Treatment-Resistant PTSD

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***Abstract*—Posttraumatic Stress Disorder (PTSD) often requires both, medication and psychotherapy. If the symptoms persist or do not decrease over time to an acceptable level, it often helps to reassess the internal and external communication patterns the individual uses. At the same time, it is important to evaluate the pharmacological options that are available in supporting the patient in psychotherapeutic treatment and everyday life.**

***Index Terms*—PTSD, posttraumatic stress disorder, treatment resistant, treatment, psychotherapy, medication, psychiatry**

I. Introduction

Posttraumatic stress disorder (PTSD) is a common diagnosis. Trauma can occur in many forms anywhere in the world and at any time. Although the world may have become more predictable and safer in some places, overall, psychiatrists, psychotherapists and mental health workers in general, are still faced with the symptoms of PTSD on a daily level.

Communication and Information Processing

What constitutes a trauma is entirely subjective. The literal definition of a trauma is that it is something causing a damage, and in the case of a psychological trauma the 'damage' is done to the mind. Since the mind is a set of cognitive faculties including consciousness, perception, thinking, judgement, language and memory, and all these faculties are concerned with the internal communication and processing of information, the damage must be to communication and information processing.

Post-traumatic stress disorder (PTSD) is the result of an event that is not supposed to occur, whether a tropical storm or a rape. They also take one outside the usual human experience. A trauma is different from the information that is normally communicated.

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The Interpersonal Dimension

The most severe traumata are usually those which contain an interpersonal aspect, such as rape or the loss of a relationship. It is not just how the individual is embedded in a social network, but more the communication system in which the individual finds comfort and a feeling of safety and security. When these interpersonal connections we rely on for the safety and security in our lives is suddenly questioned, life itself, and as a result the sense of the own person, can break away. (Haverkampf, 2012, 2013, 2015)

Disconnection

Trauma seems to question the connections between oneself and the world and also within oneself. Reality has changed in how it feels and in what it seems, and this divergence between the old and the new reality can lead to anxiety, a loss of direction and dissociation.

Communication is the process through which PTSD can be addressed and its symptoms resolved. It is not instant treatment, but a gradual process which helps to resolve the core problem and eliminate or at least significantly reduce the symptoms. As the patient becomes more confident in using in communication and sees more stability in the world, the symptoms from the PTSD and the pressure at its core fade out.

Memory

Memories associated with trauma are implicit, pre-verbal and cannot be recalled, but can be triggered by stimuli from the environment. The person's response to aversive details of traumatic event involve intense fear, helplessness or horror. In children it is manifested as disorganized or agitative behaviors.

A. The Trauma

Much of our experience with PTSD comes from studies with military personal, such as the work done by the Veterans Health Administration (VHA) in the US. It is not entirely clear to what extent the insights can be transferred to other traumata,

particularly to the ones which have a stronger interpersonal element.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines trauma as direct personal experience of an event that involves actual or threatened death or serious injury; threat to one's physical integrity, witnessing an event that involves the above experience, learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or close associate.

Trauma can be caused by a wide variety of events, but there are a few common aspects. There is frequently a violation of the person's core assumptions about the world and their human rights, putting the person in a state of extreme confusion and insecurity. This is seen when institutions depended upon for survival violate, humiliate, betray, or cause major losses or separations instead of evoking aspects like positive self-worth, safe boundaries and personal freedom.

Comorbidity

It may sometimes not be easy to distinguish a PTSD symptom from a separate diagnosis. For example, anxiety and panic attacks are also common as symptoms in PTSD, but they may also constitute a separate diagnosis with a separate etiology. To recognize two underlying conditions can be important to effectively treat the symptoms the patient is presenting with.

II. Treatment

Evidence-based treatment guidelines to improve PTSD care that emphasize the first-line treatments of serotonin reuptake-inhibiting agents, generally discourage the use of benzodiazepines, particularly as a longer-term treatment. The use of serotonergic antidepressants and second-generation antipsychotics is supported only to some extent.

III. Medication

A systematic literature review by Hoskin et al (2015) found statistically significant evidence on meta-analysis for three pharmacological agents v. placebo in the treatment of PTSD (fluoxetine, paroxetine and venlafaxine) but no evidence for brofaromine, olanzapine, sertraline or topiramate. Four drugs – amitriptyline, GR205171 (a neurokinin-1 antagonist), mirtazapine and phenelzine – showed superiority over placebo in single RCTs, whereas eleven did not: alprazolam, citalopram, desipramine, escitalopram, imipramine, lamotrigine, nefazadone, risperidone, tiagabine and valproate semisodium. When metaanalyses were undertaken by class of drug rather than individual drug, SSRIs were found to perform better than placebo. The absence of sufficient data precluded meta-analyses of other drug classes. The absence of difference in numbers of individuals leaving the study early for any reason suggested to the investigators that the drugs included were well tolerated overall.

