

Review Article

The Vicious Cycle of Impaired Self-Efficacy: Conceptualization and Treatment Guide lines for Severe, Chronic Posttraumatic Disorder

Caspi Y*

Department of Psychiatry, Rambam Medical HealthCare Center, Israel

*Corresponding author

Yael Caspi, Department of Psychiatry, Rambam Medical Health Care Center, P.O. Box 9602, Haifa, 310960, Israel, Tel: 972-4-7773182 ; Fax: 972-4-7773090; Email: y_caspi@rambam.health.gov.il

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Abstract

Against the backdrop of the changes introduced in the definition of posttraumatic stress disorder (PTSD) in the 5th edition of the Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-5), this paper proposes a comprehensive perspective on the chronic posttraumatic disability that follows the long-term struggles with adult-onset PTSD, especially in the context of combat trauma. The vicious cycle created by the perceived and factual damage to self-efficacy and the disintegration of the sense of self is presented thoroughly, with a special focus on the powerful ripple effect of posttraumatic shame. The paper offers guidelines for treatment and a conceptual approach to intervention developed during years of treating combat veterans with severe and complex manifestations of chronic PTSD, including veterans from Arab minority communities.

ABBREVIATIONS

PTSD: Posttraumatic Stress Disorder; DSM: Diagnostic and Statistical Manual of Psychiatric Disorders

INTRODUCTION

The enduring distress that accompanies chronic posttraumatic stress disorder (PTSD) has not been well-captured by the symptom clusters that compose the definition of the diagnosis. Understood as a fear-based disorder for more than three decades, the definitions in the 3rd and 4th editions of the Diagnostic and Statistical Manual of Psychiatric Disorders [1-4], described three primary dimensions to the disorder –re experiencing, avoidance, and hyper arousal. However, the clinical complexities observed by clinicians treating these patients were by far wider reaching, requiring almost always additional, co-morbid diagnoses, such as depression, substance abuse, personality disorders, eating disorders, obsessive compulsive disorders, panic disorders, and more [5,6].

The changes introduced by the DSM 5th edition [7] can be viewed as an improvement; First, PTSD was removed from the anxiety disorders and included in a new, separate chapter,

“Trauma- and Stressor-Related Disorders” [8], with other diagnoses that require that the onset or worsening of symptoms was preceded by exposure to an aversive or traumatic event [9]. Secondly, voting for a broad rather than narrow definition of PTSD, the numbing symptoms, often overlapping with depression, were included in a new, fourth, cluster - “Negative cognitions and mood” [10]. Three new symptoms were introduced: “Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences” and “Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame)” were added to the new Cluster D, and “Self-destructive or reckless behavior” was added to Cluster E: “Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event” [7]. These additions echo the symptoms specified for complex PTSD (or DSM-IV’s disorders of extreme stress not otherwise specified, DESNOS) [11]. Indeed, this emphasis on emotional dysregulation [12] may now incorporate within the diagnosis of PTSD those emotional and behavioral elements that contributed to the perceived need for Axis II diagnoses when treating chronic and delayed-onset PTSD. Thirdly, a PTSD dissociative subtype was added [13], identifying only the symptoms of de-personalization and de-

realization as dissociative symptoms, and evading the diagnostic complexities suggested by the positive and negative psycho form and somatoform dissociative symptoms that seem to be related to PTSD [14].

The revisions in DSM-5 place more emphasis on the role of “nurture” in the development of stress-related problems [15], and reflect a fuller scope of clinically significant chronic posttraumatic presentations [10]. These better represent the “. devastation of mental life...the damaging personality changes that frequently follow prolonged, severe trauma” [16].

A similar change in formulation has long been wanting in the theoretical conceptualization of the massive and enduring impact of traumatic events that occur in adulthood, the subject of Ghislaine Boulanger’s insightful book “Wounded by Reality: Understanding and Treating Adult Onset Trauma” [17]. The profound conviction of psychoanalytic thinking that adult psychopathology can only be explained by childhood problems, coupled by the ambivalent view of “real” trauma occurring in external reality [18,19], may be the primary reason that psychodynamic approaches to the treatment of trauma and PTSD are more readily applied to complex and developmental trauma [20] without addressing the destructive effects that late trauma can have on functioning adults.

