reacting instantly to any surprise by becoming fully alert and ready to respond with violence. Bill entered the army as an idealistic gung-ho warrior, but he had already become disillusioned by the gritty reality of war, and had decided that it was a tragic and futile waste, making his losses and burdens utterly meaningless.

Regret, grief, guilt, shame, physical disability, loneliness, insomnia, rages, drug use, self-criticism, depression, generalized anxiety, hypervigilance, violence, disillusion — all of these (and more) may be part of what is often called PTSD. Each of these tends to make the other aspects worse, in a “perfect storm” that often seems to the sufferer to be part of one confusing and tangled ball of chaos and emotional instability. It is vitally important to be able to separate the different aspects and work with each one separately using different processes.

There are a great many PTSD sufferers, and there is a desperate need for rapid and effective ways of working with them. Most current treatment approaches are simplistic and grossly ineffective. When I asked an Iraq vet I worked with recently about her previous 5 years of treatment, she said:

“I think I saw 8 or 9 different shrinks, and all they wanted to do was give me meds, and then they had all these stupid things they wanted to do, like a tapping thing where you thought about the war and they did this tapping thing, and that was supposed to make it lessen. And they had this finger thing, follow the finger while you thought about the bad—it was stupid! That didn’t do anything; it just kind of pissed me off—and then off to the next shrink. That was a waste of my time. . . . I like having tools (which I taught her) now because they didn’t give you any of this when we
came back. . . . Now I have a way to cope with everything—something to do at least to make it better.”

This quote is from a 14-minute video excerpt from the 9 hours of sessions I did with her, that includes an example of the phobia cure, which can be viewed on YouTube at: www.youtube.com/watch?v=xC5AmriQse4 (Or search for “A Demonstration of Effectively Resolving PTSD Symptoms.”)

The so-called “gold standard” for treating PTSD is “exposure therapy” in which the client is asked to re-experience a terrifying traumatic memory repeatedly. This is very uncomfortable, so there is a huge dropout rate, and it is also very undependable and slow, taking many sessions to achieve meager results. Some people’s symptoms get worse, not better. If exposure alone worked, then someone with a phobia, or who has flashbacks repeatedly, would soon get over it. So exposure alone is not a cure; there must be something else.

Virginia Satir often asked clients to “see a troubling memory with new eyes,” a metaphor that at least some clients were able to utilize successfully in the context of her nonverbal evocative presence and watchful eyes. But Virginia also taught a much more detailed process for resolving troubling memories, called “Family Reconstruction,” which she utilized in groups. After gathering some information about a client’s family members and their disturbed patterns of interaction, she would ask them to select someone in the group to role-play each family member. Then she would use physical postures, gestures and sounds to create a vivid tableau of how they interacted. Sometimes Virginia would use ropes and other props to show how family members were tied to each other by their patterns of interaction—and how miserable they all were.

A key element in this process was that the client also chose someone to play herself in this reenactment, so she could see herself, and her own misery in the context of the tableau that Virginia had created. This was an elaborate way to create a very moving new set of images with the client as an outside observer.

Those who have any familiarity with the NLP phobia cure will recognize this as a way to re-view a troubling memory as a distant observer. In contrast, exposure therapy instructs the client to re-experience the troubling memory as a participant, as if it were happening again in the present—which is what they are already doing when they experience “flashbacks.”

This process has an even older history. For thousands of years, many
meditations have taught a similar process of “stepping back” and observing thoughts as if they are separate, something that is an essential process at the core of most teachings of “mindfulness.” Some people are able to successfully use this instruction to “step back” in order to re-experience a troubling memory as unreal, and therefore no longer troubling. But for many others this instruction alone will be inadequate to actually achieve an objective viewpoint, for a number of possible reasons.

One step back may not be nearly enough. A client may need to take ten steps back—or two hundred—in order to create sufficient distance to view a disturbing memory objectively.

Even at two hundred steps, a client may need to shrink a troubling image to make it small, flat, dim, or black and white—or all of these—before being able to view it without distress.

To be really effective, the client needs to be at sufficient distance that they can see themselves responding to the troublesome event, not just the troubling event alone. When a client sees an image of himself freaking out “over there,” that implies that he doesn’t have to feel those feelings himself.

People suffering from traumatic memories often speak of feeling “frozen in time” because they have an unchanging still image of the traumatic event at the peak of their terror. Even if they are able to step back and view it at a distance, they may still have that static troubling image. If they remember a point in time that is still disturbing, you can ask them to make that still image into a movie, and continue the movie until later, when the terror is over and they are safe, providing an exit to the terror.

When a client is already experiencing overwhelming feelings, it can be very difficult or impossible for them to take an objective point of view because of their emotional arousal. However, if they are first distracted, and then asked to imagine sitting in a movie theater before watching a movie of the disturbing memory, they will usually be able to become a detached observer.

The many sensory aspects of a movie theater—the seats that spring up when you stand up, the curtains at the sides of the movie screen, the dim lights, the scrollwork on the ceiling—all silently imply that the movie is only a record on film or video of what happened in the past, some of which may have been achieved through makeup, special effects or other fakery, etc. These sensory elements are far more effective in conveying the message “This is not real” to the client’s unconscious than a verbal message to the clients’ conscious mind.

The impact of these implications is an example of the importance of “what you know, but you don’t know that you know,” often pointed out by
Milton Erickson.

But even all that may not be enough; the client may need to float up into the projection booth of the theater and look down at himself sitting in the audience in order to achieve a double separation from the troubling experience that will be displayed on the movie screen.

Asking the client to reach out and place her hands on the Plexiglass in the front of the projection booth concretizes the separation from the events on the movie screen, making it even more difficult for her to “fall back into” the terrifying feelings being felt by that woman on the movie screen. It also occupies the kinesthetic modality with feeling the Plexiglass, making it less likely that there will be sufficient remaining “bandwidth” in the kinesthetic modality for feeling terror.

After watching a black and white movie of themselves in the terrifying event, the client is instructed to go inside the movie at the end, and experience the whole event backward and in color, in a very fast rewind. This provides an experience of a new behavioral choice—running the event backward swiftly to the beginning, before anything bad happened. If at some future time the client falls back into any part of the terrifying event, they now know how to rapidly rewind to the beginning and be safe.

All these elements and more have been built into a detailed protocol that has been the core of the NLP phobia process since the late 1970’s, and which is the process of choice for the phobic core of PTSD. This protocol takes the simple conscious mind instruction to “step back” from a problem memory and “see it with new eyes” into an experience of being a detached observer that elicits new and more resourceful unconscious responses through implication. Although this is the treatment of choice, both for its speed and efficacy, it is not widely practiced in psychotherapy, despite the increasingly huge number of clients who need it.

Summary of diagnostic criteria for the DSM 5
Identify the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:
• directly experiences the traumatic event;
• witnesses the traumatic event in person;
• learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
• experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies
unless work-related). DSM-5 pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal.

**Re-experiencing** covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.

**Avoidance** refers to distressing memories, thoughts, feelings or external reminders of the event.

**Negative cognitions and mood** represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

Finally, **arousal** is marked by aggressive, reckless, or self-destructive behavior, sleep disturbances, hypervigilance or related problems. This includes the “fight” aspect associated with PTSD as well as the “flight” aspect.