The effect sizes for pharmacological treatments for PTSD compared with placebo are low and inferior to those reported for psychological treatments with a trauma focus over waiting-list or treatment as usual controls. (Bisson et al, 2007) They are, however, similar to those found for antidepressants for depression compared with placebo. (Leucht et al, 2012)

The variation in efficacy between different agents is striking and could be explained by a number of factors. First, there may be real differences between drugs, even those in the same family. For example, paroxetine's superior efficacy over sertraline may possibly be explained by its increased dopamine receptor activity. Differences in the pharmacology of phenelzine and brofaromine are also marked and grouping all drugs in one class together seems less desirable than considering each one individually. This confirms previous observation that class membership does not confer the same level of efficacy in the treatment of PTSD. (Stein et al, 2004)

The importance of the psychological aspect is also visible in the treatment with medication. For example, in two venlafaxine studies the mean reduction in PTSD symptoms of those on placebo was greater than 40%. (Davidson et al, 2006; Hertzberg et al, 2000)

Benzodiazepines

It is a difficult task to accurately determine whether the benefit of a benzodiazepine will outweigh the risk of polypharmacy or abuse potential. Once these medications are started, it is difficult to terminate them. The best approach is usually to require from oneself to have a clearly defined purpose for prescribing the benzodiazepine.

One good reason for a benzodiazepine may be bridging the time until an antidepressant works, particularly as both SSRIs and SNRIs can even increase anxiety in the beginning. Since the effect of antidepressants usually arrives within a few weeks, the use of benzodiazepines is then not open ended.

Another reason to continue prescribing benzodiazepines can be to control the use benzodiazepines with the aim of ultimately reducing them, provided that another non-addictive medication can be found that brings a significant relief, which usually is the case. Many patients with PTSD have used benzodiazepines for long periods without evidence of harm, so that the potential benefit of stopping it can be outweighed by an almost certain worsening in symptoms, and the reduction in quality of life and possible impairment of work and relationships this often brings about.

IV. Psychotherapy

The absence of a common control condition and head-to-head pharmacological versus psychological treatment trials makes comparison of the relative efficacies of these treatment approaches difficult. This is compounded by the fact that a significant number of participants in psychological treatment trials are continuing pre-existing pharmacological treatment at the same time.

It is well accepted that a well-masked, placebo-controlled trial is a tougher test for an experimental intervention than a trial with a waiting-list control. The UK's NICE guidelines development group attempted to address this by determining a higher effect size threshold for psychological treatments than pharmacological ones (0.8 v. 0.5), (NCCMH, 2005), but it is unclear whether such arbitrary cut-offs may have introduced bias against either form of treatment.

Changes in Communication Patterns

The most significant consequence of a trauma is how it affects the communication with oneself and with others. From negative thoughts about oneself to anxiety when talking to others, a trauma impairs the most global and most important mechanisms of any living organism, the exchange of information. It is through communication that we perceive, feel and change our environment, and disturbances in it lowers these abilities and an individual's confidence and sense of efficacy in the world.

Communication Space

Traumas do not have to be caused by other people, however, the most devastating ones often are. A trauma makes the world a less predictable and less safe place. Trust in the world, and by extension in oneself, is shattered by the effect the trauma has on how one estimates risk, but most importantly on the emotions it evokes, which are communicated. Silence amplifies the effect of the trauma.

Communication space describes the space across which communication can take place in a given moment. If someone in Europe is on the phone with a relative in Australia, then communication space extends to this person in Australia, but probably not to the next-door neighbor. Communication space changes as one becomes receptive to messages from different sources and can send messages to different people.

Trauma often brings with it social withdrawal, a shrinking of the communication space. This often is a protective mechanism, as the organism tries to avoid further hurt, but it also makes it more difficult to communicate one's thoughts and emotions, which could help against the symptoms of the trauma. The vicious cycle of less communication leading even to a further decline in communication often causes patients to get stuck in their PTSD. The way to get 'unstuck' is to develop insight into what is going on and develop the skills to escape from it through communication. This usually requires being able to take a step back, which can be practiced in the therapeutic process.

Protection vs Communication

A trauma often does not cause direct physical harm, but it has an effect on the organism through the changes it triggers in it. Someone who gets hit by a sudden trauma or is exposed to traumatic experiences over a long period of time becomes confronted with emotions and thoughts that are directed at avoiding another trauma and helping the organism to adjust to the world after the trauma. Since the scope of traumatic situations in the modern world shifts faster than evolution could follow, the ingenuity and innovativeness of the higher brain functions needs to be activated. Unlike the emotions, it can adapt to changing situations quickly, if the required openness exists and anxiety is not too high. There can be a conflict, however, between an emotional reaction that tries to protect the organism and an emotional and cognitive reaction that wants to communicate and 'solve' the trauma.