Boulanger’s review of the ways psychoanalytic assumptions and methods have rendered the comprehension of adult onset trauma unattainable, paves the way to her description of the differences between the trauma-induced states in childhood and the catastrophic dissociation in adulthood. She astutely states “... catastrophic dissociation becomes an assault on the core self” (p.14), and “...physiologically and psychologically massive psychic trauma catastrophically disrupts the baseline sense of self that under normal circumstances would never be in doubt” (p. 73). The disintegration that follows and the challenge it presents for meaningful therapeutic interventions, especially in the context of combat trauma, is the focus of the current paper.

The phenomenology of living with chronic PTSD is, in its essence, a vicious cycle created by the perceived and factual damage to self-efficacy and its correlates and derivatives. Veterans become aware of the connection between symptoms of delayed-onset PTSD and war-zone stress and the decision to seek treatment [21], only after they had experienced the downward spiral of failed employment, broken relationships and impaired physical health [22]. The repeated and frequent occurrence of traumatic intrusions, the chronic arousal, and the elaborate systems of avoidance, are thus compounded in the majority of veterans by the experience of a massive breakdown in their sense of self and loss of self-capacities [23].

Self-efficacy - the personal beliefs about one’s ability to exercise control over one’s environment and level of functioning [24, 25], is reduced dramatically in these patients. Everyday tasks become challenges of grand proportions. The poor cognitive performance caused by the high levels of tension and pressure, is reflected in poor ability to concentrate and focus on the ‘here and now’. The consequential behavioral problems (e.g., lighting a fresh cigarette while holding the previous one still burning; inability to follow and comprehend a simple conversation),

harm the veteran’s self-esteem, and deepen the loss of faith in one’s capabilities, thus further enhancing self-doubt and the withdrawal from daily functioning. The diminished self-efficacy therefore becomes not only an outcome of the long-term effects of traumatic experiences, but also their predictor [26].

Chronic combat-related PTSD is also permeated by a constant sense of certain yet elusive danger, a perpetual ‘ON’ state of alertness. This sensed danger is oftentimes displaced or projected onto almost anything in the environment, and can gradually drive the veterans into protective isolation and estrangement from their surroundings [27]. While external triggers may be thus avoided, ruminations about the loss of their past life become laced with uninterrupted dissociations and flash backs. The hyper vigilance and reactivity that accompany PTSD often leads to aggressive and even violent outbursts. Veterans with PTSD are impatient, jumpy, and easily offended. They experience the environment as hostile, judgmental, persecutory, and ridiculing.

Contributing further to the vicious posttraumatic cycle are the multiple physical problems that are associated with PTSD, such as chronic musculoskeletal pain, hypertension, persistent pain, obesity and cardiovascular disease [22, 28]. Observed deterioration over time [29] may also be enhanced by poor engagement with health care providers and poor adherence to medical treatment due to avoidance, depression, denial or poor concentration, typical of chronic PTSD [30]. Not only are the veterans burdened by the need to navigate within a complex system of care, but it has been established that somatic predicaments are triggers that exacerbate the posttraumatic symptoms through complex physiological and psychological pathways [31]. Indeed, the life of veterans grappling with chronic posttraumatic disorder can be viewed as numerous illustrations of the loss of control over one’s mind and body, all leading to multiple feedback loops of self-loathing and shame.

The terms “discredited personhood” [32], “mental death” [33] and “collapsed self” [17] are examples of attempts to depict the dehumanizing effect of traumatic disorders. A patient with severe PTSD, haunted by the past through daily dissociations, flashbacks and recurrent nightmares, said: “I live like an animal. I don’t know my own mind. I just survive every day. I am not alive. I am unable to return to humanity”. The sense of self, of agency, is disintegrated, and with it, self-respect and any hope for change.

The suggested guidelines for treatment and intervention presented here were developed during years of treating combat veterans with severe and complex manifestations of chronic PTSD, including veterans from Arab minority communities. The realization that self-efficacy is at the heart of the subjective experience of adult onset post-traumatic disability may not in itself be new or original. However, the described conceptual approach to intervention brings together several perspectives through which treatment goals can be selected, defined, and broken down into manageable tasks that are applicable and suitable for the disintegrated state the patient is in. As such, the relevance of these guidelines should apply even with the introduction of future revisions to the DSM-5 regarding the remaining questions about complex PTSD, the new dissociative subtype of PTSD [34, 9], and the much expected inclusion of culture in the discourse on traumatic stress [35].

Clinical experience seems to indicate that the effects of the post-traumatic loss of efficacy are more devastating for indigenous veterans from minority, non-Western traditional backgrounds [36]. The central role of post-traumatic shame and its visceral effect on the disintegration of the self in these groups is discussed in depth elsewhere [37].