Emotional Communication

The emotions are strong signals made up from an enormous amount of information received in the nervous system. As the name "e-motion" suggests, their purpose is to bring about some movement or change. However, in many situations this may not seem possible to the person in the short run, and so the emotion stays around. In face of strong emotions, the organism tries to cut its links with the environment to protect itself. This, however, removes an important area where motion could be possible, and the emotion resolved, namely communication.

Communicating an emotion helps to resolve it. To the brain it makes little difference whether one carries bricks for a bridge or draws a plan for a bridge. If one feels that there needs to be a bridge, both are steps that will eventually lead to a bridge. Emotions can be resolved in many ways, as long as something constructive happens. Communication is one way of doing this, because all one's interactions with the world are based on information flows, whether between nerve cells and muscles, vocals cords and air, air waves and the ear membrane, and so on. It is only important that some meaningful information is transmitted. Beating on air with a fan just for the purpose of a refreshing wish of air, is just that.

After a trauma, it is not easy to get a patient to move from self-protection to communication. The important bit is to engage with the patient and make him or her feel safe in the process. This usually requires reflecting on communication, what it means, and how the patient interprets, processes and responds to certain messages.

Reconnecting

The goal is to reconnect with oneself and with the world. The tool to accomplish this is through meaningful in the context of a facilitating relationship, such as in a patient-therapist interaction. To be meaningful it requires that there is a genuine willingness to understand and empathy on the therapist's side and an interest for the process on the patient side. Part of the therapeutic process is educating a patient on how this can be accomplished, from recalling situations or thoughts and identifying associated emotions to reflecting on how one feels in the moment. The important element is, however, that the patient has a sense that the therapist understands what he or she is experiencing. This understanding helps the patient to feel safer and willing to embark on a therapeutic process because it communicates that there is a commonality, a process shared by humans in general, which is understandable and predictable.

Reconnecting with one's emotions happens through the ability to identify emotions and decode their meaning. In other words, reconnecting is about being able to see and understand meaning in information, such as the information provided by the emotions in this instance. The first step in reconnecting is usually to appreciate that the emotions contain not only valuable but also quite specific emotion, which can be helpful to the individual.

Safety and Certainty

When something has happened, which is not supposed to happen, it seems a formidable task to get the patient used to the fact that what happened has been a statistical outlier, something that usually does not happen in this world. Since some of the most severe traumata happen on the interpersonal level, through exchanging meaning, including individual perspectives and values, in therapy, the patient can again rebuild trust in others and in oneself.

It is difficult to see meaning in losses and crimes, and one is not supposed to. The meaning is likely to be in the response. If life can be made safer in the future, then this is where the meaning is. It will difficult to decode the meaning conveyed by a hurricane, but it is conveyed by how people respond to it. Life overall is tenacious, and that also helps the individual.

Psychodynamic Psychotherapy and CBT

Both therapies have shown effectiveness in the treatment of PTSD. Both have theories about why they help. The former sees learning processes about certain thought processes as central, the latter psychodynamic processes that bring about a change. However, they both neglect the communication process and changes in how people communicate as what ultimately helps. The difference to interpersonal psychotherapy is that the latter focuses more on the interpersonal setting than the actual communication processes.

The tool that helps in the end is the communication between therapist and patient which can bring about change through the meaningful messages that are exchange in it. This is why focusing on communication in the first place, can help bring about deeper and lasting change. Communication is this sense consists of the communication patterns and the way information is processed and meaning extracted from the information. Most psychotherapeutic approaches focus on specific content or how thoughts and emotions are processed, rather on the underlying process, which is the information processing.

V. Communication-Focused Therapy (CFT)

Communication-Focused Therapy (CFT) was developed by the author to focus more specifically on the communication process between patient and therapist. The central piece is that the sending and receiving of meaningful messages is at the heart of any change process. CBT, psychodynamic psychotherapy and IPT help because they define a format in which communication processes take place that can bring about change. However, thy do not work directly with the communication processes. CFT attempts to do so.

We engage constantly in communication. The cells in our bodies do so with each other using electrical current, molecules, vibrations or even electromagnetic waves. People communicate with each other also through a multitude of channels, which may on several technologies and intermediaries. It does not have to be an email. Spoken communication requires multiple signal translations from electrical and chemical transmission in the nervous system to mechanical transmission as the muscles and the air stream determine the motions of the vocal chords and then as sound waves travelling through the air, followed by various translations on the receiving end. At each end, in the sender and in the receiver, there is also a processing of information which relies on the highly complex networks of the nervous system. Communication, in short, happens everywhere all the time. It is an integral part of life. Certain communication patterns can, however, also contribute to experiencing anxiety and panic attacks.

Autoregulation

Communication is an autoregulatory mechanism. It ensures that living organisms, including people, can adapt to their environment and live a life according to their interests, desires, values, and aspirations. This does not only require communicating with a salesperson, writing an exam paper or watching a movie, but also finding out more about oneself, psychologically and physically. Whether measuring one's strength at the gym or engaging in self-talk, this self-exploration requires flows of relevant and meaningful information. Communication allows us to have a sense of self and a grasp of who we are and what we need and want in the

world, but it has to be learned similar to our communication with other people.

Insight

Within the meaningful interactions of therapist and patients, or in any other relevant setting, if it s working well, relevant messages are generated which have the power to bring about change. Messages can bring about change if the recipient regards it as relevant and it contains some new information. The processing of this new information adds something to the recipient, even if the content is rejected as false. In other words, every meaningful interaction gets us further, helps us develop insight into ourselves and the world.

Especially in the case of PTSD, this insight is relevant because it makes the world predictable again. One may not understand why the hurricane hits a specific village or why a parent was abusive, but to realize that how such horrible experiences are processes has a certain course and is predictable, makes the world a better place again.

Integration

The therapeutic setting should also make it easier to determine in a safe environment that the person with issues is not the victim, but the perpetrator, if there is one. Insight into certain disasters or catastrophes helps, because it helps shifts the focus to where the issue is, rather than oneself.

At a later stage, communication should be seen as a tool to integrate all the information into one's perspective of the world. A patient needs to be able to integrate the information from the trauma to an extent that it no longer feels as an alien object or emotion in the mental landscape. To get there may require a new perspective on communication and new ways of working with it, which can be learned and trained in the therapeutic session.

Integration means not necessarily seeing meaning in the traumatic event, but in how one reacts, thinks and feels about it. This should correlate with one's needs, wants, aspirations and values. One cannot choose a traumatic event, but one can choose how to react to it, and this goes a long way to feeling whole and well. It needs to make sense in the context of one's sense of oneself.

Understanding PTSD

The trauma is highly personal. Some people may interpret something as a trauma, which others do not. Much depends on one's outlook on life and one's past experiences. It is highly subjective. However, in many extreme situations, it is unlikely that there is no traumatization in even the most resilient person. Rape or torture in the vast majority of cases cause symptoms of PTSD, sometimes with a substantial delay of years or even decades.

PTSD is subjective because it is generated from the interaction between one's basic parameters, view of the world and oneself, basic needs, aspirations and values, and the trauma, which is roughly equivalent to saying how the information about the trauma is processed by oneself. Since information transmission and communication plays such an important role in trauma, these are also the processes that can be used to treat it.

The Trauma

Trauma does not require physical harm or wounds. Rape, for example, does not have to leave physical scars, but it usually does leave psychological ones. To understand trauma, one needs to understand that physical integrity is usually complimented by psychological integrity, a sense of self and person which is a whole and deserves respect as such. Communication can be used as a weapon to inflict great psychological harm.

Often, there are already maladaptive communication patterns before, that cause the problems in the relationship or interpersonal interactions. These patterns can be analyzed and changed. In the processing of the trauma the patterns of communication with oneself and others play a significant role. Since the communication on the inside and on the outside are at least to some degree partial reflections of each other, changing one, can help influence the other. This is why developing insight and skills through the communication processes in the therapeutic setting also have a beneficial influence on the communication a patient has with himself or herself. The blurring between internal and external communication, however, can also maintain the trauma. Since information does not carry a tag about its source, fears can seem real and reality be willed with representations of emotions and thoughts which have remained unresolved from the trauma.

A trauma is a blow to the representation of the world and the self. Just reconstructing everything as it was before is usually not an option, since this would require unmaking the trauma also in the real world. Denial and repression may try to accomplish this, but at some point, they will break down as patients diverge increasingly from the fabric of reality in their thoughts, behaviors and decisions. Only by finding ways to get back to the shared reality, rather than farther away from it, can feelings of belonging and efficacy in the world through interactions with others, and oneself, be reestablished. Thus, focusing on how individuals suffering from PTSD communicate with themselves and others to steer their life according to their values, needs and desires is important to reconnect them with a reality that can meet their needs.

Uncertainty

In life, one has to live with uncertainty. Uncertainty just means that there is no manual in the beginning and there are still unknowns which leave room for excitement and exploration. Life is a learning experience. An individual suffering from anxiety may have areas in life where she thrives on excitement, and other areas where images of worst-case scenarios cause her to freeze when she just considers a change in action or any action at all. Uncertainty to someone suffering from anxiety seems to be bearable in some areas and avoided in others. Often, the areas where it is not tolerated feel meaningful only to the person suffering from anxiety.

Communication Deficits

Areas which people often feel anxious about are where there has been an issue with their interpersonal interactions in the past. Early traumata, like a disappearing or abusive parent, stay unresolved. For example, if a parent feels fearful and angry with himself and this is picked up by a child, the latter may decode these messages correctly in that the parent is angry, but since the parent may not be conscious about it, the child does not pick up on the second important half of the message, that the parent has a problem with himself and his issue is unrelated to the child. Of course, one can learn to pick up on the self-blame and frustration of the parent, and therapists should become experts at reading between the lines in this fashion, but it requires experience, reflection and insight into transference and counter-transference phenomena, for example, to use the psychoanalytic terms.