Treatment guidelines

The guidelines are based on seven inter-related components that, together, form a comprehensive approach centered on the vicious cycle of posttraumatic disintegration that stems from severe impairment in self-efficacy (Figure 1). The components draw from several theoretical and clinical formulations utilized in the context of different patient populations. Two components suggest the mode of intervention - Psycho-education and Phased treatment. The other five components describe content areas reflecting the different needs patients suffering from severe PTSD have for Safety, Case management, Illness management, Rehabilitation, and Patient advocacy. Because all components are interrelated and simultaneously impact the vicious cycle of impaired self-efficacy as they are affected by it, it is recommended that treatment plans attempt to address all of these.

Psychoeducation

Embedded within the psycho educational approach is the view that patients should have knowledge of their problem and that they can be helped to understand it. The information offered on the nature and course of combat-related posttraumatic stress reactions and the identification of PTSD internationally, is the first step in inviting the patient to come out of isolation. Psycho education, listed as a common element in the currently available empirically supported psychotherapies for trauma survivors [38].

Psycho education should not be just the first stage of treatment, but rather a mode of being for the therapist, whereas patients are repeatedly educated about the meaning of what they are experiencing, not only in terms of their personal story

but also in terms of trauma theory and stages of treatment and recovery. Psycho education also requires the therapist to take the role of the expert, the teacher, in an active, involved, and direct manner, demystifying both the experience of PTSD and the workings of the therapeutic relationship. This approach is more likely to cut through the levels of distrust and fear of disappointment that are but a few of the barriers to treatment in chronic PTSD. Also, providing clear explanations about the nature of mental health problems, guidance, advice and direction is recommended for physicians working with refugees from non-Western backgrounds [39], as well as with Arab clients [40, 41].

Making use of actual vignettes from the patient's daily life, the nature of the trauma response and its impact can be repeatedly clarified, especially the impairment in self-efficacy and the evasive nature of posttraumatic shame. Words are gradually identified that describe the unspoken emotional states associated with shame and self-loathing. Concepts such as emotional regulation are introduced and the understanding of their relationship to angry outbursts on the one hand and to attempts at total avoidance on the other, are gradually internalized. A true acceptance of the disorder and its impact on the selfish a gradual and difficult process, requiring an acceptance of not having control, reminiscent of the Serenity Prayer which lays the groundwork for the recovery process. Eventually, a sense of belonging and renewed relevance begins to surface, powerful antidotes to long-held feelings of shame and self-stigma [42].

Phased treatment

The notion of phase-oriented treatment emerged from the clinical literature on survivors of severe childhood abuse who developed complex forms of post-trauma and required an initial and lengthy period to develop and improve fundamental coping skills [43-45]. Adult onset traumatic stress disorders occur primarily in persons whose self-capacities were previously effective. Yet, the damage can be so profound, that, like adult survivors, they have to develop self-regulation skills that reduce stress and contribute to safety, stabilization, and emotional engagement, before they can fully, safely and systematically process the traumatic events. Oftentimes, a deliberate avoidance of traumatic content during the initial phase of treatment is required, and the rationale for it is explained repeatedly to the patient. During this phase, patients can be referred to a 15-sessions PTSD and anger management group [46], and then to a PTSD and sleep management group [47]. Patients gain tools for grounding and better self-control, and learned about the dynamics of posttraumatic disorder from the other men in the group.

Safety

Safety is considered to be the focus of the first phase of trauma treatment [48] and continues to be a guiding principle throughout the different phases of treatment. Achieving emotional as well as physical safety necessitates a framework for the inclusion of close family members (spouse, father and sibling) in the process. This is done only with the veteran's permission but its importance is forcefully explained. Given the high prevalence of anger outbursts, efforts to minimize damage (at home and outside) are a priority of the therapy process. By