Avoidance

Anxiety can lead to avoidance, which in turn can attach even more anxiety to the situations or behaviors which are being avoided. In social situations, not interacting with others deprives the person of continuously updating and honing the skills and confidence of interacting with others. Avoidance can thus lead to an increase rather than a decrease in anxiety in the long-run.

Meaning

Individuals suffering from anxiety and panic attacks often see less meaning in the things they do. In therapy an important part is to rediscover meaning and find it in the things that are relevant to the patient. Relevant is anything that is close to his or her values, basic interests, aspirations, wants, wishes and desires.

An important step in therapy thus to make the person aware of how anxiety affects one's thinking. Individuals from anxiety often focus differently from other individuals. There is often a focus on worst outcomes and strong fears which are caused by it. Underlying this are often strong emotions or conflicts which need to be defended against. The danger and uncertainty is quite frequently inside oneself, rather than on the outside. An individual with a fear of flying may be more afraid of not containing oneself and not being able to leave the plain than anything else. Anxiety is the fear of crashing oneself and the feelings of a dreaded uncertainty about oneself and one's emotional states.

Meaning of the Trauma

A traumatic event is communicated, relevant and has the potential to bring about a change in the recipient, if that individual is ready to receive and identify a message in it. It is therefore meaningful. However, more interesting and helpful is the meaning one can identify in the response to the trauma, which may be the real meaning of the trauma. Often in traumatic situations, once the aftermath has been dealt with, to the extent this is possible, things may become clearer, and if a patient uses communication in a helpful way, the emotions and thoughts triggered by the trauma can be reflected upon.

Traumata can get processes moving that have been stuck or bring misplaced information closer to awareness. This is not to say that a trauma is good, or even therapeutic, but that a trauma can generate a significant amount of meaning which would not have been produced otherwise. The responses to trauma contain information which is often not available to consciousness, whether because it never seemed relevant, even though it is, has been repressed or a relevant association between it and something else has never been made. In any case, most of the meaning can be found in the response to the trauma rather than in the trauma itself. This is then also the starting point for the therapeutic process, where communication is used to give the patient the tools to distill meaning from his or her response to the trauma.

Integration of the Meaning into the Sense of Self

The important next step is to integrate the effect it has on the individual into the individual's sense of self. In the case of the hurricane, it may be that one is sad and angry about the loss of a loved one, but that hurricanes, storms, and the changing weather itself, is a part of a dynamic changing world in which one lives as a human being. Identifying the emotions and one's response, as well as the needs, aspirations and values that seem relevant in the context of the trauma and the response to it, provides the information needed to identify meaning and integrate the trauma into the sense of self.

Integrating a traumatic event into the self means that some change in interacting with oneself and others will result, even if a person's basic needs and wants to remain the same. Since the self is a product of observing communication flows, the sense of self will be affected by the trauma, although this can be in a

positive rather than in a negative way. The sense of self evolves over time throughout life, as information flows change, it can become better defined and feel stronger, since over time there is more experience about communication with oneself and others and the effects of changing flows of meaningful information and the responses to them.

Experiencing the World

To break through the vicious cycle of anxiety, in which emotions like fear and anxiety cause safety thoughts and behaviors, which in turn reinforce feelings of fear, loneliness, sadness, and so forth, it is helpful to focus on identifying what is meaningful and having more of it in life. Communication helps in identifying and finding meaning, either communication with oneself or with others. The exchange of messages is like a learning process in which meaning can be identified, found and accumulated. Through meaningful interactions one accumulates more meaning, more connectedness with oneself and the world and reduces the need for thoughts and behaviors which are triggered by fears, guilt, self-blame and other negative emotions. This also helps against depression and anxiety.

Perceiving more meaning also makes interacting with others and oneself more meaningful. This has a positive effect on one's interaction patterns, how and in which one way one relates to one's environment and exchanges messages with it. Knowing more sharpens and strengthens the sense of self, which is particularly helpful in patients suffering from PTSD.

Change

A trauma has the power to change how one experiences the world, even though no one wishes for this change. However, one has a choice over the flavor of this change, whether it changes the meaning one gives to aspects of the world. In the best-case scenario, one may even see more in the world, more meaning, than before. At a minimum, therapy should make it possible to exchange information about the meaning aspects of the trauma have to the person and be understood by the therapist. If the therapist does not understand a particular piece, he or she should ask to get at least a good sense for it to be able to engage in the process which ultimately creates new meaning through the exchange of meaningful messages.

Values, Needs and Aspirations

Often, individuals suffering from PTSD lose track what is important to them and the fit between these values and interests and their current life situation. This then leads not only to various psychiatric symptoms, but also to life decisions which may be too risk-averse or too risk-seeking, for example.

When patients learn to reconnect with themselves and get a better insight into their values, needs and aspirations, it helps to make better decisions but also to use interactions with others to find one's needs, aspirations and values met. Since communication with oneself and others is the mechanism by which this will be accomplished, and they are reflected in one's communication and interaction patterns, there is a strong link between the self-image and the use of communication. They are closely linked.

Self-Image

The conception of the self and the view of the own personality attributes together make up how one sees oneself. Values, basic interests and aspirations play a major role are basic parameters that must align with the self-image. If the self-image does not align with them, there is a weakness in the self-image which can cause problems in stressful situations, under high expectations or after traumatic events. Since no one prepares for a traumatic event, the alignment of self and basic parameters plays a role mostly in the post-event therapeutic process.

Development

Developing the values, needs and aspirations further means getting more detailed information about them. Insight and skills n the communication process play here an important role, because it is through communication with oneself and others that the basic parameters can be identified in greater detail. Especially after a traumatic situation, a more detailed knowledge of them can give a greater sense of stability and help to connect with them.

Greater insight is a way to develop the basic parameters further, but it is also through the experimentation in the communication processes one has with oneself and others that they can be extended into new areas. If one has no knowledge or exposure to a specific event, one's values, needs and aspirations can not reflect it. However, often a value in a more specific situation can be deduced from a more basic value, if one become aware of the specific situation or event. Still, deduction alone is not enough, because the more specific value or need, and possible conflicts between more basic values and needs, could not be specified without awareness of the existence of the event or situation. Communication is the mechanism which delivers this information, and through which one can become of specific situations and events, and thus of more detailed knowledge about one's basic parameters.

Meaningful Messages as the Instrument of Change

Communication is the vehicle of change. The instruments are meaningful messages which are generated and received by the

people who take part in these interactions. In a therapeutic setting, keeping the mutual flow of information relevant and meaningful brings change in both people who take part in this process. The learning curve for the patient may be steeper in certain respects because he or she spends less time in this interaction style than a therapist.

Maintaining the Communication Process

The process through which change can occur in many cases runs automatically, since communication processes are inherently autoregulatory, if one lets them run their course. However, in a number of cases people get stuck in PTSD. Change requires meaningful communication, and if a patient becomes afraid of the process or loses faith in it, constructive and dynamic communication can effectively shut down. Communicating about the trauma and the emotions that are associated with it can cause fears, which over time are also best addressed with communication.

Overcoming Fears

The thought of engaging in communication about emotions or thoughts that are close to one's sense of self can invoke fears. Underlying those fears are often other emotions, such as anger, resentment or guilt or self-blame.

Reconnecting

The reason of communicating emotions is uncertainty about and a disconnect from them. However, to reconnect, communicating with oneself is necessary, which is difficult because one's image of the self may not correlate with the attributes retrieved from one's emotions and thoughts. Regardless of whether an individual has suffered from a trauma, discovering attributes of one's self and personality is a continuous process. To overcome the fear of self-discovery, it important to realize that changes to one's concept of the self are made throughout one's life. Since information flows overall are largely determined by biology, which can be plastic, but mostly remains relatively constant, a pre-determined basic sense of self exists relatively constant over time. One may say, that throughout one's life the concept of the self approaches increasingly this basic self.

Safe Space

A therapist should provide a setting that feels safe enough to engage in the process but be inquisitive and active enough to move the process along if there are resistance points coming up, whether in the patient or the therapist. In any instance, the therapist should be alert, thoughtful, reflecting, be able to take a view from a distance, and be empathetic. The approach the therapist takes to communicating with the patient largely determines how safe the letter can feel in a therapeutic session and the success of the therapy.

Experimentation

In a safe space the patient can experiment with different communication patterns and approaches to the interaction with the therapist and others, which not only helps reconnecting with the world around, but also with oneself. This then builds the confidence to become more inquisitive in the communication process, and to acquire the skills to use it to one's advantage.

New Meaning and Integration

The construction of new meaning and the integration of this into one's sense of self is one of the primary goals of the therapy of PTSD. This also includes addressing, resolving and integrating emotions into the self in a meaningful way. The end result should make the trauma an event in the past, whose story is integrated into the much larger story of the individual.

Individual Narrative

The individual narrative is a series of interactions with others and oneself. It is important because it injects life events with additional meaning in relation to one's personality and sense of self. Humans have a need for a well-rounded narrative or life story, because it makes it easier to decide in the present and makes the future seem more predictable.

A trauma has an impact on one's life story. However, one needs to separate the events from the responses it triggers, one's thoughts, emotions and behaviors in the face of and after the traumatic event. It is less the actual event of the trauma than the individual response to it, which needs to be integrated in one's life story. However, doing this requires the reconnection with oneself, one's thoughts and emotions as already described above. If one's response does not fit the image has about oneself, either the response has to be change in the future or one's image of self needs to change.