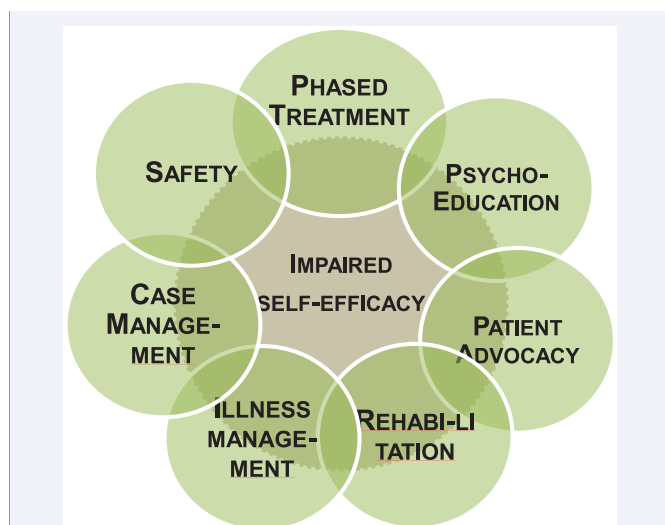


Figure 1 Components of a comprehensive approach for the treatment of post-traumatic impairment in self-efficacy.

forming alliances and active involvement with family members, they not only become more aware of the problem but can also be a resource of support at a later stage of treatment, when direct trauma work may cause temporary regression in the veteran's behavior. Safety is also understood in terms of the veterans' physical health, which especially in the case of minority veterans may be related to existing gaps in health literacy, access, and quality of services [49]. The way somatic problems may instigate a ripple effect that ends with dissociation and flashbacks of the traumatic event is described and explained to patients, and they are constantly encouraged to prioritize their medical problems. Avoidance of the primary care physician is a common barrier, and an opportunity to exercise coping strategies; the waiting area is likely to produce shame and anger, and the actual conversation with the doctor is likely to produce self-loathing for 'complaining' and not remembering all the important issues. These difficulties can be broken down into a string of concrete actions and alternative, more adaptive, reactions are suggested (e.g., scheduling the first or last appointment of the day), gradually helping patients to resume responsibility for their healthcare. Similar efforts are directed at helping patients maintain financial safety. Throughout these conversations and exercises, the psycho education on the debilitating effects of traumatic stress continues, helping the patient accept the disability while learning to regain control.

Case management

Much can be learned from the literature on dual diagnosis in terms of the recognition of the central role of traumatic life experiences in the etiology of posttraumatic and substance abuse problems, and the need for integrated care in order to minimize the risk for additional medical and social complications [50-51]. Persons suffering from severe PTSD, especially if they are also from minority background, are unable to advocate for themselves, especially if the care they need is provided by separate unconnected systems. Whether it is substance abuse or physical health conditions, veterans are required to actively initiate medical appointments and even if they make and keep them, many of the providers are not aware of their PTSD status or its complications. Medications may be prescribed without coordination, especially in places where medical care is split between the Ministry of Defense (MOD) and the standard national health care system. Additional problems may arise due to financial debts accrued by veterans before PTSD was diagnosed, when regular employment was still attempted. Connecting the family to the community social services becomes a challenge because of limited community resources, stigma and the vicious cycle of posttraumatic shame. Consequently, in order to ensure that patients' health and their families' well-being do not continue to deteriorate, it is imperative that responsibility for case management is undertaken by the treatment team, starting with ongoing contact with physicians and social workers in the MOD and with the primary care physician and social services in the community. This is not a traditional role for therapists and if a treatment team is available, one of the other team members can assume this role [52].

Illness management

Recovery or living successfully with any chronic health condition requires self-management in collaboration with treatment providers. Recent years have witnessed meaningful advances in the field of chronic severe mental illnesses, primarily schizophrenia, with the focus on teaching patients illness management skills in order to avoid relapse and improve quality of life [53]. In the absence of integrated care, patient engagement with self-management is even more critical for the outcomes of chronic conditions [54]. The vicious cycle of PTSD can be triggered by anything, and veterans are therefore at a high risk of exacerbation and deterioration if self-management skills are not developed. Accordingly, tasks related to self-management should be translated into treatment objectives. Psycho education regarding the expected difficulties in different aspects of daily life, from marital relationship to shopping for food and negotiating health-related needs are discussed in detail and concrete and specific 'homework' exercises are then devised. For example, the automatic and rapid sequence that may start with a relative mundane non-event such as a child raising her arms to be picked up and then ends in a flashback of the traumatic event is analyzed step by step and explained in terms that gradually become familiar to the veteran. Success is the following: a veteran described walking to the store on an errand and realizing as he got there that he was unable to recall what he was supposed to buy. Rather than allowing the feelings of self-disgust and shame overwhelm him and send him on the regular trajectory back to the traumatic event that ruined his life, he walked in to the store and bought a few things. This was a small and meaningful step towards self-efficacy, regaining control over his mind, emotions and behavior.

Rehabilitation

The rehabilitation sub-culture focuses on return to functioning which normally that in the work with veterans suffering from severe chronic PTSD frames the expectation of creating normalcy, even at a level much more basic than before post-traumatic disability set in. The problem of psychiatric rehabilitation for returning veterans was a major concern for psychiatrists after WWII, when community mental health clinics were scarce and the Veterans' Bureau was unable to provide solutions [55].

The rehabilitation viewpoint of the suggested treatment guidelines is that intervention efforts are expected to target basic skills previously mastered, much like the rehabilitation of physical abilities, such as walking or writing for veterans with amputated limbs. For example, one of the first treatment tasks to pursue is sitting down for dinner with the family, even for the part of the meal, while controlling their reactions. This most routine event is broken down into small elements, and different scenarios are played out to create an arsenal of relevant coping tricks. Success is defined as a meal not interrupted by abrupt departures or angry outbursts. The concrete nature of such a discussion about the meal does not preclude explanations about deep, unconscious processes related to posttraumatic shame ("the children see that I am not normal"), its immediate and automatic translation into elevated bodily tension and the more readily identified posttraumatic reactivity to sudden noises (e.g.,

children bursting into laughter or arguments). The therapist proceeds to describe the potentially inevitable loss of control (screaming at the children), the ensuing and already familiar self-loathing (I am weak, I am nothing) and the exacerbation of the posttraumatic symptoms (if not for that day, all of this would not be happening), including dissociations and flashbacks, and the further disintegration of the sense of self. Clearly, subsequent family meals will be avoided.

What is requested of these patients is to build tolerance for very difficult emotions, primarily shame, viewed as an overwhelming sense of disgrace, dishonor, loss of self-esteem, loss of virtue, loss of personal integrity, and questioning self-worth in its core [56]. A basic request of a social worker attempting to encourage a veteran to search for work is to prepare a curriculum vitae, a résumé. If the veteran comes to the appointment without it, it will be viewed as indicative of lack of motivation and lack of initiative. The veteran himself may not be aware that every time he tried to write his CV, the flashbacks and angry outbursts that interrupted him were due to unbearable feelings about the life he once had and the comparison to the present. When this is explained to him, or better yet, when writing the CV becomes an activity undertaken in the therapy session, the obstacle is removed and another achievement is attained

Patient advocacy

One of the most persistent sources of distress for veterans is the process of claiming injury-related benefits and dealing with the medical committees involved [57]. This is oftentimes a long bureaucratic ordeal. The anonymity and lack of personal attention can be interpreted as lack of respect, and veterans, especially those from traditional non-Western backgrounds, report feeling as if they were forsaken in battle by the same state they were fighting for [37].

The U.S. Veterans Health Administration (VHA) established in 1990 a Patient Advocacy Program for all veterans and their families who receive care at VHA facilities and clinics [58]. From an administrative response to patient' complaints, the program has evolved to include facilitation, problem-solving and interaction at the individual level to ensure that veterans know their rights and responsibilities related to their care at the VA.

In mental health programs that operate within national systems that do not have a built-in advocacy function, mental health care for veterans, especially those suffering from PTSD, should include patient advocacy as an integral component of the treatment approach. The rules and regulations of systems such as the VA are complex and difficult to navigate, especially for those veterans suffering from the problems associated with combat trauma, as previously described. From writing letters regarding patients' psychiatric and psychological status to accompanying the veterans to meetings, therapists should make themselves available and remain cognizant of the veteran's life problems. In specific cases, especially when additional community organizations are involved, multidisciplinary meetings are held, and collaborative follow-up consultations pursued.

CONCLUSION

Those who work in therapy with veterans struggling with

post-trauma know the many emotional, involved, sometimes scary hours shared in the courageous effort to detach the hold of the past from the present. It seems that the way to regain the right to a life that is free of the grip of trauma winds through a phase in therapy where the devaluation and self-loathing that accompany the disintegration of self-efficacy is better tolerated. It is an intimate and painful process, whereby, gradually, the patient is able to willingly become exposed and known by the therapist. It is a re-humanizing process and one that allows for grief to take the place of shame and self-disgust [59].

The seven components described in these treatment guidelines provide, jointly, a conceptual holding space in which the therapeutic work can take place. Step by step, through explorations of the intricate inter-relations between symptoms, the traumatic memories, and the impaired self, a change in the emotional tolerance of potentially shaming experiences can take place, followed by acceptance of the posttraumatic impairment, and a gradual reconstruction of daily life.

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