Change in Response or Change in Self-Image

This may seem like a stark choice, but it is at the heart of how to manage trauma. The trauma is not one's choosing, so it does no reflect of one's self or personality. The response, however, is of one's choosing, and it will reflect on how one sees oneself. Of course, it is important not to forget that a traumatic event is a special situation, which may elicit unusual responses, but even the fear of a response is a response and will form part of how the individual sees himself or herself in the future.

Reconnecting with oneself and discovering more about one's values, needs and aspirations as well as one's emotions and personality traits helps to create responses that are more in tune with oneself, and the blow to the self from a trauma in future will be lower, because the divergence between conceived self and basic self is smaller.

Reducing the Divergence between Conceived Self and Basic Self

In the long-run, the more one's image of oneself and the basic sense of self are closer aligned the easier is it to manage traumatic situations. The basic sense of self is, as described above, how one perceives the information flows inside oneself and also with the respect to the environment. 'Alignment' does not mean that they have to be identical, but that the conceived self extends the basic self in a valuable way. In the treatment of trauma, patients need to rediscover attributes of their basic self and have the courage to experiment with extensions to it. This set of attributes then helps in the face of adverse life events.

Using Communication to Integrate Information

Communication with oneself and others also has the purpose to integrate flows of information and meaningful messages into a coherent sense of oneself. A trauma usually shatters a coherent sense of self, or at least pushes strongly against it, which leads to greater vulnerability and many of the post-traumatic symptoms. To make the sense feel more whole and coherent again requires a shift in perspective, a change in how one sees oneself and the world, which is facilitated by having a good connection with oneself and the world around. Learning to observe communication, the exchange of meaningful messages, and developing the skills to shape it in a way that makes change, adaptation and healing possible, is a central piece of therapy.

VI. Conclusion

Clearly, there are a number of tools available which have been shown to be helpful in the treatment of PTSD. Psychotherapy should always be included in a treatment package with a focus on the communication and interaction between patient and therapist.

Declaration of Interests

The author reports no competing interest.

References

Abrams TE, Vaughan-Sarrazin M, Rosenthal GE: Variations in the associations between psychiatric comorbidity and hospital mortality according to the method of identifying psychiatric diagnoses. Journal of General Internal Medicine 23:317–322, 2008 Crossref, Medline

Ashton CM, Petersen NJ, Souchek J, et al.: Geographic variations in utilization rates in Veterans Affairs hospitals and clinics. New England Journal of Medicine 340:32–39, 1999

Bisson JI, Ehlers A, Matthews R, Pilling S, Richards D, Turner S. Psychological treatments for chronic post-traumatic stress disorder: systematic review and meta-analysis. Br J Psychiatry 2007; 190: 97–104

Cabana MD, Rand CS, Powe NR, et al.: Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA 282:1458–1465, 1999

Capehart BP: Benzodiazepines, posttraumatic stress disorder, and veterans: good news and why we're not done yet. Journal of Clinical Psychiatry 73:307–309, 2012

Corrigan PW, Steiner L, McCracken SG, et al.: Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. Psychiatric Services 52:1598–1606, 2001

Davidson J, Baldwin D, Stein DJ, Kuper E, Benattia I, Ahmed S, et al. Treatment of posttraumatic stress disorder with venlafaxine extended release: a 6 month randomized controlled trial. Arch Gen Psychiatry 2006; 63: 1158–65

Ernst ME, Lund BC: Renewed interest in chlorthalidone: evidence from the Veterans Health Administration. Journal of Clinical Hypertension 12:927–934, 2010

Gravely AA, Cutting A, Nugent S, et al.: Validity of PTSD diagnoses in VA administrative data: comparison of VA administrative PTSD diagnoses to self-reported PTSD Checklist scores. Journal of Rehabilitation Research and Development 48:21–30, 2011 Crossref, Medline

Harpaz-Rotem I, Rosenheck RA: Tracing the flow of knowledge: geographic variability in the diffusion of prazosin use for the treatment of posttraumatic stress disorder nationally in the Department of Veterans Affairs. Archives of General Psychiatry 66:417–421, 2009 Crossref, Medline

Haverkampf, C. J. (2012). A Case of Severe Panic Attacks. *J Psychiatry Psychotherapy Communication*, *1*(1), 12–19.

Haverkampf, C. J. (2013). A Case of Borderline Personality Disorder. *J Psychiatry Psychotherapy Communication*, *2*(2), 75–80.

Haverkampf, C. J. (2015). Treatment-Resistant Social Anxiety. *J Psychiatry Psychotherapy Communication*, *4*(4), 117–123.

Haverkampf, C. J. (2017). Communication-Focused Therapy

(CFT) for Depression. *J Psychiatry Psychotherapy Communication*, *6*(4), 101–104.

Hermos JA, Young MM, Lawler EV, et al.: Long-term, high-dose benzodiazepine prescriptions in veteran patients with PTSD: influence of preexisting alcoholism and drug-abuse diagnoses. Journal of Traumatic Stress 20:909–914, 2007 Crossref, Medline

Hertzberg MA, Feldman ME, Beckham JC, Kudler HS, Davidson JR. Lack of efficacy for fluoxetine in PTSD: a placebo controlled trial in combat veterans. Ann Clin Psychiatry 2000; 12: 101–5.

Hoge CW, Auchterlonie JL, Milliken CS: Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 295:1023–1032, 2006 Crossref, Medline

Hoskins, M., Pearce, J., Bethell, A., Dankova, L., Barbui, C., Tol, W. A., ... & Bisson, J. I. (2015). Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis. The British Journal of Psychiatry, 206(2), 93-100

Jain S, Greenbaum MA, Rosen C: Concordance between psychotropic prescribing for veterans with PTSD and clinical practice guidelines. Psychiatric Services 63:154–160, 2012

Krein SL, Hofer TP, Kerr EA, et al.: Whom should we profile? Examining diabetes care practice variation among primary care providers, provider groups, and health care facilities. Health Services Research 37:1159–1180, 2002 Crossref, Medline

Leslie DL, Mohamed S, Rosenheck RA: Off-label use of antipsychotic medications in the Department of Veterans Affairs health care system. Psychiatric Services 60:1175–1181, 2009

Leucht S, Hierl S, Kissling W, Dold M, Davis JM. Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. Br J Psychiatry 2012; 200: 97–106

Lund BL, Abrams TE, Bernardy NC, et al.: Benzodiazepine prescribing variation: an examination of clinical uncertainty in posttraumatic stress disorder. Psychiatric Services (Epub ahead of print, Oct 15, 2012); doi: 10.1176/appi.ps.201100544

Lund BC, Abrams TE, Gravely AA: Rebuttal to Gravely et al "Validity of PTSD diagnoses in VA administrative data: comparison of VA administrative PTSD diagnoses to self-reported PTSD Checklist scores." Journal of Rehabilitation Research and Development 48:vii–ix, 2011 Medline

Lund BC, Bernardy NC, Alexander B, et al.: Declining benzodiazepine use in veterans with posttraumatic stress disorder. Journal of Clinical Psychiatry 73:292–296, 2012 Crossref, Medline

Management of Post-Traumatic Stress. VA/DoD Clinical Practice Guideline. Washington, DC, US Department of Veterans Affair and U.S. Department of Defense, 2010. Available at www.healthquality.va.gov/PTSD-FULL-2010c.pdf. Accessed Dec 14, 2011

McLay RN, Klam WP, Volkert SL: Insomnia is the most commonly reported symptom and predicts other symptoms of post-traumatic stress disorder in US service members returning from military deployments. Military Medicine 175:759–762, 2010 Crossref, Medline

Mohamed S, Rosenheck RA: Pharmacotherapy of PTSD in the US Department of Veterans Affairs: diagnostic- and symptom-guided drug selection. Journal of Clinical Psychiatry 69:959–965, 2008 Crossref, Medline

Mohamed S, Rosenheck R: Pharmacotherapy for older veterans diagnosed with posttraumatic stress disorder in the Veterans Administration. American Journal of Geriatric Psychiatry 16:804–812, 2008 Crossref, Medline

Morin CM, Bastien C, Guay B, et al.: Randomized clinical trial of supervised tapering and cognitive behavior therapy to facilitate benzodiazepine discontinuation in older adults with chronic insomnia. American Journal of Psychiatry 161:332–342, 2004 Link

National Collaborating Centre for Mental Health (NCCMH). Post-traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. British Psychological Society/Royal College of Psychiatrists, 2005.

Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. Clinical Practice Guideline 26. London, National Institute for Health and Clinical Excellence, 2006. Available at guidance.nice.org.uk/CG26/Guidance. Accessed Dec 14, 2011

Rickels K: Are benzodiazepines overused and abused? British Journal of Clinical Pharmacology 11(suppl 1):71S–83S, 1981 Crossref, Medline

Risse SC, Whitters A, Burke J, et al.: Severe withdrawal symptoms after discontinuation of alprazolam in eight patients with combat-induced posttraumatic stress disorder. Journal of Clinical Psychiatry 51:206–209, 1990 Medline

Stein DJ, Zungu-Dirwayi N, Van der Linden GJ, Seedat S. Pharmacotherapy for posttraumatic stress disorder. Cochrane Database of Systematic Reviews 2004; issue 2.

Valenstein M, Taylor KK, Austin K, et al.: Benzodiazepine use among depressed patients treated in mental health settings. American Journal of Psychiatry 161:654–661, 2004 Link

Voshaar RC, Gorgels WJ, Mol AJ, et al.: Tapering off long-term benzodiazepine use with or without group cognitive-behavioural therapy: three-condition, randomised controlled trial. British Journal of Psychiatry 182:498–504, 2003

Weisberg RB, Dyck I, Culpepper L, et al.: Psychiatric treatment in primary care patients with anxiety disorders: a comparison of care received from primary care providers and psychiatrists. American Journal of Psychiatry 164:276–282, 2007